General Practitioner, Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 17HDC00974)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 27 May 2015, Ms A (40 years old at the time) presented to Dr B at a medical centre with right nipple discharge. Ms A had a family history of breast cancer and was on yearly surveillance. Dr B ordered Ms A's routine screening mammogram but did not include on the referral form the clinical details about the recent nipple discharge.

2. On 1 October 2015, Ms A saw Dr D with continuing nipple discharge. Ms A was referred for an ultrasound scan but there was confusion over whether Ms A or Dr D would organise the appointment. Hence, on 9 November 2015, during an appointment with her son, Ms A mentioned that she had not had an ultrasound scan. She was re-referred, and in December 2015 underwent a mammogram, an ultrasound, and a biopsy, which revealed cancer in the right breast.

3. Ms A attempted to make a complaint to the medical centre, but she received no response.

Findings

4. Dr B failed to refer Ms A for diagnostic testing on 27 May 2015. Furthermore, when Dr B referred Ms A for her routine breast screening, Dr B failed to provide the Breast Service with relevant clinical information that could have led to diagnostic testing and earlier diagnosis of Ms A's right breast cancer. Dr B did not provide services to Ms A with reasonable care and skill and, therefore, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

5. Adverse comment is made regarding Dr D's method of communication about the ultrasound booking. Although it was difficult to determine the cause of the communication issue regarding who was to organise the ultrasound appointment, the Commissioner reminded Dr D 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.

6. Regarding the medical centre's management of Ms A's complaint, the Commissioner reminded the medical centre that Right 10 of the Code does not require a complaint to be made in writing. It was noted that 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

7. It was recommended that Dr B provide Ms A with a written letter of apology for her breach of the Code.

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

Complaint and investigation

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

- *Whether Dr B provided Ms A with an appropriate standard of care between May 2015 and December 2015.*
- *Whether the medical centre provided Ms A with an appropriate standard of care between May 2015 and December 2015.*

9. The parties directly involved in the investigation were:

Ms A	Consumer
Dr B	General registrant
Medical centre	Provider

10. Further information was received from:

Dr C	General practitioner
Dr D	General practitioner

11. In-house clinical advice was obtained from vocationally registered general practitioner (GP) Dr David Maplesden, and is included at **Appendix A**.

Information gathered during investigation

12. Ms A (aged 40 years at the time) was a patient at the medical centre.

13. Ms A had a family history of breast cancer and was having annual breast screening. Ms A's mammogram in 2014 showed some small simple cysts in the right breast with no features of malignancy.[2]

14. On 27 May 2015, Ms A presented to Dr B[3] with right breast nipple discharge. Dr B documented that, on examination, she found no breast lumps and could not express any discharge from the nipple. Dr B noted that her impression was of a breast abscess from a breast cyst. Dr B also documented that she gave Ms A a swab[4] to take if there was further discharge, and advised her that if the discharge continued for another two to three weeks, to come back for another review.

[2] The presence of cancer.
[3] At the time of events, Dr B was an independent contractor working out of the medical centre, and was working under general oversight as part of the general practice training scheme.
[4] An absorbent piece of material used to take specimens for laboratory testing.

15. Dr B told HDC that since Ms A was overdue for her yearly mammogram, she also sent an e-referral to the District Health Board (DHB) Breast Service, for a routine screening (non-diagnostic) mammogram.[5] The referral noted: "Recommended for annual mammogram — mother breast cancer at 50." Dr B did not refer to the current symptom of unilateral breast discharge.

16. On 21 July 2015, Ms A underwent the screening mammogram, which showed no features suspicious for malignancy.

17. The Breast Service sent Dr B a letter on 30 July 2015 advising that Ms A had undergone a triaging process based on the clinical information provided in Dr B's referral letter, and advising of the mammogram results. The letter also stated that because of the large volume of referrals, no further appointments at the Breast Clinic had been arranged for Ms A, and care was being returned to Dr B.

