A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC01340)

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Introduction

1. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The report concerns a complaint from Mr A about the care and treatment provided to him by Dr B, a general practitioner (GP), and a primary healthcare provider (the medical centre).

2. Mr A raised concerns about the care he received at appointments with Dr B on 19 February and 5 August 2021. In particular, Mr A complained that Dr B failed to take a lump on his neck seriously at the two appointments. When the lump was biopsied in April 2022, Mr A was diagnosed with adenoid cystic carcinoma, a rare cancer of the salivary gland. Mr A said that his cancer continues to require aggressive surgical treatment, and it would have been diagnosed much earlier if Dr B had initiated investigations of the lump at his appointments.

3. The following issues were identified for investigation:

- *Whether Dr B provided Mr A with an appropriate standard of care in 2021, particularly during the 19 February and 5 August 2021 appointments.*
- *Whether the medical centre provided Mr A with an appropriate standard of care in 2021, particularly during the 19 February and 5 August 2021 appointments.*

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4. This report sets out the Deputy Commissioner's opinion on the quality of the care Mr A received from Dr B and the medical centre in relation to his neck lump at his 19 February and 5 August 2021 appointments.

5. Information and comments were sought from Mr A, Dr B and the medical centre. In-house clinical advice about Mr A's care was obtained from Dr David Maplesden, a GP (Appendix A).

6. Having carefully considered all relevant information, the Deputy Commissioner found that Dr B breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to urgently refer Mr A for specialist review and/or investigations of his neck lump in line with accepted practice and relevant clinical guidance.

7. The Deputy Commissioner recommended that Dr B audit her assessments of 20 patients who presented with unexplained lumps, masses or lesions, and report to HDC about whether the audit showed that appropriate steps were taken in each case as mandated by the relevant clinical guidance.

8. The Deputy Commissioner did not find any breach of the Code by the medical centre.

Chronology — key events

15 February 2021

9. Dr B, who studied and initially practised medicine overseas, began a permanent position as a GP at the medical centre two weeks after arriving in New Zealand.

10. Dr C, a GP at the medical centre, was Dr B's supervisor. Dr B undertook orientation and training activities in her first week of employment and saw some patients with Dr C. Dr B reviewed Mr A on the final day of her first week at the medical centre (19 February 2021). Dr C was not present during that appointment.

19 February 2021

11. Mr A, then aged in his fifties, attended an appointment with Dr B at the medical centre for review of a lump on his neck. Dr B's notes of this appointment state that Mr A said that the lump had been present on his neck for about a year, but it was increasing in size and had become more tender over the past three months. Further, Mr A reported having problems swallowing liquids, but had no pain or other symptoms,[2] and could work without difficulty.

12. Dr B documented that on examination Mr A's head, eyes, ears, nose and throat were normal with no signs of trauma. She noted that he was a smoker and had poor dentition[3] but had no active abscesses. Mr A's neck lump was recorded as being '1.5 x 1cm tender, movable submandibular gland[4] with no overlying skin changes'.

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[1] Right 4(1) stipulates: 'Every consumer has the right to have services provided with reasonable care and skill.'
[2] 'No H/A [headache], lightheadedness, dizziness, cough, chest pain.'
[3] The condition and/or arrangement and/or character of the teeth.
[4] A saliva-producing gland that is located below the jaw.

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13. Dr B told HDC that her impression was that Mr A's neck lump was an 'enlarged lymph node that was likely reactive'.[5] She said that her 'original thought process was that it is not uncommon for lymph nodes to be enlarged and painful in adults due to dental concerns or sinus or ear drainage'. However, she also noted that although Mr A had poor dentition, 'there was no infection in the mouth'. Dr B explained to HDC that she elected to treat Mr A's neck lump with anti-inflammatory medication for two to four weeks. She asked him to notify her if his symptoms worsened, and to return in four weeks' time for a follow-up review. This assessment and plan is documented in Dr B's notes of the appointment.

