Missed diagnosis of lung cancer
(10HDC00610, 29 February 2012)

Medical officer ~ Standard of care ~ Lung cancer ~ Missed diagnosis ~ Clinical examination ~ Record keeping ~ Rights 4(1), 4(2), 4(4)

A 52-year-old woman with an extensive history of smoking and a family history of lung cancer presented to her doctor on multiple occasions between June 2008 and February 2010 with complaints of persistent coughing, chest and throat pain, fever and sweating, haemoptysis (coughing up blood), and shortness of breath. The woman also had a long standing benzodiazepine dependency.

Over the 20-month period, the doctor diagnosed the woman with respiratory tract infections and acute pharyngitis and prescribed the woman antibiotics and cough medicine. During that period, the doctor did not physically examine the woman or take any steps to investigate her respiratory symptoms.

The doctor's notes were, in places, illegible and incomplete and did not comprehensively and accurately document the woman's symptoms of persistent coughing and chest and throat pain, or what examinations, if any, were undertaken. Moreover, the doctor's computer and handwritten notes were not adequately integrated.

In February 2010, the woman was taken to hospital suffering from severe chest pain. A chest X-ray revealed a large mass in the woman's lower right lung and she was diagnosed with primary lung cancer with extensive metastases in the liver, lung and mediastinum. The woman was referred to palliative care and died a few months later.

It was held that, at the very least, the doctor should have physically examined the woman and referred her for an urgent chest X-ray in May 2009. By failing to do so, the doctor breached Rights 4(1) and 4(4). The doctor should have been capable of managing the woman's drug dependency without overlooking the clear need to investigate the woman's respiratory symptoms. The doctor also breached Right 4(2) as his documentation did not meet professional standards.

The doctor no longer holds a current practising certificate. However, should he decide to return to practice in the future, the doctor was recommended to first familiarise himself with relevant guidelines and undergo additional training on clinical documentation. It was also recommended that the Medical Council undertake a competency review of the doctor before issuing him a new practising certificate.

He was referred to the Director of Proceedings, who decided not to issue proceedings.