General Practitioner, Dr B

Medical Centre

A Report by the

Health and Disability Commissioner

(Case 14HDC00054)

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Executive summary

Background

1. On 15 December 2011, Mr A consulted Dr B at a medical centre about a lump in the right posterior triangle of his neck. Dr B referred Mr A to a specialist surgeon, Dr F. Dr F saw Mr A on 26 January 2012 and identified the lump as a lymph node. Dr F concluded that no further investigations needed to be done, and that Mr A should return to see him if the lymph node grew or if he developed other lumps.

2. On 1 July 2013, Mr A consulted Dr B again about the lymph node in his neck. Dr B stated that he discussed the treatment options with Mr A, which were to follow Dr F's earlier advice of monitoring the lymph node or, alternatively, to have the lymph node removed for histological analysis for peace of mind. Dr B stated that Mr A was keen to have an excision biopsy, and so he referred Mr A to Dr F again.

3. Mr A contacted Dr F to arrange an appointment, and was advised that Dr F was not available for at least 10 weeks. Dr B then arranged for Mr A to come to the medical centre for the removal of the lymph node. Mr A stated that Dr B did not suggest referral to another specialist, or performing any tests before removing the lymph node.

4. On 2 July 2013, Dr B surgically removed Mr A's lymph node. It was later identified that, during the surgery, Dr B had severed Mr A's spinal accessory nerve, which required subsequent complex surgery.

Findings

5. Dr B's actions in 2011 and early 2012 were appropriate.

6. However, Dr B did not provide services to Mr A with reasonable care and skill when he decided to remove Mr A's lymph node in the absence of it being clinically indicated to do so, and by failing to follow up on Mr A's histology results adequately. Accordingly, Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

7. Dr B failed to comply with professional standards and breached Right 4(2) of the Code by failing to recognise and work within his level of competence by undertaking the lymph node removal with insufficient experience, and failing to keep adequate patient records.[2]

8. Dr B also did not explain to Mr A his limited experience in removing lymph nodes. That information was information that a reasonable consumer in Mr A's circumstances would expect to receive. For failing to provide an adequate explanation of the options available, including an assessment of the expected risks, side effects, and benefits of each option, and for failing to provide Mr A with an explanation of his experience and expertise in conducting that particular surgery, Dr B breached Right

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

[2] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

HDC

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6(1) of the Code.[3] It follows that Mr A was not in a position to make an informed choice and give informed consent to the surgery and, accordingly, Dr B also breached Right 7(1) of the Code.[4]

9. The medical centre did not breach the Code.

Complaint and investigation

10. The Health and Disability Commissioner received a complaint from Mr A regarding the services provided to him by Dr B. An investigation was commenced on 1 May 2014. The following issues were identified for investigation:

- *Whether Dr B provided an appropriate standard of care to Mr A in July 2013.*
- *Whether the medical centre provided an appropriate standard of care to Mr A in July 2013.*

11. The parties directly involved in the investigation were:

Mr A	Consumer
Mr A's parents	
Dr B	Provider
Medical centre	Provider

12. Information was reviewed from the above parties and from:

Dr C	Plastic surgeon/provider
Dr D	General practitioner/provider
Dr E	Specialist surgeon/provider
ACC	
Medical Council of New Zealand	

Also mentioned in this report:

Dr F	Specialist surgeon

13. Independent expert advice was obtained from general practitioner Dr David Maplesden (**Appendix A**).

[3] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"
[4] Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

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Information gathered during investigation

Background

14. On 15 December 2011, Mr A, aged 27 years at the time of events, first consulted vocationally registered general practitioner (GP) Dr B at the medical centre, as he was concerned about an increase in the size of a lump on the right-hand side of his neck. Mr A said that he indicated to Dr B at that consultation that he had been "suffering with headaches, night sweats, insomnia and general malaise".

15. Mr A had played sport at a representative level from a young age. Mr A is right-handed.

16. Dr B stated that he is a self-employed practitioner at the medical centre[5]. Dr B said that he has over 30 years' experience in general practice, and that he performs minor surgery on patients on average two or three times a month. He told HDC that he had not undertaken any specific postgraduate training on minor surgery. He stated that prior to these events he had removed one or two other lymph nodes, but it is not his routine practice to undertake surgery of that type. He said that he has mainly excised suspected skin cancer, but has also removed lipomas[6] and sebaceous cysts.[7]

17. At the consultation, Dr B assessed the lump on Mr A's neck and decided to refer him to a specialist surgeon, Dr F. Dr B recorded: "Lump R[ight] post triangle Clinically lipoma refer [Dr F]."

18. The referral letter to Dr F, dated 15 December 2011, states:

> "[Mr A] noticed a lump in the right posterior triangle of his neck which is increasing in size. He is otherwise well on no regular medication and works as a […]. Examination shows a soft ill defined 15mm lump in the right posterior triangle. There is no lymphadenopathy[8] in the neck."

19. On 26 January 2012, Dr F reported to Dr B that he had performed an ultrasound examination, which demonstrated a 10.7mm x 2.6mm ovoid lymph node. Dr F stated that Mr A was completely asymptomatic, and that he had reassured him about the lymph node, which was "well within the normal range but slightly bigger than normal and thus palpable". Dr F concluded that no further investigations needed to be done, and that Mr A should return to see him if the lymph node grew or if he developed other lumps.

Consultation, 1 July 2013

20. On 1 July 2013, Mr A consulted Dr B again. Dr B told HDC that Mr A again raised concern about the lymph node on the right-hand side of his neck. Dr B stated:

[5] The medical centre is operated by a company of which Dr B is the sole director.

[6] Lipoma is a benign tumor composed of adipose tissue (body fat). It is the most common benign form of soft tissue tumor.

[7] A sebaceous cyst is a closed sac under the skin filled with a cheese-like or oily material.

[8] Lymphadenopathy refers to lymph nodes that are abnormal in size, number or consistency, and is often used as a synonym for swollen or enlarged lymph nodes.

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"I referred to [Dr F's] report of his assessment of the lump back in December 2011 and with this in mind I ascertained from [Mr A] that there were no clinical changes which raised his concerns, such as an increase in the size of the lump or the development of other lumps in his neck. Rather, [Mr A] made it clear to me that he was anxious the lump may be cancerous or something sinister like that. I examined the lump and confirmed that it appeared to have not increased in size and nor were there any other apparent clinical signs of change. Had that not been so, I would have undertaken further testing such as an ultrasound or FNA.[9] I was confident that the lump was the same as when he had been seen by [Dr F] at the end of 2011."

21. In contrast, Mr A stated that he returned to Dr B because the lymph node had recently grown larger. Mr A said that it was "noticeably bigger at around 2cm in visual diameter".

22. Dr B stated that he discussed the treatment options with Mr A, which were to follow Dr F's earlier advice of monitoring the lymph node or, alternatively, to have the lymph node removed for histological analysis for peace of mind. Dr B stated that he felt confident he could surgically remove the lymph node, as it appeared superficial and well contained, but he chose to refer Mr A back to Dr F and asked Mr A to contact Dr F to make an appointment. Dr B recorded in the clinical notes: "Lump R[ight] side of neck. Saw [Dr F] last year ? lymph node For excision ? here ? there."

23. Mr A said that in the 12 to 18 months leading up to making this appointment, he had been feeling very tired and run down, and had been getting night sweats. He said that he told Dr B of these symptoms. In response to the "information gathered" section of my provisional opinion, Mr A said that Dr B did not give him sick leave. Dr B told HDC that he does not recall Mr A presenting with any other symptoms at this appointment. Dr B's clinical notes do not record any other symptoms. Dr B stated: "Had [Mr A] complained of such symptoms [night sweats and feeling tired and run down] I would not have proceeded to give him the requested influenza vaccination. I cannot now recall the entire consultation but my notes and the fact that I proceeded to give him the vaccination would suggest to me that he did not complain of any other symptoms on that day."

