General Practitioners, Dr B and Dr C

A Report by the

Health and Disability Commissioner

(Case 02HDC13523)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Dr B	Provider / General Practitioner
Dr C	Provider / General Practitioner
Ms D	Practice Nurse
Dr E	Head and Neck Surgeon / Otolaryngologist
Dr F	General Surgeon
Dr G	General Practitioner

Complaint

On 23 September 2002 the Commissioner received a complaint from Mr and Mrs A about services provided by Dr B and Dr C. The complaint was summarised as follows:

During March and April 2002, Dr B, general practitioner, did not provide services of an appropriate standard to Mr A. In particular:

- *Dr B did not undertake adequate investigation of a visible lump in Mr A's neck, although routine tests were inconclusive.*

In July 2002 general practitioner Dr C did not provide services of an appropriate standard to Mr A. In particular:

- *Dr C inappropriately advised Mr A that he was able to perform surgery in his rooms to remove the lump from Mr A's neck, rather than conducting further tests or referring him to a specialist*
- *Dr C inappropriately commenced an operation to remove a lump from Mr A's neck, during which he severed one of Mr A's saliva glands*
- *Following the failed surgery, Dr C did not organise an urgent referral for Mr A to a specialist*
- *Dr C inappropriately suggested that Mr A be referred to surgeon Dr F for further treatment, rather than referring him for assessment by an ear, nose and throat specialist.*

An investigation was commenced on 11 December 2002.

Information reviewed

- Complaint material from Mr and Mrs A
- Information from Dr B
- Information from Dr C
- Information from practice nurse Ms D
- Medical records and information provided by Dr E, head and neck surgeon/ otolaryngologist
- Medical records and information provided by Dr F, general surgeon
- Medical records provided by Dr G, general practitioner

Independent expert advice was obtained from general practitioner Dr Niall Holland.

Information gathered during investigation

Initial consultation/Dr B
On 13 March 2002 Mr A consulted Dr B at a surgery for a persistent cough. At that time Dr B was an associate of the surgery, together with Dr C and Dr G. Dr B is now the sole director of the surgery, and continues to provide services from the surgery.

Dr B prescribed a ten-day course of antibiotics. Mr A stated that, after taking the course of antibiotics, he noticed a swelling/lump in his neck and thought that his glands might be swollen.

On 19 April 2002 Mr A consulted Dr B about the swelling in his neck. Mr A recalled that Dr B did not express any particular concern about the swelling, or express an opinion as to the cause. Dr B recommended routine blood tests and a throat swab.

Dr B recalled that Mr A consulted him for a routine follow-up treatment to lesions on his skin. Mr A also mentioned a lump in the right side of his neck, with no associated symptoms. Dr B advised that after examination he considered the lump was suspicious of malignancy. He stated:

> "I examined the lump, which was approx 0.5cm by 0.5cm, lateral to the upper part of the larynx. It appeared tethered to the underlying tissues, and was clinically suspicious of malignancy.
>
> I discussed the implications of investigation of this lesion with [Mr A] at the time, and we agreed to arrange for some blood tests in the first instance. It was agreed between us that [Mr A] was to ring me to discuss the test results, and on review of these tests with [Mr A], I was to arrange an ENT follow-up."

Dr B's medical notes for 19 April state:

> "Hx: Hard R j-d node. ?Tethered to di-gastric muscle. LN2 to 2× s-k lesions dorsum of R hand.
>
> → : ENT REFERRAL.
> → : ? FNA
> → lab: FBC
> → lab: ESR
> → lab: Throat swb."

Mr A did not recall any discussion about the purpose of the tests. Mr A stated that he did not know the purpose of the tests, and Dr B advised him to "ring back for the results".

Dr B stated:

> "I was trying to exclude common haematological and infective causes of laryngeal adenopathy, as a means of triage, in order to ascertain the best service for [Mr A] to be referred to."

When Mr A telephoned the following week to check the test results, the practice nurse advised him (correctly) that the blood test results were normal. Dr B was not made aware by the practice nurse at that time (or afterwards) that Mr A had contacted the surgery. Dr B stated that, as a consequence, Mr A's test results were not discussed as they had agreed.

Following Mr A's discussion with the practice nurse about his test results, he received no further communication from the surgery staff or Dr B. Dr B did not arrange an ENT referral for Mr A, or take any further action in relation to his care. He did not ascertain from his staff whether Mr A had called. Dr B stated:

> "This conversation was not reported to me by the Practice Nurse, nor was the file drawn to my attention, as I would have expected to occur at that time, in order to organize a referral."

Dr B explained that the system in place at that time in relation to test results was as follows:

> "Test results were downloaded into our computer system, checked and filed by the Doctor concerned. If there were any recalls etc, then these were entered into a recall book, or into the computerised recall system by a Nurse or Doctor. If at the time of the consultation, there was a need for a recall, then this was entered at that time."

Dr B added that the results were "automatically" downloaded onto the computer, and confirmed that he checked Mr A's results himself. He advised:

> "I did consider that there was a possible need for follow-up, and I printed a consultation slip for him with a message on it to myself to follow things up. This I then placed in my in-tray. After a normal length of time, with a normal blood film, a low likelihood of

> significant problems, and no known word from [Mr A], I discarded the slip, presuming all was well.
>
> I found nothing abnormal on the test results, and was relying on the consultation slip, and the advice that I had given [Mr A] re follow-up, to remind me."

Mr A assumed that the nurse had spoken to Dr B or looked up his file. He did not see any particular reason to speak to Dr B directly and assumed that there was no reason for undue concern after receiving advice that his results were normal.

