Medical Centre

General Practitioner, Dr A

A Report by the

Health and Disability Commissioner

(Case 17HDC01680)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 20 April 2016, Mr B saw general practitioner Dr A at a medical centre with respect to a lump in his right testicle. On examining Mr B's testicles, Dr A believed that the lump was in the epididymis, rather than the body of the testicle, because he could palpate a gap between the two. Given these examination findings and Mr B's history of a vasectomy, which can predispose men to epididymal cysts, Dr A was reassured that the lump was an epdidymal cyst.

2. Although not documented in his notes, Dr A told HDC that he told Mr B to return for a follow-up should he have concerns, or if his symptoms worsened or did not improve. By contrast, Mr B told HDC that Dr A did not give him any follow-up advice, and his impression was that Dr A believed that the lump was related to his vasectomy.

3. On 22 June 2016, Mr B saw general practitioner Dr C at the medical centre, as the cyst had continued to grow, and Mr B's right testicle was now bigger than the left. Dr C referred Mr B for an ultrasound, which was carried out on 12 July 2016.

4. Later that day, Mr B saw Dr C to review the ultrasound results, and was advised that the lump was likely to be testicular cancer. As a result, Dr C made an urgent urology referral to the public hospital. Mr B was seen the next day, and the diagnosis was confirmed.

5. On 18 July 2016, Mr B's right testicle was removed, and a subsequent CT scan revealed two pulmonary metastases (lung cancer), which required chemotherapy treatment.

Findings

Dr A

6. Dr A had a duty to provide services to Mr B with reasonable care and skill. By failing to transilluminate the lump in Mr B's right testicle, identify the possible diagnosis of the testicular cancer, refer Mr B for an ultrasound and/or specialist review, failing to comply with the New Zealand Suspected Cancer in Primary Care guidelines, and failing to give follow-up advice to Mr B, Dr A was found in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

The medical centre

7. Dr A's actions were considered to be matters of individual clinical judgement and practice, and there was no evidence that the policies or practices at the medical centre contributed to Dr A's errors of clinical judgement. Accordingly, the medical centre was not found vicariously or directly liable for any breach of the Code.

Complaint and investigation

8. The Medical Council of New Zealand referred a complaint to the Commissioner about the services provided by Dr A to Mr B at the medical centre. Mr B was contacted and he supports the complaint. The following issues were identified for investigation:

- *Whether Dr A provided an appropriate standard of care to Mr B in 2016.*
- *Whether the medical centre provided an appropriate standard of care to Mr B in 2016.*

9. An investigation was commenced on 16 May 2018.

10. The parties directly involved in the investigation were:

Dr A	Provider
Mr B	Complainant
Dr C	General practitioner
Medical centre	Provider

11. Information received from ACC was also considered.

12. Independent expert advice was obtained from Dr Gerald Young and is included as **Appendix A**.

Information gathered during investigation

13. On 20 April 2016, Mr B saw general practitioner (GP) Dr A at the medical centre. Mr B had recently noticed a lump in his right testicle. Dr A's clinical notes record that the left testicle was normal. However, although the right testicle was recorded as being the same size as the left, the presence of a "large cyst mid-epididymis"[1] was noted on the right. It was also noted that the lump was tender to pressure and that Mr B had a history of a vasectomy.[2]

14. Dr A recorded his examination of Mr B as follows:

> "lump on testicle recently noted
> tender to pressure
> o/e [on examination]
> L testicle normal
> R testicle — same size/large cyst mid-epididymis[3]

[1] An epididymal cyst is a benign fluid-filled sac that grows at the top end of the testicle.
[2] A vasectomy is a surgical procedure designed to make a man sterile by cutting or blocking the tubes through which sperm pass into the ejaculate.
[3] The epididymis is a tube that connects the testicle to the male reproductive system.

Mx

reassure re testicle

treatment is surgical removal if indicated."

15. Although not documented in the notes, Dr A states that, as per his standard practice, he also invited Mr B to return for a follow-up review if his symptoms worsened, did not improve, or he had concerns.

16. By contrast, Mr B stated that Dr A did not give him any follow-up advice to return if he was concerned. Mr B told HDC that his impression was that Dr A was not concerned by the mass because he believed it was related to Mr B's history of a vasectomy.