14. On reflection and having since reviewed the HealthPathways guidance for management of neck lumps,[6] Dr B told HDC that it would have been prudent to have arranged urgent evaluation of Mr A's neck lump at this appointment. She considers that with the benefit of hindsight, she would have at least referred Mr A for Ear, Nose and Throat (ENT) review and organised a fine needle aspiration (FNA)[7] and/or relevant imaging.

15. Dr B told HDC that she is unsure whether she was made aware of HealthPathways prior to Mr A's appointment. She attended an orientation day two days before she saw Mr A. Dr B said that she was provided with a lot of information on that day, and she cannot be certain whether she was informed about HealthPathways at that time.

5 August 2021

16. Mr A returned to see Dr B at the medical centre. His records show that this was his first appointment at the medical centre since his 19 February 2021 appointment with Dr B. Mr A had not made a follow-up appointment four weeks after the first appointment, as Dr B had advised. There is also no record of Dr B or the medical centre attempting to contact Mr A during this period to arrange the follow-up appointment.

17. Dr B's notes from this appointment state that Mr A reported having had a sore tooth for around one month, which had been pushing on his right upper gum and expressing fluid/blood from the gum. Dr B documented that Mr A had poor dentition and visible swelling of the right upper gums, but he was well nourished and not in acute distress. She recorded that his neck lump was 'still there, [h]asn't really changed' and that his 'submandibular gland [was] unchanged'. Dr B's documented assessment and plan stated that Mr A had a dental abscess, for which she had prescribed antibiotics, and she had advised Mr A to use mouthwash, brush his teeth daily, and contact his dentist.

18. Dr B told HDC that in hindsight, it would have been prudent for her to have arranged further evaluation of Mr A's neck lump at this appointment. She said that Mr A's dental infection was a distracting factor in that respect.

[5] A lymph node (part of the lymphatic system, which helps to fight off infection) that is swollen and reacting to something in the body, such as infection, injury or inflammation.
[6] HealthPathways is an online resource, primarily aimed at general practice, which provides local, evidence-based clinical assessment, management and referral information.
[7] Insertion of a thin needle to collect a tissue sample to either diagnose or rule out conditions such as cancer.

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20 May 2022

19. Mr A emailed the medical centre to advise that he had been diagnosed with adenoid cystic carcinoma overseas[8] and was due to have surgery within three weeks.[9] Mr A referred to his appointments with Dr B in 2021 and said that she had told him that his neck lump was related to his teeth and it could not be cancerous because it was sore.

20. The medical centre responded to Mr A on 25 May 2022, advising that it was 'very sorry' to hear of his situation and would investigate the matter and respond accordingly. The medical centre told HDC that Mr A's case was the subject of peer review by its GP team following his complaint, and 'upskilling had occurred as a result'.

23 June 2022

21. The medical centre formally responded to Mr A's email, attaching a letter from Dr B. The medical centre told HDC that Dr B 'acknowledged that she could have done better by [Mr A] and now has a much lower threshold for ruling out cancer as a likely diagnosis'.

22. In her letter, Dr B outlined her examinations and assessments of Mr A at his 19 February 2021 and 5 August 2021 appointments.[10] She said that she was very sorry that he had been diagnosed with cancer and would need surgery. Dr B recognised how difficult the situation must be for Mr A and his family and apologised that the care he received in 2021 'did not lead to a more expedient diagnosis and treatment'. Dr B also informed Mr A that she had taken learning from his case to minimise the risk of the same situation happening again.

Further information

Mr A

23. Mr A said that he would like to ensure that no one else has the same experience as him. He told HDC that he has now undergone two surgeries on his neck and had all of his teeth and half of one of his lungs removed, as the cancer had spread to the lung by the time it was diagnosed. Mr A could not work for nine months, and he expects that his treatment journey is not over. He stated that his specialist team told him that his lung surgery and the loss of his teeth could have been avoided if his neck lump had been dealt with appropriately 12 months earlier. In June 2022, he said that he had been advised that he had three to five years to live.