Former practice nurse Ms D remembered Mr A as a patient but did not recall discussing his blood test results. Ms D confirmed that generally there were two nurses present, and that reception staff did not give out test results.

Ms D commented that for other doctors in the practice, normal results were usually given directly to patients on request, unless there was something documented to state otherwise. Dr B usually gave out all test results directly to patients himself. If tests required follow-up, Dr B would note this in the recall book. Alternatively, he would print out the result and give it directly to a nurse with verbal and written instructions if immediate action was required. Ms D advised that there was nothing on the computer record to alert nursing staff to take any further action in relation to Mr A's test results.

According to Dr B, the other practice nurse has no recollection of the incident.

Initial consultation/Dr C

On 13 July 2002 Mr A returned to the surgery, as the lump had increased visibly in size, and this time consulted with Dr C. (Mr A stated that Dr B was the main doctor he saw at the practice, although he did not go very often and used to consult whoever was available.)

Dr C recommended removal of the lump, and advised that he could do it himself at the surgery, or he could refer Mr A to a specialist. Dr C told him that it was a simple procedure to remove the lump, which would then be tested for malignancy. Dr C was totally confident in his ability to perform the proposed procedure. Mr A made an appointment with Dr C for the following week.

Dr C confirmed that he observed a lump in Mr A's right upper cervical region:

> "On initial consultation, the lump appeared to be mobile and sit in the posterior triangle under the superficial layer of the deep cervical fascia."

Dr C advised that Mr A's medical records indicated that he had previously been referred by Dr B to an ENT specialist for further investigation of the lump. Dr C discussed the matter with Mr A:

> "We both agreed that the referral was probably still on the waiting list. We also discussed the other options available that included [private] specialist referral.

> We believed [Mr A] had been referred however [Mr A] indicated he wanted to have the surgery done sooner at the surgery rather than on the waiting list."

Dr C did not discuss Mr A's ENT referral with Dr B or have any communication with him about Mr A's condition. (This was confirmed by Dr B.) Dr C explained that this was because the consultation occurred on a Saturday, and Dr B was not present.

Dr C was very concerned and discussed with Mr A the possibility of metastatic disease. Dr C recalled that he discussed management of the lump and recommended biopsy and referral to a specialist. He stated:

> "When the lump was noted, I discussed with [Mr A] the options and he agreed to me performing the biopsy. I believe this was the most definitive action I could take, as I did not think alternative investigations would be helpful, particularly in view of the lump being potentially malignant."

Dr C stated that the nature of the lump and the proposed surgery were fully discussed, together with an explanation of the benefits and potential risks. This included the risks of injury to adjacent vessels and tissues, and scarring and infection. He explained that the proposed surgery was a biopsy of the enlarged lymph nodes:

> "This was to help reach a diagnosis but not intended to remove the lump. The option of a FNA [fine needle biopsy] was discussed but it was felt the chances of getting a better sample via biopsy were higher."

Mr A denied that there was any discussion of risks or alternative options for treatment.

Dr C's medical notes state:

> "13/07/2002: (HK) RIGHT CERVICAL NODES, ? NATURE.
>
> Hx: Right upper cervical lymph nodes increasing in size for the past 6 months. No other complaints noted. No signs of infection being identified.
>
> OE: 3.5 × 5cm lymph nodes noted, deep in right upper cervical area, mobile, no tender.
>
> Throat; nad.
>
> Ear: nad.
> → :For excisional biopsy next Thursday."

Dr C advised me that his experience and training is as follows:

> "I was senior general surgical trainee with seven years of surgical experience including neck, thoracic and abdominal surgery before I came to New Zealand in 1995."

Dr C further advised that his surgical training was in the medical system overseas. During this period he was rotated between different specialities within the hospital surgical

department, including "general surgical, head/neck surgery and orthopaedics". This also included minor surgical procedures at outpatient hospital facilities, including (as a matter of routine) cervical lymph node biopsy. Dr C stated that, since his arrival in New Zealand:

> "I had attended quite a lot of surgical procedures while I was in [a public hospital] as a Senior House Surgeon in the O & G and Orthopaedic Hand Teams. I was on the waiting list for a minor surgery training course organised by […]."

Dr C explained that the surgery has a dedicated minor operation room. "This has a minor operation set up and includes resuscitation facilities." Dr C advised that the equipment available to control any bleeding he encountered during surgery was as follows:

> "There was a suction device, O2 [oxygen] IV fluids and resuscitation trolley and varieties of straight/curve standard surgical clamps and stitches available to control bleeding in this room.
>
> Initially, I believed this was a superficial lump and that no deep vascular structures would be involved. For superficial bleeding, compression and clamping would be necessary for controlling bleeding. As above, suitable equipment to control superficial bleeding was available."

Surgery

On 18 July Mr A attended Dr C at the surgery for the proposed biopsy surgery. Mr A recalled that Dr C administered local anaesthetic and made a deep incision in his neck. There was a lot of blood and Dr C "cut and thrust and pulled" for about 20 minutes. Afterwards Dr C said that the lump was too deep, but that he had a "really good go at it". Mr A was surprised when Dr C told him that he was not able to get the lump out. Mr A was also concerned that during the attempted biopsy, Dr C cut through a saliva gland, which later had to be removed.

Dr C stated that in the early stages of the procedure he realised that the lymph nodes were too deep and abandoned the biopsy. Dr C discussed this with Mr A and it was agreed that Dr C would refer Mr A to a private general surgeon.