18. On 7 August 2015, Dr B went on leave.

19. On 1 October 2015, Ms A was seen by Dr D for a non-healing lesion on her right breast. Dr D noted Ms A's family history. The examination was normal apart from crusting over the right nipple, and Dr D's diagnosis was of possible yeast infection. Dr D documented the following for Ms A's plan going forward:

> "For Micreme H[6]
> Will do USS[7].
> Review after USS — if still not healing consider referral breast service."

20. Dr D told HDC that in order to exclude breast disease, she advised Ms A to have an ultrasound scan with a private provider and to see her afterwards. Dr D understood that Ms A would organise the appointment.

21. Ms A told HDC that she agreed to the ultrasound, but said that "it was never followed up". She added that she was never given any information on whom to call, and had assumed that she would be contacted and given an appointment.

22. Ms A was given an ultrasound scan form that had no radiology provider information on it. Consequently, Ms A did not have the scan at that time.

23. On 9 November 2015, Ms A's child was seen by Dr C at the medical centre. At that appointment, Ms A told Dr C that she had not heard about her ultrasound scan appointment, and therefore he referred her back to the Breast Service for further review.

24. In December 2015, Ms A underwent investigations including an ultrasound and a biopsy, and was diagnosed with right breast cancer.

[5] A low-dose X-ray used for early detection of cancer.
[6] A broad spectrum anti-fungal and anti-inflammatory cream.
[7] Ultrasound scan.

25. Ms A told HDC that she did not feel supported by the medical centre throughout the process of finding out that she had cancer. Ms A made a verbal complaint by telephone to the medical centre, and was advised to put her complaint into writing. Ms A told HDC that she attempted to email the complaint on a number of occasions, but the emails bounced back so she gave up. The medical centre did not respond to Ms A's complaint.

Further information — Dr B

26. Dr B told HDC:

> "With the benefit of hindsight … I should have included a relevant current medical history and examination in the mammography request. At the time, I did not think that was necessary, as I had concluded that [Ms A's] symptom was because of a resolving breast abscess, I regret that I did not do so."

27. Dr B also told HDC:

> "This case has been an educative one for me and which I reflect on often. It has prompted me to ensure I am proactive and thorough in my assessments and referrals. I would like to also further extend my sincere apologies to [Ms A] for her delayed diagnosis and the understandable distress she has and continues to experience."

28. Dr B advised HDC that following this event:

- She reviewed the current guidelines on breast cancer.
- Now, regardless of her provisional diagnosis, she always includes relevant current clinical information in her mammogram requests.
- She completed a clinical audit pertaining to patients presenting with breast symptoms. In all cases, she has made appropriate management plans and referred appropriately.
- She tracks any patients with concerning symptoms to ensure that follow-up occurs.

Further information — Dr D

29. Dr D told HDC:

> "I am truly sorry for the misunderstanding that occurred in regards to the Ultrasound scan [appointment] … To try and avoid this happening again I now set a task on the computer to look for the results of any important tests that I have ordered especially those that will require further follow up …"

Further information — the medical centre

30. The medical centre submitted that Dr B is an excellent doctor who made an error by excluding the appropriate clinical details from the form. It is the medical centre's view that there are no practice policies that can be put into place to mitigate what happened.

31. With respect to its complaints policy, the Clinical Director of the medical centre told HDC:

> "It is our policy to respond to written complaints within 10 working days of receipt. I do not recall receiving a written complaint."

32. The medical centre has since reviewed its complaints policy and advised HDC that it now forwards all complaints to the Clinical Director for review and response.

Responses to provisional opinion

Ms A

33. Ms A was given an opportunity to comment on the "information gathered" section of the provisional opinion. Where relevant her comments have been incorporated into the report.

Dr B

34. Dr B was provided with an opportunity to comment on the provisional opinion, as it related to her.

35. Dr B told HDC that she accepts the decision. She commented that she did not take a "wait and see" approach but rather felt confident that Ms A understood to return if symptoms persisted. However, in hindsight, she agrees that she should have included the relevant clinical features on the mammogram referral form.

The medical centre

36. The medical centre was given an opportunity to comment on the provisional opinion, and advised HDC that it had no comment to make. It confirmed that Dr D was provided with a copy of the report and an opportunity to comment.

