Medical Centre

Doctor, Dr C

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01694)

Table of contents

Executive summary 1

Complaint and investigation 2

Information gathered during investigation 2

Opinion: Dr C — breach 6

Opinion: Medical centre — no breach 7

Recommendations 8

Follow-up actions 8

Appendix A: Independent advice to the Commissioner 9

Executive summary

1. Ms A, aged 50 years at the time of these events, had been a patient of Dr B at a medical centre for over 20 years.

2. On 14 June 2016, Ms A consulted Dr B because she had detected a lump in her right breast and had a swollen and painful axilla (armpit). Because the swollen area was too painful to examine thoroughly, Dr B treated the infection with an antibiotic and advised Ms A to come back in two weeks' time if the swelling did not resolve.

3. Ms A next returned to the medical centre on 13 July 2016 and consulted Dr C because she was not able to obtain an appointment with Dr B. Ms A told Dr C that although not painful, her breast lump had increased in size.

4. Dr C examined Ms A and told her to monitor the breast lump by monthly self-examinations and to return to the medical centre if there were any changes or if Ms A had any concerns, so that an ultrasound scan could be arranged.

5. On 17 October 2016, Ms A consulted Dr B and reported that her right upper breast and armpit had swollen within the last two days and was painful, and the lump in her breast felt a "little bigger". Dr B examined Ms A that day and referred her for further investigations, including a mammogram, ultrasound scan, and a whole body bone scan.

6. On 28 October 2016, Ms A was diagnosed with invasive breast cancer that also involved her right armpit lymph nodes.

Findings

7. By failing to refer Ms A for further investigation, Dr C did not provide Ms A services with reasonable care and skill and, therefore, breached Right 4(1)[1] of the Code.

8. The medical centre was found to have taken such steps as were reasonably practicable to prevent the particular errors that led to Dr C's breach of the Code. Accordingly, the medical centre did not breach the Code.

Recommendations

9. In response to the recommendation in the provisional opinion, Dr C provided a written letter of apology to Ms A for her breach of the Code.

10. It was also recommended that Dr C provide documentary evidence of continuing professional development she has completed on breast cancer management, since November 2016.

[1] Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states: "Every consumer has the right to have services provided with reasonable care and skill."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Complaint and investigation

11. The Commissioner received a complaint from Ms A about the services provided by Dr C and the medical centre. The following issues were identified for investigation:

- *Whether Dr C provided Ms A with an appropriate standard of care between June 2016 and November 2016.*
- *Whether the medical centre provided Ms A with an appropriate standard of care between June 2016 and November 2016.*

12. This report is the opinion of Kevin Allan, Deputy Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

13. The parties directly involved in the investigation were:

Ms A	Consumer
Dr B	General practitioner/provider
Dr C	Doctor/provider
Medical centre	Provider

14. Independent expert advice was obtained from general practitioner (GP) Dr David Maplesden (Appendix A).

Information gathered during investigation

Introduction

15. At the time of these events Ms A (then aged 50 years) was registered with the medical centre. Ms A had been a patient of the medical centre and general practitioner (GP) Dr B[2] for over 20 years.

16. Ms A was postmenopausal, did not have a family history of breast cancer, and her alcohol intake was considered minimal. A mammogram examination carried out in July 2015 reported no evidence of breast cancer.

17. On 14 June 2016, Ms A presented to her regular GP, Dr B. Ms A had detected a lump in her right breast, and had a swollen and painful axilla (armpit). Ms A's temperature was recorded as 37.7°C. Dr B examined Ms A's right breast and recorded in the medical notes: "[B]reast [right] tender mass and even more tender into axilla, rest of breast not examined today."

18. Dr B prescribed an antibiotic and documented in the medical notes that Ms A should be reviewed in two weeks' time. Dr B instructed Ms A to take the antibiotics and return in two weeks' time.

[2] Dr B is a vocationally registered GP.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

19. Dr B told HDC:

> "On examination I found a hot, painful mass and swelling into the axilla, associated with fever. I am aware of the risk of malignancy in inflammatory breast lesions in this demographic. However, the swollen area was too painful to examine thoroughly, so I treated the infection and advised [Ms A] that she should come back in [two] weeks (or sooner if the swelling did not resolve). I also advised her that, regardless of whether the symptoms resolved, she should see me in [two] weeks for a full examination and appropriate referral."