Arranging removal of lymph node

24. Mr A said that he contacted Dr F to arrange an appointment, and was advised that Dr F was not available for at least 10 weeks. Mr A told HDC that he rang Dr B back, and asked for a referral to another specialist. Mr A stated that Dr B said: "Why don't you just come in here tomorrow and I can take it out for you?"

25. In contrast, Dr B said that Mr A did not ask for a referral to another specialist. Dr B said that he endeavoured to reassure Mr A that the lymph node did not require further medical management, and that had Mr A asked him for another referral, he would have done so. Dr B stated: "To the contrary, [Mr A] told me he did not want to wait

[9] Fine needle aspiration biopsy is a diagnostic procedure used to investigate superficial (just under the skin) lumps or masses.

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any further and wanted me to remove the lump in order to have it analysed." Dr B said:

> "As I did when he first contacted me, my usual and routine practice is to refer patients like this to a specialist and I would have referred [Mr A] to another specialist other than [Dr F] had he not been so keen for me to promptly remove the lump. In saying that, I must stress I am not blaming [Mr A] for what happened because I now accept that I made an error of judgment when I proceeded to perform the removal of the lump myself."

26. Mr A stated that Dr B did not suggest referral to another specialist, or performing any tests before the surgery.

27. Mr A said that when he asked what the differences were between Dr B and a specialist removing the lymph node, Dr B said there would be no difference other than possibly the scarring and the equipment used, and said that he had removed plenty of similar lumps previously.

28. Dr B arranged for Mr A to come to the medical centre later that afternoon (2 July 2013) for the removal of the lymph node. Dr B stated: "The fact that the surgery was scheduled for later that afternoon is entirely consistent with [Mr A's] insistence for urgent action. My own assessment was that the lump was benign and not sinister and I would not have arranged for its immediate excision but for [Mr A's] insistence."

29. In contrast, Mr A told HDC that he did not insist Dr B remove his lymph node, nor did he, at any time, ask him to remove it.

30. Mr A's father told HDC that his son rang him after speaking to Dr B, and told him about his conversation with Dr B. Mr A's father said that Mr A was unsure whether Dr B should remove the lymph node, and asked him what he thought.

Removal of lymph node, 2 July 2013

31. On the afternoon of 2 July 2013, Mr A attended the medical centre for the removal of the lymph node. Mr A's partner attended the appointment as a support person.

32. Mr A stated that when he arrived for the appointment a nurse escorted him into the room, where he waited for Dr B to arrive. Mr A told HDC that there was no written or oral explanation of the risks involved, other than warning him of the risk of scarring and infection. Mr A stated that Dr B did not warn him about the risk of severing a nerve, loss of muscle function, or severing an artery. Mr A stated: "Had these risks and options been explained to me, I would have not agreed to [Dr B] operating on me."

33. Mr A stated that Dr B told him he would be given a local injection to his neck, and that the lymph node would be removed and sent away to the laboratory for testing. Mr A said he was told that he would feel a little bit of numbness to his neck.

34. Dr B said that he followed his usual procedure by describing to Mr A what he proposed to do. Dr B stated:

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"[Mr A] is quite wrong to say I did not advise him of potential risks. I spoke with him about the risks of scarring as well as infection and also of possible discomfort and pain. I have not recorded any written consent on the part of [Mr A] and nor was there a written consent form signed at the time. I can be sure however that [Mr A] gave his verbal consent before the surgery proceeded."

35. Mr A stated that Dr B drew a line where he was going to cut, administered a local anaesthetic, and began cutting his neck. Mr A said that after about five minutes he heard Dr B say to the nurse that it was deeper than he thought. Mr A said that Dr B began cutting deeper and, at that stage, he said he was in a lot of pain. Mr A told HDC that Dr B administered a second anaesthetic, which alleviated the pain. Mr A told HDC that there was a lot of bleeding, to the point that the top half of his t-shirt was saturated in blood. Mr A said he had been told that the procedure would take 20 minutes, but probably it took around half an hour.

36. Dr B said he made a skin crease incision, removed the lesion, controlled the bleeding, and sutured the wound. He said that he "maintained clear vision of the operating field and took all possible care to avoid causing unnecessary damage". He stated that the surgery appeared to proceed in a relatively uncomplicated manner, apart from a small arterial bleed, which was easily controlled by pressure, and he was unaware at the time that he had severed a nerve.[10] He stated that the surgery took about half an hour, which was the anticipated duration, and disagreed that it took longer than expected. Dr B stated that the lymph node was not difficult to remove, and that Mr A did not complain of being in extreme pain. Dr B also said that Mr A is incorrect when he said that the first anaesthetic did not work. Dr B stated: "Had any of these complications occurred, I would have noted them in the notes, as I did with respect to the arterial bleed."

37. Mr A stated that after the surgery he sat up on the end of the bed and was feeling very light headed. He felt a strange sensation in his right arm, and described it as a "shooting feeling going down [his] arm". He said that Dr B told him that it was probably just the anaesthetic. Dr B rejects Mr A's suggestion that he told him that his right arm had an unusual sensation and that he felt light headed.

38. Mr A stated that Dr B told him that he would email the results from the laboratory as soon as he could, because Mr A was about to go overseas. Mr A stated that Dr B told him that the stitches were dissolvable and needed to stay in for 10 days, and that the practice nurse would check the wound. In response to my provisional opinion, Dr B said that he does not use dissolvable sutures in these circumstances (the nursing notes dated 11 July 2013 record "for ROS [removal of sutures]".

39. The only record Dr B made about the procedure was: "[E]xcise subcut lymph node R[ight] side of neck Arterial bleeder controlled with pressure Firm dressing."

[10] Later, it was discovered that during the procedure, Dr B severed Mr A's spinal accessory nerve, requiring subsequent complex surgery. The spinal accessory nerve provides motor innervation from the central nervous system to two muscles of the neck: the sternocleidomastoid muscle and the trapezius muscle. The sternocleidomastoid muscle tilts and rotates the head, while the trapezius muscle has several actions on the scapula, including shoulder elevation and abduction of the arm.

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40. The practice nurse who was present during the procedure, recorded the particular dressings used for dressing the wound, and noted that Panadol was given, and that Mr A was to be reviewed the next day.

Review by nurse, 3 July 2013

41. On 3 July 2013, Mr A returned to the medical centre and saw a practice nurse who recorded that there was no sign of infection and scant dried blood. Mr A's wound was redressed, and he was advised of signs of infection to watch for.

42. Mr A said that at that stage he had a very sore neck and a lot of bruising, but did not feel any difference in his shoulder.

Histology results

43. On 4 July 2013, Dr B emailed the histology results to Mr A. The email stated: "We have received your histology result which I attach for your information. You will see that it is all friendly which is good news. See you next week. Safe [travels]."

44. The histology report states that the diagnosis was a reactive lymph node with features suggestive of toxoplasmosis.[11] The comment on the report is: "[S]erology[12] and clinical correlation[13] are required"; however, Dr B did not follow up on the results or conduct any further tests.

Review by nurse, 11 July 2013

45. On 11 July 2013, Mr A attended the medical centre and saw a practice nurse who noted that the wound was healing well and had been taped. Mr A recalls that Dr B came in briefly and said, "I have done a great job, it looks good." In response to my provisional opinion, Dr B stated that he disputes ever saying this.

Deterioration in condition and transfer of care

46. In response to the "information gathered" section of my provisional report, Mr A stated that following the surgery, "[he] continued to feel confused about why [he] felt so unwell …" On 27 August 2013, Mr A transferred his care to Dr D.

47. Dr D noted that Mr A had been diagnosed with toxoplasmosis, and that from late 2012 he had been experiencing fatigue. Dr D prescribed antibiotics to treat the toxoplasmosis. Dr D noted that Dr B had done no blood tests before or after removing the lymph node.

