Medical Centre

General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 15HDC00484)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In January 2013 Mr A (aged 46 years at the time of these events) consulted a general practitioner (GP), Dr B at a medical centre, about a scalp lesion.

2. On 19 February 2013 Dr B excised the lesion and sent the lesion specimen to a medical laboratory. Mr A was told that if he heard nothing, "all was well". On 27 February 2013 Dr B received a two-page histology report, which stated that the lesion had features consistent with a keratoacanthoma[1], and that because of the lesion's similarity with squamous cell carcinoma[2] (SCC) and incomplete excision at the deep margin, "follow up" was advisable. Dr B saw the diagnosis of keratoacanthoma and, as he regarded it as normal, did not pass it on to Mr A. He did not read the advice to follow up.

3. Dr B concluded that a further biopsy was not required at that time. He saved the report to Mr A's file and did not make a file note. Dr B did not tell Mr A the results or provide any follow-up advice, despite Mr A having been told that he would be contacted again if follow-up was necessary.

4. On 21 February and 1 March 2013 Mr A returned to the medical centre for wound review and suture removal by registered nurses. The pathology was not discussed with Mr A. It was the medical centre's policy that nursing staff did not discuss pathology with patients.

5. In late 2013 and onwards, Mr A consulted staff at the medical centre for lesions on his ears, lip, left leg and hands. The results of the biopsies in each case were given to Mr A at the time of suture removal. Mr A did not mention any recurrence of the scalp lesion at these appointments.

6. Mr A's scalp lesion reappeared in October 2014, and he decided to see a specialist. A further biopsy was taken and sent to histology. The new report was positive for SCC, and Mr A was advised that urgent surgery was required.

7. Mr A has since had seven operations and a large amount of his scalp removed down to his skull, along with skin grafts.

Findings summary

8. The information contained in the histology report of 27 February 2013 was information that a reasonable consumer in Mr A's circumstances would expect to receive. By failing to provide Mr A with that information, Dr B breached Right 6(1)(f) of the Code of Health and Disability Services Consumers' Rights (the Code).[3] In addition, Dr B failed to provide services with reasonable care and skill by not

[1] A low-grade tumour that originates in the pilosebaceous glands and closely resembles SCC.
[2] Uncontrolled growth of abnormal cells contained in the skin's upper layers. It can become malignant if allowed to grow.
[3] Right 6(1)(f) 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, including the results of tests."

reading the histology report properly and not arranging the follow-up care that had been recommended, and breached Right 4(1) of the Code.[4]

9. The medical centre was found not to have breached the Code or to be vicariously liable for Dr B's breaches of the Code.

Complaint and investigation

10. The Commissioner received a complaint from Mr A about the services provided to him by Dr B and the medical centre. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Dr B.*
- *The appropriateness of the care provided to Mr A by the medical centre.*

11. An investigation was commenced on 10 September 2015.

12. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	Provider
Medical centre	Provider

Also mentioned in this report:

Dr C	Medical director
Dr D	General practitioner

13. Information from these parties was received during the investigation.

14. Clinical advice was obtained from in-house clinical advisor Dr David Maplesden (**Appendix A**).

Information gathered during investigation

Background

15. In January 2013 Mr A (aged 46 years at that time) consulted general practitioner (GP) Dr B at the medical centre about a sebaceous cyst[5] on his scalp. At that time Dr B was

[4] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."
[5] A swelling in the skin arising in a sebaceous gland, typically filled with yellowish sebum.

partially retired and working only a few shifts a week.[6] Dr B told HDC that he told Mr A that the lesion might be a squamous cell carcinoma (SCC)[7] and that excision was necessary. Dr B's clinical notes state: "Has ? SCC on scalp which is infected. See in one week and excise." In contrast, in response to the information gathered section of my provisional opinion, Mr A told HDC that Dr B did not mention to him that the lesion might be a SCC.

16. On 19 February 2013 Dr B excised the lesion and sent the specimen to the medical laboratory. Mr A told HDC that he was told, either by Dr B or staff at the medical centre, that the lesion would be sent to pathology to rule out any malignancy, and that, if he heard nothing, "all was well". The medical centre accepts that this is "probably what happened".