20. Dr B also told HDC:

> "It is not our practice or policy to routinely book a follow up appointment, set reminder tasks or recall all patients (and in particular, patients who are advised of and appear to understand near-future follow up plans). To do so would be impractical and inefficient."

21. Ms A next returned to the medical centre on 13 July 2016 to have her breast lump reviewed but was not able to obtain an appointment with Dr B. The practice nurse recorded that Ms A had stopped taking the antibiotic after two and a half days because there was no improvement in the swelling and pain. Ms A informed HDC that instead she applied Voltaren gel, which resolved the symptoms within 24 hours. The nurse also recorded that Ms A felt that her breast lump had increased in size but it was not painful.

22. That same day, Ms A had a consultation with Dr C.[3] Dr C told HDC that she knew that the consultation was for a review of a breast lump, she had reviewed the clinical notes made by Dr B following the 14 June 2016 consultation, and she also knew that the results of Ms A's mammogram screening in 2015 had been normal.

23. Dr C examined Ms A's breast and recorded: "[B]reast [examination] — skin normal, nil [lymph nodes], form and movement [no abnormality detected], palpable 'lump' right upper outer quadrant, mobile, non tender, [approximately] 2cm [impression] cyst."

24. Following examination, Dr C also recorded: "p/ monitor monthly, if any further changes or concern > uss". Dr C explained that this meant: "[P]lan, as made with patient, is to monitor the palpable lump with monthly self-examination and for the patient to return to clinic if any changes occur or patient has ongoing concern so that an ultrasound will be arranged."

25. Dr C also told HDC that she felt sure that the palpable lesion was a cyst related to the resolving abscess, and that it would be safe to monitor whether it would resolve further over the following weeks. Dr C said that the result of her examination led her to reassure Ms A and advise her to monitor the lump closely.

26. On 16 October 2016, Ms A felt an ache in her right arm and noticed that her right axilla seemed more padded than usual. On inspection she found significant axillary swelling leading down the right side of her breast and up into her collar bone.

---

[3] At the time of these events Dr C was registered with the Medical Council of New Zealand under a provisional general scope of practice and was an employee of the medical centre.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

27. On 17 October 2016, Ms A presented to the medical centre and informed a nurse that her right upper breast and axilla had swollen within the last two days and was painful, and the lump in her breast felt a “little bigger”.

28. Dr B examined Ms A and recorded: “[C]raggy lump [right] breast at 10 o’clock, hard and irregular [approximately] 2.5 cm strange large swelling [right] axilla 12x10 cm with odema extending up to clavicle.”

29. On 21 October 2016, Dr B ordered a bilateral mammogram and ultrasound breast scan for Ms A. On 27 October 2016, Dr B arranged for Ms A to undergo a whole body bone scan, and a CAT (computerised axial tomography) scan of the chest, abdomen, and pelvis.

30. On 28 October 2016, Ms A was diagnosed with invasive breast cancer that also involved her right axillary lymph nodes. Ms A underwent urgent chemotherapy followed by surgery and radiation.

Relevant standards

31. The New Zealand Ministry of Health *Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparities* (2009) includes the following recommendations:

“(i) Urgent referral (within two weeks)

- A woman with a palpable hard, fixed or tethered breast lump should be referred urgently to a specialist
  …

(ii) Referral/investigation

- A palpable breast lump in a woman should be investigated
- A woman with an abscess or mastitis which does not settle after one course of antibiotics should be referred to a specialist
- A woman over 40 years of age with a breast abscess that has settled should be referred for mammography
- Persistent, unilateral, unexplained breast pain in a postmenopausal woman should be investigated”

32. The Australian Government/Cancer Australia publication *The investigation of a new breast symptom: a guide for General Practitioners* (February 2006) contains recommendations on management of a discrete breast lump. The guidelines include the triple test approach to diagnosis.

Further information

33. The practice informed HDC that a web-based information portal[4] tool was available to the GPs at the medical centre at the time.

[4] A web-based information portal to help general practitioners to manage and refer patients to secondary, tertiary, and other community services.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.

34. Dr B told HDC on behalf of the medical centre:

> "I can with absolute certainty say that [Dr C] was aware of the [web-based] tool. We had on several occasions prior to this event discussed breast lump investigation, both at peer review weekly meetings and in supervision."