Dr C's medical notes for 18 July stated: "Attempted to excisional biopsy – failed. → Ref: [Dr F]." Dr C stated:

> "The incision I made was about 3.0cm down the mastoid process, 2.5cm lateral to the angle of the mandible [the outer edge of the lower jaw] along the sternomastoid muscles [muscles extending from the skull to the clavicle and sternum, which rotate the neck and flex the head] and was about 2.0cm long. Upon entering the subcutaneous tissue, I noticed that the lymph nodes were deep under the sternomastoid muscles and probably along the deep cervical neurovascular space. At this point I told [Mr A] that the lymph node was too deep for me to biopsy."

Dr C was not assisted by a nurse at the time of surgery. Dr C advised that other medical staff were available if necessary, including Dr G and the practice nurse.

Dr C advised me that he no longer performs this procedure in his surgery. With regard to the injury to Mr A's parotid gland, Dr C stated:

> "As I recall the procedure was straightforward and I do not recall injuring the parotid gland. The incision I made was a few centimeters below the angle of the mandible and very unlikely to have been able to involve the tail of the parotid gland."

As noted above, following the abandoned biopsy, Dr C recommended a referral to a general surgeon, Dr F. Mr A recalled that Dr C said that Dr F would contact him directly. He does not know if Dr C actually sent a letter of referral. Mrs A eventually contacted Dr F directly to organise an appointment. (Mr A received an appointment with Dr F on 31 July 2002.)

Dr C advised that he did write a referral letter to a private specialist, general surgeon Dr F. Dr C stated:

> "I was not aware there was a delay in being seen by the General Surgeon privately. If I had been aware of it I would have made further arrangements for him to see another surgeon urgently."

Dr C provided copy of the letter of referral, dated 18 July 2002 (the date of the abandoned biopsy surgery). The letter requests Dr F' opinion and that he "arrange to see" Mr A, and includes the relevant medical notes.

Subsequent surgery
Mr A saw general surgeon Dr F on 31 July 2002 (almost two weeks after the attempted biopsy). Dr F immediately referred Mr A to Dr E, head and neck surgeon/otolaryngologist. Mrs A stated:

> "After several weeks of waiting for an appointment to arrive I prompted the Doctors office several times before we finally had an appointment. This was a waste of time, as the referred Doctor then sent [Mr A] on to an ear nose and throat specialist."

Dr F, general surgeon, advised that "upon reading the letter and assessing the problem I realised this referral had come to the wrong specialist". Dr F also noted that Dr C's notes mention an ENT referral, and that it appeared Dr C may have intended an ENT referral.

Dr C confirmed that he intended to refer Mr A to a general surgeon. He stated:

> "In my experience biopsies of the neck and shoulder region are often seen by General Surgeons. With hindsight I accept that it may have been more appropriate for an ENT Surgeon to see [Mr A] first."

Dr E performed a fine needle biopsy on 5 August 2002 and a CT scan of the chest and neck. Dr E operated on 13 August to remove suspicious neck nodes. During the surgery he removed an induration (thickening) of the tail of the parotid gland, which he presumed was associated with the previous operation:

> "[I]t was appropriate that anything associated with the previous incision be excised including any thickening in deeper tissues, such as the tail of the parotid gland."

Histology of the neck lymph nodes confirmed the presence of cancer. A further tumour was found in Mr A's right tonsil and was removed in another operation. Mr A subsequently underwent an intensive course of radiotherapy and chemotherapy.

Independent advice to Commissioner

Advice concerning Dr B
The following expert advice was obtained from Dr Niall Holland, general practitioner, concerning Dr B:

> "I have been asked to provide an opinion to the Commissioner on case number 02/13523/…, and I have read and agree to follow the Commissioner's Guidelines for Independent Advisers.
>
> …
>
> **Expert Advice Required**
>
> To advise the Commissioner whether, in your professional opinion, the services provided by [Dr B] comply with professional and other relevant standards. In particular, please advise:
>
> *Given [Mr A's] presenting symptoms on 19 April 2002, and [Dr B's] opinion that the lump was suspicious of malignancy, what further investigation/action was appropriate at that time?*
>
> I note that [Dr B] describes the lump as being 'approx 0.5cm x 0.5cm'. This statement appears to be from his later recollection, as the size is not described in his notes made on 19 April.
>
> Usually, by the time a patient brings it to the general practitioner's attention, a cervical gland infiltrated with cancer is larger than this (perhaps more in the order of 2cm x 1cm). This small size may have contributed to [Dr B's] decision to delay referral until he had more information from a blood test and a further examination to review the rate of growth of the lesion.
>
> In doing a blood test and throat swab, [Dr B] states he was 'trying to exclude common haematological and infective causes of laryngeal adenopathy'. This may suggest that the palpation of the node was not entirely characteristic of cancer. Nevertheless my impression from the notes is that [Dr B] did strongly suspect cancer.
>
> Other possible causes for such a lump might include a small sebaceous cyst or infection.

A cyst would be in the skin rather than attached to deeper tissues.

Local infection with reactive glands should also be considered (as it was by [Dr B]), but in this case glands do not usually have the same hard feel.

In either case the lump would not generally be '? tethered to di-gastric muscle' which is an important warning sign of cancer.

The lump might also reflect a systemic illness such as Hodgkin's Disease or a leukaemia. But generally other nodes and the spleen would show signs of involvement as well.

In general, cervical glands involved with cancer do have a characteristic hardness. An experienced general practitioner would usually have a high level of certainty that this was what the problem was, based solely on the physical examination. This also seems to have been true of [Dr B] at the time, since his notes indicate that he planned an ENT referral and considered a Fine Needle Aspirate (FNA) test. This test would have been very appropriate. A positive FNA would have triggered early referral and provided an incentive for the hospital or a private specialist to give [Mr A] a high priority to be seen.