[11] Toxoplasmosis is a disease that results from infection with the *Toxoplasma gondii* parasite, one of the world's most common parasites. Toxoplasmosis may cause flu-like symptoms in some people, but most people affected never develop signs and symptoms, and often do not require treatment.
[12] A blood test performed for diagnostic purposes.
[13] A clinical correlation compares clinical findings with a patient's age, medical history, and symptoms to determine a diagnosis.

HDC

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48. Mr A stated that at that stage his shoulder was becoming sore, and he had developed a lump on his collarbone, which was caused by a muscle starting to wither so that the bone was exposed. In October the lump was diagnosed by Dr D as a wing scapular.[14]

Review by plastic surgeon

49. In October 2013, Mr A, together with his father, consulted plastic surgeon Dr C about the lump in his shoulder and weakness in his arm. Dr C reported to Dr D that there appeared to be a muscle imbalance, presumably due to the nerve supply to the muscles, which was presumably related to damage at the time of surgery. Dr C said that if an accessory nerve had been damaged, it might be permanent. He noted:

> "One can hope there is a neuropraxia[15] and that this will start to recover although I note it is already 3 months but as you suggested he may require surgical exploration and repair or grafting. I cannot quite put together why his rhomboids[16] appear weak as this nerve would not usually be at risk in the posterior triangle of the neck unless very deep dissection had been carried out."

50. Dr C referred Mr A to a specialist surgeon, Dr E. In his referral letter, Dr C noted that he had suggested to Mr A and Mr A's father that he found it unusual that a GP would be excising a large lymph node in the posterior triangle.

Review by specialist surgeon

51. On 13 November 2013, Dr E reviewed Mr A and reported that Mr A had no function in his right trapezius,[17] resulting in lateral weakening of his shoulder. Dr E noted that this was almost certainly due to injury to the nerve at the time of the lymph node biopsy, with a high likelihood that the nerve had been divided, as there had been no clinical recovery seen on Mr A's most recent electromyographies (EMGs).[18]

52. Dr E suggested to Mr A that the most effective way of regaining some recovery would be to explore his nerve and reconstruct it with a nerve graft taken from his leg.

53. In a report to ACC on 27 November 2013, Dr E noted that the toxoplasmosis did not have a contributory part in the neuropathy, and that the nerve damage was out of the ordinary for this particular clinical situation. He noted: "[T]he nerve was working prior to the excision of the lymph node. The accessory nerve is a known structure at risk when excising a node in this area and should be protected during the surgical procedure."

[14] Wing scapula is a condition in which the shoulder blade, or shoulder bone, protrudes from a person's back in an abnormal position.
[15] Transient loss of neural conductivity due to nerve fibre compression without loss of neurofibrils in which spontaneous recovery occurs in a few days to weeks.
[16] The rhomboid is a skeletal muscle on the back that connects the scapula with the vertebrae of the spinal column.
[17] A muscle that extends longitudinally from the neck to the spine of the scapula. Its function is to move the scapula and support the arm.
[18] Electromyography (EMG) is an electrodiagnostic medicine technique for evaluating and recording the electrical activity produced by skeletal muscles.

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54. On 19 December 2013, Dr E removed a nerve from Mr A's leg to bridge a 2cm gap between the nerve ends in the region of the previous scar.

55. On 31 January 2014, Dr E referred Mr A to a physiotherapist noting that signs of muscle function in the trapezius could not be expected for at least six months, and that the physiotherapy was to maintain the range of movement and maximise the strength of the other muscles of Mr A's shoulder girdle.

Further information from Dr B

56. Dr B stated that after Mr A transferred to a different medical centre he heard nothing from him until 2 December 2013. Mr A called him then and told him that he had severed a nerve in his neck, which had caused paralysis of the muscles around his shoulder blade, and that he faced major surgery to restore function.

57. Dr B said that he was unaware at the time of surgery that he had severed a nerve in Mr A's neck. Dr B stated: "I am extremely upset that this happened and I apologise for this. If I had detected this had happened I would most certainly have addressed it." Dr B subsequently undertook not to perform subcutaneous surgery in the neck region. He stated: "[I]n this case I was motivated entirely by doing what I thought was best for [Mr A] given his anxiety and his eagerness to have the lump removed."

58. Dr B intends to introduce written consent forms if he returns to performing minor surgery. He has also advised that he is making an effort to keep more comprehensive records.

The medical centre

59. The medical centre advised that the facilities at the medical centre are compliant with relevant office surgery standards, and it follows best practice guidelines with regard to sterilisation, and takes all precautions to minimise the risk of wound infections and other complications of surgery.

60. The medical centre stated that there were no formal written guidelines in relation to performing minor surgery in place at the time of Mr A's surgery, but Dr B has performed many minor procedures without significant complications or adverse outcomes.

Further information from Mr A

61. Mr A said that he was unable to work for eight months, and he experiences ongoing pain. Following these events he has suffered from depression, which has affected his career. He told HDC that he cannot go to the gym or play sport. In response to the "information gathered" section of my provisional opinion, Mr A also stated that Dr B's actions have cost both him and his family financially, owing to his ongoing medical costs, travel expenses and time away from work.

62. Mr A stated that Dr E has advised him that although there has been some improvement, his right shoulder has been damaged for life.

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Responses to the provisional opinion

63. A response to the "information gathered" section of my provisional opinion was received from Mr A and, where appropriate, has been incorporated above.

64. A response to the provisional opinion was received from Dr B, and has been incorporated above and as follows.

65. In response to my provisional opinion, Dr B stated: "Firstly, I sincerely regret causing the nerve injury to [Mr A] and accept that I acted outside the scope of my competence … I want to again repeat my sincere apology and regret for what happened to [Mr A] and for his dissatisfaction with my conduct. I am very sorry that this happened."

Relevant standards

66. The Medical Council of New Zealand publication *Good Medical Practice: a guide for doctors* (2013) provides:[19]

> "**Providing good clinical care**
>
> 2. When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:
>
> - adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate
> - providing or arranging investigations or treatment when needed
>
> …
>
> **Keeping records**
>
> 5. You must keep clear and accurate patient records that report:
>
> - relevant clinical information
> - options discussed
> - decisions made and the reasons for them
> - information given to patients
> - the proposed management plan
> - any drugs or other treatment prescribed.

[19] See Medical Council of New Zealand, *Good medical practice: a guide for doctors*. Medical Council of New Zealand, Wellington (2013).

6. Make these records at the same time as the events you are recording or as soon as possible afterwards.

…

Assessing patients' needs and priorities

29. The care or treatment you provide or arrange must be made on the assessment you and the patient make of his or her needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.

…

Accepting the obligation to maintain and improve standards

Keep your professional knowledge and skills up to date

Recognise, and work within, the limits of your competence

…"

Opinion: Dr B — Breach

Introduction

67. On 15 December 2011, Mr A consulted Dr B about a lump in the right posterior triangle of his neck. Dr B referred Mr A to specialist surgeon Dr F. On 26 January 2012, Dr F reported to Dr B that he had performed an ultrasound examination and that no further investigation was required. Dr F added that Mr A was completely asymptomatic and that Mr A should return to see him should the lymph node get bigger or should he develop other lumps.

68. Dr Maplesden advised me that Dr B was conscientious in making a specialist referral and, at that stage, followed the advice he was given.

69. In my view, Dr B's actions in 2011 and early 2012 were appropriate.

70. This report considers Dr B's actions in July 2013, when he subsequently removed the lymph node during surgery carried out at the medical centre. Dr B severed Mr A's spinal accessory nerve during the surgery, which required subsequent complex surgery.

71. I note that my expert advisor, general practitioner Dr David Maplesden, advised that damage to the spinal accessory nerve can occur even under optimum operating conditions. However, procedures such as using blunt rather than sharp dissection in vulnerable areas, ensuring adequate visualisation of the operative field, and identifying and protecting vulnerable structures, can minimise the risk of iatrogenic nerve injury.

72. It is clear that Dr B made an error during the surgery, which led to Mr A's nerve injury. I have concerns about Dr B's actions in a number of areas, as discussed below.