Dr B

24. Dr B stated that at her prior practice in her home country she had no mentor or someone to 'lean on, so most times [she] had to figure it out [herself]'. Dr B said that she was still in that mindset when she first saw Mr A, as she had just arrived in New Zealand. She stated that since then, she has come to value the importance of asking for help if she is unsure or needs perspective. She said that she is 'truly sorry' for Mr A's delayed diagnosis and pain

[8] Where he now resides.

[9] Mr A was diagnosed on 8 April 2022 after his neck lump increased in size.

[10] This information was virtually the same as the information Dr B provided to HDC, which is outlined in the preceding paragraphs.

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and suffering, and now has 'a heightened awareness of these issues and a lower threshold of when to ask for and seek advice'.

The medical centre

25. The medical centre said that the failings in Mr A's care were the result of an individual error of judgement by Dr B, which Dr B has accepted and apologised for.

26. The medical centre submitted a supervision plan to the Medical Council of New Zealand (MCNZ) as part of Dr B's recruitment and employment process. The medical centre was also required by the MCNZ to apply to have Dr C approved as Dr B's supervisor. The supervisor application stated that Dr C would work with Dr B 'daily for the first two weeks (40 hours) [and] weekly for 3 months (16 hours)'. This supervision plan was consistent with the MCNZ's guidance about the orientation, induction and supervision of international medical graduates, which I discuss further below.

27. The medical centre said that Dr B's orientation included the following:

- She attended a three-day NZ Locums orientation course via video-conference prior to starting work;
- She reviewed the medical centre's orientation manual with Dr C, in addition to MCNZ policies, including supervision requirements, peer review, and the use of *Coles Medical Practice in New Zealand*;[11]
- She was provided with an introduction to key systems in New Zealand primary care, including the Accident Compensation Corporation, the Ministry of Social Development, Pharmac, and the New Zealand Formulary;[12]
- She was provided with information about the workings of the District Health Board (now Te Whatu Ora), referral processes (which at that time involved emailing a paper referral),[13] and how to obtain advice from on-call hospital clinicians;
- She attended an off-site orientation day; and
- She sat in on Dr C's consultations, and Dr C sat in on Dr B's consultations with patients. Dr B's supervision calendar included 'patient review' sessions between every patient for much of her first week at the medical centre, tapering to approximately every three patients in the second week.

[11] *Coles Medical Practice* is a handbook that gives practical advice to new doctors in New Zealand, including all aspects of medical practice and legal, regulatory, and ethical matters.

[12] The New Zealand Formulary is an independent resource for clinically validated information on medicines and best-practice guidance.

[13] The electronic referral management system (ERMS) was not operational in the region when Dr B joined the medical centre.

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28. The medical centre said that HealthPathways is now used routinely as part of its clinical practice. However, during Dr B's orientation, HealthPathways was in its infancy, and other online sources of information were utilised, including bpac^{nz}.[14]

29. The medical centre said that it has ongoing regular protected[15] supervision and peer review sessions with Dr B, and all staff are encouraged to ask questions and seek advice via 'corridor supervision' whenever necessary. This type of support was increased for Dr B after Mr A's complaint, on both a formal and informal basis.

30. The medical centre advised that the Cancer Coordinator Nurse at Te Whatu Ora is the point of contact for primary care doctors in respect of a patient's treatment pathway. Each doctor at the medical centre is responsible for ensuring that high-risk patients are referred and seen by an appropriate specialist. The medical centre said that it does not have a specific policy on neck lumps, and doctors would be expected to follow bpac^{nz} and HealthPathways guidance in that respect.

31. The medical centre's population includes lower socioeconomic and significant Māori demographics, and it is the only medical centre in the area. The medical centre said that all its new doctors should therefore have a high suspicion of cancer, with atypical presentations being common. It said that system-wide process improvements were needed to improve the early detection and management of cancer for its patients.