[Dr B's] notes do not document whether he examined the region for a primary lesion. Once the suspicion of cervical lymph node involvement with cancer was raised, it would be usual to examine the mouth and the surrounding skin for any sign of a primary cancer.

No specific follow-up appointment was arranged. Rather the contact was to be by phone. Given the high suspicion of cancer, face to face contact in the surgery to review the results with the patient would be the optimum practice and both reduce the risk of loss of follow-up and ease the breaking of bad news to the patient.

What further investigation/action was appropriate following the receipt of [Mr A's] blood test results?

Options include any or all of the following:

1. Follow-up in the surgery to re-examine the node.
2. Referral to a laboratory (at no cost to the patient) for Fine Needle Aspirate
3. Referral to an ENT specialist.

What are the relevant standards relating to this complaint and did [Dr B] comply with those? If [Dr B] deviated from those standards, do you consider the deviation to the minor, moderate or major?

Standards regarding record keeping:

[Dr B's] notes are recorded by computer. They are well structured, legible and clearly outline the content of the consultation.

Standards regarding patient management:

Examination: While [Dr B] clearly had in mind that the node could be due to cancer, his records do not show that he did a local examination for a primary lesion or a general examination for a systemic illness. This is a minor deviation from the expected standard for general practice examination, as the critical management decision did not necessarily depend on the examination.

Diagnosis: [Dr B] considered the appropriate diagnosis when he examined [Mr A] and kept an open mind as to other diagnostic possibilities. This was appropriate.

Investigations: The choice of throat swab and a full blood count with ESR could be justified, provided a reliable system for follow-up was in place. A more complete set of tests would have also included an FNA test at the same time. This is fully funded so there is not a cost problem for the patient. The omission of the FNA at this time was not necessarily a failure to meet the appropriate general practice standard for investigation.

Follow-up: The possibility that the node was cancerous, and the fact that the management on 19 April was intermediate only, meant that a reliable system for follow-up was critical to achieving an acceptable standard of management.

Where the next management step may depend on finding a negative test result, as in this case, the risk of a system failure is very high. When perusing results it is natural to respond to positive results with an action to address the problem revealed. It is correspondingly easy to take no action in regard to negative results, especially when these may be conveyed to the patient by staff who cannot be expected to fully understand why the test was ordered.

[Dr B] appears to have relied largely on the patient to ensure that this follow up occurred. He does not seem to have had in place a system to ensure that he would be alerted to the need for further action. This was inadequate, as the possibility of patient denial or misunderstanding may render patient-driven follow-up unreliable.

[Dr B] did not have an adequate plan for the follow-up of these test results. This is a moderately serious omission, (though probably a common one in general practice).

The appropriate course of action would have been to arrange a follow-up appointment on 19 April, at the time of ordering the tests. An even better solution would have been to have a bring-up or recall process in place to ensure that follow-up occurred.

Are there any other matters relating to professional standards which you believe to be relevant to this complaint?

No.

General comments

It is easy to understand how this sort of error could occur in a busy surgery. It is often out of a wish to minimise the cost to the patient that a general practitioner will suggest phone follow-up. In my experience patients are often very reluctant to pay for follow up consultations.

Furthermore, despite the qualifications made above, the patient does hold a measure of responsibility to ensure follow-up happens as intended, particularly when the possibility of a serious cause such as cancer has been raised by the doctor.

This would be a good example to share with the profession for educational purposes, to alert doctors to the risks around test follow-up."

Advice concerning Dr C
The following expert advice was obtained from Dr Niall Holland, general practitioner, concerning Dr C:

"**Papers Received and Considered**

- Cover letter from HDC
- HDC Background paper
- Letter from [Mrs A] – To whom it may concern
- Letter from [Commissioner] to [Dr C]
- Letter from [Dr F] to HDC Office with copies of records and letters
- Notes from [the surgery] 19/4/02 to 20/9/02 and related correspondence
- Letters from [Dr E] to [Dr C] and operation report
- Letter from [Commissioner] to [Dr G]
- Various laboratory results

The Complaint

THAT [Dr C] did not provide services of an appropriate standard to [Mr A].
THAT he inappropriately advised [Mr A] that he was able to perform removal of a neck lump in his rooms.
THAT during this procedure he damaged a salivary gland.
THAT following this failed surgery he delayed in referring to a specialist.
THAT he referred inappropriately to a general surgeon rather than an ENT specialist.

Advice Required

Were [Dr C's] qualifications, experience and facilities appropriate to this surgery?

The neck is a complex part of the body containing a number of structures critical to life as well as nerves and glands that exist in close proximity to each other. Surgery in this area requires considerable skill and a very good understanding of the anatomy. It requires a bloodless field to ensure clear identification of all structures.

Few general practitioners have enough continuing practice at operating on this part of the body to maintain the necessary competence. Few of us have sufficient need to consider the details of the anatomy of the neck to remain well versed in the relationship of its various parts. Few practices have adequate cautery equipment to maintain a bloodless field. This is difficult to achieve with hyfrecation of the battery operated devices common in general practice [hyfrecation refers to the application of heat with a surgical instrument]. It requires the type of diathermy equipment usually only available in surgical suites. Good control of the bleeding would also usually require the presence of an assistant throughout the procedure.

[Dr C] states that he has had extensive relevant surgical experience overseas. However I do not know of any other general practitioners in New Zealand who would regard themselves as having the necessary (and current) experience and competence to operate in this region. Secondary care is readily available in all parts of New Zealand making general practitioner intervention for this type of problem unnecessary.

What was the intention of the surgery described as 'excisional biopsy'?