17. Dr B received a two-page histology report on 27 February 2013 (**Appendix B**). The diagnosis section of the report, spread across both pages, was produced as follows:

> "Diagnosis:
> SKIN LESION SCALP
> FEATURES CONSISTENT WITH A KERATOACANTHOMA[8]
>
> Comment: Due to the histological similarity of
> Keratoacanthoma and
>
> [page 2]
>
> squamous cell carcinoma and incomplete excision at the deep
> margin
> follow up would be advisable."

18. Owing to the lesion's similarity with an SCC and the incomplete excision, the report advised "follow up". The medical centre told HDC that Dr B does not remember reading the remark "follow up"; he "saw the diagnosis of keratoacanthoma and, regarding this as normal did not pass this on … unfortunately he missed reading the after note to the report".

19. Dr B told HDC that "[he] must have read the diagnosis of keratoacanthoma and been reassured that this was a benign lesion". Dr B's conclusion that Mr A's scalp lesion was a keratoacanthoma meant that he concluded that a further biopsy was not required at that time. Dr B said that he saved the report to Mr A's file and did not make a file note. Dr B did not tell Mr A the results or provide any follow-up advice.

20. On 21 February and 1 March 2013 Mr A returned to the medical centre for wound review and suture removal by two registered nurses. The medical centre told HDC

[6] Dr B was vocationally registered. He retired fully in March 2013. His practising certificate lapsed later in 2013.
[7] Uncontrolled growth of abnormal cells contained in the skin's upper layers. It can become malignant if allowed to grow.
[8] A skin lesion that erupts in sun damaged skin. It is a benign lesion; however, as clinically it cannot be reliably distinguished from more serious forms of skin cancer, it is usually surgically removed.

that it had checked with the nurses, and that "neither of them discussed [the] pathology" with Mr A. It said that it is the medical centre's policy that nursing staff do not discuss pathology with patients. Mr A did not consult with Dr B again.

Subsequent events

21. On 12 August 2013 Mr A consulted Dr D for non-skin related matters. On 16 October 2013 Mr A consulted Dr D for review of several skin lesions on his lip, leg and hands.[9] On the same day, Mr A saw another staff member for treatment of lesions on his ears.

22. On 12 December 2013 a leg lesion was reviewed by Dr D and, on 20 February 2014, the ear lesions were reviewed (again by Dr D). Mr A was referred for punch biopsies of his ears in February 2014. The results of the biopsies were given to Mr A at the time of suture removal on 3 March 2014 by a GP. The medical centre said that Mr A did not mention any recurrence of the scalp lesion at these appointments, and so the histology report of 27 February 2013 was, therefore, unlikely to have been rechecked. No further consultations at the medical centre are recorded.

23. In response to the information gathered section of the provisional opinion, Mr A said that there was no reason for him to mention the lesion surgery because, as far as he was aware, there was no further issue relating to it and, at that stage, there was no physical sign of any recurrence and no pain associated with it.

Recurrence of scalp lesion

24. Mr A told HDC that the scalp lesion reappeared in October 2014 and he decided to see a specialist for further review. He was referred to a specialist at a private clinic. The specialist removed the skin lesion and sent it for a new pathology report. Mr A was informed by the private clinic that the report had come back positive for SCC, and that urgent surgery was required.

25. Mr A told HDC that he immediately contacted his new GP at the medical centre, to request the original pathology test report, and discovered that the report had recommended follow-up.

26. Mr A told HDC that since the diagnosis of SCC he has had seven operations to remove it and a large amount of his scalp removed down to his skull, along with skin grafts.

Further contact with Dr B

27. Dr B told HDC that he was later contacted by Mr A and advised of the "extensive spread of [the] SCC" which Dr B had partially excised two years earlier. Dr B recalls that he believed the lesion had proved to be benign. Dr B said that he apologised to Mr A for what had happened and resolved to determine what had caused the mistake.

[9] Dr D's clinical record notes that Mr A was worried about the return of a lesion he had had removed from his lower lip several years ago, and another skin lesion on his lower left leg. Dr D recorded that Mr A's dermatologist was advised.