35. Dr C told HDC:

> "I accept that the guidelines state that a palpable breast lump should be referred for further imaging …
>
> I accept … that I should have followed a more thorough approach to exclusion of malignancy by way of the 'triple testing' … In hindsight, I regret that I did not make a referral for imaging for [Ms A], despite the apparent benign feel of the lesion. I acknowledge that [Ms A] should have had imaging organised instead of further monitoring the lesion. I do sincerely regret this omission."

36. Dr C advised HDC that following this event she:

- Re-read the guidelines on breast cancer management;
- Recognises the importance of the triple testing approach to exclude malignancy, and follows it where applicable;
- Is conscious of the need to refer patients with a palpable breast lump to the breast clinic regardless of a clinical examination, to avoid risking a delay in diagnosis;
- Will arrange follow-up appointments for younger patients after a menstrual cycle regardless of red flags;
- Uses the computer-based MedTech ad hoc recall system to follow up patients who fail to return for planned reassessment;
- Uses special software for medical professionals, which was made available at the medical centre recently, to access health information from a number of data sources; and
- Will endeavour to attend continuing professional development (CPD) sessions on breast cancer management.

37. Dr C also told HDC:

> "I wish to apologise to [Ms A] about not making a referral for imaging and the likely delay in diagnosis that occurred. I hope that my response, and in particular, the efforts that I have made, (and continue to make), reassures [Ms A] that I am doing all I can to ensure that I do not make a similar mistake again."

38. The practice informed HDC of the following action taken after receiving the complaint:

- Dr B discussed with Dr C Ms A's case, the appropriate management of breast changes, and the protocol that the medical centre follows.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Ms A's case was discussed by staff in a number of peer reviews, and the medical centre is confident that all staff are aware of the importance of the triple test approach.
- The review process involved several discussions of Ms A's case at practice business meetings attended by the medical centre manager, nurse manager, two independent nurses, the reception manager, and all doctors.
- Ms A's case was also discussed at the medical centre's weekly meeting.

39. On behalf of the medical centre, Dr B told HDC:

> "Myself and the medical centre wish to thank [Ms A] for her courage in highlighting the problems which have occurred. We apologise profusely to [Ms A] and her family for any difficulties they have had to endure by the lengthened diagnostic process."

Response to provisional opinion

40. Ms A was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. She told HDC: "I note the medical centre and [Dr C] acknowledge their error and have implemented changes in their diagnostic procedures, that is positive."

41. Dr C was provided with a copy of the relevant sections of the provisional opinion. She informed HDC that she accepts the findings in relation to the care she provided to Ms A. Dr C also stated that she was not aware of Dr B's intention to undertake the triple testing review. She stated:

> "With the benefit of hindsight, I accept that I should have referred [Ms A] for imaging to exclude malignancy, despite my (falsely reassured) view that the lump was a cyst. Nevertheless, if I had been aware of [Dr B's] plan for referral, this may have guided my decision towards a referral that day."

42. The medical centre was provided with an opportunity to comment on the provisional opinion and had no further information to add.

Opinion: Dr C — breach

43. When Dr C examined Ms A on 13 July 2016, she was aware of Dr B's previous examination, the antibiotic treatment, and the advice provided that Ms A take the course of antibiotic and return for a further consultation in two weeks' time. However, following examination, Dr C decided on an observational approach and did not refer Ms A for further investigations.

44. The New Zealand Ministry of Health publication *Suspected Cancer in Primary Care: Guidelines for investigation, referral and reducing ethnic disparities* (2009) states that a palpable breast lump in a woman should be investigated, a woman with an abscess or mastitis that does not settle after one course of antibiotics should be referred to a specialist, a woman over 40 years of age with a breast abscess that has settled should be referred for

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

mammography, and that persistent, unilateral, unexplained breast pain in a postmenopausal woman should be investigated.

45. My expert advisor, Dr David Maplesden, advised:

> "At the consultation of 13 July 2016 [Ms A] reported a persistent non-tender breast lump which she felt had grown … Expected management of a new discrete breast lump is prompt referral for further investigation. In this case, I do not believe urgent specialist referral (high suspicion of cancer) was indicated, but referral for imaging in the first instance was required. I do not think it was appropriate to defer such imaging and make it dependent on further change in the breast lump, which [Ms A] had already reported was growing, despite the apparent benign feel of the lesion. While the safety netting advice provided was reasonable, such advice should have followed more thorough exclusion of malignancy by way of the 'triple testing' approach."