In a male over 50 a 'Hard R j-d node' as noted by ([Dr B]) who I presume to be [Dr B], is cancer until proved otherwise. [Dr C] appears to have also drawn this conclusion and recognised the need for some urgency in gaining a definitive diagnosis. This was clearly his intention in attempting to operate on the lump. Removal could not be curative as it is likely that by this stage other nodes would also be involved and the primary was still not identifiable.

Should [Dr C] have conducted further tests or referred to a specialist instead?

It is usual practice to first do a Fine Needle Aspirate (FNA) of lumps such as this. This procedure is available for general practitioners to order through the private pathology laboratories at no charge to the patient. While it can sometimes be of limited diagnostic value (as it turned out to be in this case) [Dr E subsequently performed a fine needle biopsy on 2 August 2002] because it does not reveal much of the architecture of the tissue biopsied, it does usually yield a good harvest of cells and these are frequently sufficient to make the diagnosis. It has the advantage of being readily available, without delay, and is a relatively non-invasive procedure.

I gather that the node was deeply placed in the anterior triangle of the neck, probably in the carotid triangle. The surgeon's notes indicate that it was in close proximity to the Accessory nerve and the Carotid Artery cannot have been far away. Working in this area requires the skills of a specialist.

What does 'excisional biopsy' entail?

'Excisional biopsy' refers to the *complete* removal of a lump or other lesion to gain a histological diagnosis. The whole (usually abnormal) structure is removed to send to a pathology laboratory. It differs from a 'biopsy' which usually samples just a small part

of the tissue of concern, leaving the main part of it to be dealt with once the biopsy result is available.

Given the location of the lump and its nature was it appropriate for [Dr C] to attempt excision in his rooms?

You will understand from the comments above that I do not believe this was appropriate. The risks are greatly outweighed by any benefits to be gained by the immediacy of the service [Dr C] was able to provide. Furthermore, as [Mr A] had private insurance, he would have been able to afford to see a private specialist to have this done and, ordinarily, would be unlikely to experience much delay in the private system.

What is the significance of the induration of the salivary gland noted and removed by [Dr E] and what does it imply about the surgery conducted by [Dr C]?

My guess is that this looked unusual to the surgeon and, while he assumed it to be damage arising from the previous attempt at surgery, he biopsied the area to be absolutely sure it was not the source of the metastatic disease in the lymph gland. It seems unlikely to me that the 'induration' would have led to any functional impairment of the salivary gland that would necessitate surgery.

It does appear likely that this was damage from the surgery performed by [Dr C] and does illustrate the risk of injury when operating on the neck in less than ideal circumstances. However it did not significantly harm the patient. Further clarification of these points, if considered necessary, would need to be gained from the surgeon.

Did [Dr C] take appropriate steps to arrange a specialist referral following the failed biopsy?

He wrote the referral letter on 18th July 2002, which, being a Thursday, appears to be the date of the failed excision. Therefore he seems to have moved speedily to arrange referral.

It is not clear how the patient was to be notified about the appointment with the specialist. Was the patient to make the appointment? In which case any delay would be of the patient's making. Was [Dr C] to arrange the appointment? This is quite common practice when the circumstances are unusual as in this case. Was the specialist to ring the patient with an appointment time? This would be unusual and is not requested in the letter. I cannot determine the answer to these questions from the material available to me.

There was a period of some 13 days between the letter written by [Dr C] to [Dr F] and the letter by [Dr F] to [Dr E].

Was it appropriate to refer [Mr A] to [Dr F] in the first instance?

It is not altogether clear whether [Dr C] referred [Mr A] to [Dr F] at the time because he mistakenly understood him to be an ENT specialist or whether he was in the habit of referring this type of problem to a general surgeon. The latter seems the most likely based on the response from [Dr C].

There is confusion at times as to whether to refer to a general surgeon or an ENT specialist for the management of lumps in the neck. Thyroid tumours are managed by general surgeons, vascular lesions by general or vascular surgeons and lumps arising from lymph nodes are managed by general surgeons in some parts of the country. This was an understandable mistake by [Dr C].

As it turned out, it was an inappropriate referral as the primary tumour was arising from the tonsil. [Dr C] was not to know this at the time of his referral, since the primary was not obvious until he had a detailed specialist examination.

What are the relevant standards relating to this complaint and did [Dr C] comply with these?

There are no specific prohibitions or standards that limit the scope of practice of general practitioners doing surgery under local anaesthetic. It is a matter for the individual doctor's judgement as to what is appropriate to do in the general practice office.

However, I think it would be fair to say that most general practitioners would regard anything but superficial (ie skin lesion surgery) in the neck to be beyond the scope of general practice. This is certainly not included in the description of procedures to be performed in general practice, covered by the commonly used texts by Prof John Murtagh.

Are there any other matters relating to professional standards relevant to this complaint?

I think all the relevant issues are covered above.

General

While there has been a regrettable delay in establishing the diagnosis for [Mr A], only a small part of this seems to be attributable to the actions of [Dr C]. Any delay he has caused will not have affected significantly the outcome for [Mr A]. Once the tumour had spread to the lymph node, achieving a good outcome for him was always going to be very difficult.

References

1. General Practice (2nd edition), John Murtagh, McGraw Hill 2001
2. Practice Tips, John Murtagh, McGraw-Hill Sydney 1992

3. Grant's Atlas of Anatomy J.C. Boileau Grant Fifth Edn. Williams and Wilkins, Baltimore 1962."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

…

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

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Opinion: Breach – Dr B

Right 4(4) of the Code requires services to be provided in a manner that minimises the potential harm to the patient. Where a general practitioner suspects malignancy and refers a patient for tests or specialist assessment, the practitioner needs to have an appropriate follow-up system in place.