Opinion: Dr B — breach

37. When Dr B examined Ms A on 27 May 2015, she was aware of Ms A's family history of breast cancer. Following examination, Dr B concluded that Ms A's nipple discharge was likely due to a breast abscess, and decided on an observational approach with the advice for Ms A to return if the discharge continued.

38. Dr B noted that Ms A was overdue for her annual screening mammogram and referred her for this, but failed to write on the referral form Ms A's current symptom of unilateral nipple discharge.

39. The screening mammogram did not show malignancy and, therefore, based on the information provided at referral, the Breast Service referred Ms A back to Dr B, and no further imaging was performed.

40. My in-house clinical advisor, Dr David Maplesden, advised:

> "[S]erous unilateral nipple discharge (likely serous in nature given the description of crusting) in a [40-]year-old patient with increased risk of breast cancer, and without any obvious additional history or clinical findings suggestive of recent breast abscess, required prompt referral for ultrasonography with relevant clinical features noted on the request form rather than the 'wait and see' approach taken."

41. Dr Maplesden advised that Dr B's failure to formally refer Ms A to the DHB's Breast Service and/or to include relevant clinical information on Ms A's mammography screening request form represents a moderate departure from expected standards of care. Dr Maplesden said:

> "Had appropriate clinical information been included on the mammography request form, triaging clinicians would have had the opportunity to perform additional imaging (ultrasound) and arrange specialist review …"

42. I accept Dr Maplesden's advice. I am critical that Dr B failed to refer Ms A for diagnostic testing on 27 May 2015. Furthermore, when Dr B referred Ms A for her routine breast screening, Dr B failed to provide the Breast Service with relevant clinical information that could have led to diagnostic testing and earlier diagnosis of Ms A's right breast cancer. In my view, Dr B did not provide services to Ms A with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

Opinion: the medical centre — other comment

43. Dr B was working under general oversight as part of her General Practice training scheme at the medical centre. I note that the information provided has not indicated that training or professional oversight by the medical centre was a concern.

44. I note that it is the medical centre's policy to respond to written complaints within 10 working days of receipt. I remind the medical centre that Right 10 of the Code does not require a complaint to be made in writing. I note that complaints can be lodged in a number of ways — in person, over the telephone, or in writing. I expect all complaints, whether verbal or written, to be acknowledged and responded to in a speedy and efficient manner.

Opinion: Dr D — adverse comment

45. On 1 October 2015, Dr D reviewed Ms A. At the end of the consultation, the plan was for Ms A to have an ultrasound. Ms A thought that Dr D would organise the scan appointment, and Dr D thought that Ms A would organise it.

46. Dr Maplesden noted that the radiology referral form did not have any provider contact details recorded, and Ms A told HDC that she was not told whom to contact about an ultrasound. Dr Maplesden advised that he would be "mildly critical" if Ms A was not given specific instructions, preferably written, on how to contact the radiology provider. Dr Maplesden commented that the clinical situation was sufficiently critical to warrant discussion with the patient of the importance of having the ultrasound performed in a timely fashion. Dr Maplesden advised that he would be "mildly critical" if such discussion did not occur. Dr Maplesden is mildly critical that Dr D did not formally monitor timely completion of the ultrasound by way of a PMS task reminder.

47. I concur with Dr Maplesden's advice. Although it is difficult to determine the cause of the communication issue regarding who was to organise the ultrasound appointment, I remind Dr D 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. Given the clinical situation, it would also have been prudent for Dr D to have had a formal process for following up the ultrasound. It is positive to note that she has now improved her practice to reflect this.

Recommendation

48. In accordance with the proposed recommendation in my provisional opinion, Dr B has provided Ms A with an apology.

Follow-up actions

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

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden on 9 August 2017:

"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 [the medical centre], GPs [Dr B] and [Dr D]; response from [the medical centre] [clinical director]; GP notes [the medical centre].

