Medical Centre

General Practitioner, Dr B

A Report by the
Health and Disability Commissioner

(Case 18HDC01066)

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Executive summary

1. In June 2012, a man had a suspected basal cell carcinoma (BCC) removed from his left cheek by a general practitioner (GP) at a medical centre.

2. The histology report from this procedure showed a BCC with incomplete excision of the lesion, which the GP was aware of, as evidenced by the annotation he made on the report. However, the results were not communicated to the man, and no relevant follow-up was arranged.

3. The man presented to the medical centre many times for various reasons over the next five years. The histology of the incomplete BCC excision from his left cheek was not raised at any of these appointments.

4. Over five years later, in November 2017, the man was diagnosed with a recurrent BCC in his left cheek.

Findings

5. The Commissioner considered that the man had the right to receive information regarding the June 2012 histology report, the implications of the histology results, and the GP's plan for follow-up care. The GP failed to provide this information and, as a result, the man was deprived of the opportunity to make decisions about his care until the disease had reached an advanced stage. Accordingly, the Commissioner found that the GP breached Right 6(1) of the Code.

6. Further, by not arranging the follow-up care that the man required, the opportunity to provide timely treatment for the BCC was missed, and the disease advanced unchecked for a period of more than five years. Accordingly, the Commissioner considered that the GP breached Right 4(1) of the Code.

7. In 2012, the medical centre's policy relating to the management of investigation results was not sufficiently robust, and was subject to individual error. As a consequence, important opportunities to identify and arrange for timely treatment of the incomplete excision of the man's BCC were lost. Accordingly, the Commissioner found that the medical centre breached Right 4(1) of the Code.

Recommendations

8. The Commissioner recommended that both the GP and the medical centre provide letters of apology to the man for the breaches of the Code identified, and that the GP present this case to the medical centre's GP team for further education.

9. The Commissioner also recommended that the medical centre undertake an audit of 30 minor surgeries performed at the medical centre in 2019 to determine whether the results of the procedures were communicated to the patients in a timely manner, and whether follow-up management was appropriate; provide further training to its staff on the

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management of test results; and consider a number of improvements to practice policy regarding the management of investigation results.

Complaint and investigation

10. In June 2018, the Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Dr B at the medical centre. The following issues were identified for investigation:

- *Whether Dr B provided Mr A with an appropriate standard of care in June and July 2012.*
- *Whether the medical centre provided Mr A with an appropriate standard of care in June and July 2012.*

11. This report is the opinion of the Health and Disability Commissioner, Anthony Hill.

12. The parties directly involved in the investigation were:

Mr A	Consumer
Dr B	General practitioner/provider
Medical centre	Provider

13. Further information was received from:

District Health Board	Provider
Accident Compensation Corporation	National accidental injury insurance scheme

14. Independent expert advice was obtained from GP Dr Gerald Young (Appendix A).

Information gathered during investigation

Removal of basal cell carcinoma in 2012

15. On 19 June 2012, Mr A, who was aged in his seventies at the time of these events, visited the medical centre to discuss the removal of a basal cell carcinoma (BCC)[1] from the preauricular region[2] of his left cheek. The procedure was performed under local anaesthetic[3] by Dr B three days later on 22 June 2012.

[1] The most common type of skin cancer, arising from the basal cells that are located in the lower layers of the skin.
[2] Near the front of the ear.
[3] Medication used to numb a small area of the body temporarily.

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16. The histology[4] report from the procedure, dated 22 June 2012, records the specimen removed from Mr A's face as measuring "20 x up to 10 x 4mm" and noted that there was a deep margin involved.[5] The report also noted that the BCC had a "sclerotic growth pattern[6]".

17. Mr A returned to the medical centre one week later on 29 June 2012 to have the sutures removed from the wound. The registered nurse who removed the sutures documented that the wound was healing well and that there was "no histology result as yet". The nurse does not recall anything regarding these events.

18. The clinical notes made on 29 June 2012 contain no record of any discussion about how the histology results would be communicated when received. Dr B told HDC that the usual process at the time was for histology results to be given to the patient at the time the sutures were removed. He advised that he did not receive Mr A's histology results until 3 July 2012, meaning they were not available to the medical centre when the sutures were removed.