Dr B correctly suspected that the lump he observed on Mr A's neck was clinically suspicious of malignancy. He requested blood tests and a throat swab to rule out other causes for Mr A's neck swelling. Dr B considered that referral to an Ear, Nose and Throat (ENT) surgeon might be appropriate following the results of the blood tests. It is not clear whether the proposed ENT referral was solely dependent on the results of the blood tests. However, it is not disputed that any planned ENT referral did not occur. Dr B's medical records also indicate that he gave consideration to a fine needle biopsy.

My advisor noted that Dr B clearly considered that the lump was suspicious of cancer. Dr Holland stated:

"In general, cervical glands with cancer do have a characteristic hardness. An experienced general practitioner would usually have a high level of certainty that this

> was what the problem was, based solely on the physical examination. This also seems to have been true of [Dr B] at the time, since his notes indicate that he planned an ENT referral and considered a Fine Needle Aspirate (FNA) test. This would have been very appropriate."

I note my advisor's comment that an examination for a primary lesion or general systemic illness should have occurred, but was not critical in terms of the general management.

Dr B's follow-up of Mr A's test results was inadequate. In a previous case (www.hdc.org.nz/99/HDC11494), I commented that GPs are required to have efficient systems for managing patient test results. The Royal New Zealand College of General Practitioners has since released a recent discussion document in relation to this area: "Interim advice on minimizing error in patient test results – a guide for General Practice".

I note that the onus for patient notification (by the doctor) is stronger when serious pathology is suspected, and that general practitioners must have efficient systems for managing patient test results.

Dr B advised me that the implications of the suspected lesion were discussed with Mr A and that there was an agreement to discuss the results directly with Dr B. However, Mr A explained that he did not have any particular reason to speak to Dr B and he was reassured by the advice of a normal result he received from the practice nurse. Consequently, he did not take any further action in relation to the swelling until July that year.

While I accept that some discussion of notification of results occurred, it appears this discussion was of a general nature and did not result in an understanding on Mr A's part of the potentially serious diagnosis.

The potential cancer diagnosis for Mr A required proactive follow-up. In my view, it was incumbent upon Dr B to ensure that he discussed next steps (such as specialist referral) following the negative blood test results, and that appropriate action followed. I agree with my advisor that the optimum practice would have been to arrange a specific follow-up appointment during the consultation of 19 April. My advisor stated:

> "The possibility that the node was cancerous, and the fact that the management on 19 April was intermediate only, meant that a reliable system for follow-up was critical to achieving an acceptable standard of management."

Dr B outlined the patient recall system in place at the surgery at that time. However, Dr B did not enter notification of Mr A's results into the practice recall system. He depended upon being alerted to Mr A's phone call by the practice nurse, without any instructions to his nursing staff about handling the results. My advisor commented:

> "Where the next management step may depend on finding a negative test result, as in this case, the risk of a system failure is very high. When perusing results it is natural to respond to positive results with an action to address the problem revealed. It is correspondingly easy to take no action in regard to negative results, especially when

> these may be conveyed to the patient by staff who cannot be expected to fully understand why the test was ordered.
>
> [Dr B] appears to have relied largely on the patient to ensure that this follow up occurred. He does not seem to have had in place a system to ensure that he would be alerted to the need for further action. This was inadequate, as the possibility of patient denial or misunderstanding may render patient-driven follow-up unreliable."

Dr B's explanation was as follows:

> "I did consider that there was a possible need for follow-up, and I printed a consultation slip for him with a message on it to myself to follow things up. This I then placed in my in-tray. After a normal length of time, with a normal blood film, a low likelihood of significant problems, and no known word from [Mr A], I discarded the slip, presuming all was well.
>
> I found nothing abnormal on the test results, and was relying on the consultation slip, and the advice that I had given [Mr A] re follow-up, to remind me."

This does not meet the required threshold of an efficient system for managing results or for proactive follow-up. There was an established system in place at the surgery. However, Dr B did not follow that system. Not only did Dr B not indicate to staff that follow-up on a negative result was required, he failed to recognise the significance of a note he had written to himself concerning Mr A and concluded, erroneously, that "all was well". There was no justification for considering that there was a "low likelihood of significant problems" when investigating a lump that he had noted to be potentially malignant.

As noted above, the investigations proposed by Dr B were generally appropriate. His initial suspicion of cancer was accurate; the swelling in Mr A's neck was indeed attributable to a malignant cancer. However, as a result of the failure to use adequate follow-up/recall procedures, Mr A was not referred to a specialist as planned. An earlier referral for specialist assessment would have resulted in earlier cancer treatment.

Although Dr B correctly considered the possibility of cancer and was considering a fine needle biopsy and referral to an ENT surgeon, in not following up the blood tests he ordered and in relying upon Mr A to contact him, Dr B did not provide services in a manner that minimised potential harm to Mr A. Accordingly, in my opinion Dr B breached Right 4(4) the Code.

Opinion: Breach – Dr C

Excisional biopsy
Under Right 4(1) of the Code, patients are entitled to services provided with reasonable care and skill. For general practitioners this requires a proper examination and assessment of the patient, and the offer of appropriate treatment. Any treatment should be undertaken in a safe environment, with appropriate resources to cope with any complications.

It is not disputed that Dr C offered to perform a biopsy on Mr A, or alternatively to refer him to a specialist. Dr C stated:

> "… I discussed with [Mr A] the options and he agreed to me performing the biopsy. I believe this was the most definitive action I could take, as I did not think alternative investigations would be helpful, particularly in view of the lump being potentially malignant."