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Failure to provide services of an appropriate standard

Decision to remove lymph node

73. On 1 July 2013, Mr A consulted Dr B. Mr A said he did so because he thought the lymph node had grown larger. In contrast, Dr B stated that there were no clinical changes in the lymph node, such as an increase in size or development of any other lumps.

74. Dr B's notes at this consultation are very limited and state only: "[L]ump R[ight] side of neck. Saw [Dr F] last year? Lymph node For excision? here? There." There is no record of the findings of any examination of the lymph node or whether it had increased in size.

75. I find it more likely than not that Mr A advised Dr B that he believed the lymph node had increased in size, and that when Dr B examined Mr A he concluded that the lymph node had not increased in size. Dr B said that he endeavoured to reassure Mr A that the lymph node did not require further medical management. Dr B said they then discussed the options of management, which were either to leave the lymph node or excise it, and Mr A said that he wanted it removed. Dr B stated that he felt confident he could remove the lymph node surgically, as it appeared superficial and well contained, but he chose to refer Mr A back to Dr F and asked Mr A to contact Dr F to make an appointment.

76. The following day (2 July), Mr A contacted Dr B to advise that Dr F was not able to see him for at least 10 weeks. Mr A stated that he asked Dr B for a referral to another specialist, and Dr B said: "Why don't you just come in here tomorrow and I can take it out for you?" In contrast, Dr B stated that Mr A did not ask for a referral to another specialist and, had he done so, he would have referred him. Dr B stated: "To the contrary, [Mr A] told me he did not want to wait any longer and wanted me to remove the lump in order to have it analysed." Due to the conflicting accounts, I am unable to make a finding as to whether Mr A requested a referral to another specialist. In any event, I consider that the decision whether to remove the lymph node or refer Mr A was Dr B's clinical responsibility, in that Dr B should not have decided to remove the lymph node if it was clinically inappropriate for him to do so.

77. Dr Maplesden advised me that if, as Dr B asserts, the lymph node had not changed since the previous consultation and was not associated with any systemic symptoms, "it is difficult to see any clinical indication for open biopsy of the lump or indeed any further investigations". Dr Maplesden advised that if Mr A was seeking additional reassurance that the lymph node was not malignant, then performing less invasive investigations such as blood count, viral serology and perhaps fine needle aspiration might have been considered, although they were not necessarily clinically indicated.

78. I have made a factual finding that, on examination, Dr B determined that the lymph node had not increased in size. In these circumstances, I accept Dr Maplesden's advice that the excision of Mr A's lymph node was not clinically indicated, and there was no urgency to remove the lymph node at that time.

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Systemic symptoms

79. Dr B and Mr A have provided conflicting accounts in relation to Mr A's presentation at his appointment on 1 July 2013. Mr A told HDC that in the 12 to 18 months leading up to his appointment with Dr B, he had been feeling very tired and run down, and had been getting night sweats. Mr A said that he told Dr B of these symptoms. In contrast, Dr B told HDC that he does not recall Mr A presenting with any other symptoms. No other symptoms were recorded by Dr B in his clinical notes. Dr B told HDC that had Mr A complained of these symptoms, he would not have given Mr A an influenza vaccination at that consultation.

80. Dr B and Mr A were the only people in the room during the consultation on 1 July 2013, so I am not able to verify either account with a third person. I do not consider that currently I have, or can obtain, sufficient information to determine whose account of what was said during the consultation is accurate. Accordingly, I am unable to make a finding as to whether or not Mr A told Dr B on 1 July 2013 that he had been feeling tired and run down, and had been having night sweats.

Management of histology results

81. On 4 July 2013, Dr B emailed the histology results to Mr A and stated: "[W]e have received your histology result which I attach for your information. You will see it is all friendly which is good news …" However, the histology report states that the diagnosis was a reactive lymph node with features suggestive of toxoplasmosis. The report indicated that serology and clinical correlation were required. Apart from the email to Mr A, Dr B did not follow up on the histology results.

82. Dr Maplesden advised that Dr B's management of the biopsy result was suboptimal. Dr Maplesden said that if Mr A had told Dr B that he was suffering from systemic symptoms (eg, fatigue) at the time of the biopsy, his concerns would be even greater. As noted above, I am unable to make a finding as to whether Mr A told Dr B of these symptoms. However, irrespective of whether or not Mr A told Dr B about his other symptoms, in my view, Dr B's email was insufficient, and he should have followed up by arranging the required tests. As noted above, according to the Medical Council of New Zealand's *Good Medical Practice*, one of the principles of good clinical care is to provide or arrange for investigations or further treatment when needed. Dr B failed to do so.

Conclusion

83. Dr B did not provide services to Mr A with reasonable care and skill when he decided to remove Mr A's lymph node in the absence of it being indicated clinically. In addition, Dr B did not follow up on Mr A's histology results adequately. Accordingly, for these reasons, Dr B breached Right 4(1) of the Code.

Failure to comply with professional standards

Inadequate experience

84. The Medical Council of New Zealand publication *Good Medical Practice* requires doctors to keep their professional knowledge and skills up to date and recognise, and work within, the limits of their competence. Dr B said that he has not undertaken any

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specific postgraduate training in minor surgery, and his prior experience was that he "may have removed one or two other lymph nodes" in the past.

85. Dr Maplesden advised that it would have been reasonable for Dr B to perform minor surgery within his scope of expertise and experience. However, Dr Maplesden noted that "because of the specific risk of SAN [spinal accessory nerve] damage related to posterior cervical triangle lymph node dissection, [he does] not think it was clinically reasonable for this procedure to be undertaken by a GP with very limited experience in this type of procedure and who was apparently unaware of the specific risks associated with the procedure". I accept Dr Maplesden's advice.

86. I consider that in light of Dr B's limited experience in removing lymph nodes from that specific location, it was inappropriate for Dr B to remove Mr A's lymph node.

Record-keeping

87. Dr B's records of the two consultations in July 2013 are minimal. On 1 July Dr B recorded: "Lump R[ight] side of neck. Saw [Dr F] last year ? lymph node For excision ? here ? there."

88. On 2 July 2013, the only clinical notes made by Dr B are: "[E]xcise subcut lymph node R[ight] side of neck. Arterial bleeder controlled with pressure. Firm dressing." Dr Maplesden advised me that the documentation of the surgical procedure is poor and gives no insight into the technique used. There is an inadequate description of the procedure, the local anaesthetic used, how asepsis was attained, the size of the excision, the nature of the dissection, and the closure process, including the type and number of sutures. The measures taken to minimise the risk of nerve damage during the surgery should also have been documented.

89. Dr B stated that he informed Mr A of potential risks of scarring, infection and pain, and obtained verbal consent, but neither the discussion nor the consent is recorded in the notes. As Mr A was not under general anaesthetic, there was no requirement that consent be given in writing; however, documentation of the consent obtained should have occurred. According to the Medical Council of New Zealand's *Good Medical Practice*, medical practitioners are required to keep clear and accurate patient records. Dr B failed to meet this professional standard.

Conclusion

90. Dr B failed to comply with professional standards and breached Right 4(2) of the Code by failing to recognise and work within his level of competence by undertaking the lymph node removal with insufficient experience, and for failing to keep adequate patient records.

Informed consent

91. Mr A stated that he asked Dr B about the differences between a specialist and Dr B performing the surgery. Dr B stated that there would be no difference other than possibly the scarring and the equipment used.

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92. Mr A said that Dr B told him he would be given a local injection to his neck, and that the lymph node would be removed and sent away to the laboratory for testing. Dr B said that he would feel a little bit of numbness to his neck.