Further information

28. Dr B said that he deeply regrets the omission. He said he did not read to the end of the 27 February 2013 report and "missed the last line which had recommended follow-up". Dr B told HDC that his usual practice was to remove stitches from wounds himself and discuss the pathology with the patient, and often he would give the patient a copy of the report. He said that had he fully read the pathologist's advice, he would certainly have made a note and advised Mr A of the results.

29. The medical centre accepted that Mr A should have been informed of the likely diagnosis (keratoacanthoma) and told to return for review if he had a recurrence of the lesion, and should have been advised to self monitor and report any changes. It said that "even if the report had been read correctly, the most likely advice would have been observation and review when/if the lesion reoccurred". The medical centre accepted that "[Mr A] would probably have sought medical attention more quickly had he known of the potential for a more serious diagnosis". The medical centre noted that the cancer was highly aggressive and present deep in the scalp; however, the histology did not suggest this in February 2013, and when the lesion became apparent on the scalp again, it had spread locally.

Medical centre policies

30. The medical centre provided HDC with a copy of its Management of Patient Test Results and Medical Reports policy which was in place at the time of Mr A's scalp excision. The policy states that incoming medical reports/lab test reports are to be seen and actioned by the practice team member who requested them. The patient's GP or practice nurse reviews each report and actions and notes it on a daily report, and then files the report. The policy then states:

> "The staff member responsible logs appropriate action (e.g. discussed with/patient informed) on the patient inbox or daily record."

31. The policy states that reports requiring urgent attention are to be entered on the task manager computer system with appropriate comments and timeframe. This "prompt" is to be marked as completed on completion. Reports of significant importance are tracked in this manner and entered into a specific register for the practice nurse to track fortnightly and report to the patient as and when necessary.[10]

32. The medical centre told HDC that following Mr A's complaint, the medical centre changed its process for managing pathology report results. It said:

> "In regard to anatomic pathology, the staff member responsible for the biopsy or excision must attend the patient at the time of wound review or suture removal and discuss the pathology result with the patient, whether they are normal or otherwise. In the event that the staff member is unable to do this, it will be done by a nominated deputy."

[10] The policy also states that patients will be informed about the process used for notifying them about their test results.

33. The medical centre also told HDC that it has put up notices in its waiting room advising patients of their right to telephone the practice to double check test results.

Responses to provisional opinion

34. Mr A's response to the "information gathered" section of the provisional report has been incorporated into the opinion where appropriate.

35. Mr A said that he takes care of himself and is proactive with regards to his health and fitness. He said: "I am not the sort of person to ignore signs or [a] doctor's advice" and that he had been led to believe that all was well. He also said:

> "I live with [Dr B's lack of care] daily. My scalp is tissue paper thin where the skin graft has adhered…It is damaged incredibly easily and has required that I stop numerous sports that I love because of it. I have to wear a hat always if outside and I am now bald whilst previously I had a full head of hair…This is very much an on-going trauma in my life and that of my family."

36. Dr B told HDC that he accepts the provisional opinion.

37. The medical centre said it accepted the provisional opinion and agreed to do an audit, as recommended by the Commissioner. It added: "…we think that it will be a useful exercise."

Opinion: Dr B — Breach

38. In February 2013 Mr A consulted Dr B regarding a skin lesion on his scalp. Dr B told HDC that he advised Mr A that the lesion might be SCC however Mr A told HDC that Dr B did not mention to him that the lesion might be SCC. The clinical note states "Has ? SCC on scalp…". Given the different accounts I am unable to make a finding regarding what Dr B told Mr A about the lesion.

39. The lesion was excised and the sample was sent for analysis. My expert advisor, GP Dr David Maplesden, advised me that Dr B's initial management of Mr A's scalp lesion was appropriate: Dr B suspected the lesion was an SCC and excision biopsy was an appropriate strategy.

40. The histology report of 27 February 2013 stated:

> "Diagnosis:
> SKIN LESION SCALP FEATURES CONSISTENT WITH A KERATOACANTHOMA
>
> Comment: Due to the histological similarity of Keratoacanthoma and
>
> [page 2]

> squamous cell carcinoma and incomplete excision at the deep margin
> follow up would be advisable."

