Management of lesion on tongue
14HDC00828, 17 October 2016

Oral and maxillofacial surgeon ~ District health board ~
Diagnosis and management ~ Tongue cancer ~ Rights 4(1), 4(2), 6(1), 7(1)

A man was referred to an oral and maxillofacial surgeon at a DHB for a painful lesion on his tongue. The surgeon undertook a biopsy of the lesion. The histology report indicated no definite evidence of dysplasia (proliferation of cells of an abnormal type).

Following the biopsy, the surgeon monitored the man at intervals of two to four months. At one point the surgeon referred the man for further dental work. After the dental work was carried out, the patient management system at the DHB discharged the patient, and he was not rebooked with the surgeon for further follow-up. The error was identified when the man contacted the DHB and another appointment with the surgeon was scheduled.

The surgeon then reviewed the man again, noting that there continued to be a white lesion on his tongue, and requested a booking for a second biopsy and removal of an impacted tooth, under general anaesthetic. Although the nature of the lesion indicated a semi-urgent need for biopsy, the surgeon did not indicate this on the operation booking form, and the second biopsy was carried out five and a half months after referral.

The histology report following the biopsy indicated squamous cell carcinoma in situ, incompletely excised at the nine o'clock margin. The surgeon should have undertaken a further biopsy or referred the man to a multidisciplinary team; however, the surgeon continued to monitor the man over the next five months. The surgeon did not inform the man of this diagnosis or discuss management options with him. The surgeon then noted that the white lesion had returned, and that an additional biopsy would need to be performed under general anaesthetic.

The patient underwent a third biopsy. The histology results again showed squamous cell carcinoma in situ, this time extending to the right excision margin. Following this biopsy the surgeon did not inform the man of this diagnosis or discuss management options with him.

Following the biopsy the surgeon saw the man on two further occasions. The surgeon did not ask the man about the pain in his tongue following the biopsies. The surgeon then referred the man, approximately two years after he first saw him, to the Radiation/Oncology Clinic at another DHB for additional follow-up.

During his care of the man, the surgeon kept minimal, and largely illegible, clinical records and operation notes.

By failing to indicate semi-urgent priority on the booking form for the second biopsy, failing to undertake a further biopsy or refer the man to a multidisciplinary team following the second biopsy, and, following the biopsy procedures, failing to question the man about pain in his tongue, the surgeon breached Right 4(1). By not adhering to professional standards regarding documentation, the surgeon also breached Right 4(2).

For failing to provide information that a reasonable consumer would require in the situation, including an appropriate explanation of the biopsy results and an explanation of the management options available, the surgeon breached Right 6(1). Without this information,

the man was not in a position to make informed choices and provide informed consent for his further treatment. It follows that the surgeon also breached Right 7(1).

By failing to have a system to monitor the surgeon's compliance with its policies and procedures, particularly those relating to documentation, and having an inadequate booking system that allowed the man to be discharged inappropriately from its system, the DHB failed to provide services with reasonable care and skill and breached Right 4(1).

It was recommended that the surgeon provide an apology for the man, and undertake further training on the importance of, and expectations for, clear, full and accurate documentation.

It was recommended that the DHB provide an apology for the man, undertake an audit of the surgeon's clinical records, and establish a formal process to ensure quality oversight within the Dental Unit, particularly in relation to staff compliance with DHB policies and procedures. In addition, it was recommended that the DHB undertake a review of the patient booking system to ensure that patients are not discharged from its system when referred to another practitioner.

The surgeon was referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken. The Director filed a disciplinary charge before the Health Practitioners Disciplinary Tribunal, which resulted in a finding of professional misconduct. The Tribunal ordered that the surgeon be censured, and pay a fine of $5,000, and costs. The surgeon appealed the Tribunal's order that he pay a fine of $5,000, to the High Court. The High Court dismissed the appeal and upheld the Tribunal's decision. The Director did not take HRRT proceedings against the surgeon.