32. The medical centre proposed that its parent company should create a policy for implementation by all its subsidiaries in respect of management of, and education on, high-risk presentations. The medical centre proposed that the policy would cover:

- How to manage 'red flag' presentations at GP triage when capacity is tight;
- The need for 'red flag' presentations to be given an urgent primary care appointment if patients have been told to return if symptoms do not improve;
- Close follow-up of patients who present to the Emergency Department with high-risk symptoms and are referred for outpatient investigations, including a recall system; and
- Explicit clinical policy on clinician responsibility in context, and a process for patients who do not return to primary care.

Responses to provisional opinion

33. Mr A was given the opportunity to respond to the sections of the provisional opinion relating to the medical centre and the information that formed the basis of the provisional opinion. Mr A did not have any further comments in those respects.

[14] The Best Practice Advocacy Centre New Zealand (bpac^{nz}) is an independent organisation that provides education and continuing professional development to medical and other health practitioners in New Zealand.
[15] Sessions that will not be rescheduled in favour of other commitments.

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34. Dr B was provided with a copy of the sections of the provisional opinion that relate to her and invited to respond. Dr B's legal representative confirmed that Dr B had nothing further to add.

Opinion: Dr B — breach

35. I have undertaken a careful assessment of the information gathered, guided by the clinical advice I received from Dr David Maplesden, a general practitioner. Taking everything into account, I have concluded that Dr B did not manage Mr A's neck lump appropriately at his appointments on 19 February and 5 August 2021. As a result, two opportunities to diagnose his cancer at an earlier stage were missed. I acknowledge that Dr B, who was provided with a copy of Dr Maplesden's advice, has said that she does not disagree that it would have been prudent to have arranged further evaluation of Mr A's neck lump at both appointments.

36. While adenoid cystic carcinoma is rare, Dr Maplesden advised that it is an important consideration when a patient presents with a (usually) painless swelling in the head or neck region, because the cancer has a high tendency to metastasise[16] to other areas of the body. Such consideration was especially relevant in Mr A's case, as a number of aspects of his initial presentation indicated that his neck lump required investigation. Dr Maplesden referenced relevant HealthPathways accepted practice guidance (the guidance),[17] which states that 'a neck lump that has been present for more than 3 weeks needs investigation, unless it is shrinking. Lumps less than 3 weeks duration are usually due to infection.' The guidance dictates that the following aspects of Mr A's neck lump should have given rise to a high suspicion of cancer:

- It was a neck or salivary mass that had no obvious explanation;
- Mr A said that the lump had already been present for 12 months;
- The lump was larger than 1cm and was felt to be slowly enlarging; and
- The lump was associated with a new symptom, as Mr A had begun to have difficulty swallowing liquids.

37. Dr Maplesden said that further investigation of Mr A's neck lump was required at his first appointment with Dr B, irrespective of the provisional diagnosis. He said that Mr A needed to be referred to an ENT specialist urgently, based on the history of his neck lump, with an FNA also being a possible option at that point. Dr Maplesden advised that guidance varies about the recommended sequence of steps in this respect, as an urgent (but non-acute) ENT referral such as that required for Mr A may be preceded by an FNA, or an FNA may be performed concurrently or deferred until specialist advice is received.

38. Dr Maplesden noted that Dr B did advise Mr A to report any worsening of symptoms and to return for review in four weeks for follow-up. Nonetheless, Dr Maplesden considered that Dr B's failure to initiate an urgent ENT referral, and/or further investigation of the neck lump

[16] Spread.
[17] 'Neck Lumps in Adults and Submandibular Gland Disorders'

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by way of an FNA, at Mr A's initial appointment on 19 February 2021 was at least a moderate departure from the accepted standard of care.

39. Further, Dr Maplesden said that Dr B's failure to refer Mr A for urgent ENT review at his next appointment on 5 August 2021 represented a moderate to severe departure from the accepted standard of care, as his neck lump remained, and Mr A was not given any follow-up or safety-netting advice. In addition, the lump was not explained by the dental infection Mr A presented with. Dr Maplesden advised:

> '[T]he [dental] infection may have been a distracting factor. [However, if] infection was felt to be a factor in the evolution of the mass, formal review of the mass following a course of antibiotics is recommended in the … guidance and no such advice is documented on this occasion.'