93. Dr B stated that he followed his usual procedure, in that he spoke about the risks of scarring, infection, discomfort and pain. Dr B warned Mr A of the risk of scarring and infection but did not warn him about the risk of severing a nerve, loss of muscle function or severing an artery. Mr A stated: "Had these risks and options been explained to me, I would have not agreed to [Dr B] operating on me." Dr Maplesden advised me that "Any decision regarding removal of the node under these circumstances (only indication being patient request) should have included discussion of the not insignificant risk of SAN damage and the possible sequelae of such nerve damage, the preference for specialist management if surgery was to take place and the reasons for this, and reassurance that there was no urgency for removal of the lesion". I accept Dr Maplesden's advice.

94. In addition, I am of the view that Dr B should also have told Mr A of his limited experience in removing lymph nodes. In my view, that was information that a reasonable consumer in Mr A's circumstances would expect to receive.

95. For failing to provide an adequate explanation of the options available, including an assessment of the expected risks, side effects, and benefits of each option, and for failing to provide an explanation of his experience and expertise in conducting that particular surgery, Dr B breached Right 6(1) of the Code. It follows that Mr A was not in a position to make an informed choice and give informed consent to the surgery and, accordingly, Dr B also breached Right 7(1) of the Code.

Opinion: The medical centre — No breach

96. Dr B is a self-employed practitioner at the medical centre. Under section 72(3) of the Health and Disability Commissioner Act 1994 (the Act) an employing authority may be vicariously liable for any act or omission of its agent. Under section 72(5) of the Act, it is a defence for an employing authority if it can prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

97. Dr B advised (in his capacity as a director) that the facilities at the medical centre are compliant with relevant office surgery standards in that they follow best practice guidelines with regard to sterilisation, and take all precautions to minimise the risk of wound infection and other complications of surgery. Dr Maplesden noted that equipment for undertaking minor surgery varies between practices, with some having dedicated theatres with operating table, surgical lighting, electro-cautery machines and so on, while others have more rudimentary facilities. Dr Maplesden stated that, based on Dr B's description, it appears that the medical centre's general processes for minor surgery, including infection control procedures, are likely to be consistent with common practice.

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98. Dr Maplesden advised me that Mr A's nursing follow-up care was reasonable. I accept Dr Maplesden's advice. I consider that the failings in Dr B's treatment of Mr A involved individual clinical errors rather than deficiencies in the processes at the medical centre. Accordingly, I do not find that the medical centre breached the Code.

Recommendations

99. In my provisional opinion, I recommended that Dr B undertake further training on minor surgical procedures. In response to my provisional opinion, Dr B provided evidence of his attendance at a workshop in primary care dermoscopy and skin cancer surgery.

100. I recommend that Dr B:

a) Provide a written apology to Mr A. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.
b) Undertake professional training on the importance of, and expectations for, clear, full and accurate medical documentation and the requirements of informed consent, and report to HDC within three months of the date of this report with evidence of the content of the training and his attendance.

101. I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

102. I recommend that the medical centre conduct an audit of Dr B's clinical record-keeping and report the results of the audit to HDC within three months of the date of this report.

Follow-up actions

103.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board and the Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent 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. I have reviewed the available information: complaint from [Mr A]; response from [Dr B]; GP notes ([Dr B], [the medical centre] and [Dr D] including relevant specialist letters. [Mr A] complains about [Dr B's] management of a right neck lump. [Dr B] excised the lump in July 2013 and severed [Mr A's] spinal accessory nerve in the process. The nerve damage was not detected for several months and [Mr A] has been left with significant disability (wasting of the right trapezius and reduced shoulder function) and chronic pain, and has required complex nerve reconstruction surgery, the effectiveness of which has yet to be established. The nerve damage has jeopardised [his career] and also his [sport]).

2. [Dr B] first saw [Mr A] in mid-December 2011 with a 15mm lump in the right posterior triangle of the neck. The lump had been slowly increasing in size over several months and [Dr B] diagnosed a likely lipoma and referred [Mr A] to [specialist surgeon Dr F]. [Dr F] saw [Mr A] on 26 January 2012 where additional history was obtained of previous left sided neck lump which had since resolved, and ultrasound showed the right sided lump to be most likely a lymph node which was not pathologically enlarged. [Dr F] advised a conservative approach (*no further investigation needs to be done*), noting [Mr A] was *completely asymptomatic.* He advised review by himself *should this lump get bigger or should he develop other lumps.*

Comment: At this stage [Mr A] had a palpable but not pathologically enlarged cervical lymph node. He was asymptomatic. The specialist advised against further investigations as there were no signs of significant pathology. [Dr B] had been conscientious in making a specialist referral perhaps assuming the lump would be removed. He followed the specialist advice he was given.

3. On 1 July 2013 [Mr A] returned for review of the neck lump. Clinical notes read *Lump R side of neck, saw [Dr F] last year ?lymph node For excision ?here ?there.* In his response, [Dr B] states he *ascertained from [Mr A] that there were no clinical changes which raised his concerns, such as an increase in the size of the lump or the development of other lumps in the neck. Rather, [Mr A] made it clear to me that he was anxious the lump may be cancerous or something sinister like that.* [Dr B] states that, following examination, he confirmed the lump had not changed since the examination some 19 months previously. *I endeavoured to reassure [Mr A] that the lump did not appear to require further medical management but he remained concerned. He wanted it removed.* [Dr B] states he then discussed options of management — leave the lump or excise it, and [Mr A] reiterated that he wanted it removed. [Dr B] states *I felt confident I could surgically remove* [the lump] as it appeared superficial and well contained, but he elected to refer [Mr A] back to [Dr F] and asked [Mr A] to ring for an appointment. [Mr A] contacted [Dr B] the next day to say [Dr F] could not see

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him for several weeks. [Dr B] states [Mr A] was keen for the lump to be removed as soon as possible and was happy for [Dr B] to undertake the surgery, which was then scheduled for later that day (2 July 2012).

4. [Mr A] recounts these events somewhat differently in his complaint. He does not mention the consultations of December 2011 and January 2012 regarding a right neck lump. He recounts a history of a rapidly growing right neck lump since June 2013 associated with some systemic symptoms — *I had been getting night sweats and feeling generally very tired and run down for some time leading up to making this appointment*. [Mr A] agrees that [Dr B] recommended he see [Dr F]. On learning there would be a long delay to see [Dr F], [Mr A] states he contacted [Dr B] and requested an alternative specialist referral. [Dr B] advised he could do the surgery himself that afternoon. [Mr A] asked how this management would differ from specialist management and was advised the specialist *might have better equipment and the scarring on my neck could be a little less with a surgeon carrying out the procedure.*

Comment: Unfortunately the paucity of [Dr B's] clinical notes on this occasion does not enable me to prefer either of the contrasting version of events supplied. It is unclear why [Mr A] might have requested removal of the lump in the absence of new symptoms or change in the lump when he had tolerated it for (by this point) two years since it was first visible (assuming it was the 'original' lump — although see account given to [Dr D] in August 2013 noted below). If it had not changed at all over this period, and was not associated with any systemic symptoms (as per [Dr B's] account), it is difficult to see any clinical indication for open biopsy of the lump or indeed any further investigations. Had [Mr A] been seeking only additional reassurance the lump was not malignant, performing less invasive investigations such as blood count, EBV/toxo/CMV serology and perhaps fine needle aspiration (FNA) might have been considered although were not necessarily clinically indicated. This acknowledges the relatively high 'false negative' rate of FNA in detecting significant pathology and that there was a negligible suspicion for significant pathology (based on [Dr B's] account) in this case. If [Mr A] was determined he wanted the lump removed despite reassurance of the negligible risk of significant pathology (again assuming the scenario provided by [Dr B] is accurate), given the situation of the lump and associated risk of nerve damage (see later discussion) it was vital that [Mr A] be made aware of this potential risk in order for him to make an informed decision whether or not to proceed with surgery. If [Dr B] was to undertake the surgery, he must be satisfied that his knowledge of the anatomy of the region and the equipment available to him meant he could safely and competently remove the lump while minimising the risk of iatrogenic nerve injury. Had the history been as described by [Mr A] (with the assumption the original lump had resolved in the intervening period, or this was a sudden change in that lump associated with systemic symptoms) I would have expected a full examination of [Mr A's] ENT [(ear, nose and throat)] system and check for other enlarged glands or organomegaly. It would have been prudent to order blood count and viral serology as discussed above particularly if more generalized lymphadenopathy was detected, and some clinicians might order a chest X-ray if there is any suspicion of lymphoma. With respect to biopsy, the