46. Dr Maplesden advised that the triple testing approach is recommended to maximise diagnostic accuracy when evaluating changes in breast tissue, and that use of the triple test is the accepted standard of care in New Zealand. He stated:

> "I think the failure by [Dr C] to initiate further investigation of [Ms A's] lump, initially by referral for imaging, represents a moderate to severe departure from expected standards of care."

47. Following her examination of Ms A's breast lump on 13 July 2016, it was Dr C's responsibility to initiate further investigation, initially by referral for imaging, to exclude malignancy. By failing to refer Ms A for further investigation, Dr C did not provide Ms A services with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

Opinion: Medical centre — no breach

48. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. In this case, I consider that the error that occurred did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

49. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any actions or omissions of its employees. A defence is available to the employing authority under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

50. At the time of these events, Dr C was an employee of the medical centre. Accordingly, the medical centre is an employing authority for the purposes of the Act. As set out above, I have found that Dr C failed to provide Ms A services with reasonable care and skill and, therefore, breached Right 4(1) of the Code for failing to refer Ms A for further investigation appropriately.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

51. The practice informed HDC that the web-based tool, which provides information and guidance on such matters, was available to the GPs at the medical centre. The practice said that it understood that Dr C was aware of the tool, and that on several occasions prior to the event it had discussed breast lump investigation with Dr C, both at peer review weekly meetings and in supervision.

52. Overall, I am satisfied that the medical centre took such steps as were reasonably practicable to prevent the particular errors that led to Dr C's breach of the Code. Accordingly, I find that the medical centre is not vicariously liable for Dr C's breach of Right 4(1) of the Code.

Recommendations

53. I recommend that Dr C provide a written letter of apology to Ms A for the breach of the Code identified in this report.

54. I also recommend that Dr C provide documentary evidence of continuing professional development she has completed on breast cancer management, since November 2016.

Follow-up actions

55. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr C's name.

56. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board, and it will be advised of Dr C's name.

57. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Health Quality & Safety Commission (HQSC) and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from general practitioner Dr David Maplesden:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Ms A]; response from [Dr C]; GP notes [medical centre]

2. [Ms A] states she attended her usual GP [Dr B] on 14 June 2016 with painful axilla, breast lump and mild fever. She was prescribed antibiotics and advised to return for review in two weeks. She reattended on 13 July 2016 and was seen by [Dr C] who examined the breast lump and got [Ms A] to raise her arms above her head, but did not examine the axillae. [Ms A] was reassured the lump did not require any further investigation. In October 2016 [Ms A] noted swelling in her axilla and an increase in the size of her breast lump. She was diagnosed with invasive breast cancer with lymph node involvement and was required to commence urgent chemotherapy. [Ms A] is concerned that her lump was not further investigated in July 2016.

3. [Dr C] states she reviewed [Ms A] on13 July 2016 after familiarizing herself with the history of a likely right breast abscess one month previously diagnosed and treated by [Dr B]. [Dr C] noted [Ms A] had had normal screening mammography in 2015. [Ms A] had evidently stopped her antibiotics after three days as she felt they were no longer necessary. [Dr C] examined [Ms A's] breasts and explained self-examination technique while doing this. She states: *I could identify a 'lump' of approximately 2cm in the upper outer quadrant of the right breast. The mass was not tender, was mobile (ie did not seem to be tethered to the surrounding tissue) and was not particularly firm. I could not feel any enlarged lymph nodes.* Given the response to antibiotics and the clinical assessment of the lump, [Dr C] felt the most likely diagnosis was a benign breast cyst. She advised [Ms A] in breast self-examination and *to return to the clinic if there was any concern so that an ultrasound scan could be arranged.* [Ms A] returned for a follow-up appointment three months later on 17 October 2016, because she had noted changes over the previous 2 days. [Dr C] acknowledges in hindsight that she should have referred [Ms A] for further investigation (as part of Triple testing) in July 2016 but she was reassured by her assessment of the lump as being a cyst. [Dr C] has reviewed recommended management of discrete breast lumps and states she will be more vigilant in the future to ensure these recommendations are followed on every occasion, although she feels the oversight in this case was a 'one-off' departure from her usual practice.

4. Notes review

(i) [Ms A] was 50 years old at the time of her diagnosis. She has no family history of breast cancer and minimal alcohol intake. She was not taking hormone replacement therapy. There are no screening mammography results on file so I am unable to confirm the precise date of the result referred to in [Dr C's] response.

