Clinical: Patient Diagnosis and mis-diagnosis
Proactive Release: 08 May 2020

23 April 2020

9(2)(a) [redacted]

Email: 9(2)(a) [redacted]

Dear 9(2)(a) [redacted]

Official Information Act (1982) Request

I write in response to your Official Information Act request, received by us on 15 April 2020. We advised you at that time that our response may take longer to provide, due to the NZ Health system response to COVID-19 priorities.

You requested the following information.

1. **How many people have been misdiagnosed under the Counties Manukau District Health Board over the last 5 years across the country?**
2. **What ethnicity were these people who were misdiagnosed over the last 5 years?**
3. **What conditions were they diagnosed with originally,**
    - **And what was the proper diagnosis of these people over the last 5 years?**
4. **What did the hospital do to compensate those who were misdiagnosed over the last 5 years?**
5. **What part of the region were these patients from, who had been misdiagnosed over the last 5 years?**
6. **What hospital diagnosed these patients over the last 5 years?**
7. **What hospital were these patients re-diagnosed in over the last 5 years?**
8. **How many patients have died over the last 5 years from being misdiagnosed under the Counties Manukau District Health Board?**
9. **How old were these patients who were misdiagnosed over the last 5 years.**
10. **What gender were these patients who were misdiagnosed over the last 5 years.**

We have considered your request, and our ability to provide the details you are seeking. We have done so weighing the public interest in releasing this information, against the impact on our services.

For the reasons outlined below, this request is for information that is not readily available, as it relates material held mainly in individual medical files and on this basis, we wish to seek clarification from you. We are therefore consulting with you, as required by the Act, but can flag that accurate

extraction and clinical interpretation of this detail for all patients seen in the last five years by our services would take significant work.

The request, and any re-scope of it, is your decision, however, we note the following details that may assist in your considerations. Should you decide to re-scope the request, please contact us again to submit it, and we will consider that as a new request.

As context, Counties Manukau Health (CM Health) provides health and support services to people living in the Counties Manukau region (approx. 569,400 people). Our services are delivered via hospital, outpatient/ ambulatory and community-based models of care. We provide regional and supra-regional specialist services (for orthopaedics, plastics, burns and spinal services). We see more than 118,000 presentations to our emergency department each year, and employ more than 1,500 medical personnel.

We note you have used the term "misdiagnosis" as the identifier for this request for aggregated data. As context, assigning a diagnosis is the clinical process of determining which disease or condition explains a person's symptoms and signs. Often this process will see one or more diagnostic options progressively narrowed down or confirmed using medical tests, but this doesn't always lead to an immediate definitive and absolute diagnosis.

A system-wide category for identification of all 'misdiagnosis' is not currently in place, as clinical coding of patient files does not use this term, information on cases where it has occurred may emerge subsequent to treatment or not at all, and application can be subjective. We accept that cases of a misdiagnosis occur, and we fully acknowledge the potential severity of the impact for some people when this occurs.

However, there is no comprehensive collation or current report on the numbers/ characteristics of potential cases arising across all health service specialities, for either health care services we provide directly to our community from CM Health, or for those delivered via other health providers (such as primary care and private entities). This information is most consistently recorded in clinical files, and managed in direct patient care. It is not feasible for us to offer to retrospectively review all medical files for this information, validate and collate it for cases over the last five years.

As it stands, we would likely need to refuse to release information for the full extent of your request, based on Section 18(f) – being that significant research and collation from medical files would be needed to extract material sought. We have considered whether charging or extending the timeframe for responding to your request would help, as required by the Act. However, the extent of the request as it stands remains large.

While we cannot meet your exact request as submitted, we are able to provide the following information.

We understand the potential for interest in this topic by the public, and advise that our services do maintain systems to fully investigate all patient/family complaints that may raise concerns on diagnosis (delays, incorrect), incidents and serious adverse events reported. We have processes of expert and peer review to consider if clinical processes - including diagnosis were sufficient. Every

year, clinical services also systematically audit some clinical processes (such as diagnostic radiology and health screening services) to investigate episodes of care.

In some cases, where a misdiagnosis results in a Treatment Injury, the individual may be entitled to support via ACC for the impact this has on their lives. ACC will hold comprehensive data on those claims.

The Health and Disability Commission has robust processes in place to investigate complaints, including those made by individuals who believe misdiagnosis has occurred. The Commission make their investigation findings and recommendations publicly available.

The Health Quality and Safety Commission also publicly reports each year on Serious Adverse Events, including sharing learning from provider investigations where the processes related to diagnosis adversely impact a patient's care;

- https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Learning-from-adverse-events2019-web-final.pdf

As noted above, we are willing to consider a revised request – potentially related to more specific elements of this matter. Alternatively if you wish to withdraw your request, please advise us, so that we do not further progress responding to this request with our services at this time.

If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive Officer
Counties Manukau Health