19. Dr B was aware that the histology results showed a BCC with incomplete excision of the lesion, as evidenced by the fact that he annotated on the histology report, "BCC left cheek, deep margin involved", meaning that the excision was incomplete because the BCC was present at the deep margin of the biopsy. However, the results were not communicated to Mr A, and no relevant follow-up was arranged.

Events after BCC removal

20. Mr A presented to the medical centre many times for various reasons between the time of the BCC removal (22 June 2012) and September 2017, including for an excision of a lesion on his right thumb. The histology of the incomplete BCC excision from his left cheek was not raised at any of these appointments.

21. Mr A experienced some subsequent growth around the area of the excision on his face, which he treated himself with liquid nitrogen and the area healed well. Mr A did not discuss his self-treatment with Dr B at any of his consultations after the excision, nor did he raise anything with Dr B to indicate that there was any recurrence of the BCC on the left cheek.

22. Over five years later, on 22 September 2017, Mr A saw Dr B and told him that he had a two-month history of increasing drooping of his left eyelid, which was interfering with his vision. Mr A also reported a dull discomfort and relative numbness in his left preauricular region, and some discomfort over the left joint connecting his jawbone to his skull.

23. Mr A was referred to the public hospital for investigation. On 20 November 2017, he had an excisional biopsy of his original BCC site and multiple biopsies of the deeper underlying tissue. The histology report showed a recurrent BCC in Mr A's left cheek.

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[4] Microscopic study of the structure of tissues.
[5] A surgical margin is technically defined as the "edge" of the tissue removed.
[6] The most aggressive subtype of BCC, as it spreads into the skin beyond clinically visible or palpable borders.

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24. On 4 January 2018, Mr A was seen in the Oncology Department at the public hospital, and subsequently he underwent six weeks of radiotherapy.[7]

Relevant policy at time of events (2012)

25. In 2012, the medical centre had in place a policy for the "Management of patient test results and medical reports". The policy stated:

> "Incoming test results
>
> …
>
> If [the results are] significant OR patient has requested to be informed the patient will normally be phoned by the doctor or practice nurse. If contact is unsuccessful a letter will be sent.
>
> …
>
> Tracking test results and medical records
>
> …
>
> When results are filed the task is automatically marked complete … Task list[s] should not be marked complete until all the tests results are received.
>
> …
>
> The doctor is responsible to ensure that tests have been done and if no results received should directly contact the patient or designate someone to do this and this is to be recorded in the notes.
>
> …
>
> Information at receipt of result — date received, receiver, action taken, advice for patient, when and by whom (see procedure for incoming results)."

26. As at 2019, this policy remained largely unchanged. An addition was made that requires patients to be contacted by the medical centre within 24 hours of receipt of test results.

Further information from Dr B

27. Dr B told HDC that incomplete excisions of BCCs are not uncommon in practice, particularly on the face, as a more conservative approach is taken to avoid injury to facial nerves. Further excision is undertaken subsequently if required.

28. Dr B told HDC that his usual practice in 2012 when there was an incomplete excision was to ask one of his nurses to arrange for the patient to return for a consultation to discuss a referral for a wider excision. Dr B told HDC that he regrets that Mr A was not referred for further excision. Dr B does not recall why Mr A was not informed of the result or asked to return for a follow-up consultation. Dr B and said that notifying Mr A of the histology is what was intended to happen.

[7] Radiation therapy to kill cancer cells.

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29. Dr B considers it possible that accidentally he filed the email containing the histology result before he had actioned it. He noted that the results management system at the time required only one click to file results, so it was "too easy to inadvertently file a result with a misstep of the mouse". The results management system now requires a double click of the mouse so that it is more difficult to file a result in error.

30. Dr B told HDC that the medical centre's policy for the "Management of patient test results and medical reports" was based on a template available at the time, and would have been similar to those used by other practices in the region. He considers that on that basis, the policy was in line with expected standards in 2012 and was adequate, but not infallible, as demonstrated by these events.

31. Since these events, the medical centre has instituted a new process to minimise a recurrence of a similar situation. Specifically, the results management system now generates a "staff task" that must be completed by the doctor when histology is requested. This step helps to prevent an abnormal result being actioned inappropriately.

32. Dr B has also made changes to his own practice as a result of this incident. He no longer leaves results in the electronic inbox, and instead generates a "staff task" in the results management system for the action he intends to take, which will remind him of the task that needs to be completed. Dr B said that he is now more inclined to write result letters to patients, or to send text messages regarding significantly negative results. He also no longer excises tumours from the face.