40. I accept Dr Maplesden's advice. Although Mr A's cancer is a rare, slow-growing type, which often hinders early diagnosis,[18] his neck lump was persistent and significant in size, with no clear reassuring cause at either appointment. At Mr A's first appointment, Dr B should have made an urgent ENT referral and/or arranged investigation of his lump by FNA. At Mr A's second appointment, with the neck lump still present, Dr B should have referred him for urgent ENT review.

41. I acknowledge Dr B's comments that when she first saw Mr A on 19 February 2021, she had been in New Zealand for less than a month, was still learning the processes of a new country, and she cannot remember whether she had been introduced to HealthPathways prior to the appointment. I also acknowledge Dr B's comments that she was distracted by Mr A's dental infection during the second appointment on 5 August 2021. However, I consider that Dr B's errors were serious departures from the accepted standard of care, and these factors do not lead me to change my overall conclusions. I note here that Dr B accepted, in her response to this investigation, that there do not appear to be substantial differences between the management recommendations in the HealthPathways head and neck lump guidance and the equivalent guidance from her home jurisdiction, which she should have been familiar with.

42. In my view, Dr B failed to provide services to Mr A with reasonable care and skill; specifically, Dr B did not act in line with accepted practice in relation to Mr A's neck lump, as there is no indication that the history and presentation of the lump caused her to consider the possibility that the lump might be malignant and require urgent referral for specialist review and/or investigations.

43. As a result, on 19 February and 5 August 2021, Mr A did not receive the standard of care and treatment he was entitled to. Accordingly, I find that Dr B breached Right 4(1) of the Code.

[18] Mohammad Ammad Ud Din and Hira Shaikh, 'Adenoid cystic cancer', updated 23 February 2023, https://www.ncbi.nlm.nih.gov/books/NBK557855/.

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Opinion: Medical centre — no breach

44. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. In this case, as Dr B had moved to New Zealand to join the medical centre, it was particularly important for the medical centre to ensure that she was adequately inducted, trained and supported to work as a GP in New Zealand.

45. The MCNZ has detailed best practice guidance (the MCNZ guidance) about the orientation, induction and supervision of international medical graduates (IMGs) in New Zealand.[19] It sets out the roles and responsibilities of employers and supervisors when a medical graduate is recruited from overseas. In terms of the timing of formal supervisory meetings, the MCNZ guidance states:

> '[S]upervision is flexible depending on the IMG's competence. Close supervision is required in the beginning, and decreases over time once the supervisor becomes comfortable about delegation and increasing the IMG's independence. At a minimum, the supervisor is expected to meet the doctor daily for the first week, weekly for the first 3 months, and monthly after that.'

46. I have seen no indication of a failure by the medical centre in respect of Dr B's induction, orientation and initial supervision. The evidence demonstrates that this was appropriate and in line with the MCNZ guidance. The supervisory plan submitted to the MCNZ provided for daily supervision for Dr B's first week, and weekly supervision for the first three months. The medical centre's records show that Dr C spent a significant amount of time with Dr B during her first two weeks, and particularly so during the first week (including on 19 February 2021), exceeding the MCNZ requirement for a daily meeting. There is also evidence that peer review sessions, which Dr B was involved in, were taking place periodically before and after Mr A's second appointment in August 2021.

47. Dr B was not being observed by Dr C during Mr A's first appointment, which took place at the end of her first week at the medical centre. That was unfortunate, given that it is now clear that Dr B did not manage Mr A's neck lump appropriately at that appointment. However, I am not critical of Dr C or the medical centre in that respect. The MCNZ guidance does not require IMGs to be supervised or observed at every patient appointment during their orientation and induction. Further, the medical centre could not reasonably have been expected to anticipate that Dr B might have needed additional encouragement to seek advice from her peers because of what she has since reported about the nature of her previous practice experience.

