



Failure to diagnose breast cancer

Case histories are based on actual medical negligence claims, however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

Failure to diagnose cancer is a relatively common cause of medical negligence claims against general practitioners. Most of these cases involve patients under the age of 40 years who are diagnosed with breast cancer.

The most common causes of these claims are:

- the physical findings failed to impress the GP as suspicious
- failure of the GP to follow up the patient in a timely manner.

This article outlines some risk management strategies for GPs to minimise the possibility of a claim arising from the failure to diagnose breast cancer.

Sara Bird, MBBS, MFM (clin), FRACGP, is Medico-legal Adviser, Professional Development Program, UNITED Medical Protection

Case history

A 25 year old woman attended a general practitioner because she thought she felt a lump in her right breast. On questioning, the patient reported the presence of a right breast lump for a six month period. She had undergone a reduction mammoplasty five years previously. The GP examined the patient's breasts but could not feel a definite mass in either breast. In the medical records the GP included a diagram of the patient's breasts with the right upper outer quadrant marked, which identified it as the area of concern (*Figure 1*). The GP reassured the patient that he thought she simply had lumpy breasts and this was normal in someone of her age. He also commented that the patient might be feeling scar tissue that had formed as a result of the reduction surgery. The patient asked if she should have a mammogram as she was concerned about the possibil-

ity of breast cancer. The GP replied that the possibility of cancer was very remote and 'that it would be at the bottom of my list of possible diagnoses'.

Five months later, the GP saw the patient for a second consultation, when the patient said that she was moving overseas next month and required a Pap smear. The patient also complained of lower back pain. The GP performed the Pap smear and prescribed a nonsteroidal anti-inflammatory for her back pain.

The patient moved to Thailand. While there her back pain worsened and she attended several doctors for treatment. The pain did not improve and subsequent investigations revealed a right breast cancer with metastatic disease involving the lumbar spine and liver. The patient returned to Australia and underwent chemotherapy and radiotherapy.

Three years after the initial consultation, the patient commenced legal proceedings against the GP.

Medicolegal issues

In her claim against the GP, the patient — now a plaintiff — alleged that the GP — now a defendant — had breached his duty of care and had negligently failed to diagnose her breast cancer. The Statement of Claim alleged that at the initial consultation the GP should have asked the patient to return for review or should have referred her for further investigations. With regard to the second consultation, the Statement of Claim alleged that the GP should have inquired about the previous breast symptoms and ordered further investigations. The plaintiff claimed that, had the appropriate investigations been undertaken, her cancer would have been diagnosed at least 12 months earlier. As a result, her pain would have been appropriately palliated at an earlier date and her life expectancy would have been extended for at least five years.

Expert opinion obtained on behalf of the defendant GP was critical of his failure

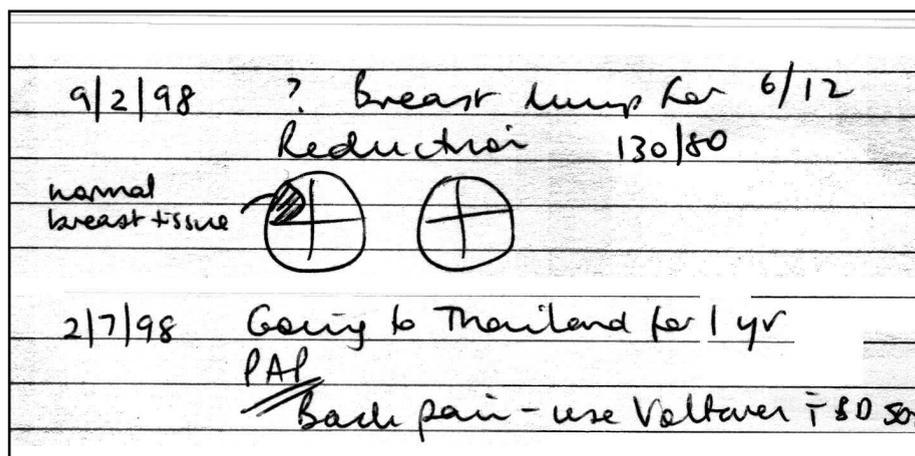


Figure 1. Medical records.

to raise the issue of the breast symptoms at the second consultation. The GP expert wrote that ‘a further history should have been taken in respect to the right breast at this second consultation for the Pap smear’. The defendant could not recall this consultation but said that it was his usual practice to perform a breast examination at the same time a Pap smear is done. However, the medical records were silent on this issue (Figure 1). The plaintiff’s GP expert also argued that the defendant should have ordered a breast ultrasound after the initial consultation. At the very least, the expert noted that ‘the GP should have asked the patient to return for another breast examination after her next period’.

