General Practitioner, Dr C

Medical Centre

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC00237)

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Executive summary

1. On 29 December 2015, Mrs A discovered a lump in her neck. She was then aged 76 years. Her usual general practitioner (GP), Dr C, was unavailable so Mrs A made an appointment with another GP at the medical centre, Dr D, for 31 December 2015.

2. Dr D arranged blood tests for Mrs A and drafted a referral for an ultrasound scan of Mrs A's neck. Because Dr D was going away, she asked Dr C to attach the blood test results, when they arrived, to the referral, and to send the referral to the hospital.

3. Dr C did not send the referral.

4. Mrs A attended Dr C for a routine gynaecology appointment on 20 June 2016. Dr C told HDC that it was more than likely that she examined the lump but she did not record this in her notes. Mrs A stated that she mentioned to Dr C that she had not received an appointment for the ultrasound scan.

5. Four weeks after this appointment, on 18 July 2016 Dr C sent a referral for an ultrasound scan. Based on the information in the referral, the referral was prioritised as "routine". The wait time for a "routine" ultrasound scan was five months.

6. Mrs A attended Dr C again on 23 September 2016 for leg pain. The consultation notes contain no record of any discussion about the neck lump.

7. On 2 December 2016, Mrs A attended Dr C for a routine gynaecology appointment. Again, there is no record of any discussion about the lump.

8. On 12 December 2016, Mrs A had the ultrasound scan, which identified a suspicious lesion. Mrs A attended Dr C on 16 December 2016 to discuss the ultrasound scan results and to make arrangements for a biopsy. The biopsy result showed an inoperable anaplastic carcinoma[1] of the thyroid, and Mrs A died as a result.

Findings

9. Dr C failed to provide services to Mrs A with reasonable care and skill by failing to refer her for an ultrasound scan in January 2016 and June 2016, and for failing to convey appropriate urgency in the referral when she did send it in July 2016. In addition, Dr C failed to track the progress of the referral and to review the management of the lump on 23 September 2016 and on 2 December 2016. Accordingly, Dr C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

10. Dr C's actions and omissions in managing Mrs A's thyroid mass were within the authority of the medical centre and, therefore, the medical centre is vicariously liable for Dr C's breach of Right 4(1) of the Code.

[1] A form of thyroid cancer that has a poor prognosis due to its aggressive behaviour and resistance to cancer treatments.

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

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Recommendations

11. It was recommended that Dr C provide evidence of training in the management of thyroid lumps within three months of the date of this report. It was also recommended that Dr C provide a written apology to Mrs A's family.

Complaint and investigation

12. The Commissioner received a complaint from Mrs B about the services provided by a GP, Dr C, to Mrs B's mother, the late Mrs A. The following issues were identified for investigation:

- *Whether Dr C provided Mrs A with an appropriate standard of care between December 2015 and February 2017.*
- *Whether the medical centre provided Mrs A with an appropriate standard of care between December 2015 and February 2017.*

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

14. The parties directly involved in the investigation were:

Mrs A	Consumer
Mrs B	Complainant/consumer's daughter
Medical centre	Provider
Dr C[3]	Provider/general practitioner

15. Information was reviewed from:

Dr D	Provider/general practitioner
District health board (DHB)	

16. In-house clinical advice was obtained from GP Dr David Maplesden (an experienced, vocationally registered GP) (**Appendix A**) and independent expert advice was obtained from a radiologist, Dr Michael Nowitz (**Appendix B**).

[3] Dr C is a vocationally registered GP. She has a contract for service with the medical centre and is also one of its owners and directors.

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Information gathered during investigation

Introduction

17. Mrs A found a small painless lump on the right side of her neck on 29 December 2015. She was then aged 76 years. Her usual GP, Dr C, was unavailable, so Mrs A made an appointment with another GP at the medical centre, Dr D, for 31 December 2015.

Consultation with Dr D on 31 December 2015

18. On 31 December 2015, Mrs A attended Dr D. Dr D told HDC that she examined Mrs A, diagnosed an enlarged right thyroid lobe, and discussed causes for the enlargement and the need to exclude cancer. Dr D ordered blood tests, which included a thyroid test.

19. Dr D told HDC that she drafted a thyroid ultrasound scan referral, which was "parked" in her computer awaiting the blood test results. She wanted the blood test results in order to give more clinical information to the radiologist for the ultrasound scan. Dr D explained that she was about to go on leave for a month, and told Mrs A that she would ask Dr C to activate the referral for the ultrasound scan once the blood test results arrived.

20. Dr D sent a task message to Dr C, which stated:

> "Hi [Dr C], please see my notes from [31 December 2015]. [Mrs A] appears to have a smooth e[n]larged [right] thyroid lobe. [I] [h]ave not ordered [an ultrasound scan] yet as [I] was going to put [the blood test] results on [the referral] form. [Mrs A] does [not] have insurance so would like to have [an ultrasound scan] through [the] hosp[ital]. Can you sort out [the ultrasound scan] and follow [up] please[?]
>
> Action: re thyroid: Due 31/12/2015 Assigned to [Dr C]."

21. Dr D told HDC that her usual safety-netting advice to patients in relation to ultrasound scans is that if they have not received an appointment for an ultrasound scan within four weeks, then they should ring the radiology department at the public hospital or ask the medical centre to do that for them. Dr D stated that she does not document this advice, but she is confident that she would have given Mrs A this advice verbally.

22. Dr D said that in this case she would have asked Mrs A to contact Dr C about following up her ultrasound scan appointment if necessary, because she was going on leave and handing over Mrs A's care to Dr C.

23. Mrs A did not recall Dr D's advice that she was to contact the medical centre within four weeks if she had not received an appointment for an ultrasound scan.

Dr C's follow-up actions after 31 December 2015

24. Dr C told HDC that she received the blood test results but did not make the referral for an ultrasound scan. She said that she had taken steps to make a referral but that she "regrettably did not action the task, that is send the referral for an ultrasound scan, as

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had been planned". As a result, an ultrasound referral was not sent after Mrs A's appointment with Dr D on 31 December 2015.

25. Dr C told HDC that on 7 January 2016 she drafted, but did not send, a letter requesting advice from the endocrinology team at the public hospital. The draft letter stated:

> "This lady presented to my colleague last week with a new lump in her [th]yroid. Blood tests are normal except that she has raised [C-reactive protein][4] with no other intercurrent illness to account for it. [Therefore] I feel that it needs to be investigated with alacrity. Can you assess and arrange whatever scan is most appropriate please?"

26. Dr C stated that she is "at a complete loss" as to why she did not action the referral as planned. She acknowledged that she "somehow failed to interpret the task" that was set correctly by Dr D. Dr C believes that she may have misread the task and presumed that because a referral form (drafted but not sent by Dr D) was visible in the notes, that it had been sent. Dr C also said that it was an "unusually busy" time at the practice, which may have distracted her.

27. Dr C stated that she is very sorry for her oversight in not making the referral, and for the delays that resulted from it.

28. Mrs A told HDC that, following her appointment with Dr D, she telephoned the medical centre for the results of her blood test, and was informed that they were normal. In respect of the ultrasound scan appointment, she said: "I assumed the [u]ltrasound appointment would come through … Being a relatively healthy person I got on with my life and did not dwell on things."

29. Mrs A told HDC that between 31 December 2015 and 20 June 2016 she received no correspondence, letters, or appointments about the ultrasound scan.