2. [Ms A], aged 40 years at the time of the events in question, complains about delays in the diagnosis of her right breast cancer. She had a significant family history of breast cancer and because of this she was receiving annual mammograms. She developed a right sided nipple discharge and saw [Dr B] in May 2015 regarding this symptom. A mammogram was undertaken and was normal but there was no follow-up arranged. [Ms A] states the problem persisted and she saw [Dr D] in October 2015 who reassured her but said she would arrange an ultrasound *at a local place with students. I agreed and it was never followed up … I was never given any information on who to call. I had assumed they would call me with an appointment as the doctor could get in contact with the ultrasound place …* About a month later [Ms A] was at an appointment with her [child] [Dr C] and mentioned she had not received an ultrasound appointment. Dr C arranged a hospital breast clinic appointment and [Ms A] had an ultrasound and biopsies which showed right sided grade 3 breast cancer. She had several positive lymph nodes found following surgery. [Ms A] is concerned at the delays in her diagnosis.

3. [Dr B] notes she saw [Ms A] on 27 May 2015 and noted a history of right nipple discharge *that was getting better.* [Ms A] had not noted any breast lump. She was receiving annual mammography as her mother had been diagnosed with breast cancer at 50 years old. The most recent mammogram was 28 March 2014 and reported *right breast cysts with no features of malignancy.* [Dr B] noted yellowish crusting on [Ms A's] right nipple but she could not express any fluid and there were no masses noted on breast or axillary palpation. [Dr B] states she made a provisional diagnosis of *breast abscess from a breast cyst. I asked [Ms A] to take a swab if there was any further discharge. I advised her to return for review in 2–3 weeks if the discharge continued. She did not return to see me.* A mammogram was requested as [Ms A] was overdue for her annual screening. This was undertaken on 21 July 2017 and was reported as normal. [Dr B] went on leave in August 2015 and did not see [Ms A] again.

4. [Dr B's] notes are consistent with her response. History includes: *Right breast discharge, not tender, no lumps. Yellowish discharge bra gets stuck on nipple, discharge getting better. FH: Mother breast cancer at 50yr.* Assessment findings are as per the response. Diagnostic impression is recorded as: *Right breast cyst* and recorded management is as noted above, including *If continues for another 2–3 weeks to come back for review, Due for mammogram this year as well*. A form was provided for skin swab. An e-referral was made for screening (not diagnostic) mammography with

indication recorded as: *Recommended for annual mammogram — mother breast cancer at 50 yrs old.* There is no reference to the current symptom of unilateral breast discharge.

5. On file is a mammography and ultrasound report dated 28 March 2014. Indication is: *Strong family history of breast cancer. Describes pain in the right lateral breast.* The report concluded: *No features suspicious for malignancy. Continued annual screening mammograms are recommended.* Ultrasound had shown *a few small simple cysts in the lateral aspect of the right breast, corresponding to the site of previous tenderness.* I have viewed the formal mammography report dated 21 July 2015, copies to Breast Clinic Outpatients and [Dr B]). The 'clinical indications' (which I presume have been transposed from the request form) are: *Routine check. Family history mother and grandmother.* The report concluded: *There are no features suspicious for malignancy.* Images had been compared with previous mammograms. In a letter addressed to [Dr B] dated 30 July 2015 it is noted [Ms A] has *undergone a triaging process at the DHB Breast Clinic* with referral letter clinical information and recent mammogram result noted. Based on the available information, no clinic appointment was made and [Ms A's] care was referred back to her GP. The letter concluded: *If you have any ongoing concerns or your patient develops more symptoms, please contact* [the DHB service].

6. [Dr D] states in her response that she saw [Ms A] on 1 October 2015 with *a non-healing lesion on her right breast … the breast discharge had settled. However, there was a crusty lesion on the right nipple that would not heal.* [Dr D] noted [Ms A's] family history of breast cancer and her previous mammogram results. [Dr D] states: *On examination there was crusting over the right nipple. The rest of the breast examination was normal. My assessment was of possible yeast infection of the nipple. However, in order to exclude any significant breast disease, I advised Ms A that she should have an Ultrasound scan with review by me after this. The ultrasound scan was going to be done privately. Ms A understood that I was going to organize the appointment and I understood she was going to do this.* [Dr D] states that she now sets reminders to review results of any important tests she has ordered.