Dr C explained that the proposed surgery was a biopsy of the enlarged lymph nodes:

> "This was to help reach a diagnosis but not intended to remove the lump. The option of a FNA [fine needle biopsy] was discussed but it was felt the chances of getting a better sample via biopsy were higher."

Dr C stated that he considered and discussed with Mr A the option of a fine needle biopsy. In contrast, Mr A stated that there was no discussion of alternative treatment options. In these circumstances, I am not able to reach a determination as to whether this discussion occurred. There is certainly no record of such a discussion, and a fine needle biopsy did not occur.

My advisor stated that it is usual practice to initially perform a fine needle aspirate (FNA) of lumps in such circumstances, although it does not always provide a determinative diagnosis. However, "[i]t has the advantage of being readily available, without delay, and is a relatively non-invasive procedure."

Dr C's medical notes refer to the procedure as an excisional biopsy. My advisor commented:

> "'Excisional' biopsy refers to the *complete* removal of a lump or other lesion to gain a histological diagnosis. The whole (usually abnormal) structure is removed to send to a pathology laboratory. It differs from a 'biopsy' which usually samples just a small part of the tissue of concern, leaving the main part of it to be dealt with once the biopsy result is available."

My advisor identified a number of concerns about the appropriateness of Dr C's decision to offer Mr A an excisional biopsy. These included Dr C's experience and training, the facilities available at the surgery, and the failure to refer and/or perform a fine needle biopsy in the first instance.

Dr Holland considered that it was inappropriate for a general practitioner to offer this type of procedure:

> "I gather that the node was deeply placed in the anterior triangle of the neck, probably in the carotid triangle. The surgeon's notes indicate that it was in close proximity to the Accessory nerve and the Carotid Artery cannot have been far away. Working in this area requires the skills of a specialist.
>
> …
>
> [Dr C] states that he has had extensive relevant surgical experience overseas. However I do not know of any other general practitioners in New Zealand who would regard themselves as having the necessary (and current) experience and competence to operate in this region."

Dr C explained that the surgery has a dedicated minor operation room ("a minor operation set up and includes resuscitation facilities") and that the equipment available was sufficient to control any superficial bleeding he encountered.

My advisor commented that maintaining a bloodless field during neck surgery requires equipment not usually found in general practice:

> "Few practices have adequate cautery equipment to maintain a bloodless field. This is difficult to achieve with hyfrecation of the battery operated devices common in general practice. It requires the type of diathermy equipment usually only available in surgical suites. Good control of the bleeding would also usually require the presence of an assistant throughout the procedure."

Dr C confirmed that he did not have specialised equipment available to control bleeding. Other practice staff were available to assist if required, including Dr G and the practice nurse. However, there is no indication that other practice staff were on stand-by, or immediately available to assist. In my view, while Dr C may have had the appropriate resources to control any superficial bleeding, this was not sufficient in circumstances where heavy bleeding was a likely complication.

I accept my expert advice that it was not appropriate for Dr C to offer to perform a biopsy for Mr A in these circumstances. These comments apply both to excisional and incisional types of biopsy. It appears from the information provided that Dr C intended to attempt to remove the lump, if this proved possible. A procedure of this anatomical depth required the skill and resources of a specialist. This is particularly so when the lump was suspicious of malignancy and would most likely require specialist treatment. As there appears to have been doubt as to whether the lump could be easily and safely removed, Dr C should have erred on the side of caution and referred Mr A to a specialist.

Injury during surgery

Mr and Mrs A were concerned that during the attempted biopsy, Dr C severed his parotid (saliva gland), which later had to be removed.

Dr C stated that in the early stages of the procedure he realised that the lymph nodes were too deep and abandoned the biopsy. Mr A stated that there was a lot of blood and Dr C "cut and thrust and pulled" for about 20 minutes. He was very surprised when Dr C told him that he was not able to get the lump out. Dr C abandoned the procedure because of the anatomical depth of the lump.

On 13 August 2002 Dr E performed surgery to remove right upper neck nodes from Mr A. Dr E commented that during this surgery he removed an induration (thickening) of the tail of the parotid gland, which he presumed was associated with the previous operation:

> "[I]t was appropriate that anything associated with the previous incision be excised including any thickening in deeper tissues, such as the tail of the parotid gland."

Dr C stated:

> "I do not recall injuring the parotid gland. The incision I made was a few centimeters below the angle of the mandible [the outer edge of the lower jaw] and very unlikely to have been able to involve the tail of the parotid gland."

My advisor commented:

> "My guess is that this looked unusual to the surgeon [Dr E] and, while he assumed it to be damage arising from the previous attempt at surgery, he biopsied the area to be absolutely sure it was not the source of the metastatic disease in the lymph gland. It seems unlikely to me that the 'induration' would have led to any functional impairment of the salivary gland that would necessitate surgery.
>
> It does appear likely that this was damage from the surgery performed by [Dr C] and does illustrate the risk of injury when operating on the neck in less than ideal circumstances. However it did not significantly harm the patient."

Dr E noted a thickening of the tail of the parotid gland, which he considered was most likely secondary to the attempted biopsy, and removed the indurated portion for histological analysis. I accept my expert advice that Dr C did not significantly harm Mr A. However, the damage to the parotid gland is an example of the type of risk involved in this type of surgery, and would not have occurred if the surgery had not been commenced. In my view, the damage sustained also indicates that the incision made by Dr C during the abandoned procedure was of significant width and depth, and that he was operating at an inappropriate depth.

In my view the injury to Mr A's parotid gland was an adverse event attributable to Dr C's inappropriate decision to attempt excisional biopsy.

Conclusion

By advising Mr A that he was able to perform surgery to remove the neck lump (rather than conducting further tests or referring him to a specialist) and by unwisely commencing

surgery and operating at an inappropriate depth, Dr C failed to exercise reasonable care and skill and therefore breached Right 4(1) of the Code.

