General Practitioners, Dr B and Dr C

A Report by the

Health and Disability Commissioner

(Case 02HDC04719)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Dr B	Provider / General Practitioner
Dr C	Provider / General Practitioner
Dr D	Plastic Surgeon
Dr E	Skin Cancer and Plastic Surgery Specialist
Dr F	Independent general practitioner advisor to ACC

Complaint

On 11 April 2002 the Commissioner received a complaint about the services provided to Mr A by general practitioners Dr B and Dr C of a medical centre (the Centre). The complaint was summarised as follows:

Dr C

Dr C did not provide services of an appropriate standard to Mr A as follows:

- *Dr C did not document in Mr A's medical notes that tissue was removed from a lesion on his forehead on 27 August 1998 and 20 September 2001.*
- *Dr C did not record the results of the laboratory tests performed on the tissue specimens taken on 27 August 1998 and 20 September 2001.*
- *Dr C did not record that the tissue samples taken on 27 August 1998 and 20 September 2001 had been sent to a laboratory for testing.*
- *Dr C did not follow up the laboratory results on the tissue samples taken on 27 August 1998 and 20 September 2001.*
- *Dr C did not recognise that Mr A was suffering from squamous cell carcinoma on his forehead.*
- *Dr C did not report the laboratory results of the tissue samples to Mr A.*

Dr B

Dr B did not provide services of an appropriate standard to Mr A as follows:

- *Dr B did not follow up and report laboratory results on tissue samples taken from Mr A's forehead on 27 August 1998.*
- *Dr B did not recognise that Mr A had squamous cell carcinoma on his forehead.*
- *Dr B did not make an appropriate referral to a skin specialist in that he did not refer Mr A to the skin specialist in relation to the lesion on Mr A's forehead.*

An investigation was commenced on 8 July 2002.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information reviewed

- Mr A's general practice records
- Mr A's records from the first public hospital
- Mr A's ACC records
- Information supplied by the laboratory
- Expert advisors' reports from general practitioners Dr Wendy Isbell and Dr Jim Vause

Information gathered during investigation

Background
Mr A had been a patient of general practitioner Dr B for more than 20 years and consulted Dr B for a variety of medical problems including a recurring skin lesion on his forehead.

Dr B first treated Mr A's skin problems in 1991. Between 1994 and 1996 Dr B referred Mr A to a public hospital's Plastic Surgery Clinic, where he saw plastic surgeon Dr D. On 2 December 1994 Dr D excised the lesion under local anaesthetic in the outpatient clinic. Mr A's records indicate that Dr D excised "a lesion on the forehead which was treated with liquid nitrogen. It hasn't resolved." Mr A required further surgery to a lesion on his forehead on 30 March 1995. Whether this was a recurrence of the lesion excised in 1994 is not indicated. Histology reports show that the lesion was a basal cell carcinoma (BCC). Dr D examined the lesion again on 6 October 1995. He reported no recurrence, but found another BCC on Mr A's right temple. Dr D removed this lesion on 23 November.

Mr A continued to have six-monthly skin checks at the Plastic Surgery Clinic until 31 May 1996 when he was discharged back to the care of Dr B.

Surgery – 1998
On 22 June 1998 Mr A consulted Dr B about a lesion on his forehead. Dr B diagnosed an epidermal cyst and referred Mr A to the Surgical Clinic at a second public hospital for removal of a lesion that was "atypical and appeared benign and cystic". On 30 June the second public hospital declined Dr B's referral because removal of benign skin tumours did not come within its surgical contract. Dr B said that in the past he would have removed the cyst but he had been joined in the partnership by Dr C, a general practitioner who had completed a minor surgery course with ProCare.

Dr B explained that his expectation of a referral to his practice colleague for minor surgery was that the doctor would examine the patient and, if he agreed that excision was necessary, excise the lesion, and arrange follow-up consultations to discuss the outcome, including the histology results, with the patient. It was normal to have verbal communication with doctors in the same practice and referral letters were not usually exchanged. Histology results were not usually sent back to the referring doctor. "However inadequate the system may seem in 2003, it worked well" at the time. Excision had always been the responsibility

of the "surgeon" (ie, the GP in the partnership specialising in minor surgery), and this had applied ever since Dr B joined the practice in 1975.

On 6 August Dr B referred Mr A to Dr C. On 27 August Dr C examined and excised the lesion on Mr A's forehead. Dr C made the following notation in Mr A's general practice records:

"[E]xc epiderm cyst, 4/5.0 sutures see 1/7 for new dress, ROS 5-6/7."

There is no record of whether Dr C sent specimens to the laboratory for histological examination. The laboratory confirmed that it has no record of receiving specimens from Dr C following the 27 August 1998 excision, nor of sending a histology report to Dr C.

The notes indicate that Dr B removed the stitches on 1 September. Dr B advised me that this is not the case and that the notes were mistakenly entered in his name. The notes are not in his style and the fees are listed under Dr C Ltd. Dr C advised me that he saw Mr A for a follow-up consultation five days after this excision and then referred him back to Dr B. He noted that the cyst had been completely removed. Although Dr B saw Mr A again on 24 September and 15 December 1998, it was for other medical matters.

Treatment – 1999-2000
During 1999 and 2000 Mr A consulted Dr B on 26 separate occasions. On 23 September and 20 December 1999 Dr B examined the excision site and decided to keep it under observation. Dr B examined the excision site again on 22 June 2000. Dr B explained that his examination of the scar on the three occasions gave variable information and that no discrete lesion was diagnosed. If he had had any suspicion he would have immediately referred Mr A for excision, as he had done in the past. Dr B made numerous skin inspections because he was aware of Mr A's BCC history. He did not rely on his memory to examine the scar but recorded it in his notes as a reminder. There was no reason for him to look for histology because the clinical evidence of alteration over that time was "scant". If he had had the histology from 1998 he still would not have referred Mr A for excision of the scar.

Treatment – 2001
On 19 June 2001 Mr A consulted Dr B with health problems and a "spot under his left eye". Dr B diagnosed a small squamous cell carcinoma (SCC) on the left side of Mr A's face below his eye. The eye "looked to be infected". Dr B prescribed Bactroban and applied liquid nitrogen to the SCC.

