Decision 23HDC01879
19 March 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

GP's failure to follow-up and/or make a re-referral for breast cancer patient

Introduction

1. In March 2017, Mrs B was diagnosed with breast cancer.[1] Mrs B's General Practitioner (GP), Dr A of the local medical centre, made a referral to Health New Zealand | Te Whatu Ora (Health NZ) General Surgery in April 2017 for Mrs B to receive treatment for her breast cancer. Following the referral, Dr A saw Mrs B on several occasions over the period 2 April 2019 until 30 August 2022. Sadly, Mrs B passed away in September 2022 (aged 80 years). The complaint referred from the Coroner to HDC on 18 August 2023, and subsequently supported by Mrs B's family, raised concerns over Dr A's lack of follow-up or further referral for Mrs B.

2. At the outset, I would like to extend to Mrs B's family my sincere condolences of the passing of Mrs B. 'Oku 'oatu 'a e kangamamahi mo'oni ki ho'omou mole.

3. I find Dr A in breach of Rights 4(1) and 6(2) of the Code of Health and Disability Services Consumers' Rights (the Code).

4. Issues regarding the provision of care by Health NZ have been dealt with separately.

Recommendations

5. Noting the changes made at the medical practice and by Dr A below, and that Dr A has since retired from clinical practice, I recommend:

   a. Dr A provides an apology in writing to Mrs B's family for the breaches of the Code identified in this report. The apology is to be provided within three weeks of the date of this report for forwarding to Mrs B's family.

   b. Should Dr A return to clinical practice, he undertakes training in relation to understanding bias and clinical record keeping and complete HDC's online learning module in relation to informed consent.[2] Evidence of the training is to be provided to HDC within three months of Dr A returning to clinical practice.

Background

6. Information was gathered from Dr A, the medical centre, Health New Zealand | Te Whatu Ora, the Coroner, and Mrs B's family during the investigation.

7. Mrs B lived at various times with her sons and their families. Mrs B was usually accompanied by one of her daughters-in-law to medical appointments as Mrs B did not speak English, and her family assisted with translation.

[1] A low to intermediate-grade ductal carcinoma.
[2] Online learning — Health & Disability Commissioner

8. On 27 March 2017, Mrs B presented to Dr A with a right breast lump. Dr A stated that she had noticed it a month previously, but he said it had clearly been there for an extended period as 'the 3cm lump was fixed to the chest wall though not to the skin.' Mrs B underwent a diagnostic mammogram and biopsy, which confirmed she had breast cancer. As a result, Dr A made a referral to general surgery in April 2017 for Mrs B to receive treatment from Health NZ.

9. At her first appointment with Health NZ, medical treatment was recommended to downstage the cancer to enable surgery in the future, and Mrs B was prescribed letrozole.[3] Follow-up appointments with Health NZ occurred in June, November, and September 2017.

10. On 30 November 2017, as Mrs B had been responding well to letrozole, a decision was made by the general surgeon for her to continue with the medication and have a further magnetic resonance imaging scan for re-imaging in January 2018. Mrs B was to be discussed in the breast multi-disciplinary meeting after that time.

11. In February 2018, Mrs B was again seen by Health NZ and, as she was responding well to treatment, with the cancer reducing in size, it was explained to her that surgery could be considered. The clinical records reflect that Mrs B was not keen on surgery at that time and wanted to continue with letrozole. It was agreed that this was not unreasonable and Mrs B should have a further clinical review in three months' time.[4] This follow-up surgical outpatient appointment did not occur.

12. On 22 February 2018, a clinic letter was sent by the Breast Surgeon at Health NZ to Mrs B's GP, Dr A, outlining the plan to review her in three months. This letter was not copied to Mrs B as it was not routine practice at that time.

13. Mrs B was not seen by Dr A again until 2 April 2019, when his clinical records note that Mrs B's breast cancer had 'very obviously enlarged to 6.5cm' and she had stopped taking letrozole. Dr A re-prescribed Mrs B letrozole, and his clinical records noted he would see her again in one month and refer her back to general surgery. This follow-up appointment did not occur.

14. On 30 April 2020, approximately a year later, Mrs B had a further appointment with Dr A, which came about because of a phone consultation on 29 April 2020 where he asked for Mrs B to be seen as her breast cancer was enlarging. The clinical records again reflect that Mrs B was not taking the letrozole medication, her breast lump was enlarging,[5] and she had also unintentionally lost weight.[6] Dr A told HDC the follow-up by general surgery was not raised by Mrs B or her family at this appointment and put his lack of re-referral back to general surgery in part down to this. Dr A explained this was also due to dealing with the complexity of Mrs B not adhering to her medication.[7] He said that this had not been helped by earlier surgical comments about Mrs B responding well to the letrozole medication, and

[3] A nonsteroidal aromatase inhibitor used in the treatment of breast cancer in postmenopausal women.
[4] May 2018.
[5] Size recorded as 6×5cm.
[6] Weight recorded as 80kg.
[7] 'Antihypertensive, thyroid medication, and letrozole.'

he considered that it was common to manage postmenopausal breast cancer with hormone treatment alone. Dr A said he emphasised the seriousness of not taking the medication to Mrs B and her family and re-prescribed letrozole and cilazapril.[8] Dr A repeated Mrs B's blood tests, and the results showed a recurrence of hyperthyroidism.

15. The clinical records show that Mrs B attended further appointments with Dr A on 11 May 2020[9] and 9 September 2020.[10] During November 2020 and August 2021, calls were made by the medical centre nurses regarding an overdue blood test and Mrs B failing to attend a carpark consultation.[11]

16. On 16 August 2021, the medical centre was contacted by a Tongan health and social service NGO as the family had asked for support. They were concerned that Mrs B was wandering and leaving the house, and they asked for a needs assessment. Information was provided at this time that someone from the NGO could assist in a GP review to translate and support Mrs B. A referral was made for a Home Needs Assessment by the medical centre nurses.