7. Clinical notes of the consultation are consistent with [Dr D's] response. History includes: *Had problems with right nipple discharge in May. This settled but since then has had crusty lesion over the nipple that doesn't seem to want to heal …* On assessment: *Crust over right nipple, remainder of exam normal … For MicremeH, Will do USS, Review after USS — if still not healing consider referral to breast service.* A radiology referral form (generic) was generated and presumably handed to the patient. The form contains no radiology provider contact details, just the heading 'Radiology Request'. Listed 'Clinical Indications' are: *Discharge from right nipple. History cysts both breasts. Recent mammogram normal. USS as part of investigation into cause for discharge. F/H mother — aged 55*.

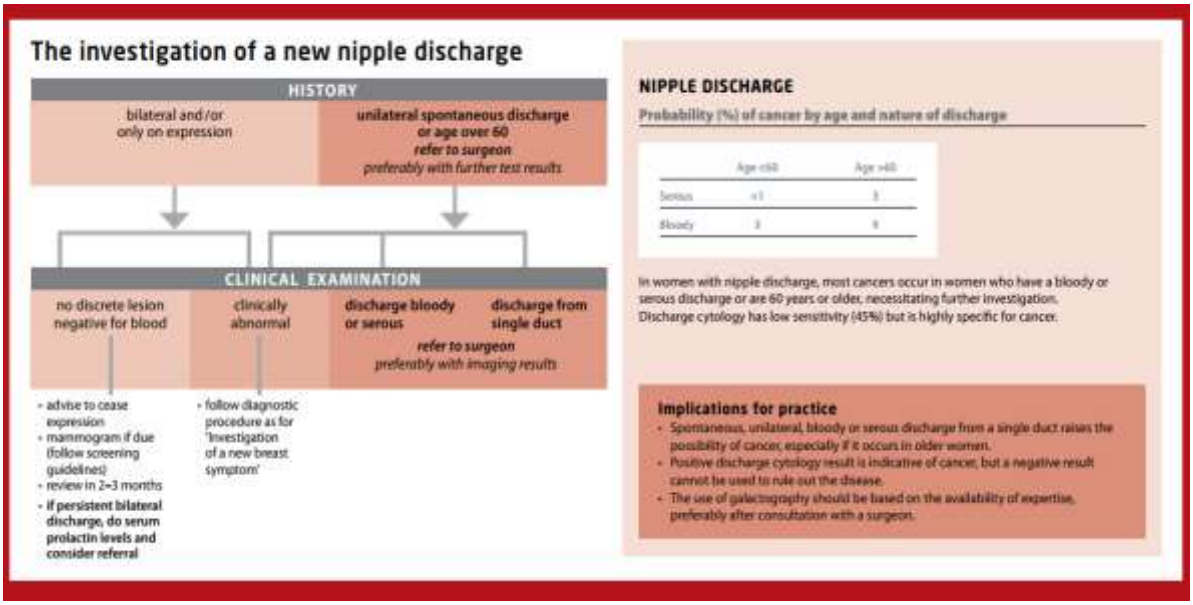
8. [Ms A] states she was under the impression [Dr D] was organizing the ultrasound appointment. At an appointment at [the medical centre] for her [child] on 9 November 2016 she mentioned she had not received an ultrasound appointment. [Dr

C] reviewed the notes and referred [Ms A] to the DHB breast clinic for imaging and further management. [Dr C] noted, on 18 December 2015: … *although there is a note from me, I only re-referred to public as she wasn't insured and saw only in conjunction with sick child, not as consultation.*

9. In early December 2015, [Ms A] underwent right mammogram and ultrasound — the latter showing an 11mm lesion at 3 o'clock on the right breast. Subsequent core biopsies (14 December 2015) revealed two separate foci of infiltrating ductal carcinoma in the right breast (the 3 o'clock lesion and a smaller lesion 4 o'clock). [Ms A] subsequently required right mastectomy and lymph node dissection. Although not apparent from the notes, [Ms A] states she had several positive lymph nodes and she has presumably required adjunctive chemoradiotherapy.