There are three elements that must be satisfied in order to establish negligence. Firstly, the plaintiff must prove that the defendant owed him/her a duty of care; secondly that there was a breach of this duty; and thirdly that the negligent act caused the plaintiff damage. In claims involving an allegation of failure to diagnose cancer, this third element of ‘causation’ is critical. In this case, the plaintiff had to establish ‘on the balance of probabilities’ that the delay in diagnosis of her breast cancer caused her to suffer additional damage. An expert report obtained from an oncologist concluded that if the plaintiff’s breast cancer had been diagnosed soon after the initial consultation, there would have been a greater

than 60% chance of localised disease and better than 50% likelihood of survival for five years or longer. At the very least, it was apparent that the plaintiff had experienced a prolonged period of increasingly severe back pain that would have been treated with radiotherapy at a much earlier stage if the diagnosis had been made soon after the second consultation. The plaintiff claimed ‘general damages’ for this additional pain and suffering.

On the basis of the expert opinions from the two GPs and the oncologist, the claim was indefensible and settled out-of-court for just over \$100 000 including legal costs.

Discussion

Almost 10% of the medical negligence claims against Australian GPs involve an allegation of failure to diagnose cancer. The majority of these cases involve breast cancer.¹ A US study of settled breast cancer claims revealed that the most common reason for the delay in diagnosis of breast cancer was the failure of the doctor to be ‘impressed’ by the findings on clinical examination.² The second most common reason for the delay was the failure to follow up the patient in a timely fashion. These two factors accounted for two-thirds of the claims. In 60% of the claims, it was the patient who initially discovered the breast lesion and the average diagnostic delay was 14 months. Interestingly, three quarters of the claims

involved patients under the age of 50 and in almost one third of the claims the patient was less than 40 years old. The incidence of breast cancer in women aged 0–29 years is one in 2486 and in women aged 30–39 years the incidence of breast cancer is one in 257.³ Clearly, women under the age of 40 are over-represented in the claims involving failure to diagnose breast cancer.

The National Breast Cancer Centre has published guidelines for the investigation of a new breast symptom.⁴ These guidelines recommend that any new breast symptom (lump, thickening, lumpiness, asymmetrical glandular prominence or pain), even in the absence of a palpable lump or discrete lesion on clinical examination, should be followed up with clinical review in 2–3 months, immediately after the menstrual period. If the breast problem persists, the patient should be sent for imaging. For patients under 35 years, breast ultrasound is recommended as the first imaging modality. Any abnormality on imaging should be followed up with either fine needle aspiration cytology or core biopsy.

In this case, the GP discounted the possibility of cancer on the basis of finding no discrete breast lesion on clinical examination. No doubt the fact that the patient was only 25 years old also contributed to this view. Nevertheless, the GP simply reassured the patient and did not ask her to return for review. At the second consultation, the GP did not review his previous medical records and consequently he failed to inquire about the breast symptoms. The patient had been reassured by the GP and did not raise the issue of her breast problem at this second consultation.

Risk management

- Follow up patients with breast symptoms and/or signs to resolution.
- Think twice before you discount the patient’s concerns. If the patient thinks something is wrong with her breasts, you should do something — review, refer or investigate.

- Do not discount the possibility of breast cancer because of the patient's young age. Low risk does not equal no risk.
- A normal clinical examination does not exclude a diagnosis of breast cancer. Be aware of the limitations of clinical breast examination.
- Adopt and follow the National Breast Cancer Centre guidelines for the investigation of a new breast symptom.
- Review previous entries in the medical records. Do not simply rely on the patient to raise significant issues at each consultation.