From 22 June and through July Mr A had several consultations with Dr C because Dr B was overseas. Mr A had "rashes on his legs" and "pimples on his hands" which Dr C thought were either an allergy or related to shingles, which Mr A had had earlier that year.

On 13 September Mr A saw Dr B for repeat prescriptions and at the same time asked him to review the "spots" on his forehead and cheek. A lesion had developed on his forehead at the site where Dr C removed the lesion in 1998. The liquid nitrogen applied to the lesion under Mr A's left eye in June had been unsuccessful. Dr B referred Mr A to Dr C for removal of

the forehead lesion. Dr B expected that the same procedure as occurred in 1998 would occur with this referral. Dr C examined Mr A and considered re-excision was necessary and "performed the minor operation at the consultation". The practice nurse treated Mr A's cheek and three other minor spots with liquid nitrogen on 18 September.

In response to my provisional opinion Dr C advised me that at the time of the second excision in September 2001 he did not realise he had excised Mr A's lesion in 1998. Mr A was referred for a re-excision of a cyst. He usually has a number of patients for minor surgery, and the patient's full medical record does not accompany the patient to the theatre room. Dr C said: "It is likely having not seen [Mr A] as a patient that I was unaware of the previous excision; I certainly did not recognise him." The Centre did not have computerised laboratory referrals in 1998 or 2001, making it impossible to trace whether specimens were ever sent to the laboratory.

Dr C advised me that he agreed with Dr B's diagnosis of an epidermal cyst on Mr A's forehead and on 20 September completely excised what he considered to be a well-encapsulated cystic lesion occurring at the same site as in 1998. Recurrence of an epidermal cyst in susceptible patients is not uncommon and Dr C was not unduly alarmed by the need for re-excision. Dr C did not see Mr A thereafter, but "ensured that he was adequately followed up". There is no documentation in Mr A's notes of the surgery performed on 20 September or whether specimens were sent to the laboratory for histological examination. The laboratory confirmed that it has no record of receiving specimens from Dr C following the 20 September 2001 excision, nor of sending a histology report to Dr C.

Dr C is certain that he would have prepared tissue samples for histological analysis, because this is his "invariable practice". He indicated that he had no reason to believe that he would have treated Mr A's case differently from his usual practice. For these reasons he cannot explain the absence of a histology report from Mr A's file. He stated that he cannot claim costs of minor surgery he performs in his rooms unless he has "made a provisional diagnosis and obtained a histological diagnosis" and, as a member of ProCare, he is required to undergo an audit during the claiming process.

Dr C submitted a claim to ProCare on 20 September. He coded his diagnosis and treatment completion codes "M262". ProCare advised that this code is for a sebaceous cyst. The date of the procedure and date of case completion are noted as 20 September 2001. ProCare considered this unusual because it is only after the histology results become available that the completion date can be added. It would be impossible to have histology results on the same day the samples were taken.

Dr B assured me that in 30 years of general practice, including many excisions, his practice was to send all tissue specimens for histological diagnosis. The histology report is returned to the doctor who performed the excision, who informs the patient and discusses the results. To his knowledge he has never undertaken an excision where a tissue specimen, however small, has not been sent for histological analysis and diagnosis. He does not believe that Dr C failed to do so on this occasion but he cannot explain the omission. He believed that the cyst had been fully excised and that Dr C would have made arrangements for samples to be sent to histology.

On 4 December Mr A returned to the Centre for other treatment. According to the records Dr B applied a second treatment of liquid nitrogen to the lesion on Mr A's left cheek. Dr B advised that this consultation was incorrectly entered under his name and that the consultation actually occurred with the practice nurse. The fee for the consultation was entered under "Nurse".

According to the records Dr B next saw Mr A for renewal of prescriptions and back pain on 20 December 2001.

Dr B noted that the lesion under Mr A's left eye (which he had been monitoring since June) appeared to have developed into a BCC. Dr B did not look for the histology reports because he referred Mr A to Dr E, a skin cancer and plastic surgery specialist, to assess and excise the lesion. Dr B did not include a request to review Mr A's forehead lesion at the same time, although he intended to do so. Dr B told Mr A that he would ask Dr E to look at the lesion on his forehead because he could not understand why the treatment had been unsuccessful. Dr B acknowledged that it was an oversight on his part that he had not requested Dr E to review the lesion on Mr A's forehead. Dr B later apologised to Mr and Mrs A for the omission.

Treatment – February 2002
Both Mr and Mrs A had appointments with Dr E on 1 February 2002. Although Dr B referred Mr A for review of the lesion under his left eye, Dr E also examined Mr A's forehead. Dr E advised Mr A that he had a tumour on his forehead that was quite invasive and that excising it would require extensive surgery. Dr E telephoned the Centre for Mr A's histology reports of the tissue excised in 1998 and 2001. There were no reports in Mr A's file.

About 1.00pm on 19 February Dr E commenced excising Mr A's lesion. About three hours later Dr E came out of the theatre to advise Mrs A that the tumour could have invaded the skull bone, and that it might be necessary to refer Mr A to hospital for consultations with a neurosurgeon and plastic surgeon. Dr E completed the operation at 6.10pm. Mr A did not require neurosurgery or plastic surgery. Histology examination confirmed BCC at both cheek and forehead sites.

Subsequent events
On 11 March 2002 Mr A had his regular three-monthly appointment with Dr B for repeat prescriptions. Mr A told Dr B about the surgery and how upsetting it had been. Dr B suggested that he and Dr C meet with Mr and Mrs A. The meeting was arranged for 20 March but Dr C was unable to attend. Mr and Mrs A questioned Dr B about his diagnoses and the failure to note the absence of pathology reports, particularly as the excision in September 2001 was the third attempt at treating the lesion. Dr B checked Mr A's physical file and computer records, but could find no record that biopsies were taken or histology reports received.