Consultation with Dr C on 20 June 2016

30. Dr C wrote a repeat prescription for Mrs A on 17 March 2016, but did not see or examine her. The next time Mrs A saw Dr C was for a routine gynaecology appointment on 20 June 2016. Dr C's consultation notes do not mention a thyroid lump.

31. In her initial statement to HDC, Dr C said that at this appointment Mrs A did not mention the thyroid lump or that she was experiencing any symptoms similar to those reported in the consultation with Dr D. However, Dr C stated:

> "Whilst it is not recorded in the notes, I have a vague recollection that we discussed the fact that she ha[d] not yet had her thyroid ultrasound scan at the hospital. I do not recall examining her thyroid at that point."

[4] A substance produced by the liver in response to inflammation.

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32. Mrs A stated: "I do recall mentioning on this visit that I had not received the [u]ltrasound appointment to Dr C."

33. In a later response to HDC, Dr C concluded:

> "I now consider it more likely that I did examine [Mrs A's] thyroid gland, noting the findings on the [ultrasound scan referral]. I acknowledge that I did not record these findings in the notes. I believe that my thinking at the time would have still been that this represented a benign process clinically, although I accept the time that had passed was concerning."

34. Dr C told HDC that a plan was made to review Mrs A in six months' time.

Ultrasound referral on 18 July 2016

35. Dr C wrote a repeat prescription for Mrs A on 15 July 2016, but did not see or examine her. On 18 July 2016, four weeks after her consultation with Mrs A on 20 June 2016, Dr C sent a referral for an ultrasound scan to the public hospital.

36. Dr C offered the following explanation for why the referral was sent four weeks later: "[I]t is likely that I had been trying to track down whether the original request had indeed been sent." Dr C further explained that she contacted the radiology department and ascertained that no request for an ultrasound had been received.

37. In making the referral, Dr C used the referral form that had originally been drafted by Dr D on 31 December 2015, which noted an "enlarged thyroid lobe on R?". Dr C added a handwritten notation onto the referral form, which said: "Solitary[.] Smooth lump moves [with] swallowing[.] [G]radually enlarge[d.] ?urgent."

38. Dr C told HDC that she "had hoped that by sending a copy of the original referral with the original date on it and [her] handwritten annotation stating 'urgent' that the Radiology Department would prioritise the ultrasound as urgent".

39. The DHB provided HDC with a copy of the referral form. The date on the form is 17 July 2016, and there is no reference to the original date on which the referral was drafted. The referral was faxed at 9.38am on 18 July 2017. The DHB told HDC:

> "Based on the clinical information provided by the referring doctor, this was prioritised as a 'routine' examination and placed on the waiting list accordingly. The wait time during this period for routine scans was five months."

40. The DHB also told HDC that there was no clinical indication that would justify an urgent scan, and that Mrs A was seen within the five-month time frame.

Mrs A's management between 23 September 2016 and 2 December 2016

41. On 23 September 2016, Mrs A attended Dr C because she was experiencing leg pain after a flight. There is no reference to a discussion about the thyroid lump in Dr C's consultation notes.

42. On 23 November 2016, the DHB sent a letter to Mrs A advising her of an appointment for an ultrasound scan on 12 December 2016.

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43. On 2 December 2016, Mrs A saw Dr C for a routine gynaecological review. There is no reference in the consultation notes to either a discussion about the thyroid lump or the ultrasound appointment that had been made for 12 December 2016.

44. In her initial response to HDC, Dr C said that Mrs A had still not received an appointment for an ultrasound scan at this point, and recalled contacting the radiology department to query the length of time it had taken.

45. Mrs B, Mrs A's daughter, told HDC that by 2 December 2016 the thyroid lump had grown substantially and was physically very obvious. She said that she could not understand how the lump had not been discussed with, or examined by, Dr C.

46. In a later response to HDC, Dr C stated:

> "Whilst the thyroid mass was more visible at this consultation, given she had an upcoming [ultrasound scan] appointment, which had been confirmed, I decided not [to] pursue anything more urgent. She was not experiencing any obstructive symptoms at this time that I detected or that she mentioned."

47. Dr C also said that she "did not recall [Mrs A] raising [the lump] as a particular concern on [this] occasion or any of the prior consultations as [their] focus was elsewhere on those occasions". Dr C stated: "[H]ad [Mrs A] reported experiencing any symptoms or neck lump, [she] would have examined her and recorded this in the notes."

48. No written information or advice was provided to Mrs A following this appointment or any of the previous appointments.

Ultrasound scan on 12 December 2016

49. Mrs A had an ultrasound scan on 12 December 2016. The scan showed a suspicious lesion, and an ultrasound-guided biopsy was recommended. The results were sent to Dr C electronically on 12 December 2016.

Consultation with Dr C on 16 December 2016

50. Dr C told HDC that Mrs A presented to this consultation in response to a letter she had sent, inviting Mrs A to come to discuss the scan results. However, Mrs A told HDC that she had not received the results of her ultrasound scan, and that is why she made an appointment to see Dr C. Mrs A added that it was at this appointment that Dr C reviewed the results for the first time. HDC was not able to obtain a copy of the letter to which Dr C refers.

51. The medical centre told HDC that the appointment for 16 December 2016 was made on 13 December 2016. The medical centre also stated that it could not tell from its records whether the medical centre contacted Mrs A for an appointment or whether Mrs A initiated the appointment. In addition, the system at the medical centre did not record the date on which Dr C read the electronic results.

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52. Dr C recorded in her consultation notes that at this appointment Mrs A reported a sudden and dramatic growth in the thyroid lump, and that it was causing intermittent dysphagia[5] and some shortness of breath when she was lying down.

53. Dr C also told HDC that over the previous 14 days the lump had “changed enormously becoming craggy irregular and hugely enlarged”, and that she had not “previously seen anything change so rapidly”.

54. Dr C said that she explained the report to Mrs A, and that the thyroid lump might be malignant. Dr C said that she then wrote a referral letter requesting a priority assessment, and started to make arrangements for the biopsy.

Subsequent events

55. On 4 January 2017, Mrs A attended the appointment for the biopsy.

56. On 7 January 2017, Mrs A was admitted to the public hospital because her symptoms were worsening.

57. On 13 January 2017, the biopsy result showed an inoperable anaplastic carcinoma of the thyroid, and Mrs A was referred for palliative radiotherapy.

58. Mrs A has since passed away.

The medical centre’s policy for management of clinical correspondence, test results, urgent referrals, and other investigations

59. The medical centre provided a copy of its policy for the management of clinical correspondence, test results, urgent referrals, and other investigations. It stated that the “expectation at [the medical centre] is that all referrals [will] be done within one week of the consultation”.

60. The medical centre also outlined the procedure for the tracking of clinical documentation when there is a suspicion of a significant abnormal result. The policy states: “For urgent [r]eferrals — All GP’s will set a task for the Practice Nurse to follow up and make sure the patient has received acknowledgement of their referral within one month.”

Further information

Dr C

61. Dr C told HDC that in response to these events she is now assiduous in recording tasks and reminders on her computer and checking that referrals are followed up in a timely manner. She ensures that patients are offered the option of a private referral, and she endeavours to give elderly patients written information when appropriate. Dr C also told HDC that she has reviewed the guidelines for the treatment of thyroid lumps, and has attended a seminar given by a thyroid surgeon on the management of thyroid lumps. Dr C said that she presented Mrs A’s case anonymously to her peer review group.

[5] Difficulty in swallowing.

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The medical centre

62. The medical centre told HDC that it is aware of the changes and actions taken by Dr C, and supported the steps that have been taken. It offered its sincere apologies to Mrs A's family.