41. Dr B saw that the lesion was a keratoacanthoma, a benign skin condition, and therefore did not contact Mr A to tell him the result. Dr B failed to read the full report and did not notice the advice to follow up. Dr B has taken full personal responsibility for his failure to read the entire histology report, in particular the comments regarding follow-up.

42. The report was filed and Mr A was not contacted with the results, and was not advised about the need for follow-up or what to do should the lesion re-occur, nor was follow-up organised for Mr A by Dr B.

43. Mr A consulted other staff at the medical centre several times later in 2013 and in 2014 for review and treatment of other lesions. In October 2014 Mr A's scalp lesion reappeared and he decided to see a specialist for further review. A further biopsy and histology report was obtained which came back positive for SCC. Mr A required urgent surgery and subsequently he has had seven operations to remove the SCC and a large amount of his scalp removed down to his skull, along with skin grafts.

44. Dr Maplesden advised me that Dr B's failure to convey to Mr A information regarding the nature of his lesion, the incomplete excision and the need for regular review of the operation site, and/or that some vigilance was required to detect recurrence of the lesion at an early stage, was a departure from expected practice. Dr Maplesden stated: "I would not regard the February 2013 histology report as 'normal' even though the lesion was apparently benign. The incomplete excision meant there was an increased risk (albeit small) of recurrence and the pathologist advice emphasised the need and rationale for follow-up … the patient should have been made aware of this." Dr Maplesden further stated that Dr B's failure to put in place some form of review was also a departure from accepted practice.

45. As this Office has stated previously, doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal results.[11] As stated in a previous case:[12]

> "Dr B did not inform Mr A that the ultrasound report suggested follow-up investigations — namely an FNA [fine needle aspiration] at the time, or a follow-up ultrasound four weeks later. In my view, the equivocal nature of the ultrasound report diagnosis and the suggested follow-up investigations indicated a degree of uncertainty about the diagnosis of the lump."

46. In this case I consider that the comment in the histology report, "due to the histological similarity of keratoacanthoma and squamous cell carcinoma and incomplete excision at the deep margin follow up would be advisable", indicated a level of uncertainty about the diagnosis and was information that a reasonable

[11] See, for example, 10HDC01419, 12HDC00413 and 14HDC00132, available at www.hdc.org.nz.
[12] 13HDC00031 available at www.hdc.org.nz.

consumer in Mr A's circumstances would expect to receive. I therefore find that, by failing to provide Mr A with the information contained in the histology report, Dr B breached Right 6(1)(f) of the Code. Mr A returned to the practice on a number of occasions before the SCC was diagnosed, but the care provided did not include any review of his scalp. Had Mr A known of the histology result he would have been in a position to be a more active partner in his own care, in particular to ask to have his scalp checked by clinical staff or to seek attention at an early stage when the lesion reappeared.

47. In addition, Dr B failed to exercise reasonable care and skill in reading the histology report and not arranging the follow-up care that had been recommended, and therefore also breached Right 4(1) of the Code.

Opinion: Medical centre — No Breach

48. During the period under investigation Dr B was an employee of the medical centre. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), employing authorities are vicariously liable for any breach of the Code by an employee. Under section 72(5) of the Act, an employer is liable for acts or omissions by an employee unless the employer proves that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

49. As commented on in a previous case, medical centres have a responsibility to have in place good systems to ensure that patients receive good quality care. In particular, they are responsible for having effective policies for the handling of incoming results and patient follow-up.[13] It is essential that those systems are robust and support clinicians in providing good quality care. The Royal New Zealand College of General Practitioners' document, "Aiming for Excellence",[14] states that practices should have an "effective system for the management of clinical correspondence, test results, and other investigations".

50. My expert, Dr David Maplesden, advised me that the medical centre's policy regarding the handling of laboratory results (which was in place at the time of these events) is robust and consistent with policies reviewed from other practices. I am satisfied that the medical centre's systems regarding the handling of laboratory results were adequate, and I consider that the failure to read the report fully, inform Mr A of the results, and follow up the results, was Dr B's alone. Accordingly, I do not find the medical centre directly liable or vicariously liable for Dr B's breaches of the Code.