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author of a recently updated review on the subject[1] recommends: *Patients with localized lymphadenopathy can be observed for three to four weeks if there is nothing else in the history and physical examination to suggest malignancy. This approach is safe and avoids unnecessary biopsies since the adenopathy will resolve or the cause will become obvious in many patients during that time. Even with 'can't miss' diagnoses such as Hodgkin lymphoma, head and neck cancer, or tuberculosis, the window of opportunity for effective treatment is likely to remain open during this period of observation. Biopsy is appropriate if an abnormal node has not resolved after four weeks and should be performed promptly in patients with other findings suggesting malignancy (eg, rapid increase in size of the node; systemic complaints of fever, night sweats, weight loss).* According to [Mr A's] account of his presentation, it was probably reasonable to consider urgent biopsy of the lymph node in the management plan if initial non-invasive tests did not provide a 'benign' diagnosis. In that case, formal referral to an appropriate surgeon clarifying the urgency of the situation should result in timely specialist intervention (as opposed to the non-urgent situation reported by [Dr B]). As discussed above, if [Dr B] felt he could competently remove a lymph node from the posterior cervical triangle because of his experience and familiarity with the anatomy of the area, and provided appropriate informed consent had been obtained, it might have been reasonable for him to proceed with the lymph node biopsy.

5. [Dr B] undertook removal of the lymph gland from [Mr A] on 2 July 2013. The only clinical notes referring to the procedure are: *Excise subcut lymph node R side of neck. Arterial bleeder controlled with pressure. Firm dressing.* Nursing notes describe dressing of the wound and *Panadol tabs given, see tomorrow.* [Mr A] describes the procedure as painful and during the surgery *my right arm had an unusual sensation … and I felt very light-headed.* He notes his tee-shirt collar was *drenched in blood.* [Mr A] denies that any information was provided to him regarding the risks of surgery. [Dr B] states he informed [Mr A] of potential risks of scarring, infection and pain associated with surgery, and that verbal consent was gained to proceed with surgery but not recorded. Surgery was uncomplicated apart from a small arterial bleed *which was easily controlled by pressure.* Surgery was completed in 30 minutes and [Dr B] does not recall [Mr A] complaining of arm sensations or light-headedness. Clinical notes show [Mr A] attended for dressing changes on 3 July 2013 and 11 July 2013 (removal of sutures on this date also — both consultations by practice nurse). There is no reference to any problems with wound healing, or any other complication, recorded at these consultations. Histology of the node showed *reactive lymph node. Features suggestive of toxoplasmosis.* [Mr A] was notified of this result by letter on 4 July 2013 with the comment from [Dr B] *We have received your histology result which I attach for your information. You will see that it is all friendly which is good news. See you next week …* [Mr A] requested transfer of his medical file on 9 September 2013 and was not see again by [Dr B].

[1] Fletcher R. Evaluation of peripheral lymphadenopathy in adults. Last updated September 2013. www.uptodate.com

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Comments:
(i) It is not possible for me to comment on whether [Dr B] had facilities appropriate to the surgery he was performing. There should be compliance with relevant published office surgery standards (Standards New Zealand)[2] including:

- NZS 8165:2005 Rooms/Office-based Surgery and Procedures
- AS/NZS 4187:2003 Cleaning, Disinfecting and Sterilizing Reusable Medical and Surgical Instruments and Equipment, and Maintenance of Associated Environments in Health Care Facilities
- AS/NZS 4815:2001 Office-based Health Care Facilities not involved in Complex Patient Procedures and Processes — Cleaning, Disinfecting and Sterilizing
- Reusable Medical and Surgical Instruments and Equipment, and Maintenance of the Associated Environment (under revision)
- NZS 4304:2002 Management of Healthcare Waste
- NZS 8164:2005 Day-stay Surgery and Procedures (for day surgery facilities)

(ii) Procedural documentation is inadequate. There is no record of consent being obtained or the information given prior to consenting. In the absence of a signed written consent form containing such information, documentation of the process should have occurred. There is inadequate description of the procedure — local anaesthetic used, how asepsis was attained, size of incision, nature of dissection, closure process including type and number of sutures. The potential risk of nerve damage should have been specifically discussed prior to surgery given the anatomical location of the surgery, and measures taken to minimise risk of nerve damage during surgery also documented. Nursing notes provided adequate follow-up documentation.

(iii) Without having viewed the actual procedure it is not possible for me to comment whether due care was taken by [Dr B] during the surgery. Surgical complications, including nerve damage, can occur even when due care is taken (see later discussion on spinal accessory nerve injury) and procedures such as using blunt rather than sharp dissection in vulnerable areas, ensuring adequate visualisation of the operative field, and identifying and protecting vulnerable structures can minimise the risk of iatrogenic nerve injury. I cannot confirm whether such measures were taken by [Dr B]. Most importantly, the surgeon should be operating within their scope of expertise and with good knowledge of the relevant anatomy, and under conditions that minimise risk of complications (with respect to operating environment, equipment etc).

(iv) Nursing follow-up was reasonable and there was no documentation to suggest [Mr A] complained of arm or shoulder symptoms to nursing staff. The wound was well-healed on discharge.

(v) Provision of results was sub-optimal in that there was no discussion of the implications or significance of the result (showing toxoplasmosis) to the patient. Had [Mr A] continued to be symptomatic of the now confirmed infection, as he states in his response, specific treatment was indicated. If he was asymptomatic,

[2] See: http://www.dermnetnz.org/doctors/lesions/surgery.html

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no further treatment was required (see discussion on toxoplasmosis below). I believe [Mr A] should have been offered an appointment with [Dr B] to discuss the results, or that he should have been provided with a more detailed written account of the significance of the results including rationale for either treating or not treating.

6. [Mr A] states that he sought a second opinion regarding his ongoing shoulder problems (since the lymph node biopsy) from [Dr D] on 27 August 2013. [Dr D's] notes for that consultation do not refer to any symptom of shoulder pain or dysfunction. There is reference to intermittent left testicular pain and also to the toxoplasmosis diagnosis. With reference to the toxoplasmosis, [Dr D] records *Fatigue — from ?late 2012. R ant cx node removed by [Dr B] 2/7/13, 'reactive'. No blood tests before or after. Lymph node had been inflamed on & off for yrs.* Following a comprehensive physical examination, antibiotics were provided for possible epididymitis and [Mr A] referred for blood tests and scrotal ultrasound. Results were consistent with current or recent toxoplasmosis infection, and Epstein-Barr virus (EBV) infection, possibly recent. Old blood results were obtained (10 November 2005) and showed that on that date [Mr A] did not have any antibodies to toxoplasmosis (implying infection more recently than 2005) but did have EBV antibodies (implying infection prior to that time). On review by [Dr D] on 30 August 2013 there is reference to [Mr A] discussing ongoing scrotal pain, a chronic back injury and the appearance of a *non-tender lump ~28mm diam R suprascapular region since lymph node excision ?haematoma.* There is no reference to back pain or shoulder dysfunction. Fine needle aspiration of the new 'lump' was ordered and undertaken on 23 September 2013 with blood only aspirated. Ultrasound of the mass was undertaken [in the town] (where [Mr A] was staying with his parents) on 26 September 2013 and suggested the mass was related to winging of the scapula. On 1 October 2013 [Mr A] was reviewed by [Dr D] who documented, for the first time, symptoms of *weakness, loss of muscle mass R shoulder/scapula area ... still fatigued, no new adenitis.* X-ray was arranged and confirmed winging of the scapula. [Dr D] informed [Mr A] of this result on 3 October 2013, including her impression *is still of this being a resolving haematoma* but offering specialist review. [Mr A] evidently then self-referred to [plastic surgeon Dr C] (seen 21 October 2013) who diagnosed winged scapula most likely secondary to nerve damage at the time of the surgery performed by [Dr B], given the temporal association of the symptoms with that event. His notes refer to [Mr A's] account (and that of his partner who was present during the surgery) that the procedure *was not smooth and there was significant bleeding ... During the procedure [Mr A] did not feel that his shoulder was quite right and this was definitely the case subsequently although he wasn't sure of anything specific ... I have suggested to [Mr A] and his father that I found it unusual a GP would be excising a large lymph node in the posterior triangle ...*[Dr C] referred [Mr A] to an [orthopaedic colleague] ([Dr E] — additional referral made by [Dr D] on 31 October 2013) who saw [Mr A] on 13 November 2013. EMG assessment suggested total division of the spinal accessory nerve and [Dr E's] clinical examination also suggested this condition, felt most likely to have occurred during the surgery performed by [Dr B].