Dr B advised Mr and Mrs A that he did recognise the true nature of the lesion on Mr A's forehead. Mr A's records indicate the correct diagnosis – in particular, notes made on 14 July 1994, 13 April 1995, 19 June 2001, 13 September 2001 and 20 December 2001. Dr B

said that following both excisions by Dr C, Dr C discussed the procedures with him and indicated that the surgery had been successful. Dr B scheduled another meeting with Mr and Mrs A at a time suitable to Dr C.

Meeting – 26 March 2002
On 26 March Mr and Mrs A met with Dr B and Dr C. Dr C assured them that he took tissue samples and sent them to the laboratory on 27 August 1998 and 20 September 2001 despite the lack of documentation and absence of histology reports. He had checked with the laboratory, but there was no record of the laboratory ever receiving the samples. Both doctors explained that it had not been their policy to record in the patient's records whether samples were sent. Dr B and Dr C assured Mr and Mrs A that, as a result of these incidents, they had introduced new procedures to ensure this did not happen in the future. Where a referral is made for even minor surgery they ensure that copies of histology reports are sent to both practitioners, and formal letters of referral are sent to other doctors, even within the practice.

ACC
On 19 April 2002 Mr A submitted a claim to ACC for medical misadventure. In reaching its decision ACC relied on a report from an independent general practitioner, Dr F. Dr F's complete report is attached as Appendix 1. In Dr F's opinion Mr A suffered medical error for the following reasons:

"a) The Plastic Surgery Department of [the first public hospital] does not appear to have ensured adequate follow up of [Mr A] after his surgery in November 1995. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

b) [Dr B] failed to recognise that the epidermal cyst on [Mr A's] forehead was in fact a BCC. Had he done so he might have referred him back to the Plastic Surgeons at [the first public hospital] rather than a failed referral to the Surgical Department at [the second public hospital]. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

c) [Dr C] twice operated to remove skin lesions and there is no evidence that the specimens were ever forwarded for his histopathological analysis. All excised skin lesions should be sent for analysis and each practitioner should have a system to ensure that this does happen and also that the results are received and acted on. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

d) It is not clear why, when [Dr B] found a BCC on [Mr A's] left cheek in December 2001 that he referred him to Dr E when he could have re-referred him to the Plastic Surgeons at [the first public hospital] or referred him to the Dermatology Department at [a third public hospital] where [a doctor] carries out Mohs surgery. Both these options would not have cost [Mr A] anything. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

e) I would like to be assured that [Dr E] pointed out these no cost options to the [couple] once he had established whether they had 'won Lotto recently, could get a bank loan or had health insurance'. If he did not then it is my opinion that he too has failed to observe a standard of care reasonably to have been expected in the circumstances."

On 8 October 2002 ACC advised Mr A that his claim had been accepted.

ACC made a finding of medical error against Dr C because, although he twice removed skin lesions from Mr A's forehead, there was no evidence that he sent specimens to the laboratory for histopathological analysis. Dr C advised ACC as follows:

"Both I and [Dr B] have discovered that on both occasions of excision, there was no histology found. It is our routine practice and that of our colleagues at the Centre to refer all tissue for histological confirmation. In both cases this is absent and despite searching both laboratory and own data, we cannot explain this."

ACC made a finding of medical error against Dr B for failing to diagnose the basal cell carcinoma. Dr B applied unsuccessfully for a review of the medical error finding by ACC.

Independent advice to Commissioner

The following independent expert advice was obtained from general practitioner Dr Jim Vause:

"Thank you for your request for opinion on this case

I have viewed the following supporting information

- [Mrs A's] letter to the Commissioner marked 'A'
- The Commissioner's notification letter to [Dr B] and [Dr C] marked 'B'
- [Dr B's] response to the Commissioner marked 'C'
- [Dr C's] response to the Commissioner marked 'D'
- [Mr A's] general practitioner records marked 'E'
- [Mr A's] medical records from [the first public hospital] marked 'F'

I do not know any of the persons mentioned in the documentation, either professionally or personally.

With respect to your questions as follows:

- *What standards apply in this case?*

These are standards covering

1. The request of histology examination (that is viewing under a microscope, slides taken from the excision specimens)
2. The audit and follow up systems for such histology specimens

In both cases as there are two events separated in time, namely the first excision by [Dr C] on 27 August and the later such repeat excision on 20 September 2001, the standards to be applied vary.

It has been standard practice for many years (at least for my personal practising time since 1979) to send any specimen of skin lesions for histological confirmation of diagnosis, except minor skin tags and viral warts. Both [Dr B] and [Dr C] acknowledge in their letters that it was their normal practice to send excision specimens for histology thus there is little doubt that on both excision occasions, the appropriate standard was for histological examination of the excision specimens. This standard is clear and applicable.

The audit trail of test results standard is somewhat different. In 1998 there was not a high level of awareness of this issue within the profession. This was prior to the Health and Disability Commissioner flagging the 'patient test results' issue. By Sept 2001 the issue had been publicised in the medical media in this country[1] but a definitive set of standards is still in process towards publishing.

A third standard to consider is the follow up of histology results at the subsequent visits of [Mr A] to [the Centre]. There were specific opportunities for such at the 'removal of sutures' consultations. The first cyst excision on the 27 August 1998 was followed about 4-5 days later by a suture removal by [Dr B]. The second excision in September 2001 was followed with a removal of sutures by '…', one of the practice nurses at the clinic.

A confounding factor in this is the time for return of histological results to the clinic. I do not know the situation at [the Centre]; it could well take more than the 4-5 days duration between excision and removal of sutures. This time is laboratory dependent, for example in my practice one laboratory can take 2 weeks and the other 4 days, to return histology results. Nevertheless, the lack of histology results should have been detected by [Dr B] on the many other occasions he examined [Mr A] and specifically on those occasions when he examined his forehead scar. His suspicion of cancer should have been raised by [Mr A's] past history of excision of basal cell cancers from his forehead in 1994 and 1995.

- *Whether [Dr B] met those standards and, if not, how were the services deficient?*
- *Did [Dr C] meet those standards and, if not, how were his services deficient?*

[1] NZ GP 4 April 2001

The responsibility for requesting the histology analysis of the excision specimens rests with the doctor performing the surgery, that is [Dr C]. The failure to do so on two occasions is deficient, especially on the occasion of the second excision when he should have checked the previous histology results.