48. I acknowledge that Dr B cannot recall exactly when she was introduced to HealthPathways during her induction, and whether this was prior to Mr A's first appointment. However, as noted above, Dr B accepted, in her response to this investigation, that there do not appear

[19] 'Orientation, induction and supervision for international medical graduates: Best practice guidelines for employers and supervisors of international medical graduates', MCNZ, January 2011, https://www.mcnz.org.nz/assets/Publications/Booklets/Orientation-Induction-and-Supervision-for-International-Medical-Graduates.pdf.

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to be substantial differences between the management recommendations in the HealthPathways head and neck lump guidance and the equivalent guidance from her home jurisdiction. I further note that the medical centre has said that other online sources of information, including bpac^{nz}, would have been available to Dr B.

49. I consider that Dr B's errors in Mr A's case were individual failings that do not reflect broader systems issues at the medical centre. I have concluded that there was no breach of the Code by the medical centre.

50. I commend the medical centre's consideration of the systemic improvements needed to aid early detection and management of cancer in its patient population. The medical centre may wish to consider working with its parent company towards implementing a policy for managing and educating providers about high-risk presentations, as I note has been proposed already.

Changes made

51. Dr B advised that she has made a number of changes to her practice in response to Mr A's case, which I commend, in particular:

a) She is now much more vigilant about any presentation that could be a potential malignancy, and her threshold for considering alternative working diagnoses and asking for advice is lower, particularly with recurrent presentations;

b) She has discussed the role of the Te Whatu Ora Cancer Coordinator Nurse with Dr C, and has since contacted the nurse with questions and/or concerns about other patients;

c) She has familiarised herself with HealthPathways information concerning head and neck lumps, and the Salivary Glands webinar on Goodfellow,[20] which was highlighted by Dr Maplesden, and has taken a number of learning points from these resources;

d) If a patient is not contacted after Dr B has made an ERMS referral for them, she will follow up by contacting the department to which the patient was referred while the patient is in the consultation room with her; and

e) She now sets aside time in her schedule to consult with her supervising doctor if she has a particular question.

Recommendation

52. Having taken into account the content of Dr B's written apology to Mr A, the changes she has already made to her practice, and Dr Maplesden's advice concerning the relevant remedial actions she has undertaken already, I recommend that Dr B conduct an audit of her assessments of 20 patients who presented with unexplained lumps, masses or lesions, and report back to HDC on whether the audit showed that appropriate steps were taken as mandated by the relevant guidance, such as local HealthPathways, bpac^{nz} or other

[20] Goodfellow is an eLearning website that provides peer-reviewed, evidence-based information and resources for primary care health professionals.

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recognised sources, within four months of the date of this report. If the audit shows that appropriate action was not taken in every case, Dr B's report should outline why, and the steps taken to ensure future compliance with relevant clinical guidance.

Follow-up actions

53. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name in covering correspondence.

54. A copy of this report with details identifying the parties removed, except the advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from Dr David Maplesden:[1]

‘1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a practising general practitioner. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided to him by [Dr B] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner’s Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Mr A]
- Response from [the medical centre]
- Response from [Dr B]
- GP notes [the medical centre]

3. [Mr A] complains about delays in the diagnosis of his salivary gland cancer, adenoid cystic carcinoma, which was confirmed following biopsy of a submandibular mass [overseas] on 8 April 2022. At the time of diagnosis the cancer had metastasized to [Mr A’s] lung and he has required surgery for this. [Mr A] states he first sought medical attention for a swelling under his jaw at [the medical centre] on 19 February 2021. He was seen by [Dr B] and was told the lump was likely related to dental issues and this was reiterated when he was reviewed by [Dr B] in August 2021. The lump continued to grow which led to [Mr A] seeking medical attention in [his new country of residence] in 2022. I have not been provided with any clinical documentation from [Mr A’s new country of residence] and my advice is provided with the assumption the mass [Mr A] presented to [Dr B] is the same mass that later biopsy revealed to be an adenoid cystic carcinoma of his submandibular salivary gland.