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7. On 19 December 2013 [Mr A] underwent complex surgery where [Dr E] noted a *divided spinal accessory nerve in the region of the previous scar with 2cm gap between the nerve ends* ... Nerve reconstruction was attempted with a graft from the right lower leg (sural nerve). [Dr E] noted *we cannot expect any signs of muscle function in trapezius for at least 6 months* so the final outcome is unknown at this point. In a report to ACC dated 27 November 2013 [Dr E] noted his suspicion (later confirmed) *the substantive cause of the damage to the spinal accessory nerve is the excision of the lymph node ... The accessory nerve is a known structure at risk when excising a node in this area and should be protected during the surgical procedure.*

8. Iatrogenic accessory nerve injury: Extracts from review articles on this subject include the following points:

(i) *Unintended injury to the spinal accessory nerve after head and neck surgery is a significant source of malpractice litigation. Timely diagnosis and treatment of this complication are essential. Regardless of whether the medical community considers careful surgical technique and nerve preservation to be the standard of care, the legal system clearly treats it as such, awarding compensation in 82% of cases*[3] [in the USA] ... *nerve injury is estimated to occur in 3% to 8% of posterior triangle lymph node biopsies ... in most cases unintentional nerve injury is preventable ... Injury to the spinal accessory nerve results in trapezius muscle weakness, disabling the shoulder girdle. Soon after surgery, the patient will notice shoulder pain and weakness on shoulder shrug and arm abduction ... Surgeons performing any manner of surgery in the posterior triangle of the neck should maintain a high suspicion for this clinical syndrome ... a neck re-exploration for nerve repair will attain best results if performed within 3–6 months ... Unfortunately the average delay to referral for nerve repair is 14 months ... before surgery in or near the posterior triangle of the neck, all patients should be informed of the risk of accessory nerve injury before informed consent is given ... the informed consent discussion should be carefully documented ... At surgery, if the posterior triangle is entered, the surgeon should anticipate the presence of the accessory nerve ... it might not be encountered in many lymph node biopsies. However, even if the nerve is not encountered, careful surgical technique can minimize risk to the nerve ...*

(ii) *Prevention is key and is best achieved by avoiding unnecessary biopsies of the posterior triangle lymph node. When operating, knowledge of posterior neck anatomy and judicious use of the bipolar cautery and magnifying loupes are essential in preventing this problem*[4].

(iii) *The severe disability associated with injury to the spinal accessory nerve (SAN) has long been recognised, with pain, weakness and paraesthesia among the major presenting features ... The nerve is most frequently damaged in the posterior triangle of the neck as a complication of a variety of procedures*

[3] Morris L et al. Malpractice Litigation After Surgical Injury of the Spinal Accessory Nerve — An Evidence-Based Analysis. Arch Otolaryngol Head Neck Surg. 2008;134(1):102–107

[4] Chandawarkar, R et al. Management of Iatrogenic Injury to the Spinal Accessory Nerve. Plast. Reconstr Surg. 2003. 111: 611

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performed by surgeons of different specialties. The main cause for concern is the high incidence of SAN injury after posterior triangle lymph node biopsy. This has been estimated in one study to occur in between 3% and 10% of such procedures. Injury to the nerve during the course of node biopsy should be avoidable with proper care and adequate anatomical knowledge ... Diagnostic biopsy of neck nodes should not be undertaken as a primary investigation and, when indicated, surgery in this region should be performed by suitably trained staff under well-defined conditions. Awareness of iatrogenic injury and its consequences would avoid delays in diagnosis and treatment ... Unfortunately, these lesions continue to occur and to present problems in diagnosis. In all cases the deficit is noted early by the patient but often their complaints are not interpreted accurately by medical staff. The delay in diagnosis may prevent effective treatment. Even when an accurate diagnosis is made, further delays often occur before definitive treatment ... [Conclusion] *Unintentional iatrogenic SAN injury should be avoidable. In particular, diagnostic biopsy of neck nodes should not be a primary investigation. Once a decision has been taken to perform such a biopsy, damage to the main components of the neck should be avoidable if the surgery is performed in optimal conditions by suitably trained staff with a good understanding of local anatomy. We recommend general anaesthesia, local vasoconstrictors, magnification and use of a disposable nerve stimulator. It is important that the SAN is identified and meticulously preserved during the operation. After surgery particular notice should be taken of the patient's symptoms as these lesions are usually recognised by the patient in the immediate postoperative period. Early diagnosis and prompt treatment at this stage are associated with improved prognosis*[5].

9. Toxoplasmosis background[6]: *Toxoplasmosis, an infection with a worldwide distribution, is caused by the intracellular protozoan parasite,* Toxoplasma gondii. *Immunocompetent persons with primary infection are usually asymptomatic, but latent infection can persist for the life of the host. However, there is a risk of reactivating infection at a later time should the individual become immunocompromised, even if infection was asymptomatic or only mildly symptomatic initially. Eighty to 90 percent of acute* T. gondii *infections in immunocompetent hosts are asymptomatic. When symptomatic infection does occur, the most common manifestation is bilateral, symmetrical, non-tender cervical adenopathy. The lymph nodes are usually smaller than 3 cm in size and are non-fluctuant ... Twenty to 30 percent of symptomatic patients will have generalized lymphadenopathy. Constitutional symptoms, such as fever, chills, and sweats, may be present, but are mild. Headaches, myalgias, pharyngitis, diffuse non-pruritic maculopapular rash, or hepatosplenomegaly may also occur. Most immunocompetent patients have a benign, self-limited course lasting from weeks to months, rarely longer than a year. Following confirmed diagnosis, immunocompetent, nonpregnant patients generally do not require treatment unless symptoms are severe or prolonged beyond a few weeks.*

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[5] London J, London N, Kay S. Iatrogenic accessory nerve injury. Ann R Coll Surg Engl. 1996;78:146–510

[6] From: Heller H. Toxoplasmosis in immunocompetent hosts. Last updated February 2014. www.uptodate.com

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10. Concluding comments

(i) There appears to be little doubt [Mr A] suffered an iatrogenic injury to his right spinal accessory nerve (SAN) during surgery by [Dr B] to remove a lymph node from the right posterior cervical triangle on 2 July 2013. This has had devastating and longstanding consequences for [Mr A]. The medical literature suggests lymph node biopsy in the region of the posterior cervical triangle should be done only when clinically indicated, should be done with appropriate forewarning of the patient, and should be performed by an operator with adequate experience and anatomical knowledge using techniques known to minimise the risk of iatrogenic damage. However, it is also acknowledged that such nerve damage is a well-recognised and not uncommon complication of the procedure although should be largely preventable.