33. As a result of these events, Dr B undertook an audit of all of the minor surgeries he performed in 2017, the year prior to receiving Mr A's complaint. The audit confirmed that every other patient had been informed of their result and was managed appropriately.

34. Dr B told HDC that he is very sorry for what happened to Mr A, and for the significant impact that his omission has had on Mr A. Dr B said that he has always sought to provide the highest standard of care to his patients, and deeply regrets that he did not meet the standard that he strives towards. Dr B stated that since this matter was brought to his attention, he has "spent a considerable amount of time reflecting on [his] care and management", and has "no hesitation in apologising unreservedly to [Mr A] for [the] failure to notify him of the abnormal histology in July 2012".

Further information from the medical centre

35. The medical centre told HDC that since these events it has made a number of changes, including the following:

- The use of text messaging to communicate results has been introduced to ensure that patient communication/contact is documented better.
- An online portal has been introduced, which allows patients who have registered their personal details to the portal to log in and access their results themselves once they have been filed by the GP.

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- The introduction of a GP Leave Buddy system to lessen the risks of missed urgent results. If the GP who ordered a test is away on leave when the results are received, the "buddy" doctor should review them and take action if required.

36. No internal review or investigation was undertaken at the time of the incident, as no complaint was made directly to the medical centre.

Further information from ACC

37. Information received as part of the complaint process included the ACC Treatment Injury claim report and ACC expert opinion.

38. The expert advisor for ACC stated:

> "In my opinion there were two significant problems in [Mr A's] treatment —
>
> - The failure to check the histology report of the tumour after excision showed it extending to the cut margin and the need for arranging a wider excision.
> - The failure to take into account the histological subtype of BCC [that was] present. There is a high probability that wider excision in 2012 would have revealed the presence of perineural[8] invasion and also made the clinician aware that the particular histological type of basal cell cancer present was more likely than usual to recur and spread."[9]

Medical Council of New Zealand (MCNZ) guidance on test results

39. The MCNZ statement on "Managing Patient Records" (October 2019) states that doctors should have "systems in place to follow up … test results promptly including informing the patient about the results".

Responses to provisional opinion

Mr A

40. Mr A was provided with an opportunity to respond to the "information gathered" section of the provisional decision. He remained concerned about the services he received from Dr B. Further comments from Mr A have been taken into account in forming my final opinion.

Dr B

41. Dr B's response stated:

> "[Mr A's] complaint to your office and resulting investigation has been a salutary lesson for me and one that I have taken very seriously. I have taken on board your comments and those of [your expert advisor] also. From the changes I have made to my own personal practice in addition to the changes to the practice's systems, I can be certain there will be no repeat in the future.

[8] Around a nerve or group of nerves.

[9] It is not the role of HDC to make findings of causation. Accordingly, any findings made in this report should not be interpreted as having any implication as to the cause of Mr A's recurrence of BCC.

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I have had a number of discussions with my GP colleagues, a visiting Plastic Surgeon, and [two] Peer Group meetings regarding this incident, and I plan to present [Mr A's] case and the HDC findings to the next GP Peer Group meeting at our practice on 19 May 2020."

The medical centre

42. The medical centre responded that it genuinely believed that in 2012 its results management policy was robust and in line with accepted standards, and noted that it was based on the template available at the time.

43. The medical centre further advised that it found the advice from my expert advisor very helpful. It stated that the advice has helped it to improve the management of patient test results by introducing some updates to current audits and consent forms, including adding a new column in the minor surgery infection control monthly audit form and a section for how and when the patient has been notified of results. The medical centre provided HDC with a copy of the audit template and some completed audit forms as examples. The medical centre's consent form now also includes a section advising the patient to telephone after two weeks if they have not been notified of their test results, which will encourage patient involvement in following up on their own test results, as per Dr Young's advice.

44. Staff at the medical centre now transpose the inbox comments from test results into the body of a patient's clinical notes, with the actions required, so that when the notes are viewed at any time (especially at the next patient visit), the need for any further action required for that patient is clear to all staff, without having to open the inbox tab. This has become an automatic process of the electronic system that is used at the medical centre.

