Opportunities to detect lung mass missed in two consecutive X-rays

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The Deputy Health and Disability Commissioner Dr Vanessa Caldwell has found a radiologist in breach of the Code of Health and Disability Services Consumers' Rights (the Code).

The breach involves the care provided to a 70-year-old man prior to the diagnosis of lung cancer. Leading up to the diagnosis, errors were made in the reporting of his chest X-rays.

Dr Caldwell says, "For failing to identify the mass in chest X-rays in 2018 and 2019, the radiologist did not provide the consumer with an appropriate standard of care, in breach of Right 4(1) of the Code."

This is the right for consumers to have services provided with reasonable care and skill.

"The radiologist had two opportunities to identify the mass," said Dr Caldwell. "I consider that a radiologist exercising reasonable care and skill would have detected the mass in both the 2018 and 2019 X-rays."

Dr Caldwell noted while it cannot be determined whether earlier detection of the lung cancer would have changed the consumer's long-term prognosis, later detection meant the consumer was denied the chance for earlier treatment. By the time the consumer's lung cancer was identified, it was inoperable.

Dr Caldwell considered the errors to be individual and the DHB (now Te Whatu Ora) had not breached the Code. However, she reminded Te Whatu Ora of its obligation to ensure consumers have services provided with reasonable care and skill, and for employees to have the conditions necessary to perform their work to an appropriate standard.

The radiologist will be referred to the Director of Proceedings to determine whether legal proceedings should be taken.

Additionally, Dr Caldwell made several recommendations including:

- For the radiologist to provide a written apology to the consumer.
- For the Medical Council of New Zealand to consider the radiologist's fitness to practise should he return to practice, and consider if a review of his competence is required.
- That Te Whatu Ora conduct an audit of the radiologist's plain chest X-ray images taken between July 2018 and July 2020 to determine if they were reported correctly.

Since the complaint, Te Whatu Ora has made a number of changes, including installing new X-ray, CT and MRI scanning equipment. A number of new staff have also since been employed in this team. All radiologists are required to participate in the Royal Australian and New Zealand College of Radiology Continuing Professional Development programme.

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