17. On 29 September 2021, Mrs B failed to attend a scheduled appointment with Dr A.

18. On 4 July 2022, Dr A's clinical records reflect that, on examination of Mrs B, she had 'no pain headache cough or [shortness of breath], her '[Right] upper medial breast cancer fixed to skin and underlying bone' and 'family thinks she has dementia, poor hearing'. A plan was made by Dr A for Mrs B to have a double appointment to see the nurse for a check-up and mini-Addenbrooke's Cognitive Examination (ACE).[12] Dr A also arranged for routine blood and urine tests and blood tests for dementia and cancer for Mrs B to be taken at the medical centre.

19. On 13 July 2022, Mrs B attended a further appointment where Dr A made a plan of action for dementia, [13] after her mini-ACE test result was consistent with dementia.

20. Mrs B was last seen by Dr A on 30 August 2022, and his clinical notes reflect that her breast cancer was 'just starting to ulcerate, not infected.' Dr A made a semi-urgent referral to general surgery for advice and indicated that Mrs B was non-compliant with letrozole. Health NZ subsequently confirmed to HDC that Mrs B was assigned a 'semi-urgent priority', which is to be seen in less than 14 days.

21. In contrast, in information provided to HDC, Mrs B's family stated that, at this appointment (30 August 2022), they were of the view that Mrs B was very unwell with severe shortness of breath. Dr A stated that Mrs B had developed a cough but there was no complaint of shortness of breath. Mrs B's family also said they were concerned that Mrs B was sent home

[8] Used to treat high blood pressure and heart failure.
[9] When Mrs B was seen due to her low thyroid-stimulating hormone.
[10] Breast cancer size recorded as 4cm in diameter, which showed a reduction in size since the previous appointment.
[11] Held in the carpark because of it being during the COVID-19 pandemic.
[12] A brief cognitive screening test that evaluates four main cognitive areas (orientation, memory, language, and visuospatial function).
[13] A referral to the community dentist, prescribed folic acid, a CT head scan, two appointments for neurological exam at time of providing CT result, and discuss urinary incontinence.

that day after being prescribed medication by Dr A instead of being referred to the Emergency Department of the local hospital.

22. On 31 August 2022, Dr A had discussions with Mrs B's family about 'uncontrolled atrial fibrillation with probable left ventricular failure' and advised them a chest X-ray had been ordered.

23. The following day (1 September 2022), Dr A had a further discussion with Mrs B's family about the need to see Mrs B for anticoagulation to prevent strokes and discussed referral to a Pacific community worker to organise disability allowance support.

24. That same day, Mrs B was rushed to the Emergency Department of the local hospital with shortness of breath and a fungating right breast mass. Dr A received notification that there had been a significant deterioration in Mrs B's shortness of breath over the last 24 hours. Mrs B was admitted under the Respiratory Service on 2 September 2022.

25. Sadly, Mrs B passed away suddenly during her stay in hospital in September 2022. The clinical opinion from the hospital record of death reported she died due to 'a sudden cardiac condition with breast cancer as an underlying condition'.

26. Dr A explained that he found the care of Mrs B challenging due to the language barrier and translation requirements, lack of medicines information in the Tongan language, her poor adherence to taking medication,[14] often needing to take longer than the standard 15-minute consultation, and the lack of communication from Health NZ.

27. Dr A stated that he regrets he did not re-refer Mrs B back to Health NZ and acknowledges he may have had an anchoring bias due to previously having postmenopausal breast cancer patients treated successfully long term with oestrogen antagonist therapy without surgery.

28. In its response to HDC, the medical centre stated that Dr A was unaware Mrs B had not attended follow-up appointments for her breast cancer and continued prescribing the letrozole medication as advised by the surgeon.

Changes made

29. As a result of these events, Dr A/the medical centre have made the following changes:

    a. Since January 2023, the medical centre now has an in-practice health coach and a case worker attached to the practice who work closely together. The health coach is available to connect with families who are struggling to get their health needs met and find health information in their own language. Dr A highlighted there is still 'a lack of appropriate translations for health information in the Tongan language.'

[14] Including 'letrozole for her breast cancer, carbimazole to prevent atrial fibrillation and reduce her risk of stroke, and cilazapril for hypertension.'

b. Dr A has stated that he is now more conscious that he cannot 'assume adherence to the appropriate course of action, even in this type of situation, and will take further steps to ensure that [his] recommendations are understood.'

c. Dr A has also adopted a recommendation for GPs to change their standard question to Pasifika patients and their families from ''Have you got any questions?', to 'What questions have you got?' in the hope that this will further facilitate the expression of questions about the illness and its management.

d. Dr A has also given considerable thought to this case and stated he has learned from it and has discussed with his colleagues as to how such patients can be provided with better follow-up in the future.

In-house clinical advice

30. To assist me in my assessment of this complaint, I sought in-house advice from Dr David Maplesden. A full copy of Dr Maplesden's advice is attached as Appendix A. Dr Maplesden advised of the following departures from accepted standards of care by Dr A:

a. Moderate departure for not establishing Mrs B's loss of contact with the breast surgical service;

b. Moderate departure for failing to discuss with Mrs B's family referral back to the surgical service as a management option at various points in Mrs B's health journey, specifically on 2 April 2019, 30 April 2020, 4 July 2022, and 13 July 2022.

Responses to provisional decision

31. Mrs B's family were given an opportunity to comment on relevant sections of the provisional decision and confirmed they had no further comment to make.

32. Dr A and the medical centre were also provided with an opportunity to comment on the provisional decision. Dr A highlighted that, in his forty years of practice, 'this case was a notable outlier in relation to family engagement with communication and management of cancer-related issues.' Dr A stated that he had not made the assumption that the surgical department was following up with Mrs B, more that he assumed 'she had been handed back to general practice.' Dr A also confirmed he does not intend to return to clinical practice. The medical centre had nothing further to add.