The responsibility for follow up appears to lie with [Dr B]. Although there is not a formal transfer of care by way of referral and discharge letters, the practical reality is that [Dr B] has appropriately taken responsibility of care back as indicated by his continued follow up of [Mr A's] forehead scar documented in the clinical records. [Dr B] should have detected the lack of histology results and his failure to do this is a deficiency in his service to [Mr A].

The responsibility for an audit trail in [the Centre] is a little more difficult as this would depend on practice policy, systems and the awareness by staff and practice governors of the 'patient test result' standard and the relevant H&DC opinions at the particular times. It does flag the issue of the promulgation of standards of care.

- *Should specimen samples have been sent for histological examination following excision August 1998 and September 2001?*

Yes.

- *Whether it is standard practice to record when tissue samples are sent to the laboratory, and if so, where?*

No, this has not always been standard practice in the past. However it should now be an essential part of the audit trail. Ideally a copy of the test request form should be kept in the clinical notes and for [the Centre], this can be done in their computer system which appears to be Medtech 32, a system which offers a facility for computer generated laboratory requests and audit trail of the results.

The laboratory to which the specimen is sent should either be practice knowledge ie the practice uses only one laboratory for such specimens, or should be recorded in the request form.

- *Whose responsibility was it to follow up and report to [Mr A] the results of his tests?*

As explained above.

Any other matters which, in your opinion, should be brought to the Commissioner's attention?

Cost of surgery:

A significant factor affecting [Mr and Mrs A's] concern is the price $5,026.10 paid for the excisions by [Dr E]. If the account of [Mr A's] initial communication with [Dr E] on 1st Feb 2002 is as recorded in 'A', I have some concerns.

This cost is, in my experience, very high but is a result I understand of the time consuming nature of Moh's surgery (as indicated by [Mr A's] account in 'A') and the need for an onsite pathologist to view the sections of tissue excised at the operation. In [Mr A's] case, the cost covered two procedures, both involving Moh's excision of the skin cancer and then an operative closure of the deficit in the skin left by the Moh's. Only one of these procedures relates to the forehead cancer, the other to a skin cancer unrelated to the previous excision below [Mr A's] left eye.

My concern is whether [Mr A] made an informed decision in terms of comparison of different surgical options, including cost and effectiveness. His account 'A' tends to indicate that such options were not given to him.

Clinical records:

I note that the Inbox records in [the Centre's] computer are not present in the printed notes, nor the outbox referral letters (eg that from [Dr C] to [Dr E]), nor is there an operative record by [Dr C] of the Sept 2001 procedure. [Mr A] in 'A' refers to the skin cancer of his forehead being a squamous cell cancer but I can find no histology results on this in the documentation. There is an entry of histology results in [the Centre's] computer printout on 20 Feb 2002 but there is no content to this entry. [Dr E], in his operation notes refers to the lesion being a basal cell cancer, presumably identified at the histology examination at operation. This may be of some relevance as squamous cell cancer tends to be a lot more malignant in its behaviour than basal cell cancer.

Other than this, these clinical record issues do not impact upon this case except as areas of awareness for both [the Centre] and the H&DC investigation.

A final comment on the problems of skin cancers:

Only very occasionally do skin cancers arise in cysts. I personally have only had one patient (last year) with a basal cell skin cancer detected beneath a classic sebaceous cyst. It was found when a surgeon excised what appeared to be, both to him and myself, a simple cyst in an area beyond my expertise for excision. This situation is hard to manage when one considers the difficulty in getting cysts excised at public hospital services. I can understand the problems for [Dr B] and [Dr C] in making a diagnosis in this case prior to the growth becoming obvious. This throws the whole problem back on the histology specimens and follow up of these."

Advice from general practitioner Dr Wendy Isbell

During the investigation of this complaint I also obtained advice from general practitioner Dr Wendy Isbell. Dr Isbell's advice is attached as Appendix 2. I have chosen not to rely on Dr Isbell's advice as I am not satisfied that it reflects the appropriate standard of care expected from a responsible general practitioner in following up test results, even at the time of the relevant incidents.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Professional Standards

Good Medical Practice – A Guide for Doctors (Medical Council of New Zealand, 2000)

"Providing a good standard of practice and care:

…

- Keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed; …"

Opinion: No breach – Dr B

Diagnosis
Mr A complained that Dr B did not recognise his skin lesion as a BCC.

Dr B considered the lesion that appeared in 1998 was an epidermal cyst, prompting a referral for excision, first to [the second public hospital] and then to Dr C. Dr C agreed with Dr B's diagnosis. The cyst re-appeared in September 2001 and this prompted Dr B, once again, to refer Mr A to Dr C. However, by December Dr B recognised that what he thought was an epidermal cyst was, in fact, a BCC, and referred Mr A to Dr E. Histological analysis from the tissue excised by Dr E confirmed the diagnosis.

Mr A regularly consulted Dr B, who was clearly diligent in treating his lesions. Those not treated successfully were referred for secondary assessment.

My medical advisor indicated that only very occasionally do skin cancers arise in cysts; he has seen only one BCC detected beneath a classical epidermal cyst. He could understand the problems Dr B faced in making a diagnosis before the growth became obvious. I am satisfied that Dr B's provisional diagnosis of an epidermal cyst was reasonable, and his failure (in 1998 and in 2001) to diagnose BCC does not amount to a breach of the Code.

Referral
From 1998 to 2001 Dr B was watching two lesions on Mr A's face, one on his forehead and one on his cheek. In September 2001 Dr B referred Mr A to Dr C, who excised the lesion on his forehead. At the same time Dr B identified a keratosis on Mr A's cheek. In December, when the liquid nitrogen treatment of the keratosis was unsuccessful and the forehead lesion reappeared, Dr B referred Mr A to Dr E. The referral omitted reference to the forehead lesion.

Even though Dr B's referral did not specifically identify the forehead lesion it was reasonable for him to expect that, in view of Mr A's past history, Dr E would do a general skin check (as indeed he did).