Responses to provisional opinion

63. Mrs B was given an opportunity to comment on the "information gathered" section of the provisional opinion. She advised HDC that she had no further comment to make.

64. The medical centre was given an opportunity to comment on the provisional opinion and advised HDC that it had no additional comments.

65. Dr C was given an opportunity to comment on the provisional opinion, as it related to her. Dr C advised HDC that she accepted the findings and the recommendations in the provisional decision.

Opinion: Dr C — breach

Introduction

66. Mrs A presented to Dr D with concerns about a lump in her neck. Dr D assessed Mrs A appropriately and handed over her care to Dr C. On the basis of the expert advice received, I have no concerns about the care provided by Dr D. Dr D gave clear instructions to Dr C on the care that Mrs A required and what action Dr C was to take.

67. Dr C did not follow the instructions from Dr D and, in particular, she did not refer Mrs A for an ultrasound scan within an appropriate timeframe. In addition, there were a number of missed opportunities over the next year for Dr C to assess Mrs A appropriately and to arrange an urgent referral for an ultrasound scan.

Failure to make referral in January 2016

68. When Dr D handed over the care of Mrs A she gave clear instructions to Dr C. Dr D identified a smooth and enlarged right thyroid lobe and advised Dr C that blood tests had been ordered. Dr D asked Dr C to order an ultrasound scan once the blood tests results arrived.

69. Dr C accepts that the request to make a referral for the ultrasound scan was clear and that she failed to make it. She also started a letter to the endocrinology team at the public hospital, which conveyed her view that the lump needed to be investigated "with alacrity", but she did not complete the letter.

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

> "[Dr C's] oversight in failing to complete [Mrs A's] ultrasound referral once blood test results were received was significant and appears most likely to be the result of human error rather than any systems failure."

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71. Dr C's failure to refer Mrs A for an ultrasound scan was a significant oversight. Dr D had clearly outlined the issue to be investigated and the steps that Dr C should take. There was a clear handover of care to Dr C who, as evidenced by the draft letter saved on the system, was aware that she was required to make the referral expeditiously.

Consultation on 20 June 2016 and subsequent referral

72. At a routine appointment on 20 June 2016, Mrs A told Dr C that she had not yet received an appointment for an ultrasound scan. Dr C has only a vague recollection that the scan was discussed. I accept Mrs A's account of the consultation, and that Dr C knew that the ultrasound scan appointment had not been made.

73. Dr C's consultation notes do not indicate whether she examined Mrs A's neck at this consultation. However, Dr C said that it is likely that she did examine the lump in Mrs A's neck, and that she recorded her findings on the referral form rather than in her consultation notes. Dr C said that at this point she believed that the lump "represented a benign process clinically", but that the amount of time that had passed was concerning. I accept that Dr C examined the lump in Mrs A's neck at this appointment. However, I am concerned that the clinical notes do not record this action or Dr C's findings.

74. Dr Maplesden advised that having assessed Mrs A's neck, he would have expected that a prompt decision would be made about the appropriate management of the mass. He further advised:

> "By this stage the lump had been slowly enlarging over six months and I think (with respect to guideline recommendations regarding duration of symptom and patient age) a degree of urgency in ascertaining the nature of the mass was required, either by urgent ultrasound referral (with updated history and assessment findings) or specialist referral."

75. Dr Maplesden was also critical of Dr C's management of her ultrasound referral on 18 July 2016 and her management of Mrs A's mass in the interim. Dr Maplesden advised:

> "I think such a referral should then have been tracked and pursued if it had not been actioned within a month (or sooner if there was high suspicion of cancer), and timely GP review scheduled to monitor the status of the mass in the interim. However, [Mrs A] was advised to return in six months, the referral was not sent for another month … and there was evidently no tracking of the referral."

76. I accept Dr Maplesden's advice that, having examined the lump on Mrs A's neck and established that no ultrasound appointment had been made, Dr C should have recognised that further investigation was required urgently. Dr C should have referred Mrs A for an ultrasound scan immediately, or referred her to a specialist or arranged a follow-up appointment. However, Dr C failed to do so.

77. Dr C did not make the ultrasound referral until 18 July 2016, which was over four weeks after this appointment. In the referral, Dr C noted her clinical findings and concluded "?urgent".

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78. My expert radiologist advisor, Dr Howitz, advised that based on the information in the referral, it was triaged appropriately by the public hospital as routine. I accept Dr Howitz's advice.

79. I consider that Dr C had sufficient information to warrant an urgent referral, but that she failed to do so, sending the referral four weeks after her consultation with Mrs A. Dr C said that she thought that the referral would be prioritised as urgent because she wrote "urgent" on the referral and included the date on which the referral had been drafted originally, some six months earlier. However, it is clear from the referral received by the DHB that there was no reference to the original consultation in December 2015, and no information provided to convey any urgency, and that Dr C's notation merely questioned whether the referral should be treated as urgent.

Consultation on 23 September 2016

80. Mrs A made an appointment with Dr C on 23 September 2016 because she was experiencing pain in her leg after a flight. There is no reference in the consultation notes to a discussion about the lump or to an ultrasound scan appointment.

81. Dr Maplesden advised that the referral completed on 18 July 2016 should have been tracked and pursued, and that this consultation "was a missed opportunity to review the management of [Mrs A's] thyroid mass". I agree with Dr Maplesden. At this appointment Dr C should have reviewed the lump in Mrs A's neck and followed up the referral for an ultrasound scan. Dr C failed to take either course of action.

Consultation on 2 December 2016

82. Mrs A attended Dr C on 2 December 2016 for a routine gynaecological review. There is no reference in the consultation notes to the lump or to the upcoming ultrasound scan appointment on 12 December 2016. Dr C acknowledges that the lump was more visible at this consultation, but said that as Mrs A was not experiencing any obstructive symptoms, she decided "not to pursue anything more urgent".

83. Dr Maplesden advised that it is "puzzling that [Mrs A's] by now rapidly increasing thyroid mass and persistent hoarseness were not detected or discussed at the consultation of 2 December 2016".

84. In my view, the consultation was another missed opportunity for Dr C to review the lump in Mrs A's neck and to escalate its management. I am critical that Dr C failed to do either.

Consultation on 16 December 2016

85. The results of the ultrasound scan were sent to the medical centre electronically on 12 December 2016. On 13 December 2016, an appointment was made, and Mrs A saw Dr C on 16 December 2016.

86. Dr Maplesden advised that once the ultrasound scan results were received and the recent rapid increase in the size of the mass and additional suspicious symptoms became apparent, Dr C acted with appropriate urgency.

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Conclusion

87. Dr C received clear instructions to refer Mrs A for an ultrasound scan in January 2016, and failed to do so. Following an examination in June 2016, Dr C had an opportunity to refer Mrs A for an urgent ultrasound scan, but did not do so until four weeks later. When Dr C made the referral in July 2016, she failed to convey the appropriate urgency to the triaging doctor and, as a result, the referral was triaged as routine. In addition, Dr C failed to track the progress of the referral and, on 23 September 2016 and 2 December 2016, Dr C should have reviewed the management of Mrs A's thyroid mass but took no steps to do so.

88. Dr Maplesden advised:

> "I think [Dr C's] management of [Mrs A] in relation to her thyroid mass, would be met with at least moderate disapproval by my peers."

89. In my opinion, for the reasons outlined above, Dr C failed to provide services to Mrs A with reasonable care and skill. Accordingly, Dr C breached Right 4(1) of the Code

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Opinion: the medical centre — breach

90. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. Dr Maplesden reviewed the medical centre's policy for the management of referrals. The policy states that all referrals should be made within one week of the consultation, and that where there is a suspicion of a significant abnormal result, the referral should be tracked. Dr Maplesden advised that the policies were reasonable.