Decision

33. The central issue for me to determine is whether appropriate actions by following up and/or making a re-referral for Mrs B were made by Dr A at the medical centre to ensure she received appropriate treatment following her breast cancer diagnosis.

Dr A – breach

34. Mrs B had the right to have services provided with reasonable care and skill as provided for in Right 4(1) of the Code.[15] Mrs B also had the right to be fully informed about options

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

available to her for the management of her progressing breast cancer, as provided for in Right 6(2).[16]

35. Dr A saw Mrs B and her family, who could translate for her, at multiple appointments leading up to her hospitalisation. At these appointments, he had the opportunity to establish Mrs B's loss of contact with the breast surgical service and to discuss Mrs B's re-referral back to the service as a management option. Dr Maplesden considered this was indicated with some urgency. I accept this advice, and I am also of the view that this was particularly important given Mrs B's difficulty in adhering to letrozole. I accept Dr Maplesden's advice that there were missed opportunities by Dr A to do this at appointments on 2 April 2019, 30 April 2020, 4 July 2022, and 13 July 2022.

36. Dr Maplesden also advised that, by not having relevant discussions with Mrs B's family about when she was last seen by the surgical service and/or when her next review was scheduled, by not reviewing the most recent breast surgical reports, and by not updating the service with her presenting symptoms, such as the unexplained weight loss and enlarging breast lump on 30 April 2020, he failed to follow best practice. Dr Maplesden also advised that it was not reasonable for Dr A to assume Mrs B had remained under the care of the surgical service and elected to take letrozole in preference to surgery without establishing the facts during consultation and/or without confirmation from the surgical service. Dr Maplesden also stated that it was clear from the final surgical report on file that surgery was the recommended definitive management for Mrs B's cancer.

37. Dr Maplesden advised that he considered the assessments of Mrs B by Dr A on 4 and 13 July 2022 were reasonably comprehensive. However, he also noted that, ideally, Dr A would have performed the neurological assessment before making the referral to the breast service in case there were abnormalities noted that might have increased prioritisation. Dr Maplesden also considered that accepted practice would have been to have made the referral to the breast service and for CT imaging concurrently at the July appointments with Mrs B.

38. Whilst there is a possibility that, if Mrs B had received the options above, she may still have preferred to avoid surgery and opted to continue with letrozole, she was ultimately not given the opportunity to do so. I note that Dr A accepts that a surgical referral as far back as 2019 was appropriate and mentions factors relevant to this. I acknowledge the level of pressure GPs are under and the challenges outlined by Dr A in paragraph 26. However, Dr A had a responsibility as Mrs B's GP to ensure that her care was escalated appropriately. I accept Dr Maplesden's advice and consider there were multiple missed opportunities, over three and a half years but specifically on 2 April 2019, 30 April 2020, 4 July 2022, and 13 July 2022 to have had appropriate discussions regarding the management of Mrs B's breast cancer and it's progression, to establish Mrs B's loss of contact with the surgical service with her family and/or the breast surgical service, and to re-refer her during that time, yet he

[16] Right 6(2) states: 'Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

failed to do so. This resulted in significant growth of Mrs B's cancer over the period concerned.

39. I also accept Dr Maplesden's advice that, due to the communication issues, diligence was required to ensure clarity over vital health issues such as the management of Mrs B's breast cancer. In this regard, I note that NGO offered support to assist with translation services, which might have been an option Dr A could have considered with Mrs B's consent. Whilst Dr A has stated he emphasised the serious implications of not taking medication to Mrs B and her family, I note that no such discussions were documented, nor was any follow-up plan documented in relation to this for the appointment on 30 April 2020, and I am critical of this.

40. Accordingly, given the failings identified, I find Dr A in breach of Right 4(1) of the Code for failing to provide services to Mrs B with reasonable care and skill. I also find Dr A in breach of Right 6(2) for failing to provide information to Mrs B and/or her family that a reasonable consumer in her circumstances would expect to receive to make an informed choice about the options for treatment of her progressing breast cancer.

41. Dr A's comments around the lack of appropriate translations for health information in the Tongan language concern me, and so I have included the Ministry of Health as part of my follow-up actions, so they are aware of this deficit for those in the Tongan community and can review the situation.

The medical centre

42. I make no finding in relation to the medical centre and commend them on putting in place the new health coach and case worker roles to support its patients.

Follow-up actions

43. A copy of the sections of this report that relate to Dr A will be sent to the Medical Council of New Zealand.

44. A copy of this report with details identifying the parties removed will be sent to the Ministry of Health and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Dr Vanessa Caldwell
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to the Commissioner

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

'**DATE:** 2 September 2025; **Addendum 1 October 2025 (s15)**

1. My name is David Maplesden. I am a graduate of Auckland University Medical School, and I am a vocationally registered general practitioner holding a current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, Dip Strat Leadership 2002, FRNZCGP (Dist) 2003. Thank you for the request that I provide clinical advice in relation to the referral from the Coroner about the care provided to Mrs [B] (dec) by Dr [A] 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

- Referral from the Coroner
- Responses to the Coroner from [Health NZ] and Dr [A]
- Responses to HDC from [Health NZ] and Dr [A]
- Clinical notes [public hospital]
- Clinical notes [the medical centre]

3. The Coroner referral notes: *Mrs [B] was an 80-year-old lady living in […] at the time of her death. Mrs [B] died* […] *[in] September 2022. No postmortem was directed but the clinical opinion is that Mrs [B] died due to a sudden cardiac death with breast cancer as an underlying condition. Mrs [B] appears to have been lost to follow up by the […] DHB's general surgical department in 2018. Her GP saw her in April 2019 and April 2020. On both occasions her breast cancer appears to have grown but the issue of following up or re-referring to the DHB does not appear to have been considered.*