Opinion: Dr B — breach

45. On 22 June 2012, Dr B incompletely excised a BCC from the preauricular region of Mr A's left cheek. The histology results from the excision were received by Dr B on 3 July 2012, and stated that the specimen removed from Mr A's face measured "20 x up to 10 x 4mm" and that a deep margin was involved. The report also noted that the BCC had a "sclerotic growth pattern". Dr B annotated the histology report with "BCC left cheek, deep margin involved".

46. Mr A was not advised of the histology results, despite presenting to the medical centre a number of times after the procedure for various other health reasons. Dr B did not follow up on the need for further excision of the lesion. On 22 September 2017 — over five years after the incomplete excision — Mr A presented to Dr B with a two-month history of increasing drooping of his left eyelid, a dull discomfort and relative numbness in the left preauricular region, and some discomfort over the left joint connecting his jawbone to his

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skull. Mr A was referred to the public hospital for investigation, and a recurrence of the BCC in his left cheek was found.

47. My expert advisor, Dr Gerald Young, considers that the care Dr B provided to Mr A on this occasion represents a significant departure from the accepted standard of care. Dr Young stated that the histology report, which noted that the BCC lesion was not fully excised, should have been conveyed to Mr A. Dr Young advised:

> "That the lesion was a sclerosing type of BCC made the requirement for further excision to clear the lesion even more imperative because of the increased risk of not just local recurrence but spread to the cutaneous nerves. Local recurrence without cutaneous spread with other types of BCC, nodular or superficial BCC, is easily dealt with by further excision but perineural spread can cause significantly more morbidity."

48. Dr Young noted that the system Dr B had in place in 2012 was inadequate for histology reports. Dr Young advised that the results management system for histology needs to be very robust and include multiple layers of safety nets to ensure that abnormal results are actioned appropriately. Such layers include asking patients to call for their results if they have not heard within a certain timeframe, transposing the "in-box" comment into the body of the notes with the actions required, and generating a staff task within the results management system. Dr Young noted that "in this instance there was only one layer — [Dr B] himself". I accept Dr Young's advice.

49. I note that the MCNZ statement on "Managing Patient Records" (October 2019) states that doctors should have "systems in place to follow up … test results promptly including informing the patient about the results".

50. The medical centre's "Management of patient test results and medical reports" policy at the time of events stated that for significant test results, normally the patient would be telephoned by the doctor or practice nurse, and that if contact was unsuccessful, a letter would be sent. Dr B did not contact (or arrange for anyone else from the medical centre to contact) Mr A with the histology results, and I am critical of this omission.

51. Effective communication between doctors and patients regarding relevant clinical information is fundamental accepted medical practice in New Zealand, and I am critical that Dr B failed to ensure that Mr A was informed of the 22 June 2012 test result and its implications, and arrange for follow-up care. Doctors owe patients a duty of care when handling test results, and this includes advising patients of abnormal test results.

52. I note that Dr B accepts that he made an error, and cannot recall why Mr A was not informed of the result or asked to return for a follow-up consultation. Dr B told HDC that notifying Mr A of the histology is what he intended to happen, and that possibly the email containing the histology result was filed accidentally before it was actioned.

53. Right 6(1) of the Code states that every consumer has the right to the information that a reasonable consumer in Mr A's circumstances would expect to receive, including an explanation of the options available and the results of tests.

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54. In my view, Mr A had the right to receive information regarding the 22 June 2012 histology report, the implications of the histology results, and Dr B's plan for follow-up care. Dr B failed to provide this information and, as a result, Mr A was not adequately informed about the incomplete excision of his BCC, and was deprived of the opportunity to make decisions about his care until the disease had reached an advanced stage. I am critical that Dr B failed to provide this information, and consider that he breached Right 6(1) of the Code.

55. Further, Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill. By not arranging the follow-up care that Mr A required, the opportunity to provide timely treatment for the BCC was missed, and the disease advanced unchecked for a period of more than five years. Accordingly, I consider that Dr B breached Right 4(1) of the Code.

Opinion: Medical centre — breach

56. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code — that is, the health services provided by the medical centre must be of an appropriate standard, and it must have in place adequate systems, policies, and procedures. The medical centre also has a responsibility for the actions of its staff.