Opinion: No breach – Dr C

Referral by Dr C
Referral of a patient for specialist assessment must be carried out in a timely manner. Mr A stated that he does not know whether Dr C organised a referral to Dr F. Mr A advised that two weeks passed without contact from Dr F. As a result of this delay, Mrs A contacted Dr F' surgery herself, to organise an appointment.

Dr C provided a copy of his letter of referral to Dr F, dated 18 July 2002 (the date of the consultation). The letter requests Dr F's opinion concerning Mr A, and includes the relevant medical notes. The request for Dr F's opinion is not described as urgent. (Mr A saw Dr F on 31 July 2002, a period of almost two weeks after the failed biopsy.) Dr C commented that he was not aware of any delay in Mr A being seen by Dr F.

My advisor noted that the letter of referral was written on the day of the failed excision and considered that Dr C "moved speedily to arrange referral". Dr Holland commented that it is not clear from the information provided how the patient was to be notified about the appointment with the specialist. He noted that it is "quite common practice" for the referring doctor to organise the appointment in unusual cases like this. (However, I note that Mr A advised that he understood that Dr C would contact him directly.)

While Dr C did not specify in his letter that the referral was urgent, he included the relevant medical information. In my view, this provided sufficient information for Dr F to prioritise the appointment in an appropriate manner. It may have been prudent for Dr C to have alerted Dr F that this was an urgent referral. However, in the circumstances I consider that Dr C discharged his responsibilities adequately by organising the referral immediately, and providing the relevant information. I note that Dr C was not aware of any delay in the appointment for Mr A, and has stated that he would have made further arrangements if he had been aware of the situation.

Accordingly, in my opinion Dr C did not breach Right 4(1) of the Code in this regard.

Appropriateness of referral
Mr A is concerned that Dr C inappropriately referred him to general surgeon Dr F for further treatment, rather than to an ear, nose and throat (ENT) specialist for assessment. When Mr A finally saw Dr F on 31 July 2002, he was immediately referred to Dr E, ENT specialist. Mrs A stated:

> "After several weeks of waiting for an appointment to arrive I prompted the Doctors office several times before we finally had an appointment. This was a waste of time, as the referred Doctor then sent [Mr A] on to an ear nose and throat specialist."

General surgeon Dr F advised that "upon reading the letter and assessing the problem I realised this referral had come to the wrong specialist". Dr F also noted that Dr C's notes mention an ENT referral, and therefore it appeared that Dr C may have intended an ENT referral. However, the reference to an ENT referral was actually made by Dr B on 19 April 2002, and was included in the information Dr C provided to Dr F.

Dr C confirmed that he intended to refer Mr A to a general surgeon. He stated:

> "In my experience biopsies of the neck and shoulder region are often seen by General Surgeons. With hindsight I accept that it may have been more appropriate for an ENT Surgeon to see [Mr A] first."

My advisor commented:

> "There is confusion at times as to whether to refer to a general surgeon or an ENT specialist for the management of lumps in the neck. Thyroid tumours are managed by general surgeons, vascular lesions by general or vascular surgeons and lumps arising from lymph nodes are managed by general surgeons in some parts of the country. This was an understandable mistake by [Dr C].
>
> As it turned out, it was an inappropriate referral as the primary tumour was arising from the tonsil. [Dr C] was not to know this at the time of his referral, since the primary was not obvious until he had a detailed specialist examination."

I accept my expert advice in relation to this issue. General practitioners have an obligation to refer their patients to the appropriate specialist. However, at the time of consultation, it may not always be obvious which speciality to refer to. The area of lymph node biopsies is an example where there is an overlapping scope of practice between general and ENT surgeons. In this instance, referral to an ENT surgeon was more appropriate, as the primary tumour arose from the tonsil. This was not known at the time of referral. Accordingly, in my opinion Dr C did not breach Right 4(1) of the Code in this regard.

Other comment

Lack of appropriate consultation

Right 4(5) of the Code states that every consumer had the right to co-operation among providers to ensure quality and continuity of services. Under this right, doctors must undertake appropriate consultation with other providers involved in their patients' care.

Dr C advised that Mr A's medical records indicated that he had previously been referred by Dr B to an ENT specialist for further investigation of the lump. Dr C did not discuss Mr A's ENT referral or condition with Dr B, who was not present that day. Dr C stated:

> "We believed [Mr A] had been referred however [Mr A] indicated he wanted to have the surgery done sooner at the surgery rather than on the waiting list."

It would have been wise for Dr C to discuss Mr A's case with Dr B, given that Mr A had previously consulted Dr B concerning his neck lump. This is particularly so since it was not clear what action had occurred in relation to the documented ENT referral. The notes indicate that Mr A was referred to an ENT specialist on 19 April 2002, and nothing further was documented in relation to this referral prior to the consultation with Dr C on 13 July 2002. In my view it was not sufficient for Dr C to ask Mr A whether this referral had occurred. Dr C stated that Dr B was not present on 13 July as the consultation occurred on a Saturday. However, there is no reason why Dr C could not have consulted with Dr B at the first available opportunity. This may have avoided the attempted biopsy, as Dr B was clearly of the opinion that if the lump was possibly malignant, then specialist referral was required.

Actions

I recommend that Dr B review his practice and systems in relation to the follow-up of test results and recall of patients.

I recommend that Dr C:

- review his practice in light of my report
- improve the standard of his medical records.

Further actions

- A copy of this report will be forwarded to the Medical Council of New Zealand
- A copy of this report, with details identifying the parties removed, 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.