91. I am satisfied that the medical centre's policies for routine referrals and urgent referrals are adequate, and the errors that occurred do not indicate broader systems issues at the clinic. Therefore, I consider that the medical centre did not breach the Code directly.

92. In addition to any direct liability for a breach of the Code, under section 72(3) of the Health and Disability Commissioner Act 1994, an employing authority is liable for acts or omissions by an agent unless the acts or omissions were done without that employing authority's express or implied authority, precedent or subsequent.

93. During the period under investigation, Dr C was a contractor to the medical centre. Accordingly, Dr C was acting as an agent of the medical centre.

94. I consider that Dr C's actions and omissions in managing Mrs A's thyroid mass were within the the medical centre's authority. Therefore, the medical centre is vicariously liable for Dr C's breach of Right 4(1) of the Code.

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Recommendations

95. I recommend that Dr C:

a) Undertake training, or provide evidence of recent training already undertaken, in the management of thyroid lumps, in conjunction with the Royal New Zealand College of General Practitioners, and provide evidence to HDC of having completed the training, within three months of the date of this report.

b) Provide a written apology to Mrs A's family for the failures identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A's family.

Follow-up actions

96. A copy of this report with details identifying the parties removed, except the experts who advised on this case, will be sent to the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, and the DHB, and they will be advised of Dr C's name in covering correspondence.

97. A copy of this report with details identifying the parties removed, except the experts who advised 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 the Commissioner

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

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Mrs B], daughter of [Mrs A]; responses from [Dr C] and [Dr D] of [the medical centre]; [medical centre] GP notes; [public hospital] clinical notes; sequential photographs of [Mrs A's] neck lump provided by [Mrs B]. A response from [the DHB] is currently awaited.

2. [Mrs B] states that her mother, [Mrs A], was diagnosed with inoperable anaplastic thyroid cancer on 13 January 2017 and has been given a poor prognosis. [Mrs A] was previously active and well and consulted [Dr D] in December 2015 because she had recently noticed a right neck swelling. [Dr D] said she would arrange an ultrasound scan (USS) of the lump in the first instance. [Mrs A] did not hear anything further about the ultrasound. She had a routine appointment with [Dr C] (her usual GP) on 20 June 2016 for repeat of long-term medications, and consulted with [Dr C] again on 23 September 2016 in relation to calf pain following a long airline flight. [Mrs B] states her mother does not recollect there being any discussion about the neck lump or USS at either of these appointments. [Mrs A] eventually had her USS performed on 12 December 2016 and was reviewed by [Dr C] on 16 December 2016 following the scan. She was told she had a goitre that would likely require surgical removal and a surgical referral was made although it appeared [Mrs A] could not be seen until January 2017. On 4 January 2017, she was reviewed by [a surgeon] and biopsy was arranged. Prior to this being performed, [Mrs A] required admission to [the public hospital] for obstructive symptoms related to the neck lump. Investigations in hospital (CT scan and core biopsy) revealed a diagnosis of inoperable anaplastic thyroid cancer and incidental finding of a small pulmonary embolus. [Mrs A] has been referred for palliative radiotherapy. [Mrs B's] major concern is the delay in getting the USS performed and apparent lack of concern shown by her mother's providers at this delay. She acknowledges that an earlier diagnosis might not necessarily have resulted in a cure but may have meant the cancer was amenable to surgery and a better prognosis than that currently faced by her mother.

3. Response and notes [Dr D]

(i) [Dr D] saw [Mrs A] on 31 December 2015 as her usual GP, [Dr C], was away. [Dr D] states: *[Mrs A] presented with a right-sided painless neck lump that she had been aware of for a week. She had no swallowing problems but did say she had some indigestion and felt tired. There was no family history of thyroid problems she was aware of. She had not had any weight loss.* [Mrs A] had normal pulse and blood pressure and *there was a smooth, non-tender mass in the right lobe of the thyroid. There were no cx nodes palpable.*

(ii) [Dr D] diagnosed an enlarged right thyroid lobe and states she discussed thyroid function with [Mrs A] together with the need for blood tests to confirm thyroid status and USS to *exclude any sinister causes for her thyroid enlarging*

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such as cancer. As there were no 'red flags' detected [Dr D] felt it was appropriate to await thyroid function results (which might assist the radiologist in interpreting USS findings) before sending off the ultrasound referral. [Dr D] completed a referral form for the USS and 'parked' it while awaiting blood results. As she was about to head off on leave for a month, [Dr D] advised [Mrs A] that [Dr C] would receive the results then activate the referral. [Dr D] then sent an electronic message to [Dr C] requesting she activate the referral once blood results were received.

(iii) [Dr D] states: *Although not specifically written each time, my usual 'safety net' advice to patients is that if they have not heard from us regarding their blood results within a week, they can phone the practice nurse for results. Regarding an ultrasound, I advise patients that if they have not received an appointment within 4 weeks they can phone the hospital radiology or contact us to do that for them. I believe I would have followed my usual practice.* [Dr D] had no further contact with [Mrs A].

(iv) [Dr D's] clinical notes are consistent with her response and read:

31/12/2015 enlarged thyroid lobe on R? (KP)

Presenting Complaint: R neck lump

History: Aware for a week of R sided painless neck lump

Has had some indigestion but no swallowing problems

Feels tired, but no weight change recently

No FHx thyroid problems aware of

Exam: Visible mass R lower neck

Mobile when swallows, feels like enlarged thyroid lobe on R — smooth, non-tender

No cery nodes palp

HR 80, reg

BP = 140/70

Action: Check TSH

Action: Discussed will need USS, [Dr C] will follow as I am away next week.

Action: Advised results may not be through until early next week

(v) The message left for [Dr C] by [Dr D] reads:

Hi [Dr C], please see my notes from 31/12. She appears to have smooth enlarged R thyroid lobe. Have not ordered USS yet as was going to put TSH results on form. [Mrs A] doesn't have insurance so would like to have USS through hosp. Can you sort USS and follow please.

(vi) Thyroid function results were normal as were results for liver and kidney function and blood count. CRP was raised at 33mg/L (range <5).

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4. Response and notes [Dr C]

(i) [Dr C] concurs with [Dr D's] statements above. She states: *I regrettably did not action the task* [sent to her by [Dr D] on 31 December 2015]*, that is send the referral for an ultrasound scan, as had been planned.* She noted the blood results which were unremarkable apart from an elevated CRP which is a very non-specific test. She states: *in the context of an otherwise well person, I would merely have repeated the test at 4 weeks to see if it had settled.*

(ii) [Dr C] notes that [Mrs A] saw another GP at the practice on 25 January and 12 March 2016 in relation to a skin condition. [Dr C] provided a repeat prescription for [Mrs A's] usual medications on 17 March 2016 (no consult) and saw her again on 20 June 2016 for a routine gynaecological check. [Dr C] states: *[Mrs A] did not mention the thyroid lump or experiencing any symptoms similar to those reported on 31 December 2015. A plan was made to review [Mrs A] in six months' time. Whilst it is not recorded in the notes, I have a vague recollection that we discussed the fact that she has not yet had her thyroid ultrasound scan at the hospital. I do not recall examining her thyroid at that point. This is likely because the purpose of the consultation was for a gynaecological check-up and [Mrs A] did not report any concerns or symptoms that made me suspicious or indicated the need for an examination. One month later, a request was sent to the DHB for the thyroid scan. It is likely that I had been trying to track down whether the original request had indeed been sent, and after establishing that it had not been.* ***I sent the referral form on 18 July 2016.***