4. A review article on adenoid cystic carcinoma[2] (ACC) notes it is a rare malignancy arising from the secretory glands, most commonly seen involving the salivary glands. Although uncommon, it is an important differential to consider for a painless swelling in the head and neck region because of its high tendency to metastasize. The tumour is typically slow-growing compared to other carcinomas with the highest incidence of cases in the head and neck area seen in the fifth to sixth decade of life. Data regarding the aetiology of the cancer are sparse, but unlike

[1] Advice received 17 October 2022.

[2] Ammad Ud Din M, Shaikh H. Adenoid Cystic Cancer. [Updated 2022 Jun 11]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK557855/ Accessed 17 October 2022

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other carcinomas of the head and neck region like squamous and basal cell carcinoma, smoking and the use of alcohol have not been linked as potential risk factors. The most common presentation of ACC is a slow-growing, hard painless swelling in the head and the neck region, though pain and paraesthesia are not uncommon as the tumour is notorious for peri-neural infiltration, particularly in the parotid region. More than one-third of the cases progress to metastatic disease. The most common site of metastases via hematogenous spread is the lungs, followed by bone and liver. The slow-growing kinetics, along with the rarity of the condition, often hinders an early diagnosis of ACC.

5. Accepted practice in the management of head and neck lumps is summarised in the [region's] HealthPathways.[3] Recommendations relevant to this case include:

- A neck lump that has been present for more than 3 weeks needs investigation, unless it is shrinking. Lumps less than 3 weeks' duration are usually due to infection.
- If a lump is likely to have an infective cause, treat with broad spectrum antibiotics. Recheck in 1 to 2 weeks for resolution, although complete disappearance may take a couple of months.
- A slow growing, painless, focal swelling in a submandibular gland is more likely to be a tumour of which 60% are malignant and 40% are benign.
- If a suspected submandibular tumour, as well as arranging FNA request a non-acute ORL assessment.
- If criteria for high suspicion of head, neck, or salivary cancer are met, select ERMS priority high suspicion of cancer, or write "high suspicion of cancer" on the request.
- Criteria for high suspicion of head, neck, or salivary cancer are listed as an unexplained neck or salivary mass and 1 or more of:
  - — mass larger than 1 cm and persisting longer than 3 weeks.
  - — mass is increasing in size.
  - — previous head and neck cancer including skin cancer.
  - — facial palsy.
  - — any new unexplained upper respiratory tract symptoms, e.g. hoarseness, dysphagia, throat or ear pain, blocked nose or ear.

6. [Mr A] presented to [the medical centre] on 19 February 2021 and was reviewed by [Dr B]. History is recorded as: Concerned about a lump under his neck. He believes it has been there for about a year but is getting bigger and is more tender over the past 3 months. No f/c [fever or chills], but does report some difficulty with swallowing liquids but no pain. Still smokes about 15 cigs/day. Had colonoscopy. No HA, lightheadedness, dizziness, cough, chest pain. Working without difficulty.

[3] HealthPathways. Sections: Neck Lumps in Adults and Submandibular Gland Disorders.

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On assessment [Mr A] was noted to appear well with normal tympanic membranes, deviation of the nasal septum to the right, poor dentition but no active abscesses and no other intra-oral pathology documented. The neck mass itself was described as 1.5x1 cm tender, movable submandibular gland with no overlying skin changes. Assessment and management plan was documented as: Enlarged lymph nodes: Reactive in nature. Will treat with 2–4 week course of anti-inflammatories. Notify us if symptoms worsen. Return in 4 weeks for follow up. A prescription was provided for naproxen and blood tests were taken for cardiovascular risk assessment (nurse initiated). It appears alcohol use was also explored and coded at this consultation as use above sensible limits.