10. Recommendations regarding appropriate investigation of nipple discharge relate to various factors including whether the discharge is unilateral or bilateral, spontaneous or only occurring with manipulation, nature of discharge including blood staining, patient age and overall risk of breast cancer. Some management recommendations reviewed include the following:

(i) Primary care guidelines published in Australia in 2006[1] (currently under review), are summarised in the following algorithm:



(ii) New Zealand 'High Suspicion of Cancer' definitions[2] (for purposes of referral using the High Suspicion of Cancer (HSCAN) pathway) include the following categories relevant to this complaint:

[1] https://canceraustralia.gov.au/system/tdf/publications/investigation-new-breast-symptom-guide-general-practitioners/pdf/inbs_guide_for_gps_v4_with_neo_headings.pdf?file=1&type=node&id=3439 Accessed 9 August 2017

[2] http://www.melnet.org.nz/uploads/hscan_defns_final_updated_2_sept_2015.pdf Accessed 9 August 2017

a. Spontaneous unilateral bloody nipple discharge

b. Women aged over 40 years with recent onset unilateral nipple retraction or distortion

c. Women aged over 40 years with unilateral eczematous skin or nipple change that does not respond to topical treatment

(iii) A literature review service[3] includes the following information relevant to this complaint:

a. Nipple discharge is categorized as normal (lactation), benign (physiologic), or pathologic based on the characteristics of presentation. Most nipple discharge is benign in origin.

b. Benign physiologic unilateral or bilateral nipple discharge (galactorrhea) is characterized by multiductal discharge that is nonbloody, regardless of color (eg, milky, brown, green, blue, gray, or clear). Galactorrhea is caused by hyperprolactinemia and may be secondary to medications, endocrine tumors (pituitary adenoma), endocrine abnormalities, or a variety of medical conditions.

c. Pathologic discharge is characterized by spontaneous, persistent, unilateral discharge limited to one duct (uniductal). The discharge can be either serous (straw-colored or clear), sanguineous (bloody), or serosanguineous (blood-tinged). An intraductal papilloma is the cause of pathologic discharge in over one-half [of] the cases, while underlying malignancy is the cause of nipple discharge in 5 to 10 percent of cases.

d. The **workup of suspicious nipple discharge should include ultrasound and mammography**. The role of imaging is to determine whether there are any underlying lesions that may account for the symptom of nipple discharge and to target the area for surgical localization. However, imaging studies do not reliably identify cancer or high-risk lesions in patients with nipple discharge. Other diagnostic testing, including ductography, breast magnetic resonance imaging, magnetic resonance ductography, and ductoscopy can be helpful in selected women but are not routinely necessary for the workup of nipple discharge. Cytology and ductal lavage are rarely helpful.

11. [Ms A] was recognised by both [Dr B] and [Dr D] as being in an increased-risk group for breast cancer because of her family history. In May 2015 [Ms A] presented with unilateral spontaneous nipple discharge, duration not defined. [Dr B] was unable to provoke the discharge so could not determine whether it was multi-ductal or uni-ductal in origin. The discharge was not bloodstained and was not associated with any palpable abnormality. The nipple apparently appeared otherwise normal. I believe accepted and recommended practice in this situation would have been to refer [Ms A] to the DHB breast service with concurrent breast imaging (mammography and

[3] Golshan M. Nipple discharge. Uptodate. Literature review current through July 2017. www.uptodate.com