Dr B acknowledged that it was an oversight on his part. He intended to include a review of Mr A's forehead lesion with his referral for the cheek spot. Dr B had readily referred Mr A in the past and I accept that he would also have done so on this occasion. Accordingly, in my opinion Dr B did not breach the Code in relation to this matter.

Opinion: Breach – Dr B

Follow-up of histology results
Dr B had been Mr A's general practitioner for over 20 years. Mr A was prone to cancerous skin lesions and Dr B had referred him to the Plastic Clinic at the first public hospital. In June 1998 Dr B was maintaining a close watch on a lesion on Mr A's forehead and on two occasions arranged for him to have the lesion surgically removed. The lesion was, in fact, a basal cell carcinoma and, by February 2002, Mr A required extensive surgery to remove it.

Dr B thought the lesion on Mr A's forehead was a cyst, and asked Dr C to remove it, which he did in August 1998 and September 2001. Dr C concurred with Dr B's diagnosis of a cyst. However, neither doctor appears to have been aware that a histology report had not been received from the laboratory, and therefore neither confirmed the diagnosis.

Dr B advised me that "there was no reason to look for the histology, as the clinical evidence of scar maturity was scant". Dr B said that he did not assume responsibility for the histology as he was "under the impression (based on practices in place) that this had been adequately addressed".

Dr B was let down by Dr C, and by the system in place at the Centre. However, he cannot be absolved of all responsibility for the failure to check the histology results for his patient, Mr A. Although Dr B has clearly been a careful and competent doctor in caring for Mr A over many years, in assuming that the histology results (in a patient with a history of skin cancers) had been properly followed up, Dr B did not provide services in a manner that minimised potential harm. Accordingly, in my opinion Dr B breached Right 4(4) of the Code.

Opinion: No breach – Dr C

Documentation of tissue removal on 27 August 1998
Mr A complained that Dr C did not document that he had removed tissue from a lesion on his forehead during the procedure performed on 27 August 1998.

Under Right 4(2) of the Code every consumer has the right to have services provided that comply with professional standards. As a general practitioner, Dr C is required to comply with standards promulgated by the Medical Council of New Zealand (the Council). In its 2000 publication *Good Medical Practice: A Guide for Doctors*, the Council states that a doctor should "keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed".

Dr C did not comment on this matter in responding to Mr A's complaint, but Mr A's records state: "[E]xc epiderm cyst, 4/5.0 sutures …" Dr C did therefore record that he had

performed an excision and, at the time, was of the view that Mr A had a cyst. Accordingly, Dr C complied with professional standards and did not breach Right 4(2) of the Code.

Diagnosis
Mr A complained that Dr C did not diagnose the lesion on his forehead as a BCC in 1998 or 2001.

It was not until Dr E's consultation in February 2002 that Mr A learned the lesion on his forehead was a BCC and the extent of it was revealed. Prior to that, both Dr B and Dr C agreed that the lesion was an epidermal cyst.

My medical advisor, Dr Vause, indicated that only very occasionally do skin cancers arise in cysts. The problems faced by both Dr B and Dr C, in making a correct diagnosis before the growth became obvious, were understandable. I am satisfied that Dr C's provisional diagnosis of an encapsulated epidermal cyst was reasonable. Accordingly, Dr C's failure to diagnose a BCC in 1998 and 2001 did not amount to a breach of the Code.

Opinion: Breach – Dr C

Documentation of tissue removal on 20 September 2001
On 20 September 2001 Dr B re-referred Mr A to Dr C for removal of what was thought to be another cyst. Dr C did not record the surgery that he performed on 20 September 2001, although he "considered re-excision was necessary, and after discussing it with Mr A, performed the minor operation at that consultation".

As discussed above, the Medical Council expects doctors to keep clear and accurate records of their findings and the treatment prescribed. Mr A consulted Dr C, who then performed a minor surgical procedure but did not document what occurred. In failing to document the consultation and procedure Dr C did not comply with professional standards and breached Right 4(2) of the Code.

Histology examination
Mr A complained that Dr C's record keeping was poor; specifically that Dr C did not record that tissue specimens had been sent to the laboratory on 27 August 1998 and on 20 September 2001, or the results of the laboratory tests performed on the two tissue specimens. In addition, Mr A complained that Dr C did not follow up the test results from the specimens.

These allegations raise matters under Right 4(1) of the Code, which states that every consumer has the right to have services provided with reasonable care and skill. It is standard practice to send tissue specimens, such as the specimens taken from Mr A on 27 August 1998 and 20 September 2001, to the laboratory for testing. My advisor noted:

> "It has been standard practice for many years (at least from my personal practising time since 1979) to send any specimen of skin lesions for histological confirmation of diagnosis, except minor skin tags and viral warts. Both [Dr B] and [Dr C] acknowledge in their letters that it was their normal practice to send excision specimens for histology thus there is little doubt that on both excision occasions, the appropriate standard was for histological examination of the excision specimens. This standard is clear and applicable."

This accepted standard is practised by Dr B and Dr C and, according to both of them, was the practice at the Centre. Dr C advised me that he is certain he would have prepared specimen samples for histological analysis because this is his "invariable practice". Furthermore, he was unable to claim costs of minor surgery he performed in his rooms unless he made "a provisional diagnosis and obtained a histological diagnosis" and, as a member of ProCare, he was required to undergo an audit during the claiming process.

On 20 September 2001 Dr C submitted a claim to ProCare on the ProCare Surgical Claim Form. The "provisional diagnosis" box contains the code M262, which is the code used by the Ministry of Health, and by ProCare for claiming purposes, for a sebaceous cyst. The "proven histology diagnosis" box contained the same code and the "margins" box was ticked as adequate. The date of "case completion/invoice" was recorded as 20 September 2001, the same date as the procedure.

While there is a claim form with the proven histology diagnosis completed, there is no other evidence that Dr C did send the specimens to the laboratory, either in 1998 or in 2001. There are no relevant laboratory results on Mr A's records. According to ProCare, it is unlikely that the laboratory would have received, tested and reported histological results on the same day. ProCare would expect to receive a claim form after the requesting doctor has received the results.