17. The size of the cyst was not recorded, nor were the clinical features that led Dr A to believe that the lump was an epididymal cyst. Although the notes record that Dr A reassured Mr B regarding his testicle, and that treatment would be surgical removal if indicated, there is no record of a referral for an ultrasound or specialist review, or of safety-netting advice having been given regarding monitoring of the cyst.

18. Dr A states that on examination he believed the lump was in the epididymis, rather than the body of the testicle, because he could palpate a gap between the two. He says that given Mr B had a history of a vasectomy, which can predispose men to epididymal cysts, and his examination findings, he was reassured that the lump was an epididymal cyst. Dr A told HDC that if he had thought that the lump could possibly be cancerous he would have insisted on an immediate ultrasound referral.

19. On 22 June 2016, Mr B saw Dr C at the medical centre, as the cyst had been growing and his right testicle was now larger than the left. Dr C noted that Mr B had an enlarging testicular mass and referred him for an ultrasound at the public hospital to determine the nature of the mass. The public hospital responded on the same day confirming receipt of the referral, and a scrotal ultrasound was carried out on 12 July 2016.

20. Later in the day Mr B saw Dr C to review the results of the ultrasound. Dr C noted that the mass was likely to be testicular cancer, and made an urgent urology referral to the public hospital. The likely diagnosis was discussed with Mr B, as were his questions and concerns.

21. Mr B was seen by a urologist at the public hospital the next day. Testicular cancer was confirmed, and on 18 July 2016 Mr B's right testicle was removed. A subsequent CT scan also revealed two pulmonary metastases[4] (lung cancer), which required chemotherapy treatment.

Dr A

22. Dr A told HDC that he was "shocked and saddened to hear [Mr B] was diagnosed with testicular cancer" and apologised "for the distress and upset he has no doubt

[4] Pulmonary metastases are cancer that has started in another part of the body and spread to the lungs.

experienced". Dr A advised that he sent an apology letter to Mr B and is happy to meet with him if he wishes.

23. Dr A stated that he has reflected on Mr B's presentation and symptoms, and the management of Mr B's care, and accepts that he should have considered testicular cancer and made an urgent referral. He regrets not referring Mr B for ultrasound and/or specialist review in April 2016.

24. Dr A stated that following the complaint he sought collegial advice and discussed the case with his Bpac[5] supervisor and practice principal. He said that he has also familiarised himself with the relevant New Zealand guidelines on testicular masses, and has undertaken readings on the natural history of testicular masses. In addition, he has now lowered his threshold for urgently referring unexplained testicular lumps for ultrasound and/or specialist review.

25. Dr A accepts that he could have given Mr B more specific safety-netting advice. He said that since this event he has been focusing on ensuring that his safety-netting advice is specific to the patient and the patient's presentation, and that the advice is recorded accordingly.

Medical centre

26. Following this incident, the medical centre also made changes to its practice. These include:

- Increasing lunchtime clinical meetings to twice a month (previously monthly) with better record-keeping and attendance records.
- Introducing a Clinic support service for 30 minutes every day, where one of the practice partners is available to discuss clinical problems with staff.
- Establishing a local peer review group at the medical centre, with the provision of dinner, to help to overcome the barriers to rural doctors receiving collegial education and support.

27. The medical centre also advised that a significant event report was completed following discussion with Dr A, Dr C, and one of the medical centre's directors. The report notes Dr A's comment that he "should have given more specific advice if not going to ask for a scan and this should be recorded in the notes".

Responses to provisional opinion

28. Mr B was provided with an opportunity to respond to the "information gathered" section of the provisional opinion, and had no further information to add.

[5] Bpac stands for Best Practice Advocacy Centre, an organisation that delivers educational and continuing professional development programmes to medical practitioners.

29. Dr A was provided with an opportunity to respond to the relevant sections of the provisional opinion. He responded noting the instructive comments of Dr Young, and had no further information to add.

30. The medical centre was provided with an opportunity to respond to the relevant sections of the provisional opinion, and had no further information to add.

Opinion: Dr A — breach

Examination, diagnosis, and follow-up advice — breach

31. On 20 April 2016, Mr B consulted GP Dr A in relation to a right testicular lump. Dr A's clinical notes document that Mr B had a testicular lump that was tender to pressure, and that an epididymal cyst was diagnosed. Dr A advised HDC that he believed that the cyst was in the epididymis, rather than the body of the testicle, because he could palpate a gap between the two. However, this clinical reasoning, including the size of the cyst, is not recorded in his notes, and he did not refer Mr B for an ultrasound and/or specialist review.