ultrasound). [Ms A] did not fulfil the criteria for a HSCAN pathway so it would have been reasonable to make a non-urgent referral initially with imaging results guiding subsequent priority. It is unclear if [Dr B] was under the impression that the request for mammogram alone might have led to appropriate clinic review or additional imaging (ultrasound) and the subsequent letter from the DHB breast service raised the possibility such follow-up might have occurred at times. However, [Dr B] did not mention in her referral that [Ms A] had a breast symptom (nipple discharge), and the referral was made for screening mammography rather than diagnostic mammography. I note the impression was gained by [Dr B] that [Ms A's] nipple discharge was resolving and there was no structural breast abnormality, she did order some imaging (albeit with the limitations discussed), and she instructed [Ms A] to return in two to three weeks if the symptom persisted. While these are mitigating factors, I feel the failure by [Dr B] to formally refer [Ms A] to the DHB breast service and/or to include relevant clinical data on the mammography request form represents a moderate departure from expected standards of care. Had appropriate clinical information been included on the mammography request form, triaging clinicians would have had the opportunity to perform additional imaging (ultrasound) and arrange specialist review if this was felt to be indicated (which I think would have been the case). I recommend [Dr B] review her management of breast symptoms in primary care to ensure her practice is consistent with current recommendations.

12. The complaint documentation suggests [Ms A's] nipple symptoms persisted. It is unclear why she did not return for review in two to three weeks as recommended by [Dr B] in May 2015. Nevertheless, she did return for review in October 2015 and was assessed by [Dr D]. [Dr D] noted [Ms A's] increased risk of breast cancer associated with her family history, and the presence of a 'crusty lesion' on the right nipple which had persisted over the preceding five months. Persistent nipple discharge is mentioned on the ultrasound request form but the impression from the clinical notes is that the discharge had resolved. I think it was reasonable to trial some topical therapy for what was presumed to be infections or eczematous changes of the right nipple (although the five-month history was perhaps not typical for a yeast infection) as failure to respond to such treatment would have made [Ms A] eligible for the HSCAN pathway. It was also appropriate to organize ultrasound imaging of the breast and if the expectation was that this would be undertaken in the near future (and was being undertaken in the private sector), it was probably reasonable to defer referral to the DHB breast service until result of the ultrasound was known. I note [Dr D] recorded an intention to refer [Ms A] to the breast service depending on the imaging result and response to therapy. In summary, I feel [Dr D's] intended management of [Ms A], as documented, was consistent with expected standards of care although best practice would have been to document follow-up arrangements — structured follow-up being required to review the response to therapy whether or not the imaging results were normal. However, it seems apparent there were issues with communication regarding the ultrasound arrangements and it is difficult to determine, from the information available, the cause of this dysfunction. I note the radiology referral form did not have any provider contact details recorded and I would be mildly critical if [Ms A] was not given specific instructions, preferably written, on how to

contact the radiology provider. I believe the clinical situation was sufficiently 'critical' (atypical persistent breast symptom in patient at increased risk of breast cancer) to warrant discussion with the patient of the importance of having the ultrasound performed in a timely fashion and I would be mildly critical if such discussion did not occur. For the same reasons, I am mildly critical that [Dr D] did not formally monitor timely completion of the investigation by way of a PMS 'task reminder'. I note she has acknowledged this oversight and altered her practice in this regard."

Further expert advice was obtained from Dr David Maplesden on 18 September 2017:

"I have reviewed [Dr B's] response to my original advice. [Dr B] responds that when she examined [Ms A] on 27 May 2015, she suspected [Ms A's] symptoms were *likely to be a simple breast abscess which was improving.* Given there was no history of breast mass, redness or tenderness I do not feel abscess was a likely diagnosis. I have regarded the fact that [Ms A] was referred for some imaging (mammography) and advised to return if her symptoms persisted as being mitigating factors, and I note [Dr B] is confident she would have referred [Ms A] for further imaging had she re-presented as instructed. However, I remain of the view that the request for mammography (whether or not it was regarded as a screening procedure) should have included relevant current medical history and this included normal breast examination and recent unilateral nipple discharge. I am also of the view that serous unilateral nipple discharge (likely serous in nature given the description of crusting) in a [40-]year-old patient with increased risk of breast cancer, and without any obvious additional history or clinical findings suggestive of recent breast abscess, required prompt referral for ultrasonography with relevant clinical features noted on the request form, rather than the 'wait and see' approach taken. I remain of the view that [Dr B's] management of [Ms A] departed from expected standards of care to a moderate degree, and the remedial actions she outlines in her response are appropriate."