(ii) Consult 14 June 2016 — Nurse notes include: *pain right axilla/breast started yesterday ... temp 37.7* GP notes are: *breast R tender mass and even more tender into axilla, rest of breast not examined today, Rx abs and r/v 2 weeks.* Prescribed Augmentin and routine cervical smear also performed.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

(iii) Consult 13 July 2016 — Nurse notes include: *Has had 3 days of Abs but stopped as not abscess. First mammogram last year was fine. Feels lump getting bigger. Not painful ...*

GP notes are: *breast exam — skin normal, nil LN* [lymph nodes], *form and movement nad, palpable 'lump' right upper outer quadrant, mobile, non-tender, appr 2cm Imp cyst. p/monitor monthly, if any further changes or concern → uss*

(iv) Consult 17 October 2016 — Nurse notes include: *in last 2 days swelling right axilla and right upper breast. Achy and lump feels little bigger ...* GP assessment notes include: *craggy lump R breast 10 o'clock hard and irreg approx. 2.5cm, strange large swelling R axilla 12x10cm with oedema extending up to clavicle*.

5. New Zealand guidelines on suspected cancer in primary care[1] include the following recommendations:

(i) Urgent referral (within two weeks)

- A woman with a palpable hard, fixed or tethered breast lump should be referred urgently to a specialist
- A person presenting with unilateral eczematous skin or nipple change that does not respond to topical treatment, or with nipple distortion of recent onset, should be referred urgently to a specialist
- A person presenting with spontaneous unilateral bloody nipple discharge should be referred urgently to a specialist

(ii) Referral/investigation

- A palpable breast lump in a woman should be investigated
- A woman with an abscess or mastitis which does not settle after one course of antibiotics should be referred to a specialist
- A woman over 40 years of age with a breast abscess that has settled should be referred for mammography
- Persistent, unilateral, unexplained breast pain in a postmenopausal woman should be investigated

6. Further recommendations in management of a discrete breast lump (as [Ms A] is described as having in July 2016) are summarised in a 2006 Australian publication[2] which I feel accurately represents expectation of local practice. Recommendations include:

(i) The triple test is the recommended approach to maximise diagnostic accuracy in the investigation of breast changes.

- Triple test involves clinical examination, imaging (mammography/ultrasound) and non-excision biopsy (needle/core biopsy)

[1] Ministry if Health. Suspected Cancer in Primary Care: Guidelines for Investigation, Referral and reducing Ethnic Disparities (2009). New Zealand Guidelines Group.

[2] Australian Government/Cancer Australia: The investigation of a new breast symptom — a guide for General Practitioners. 2006 Available at: https://canceraustralia.gov.au/sites/default/files/publications/ibs-investigation-of-new-breast-symptoms_50ac43dbc9a16.pdf

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- A triple test positive (indeterminate, suspicious or malignant) was found in 99.6% of breast cancers. Any positive result requires specialist referral and further investigation, with the likelihood of cancer increasing if more than one component is positive.
- A triple test negative on all components provides good evidence that cancer is unlikely (less than 1%) and further investigation can be avoided for most of these women (if there are no other high risk factors).
- Where symptoms persist or there are high risk factors such as strong family history or previous personal history of breast cancer, or the woman remains concerned, a specialist opinion may be warranted.

(ii) Imaging 35–50 years age group:

- In keeping with expert consensus opinion mammography and targetted ultrasound are used as complementary modalities for the evaluation of symptomatic women in this age group
- In the absence of strong evidence comparing these modalities, no absolute age recommendation can be provided in relation to the use of mammography or ultrasound as the initial imaging modality for symptomatic women in the age range 35–50 years.

(iii) See Appendix 1 for management algorithm

7. Comments

(i) [Ms A's] presentation on 14 June 2016 was suspicious for a non-lactational breast abscess. There was no history of preceding breast lump. There was acute onset of pain and swelling associated with fever. The breast was tender. Assessment and management was appropriate for this diagnosis, particularly with respect to scheduled follow-up irrespective of recovery. It is unclear why [Dr B] was unable to provide this follow-up as this would have been ideal for continuity of care.

(ii) At the consultation of 13 July 2016 [Ms A] reported a persistent non-tender breast lump which she felt had grown. [Dr C] describes an adequate breast examination. Examination of the lymph nodes is recorded although [Ms A] does not recall an axillary examination. [Ms A] describes assessment for lump tethering which was evidently negative. Assessment findings were of a discrete 2cm breast lump which was not overtly malignant in that it was mobile, smooth, no overlying tethering and apparently no local lymphadenopathy. These were somewhat reassuring findings, particularly when a relatively recent normal screening mammogram was taken into account. However, the history of recent enlargement of the lump was not reassuring. I think the overall assessment, as recorded, was satisfactory and consistent with expected standards of care.