The laboratory informed me that its computer records show no request from Dr C, the Centre, on 27 August 1998 and 20 September 2001 for histological analysis of tissue samples from Mr A.

Dr C advised ACC that "both I and [Dr B] have discovered that on both occasions of excision, there was no histology found. It is our routine practice and that of our colleagues at the Centre to refer all tissue for histological confirmation. In both cases this is absent and despite searching both laboratory and own data, we cannot explain this." The Centre had a manual laboratory system operating at the time, making it impossible to trace whether specimens were sent by Dr C. However, Dr C has no doubt that he prepared them.

My advisor said that the responsibility for requesting the histology analysis of the excision specimens rests with the doctor performing surgery and that "the failure to do so on two occasions is deficient".

I note that Dr F, an independent expert who submitted a report to ACC following Mr A's claim to the Medical Misadventure Unit, stated that there is no evidence that specimens

were ever forwarded for histopathological analysis. He also advised that all excised skin lesions should be sent for analysis.

Finding
I am not satisfied that specimens were sent to the laboratory for histological analysis after either excision. Payment of a ProCare claim does not provide confirmation; the laboratory has no record of receiving the specimens; and there is no evidence on file of the results of the tests being sent from or returned to the Centre. Unfortunately, the manual laboratory referral system operating at the time makes it impossible to trace whether specimens were sent. Although Dr C assured me that he prepared specimens, there is reason to doubt that the specimens were sent.

It seems unlikely that specimens from the same patient would have gone astray on two separate occasions, three years apart, and this is the only time this has happened at the Centre. Faced with this evidence I doubt that the specimens taken by Dr C were sent to the laboratory. I agree with all the doctors consulted during this investigation, including Dr B and Dr C, that it would have been reasonable to obtain histology analysis on both occasions. Accordingly, in my opinion Dr C did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

Follow-up of histology results
Under Right 4(4) of the Code every consumer has the right to services provided in a manner that minimises harm and optimises the quality of life.

Dr C clearly believes that he sent specimens for histological analysis after the surgery in 1998 and 2001. Yet there is no evidence that he followed up the histology results or discussed them with Mr A or the referring practitioner, Dr B.

My advisor said that Dr C's care was inadequate, "especially on the occasion of the second excision when he should have checked the previous histology results". I agree. However, Dr C casts doubt on whether he knew, when he removed the cyst in 2001, that he had removed the cyst in 1998. Dr C said: "It is likely having not seen [Mr A] as a patient that I was unaware of the previous excision; I certainly did not recognise him." Dr C agreed with Dr B that re-excision was necessary and simply removed the cyst.

Dr C did not have access to Mr A's full medical record and excised the lesion with minimal medical information. In my view it would have been prudent for Dr C to have gained some information about the history of the lesion before proceeding. If he had been unaware that he performed the first excision, he should have asked further questions of Mr A and, if necessary, Dr B.

On each occasion after Dr C excised the lesion, he should have reviewed the histology results, arranged to see Mr A, examined the excision site and explained the outcome of the surgery. He failed to do so in 1998 or 2001.

Dr C acknowledged that he saw Mr A five days after the first excision, to remove the stitches. That would have been a good opportunity to explain to him what he thought he

had removed and give him the histology report. In the event that no results had come from the laboratory he could have taken the opportunity to follow up the results and ensure it was sent to Mr A. In the event, Dr C failed to follow up the histology results in 1998 or 2001.

In these circumstances, Dr C failed to provide services in a manner that minimised potential harm, and breached Right 4(4) of the Code.

Actions

Dr B and Dr C have assured me that they have developed formal procedures at the Centre for the dispatch of histology specimens, and have instigated formal channels of communication between doctors in the practice. Dr B and Dr C have each provided an apology to Mr A.

Further actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal New Zealand College of General Practitioners.
- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 1 – Report to ACC by Dr F

"**[Dr F]**
MB BS MRCS LRCP MRCGP FRNZCGP

Medical Misadventure Report re Claim No: … [Mr A]

Attention: [ACC Officer]

Issue Management of recurrent Basal Cell Cancers of his face

Facts of Claim

In July 1990 [Dr B], a General Practitioner, referred [Mr A] to the Surgical Clinic at [the second public hospital] for removal of a clinical Basal Cell Carcinoma (BCC) of his forehead. In December 1990 Surgeons at [this hospital] removed the BCC from [Mr A's] forehead. There is no copy of the histology report in the hospital letters but they described the lesion as a BCC. It required some liquid nitrogen in the follow up period but at review at [this hospital] in 1990 it was reported to have completely healed and he was discharged to his General Practitioner, [Dr B], for observation.

In October 1991 there is reference in [Dr B's] notes to a skin lesion of the forehead excised and the histology reports Bowen's Disease. There was a skin reaction afterwards but that seemed to settle with Aristocort (hydrocortisone).

In December 1991 liquid nitrogen was administered to a '**SCC**' (Squamous Cell Carcinoma) on his forehead.

July 1994 is the next episode of a skin problem being recorded when [Dr B] referred [Mr A] to the Plastic Surgery Department of [the first public hospital] for removal of a BCC from his forehead next to the scar of his previous surgery.

On 2 December 1994 [Dr D], Plastic Surgeon, saw him and placed him on the waiting list for removal of the BCC.

In March 1995 this lesion was excised and the histology showed that it was a BCC extending to less than 1 mm from one edge. Therefore 6 months later in November 1995 he had a further excision by [Dr D] – histology showed a completely excised BCC.

There are no letters from [the first public hospital] to [Dr B] or vice versa after the initial consultation on 2 December 1994 or advice as to follow up that I can find in either [Dr B's] notes or the notes forwarded from [this hospital].

June 1998 is the next recorded skin problem when [Dr B] referred [Mr A] to the Surgical Clinic at [the second public hospital] for excision of an 'Epidermal Cyst'. This referral was refused by [this hospital], as it did not meet the Hospital's referral criteria.

