Co-ordination of care of woman with family history of breast cancer
17HDC00974, 13 September 2018

General practitioner ~ Medical centre ~ Nipple discharge ~ Mammogram ~ Ultrasound ~ Complaint process ~ Rights 4(1), 10

A 40-year-old woman presented to a medical centre with right nipple discharge. The woman had a family history of breast cancer and was on yearly surveillance. The general practitioner (GP) noted that the woman was overdue for her yearly mammogram, so sent a referral to the DHB breast clinic for a routine screening mammogram. The GP did not include on the referral form the clinical details about the recent nipple discharge. The mammogram showed no features suspicious for malignancy.

Several months later, the woman saw another GP at the medical centre for a non-healing lesion on her right breast. The GP advised the woman to have an ultrasound scan with a private provider. There was confusion between the GP and the woman as to who would organise the appointment, and consequently the woman did not have the scan at that time.

Several months later, during an appointment for her child at the medical centre, the woman mentioned that she had not heard about her ultrasound scan appointment. She was re-referred, and underwent a mammogram, an ultrasound, and a biopsy, which revealed cancer in the right breast.

The woman made a verbal complaint to the medical centre, but was told to put her concerns in writing. She made a number of unsuccessful attempts to email her complaint to the medical centre and eventually gave up. She received no response to her verbal complaint.

Findings

The first GP failed to refer the woman for diagnostic testing, and her referral for routine breast screening failed to provide the Breast Service with relevant clinical information that could have led to diagnostic testing, and earlier diagnosis of breast cancer. The GP did not provide services to the woman with reasonable care and skill and, therefore, breached Right 4(1).

Adverse comment is made regarding the second GP's communication about the ultrasound booking, and her failure to monitor timely completion of the ultrasound. Although it was difficult to determine the cause of the communication issue regarding who was to organise the ultrasound appointment, the Commissioner reminded the GP of the importance of effective communication, including her responsibility to ensure that her patients are provided with clear, preferably written, instructions for any investigations they are expected to organise themselves.

Regarding the medical centre's management of the woman's complaint, the Commissioner reminded the medical centre that Right 10 of the Code does not require a complaint to be made in writing. Complaints can be lodged in a number of

ways — in person, over the telephone, or in writing. The Commissioner expects all complaints, whether verbal or written, to be acknowledged and responded to in a speedy and efficient manner.

Recommendation

It was recommended that the first GP provide the woman with a written letter of apology for her breach of the Code.