[13] See Opinion 10HDC01419 available at www.hdc.org.nz.
[14] "Aiming for Excellence". RNZCGP Standard for New Zealand General Practice 2011–2014. The Royal New Zealand College of General Practitioners, Wellington, 2011.

Recommendations

51. I recommend that Dr B apologise in writing to Mr A for his breaches of the Code. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

52. I recommend that, within three months of the date of this report, the medical centre conduct an audit of its patient records dated from the beginning of 2013 that contain abnormal test results, and check whether there are any outstanding histology reports requiring follow-up. This is to ensure that all patients have been informed of those results and, if necessary, have had appropriate follow-up organised. The medical centre should report back to HDC with the results of the audit within three months of the date of the final report.

Follow-up actions

53.
- 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 the district health board, 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 sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from GP Dr David Maplesden on 26 May 2015:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Mr A]; response from [Dr C], Medical Director [the medical centre]; [the medical centre's] clinical notes. [Mr A] complains that in February 2013 [Dr B] removed a skin lesion from his scalp. [Mr A] was told he would be notified if the lesion was of any concern. He heard nothing and was therefore reassured. In October 2014 the lesion had regrown and he saw a specialist who removed the lesion. Histology revealed an aggressive squamous cell carcinoma (SCC) and [Mr A] has required extensive surgery to the area to ensure total removal of the lesion. He states he has been told he would not have required such surgery had the lesion been treated appropriately from the outset.

2. [Dr C] notes [Mr A] had a lesion excised from his scalp by [Dr B] on 19 February 2013. The provisional diagnosis prior to excisions was possible SCC. The histology report was received on 27 February 2013 and evidently read and filed by [Dr B] that day although no notes were made. The histology was keratoacanthoma[1] (KA) with positive deep margins and the pathologist advised follow-up. [Dr B] does not recall reading this advice. [Mr A] had wound follow-up with practice nurses and his recovery was uneventful. Over the next 12 months he attended other doctors at the practice with various skin lesions but no attention was drawn to the scalp lesion and [Mr A] evidently did not enquire further after the result. There was therefore no indication for other doctors to review the filed result. [Dr C] assumes [Mr A] had rapid regrowth of the scalp lesion later in 2014 and this led to him seeing a specialist. [Dr C] notes [that Dr B] has apologized in person to [Mr A] regarding the failure to notify him of his histology result. Since this incident [the medical centre] has altered its results policy so that all histology results are discussed with patients when they return for removal of sutures. The practice also has notices in the waiting room explaining that patients have a right to ring for any results.

3. The response is consistent with clinical notes. [Mr A's] scalp lesion was removed on 19 February 2013 by [Dr B]. There was practice nurse follow-up on 21 February and 1 March 2013. There is no documentation to suggest histology results were discussed. The formal histology report summary was written as: *SKIN LESION SCALP. FEATURES CONSISTENT WITH KERATOACANTHOMA. Comment: Due to the histological similarity of keratoacanthoma and squamous cell carcinoma and incomplete excision at the deep margin follow up would be*

[1] Keratoacanthomas (KAs) are relatively common benign skin growths from the cells surrounding the hair unit that usually appear in sun exposed skin. Clinically they can't be easily differentiated from a more serious skin cancer, a squamous cell carcinoma (SCC) and are often excised to confirm the diagnosis. KAs grow quickly over the first few weeks but do not spread to other parts of the body. They may resolve spontaneously after several months (adapted from British Association of Dermatologists patient information leaflet available at http://www.bad.org.uk/shared/get-file.ashx?id=96&itemtype=document)

advisable. [Mr A] had his next consultation with provider [Dr D] on 12 August 2013 (prostate check) and review of several skin lesions (ears, lip, left leg and hands) on 16 October 2013. There is no reference to complaint of a scalp lesion on these occasions. On 12 December 2013 the left leg lesion was again reviewed and on 20 February 2014 the ear lesions were reviewed (both consultations with [Dr D]) and [Mr A] referred for punch biopsies of the ears (24 February 2014 — provider [initials]). Results of the biopsies (benign solar keratosis) were given to [Mr A] at the time of suture removal on 3 March 2014. There was no reference to a scalp lesion at these consultations and no further consultations at [the medical centre] are recorded.

