Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

# Canterbury DHB and a physician breached Code for delaying the diagnosis of a man's lung cancer

## 20HDC00132

Canterbury District Health Board (DHB) (now Te Whatu Ora Waitaha Canterbury) and a physician breached the Code of Health & Disability Services Consumer's Rights (the Code) for delaying the diagnosis of a man's lung cancer.

The man presented to an emergency department several times with chest pain and was diagnosed with angina. A chest X-ray taken during one of the admissions identified a mass on his right lung, and a CT scan was recommended by the reporting radiologist.

This recommendation was not actioned, and the man was not told of any abnormality in the X-ray. When the man was admitted over a month later, a CT scan was taken. At this time, the man was told there would be further investigations to confirm suspected lung cancer, including a biopsy. However, he was not told that the mass on his lung had been identified in an earlier X-ray and not followed up.

An X-ray, performed on the same day as the biopsy, noted the mass in the man's right lung had increased in size from when it was first identified. The man unfortunately died from lung cancer the following year.

In his complaint to HDC, the man noted that decisions were made without his knowledge concerning his condition and treatment. He was not fully informed about his condition and had no opportunity to question his treatment. He also expressed concern that his frequent admissions to the ED could have been an indicator of the lung cancer and should have been investigated further.

Deputy Health and Disability Commissioner, Deborah James, found the physician's failure to act on the radiologist's report of the chest X-ray delayed the diagnosis of lung cancer for approximately four weeks. She found the physician in breach of Right 4(1) of the Code, which states that every consumer has the right to have services provided with reasonable care and skill.

Ms James also noted that, despite several different clinicians in two different departments being aware of the failure to action the radiologist's report, no clinician took responsibility for ensuring that the man was informed of this error at the earliest opportunity.

"Systemic issues at Canterbury DHB constituted a failure to ensure that the man had all the information that a reasonable consumer in his circumstances would expect to receive," Ms James said.

She found Canterbury DHB in breach of Right 6(1) of the Code, which relates to the right of the consumer to be fully informed.

Ms James recommended the physician arrange for an audit of 50 radiology reports to identify whether significant abnormal findings are being actioned.

She made a number of recommendations to Canterbury DHB, including that they:

- Audit compliance with the requirement to update discharge summaries with abnormal results that are received after a patient has been discharged, and compliance with sending the updated summary to the patient's GP.
- Introduce a further requirement that discharge summaries note any results that are still awaiting reporting.
- Audit compliance with its current policy on open disclosure, in particular the requirement that (if possible) disclosure has been made within 24 hours, and any communication with the patient documented in the patient's record.

Ms James also recommended both the physician and Canterbury DHB write a formal apology to the man's family.

14 August 2023

ENDS

***Editor's notes***

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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