4. Mrs [B]'s family reported verbally to an HDC Navigator on 29 August 2023 the following concerns regarding Dr [A]'s management of their mother:

- *GP seen Mrs [B] on the day before she died, she was very unwell with severe sob. The GP should refer her to ED however she was sent home with some medications and later she presented to ED.* [This refers to a consultation on 30 August 2022. Mrs [B] attended ED on 1 September 2022 and was admitted under the respiratory service on 2 September 2022. She died unexpectedly [in] September 2022].
- *When the consumer ran out of breast cancer medications, […] took her to see her GP for a new prescription, family noticed later she was given different medications and approached GP. Her cancer medication only restarted prior to her death and the family question the GP why he stops prescribing her cancer medication.*

- *On one GP consultation, the family asked questions around what the outcome would be if Mrs [B] go ahead with surgery, the GP responded, there is no need for surgery because of her age and even after she had surgery, she will continue to take breast cancer medications.* [The facts regarding this comment are not established and it is not addressed in the provider response].

5. I have been asked to comment on Dr [A]'s management of Mrs [B] from April 2019 to September 2022 as regards the following issues:

- Re-referral to the […] breast oncology service when Mrs [B] was apparently lost to follow-up
- Management of letrozole prescribing as palliative treatment for Mrs [B]'s breast cancer
- Assessment and management of Mrs [B] on 30 August 2022

6. Background: Mrs [B] (B:1941) was a patient of Dr [A] at [the local medical centre] since at least 2012. She spoke no English and usually attended appointments with a family member who would translate. Mrs [B] tended to consult infrequently and adherence to treatment regimens was an issue. Medical history included hypertension (prescribed cilazapril), impaired glucose tolerance, toxic multinodular goitre diagnosed 2014 (treated intermittently with carbimazole). She was a cigarette smoker. In March 2017, Mrs [B] was referred by Dr [A] to the […] Breast care service with a right breast lump. Subsequent investigations confirmed a low to intermediate grade ductal carcinoma strongly ER +ve and PR +ve. The cancer was fixed to the chest wall, but there was no nodal involvement or distal metastatic disease evident. Neoadjuvant therapy with oral letrozole was commenced, and the tumour responded well with significant shrinkage. Mrs [B] tolerated the treatment well and was regularly reviewed by the breast surgical team (Dr [C]), with surgery deferred while the tumour continued to shrink. At review on 22 February 2018, Dr [C] recommended to Mrs [B] that she undergo surgery sometime during the year. Mrs [B] was agreeable but preferred to persist with letrozole therapy initially, and a three-month prescription was provided with report to the GP noting *I have given her a new prescription for* [letrozole] *today and I will see her again in three months' time to re-assess.* The [Health NZ] response notes that there were then administrative errors meaning Mrs [B] was not booked for a follow-up appointment.

7. Letrozole was subsequently prescribed for Mrs [B] intermittently by Dr [A], but she was not referred back to the surgical service by him until 30 August 2022 when her breast mass had started to ulcerate and she was not adhering to the letrozole regimen. The [Health NZ] response states there were efforts made by the Breast care service to contact Mrs [B] to come in for review, but these contacts were not recorded and did not result in Mrs [B] attending. Dr [A] notes he did not receive any correspondence from the Breast care service in relation to Mrs [B]'s overdue review, and he was not notified by Mrs [B] or her family that they were not attending outpatient appointments.

8. The first appointment Dr [A] had with Mrs [B] following the February 2018 […] breast surgical review was 2 April 2019. This and subsequent appointments have been summarised by Dr [A] and are presented as Appendix 1. The summaries appear consistent with the

clinical notes reviewed. Dr [A] had annotated the February 2018 breast surgery report *letrozole – surgery recommended.* On 30 July 2018, Dr [A] recorded *Consider social worker next time to make sure getting benefits? Not taking BP meds due to cost.* There was no apparent request for a letrozole prescription from Mrs [B] between February 2018 (when Dr [C] provide a three-month supply) and April 2019.

Comment: I believe it was a reasonable expectation by Dr [A] that the follow-up referred to in the February 2018 breast clinic report would occur. I would not expect Dr [A] to have tracked receipt of clinic letters or requests for letrozole prescriptions over this period. There was no prompting to the GP or enquiry from either Mrs [B] and her family or from CH regarding Mrs [B]'s overdue surgical review and/or letrozole prescriptions.

9. On 2 April 2019, Dr [A] notes Mrs [B] was not taking her letrozole and *R medial breast lump enlarged 6.5cm diameter* [was around 3x2cm in February 2018], *non-tender, fixed to chest wall* [as previously], *no axillary or supraclavicular lymphadenopathy, liver nad.* Adherence to therapy was discussed. Plan was for blood tests and *see 1 mo to restart BP medication? refer back to gen surgery.* A three-month supply of letrozole was prescribed. Blood tests were completed, and results were unremarkable (chronic suppression TSH with normal FT4). There was no further contact from Mrs [B] or her family (including no request for letrozole) over the next 12 months, although Mrs [B] was sent a form and reminder for repeat blood tests (TFT) on 1 July 2019 and an invitation for shingles vaccine on 30 July 2019.