(iii) [Dr C] provided [Mrs A] with a repeat prescription in September 2016 then reviewed her on 23 September 2016 in regard to leg pain which required exclusion of DVT. [Dr C] states: *I did not see her again until 2 December 2016, again for a routine gynaecological review and at that point she still had not received an appointment for the scan. Nothing is documented in the notes from that appointment regarding her thyroid but I do remember telephoning the Radiology Department to query the length of time it had taken. I do not recall [Mrs A] raising it as a particular concern on that occasion or any of the prior consultations as our focus was elsewhere on those occasions. Had she reported experiencing any symptoms or neck lump, I would have examined her and recorded this in the notes.*

(iv) The scan was performed on 12 December 2016 and on receipt of the result [Dr C] asked [Mrs A] to attend an appointment (16 December 2016) at which stage the result was discussed including possible implications and necessary follow-up. A referral was made the same day to expedite biopsy and possible surgical management of the mass. [Dr C] notes that at this appointment, [Mrs A] *noted that the thyroid mass had suddenly and dramatically grown and was causing symptoms of intermittent dysphagia and some shortness of breath (dyspnoea) on lying down.*

(v) [Dr C] is unsure how she managed to overlook sending the scan request. She states she may have queried whether ultrasound was the best imaging technique to be requested and in fact started to write a letter to the DHB endocrinology service to gain advice on this aspect of care, but the letter was never

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completed/sent, possibly because results were awaited. She states January was a particularly busy period in the surgery. She states: *In terms of the referral time, it is not unusual to wait up to six months in our area for a publicly funded ultrasound scan, and so with no particular concerns from either myself or reported by [Mrs A], it was not until July 2016 that I looked into what was happening with the referral.*

(vi) [Dr C] has apologized to [Mrs A] for her oversight. She notes: *As a practice, we have considered and discussed [Mrs A's] case. It has been a good reminder of ensuring all alerts/tasks are checked and referrals are followed up in a timely manner. I also intend to present [Mrs A's] case (anonymously) to my peer review group to discuss how we can make sure that requested tests/referrals actually are requested, and then happen and any practical steps that we can take to monitor these. Finally, I would like to reassure [Mrs A] and the HDC that I have always understood professional obligations in managing patient referrals.*

(vii) GP notes are consistent with [Dr C's] response. There was a consultation with [Dr C] on 11 December 2015 for gynaecological issues and no reference to a neck lump. The next consultation was with [Dr D] on 31 December 2016 (see above). On 7 January 2016 notes indicate an endocrinology referral has been 'parked' (initialed VV). [Dr C] has provided what I assume is the content of this referral which includes a copy of [Dr D's] consultation note and the opening statement: *This lady presented to my colleague last week with a new lump in her thyroid. Blood tests are normal except that she has a raised CRP with no other intercurrent illness to account for it. Therefore, I feel that it needs to be investigated with alacrity. Can you assess and arrange whatever scan is most appropriate please?*

(viii) On 25 January 2016 [Mrs A] presented to provider [initials] with a skin rash diagnosed as folliculitis and treated with antibiotics. [Mrs A] evidently then saw [a dermatologist] who provided a report, and [provider] contacted [Mrs A] by telephone on 17 March 2016 confirming her rash was responding to the treatment prescribed by the dermatologist. There is no reference in the GP note or specialist letter to [Mrs A's] thyroid swelling.

(ix) On 20 June 2016 [Dr C] saw [Mrs A] for routine gynaecological and blood pressure review and provided her usual prescriptions with follow-up *see 6m.* On 15 July 2016 a prescription was provided for travel medications (no consult). On 18 July 2016 provider ADB has recorded: *Referral for US Thyroid faxed to [the public] Hospital Radiology* (**there does not appear to be a copy of the referral request on file and this should be obtained if possible**).

(x) The next face-to-face consultation was 23 September 2016 when [Mrs A] presented with right leg pain three weeks after a long-haul flight. D-dimer blood test was arranged and was normal. CRP was repeated at this time and was normal as was blood count. [Dr C] reviewed [Mrs A] next on 2 December 2016 in relation to gynaecological issues. There is no reference to discussion regarding [Mrs A's] thyroid swelling at the June or September consultations.

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(xi) [Mrs A] underwent her thyroid USS on 12 December 2016 with clinical details recorded as: *Enlarged thyroid lobe on the right.* Findings were reported as: *An enlarged right thyroid with a lobulated outline and a heterogeneous appearance is noted. A 16 mm hypoechoic indeterminate nodule with peripheral and internal vascularity is seen on the lateral aspect of the upper right lobe. Further, two borderline lymph nodes measuring 10 and 9 mm in short axes are seen in the mid right lateral neck. An 11 mm cystic nodule is seen in the left lower thyroid and another benign appearing 7 mm nodule is seen in the upper left thyroid. FNA from right thyroid is advised.*

(xii) At the consultation of 16 December 2016 [Dr C] recorded: *Goitre hugely enlarged on the right since I last saw her. Causing some dysphagia — aware of discomfort when swallowing although no actual blockage. Findings difficult to breathe lying on her back also turning her neck is restricted. Ultrasound result explained, benign sounding lesions in the left thyroid but the right has a solid lesion that requires FNA. Radiologist ... contacted and he will arrange appointment urgently. Discussed the possibility that this may be a malignancy and I will refer… for urgent surgical outpatient appointment.* A photograph was taken of the neck mass and attached to the referral.

5. Additional clinical notes

(i) [Mrs A] was seen by the DHB surgical service on 4 January 2016 and the clinic letter includes: *She tells me that* [the neck lump] *first came to attention more than a year ago, and initially was booked for an ultrasound scan. Unfortunately it appears as though this has not come to fruition, and it is only recently when she has started experiencing breathing symptoms and a hoarse voice that she has come to see you.*

(ii) While awaiting further outpatient investigation [Mrs A] was admitted to [the public hospital] on 7 January 2017 after experiencing sudden increase in size of the swelling and development of obstructive symptoms. Discharge summary includes the comment: *voice has become hoarse over period of months.* Investigations were completed while she was an inpatient from 7–13 January 2017. Core biopsy request form includes the comment: *Rapidly enlarging (Rt) thyroid nodule over 2 months* ... Referral letter from radiation oncologist to medical oncologist dated 16 January 2017 includes: [Mrs A] *remains remarkably asymptomatic from the rapidly enlarging right neck mass. Although she experiences a tight feeling in her neck, she denies any shortness of breath or dysphagia. Clinically she does not have any stridor. She does have a hoarse voice, probably due to a recurrent laryngeal nerve palsy.*

(iii) CT scan undertaken on 7 January 2017 was reported as: *Large predominantly right-sided thyroid goitre causing mass effect on the trachea and the adjacent structures. An area of increased density within the thyroid goitre on the right side and several areas of increased density in the left lobe, have density that is higher than expected for haemorrhage, and may represent islands of normal thyroid tissue or calcifications. Correlation with ultrasound scan is recommended.* The thyroid mass measured 96mm across and anteroposterior diameter of 69mm. Ultrasound guided core biopsy was undertaken on 10 January 2017 with

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histology revealing anaplastic thyroid cancer. Staging CT scan on 11 January 2017 gave clinical request details as: *Large neck mass, recent rapid growth, possible underlying malignancy.* There was borderline retrosternal lymphadenopathy noted and no obvious metastatic spread. An incidental small right apical pulmonary embolus was noted also. The proximity of the tumour to vital neck structures unfortunately prohibited surgical removal of the cancer (this decision made in consultation with a tertiary hospital based thyroid surgeon) and [Mrs A] was referred for palliative radiotherapy. Sadly, it appears her prognosis is very poor and this has been discussed with her.