(iii) Expected management of a new discrete breast lump is prompt referral for further investigation. In this case, I do not believe urgent specialist referral (high suspicion of cancer) was indicated, but referral for imaging in the first instance was required. I do not think it was appropriate to defer such imaging and make it dependent on further change in the breast lump, which [Ms A] had already reported was growing, despite the apparent benign feel of the lesion. While the safety netting advice provided was reasonable, such advice should have followed more thorough exclusion of malignancy by way of the 'triple testing' approach. I think the failure by [Dr C] to initiate further

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

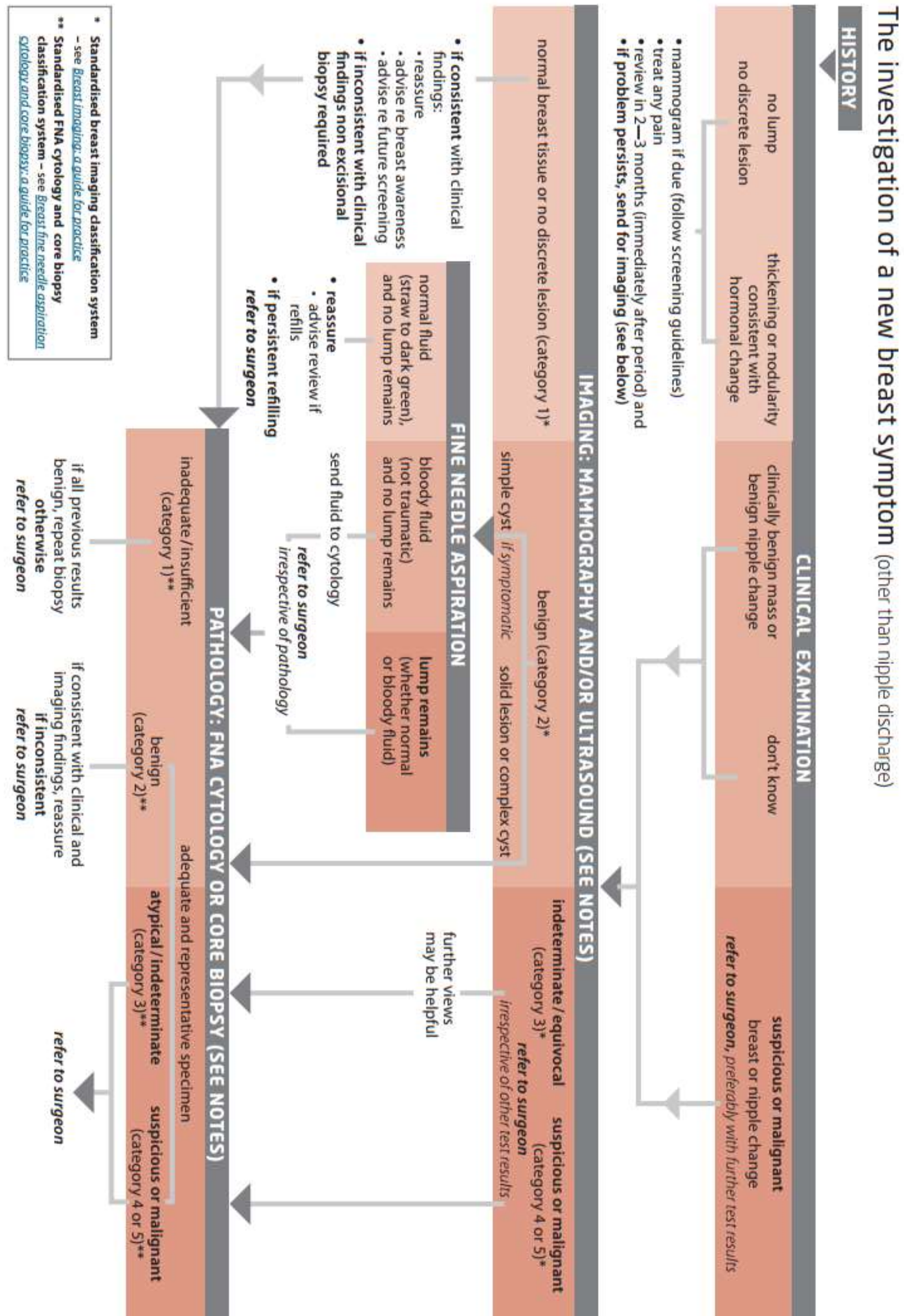
investigation of [Ms A's] lump, initially by referral for imaging, represents a moderate to severe departure from expected standards of care. I note [Dr C] regards this omission as a departure from her usual practice and has increased her vigilance in this regard.