57. In 2012, at the time of these events, the medical centre had in place a policy entitled "Management of patient test results and medical reports". The policy stated:

> "When results are filed the task is automatically marked complete … Task list[s] should not be marked complete until all the tests results are received.
>
> …
>
> The doctor is responsible to ensure that tests have been done and if no results received should directly contact the patient or designate someone to do this and this is to be recorded in the notes."

58. My expert advisor, Dr Young, noted that this policy (which remained largely unchanged in 2019) was indeed in line with the medical centre's network PHO recommendations. He stated:

> "However, for a general practitioner that does minor procedures and relies on histology results for management of the lesion(s) [with this system] they are only one human-error-click away from potential significant morbidity as in this case or potentially mortality if the lesion were a melanoma.
>
> My view is that for histology results, more layers need to be inserted in the process to prevent errors in conveying histology results to patients from occurring, as incomplete

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management can result in significant issues. The policy as it is relies on no human error in the filing process which I find does occur when filing a long list of results.

This unfortunately occurred and with no back-up process for the histology results, this single error by [Dr B] resulted in a significant error in the provision of adequate health care to [Mr A]."

59. Dr Young also advised:

"[Dr B] has advised that histology requests with excisions are now linked to the 'Task Management' system in the PMS. However as documented in both the 2012 [and] 2019 results management policies 'when results are filed the task is automatically marked complete'.

Unfortunately this still does not prevent the human error of inadvertently filing the test result without notifying the patient, as occurred in this case, because 'when results are filed the task is automatically marked complete'."

60. Dr Young advised that the best way of ensuring that patients always receive their results is to involve them in the results process. He suggested the following alternative back-up processes to achieve this:

- Give patients written postoperative advice to telephone the medical centre within a certain defined period if they have not been advised of the result.
- Advise patients that they must not assume that their test results are normal if they have not heard from the medical centre. The patient must call for confirmation.
- When a patient has been advised of test results, record this in the clinical record so that it can be confirmed easily at the next consultation.
- Transpose the "inbox" comment into the body of the notes with the actions required, so that when the notes are viewed at any time, especially at the next patient visit, the need for further action required for that patient is clear to all staff (not just the primary GP) without having to open the inbox tab.
- If a manual consent form is used, keep it unfiled as a reminder until the histology has been reviewed and actioned.

61. Dr Young noted that further evidence that the system was inadequate is indicated by the fact that Mr A attended the medical centre numerous times after the BCC excision, and the histology was not raised with him at any of these appointments. Dr Young considers that this shows a "systemic problem with the results process".

62. I agree with this advice. The establishment of an effective results management system, with adequate safeguards to account for human error, is a reasonable precautionary action for a medical practice to take to ensure that results are communicated and not overlooked.

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63. I am critical that although the medical centre's policy relating to investigation results management in 2012 was in line with its network PHO recommendations, it remained subject to individual error, and therefore was not appropriately robust. As a consequence, important opportunities to identify and arrange for timely treatment of the incomplete excision of Mr A's BCC were lost. Accordingly, I find that the medical centre breached Right 4(1) of the Code.[10]

Recommendations

Dr B

64. In my provisional report, I recommended that Dr B provide a written letter of apology to Mr A for the breaches of the Code identified, to be forwarded by HDC to Mr A. On 7 May 2020, Dr B sent the apology to HDC.

65. I had also recommended that Dr B present this case to the medical centre's GP team for further education. In response to my provisional report, Dr B told HDC that he has had a number of discussions with his GP colleagues and a visiting Plastic Surgeon, and two Peer Group meetings regarding this incident, all of which I consider appropriate in the circumstances. He also presented Mr A's case to his peer group and, as a result of the discussion that took place, the medical centre instituted a number of changes to its management of investigation results, and refined its continuous auditing of minor surgeries performed at the medical centre.

66. I note that recently Dr B completed an audit of all the minor surgeries he performed in the year prior to receiving Mr A's complaint. I consider this appropriate in the circumstances.

67. I therefore consider that the recommendations with respect to Dr B have been met.

Medical centre

68. In my provisional report, I recommended that the medical centre provide a written letter of apology to Mr A for the breach of the Code identified in the report. The apology was forwarded to HDC on 27 May 2020.

69. I also recommended in my provisional report that the medical centre undertake an audit of 30 minor surgeries performed at the medical centre in 2019, to determine whether the results of these procedures were communicated to the patients in a timely manner and follow-up management was appropriate. The medical centre has since reported to HDC that the audit has been completed, and a copy of the results was provided to HDC, which showed that both results and follow-up management were appropriate for all 30 minor surgeries.