References

1. This figure is based on a review of 230 claims involving GPs that were notified to UNITED Medical Protection between January 1999 and February 2001.
2. Physician Insurers Association of America. Breast Cancer Study June 1995.
3. National Breast Cancer Centre: www.nbcc.org.au/pages/info/resource/nbccpubs/bc21-94/riskbcag.htm (10 May 2002).
4. National Breast Cancer Centre. The investigation of a new breast symptom. A guide for General Practitioners. October 1997: www.nbcc.org.au/pages/info/resource/nbccpubs/symptom/investig.pdf

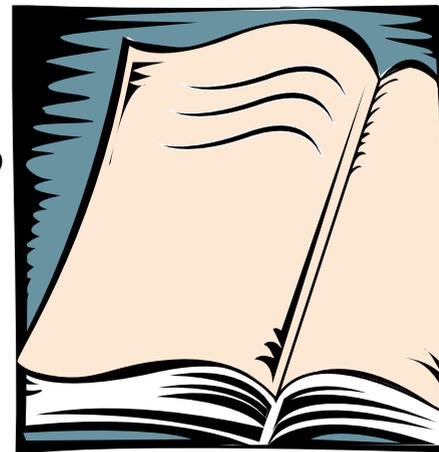
SUMMARY OF IMPORTANT POINTS

- Almost 10% of the medical negligence claims against Australian general practitioners involve an allegation of failure to diagnose cancer. The majority of these cases involve breast cancer.
- General practitioners should follow up all patients with breast symptoms to a definitive diagnosis or resolution of the symptoms, in accordance with the National Breast Cancer Centre guidelines.
- Do not discount the possibility of breast cancer because of the patient's young age — low risk does not mean no risk.

REPRINT REQUESTS

Dr Sara Bird
PO Box Q746
Queen Victoria Building
Sydney NSW 1230.

Book reviews



Beyond Advice Becoming a Motivational Practitioner

255 pages US\$30
Rick Botelho

Beyond Advice Developing Motivational Skills

206 pages US\$25
Rochester, New York:
www.MotivateHealthyHabits.com

Do you get frustrated at patients who don't follow your advice? Would you like to be more effective in helping your patients to stop smoking or reduce excessive drinking? Then these may be the books for you.

Written and published by a British trained Professor of Family Medicine and Nursing from Rochester, New York, these twin volumes aim to help students and practitioners learn how to change their professional roles, assumptions and mental maps (Book 1) before developing the skills to help others (Book 2). Adopting an interdisciplinary approach to motivating behaviour change, the books build on the transtheoretical model of change, motivational interviewing, self determination theory, self efficacy theory, relapse prevention and solution based theory. Shifting the practitioner from a traditional 'fix-it', advice giving role to a motivational role is the basic philosophy underlying these innovative volumes.

Book 1 outlines a six step approach for motivating health behaviour change, assisting the practitioner to develop individualised interventions to meet patients' changing needs over time. The six steps are:

- building partnerships,
- negotiating an agenda,
- assessing resistance and motivation,

- enhancing mutual understanding,
- implementing a plan for change and
- following through.

Book 2 is intended to help the practitioner learn how to initiate 'change' dialogues with patients and provides a model for continuing professional development, using a learner centred approach. This is based on the practitioner using the PARE (Prepare, Act, Reflect, Enhance) improvement cycle to work on achieving his/her goals. Three specific health behaviours — excessive alcohol use, tobacco use and self care of diabetes are addressed in the second volume. This process is facilitated by the use of the decision balance, a tool which helps patients to explore four domains related to their unhealthy behaviour — body (physical health), mind (thoughts and perceptions), heart (feelings) and soul (values).

These are practical manuals, each chapter beginning with a question for reflection and an overview, and ending with a moving on section. Sprinkled with numerous learning exercises and worksheets to help the reader to develop a learning plan and a portfolio, the text is underpinned by a solid evidence base and extensive references. Some practitioners may find the North American behavioural science-speak a little irritating, but the basic approach and practicality of these two volumes should be of interest to those who wish to expand their repertoire of clinical skills.

*Brian McAvoy
Elwood, Vic*