In August 1998 [Dr B] referred [Mr A] to his partner [Dr C]. [Dr C] had an interest in Minor Surgery and had completed the ProCare Minor Surgery course. This is a course for General Practitioners of the ProCare Independent Practitioners Association (IPA) overseen by the Surgical Department of the University of Auckland. The course is designed to increase the surgical skills of General Practitioners to fill the gaps in service arising from the inability of the Public Hospital to deal with 'minor' surgery. The IPA's own funds, **not** the Health Authority's, are used to provide free surgery, when appropriate, in General Practice by those General Practitioners who successfully pass this course.

In August 1998 and again in September 1999 [Dr C] excised lesions from [Mr A's] forehead referred to as epidermal cysts. There is no histology available from these operations and only brief operation notes are in the notes forwarded.

In December 1999 there is reference in [Dr B's] notes to an examination of the forehead scar which had '**firm scar like tissue mid scar – no cyst recurrence**' and it was decided to observe the scar.

In June 2000 the scar was reviewed and '**slight area of trauma distal end of scar – observe**'.

In June 2001 [Dr B] records a '**small? SCC on his left face below eye – infected**' Bactroban ointment and then liquid nitrogen was prescribed.

On 13th September 2001 [Dr B] records '**Recurrence of cyst forehead – to see ([Dr C]?) also BCC L face**'.

Liquid nitrogen was applied on 18 September 2001 to 'facial lesion'. At some stage after this the 'cyst' was excised as he had a dressing change on 21 September 2001 and then removal of sutures on 25th September 2001.

Again there is no record of the histology or any records of the procedure consent forms etc. On 20th December 2001 [Dr B] records – **has BCC left cheek refer [Dr E]**.

[Mr A] attended [Dr E] who noted not only the BCC below his left lower eyelid but also a large infiltrating BCC above his left eyebrow.

[Mr A] then had extensive (and expensive) Mohs (micrographic surgery) to remove the tumour.

Circumstances of Health Professionals

[Dr B] is a General Practitioner. He does not include Membership or Fellowship of the Royal New Zealand College of General Practitioners in his qualifications. I do not know if he is Vocationally Registered or in what branch. He is a partner in [the Centre].

[Dr C] is a General Practitioner who does hold the FRNZCGP and has completed the ProCare Minor Surgery course. He is a partner in [the Centre].

[Dr E] is a Dermatologist with a special interest and overseas training in Mohs surgery. He has set up his own private Specialist practice in his own purpose built premises to pursue his interest.

Personal Injury

[Mr A] has had a traumatic time due to delay in diagnosing and treating recurrences of his BCCs. He has had extensive spread of his BCC consistent with his claim of delayed diagnosis of recurrence of his BCC.

Causal Link

Whilst [Mr A] is obviously predisposed to developing BCCs, had the recurrences been managed differently [Mr A] could have perhaps avoided such extensive and expensive Surgery.

Medical Error

Medical error is defined as a failure of a registered health professional (or since the 2001 Act organisations) to observe a standard of care and skill reasonably to be expected in the circumstances.

It is my opinion that there has been Medical Error in this case in the following instances:

a) the Plastic Surgery Department of [the first public hospital] does not appear to have ensured adequate follow up of [Mr A] after his surgery in November 1995. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

b) [Dr B] failed to recognise that the epidermal cyst on [Mr A's] forehead was in fact a BCC. Had he done so he might have referred him back to the Plastic Surgeons at [the first public hospital] rather than a failed referral to the Surgical Department at [the second public hospital]. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

c) [Dr C] twice operated to remove skin lesions and there is no evidence that the specimens were ever forwarded for histopathological analysis. All excised skin lesions should be sent for analysis and each practitioner should have a system to ensure that this does happen and also that the results are received and acted on. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

d) It is not clear why, when [Dr B] found a BCC on [Mr A's] left cheek in December 2001 that referred him to [Dr E] when he could have re-referred him to the Plastic Surgeons at [the first public hospital] or referred him to the Dermatology Department at [the third public hospital] where [a doctor] carries out Mohs surgery.

Both these options would not have cost [Mr A] anything. This is a failure to observe a standard of care reasonably to have been expected in the circumstances.

e) I would like to be assured that [Dr E] pointed out these no cost options to the [couple] once he had established whether they had 'won Lotto recently, could get a bank loan or had health insurance'. If he did not then it is my opinion that he too has failed to observe a standard of care reasonably to have been expected in the circumstances.

Medical Mishap

As treatment was not properly given here then Medical Mishap does not arise.

[Dr F]
MB BS MRCS LRCP MRCGP FRNZCGP

Background information

1. BASAL CELL CARCINOMA (BCC)

Basal cell carcinoma is the commonest skin malignancy in local populations. It is usually on the face, nearly always after the age of 50 years. The early lesion is a small smooth papule which over several months or years enlarges to a rounded lesion with pearly nodules in a rolled edge over which small dilated blood vessels course. Sometimes a crateriform ulcer is found in the centre, covered by a brownish crust. However, clinical variants occur and these include nodulocystic BCC, morphoeic BCC, superficial multicentric BCC and pigmented BCC. Basal cell carcinoma only very rarely metastasises but it can be very destructive locally, even penetrating bone such as the skull, in which case death may result from sepsis.

Predisposing factors includes excessive sunlight exposure, X ray irradiation and arsenic poisoning. It can arise from other lesion such as sebaceous naevus. Certain genodermatosus e.g. Xenoderma pigmentosa, Gorlin's syndrome are also risk factors.

The diagnosis should always be confirmed by biopsy, which shows proliferation of atypical basal cells with peripheral cells arranged in a regular row called palisading.

Depending on the patient's age and health, site, type, and size etc. of the tumour, basal cell carcinoma can be treated by surgical excision, radiotherapy, curettage and electrodessication and cryotherapy. **All have a 5-10% recurrence rate**. Mohs surgery, guided by frozen sections, is tissue sparing but time consuming. Long term follow up is required especially if there is concern about adequacy of removal and the underlying carcinogenic factors may lead to further primary tumours in the future."

Appendix 2 – Advice from Dr Wendy Isbell

The following independent expert advice was provided to the Commissioner by general practitioner Dr Wendy Isbell:

"**Summary**

[Mr A] had a long history of having squamous cell carcinomas and basal cell carcinomas, which had been excised at [the first public hospital] (1995-1996), but later that service was removed from [this hospital's] out patient services.