32. My independent expert advisor, GP Dr Gerald Young, found that Dr A's examination of Mr B amounted to a moderate to significant departure from a reasonable standard of care. Dr Young advised that Dr A should have transilluminated[6] the swelling to establish whether it was entirely cystic or not. Dr Young stated that without transillumination, a diagnosis of an epididymal cyst cannot be made with certainty, as cystic swellings always transilluminate, whilst solid swellings do not.

33. Dr Young also advised:

> "[I]f there is any doubt about the clinical exam, if the lesion is not smooth, feels firm/hard, uncertainty about which structure that it is arising from and/or doesn't transilluminate then further investigations are required and/or referral for specialist review. The investigation required is usually a scrotal ultrasound scan."

34. Dr Young's advice is consistent with the New Zealand Suspected Cancer in Primary Care guidelines, which state:

> "A man with a scrotal mass that does not transilluminate and/or the body of the testis cannot be distinguished, may be referred for an urgent ultrasound, but this should not delay referral to a specialist."

35. Dr A accepts that he should have considered testicular cancer and referred Mr B for an urgent ultrasound and/or specialist review. He has now lowered his threshold for referring unexplained testicular lumps.

[6] Transillumination is the passing of a strong light through an organ or part of the body to detect abnormalities or disease.

36. Although not documented in his notes, Dr A told HDC that he advised Mr B to return for a follow-up review if his symptoms worsened or did not improve, or if he had concerns. Mr B disputes that he was given this follow-up advice, and said that Dr A did not seem concerned by the mass as he believed it was vasectomy related.

37. Given that follow-up advice was not recorded in Dr A's notes, and Mr B does not recall being given such advice, I accept Mr B's version of events. This version of events is also consistent with Dr A believing that the mass was vasectomy related and that it did not pose a risk. Further, I note that Mr B did not re-present for two months, even though the lump was continuing to get bigger and the testicle itself was starting to enlarge.

38. Dr Young advised that, when given, follow-up advice should be specific. I am critical that Dr A did not give Mr B specific follow-up advice about monitoring the swelling, including advice that he should seek immediate review if it continued to grow bigger, harder, more irregular, or more tender.

39. Dr A had a duty to provide services to Mr B with reasonable care and skill. By failing to transilluminate the swelling, identify the possible diagnosis of testicular cancer, refer Mr B for an ultrasound and/or specialist review, failing to comply with the New Zealand Suspected Cancer in Primary Care guidelines, and failing to give follow-up advice to Mr B, I find that Dr A breached Right 4(1) of the Code.[7]

Opinion: Medical centre — no breach

40. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

41. 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), an employing authority can be held liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

42. In April 2016, Dr A was an employee of the medical centre. Accordingly, the medical centre is an employing authority for the purposes of the Act. As set out above, I have found that Dr A breached Right 4(1) of the Code for failing to transilluminate the swelling in Mr B's testicle and refer him for ultrasound and/or specialist review, and for failing to provide follow-up advice.

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

43. I consider that these were matters of individual clinical judgement and practice. There is no evidence that the medical centre's policies or practices contributed to Dr A's errors of clinical judgement. Copies of the medical centre's policies, which were provided to HDC, were appropriate, and Dr Young did not find these to be a contributing factor. Therefore, I find that the medical centre is not vicariously liable for Dr A's breach of the Code, or directly liable for any breach of the Code.

Recommendations

44. I recommend that Dr A:

a) Provide a written apology to Mr B for his breach of the Code. The apology should be sent to this Office within three weeks of the date of this report, for forwarding to Mr B.

b) Provide this Office with evidence of his further training and education in relation to testicular masses, within three weeks of the date of this report.

Follow-up actions

45. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr A's name.

46. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from general practitioner Dr Gerald Young:

"I have been asked to provide specific advice regarding the care provided to [Mr B] by [Dr A] if it was reasonable in the circumstances, and why.

In particular, please comment on:

1. The appropriateness of [Dr A's] examination of [Mr B] on 20 April 2016.
2. Whether [Dr A] should have referred [Mr B] for an ultrasound and/or specialist appointment on 20 April 2016.

In preparing the advice on this case to my knowledge I have no personal or professional conflicts of interest giving advice in this case.