5. A UK clinical evidence-based website provides a well referenced summary of thyroid cancer including the following points[1]:

(i) *Carcinoma of the thyroid gland is an uncommon cancer but is the most common malignancy of the endocrine system. Differentiated tumours (papillary or follicular) are highly treatable and usually curable. Poorly differentiated tumours (medullary or anaplastic) are much less common, are aggressive, metastasise early and have a much poorer prognosis.*

(ii) *Anaplastic thyroid carcinoma (ATC) is the most aggressive thyroid tumour and one of the most aggressive cancers in humans … The peak incidence is in the sixth to seventh decades (mean age at diagnosis 55–65 years) and the prevalence is very low (<2% of all thyroid tumours). In most cases, ATC develops from a pre-existing well-differentiated thyroid tumour, which has undergone additional mutational events. The clinical diagnosis is usually easy with a large, hard mass invading the neck and causing compression (dyspnoea, cough, vocal cord paralysis, dysphagia and hoarseness). Almost 50% of the patients present with distant metastases, mostly in the lungs but also in the bones, liver and brain. The mean overall survival is often less than six months, whatever treatment is performed.*

(iii) *Thyroid cancer presents as a thyroid nodule. Thyroid nodules are frequent (4–50% depending on the diagnostic procedures and the patient's age); however, thyroid cancer is rare (c. 5% of all thyroid nodules). Solitary thyroid nodules can vary from soft to hard. Hard and fixed nodules are more suggestive of malignancy than soft mobile nodules. Thyroid carcinoma is usually non-tender to palpation. Firm cervical masses are suggestive of regional lymph node metastases. Vocal cord paralysis implies involvement of the recurrent laryngeal nerve.*

(iv) *Red flag features*

- *A family history of thyroid cancer.*
- *History of previous irradiation or exposure to high environmental radiation.*
- *A child with a thyroid nodule.*
- *Unexplained hoarseness or stridor associated with goitre.*
- *A painless thyroid mass enlarging rapidly over a period of a few weeks.*

[1] http://patient.info/doctor/thyroid-cancer-pro#ref-6 Accessed 15 March 2017

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- *Palpable cervical lymphadenopathy.*
- *Insidious or persistent pain lasting for several weeks.*

(v) *Thyroid function tests (TFTs) should be performed for any patient with a thyroid nodule. However, TFTs (most patients will be euthyroid) and thyroglobulin (Tg) measurement are of little help in the diagnosis of thyroid cancer. Serum calcitonin is a reliable tool for the diagnosis of MTC (5–7% of all thyroid cancers). Thyroid ultrasound is extremely sensitive for thyroid nodules and is used as a first-line diagnostic procedure for detecting and characterising nodular thyroid disease.*

(vi) *Patients who have suspicious features (red flags — as above) should be referred urgently to a secondary care physician with expertise in the diagnosis and management of thyroid cancer, and seen within two weeks. Any patient with a thyroid lump and associated stridor should be referred for same day review by a secondary care specialist, as this may be due to recurrent laryngeal nerve involvement secondary to a thyroid carcinoma.*

6. The same source, in a review of thyroid lumps[2], includes the following information:

(i) *Most thyroid lumps are benign but around 5% are malignant and it is important to distinguish this sinister minority. The term goitre refers to enlargement of the thyroid gland. A thyroid nodule may be a lump in an otherwise normal thyroid gland. However, goitres may consist of many nodules (multi-nodular goitre) and solitary nodules may exist within a goitre. Nodules may be cystic, colloid, hyperplastic, adenomatous or cancerous.*

(ii) *Between 4–7% of adults have palpable thyroid lumps. Many more will be detectable on high-definition ultrasonography. Up to 40% of people having an ultrasound scan on their neck are found to have a thyroid nodule incidentally, and similar numbers are found incidentally at autopsy. 95% of these thyroid lumps in adults are benign. Thyroid cancer represents 1% of all malignancies. Thyroid nodules are uncommon in children and adolescents (1–1.5% are estimated to have palpable lumps). However, the risk of nodules being cancerous in this population is higher.*

(iii) The differential diagnosis of a thyroid lump is extensive but includes: *non-toxic (simple) goitre — non-functioning nodules. TFTs are normal; toxic multinodular goitre — functioning nodules. Abnormal TFTs; retrosternal goitre (usually multinodular); hyperplastic nodule (single nodule or part of multinodular goitre); colloid nodule; thyroid adenoma; thyroid cyst; thyroid carcinoma; Graves' disease — diffusely enlarged overactive thyroid gland; Hashimoto's thyroiditis — autoimmune destruction of the gland may cause diffuse enlargement; other types of thyroiditis; and a variety of non-thyroid congenital and acquired lumps and swellings.*

[2] http://patient.info/doctor/thyroid-lumps-including-goitre Accessed 15 March 2017

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(iv) Red flags for urgent referral are as above (s5(iv)). Indications for non-urgent referral are: *Thyroid nodules with abnormal TFTs. Refer to an endocrinologist; Sudden onset of pain within a thyroid lump. (Likely cause is a bleed into a thyroid cyst.)*

(v) *British Thyroid Association guidelines recommend GPs perform TFTs to determine the need for referral, and if so who to. Those with abnormal TFTs and no suspicious features should be referred to an endocrinologist. Those with thyroid swelling and normal TFT should be referred under the timeline in the 'Red flag features' section, above. These guidelines advise that in those with a new thyroid swelling, GPs should NOT arrange an ultrasound as this delays specialist opinion in those who may have thyroid cancer. Referral should be to a surgeon, endocrinologist or other member of a specialist multidisciplinary team.*

7. New Zealand guidelines in relation to suspected cancer in primary care (2009 — not yet updated) include the following recommendations[3]:

(i) *A person presenting with symptoms of tracheal compression including stridor due to thyroid swelling should be referred immediately to secondary care for emergency care*

(ii) *A person should be referred urgently to a specialist if they have a thyroid swelling AND one or more of the following:*

- *a solitary nodule increasing in size*
- *a history of neck irradiation*
- *a family history of an endocrine tumour*
- *unexplained hoarseness or voice changes*
- *cervical lymphadenopathy*
- *young age (pre-pubertal)*
- *age 65 years and older*

(iii) *A person should have thyroid function tests if they present with a thyroid swelling without stridor and do not have any of the following features:*

- *a solitary nodule increasing in size*
- *a history of neck irradiation*
- *a family history of an endocrine tumour*
- *unexplained hoarseness or voice changes*
- *cervical lymphadenopathy*
- *young age (pre-pubertal)*
- *age 65 years and older*

[3] New Zealand Guidelines Group. Suspected cancer in primary care: guidelines for investigation, referral and reducing ethnic disparities. Wellington: New Zealand Guidelines Group; 2009.