Comment: A reasonable history and examination is documented although the site of the lump might have been more clearly defined (right or left). Based on the history, [Mr A] required further investigation of his neck mass by way of urgent ORL referral with or without FNA whether [Dr B] felt it was an enlarged submandibular lymph gland or a submandibular salivary gland mass. (*Addendum 23 May 2023*: As clarification, further investigation of the mass was required at this point irrespective of the provisional diagnosis. Guidance varies regarding the recommended sequence of steps with urgent (but non acute) ORL referral generally recommended which may be preceded by FNA, FNA performed concurrently or FNA deferred until specialist advice received.) The mass had been present for many months and was felt to be slowly enlarging. The mass was larger than 1cm. The mass was associated with a new symptom of dysphagia for liquids. There was no obvious "benign" explanation for the mass. [Mr A] had risk factors for some head and neck malignancies of positive smoking status and significant alcohol intake. I note [Dr B] advised [Mr A] to report any worsening of symptoms or to return for review in four weeks for follow-up and I have regarded this action as a mitigating factor. Nevertheless, I believe the failure by [Dr B] to organise urgent specialist review and/or further investigation of the neck lump by way of FNA following the consultation of 19 February 2021 would be met with at least moderate disapproval by my peers.

7. There is no record of [Mr A] returning for review of his neck mass until a consultation with [Dr B] on 5 August 2021. [Mr A] reported a sore tooth for about a month, has been pushing on his right upper gum and expressing blood/ fluid from the gums. Node still there. Hasn't really changed. On examination [Mr A] was noted to have poor dentition with visible swelling of the right upper gums and submandibular gland unchanged. Management was antibiotic (amoxicillin), Savacol mouthwash and to self-refer to a dentist. There is no follow-up or safety-netting advice documented on this occasion.

   Comment: The management provided for [Mr A's] apparent dental infection was appropriate. However, there had been no resolution of his submandibular mass and I believe the current dental infection did not adequately explain the presence of the mass which had now been present for over 18 months although the infection may have been a distracting factor. If infection was felt to be a factor in the

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evolution of the mass, formal review of the mass following a course of antibiotics is recommended in the cited guidance and no such advice is documented on this occasion. For the reasons previously described and noting the objective persistence of the mass described by [Dr B], I believe [Mr A] required urgent ORL referral for review of the mass. In the absence of any follow-up or safety-netting advice provided on this occasion, I believe [Dr B's] management of [Mr A's] neck mass on this occasion would be met with moderate to severe disapproval by my peers. Mitigating factors considered are the rarity of ACC and the acknowledgement in the cited reference article that the slow-growing kinetics of ACC often hinders an early diagnosis. Nevertheless, [Mr A] had a persistent and significant neck mass without a clear "reassuring" cause and there were two missed opportunities to diagnose his cancer at an earlier opportunity than the eventual timing.

8. I note [Dr B] had recently arrived in New Zealand at the time of her first consultation with [Mr A]. However, I am not aware that teaching or guidelines regarding the management of head and neck masses differs substantially between [Dr A's home country] and New Zealand, and I would expect even a recent medical graduate to have some knowledge in this area or recognise the need to access advice if there is uncertainty regarding appropriate management. The various regional HealthPathways give useful management advice (with a local flavor) for many health conditions and orientation of new doctors should include ensuring access to this resource. [Dr B] has since accessed this resource to improve her knowledge of neck lump management and, appropriately, she has apologized to [Mr A] for any deficiencies in her management contributing to the delay in his diagnosis. As an additional remedial measure I recommend [Dr B] access the Goodfellow Unit educational webinars on "Neck lumps, head and neck cancers and the role of HPV"[4] and "Salivary gland conditions"[5].'

[4] https://www.goodfellowunit.org/events/neck-lumps-head-and-neck-cancers-and-role-hpv Accessed 17 October 2022

[5] https://www.goodfellowunit.org/podcast/salivary-gland-conditions Accessed 17 October 2022

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