Comment: I believe accepted practice on 2 April 2019 would be for Dr [A] to have attempted to clarify Mrs [B]'s current management by the breast surgical service (including reviewing the most recent report on file) and, if it was evident there was a likelihood she had been lost to follow-up, to offer her the option of re-referral noting the content of the February 2018 report. If Mrs [B]'s preference was to continue conservative management with letrozole, I believe it was quite reasonable for Dr [A] to prescribe the medication as was done. The surgical service had presumably previously discussed with Mrs [B] the pros and cons of deferring surgery. If Mrs [B] consented to Dr [A] contacting the surgical service, I believe best practice would be for him to have updated the service regarding Mrs [B]'s decision and current management plan, including the most recent breast examination findings indicating growth of the breast lump. The importance of adherence to therapy was apparently discussed, and there was no reason for Dr [A] to expect Mrs [B] would not continue with her treatment and return for review as advised, noting a family member was with her as translator and was aware of the increase in size of the breast lump and importance of taking letrozole. I do not believe it would be expected practice to track Mrs [B]'s re-attendance or prescription requests, noting the importance of patient autonomy versus infantilisation provided the patient is adequately informed. I have no doubt the language barrier and level of health literacy likely impacted on Mrs [B]'s understanding during the consultation, but it was reasonable to expect her translator (family member) to accurately convey the content of the consultation at the time of the consultation and subsequently. If there was no discussion during the consultation of referral back to the surgical service as a management option, I would be moderately critical as I believe this information was important in enabling Mrs [B] to make an informed choice regarding her management. If this option was discussed, best practice would be to have documented the discussion, but it is unclear if the reference

in the notes to*? Refer back to gen surgery* represents the discussion. I do not believe it was reasonable for Dr [A] to assume Mrs [B] remained under the care of the surgical service and had elected to take letrozole in preference to surgery as long-term management of her breast cancer (if this was the case) without establishing the facts during the consultation (and see next section). Recognition of the communication issues described meant particular care was required to ensure there was clarity over vital health issues such as management of Mrs [B]'s breast cancer.

10. On 29 April 2020, Mrs [B]'s daughter-in-law spoke with Dr [A] with concerns Mrs [B]'s breast lump was growing, and she was not taking her letrozole. Mrs [B] was reviewed the next day and Dr [A] notes: *At that consultation the issue of further follow up by general surgery was not raised by Mrs [B] nor the family. In part, because of this, and dealing with the complexity related to nonadherence to her antihypertensive, thyroid medication and letrozole, and probably because of earlier surgeon comments about continuing with letrozole to which she 'responded very well' and that it is common to manage postmenopausal breast cancer with hormone treatment alone, consideration of re-referral back to general surgery was not raised by me at that time.* Consultation notes refer to new symptom of unintentional weight loss, and *no side effects from letrozole, R medial breast lump fixed to underlying tissues, hard 6x5cm, no axillary or supraclavicular lymphadenopathy.* BP was 151/87. Plan was for blood tests and restart letrozole. A prescription for letrozole and cilazapril had been provided the previous day. There is no follow-up plan documented. Blood tests showed subclinical hyperthyroidism (normal FT4 and FT3, TSH suppressed at 0.07 mIU/mL – these results were similar to those in Jun 2017, April 2019, April 2020 and September 2020). Dr [A] reviewed Mrs [B] on 11 May 2020 in relation to the results, noting regular pulse of 70 and thyroid palpation normal. Plan was to restart carbimazole and repeat blood tests in two months. Information was provided regarding radioactive iodine (definitive treatment for the condition). Recall for bloods was sent 19 June 2020 and undertaken on 3 September 2020 (TFTs similar to previous) with advice-only endocrinology referral made shortly afterwards.

Comment: My comments regarding management of Mrs [B]'s breast lump remain unchanged from those expressed in section 9, although it appears from Dr [A]'s response, which seems somewhat at odds with the previous comment about referring back to the surgical service, that he had not established Mrs [B]'s loss of contact with the surgical service. With the new symptom of unexplained weight loss coupled with the description of the breast lump, I believe presence of metastatic disease required consideration and, if Mrs [B] consented, re-referral to the surgical service was indicated with some urgency. If Dr [A] believed Mrs [B] was still engaged with the surgical service, best practice would be to have asked when her next review was scheduled, reviewed the most recent report, and to have updated the service with the new symptom of unexplained weight loss if that review was not imminent. Re-prescribing of letrozole in the interim was a reasonable action, and not re-referring to the surgical service was a reasonable action if that was Mrs [B]'s informed choice (which does not appear to be the case). It appears Dr [A] subsequently gave Mrs [B]'s subclinical hyperthyroidism some priority even though her thyroid function tests were not significantly different from those recorded over the previous three years despite very intermittent use of carbimazole over this period. Mrs [B] was not tachycardic or in [atrial

fibrillation] AF and, while unexplained weight loss could be a symptom of hyperthyroidism (and in hindsight may have been the cause), metastatic breast cancer was also a possible cause. I am not sure in this context it was reasonable to apparently prioritise management of Mrs [B]'s stable subclinical hyperthyroidism over at least seeking surgical advice (with patient consent) regarding her enlarging breast lump and weight loss symptom. I acknowledge again the likely impact related to Mrs [B] requiring use of an interpreter both on her understanding of her conditions and options, and on the dynamics of the consultation. I note also that from this point forward, there were additional very significant stressors on primary care with the COVID pandemic and associated changes in work patterns. Nevertheless, I believe if Dr [A] did not establish Mrs [B]'s loss of contact with the surgical service and offer re-referral as a management option (as may have been the case), this represents a moderate departure from accepted practice.

11. On 2 September 2020, Mrs [B] was prescribed three months of letrozole, cilazapril, and carbimazole, presumably at family request. Dr [A] reviewed Mrs [B] on 9 September 2020, noting she was taking cilazapril intermittently with BP 160/?. Pulse was 75 and regular rhythm. Weight had increased from 80kg to 88kg since re-introduction of carbimazole and letrozole, and the breast lump had decreased in size to 4cm. Endocrinology advice regarding carbimazole dose was received on 10 September 2020 and conveyed to Mrs [B], together with a prescription for carbimazole at the revised dose. On 11 November 2020, a practice nurse notified Mrs [B]'s family that her blood test was overdue. There was no further contact (including request for or provision of prescriptions) until 5 July 2021, when Mrs [B] was assessed by a GP registrar whose notes include: *No new concerns, was living with her other son so far but now moved to live with his daughter in law, doesn't know much about her health conditions.* There is no reference to concerns expressed regarding breast symptoms and no breast examination is recorded. Blood pressure was normal and repeat prescriptions provided for letrozole, cilazapril and carbimazole together with a blood test form (results 6 July 2021 unremarkable – thyroid function stable).