4. [Mr A] was either referred to a specialist by another GP or self-referred. There is no documentation on file regarding the referral and subsequent management other than four histology reports. The first report regarding a scalp lesion removed on 13 November 2014 noted a cystic lesion associated with moderately differentiated squamous cell carcinoma but multiple positive margins. The second report on scalp tissue removed on 3 December 2014 reports invasive squamous cell carcinoma, poorly differentiated and involving margins. Pathologist comment includes: *This tumour involves the entire deep aspect of the specimen. The tumour appears to be tracking along the subcutaneous tissues ….* The third sample was removed on 22 December 2014 and showed foci of squamous cell carcinoma, widely completely excised. The final report dated 26 February 2015 notes removal of three benign lesions (intradermal naevi) from the scalp.

5. Comments

(i) Initial management of [Mr A's] scalp lesion was appropriate. [Dr B] suspected the lesion was a SCC and excision biopsy was an appropriate strategy. The histology result was somewhat reassuring noting presence of a benign lesion (KA) but that the lesion had been incompletely excised. I think a majority of my peers would have been reassured that the diagnosis was a benign lesion, and would have adopted a 'watch and wait' approach having discussed this with the patient. This might have involved instructing the patient to promptly report any signs of recurrence of the lesion and to review the operation site opportunistically or on a pre-scheduled basis, and to undertake or arrange re-excision of the lesion if there was any sign of recurrence. A reputable local dermatology website advises: *If keratoacanthoma recurs, it should be treated again … Patients with keratoacanthomas are at risk of further similar lesions and other skin cancers.*

(ii) I do not have sufficient information to determine the SCC removed from [Mr A's] scalp in November 2014 was directly related to the incomplete removal of his KA in February 2013 noting patients having KA are at risk of developing other skin cancers. The precise categorisation and natural history of KA are debated eg a 2010 review article[2] was summarised as: *The keratoacanthoma and its variants are clinically and histologically heterogenous. Some consider the keratoacanthoma to be benign, whereas others classify it as a subtype of squamous cell carcinoma. The keratoacanthoma is generally treated rather than*

[2] Ko C. Keratoacanthoma: facts and controversies. Clin Dermatol. 2010 May–Jun;28(3):254–61

observed for spontaneous resolution. This hampers evaluation of the true natural history of lesions diagnosed as keratoacanthoma. In addition, studies have not found a reliable marker to differentiate keratoacanthoma from squamous cell carcinoma. It currently remains unclear how the keratoacanthoma relates to squamous cell carcinoma, and continued investigation is necessary. A more recent article[3] attempting to clarify the natural history of KA after partial biopsy (as occurred in [Mr A's] case) noted the regression rate of lesions identified as 'true' KA was 98.1% but the progress of some lesions also indicated that *KA is biologically unstable, and some KA tend to evolve into conventional SCC with a gradual loss of the capacity for the spontaneous regression*. If [Mr A's] SCC was related to his original KA, and assuming the original histology was accurate, it appears the evolution of the lesion into an aggressive SCC was somewhat unusual and not foreseeable.

(iii) Taking into account the discussion above, I think it was reasonable that [Dr B] did not immediately re-excise the lesion on [Mr A's] scalp. However, his failure to convey to [Mr A] information regarding the nature of his lesion, the incomplete excision and the need for regular review of the operation site, and/or that some vigilance was required to detect recurrence of the lesion at an early stage, was a departure from expected practice. In 2013 I would expect the practice to have had a policy in place regarding management of laboratory results as per the guidance provided by the RNZCGP in 2005[4]. It is not uncommon practice for patients to be told that normal results will not be notified but this should be accompanied by the verbal or written reassurance that they are able to obtain their results whatever the outcome. I would not regard the February 2013 histology report as 'normal' even though the lesion was apparently benign. The incomplete excision meant there was an increased risk (albeit small) of recurrence and the pathologist advice emphasised the need and rationale for follow-up. As discussed above, the patient should have been made aware of this.