He had excisions of lesions in 1998 and 2001, by [Dr C], a colleague of his general practitioner [Dr B]. There is no record made in the case notes of tissue samples having been sent to the laboratory, and there was no record of samples having been received at the laboratory.

[Dr B] referred [Mr A] to a [Dr E], a dermatologist in 2002, and he found a basal cell carcinoma of the left upper cheek lesion, and a large recurrent basal cell carcinoma of the central forehead. The latter was removed in stages, with frozen sections being obtained, on 19 February 2002.

Complaint

[Dr C]

[Dr C] did not document in [Mr A's] medical notes that tissue was removed from a lesion on his forehead on 27 August 1998 and 20 September 2001.

I agree it would be standard practice to write in the medical notes that a lesion was removed, or that tissue had been obtained.

[Dr C] did not record the results of the laboratory tests performed on the tissue specimens taken on 27 August 1998 and 20 September 2001.

Normally the results would be written in the case notes when the result was received, and appropriate action taken at that time. It does not appear that any results were obtained from these samples.

[Dr C] did not record that the tissue samples taken on 27 August 1998 and 20 September 2001 had been sent to a laboratory for testing.

It would be standard practice to write in the medical notes that samples had been sent to the laboratory for testing.

[Dr C] did not follow up the laboratory results on the tissue samples taken on 27 August 1998 and 20 September 2001.

[Dr C] did not follow up the laboratory results on the tissue samples taken.

In my opinion, once laboratory tests have been arranged, the responsibility is considered out of the hands of the general practitioner, until results are obtained.

If there is a further consultation including the same problem, then that would usually prompt a call for previous results.

[Dr C] did not recognise that [Mr A] was suffering from squamous cell carcinoma on his forehead.

[Dr C] thought the lesion on [Mr A's] forehead was a cyst, and when it returned, he considered it a recurrence of the cyst.

[Dr C] did not report the laboratory results of the tissue sample to [Mr A].

I presume that this is because a result was not received.

[Dr B]

[Dr B] did not follow up and report laboratory results on tissue sample taken from [Mr A's] forehead on 27 August 1998.

I agree that [Dr B] did not follow up and report the laboratory results.

[Dr B] did not recognise that [Mr A] had squamous cell carcinoma on his forehead.

The lesion was a basal cell carcinoma. [Dr B] had thought this was an epidermal cyst. But he would expect it to be reviewed when [Mr A] saw the dermatologist.

Some of these lesions can be very hard to diagnose in a non-specialist setting.

I see that [Dr B] initially tried to refer [Mr A] to the skin clinic at [the second public hospital] on 22 June 1998, but this referral was not accepted by the hospital.

[Dr B] did not make an appropriate referral to a skin specialist in relation to the lesion on [Mr A's] forehead.

I agree that [Dr B] did not mention the lesion on [Mr A's] forehead in his referral letter to [Dr E].

But he could reasonably expect, in view of [Mr A's] past history, that [Dr E] would do a general skin check.

Advice

What standards apply in this case?

When a lesion or a piece of tissue is excised, that should be reported in the patient's notes.

It should be routine policy that all tissue removed should be sent to the laboratory, and it should be recorded in the notes that the tissue has been sent.

When results are received, they are reviewed by the doctor, and appropriate action taken.

Routine follow up of each result is not usually undertaken by the doctor.

Whether [Dr B] met those standards and, if not, how were the services deficient?

I think that [Dr B] did meet those standards.

He mentioned in his case notes that he would review the lesion clinically, although routine review is not mentioned in his notes. However he does mention it when it is clinically significant, and has made a plan of action on each occasion.

Whether [Dr C] met those standards and, if not, how was his care deficient?

[Dr C] did meet the standards of care, apart from not recording in the case notes that tissue had been excised and sent to the laboratory.

Whether it is standard practice to record when tissue samples are sent to the laboratory in the patient's notes?

Yes, it is.

Whose responsibility was it to follow up and report to [Mr A] the results of his tests?

In my opinion, the way general practice is set up at present, once the specimen has been sent away, the doctor can reasonably assume that the result will be returned to him. Both the general practitioner and the laboratory have quality obligations in regard to carrying out their aspects of this chain of information.

If there was a further consultation for the same problem, or if the same problem arose in a further consultation, then the results would be searched for.

Other comments

[Mr A] had complicated medical and surgical problems, which were all dealt with appropriately and in depth by [Dr B].

I can see how the lesion on his forehead could have become an 'inactive' problem, although this is really no excuse.

[Mr and Mrs A] put a lot of credence in comments the dermatologist made. I think this chain of events is unfortunate, because it makes the problem seem more a case of mismanagement than it probably should, and has introduced an emotive component to their complaints.

Opinion

I think that [Dr B] has provided excellent general practitioner care for [Mr A].

He did not realise that the lesion on [Mr A's] forehead was a basal cell carcinoma, but was watching it for signs of change. When a basal cell carcinoma developed on [Mr A's] cheek, he referred him to a dermatologist for excision.

Basal cell carcinomas and squamous cell carcinomas are not always obvious in a general practice setting, and this is why patients are often referred on to out patient departments or dermatologists.

In retrospect, it would have been good to have an earlier specialist opinion on the lesion on [Mr A's] forehead. [Dr B] attempted this at [the second public hospital], but when the referral was refused, referred [Mr A] to his colleague [Dr C].

[Dr C] has done a course on excision of skin lesions, and says he followed the protocols from the course.

The main error was that on two occasions he has not reported in the notes that tissue was taken, and was sent to the laboratory. I gather that this error has been redressed, and formal referral practices have now been put in place, although I think these are above the standard that is required.

It is a problem that neither [Dr B] nor [Dr C] actively followed up the laboratory results. I can see that each one may have thought that the result had been seen by the other.

In my opinion, in general practice it is only on a clinical review that a result is searched for. It is not general procedure to routinely follow up laboratory results that have been requested, and it would be difficult to set up a system for this, with current systems that are used."