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(iv) *A referral to an endocrinologist (or if unavailable a physician) should be made if the person has a goitre and normal thyroid function tests. A referral to an endocrinologist (or if unavailable a physician) may be considered if the person has hyperthyroidism or hypothyroidism and an associated goitre.*

(v) *Good practice point: For a person presenting with symptoms and/or signs suggestive of thyroid cancer, a referral for an ultrasound investigation may be made, but this should not delay referral to a specialist.*

(vi) The updated NICE guidelines[4] which have previously influenced these NZ guidelines now state: *Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for thyroid cancer in people with an unexplained thyroid lump.*

8. A Ministry of Health resource for triaging clinicians[5] includes the following criteria for high suspicion of cancer in relation to neck masses:

HEAD AND NECK CANCER - Neck/Salivary Lump[11]	
If the patient presents ***with one or more*** of the following red flags, then the referral should be triaged as 'High Suspicion of Cancer'.	
Red flags	YES or NO
An unexplained neck/salivary mass ***and one or more*** of the following:	
• mass > 1cm and persisting > 3weeks	
• mass is increasing in size	
• previous head and neck cancer including skin cancer	
• facial palsy	
• any new unexplained upper respiratory tract symptoms such as hoarseness, dysphagia, throat or ear pain, blocked nose or ear	

8. Discussion

(i) Thyroid swellings are common in the general population and a minority of these (around 5%) is malignant. The range of differential diagnoses for a thyroid swelling is large. Anaplastic thyroid cancer represents a small proportion of thyroid cancers but has the worst prognosis. There are some 'red flags' that might raise suspicion for thyroid malignancy and these have been discussed above. At the time [Mrs A] developed her thyroid swelling in December 2015, she was aged 76 years. The description of the swelling and assessment findings (as described

[4] https://www.nice.org.uk/guidance/ng12/evidence/full-guideline-74333341 Accessed 15 March 2017
[5] Ministry of Health. Faster Cancer Treatment: High suspicion of cancer definitions September 2015. http://www.melnet.org.nz/uploads/hscan_defns_final_updated_2_sept_2015.pdf

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by [Dr D]) were not immediately alarming and the history was short. The swelling was described more as a diffuse enlargement of the right thyroid lobe rather than a discrete nodule. While the cited New Zealand guidelines include age over 65 years as a reason for urgent referral in a patient with a thyroid mass, I believe [Dr D's] actions in wanting to first determine [Mrs A's] thyroid status (blood test) and the nature of the mass (ultrasound) was consistent with accepted and common practice in the clinical scenario described. The proviso to this is that adequate information has been provided to the patient including 'safety-netting' advice. Importantly, the patient should be instructed to return if there is rapid growth of the mass or development of 'red flag' symptoms (including hoarseness) while awaiting investigations, and given a time-frame within which to expect test appointments and results. Best practice in this case, given [Mrs A] was not a regular patient of [Dr D], might have been for advice to have been given that [Mrs A] schedule an appointment with [Dr C] at a specified interval to review the mass and coordinate further management. Best practice is also to document provision of safety-netting advice if such advice was provided. However, I feel it was reasonable for [Dr D] to expect that [Mrs A] would receive timely and appropriate management by [Dr C] given the explicit instructions she had left for [Dr C] and the overall reasonable quality of her clinical documentation which [Dr C] could review. I am currently unable to comment on the adequacy of the ultrasound referral itself but if it included the content of the clinical notes, this would have been adequate. Based on [Dr D's] recollection of her discussion with [Mrs A] on 31 December 2015, I think [Dr D's] management of [Mrs A] was reasonable from a clinical perspective.

(ii) [Dr C's] oversight in failing to complete [Mrs A's] ultrasound referral once blood test results were received was significant and appears most likely to be the result of human error rather than any systems failure. Nevertheless, I think **[the medical centre] should be asked to provide their policies on handling of referrals and results to ensure they are robust.** It is apparent [Dr C] had an intention to refer [Mrs A] for further investigation following her return from leave, but the partially completed referral was never sent. This might also account for the failure by [Dr C] to track the referral and to organize an alert if it had not been actioned within a reasonable time frame — a foreseeable chain of events if the first step (completing and sending the referral) was never completed. It is difficult to see how this risk can be successfully mitigated unless more use is made of electronic reminders at an 'intention to refer' stage rather than once the referral is completed. Normally a 'task' (in this case the message from [Dr D]) will remain active until intentionally deleted or ticked as actioned by the recipient. I assume [Dr C] must have removed the task once she began her endocrinology referral and I think she should reflect on the wisdom of such an action in light of this incident.

(iii) On the basis of the clinical notes and photographs supplied by [Mrs B], it is apparent there may have been very gradual increase in the size of [Mrs A's] mass but no other particular alarm symptoms until around October 2016. From this point, there may have been gradual onset of hoarseness (an alarm symptom) and, particularly from November or early December 2016, a much more rapid increase

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in size of the mass. It would be somewhat surprising that if [Mrs A] had been advised to report any increase in size of the mass or apparent delay (beyond a month) in receiving her ultrasound appointment, this issue was not raised by her at the consultations she had with [Dr C] in June 2016. In fact, [Dr C] states she has a 'vague recollection' of some discussion around the overdue ultrasound at this consultation, and the referral was sent about a month later (the prompt at this time being unclear but [Mrs A] had phoned for a medication prescription two days beforehand). I have some concerns with this sequence of events. I would expect that, had [Mrs A] raised the question of her ultrasound at the consultation of 20 June 2016, [Dr C] would have reassessed the status of the mass (had it grown, were there any new associated symptoms), examined the mass and then made a prompt decision regarding appropriate management. I think this should have occurred, or arrangements made for an urgent second GP appointment, whether or not the original appointment was for routine gynaecological review. By this stage the lump had been slowly enlarging over six months and I think (with respect to guideline recommendations regarding duration of symptom and patient age) a degree of urgency in ascertaining the nature of the mass was required, either by urgent ultrasound referral (with updated history and assessment findings) or specialist referral. I think such a referral should then have been tracked and pursued if it had not been actioned within a month (or sooner if there was high suspicion of cancer), and timely GP review scheduled to monitor the status of the mass in the interim. However, [Mrs A] was advised to return in six months, the referral was not sent for another month (and I have yet to ascertain whether updated information was included) and there was evidently no tracking of the referral.

(iv) When [Mrs A] returned for review of an acute leg problem in September 2016 she apparently did not mention her thyroid mass or delayed USS, and [Dr C] was not prompted to enquire after either of these issues. However, the current issue (possible deep vein thrombosis) was a priority at the time and may have distracted both parties. This was still a missed opportunity to review the management of [Mrs A's] thyroid mass. Having reviewed the patient photographs and history recorded by other providers, it is somewhat puzzling that [Mrs A's] by now rapidly increasing thyroid mass and persistent hoarseness were not detected or discussed at the consultation of 2 December 2016. From [Mrs A's] perspective, it is possible she had received an appointment for her USS by this stage (performed 10 days later) and was not currently experiencing any obstructive symptoms. Once the ultrasound result was received and [Mrs A] admitted to recent rapid increase in size of her mass and additional suspicious symptoms, I think [Dr C] acted with appropriate urgency.

(v) On the basis of the discussion above, I think [Dr C's] management of [Mrs A] in relation to her thyroid mass, would be met with at least moderate disapproval by my peers and may be sufficiently deficient to warrant referral to the Medical Council. This takes into account the observation that the original oversight appears to be the result of 'one off' human error, that [Dr C] did document an intention to refer [Mrs A] in January 2016, and that the initial progression of [Mrs A's] mass was very gradual and without additional symptoms.

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(vi) The role of the DHB in the lengthy wait for [Mrs A's] ultrasound (from July to December 2016) has yet to be established and a response from the DHB (which may include a copy of the original referral documentation) is awaited.