HDC

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 1: From: Australian Government/Cancer Australia: The investigation of a new breast symptom — a guide for General Practitioners. 2006

https://canceraustralia.gov.au/sites/default/files/publications/ibs-investigation-of-new-breast-symptoms_50ac43dbc9a16.pdf



Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Expert Opinion Report Two:

I have reviewed additional information provided on this file.

1. Response from [Dr C] dated 17 July 2017

(i) [Dr C] clarified that she did not specifically reassure [Ms A] that the breast lump did not require further investigation, but she '*advised [Ms A] that she should self-examine her right breast regularly and to return to the clinic if there was any concern, or if she noticed any changes, so that an ultrasound could be arranged … At the time of the consult, I felt sure that the palpable lesion was a cyst related to the resolving abscess and it would be safe to monitor whether it would further resolve over the following weeks. Unfortunately, I did not ask the patient regarding her hormonal status.'*

(ii) [Dr C] outlines remedial measures undertaken since this complaint including reviewing and updating her management of breast lesions, increased use of the PMS 'Task Manager' functionality to monitor patient recalls, and use of [new knowledge management software].

(iii) [Ms A's] most recent mammogram prior to the consultation with [Dr C] on 13 July 2016 was 6 July 2015 and this was reported as normal.

(iv) Comment: The additional information provided does not alter my comments regarding [Dr C's] management of [Ms A] as discussed in section 7 of my original advice, other than to note the remedial actions undertaken by [Dr C] appear appropriate.

2. Response from [Dr B] dated 27 July 2017

(i) [Dr B] states that at the consultation with [Ms A] on 14 June 2016 '*I explained, as is my usual practice when a person presents with breast changes and after taking a history, that regardless of what I might find on examination, she would need to have a USS, mammogram and be referred to a specialist.'* Following examination of [Ms A's] breast, findings were consistent with an abscess but the breast was too tender for a complete examination and [Dr B's] intention was to review [Ms A] once the prescribed antibiotics had had an effect and to make an appropriate referral based on the findings at that time. [Dr B] emphasizes the instructions provided to [Ms A]: '*I also advised her that, regardless of whether the symptoms resolved, she should see me in 2 weeks for a full examination and appropriate referral. As outlined above, I have known and treated [Ms A] as a patient for over 20 years and I was certain that [Ms A] understood that she should return in 2 weeks*.'

(ii) [Dr B] notes she was available to see [Ms A] for three weeks following the appointment of 14 June 2016, and again from 18 July 2016. However, [Ms A] chose to see a different provider ([Dr C]) during [Dr B's] absence and some time after the interval recommended by [Dr B].

(iii) [Dr B] states: '*It is not our practice or policy to routinely book a follow up appointment, set reminder tasks or recall all patients (and in particular, patients who*

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

are advised of and appear to understand near-future follow up plans). To do so would be impractical and inefficient. [Ms A] is an intelligent woman who has worked in health. She is well known to me and I was sure she understood the follow up plan that I advised her.'

(iv) Comment: I remain of the view that the management of [Ms A] by [Dr B] was consistent with expected standards of care. [Dr B] gave explicit instructions to [Ms A] regarding the need for review irrespective of the progress of her symptoms and notes her intention to undertake 'triple testing' following the review. She was confident [Ms A] was adequately informed regarding the need for review, and that [Ms A] would follow her recommendations. I agree with [Dr B's] comment in point 2(iii) above, with the qualification that ensuring the patient has an adequate understanding of the reasons for review is critical in this situation, and information must be provided in a manner appropriate to the level of health literacy exhibited by the patient. It is also important to recognize and address potential barriers to the patient complying with follow-up recommendations. In some cases use of a formal reminder system might be appropriate.

3. [The medical centre's] generic policies for management of test results and referrals have been reviewed and are consistent with expected standards. A practice would be expected to have such policies in place at the time of the events in question."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.