(iv) I feel the failure by [Dr B] to discuss with [Mr A] the histology results of February 2013, and to have put in place some form of review, was a moderate departure from expected practice. A mitigating factor is the apparent benign nature of the lesion although an aggravating factor is the fact pathologist advice was either overlooked or ignored. It is not clear when recurrence of [Mr A's] scalp lesion first became apparent — the lesion was evidently not mentioned to providers [Mr A] saw at [the medical centre] in the year following the excision despite him bringing other skin lesions to their attention over that time. It therefore remains unclear whether, even had a follow-up process been in place, there would have been significantly earlier detection and management of recurrence of the lesion. I note [Dr B] has now retired from general practice and that he has personally apologised to [Mr A]. [Mr A's] main concern is that there is no repeat of the incident he suffered and I feel the remedial measures documented

[3] Takai T, Misago M, Murata Y. Natural course of keratoacanthoma and related lesions after partial biopsy: Clinical analysis of 66 lesions. J Derm. 2015;42(4):353–362

[4] RNZCGP. Managing Patient Test Results MINIMISING ERROR. 2nd edition 2015. Available at: http://www.rnzcgp.org.nz/assets/documents/Publications/College-Resources/Managing-Patient-Test-Results-July-2005.pdf

in [Dr C's] response (consistent notification of histology results to the patient irrespective of the nature of the result) will achieve this goal.

(v) In terms of the role of the [new GP] in monitoring of [Mr A's] excision site, I would expect the new GP to familiarise himself with the patient's current medical history, prescriptions and allergies and any past medical history requiring ongoing monitoring or having a bearing on current health issues. However, I would not expect the new GP to proactively review the patient's historical lab results. There is some trust that a colleague will adequately record relevant health issues and, if keratoacanthoma had been previously recorded in the narrative records as a diagnosis, I would not expect this to 'ring alarm bells' with respect to a need for formal surveillance, such pathology usually being regarded as benign as previously discussed. There would also be the reasonable assumption that a previous GP would have acted appropriately on any pathologist recommendations, and that the patient would have been instructed to promptly report any signs of recurrence of a previously excised skin lesion, or that the patient might do that of their own volition. Unfortunately it appears [Dr B's] management may have been deficient with respect to these issues as previously discussed.

(vi) If [the medical centre] did not have a robust policy in place for management of laboratory results in place at the time of the events in question I would regard this as a mild to moderate departure from expected practice. I note the practice states it does currently have such a policy and it would be reasonable if this was submitted to the Commissioner for review."

The following further advice was received from Dr Maplesden on 28 July 2015:

"I have reviewed the [the medical centre's] policy on handling of lab results. This policy is current and was in place at the time of the events in question. The policy is robust (if followed) and is consistent with such policies I have reviewed from other practices. The submission of the policy means point 5(v) of the comments in my original advice has been resolved. All other comments are unaffected."

Appendix B: Pathology report

Inbox Report

Patient:
Subject: Histology
Reference: labtests

DOB:
Date: 19 Feb 2013

HISTOLOGY

HISTOPATHOLOGY

Specimen:
SKIN LESION SCALP

ose Description:
The specimen consists of a skin ellipse 23 x 17 x 7 mm with a central
keratotic nodule 12 x 13 mm.
2 s

Microscopy:
Sections show skin without deep dermis or subcutaneous tissue. The
nodule is a crater-like, papillary, hyperkeratotic and parakeratotic
squamous lesion. Irregular branching cords of keratinocytes with
abundant glassy cytoplasm extend into the upper and mid dermis. The
dermis adjacent to the lesion is focally scarred and infiltrated with
lymphocytes. The appearances are consistent with a keratoacanthoma.
cision is incomplete at the deep margin.

Diagnosis:
SKIN LESION SCALP
FEATURES CONSISTENT WITH A KERATOACANTHOMA

Comment: Due to the histological similarity of keratoacanthoma and

Inbox Report

squamous cell carcinoma and incomplete excision at the deep margin
follow up would be advisable.

Reported By:
Anatomical Pathologist
Mob No:
DDI No:
Office Date:

rdered by:
Laboratory:
Observation date:

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.