Comment: The reduction in size of the breast lump and weight increase might be regarded as reassuring, and Mrs [B] did not apparently express any particular health concerns over this period. I note adherence to therapy apparently remained erratic, but there is certainly no suggestion that Mrs [B] was advised to stop her letrozole.

12. On 4 August 2021, Mrs [B] did not attend an appointment for review of cough symptom arranged in response to a request from her daughter-in law. On 16 August 2021, a [local medical centre] nurse received a call from a Pasifika health and social service NGO staff member, noting Mrs [B]'s son had contacted them expressing concern regarding his mother's wandering and increasing dependence, for which he was requesting support. A translator was offered to support any GP review. The nurse sent a referral for a needs assessment (NASC), and a GP appointment was scheduled for 29 September 2021, but Mrs [B] did not attend. On 6 January 2022, a blood test reminder was sent to Mrs [B], and on 17 January 2022 a practice nurse has recorded contact with the Older Persons Service (presumably in relation to the NSAC referral) who had been unable to contact Mrs [B] (multiple messages left and letter sent with no response). The next face-to-face

appointment with Mrs [B] was 4 July 2022, a year since the previous review, with no prescriptions provided or requested since July 2021.

Comment: It appears there were no health concerns observed by Mrs [B] or her family over this period that were perceived to warrant attendance at a face-to-face appointment, although it is apparent Mrs [B] may have had some deterioration in cognition. It is unclear what barriers may have affected Mrs B's access to health care, but it appears family had accessed culturally appropriate support services and [the local medical centre] staff had initiated a needs assessment (although I cannot see this was completed). The relatively recent evolution of Health Improvement Practitioners (HIPs) as part of the primary care team in some areas may have been a useful resource to support Mrs [B] in accessing appropriate health care had they been available at the time, and ongoing liaison with TAT to support Mrs [B] might have been an option although would have required Mrs [B]'s consent. The impact of the COVID pandemic on available primary care resources remained an issue over this period. While Mrs [B]'s access to her prescribed medication and medical review over this period was suboptimal, I do not believe the relatively passive role [the local medical centre] staff played in this regard represents a deviation from common practice. There is nothing to suggest Dr [A] deliberately stopped or withheld Mrs [B]'s letrozole as alluded to in the complaint.

13. At the consultation of 4 July 2022, Dr [A] noted Mrs [B]'s desire to attend a family wedding in USA the following month. Notes include *No pain, headache, cough or SOB…R upper medial breast cancer fixed to skin and underlying bone…family think she has dementia, poor hearing, TBS* [to be seen] *for double appt, see nurse first for a checkup and mini-ACE.* Flu vaccine was administered and blood tests taken. Blood test results showed increased ferritin (inflammatory marker), mildly reduced folate and continued suppressed TSH. Further review was undertaken by Dr [A] and a practice nurse on 13 July 2022 as planned. Mrs [B] scored 15/30 on a mini-ACE test. Weight was constant, normal vital signs, deaf right ear noted and poor dentition. Vital signs were normal as was auscultation of heart sounds. There is no reference to shortness of breath symptoms. Referrals were made for audiology and dental assessment. CT head referral was made *to exclude cerebral metastases.* This was not undertaken prior to Mrs [B]'s attendance at […] ED (see below). Follow-up was to be a double appointment *for neuro exam at time of providing CT result + discuss urinary incont.* I could not see that any prescriptions were provided. Dr [A] states in his response that surgical referral was not made at this time as *it was appropriate to get more information before a referral was made to ensure that the general surgeon received a good quality referral and had sufficient information.* Mrs [B] was next reviewed on 30 August 2022. Notes include: *breast cancer just starting to ulcerate, not infected, refer general surgery for advice* [semi-urgent referral made and prioritised by surgical service as to be seen within 14 days]. *Cough today – O2 sats 97%, pulse irreg irreg, JVP nad, creps bases, dec air entry R base.* ECG confirmed atrial fibrillation with ventricular rate 105. BP 160/100. Diagnosis was *a fib secondary to subclinical hyperthyroidism +?LVF ??Metastatic lung disease.* Plan was referral for chest X-ray, recommence carbimazole and seek endocrinology advice once X-ray result available regarding echocardiogram and anticoagulation. The plan was discussed with Mrs [B]'s daughter per phone on 31 August 2022, but prior to its implementation Mrs [B] presented to […] ED on 1 September 2022. History recorded there was of gradually

increasing shortness of breath with more acute deterioration in the preceding 24 hours. Mrs [B]'s vital signs were stable (P85, BP 138/92, resps 20, O2 sats 95% on room air, temp 37.0) with reduced air entry noted in the right lung and pleural effusion demonstrated on chest X-ray. She was admitted under the respiratory service and Dr [A] had no further input into Mrs [B]'s management.