(ii) In regard to [Dr B's] account of [Mr A's] presentation in early July 2013, there did not appear to be any clinical indication for lymph node biopsy. The node had been previously reviewed by a specialist and conservative approach advised. There were no systemic symptoms and no change in appearance of the lump. Open lymph node biopsy should not have been the primary investigation (noting absence of record of physical examination beyond examining the node and absence of less invasive preliminary investigations). The only apparent indication for removal was patient request, and it is evident this request was acquiesced to without the patient being informed of the significant risk of SAN damage. A mitigating factor is that referral to a specialist was considered as the preferable option and attempts were made to follow this course of management.

(iii) In regard to [Mr A's] account of his presentation in early July 2013, it might have been clinically appropriate to consider lymph node biopsy given the presence of systemic symptoms perhaps suggestive of lymphoma, and apparent rapid change in size of the gland. However, such management would usually be preceded by blood tests and perhaps chest X-ray which, in this case, may have led to earlier consideration of toxoplasmosis as a cause of the symptoms without the need for urgent node biopsy.

(iv) As noted previously, it is difficult to comment definitively on [Dr B's] surgical knowledge, skill and equipment without having been present at the time of surgery and inspecting his surgical facility. Experience and skills in minor surgery vary markedly between primary care practitioners, with some undertaking additional training in minor surgery to enhance their skills. [Dr B] does not report such training. Similarly, equipment for undertaking minor surgery varies between practices with some having dedicated theatres with operating table, surgical lighting, electro cautery machines etc and others having somewhat more rudimentary facilities. The documentation of the surgical procedure was poor and gave no insight into the technique used. The posterior cervical triangle is well known as a 'fraught' anatomical area and should always be approached with caution. The fact that the risk of damage to the SAN was not discussed prior to the operation leads me to believe [Dr B] may not have adequately considered the anatomy of the region when agreeing to perform the surgery and during the actual surgical process. Lymph node biopsy in this area should only have been

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undertaken if [Dr B] was confident in his knowledge of local anatomy and in his ability to protect the SAN, and under suitable conditions.

(iv) As noted above, documentation in general was poor as was the consenting process. This is discussed further in 5 (ii).

(v) Follow-up arrangements, with respect to wound care, appear to have been adequate. However I feel management of the biopsy result was suboptimal as discussed in section 5(v). The departure from expected standards in this regard is more severe if [Mr A] was suffering from systemic symptoms at the time of the biopsy as he claims and is reported in [Dr D's] notes subsequently. In fact, if [Mr A] had reported systemic symptoms to [Dr B] in July 2013 as he claims, I would be critical of the overall medical management (leaving aside the lymph node biopsy) including failure to adequately examine the patient, poor clinical documentation, poor handling of results and failure to treat the patient if persistent symptomatic toxoplasmosis was the apparent diagnosis (as made by [Dr D] a few weeks after surgery).

(vi) Contemporaneous notes made by [Dr B's] practice nurses and [Dr D] do not suggest [Mr A] complained of shoulder weakness or pain until 1 October 2013, although he had complained of a subscapular lump to [Dr D] prior to that time. While it is apparent he had some shoulder symptoms from the time of surgery, it is not possible to confirm these were brought to the attention of his providers and even when they were, there was some delay in making the eventual diagnosis ([Dr B] not involved with this). This delay appears to be a common occurrence as noted in 8(ii).

(vii) Taking all of the factors discussed into account (including consenting process and documentation), I believe the overall management of [Mr A] by [Dr B], taking into account [Dr B's] recollection of events, departed from expected standards to a moderate degree. If [Mr A] was complaining of systemic symptoms of unexplained night sweats and fatigue at the time of the July consultation as he claims, I would regard the overall management by [Dr B] as a moderate to severe departure from expected standards. The actual iatrogenic injury to the SAN constitutes only a part of this decision as it cannot be assumed unequivocally that such damage would have been avoided by another provider or by [Dr B] if he had used meticulous technique."

Further advice: 21 July 2014

"1. I have reviewed the response from [Dr B] dated 23 May 2014 to my original advice (dated 18 March 2014).

2. [Dr B] states that he offered [Mr A] a 'wait and see' approach to the management of his neck mass because there were no clinical features of concern. He emphasises that there were no systemic symptoms or recent change in the lump in contrast to [Mr A's] recollection of events and information contained in subsequent clinical notes. [Dr B] states that [Mr A] declined the offer to 'wait and see' and insisted the lump be removed. [Dr B] states that [Mr A's partner], who was with him at the time of the consultations in question, could confirm that [Mr A's] sole concern was anxiety that the lump might be malignant and he would be reassured only if it was removed.

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3. [Dr B] has described the process he normally undertakes for minor surgery, including equipment used. Based on his description it appears his general processes for minor surgery, including infection control procedures, are likely to be consistent with common practice.

4. [Dr B] confirms verbal consent for surgery was obtained. He did not discuss the specific risk of nerve damage with [Mr A]. However, he did discuss in general terms the risk of infection, bleeding, scarring and pain.

5. [Dr B] describes the specific surgical technique he undertook with [Mr A] including that a good view of the operative field was obtained and maintained and that the spinal accessory nerve (SAN) was not identified. However, he acknowledges it is likely he inadvertently severed the nerve. His comments are somewhat at odds with [Mr A's] recollection of the procedure (with respect to bleeding during the procedure that was difficult to control) and [Dr B's] own contemporaneous documentation that indicated there was arterial bleeding that was controlled with pressure.

6. [Dr B] has not undertaken any specific post-graduate training in minor surgery. He recalls he may have removed *one or two other lymph nodes* in the past, but has performed other types of minor surgery on a regular basis over many years.

7. [Dr B] acknowledges there were deficiencies in his documentation regarding patient consent and documentation of the surgical procedure. He acknowledges there were deficiencies in his communication with [Mr A] regarding the lymph node histology report suggestive of toxoplasmosis.

8. Comments

(i) I remain of the view that primary excision of [Mr A's] lymph node was not clinically indicated and there was certainly no urgency to remove the node even if a mutual decision was made that it might be removed. Any decision regarding removal of the node under these circumstances (only indication being patient request) should have included discussion of the not insignificant risk of SAN damage and the possible sequelae of such nerve damage, the preference for specialist management if surgery was to take place and the reasons for this, and reassurance that there was no urgency for removal of the lesion. In this way, [Mr A] might have been more able to more reasonably weigh up the risks and benefits of such surgery before proceeding.

(ii) It is reasonable that [Dr B] is performing minor surgery within his scope of expertise and experience and the general processes relating to minor surgery in his practice, as described by him, appear satisfactory. However, because of the specific risk of SAN damage related to posterior cervical triangle lymph node dissection, I do not think it was clinically reasonable for this procedure to be undertaken by a GP with very limited experience in this type of procedure and who was apparently unaware of the specific risks associated with the procedure. That is not to say that [Mr A] would necessarily have escaped his complication under other circumstances because it is, by its nature, an inherently 'risky' procedure.

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(iii) [Dr B] has acknowledged deficiencies in aspects of his documentation and these require a commitment to improvement.

(iv) The delayed diagnosis of the nerve injury was not related to any deficiency on the part of [Dr B] or his staff in the post-operative period. Delayed diagnosis of such an injury is a feature of the injury as discussed in my original advice.

(v) Taking into account the apparent insistence of the patient that surgery be undertaken and the offer of conservative management and appropriate specialist referral, both of which were apparently declined by the patient, I remain of the view (as per my original advice) that the overall management of [Mr A] by [Dr B] departed from expected standards to a **moderate** degree. This takes into account deficiencies in documentation, follow-up of results, and the decision to perform potentially risky surgery when there was no clinical indication to do so, without adequate communication with the patient regarding potential risks, and without adequate experience in such surgery.

(vi) I am unable to comment on whether [Dr B's] surgical technique departed from expected practice because, as discussed in my original advice, damage to the SAN can occur even under optimum operating conditions.

(vii) I would be more critical of [Dr B's] management of [Mr A] if it was confirmed [Mr A] was complaining of systemic symptoms and recent change in the size of the lesion in question prior to removal of the lesion being considered. This has been discussed in detail in my original advice."

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