9. Addendum, 27 March 2016

(i) I have noted additional information received from [Mrs A] and her daughter, [Mrs B], dated 23 March 2017. Most of the issues have been covered in the advice above but I note [Mrs A] does not recall receiving 'safety-netting' advice from [Dr D] or [Dr C] in regard to her neck lump or scan, and she states she proactively made the appointment to discuss the scan with [Dr C] in December 2016 rather than being called in by [Dr C] to discuss them. I agree with [Mrs B] that patients should be given the option of private referral for investigations/specialist review particularly when delays in the public system might be expected or become apparent, and I am mildly critical that [Mrs A] was evidently not provided with this option at any stage. I agree also that provision of written information to elderly patients with respect to a management/follow-up plan is good practice and should be encouraged.

(ii) The DHB response dated 16 March 2017 has been reviewed. The response confirms that the ultrasound referral was received on 17 July 2016, written by [Dr D]. The typed clinical note was: *enlarged thyroid lobe on R?* There was an accompanying handwritten comment: *Solitary smooth lump, moves with swallowing, gradually enlarge ?urgent.* **The DHB should be asked if they can fax us a copy of the scan request form, and [Dr C] should be asked to confirm if she added the handwritten comment.**

(iii) The referral was prioritized as 'routine' on 18 July 2016 on the basis of the clinical information received suggestive of an uncomplicated right sided goitre. The waiting time for routine ultrasound was five months. No additional referrals were received. On 23 November 2016 [Mrs A] was notified that an appointment was scheduled for her on 12 December 2016. She attended this appointment and the scan was completed.

(iv) Comments: The additional information received does not alter my opinion that the management of [Mrs A] by [Dr D] was largely consistent with expected standards of care, provided the 'safety-netting' advice she describes in her response was provided to [Mrs A]. I would be mildly critical if it was not provided, and mildly critical if the option of private referral was not discussed (although there was no particular clinical urgency evident at this point as discussed previously). I remain of the view that [Mrs A's] management by [Dr C] departed from expected standards to at least a moderate degree for the reasons described previously. I think the management of [Mrs A] by [the DHB] was probably appropriate to the clinical scenario presented in the ultrasound referral letter, but very brief expert advice on this point might be obtained from a radiologist if required."

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Further advice was obtained from Dr Maplesden:

> "1. I have reviewed the additional information provided by [Dr C]. [Dr C] notes it is very likely she discussed [Mrs A's] thyroid swelling with her at the consultation of 20 June 2016, most likely examined [Mrs A's] thyroid and annotated by hand the assessment findings in the ultrasound referral subsequently forwarded to [the public hospital] (on 18 July 2016). She did not refer to any such discussion or assessment in the clinical notes. The reason for the one month delay between this assessment and provision of the referral remains unclear. This information and additional clarification provided by [Dr C], does not alter my opinion that her overall management of [Mrs A] departed from expected standards of care to at least a moderate degree. The remedial actions undertaken by [Dr C] as noted in her response appear very reasonable.
>
> 2. I have reviewed further information provided by [Dr D] including clarification regarding safety-netting advice provided to [Mrs A] and discussion regarding private versus public ultrasound. I remain of the view that the management of [Mrs A] by [Dr D] did not depart from expected standards of care.
>
> 3. I have reviewed the [the medical centre] policy on management of clinical correspondence and test results. This policy appears consistent with others I have seen, with tracking or clinical documentation recommended if there is suspicion of a significant abnormal outcome/result. There is an inherent weakness in all such 'tracking' policies that if there is not a significant degree of suspicion the correspondence will not be tracked. However, the alternative of tracking all clinical correspondence generated is impractical and I think the current solution is a reasonable one (and commonly applied) provided patients are given some expectation of when results/appointments are likely to be received, and with increasing access by patients to their own results via patient portals. The [the medical centre] Policy does specify that if a GP is away for a week or longer, then an arrangement with a colleague is to be made to review results. There is also reference to practice nurses being tasked to follow-up urgent blood results if they have not been received and actioned within one week. I think some results are more 'time critical' than a one week review or action window, but I note there is reference elsewhere in the document to the practice A&M doctor being responsible for reviewing urgent results in the absence of the requesting doctor. I presume this addresses the issue of possible time-critical results being un-reviewed for up to a week.
>
> 4. [Dr C] raised the possibility of the referral for [Mrs A's] ultrasound being urgent in her referral from 18 July 2016. The ultrasound appointment was scheduled for 10 December 2016. I think brief comment should be sought from a radiologist as to the 'reasonableness' of this scheduling based on the clinical information provided in the referral letter from [Dr C]."

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Appendix B: Independent expert advice to the Commissioner

The following expert advice was obtained from a radiologist, Dr Michael Nowitz:

"**HDC Guideline**:
I have read and agree to follow the HDC guidelines.

Experience and Qualifications:
I practice as a general radiologist at Pacific Radiology in Wellington, New Zealand and as the Senior Lecturer in Radiology in the Department of Medicine, University of Otago Medical School, Wellington.

Qualifications:
MB,BCh, FFRad (D) SA, FRANZCR.

HDC Advice Requested:
'Review the enclosed document and advise whether you consider the decision by the Radiology Department to prioritise the referral as routine was reasonable in the circumstances.'

Information Provided:
Copy of an ultrasound request form:

- Date 17/07/2016 Date stamped 18/07/2016
- [Mrs A]
- [Date of Birth]
- [NHI]
- Clinical Note:

  ▪ 'Enlarged thyroid lobe on R?'
  ▪ 'Solitary smooth lump moves with swallowing'
  ▪ 'Gradually enlarging'
  ▪ '? Urgent'
  o Test
  ▪ US: thyroid
  (XX = Illegible)

Opinion:
The scenario of a gradually enlarging smooth lump (presumably of thyroid origin as it moves with swallowing) is common.

'Palpable thyroid nodules occur in up to 7% of the general adult population, and the incidence of nonpalpable thyroid nodules visible by ultrasound is up to 10 times greater (ie, 70%).'[1]

The Request form does not indicate a history or clinical features that suggest malignancy, namely:

- History of childhood head and neck irradiation
- Total body irradiation

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- Family history of thyroid carcinoma
- Multiple endocrine neoplasia
- Rapid growth
- Hoarseness
- Vocal cord paralysis
- Lateral cervical adenopathy
- Fixation of the nodule to the surrounding tissues.[2]

Based on the clinical information provided it would be reasonable for this study to be allocated to the routine booking list.

The '? Urgent' in the request is discordant with the information given and makes one wonder if there was clinical uncertainty about the nature or the origin of the lump.

Provided the booking process ensures that:

- The referrer is notified of the proposed date for the study.
- There is a mechanism available to expedite the study should the clinical context change.

I would still have prioritised the study as routine.

If the above booking processes were not in place, then given the ambiguous nature of the request[3] I would have arranged for the referrer to be contacted for clarification.

PS. Reference 3 though not directly quoted provides useful insights into the requisitioning of diagnostic imaging procedures.

References:

1. Gerald T. Kangelaris, Ma, Theresa B. Kim, MD, Lisa A. Orloff, MD **Role of Ultrasound in Thyroid Disorders.** Ultrasound Clin 2012; 7: 197–210

2. David S. Cooper, M.D., Gerard M. Doherty, M.D., Bryan R. Haugen, M.D. etal. **Revised American Thyroid Association Management Guidelines for Patients with Thyroid Nodules and Differentiated Thyroid Cancer.** THYROID 2009 19(11): 1167–1214.

3. Pitman A G. **Quality of referral: What information should be in a request for diagnostic imaging when a patient is referred to a clinical radiologist?** JMIRO 2017; 61:299–303:"

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