Comment: The assessments of Mrs [B] by Dr [A] on 4 and 13 July 2022 were reasonably comprehensive, although neurological assessment was indicated prior to CT referral if there was suspicion of metastatic brain disease (presence of focal abnormalities might have increased priority for imaging). The breast cancer had progressed, which is unsurprising given the lack of adherence to the letrozole regimen. In line with my previous comments, I believe the option of re-referral to the surgical service required discussion at one or both of the July consultations given the breast examination findings, and if Mrs [B] consented to re-referral, accepted practice would be to have made the referral to the breast service and for CT imaging concurrently unless it was believed the CT would be performed very promptly. I note Mrs [B] was referred to the breast service about six weeks later without the CT having been performed after her breast cancer started to ulcerate. I am moderately critical if urgent re-referral was not presented as a management option in July 2022 or, if Mrs [B] consented to this option, that a referral was not made for a further six weeks. It is unclear why letrozole was not recommenced if a several-weeks wait for CT scanning was expected. With respect to the consultation of 30 August 2022, it was appropriate for Dr [A] to make a referral to the surgical service (albeit belatedly) and the content of the referral enabled appropriate prioritisation. The assessment on that date was reasonable, and it was established Mrs [B] was in new AF, tachycardic, and with abnormal lung auscultation findings on a background of recent-onset shortness of breath. I believe it was reasonable to consider both heart failure and lung metastases in the differential diagnosis and to order a chest X-ray, as was done. I am not sure when the X-ray result was expected, but consideration might have been given to initiation of AF rate control treatment while awaiting the result if any significant delay was expected. On review of hospital notes, it appears there was a significant deterioration in Mrs [B]'s shortness of breath the day after the consultation, leading her to re-present to […] ED where her lung effusion was diagnosed. Vital signs on presentation to ED were stable and not overly concerning. Taking into account the assessment findings recorded on 30 August 2022, and without the benefit of hindsight, I believe it was reasonable for Dr [A] to manage Mrs [B] initially as an outpatient while awaiting the chest X-ray result, assuming she had been provided with appropriate safety netting advice (no such advice documented but this is a common finding in my review of notes).

14. I note Dr [A] has reflected on this case and particularly on the communication issues present when the patient has limited or no English and low health literacy. Dr [A] makes the statement *Unfortunately, I was unaware that Mrs [B] had not attended a number of outpatient appointments, as this was never relayed to me. Such information is not available to general practitioners, unless relayed through the appropriate channels.* I believe had Dr [A] reviewed Mrs [B]'s recent breast surgical reports at any stage over the period in question, and/or directly questioned Mrs [B] via her family member interpreter as to when she was last seen by the surgical service, this might have led to him querying whether she had been lost to follow up. There was no report on file that indicated a final decision had

been agreed that Mrs [B]'s breast cancer would be managed with letrozole alone and without regular surgical clinic follow-up, and I believe it was inappropriate to make this assumption without confirmation from the surgical service. I acknowledge that deficiencies in secondary care processes were the direct cause of follow-up failure, but there were multiple missed opportunities over three and a half years for Mrs [B] to have been re-referred to the service by Dr [A], and the communication difficulties referred to above meant extra care was required to ensure there was clarity regarding Mrs [B]'s management.

15. Addendum 1 October 2025: Dr [A] has provided a response to my initial advice as briefly summarised below (by section reference as per the response)

(i) s4: Dr [A] confirms Mrs [B]'s predominant symptom on 30 August 2022 was cough and she did not complain of, and was not observed to have, significant shortness of breath.

Comment: This has been acknowledged and considered in my original advice (s13)

(ii) s9: Dr [A] refers to my comment *there was no further contact from Mrs [B] or her family over the next 12 months* following the 2 April 2019 consultation, and that he phoned Mrs [B] on 29 April 2019 and fitted her in for an urgent appointment.

Comment: Per the notes, this comment appears to relate to a phone call on 29 April 2020 with face-to-face consult the next day, and I believe my original interpretation of the notes is accurate. There is no reference in the notes to a phone consult on 29 April 2019 or to a further face-to-face consult in 2019 after that of 2 April.

(iii) s9: Dr [A] reiterates that he believed Mrs [B]'s long-term management plan was for letrozole therapy and he had had post-menopausal patients managed in a similar way in the past. This assumption underpinned his subsequent management decisions, and Dr [A] recognises this became an anchoring bias supported by the fact the tumour had been very sensitive to letrozole, the surgeon had supported a prolongation of letrozole therapy, and neither Mrs [B] nor her family ever raised the issue of surgery having been discussed as an option.

Comment: I acknowledge the influence of a cognitive disposition to respond affecting Dr [A]'s management of Mrs [B], and there is no clinician immune from such influences. I acknowledge also the significant impact of having to communicate via an interpreter and the influence the health literacy of both the interpreter and Mrs [B] may have had on her understanding of treatment options and goals. Considering the complaint, it appears there was a perception by Mrs [B]'s family that Dr [A] maintained long-term letrozole therapy was the preferred option for Mrs [B] and surgery was not to be considered, and this is consistent with Dr [A]'s understanding of Mrs [B]'s treatment goals (per his response) although is not consistent with the recommendation contained in the surgeon's letter dated 22 February 2018. It is less clear whether the prior communication with the surgeon at the appointment of 22 February 2018, in which the need for surgery was reiterated, was effective and had been understood by Mrs [B] and her family, ie, communication issues may not have been confined to the primary care consultations. As discussed in s14, this case illustrates the importance of ensuring the patient has an accurate understanding of the intended advice,

and it may be the surgeon's recommendation for surgery later in 2018 was not understood by Mrs [B] or her family. The possibility Mrs [B] did not want to undergo surgery must also be entertained, although was apparently never presented or discussed. Notwithstanding the discussion above, I remain of the view that it was clear from the final surgical report on file that surgery was the recommended definitive management for Mrs [B]'s cancer and Dr [A] has mentioned at one stage considering referral back to the surgeons, although this was apparently never offered as a management option. I continue to believe that the failure by Dr [A] to discuss referral back to the surgeons as a management option at various points in Mrs [B]'s health journey, particularly when it was apparent she had difficulty adhering to her letrozole regimen, resulting in significant growth of her cancer, represents a moderate departure from accepted practice with mitigating factors as presented in my original advice. I cannot discount the possibility that even had this option been provided, Mrs [B] may have preferred to avoid surgery and opted for ongoing letrozole therapy.