References provided to complete the report:

1. Letter of referral from the Medical Council of New Zealand dated 1 September 2017;
2. [Dr A's] response dated 13 November 2017;
3. Clinical records from [the medical centre] covering the period January 2016 to September 2016.

Other references used:

6. 'General Practice' — John Murtagh — McGraw-Hill 1994 pages 799–802 (Scrotal Lumps)

Advice:

A. The appropriateness of [Dr A's] consultation and examination of [Mr B] on 20 April 2016.

In my opinion the examination of [Mr B] by [Dr A] was a moderate to significant departure from a reasonable standard of care. The reasons for this finding are detailed below.

The records note that [Mr B] was aged 35 years when he presented with a 'lump on testicle recently noticed' that was '… tender to pressure' although the time frame of 'recently' was not defined. That [Mr B] has had a vasectomy was recorded.

The examination recorded the left testis was normal. The right testis was the same size as the left. A '… large cyst mid-epididymis' was noted.

In the management, [Mr B] was '… reassure[d] re testicle' and advised that '… treatment is surgical removal if indicated'.

[Dr A's] examination revealed to him that the R testis was the same size as the left, which he noted on exam as being normal. The lump on exam [Dr A] felt that it was a

'large cyst' arising from the 'mid-epididymis' and not from the testicle itself. The size of the cyst was not recorded.

In most instances a cyst in the scrotum has a very smooth surface whilst other lumps in the scrotum usually have an irregular surface. Cysts also tend to be soft, being compressible. Solid tumors are much harder and usually not compressible at all.

The clinical findings and examination findings as recorded by [Dr A] raises the possibility that at the time of presentation to [Dr A] on 20 April 2016 the lesion was a nodular-cystic lesion with an inner solid component and surrounded by an outer cystic layer. This scenario is further supported by the symptom of tenderness on presentation as the majority of testicular tumours are painless. This suggests that there may have been an inflammatory component to this growing tumour, this inflammation may have produced a layer of inflammatory fluid over the tumour making the surface feel smooth and cystic, as well as producing the tenderness. This fluid swelling over the solid component may also have made the lesion feel separate from the testicle itself.

[Dr A] should have used a light in a darkened room to attempt to transilluminate the swelling to help delineate if the swelling was indeed totally cystic or not. A cystic lesion would usually transilluminate with a red glow whilst solid lesions would not. If the lesion did not transilluminate then further investigations would be required to confirm a diagnosis.

[Dr A] could have given more specific safety net advice about monitoring the lesion, if the lesion continued to grow bigger/harder/more irregular, became more tender or other changes then the lesion should be reviewed and/or investigated immediately. It is noted that [Mr B] did not re-present for 2 months even though the lump was continuing to get bigger and the testicle itself was starting to enlarge.

B. Whether [Dr A] should have referred [Mr B] for an ultrasound and/or specialist appointment on 20 April 2016.

As discussed above [Dr A] should have confirmed that the lesion was a cyst by transilluminating the lesion. If the lesion did not transilluminate then [Mr B] should have been referred for an ultrasound scan of the lesion and/or for specialist urologist review of the lesion, at the consultation of 20 April 2016.

[Dr A] was sure of his diagnosis of a cyst, without the confirmation of transilluminating the lesion and he conveyed this certainty to [Mr B], which probably falsely reassured [Mr B].

If more detailed monitoring advice had been given to [Mr B] at the consultation of 20 April 2016 he may have re-presented earlier when he noticed the lump and/or testicle continuing to change and further investigation could have been initiated earlier than when he re-presented on 22 June 2016, 2 months later.

C. Other Comment.

Cysts within the scrotum are quite a common clinical finding in adult males. The diagnosis is usually made clinically with good palpation to carefully feel the texture of the surface of the lesion and its consistency, also to clearly define which structure that the cyst is arising from. Cysts arise from the epididymis separate from the testicle itself. Cysts always transilluminate. Therefore, if a lesion is detected that is smooth arising from the epididymis separate from the testis and transilluminates then the diagnosis of an epidermal cyst can be made with certainty and no further investigations are required.

However, if there is any doubt about the clinical exam, if the lesion is not smooth, feels firm/hard, uncertainty about which structure that it is arising from and/or doesn't transilluminate then further investigations are required and/or referral for specialist review. The investigation required is usually a scrotal ultrasound scan.

Please contact me if any part of my opinion requires clarification.

Yours sincerely,

Dr Gerald Young"