Failures in surveillance and monitoring led to missed opportunities for cancer diagnosis
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In a decision by Deputy Commissioner Carolyn Cooper, a radiologist and a urologist were found in breach of the Code of Health and Disability Services Consumers' Rights (the Code) as they did not recommend or arrange appropriate follow-up for a woman diagnosed with cancer, thereby failing to provide services with reasonable skill and care.

The woman was diagnosed with a renal cell carcinoma (RCC) requiring surgery to remove her kidney. Before the surgery, the woman had a CT scan to assess the stage of the cancer. In reporting the CT scan, the radiologist identified an abnormality in the woman's lung but did not make a diagnosis or recommend follow-up. Following the surgery, the urologist intended to see the woman for a 12-month follow-up review and arrange surveillance imaging, but this did not occur. About two years after the surgery, the woman was diagnosed with advanced lung cancer and sadly died shortly afterwards.

In their complaint to the Health and Disability Commissioner, the woman's family raised concerns that inadequate radiology reporting and inadequate follow-up after surgery resulted in a delayed diagnosis of her lung cancer.

In her report Ms Cooper highlighted the need for radiologists to follow current guidelines for written radiology reports, including possible diagnoses if anything appeared abnormal, and appropriate recommendations to follow-up. She highlighted the importance of robust processes for postoperative follow-up and surveillance after surgery to remove cancer.

"I want to acknowledge the distressing impact of these events on the woman and her family. Given the advanced stage of her lung cancer at the time of diagnosis and the devastatingly short timeframe between diagnosis and death, it is understandable that her family sought an independent review from HDC."

Ms Cooper found that the radiologist failed to report on the findings of the woman's CT scan adequately and failed to make appropriate recommendations for follow-up.

"In my view, in failing to report on the findings of the [abnormality] in the right lung adequately and make appropriate recommendation for follow-up, the radiologist did not provide services to the woman with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights."

Ms Cooper found that the urologist did not have adequate processes in place to ensure that appropriate follow-up review and surveillance imaging was arranged after the woman's kidney surgery.

She found timely follow-up imaging was not arranged in accordance with relevant guidelines (either at six months or one year postoperatively). As a consequence an opportunity to diagnose and treat her lung cancer at an earlier time was missed.

“In my view the urologist failed to provide services to the woman with reasonable skill and care and, accordingly breached Right 4(1) of the Code,” said Ms Cooper.

Ms Cooper recommended the radiologist arrange for a clinical peer review of the standard of his radiology reporting.

She recommended the urologist provide an evaluative report on the effectiveness of the changes that were implemented as a result of this case, and advise of any further changes made or considered as a result of the evaluation. He was also required to apologise in writing to the family.

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