(iv) s10: I have corrected my erroneous reference to hypothyroidism. Dr [A] disagrees there was an indication to notify the surgical service of Mrs [B]'s weight loss as hyperthyroidism was a more likely cause of her weight loss, and she showed no other symptoms or abnormal blood test results to suggest metastatic disease. He notes the weight loss reversed when carbimazole was restarted. My comments were made without hindsight and in the context of sudden weight loss occurring when there had been no significant change in thyroid function in the previous three years, tests showed sub-clinical hyperthyroidism, there were no additional associated symptoms of hyperthyroidism, including tachycardia or atrial fibrillation, and Mrs [B] had a known malignancy with signs her breast lump was enlarging. I remain of the view that the possibility of metastatic disease required consideration and prioritisation (along with symptomatic hyperthyroidism) at this time.

(v) s13: Dr [A] disagrees that there were *new reasons to refer Mrs [B] to general surgery when seen on 4/7/22*. He notes the consultation was initiated by family primarily to discuss if Mrs [B] was fit to travel to the USA for a family wedding. The memory issue was not presented by family as being of major concern. I agree with Dr [A] that it was reasonable and good practice to schedule a double appointment for a more thorough assessment (undertaken on 13 July 2024). When new symptoms were reported that apparently left no time for a formal neurological assessment, Dr [A] states he advised a further appointment for the neuro exam and *If the subsequent neurological examination had shown localising signs, radiology could have been notified to expedite the scan.* The clinical notes dated 13 July 2024 state *CT head scan to exclude metastasis, 2x appointment for neuro exam at time of providing CT result.* My interpretation of the notes was that Dr [A] intended to undertake a neurological examination after the CT scan was performed. I apologise if my interpretation was incorrect but maintain my view that it would be best practice to have performed the neurological assessment prior to making the referral in case there were abnormalities noted that might have increased prioritisation of the imaging procedure.

(vi) Dr [A] notes the reason he finally referred Mrs [B] back to the surgical service was because her breast cancer had started to ulcerate. He accepts a referral back to the service in 2019 was appropriate and discusses factors relevant to this omission as *my oversight of relevant information in an early outpatient discharge letter, unintentional cognitive biases*

(anchoring, confirmation and inertia biases), administrative problems with secondary care follow up, complex, somewhat pressured consultations including low health literacy, lack of communication by the family and Mrs [B]'s nonadherence to medication, all of this in the context of high levels of pressure in general practice. I agree with the relevance of all these factors. I believe I have given them adequate consideration in my advice and assume they will be taken into account by the decision-maker when this case is assessed.

(vii) Dr [A] notes also *It does not appear that this oversight and resulting misplaced assumption about long term hormonal therapy had a significant impact on Mrs [B]'s quality of life. Health Pathways states that 'identification of metastatic disease before it is symptomatic yields little benefit'. I note that this problem was unrelated to Mrs [B]'s unfortunate death for other reasons*. These comments are made with the benefit of hindsight, and I am unable to confirm Dr [A]'s impression that his management of Mrs [B] did not have a significant impact on Mrs [B]'s quality of life. Mrs [B]'s family may offer a perspective on this comment.

Appendix 1: [The local medical centre] consultation notes summary presented by Dr [A]

2 April 2019	Mrs [redacted] presented to me. She had stopped taking letrozole (as prescribed by the general surgeon) and her breast lump had enlarged. I prescribed 90 Letrozole tablets and asked to see her again in one month.
29 April 2020	I had a phone consultation with a family member of Mrs [redacted]. I was informed that Mrs [redacted] was not taking her letrozole and her breast lump had enlarged. I asked for her to be seen the following day and prescribed 90 Letrozole tablets.
30 April 2020	I saw Mrs [redacted] and noted that she had unintentionally lost weight and ordered a blood test. I was not aware that Mrs [redacted] had not attended follow-up outpatient appointments with the general surgeon. Consideration of re-referral to general surgery was not discussed at this consultation, partly due to the number of other matters discussed, including the complexity of her non-adherence to taking prescribed medications. I again prescribed 90 Letrozole tablets.
11 May 2020	I saw Mrs [redacted] and prescribed carbimazole and gave her information about radioactive iodine. I noted that her thyroid function was to be re-checked in two months.
2 September 2020	Mrs [redacted] was prescribed 90 Letrozole tablets.
9 September 2020	I saw Mrs [redacted] again, and the notes recorded that she was off and on cilazapril and had moderately elevated blood pressure and she was still mildly thyrotoxic. Advice was sought from Endocrinology which was provided to Mrs [redacted] on 10 September 2020 by a nurse.
11 November 2020	The nurse phoned Mrs [redacted] family member, informing them Mrs [redacted] was overdue for a blood test.

13 July 2022	I saw Mrs [redacted]. The notes record that the dementia blood tests showed low folate. Mrs [redacted] was referred to the community dentist and prescribed folic acid. She was also scheduled to undergo a CT head scan to exclude cerebral metastasis.
30 August 2022	I saw Mrs [redacted] and referred her to general surgery for advice regarding her breast lump, which was starting to ulcerate. Ms [redacted] was not seen by general surgery before she was admitted acutely via the Emergency Department. Mrs [redacted] was still awaiting her CT head scan.
31 August 2022	I had a phone call with Mrs [redacted] family member. A chest x-ray was ordered and carbimazole was prescribed, as well as her usual medications.
1 September 2022	I had a phone call with Mrs [redacted] family member to inform them that I wished to see Mrs [redacted] for anticoagulation to prevent strokes. The higher risk of stroke remained as long as Ms [redacted] was not on anticoagulant medication so I wished to see her as soon as possible. A nurse also rang Mrs [redacted] family member on this day and left a message regarding blood tests to be done.