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

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70. The medical centre also reported to HDC that it has provided training to staff on the management of test results. This case and the proposed changes that it has brought about were discussed and agreed to by the GPs at the medical centre at their peer review meeting. The medical centre has scheduled a discussion of the changes with its nursing staff at the nurse practitioner meeting to be held in June 2020.

71. In my provisional report I asked the medical centre to consider a number of improvements to practice, as suggested by my expert advisor. These included:

- Advising patients to call for their histology results if they have not been received within a certain time. Patients should be advised that they must not assume that if they have not heard from the clinic, there are no concerns with their test results, but should call for confirmation.
- When a patient has been advised of test results, document this in the clinical record so that it can be confirmed easily at the next consultation.
- Transpose the “inbox” comment into the body of the notes with the actions required, so that when the notes are viewed at any time, especially at the next patient visit, the need for further action required for that patient is clear to all staff (not just the primary GP) without having to open the inbox tab.
- If a manual consent form is used, keep it unfiled as a reminder until the histology has been reviewed and actioned.

72. The medical centre has reported that it has introduced some updates to current audits and consent forms, including adding a new column in the minor surgery infection control monthly audit form and a section for how and when the patient has been notified of results. The medical centre provided HDC with a copy of the audit template and some completed audit forms as examples. The medical centre’s consent form also now includes a section advising the patient to telephone after two weeks if they have not been notified of their test results, which will encourage patient involvement in following up on their own test results, as per Dr Young’s advice.

73. Staff at the medical centre now transpose the inbox comments from test results into the body of a patient’s clinical notes with the actions required, so that when the notes are viewed at any time (especially at the next patient visit), the need for any further action required for that patient is clear to all staff without having to open the inbox tab. This has become an automatic process of the electronic system that is used at the medical centre.

74. I therefore consider that my recommendations with respect to the medical centre have been met.

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Follow-up actions

75. 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 Royal New Zealand College of General Practitioners, and they will be advised of Dr B's name.

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

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Dr Gerald Young on 22 April 2019:

"**Advice on [Dr B] at [the medical centre] C18HDC01066**

I have been asked to provide specific advice regarding whether the care provided to [Mr A] by [Dr B] was reasonable in the circumstances, and why. In particular, please comment on: The appropriateness of care provided to [Mr A] in 2012 by [Dr B] and whether this was consistent with accepted standards of practice at that time; The failure by [Dr B] to follow up with [Mr A] following the procedure in 2012; and Any other matters in this case that you consider warrant comment. 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:

Complaint dated […]
[Dr B's] response dated 16 July 2018
Clinical records from [the medical centre] covering the period 19 June 2012 to 25 September 2018

Other references used: Basal Cell Carcinoma DermNet NZ Honorary Associate Professor Dr Amanda Oakley, Dermatologist, Hamilton, New Zealand.

Advice:

Consultations
22-Jun-2012: The excision of a lesion on the left cheek which was clinically suspected to be a basal cell carcinoma (BCC) was performed by [Dr B] under local anaesthetic using a vertically orientated ellipse of skin to remove the lesion. The wound was closed with 4.0 nylon sutures. The sutures were scheduled to be removed between 7 to 10 days post operatively.

29-Jun-2012: [Mr A] presented for suture removal, 7 days post operatively (with [a nurse]). It was noted that 'no histology result as yet'. No record was made of any further discussion about how the histology was to be communicated when received. [Dr B] states that the histology was received by him on the 3rd July 2012. It is noted that [Dr B] was aware that the histology was a BCC with incomplete excision of the lesion as [Dr B] commented on the result by annotating in the 'in-box' file 'BCC left cheek, deep margin involved.' There was another important finding in the histology report that should have been noted, this being '… basal cell carcinoma with a sclerotic growth pattern.' The importance of this finding is that this type of BCC (sclerosing also known as morphoeic) has a much higher risk of perineural spread infiltrating cutaneous nerves [4], which indeed occurred in this case. It is recorded that [Mr A] presented a number of times after the 3rd July 2012; on 15-Aug-2012, 25-Oct-2012 and 29-Nov-2012 for an excision of a lesion on the right thumb. The histology of the

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BCC incomplete excision on the L cheek was not raised with the patient at any of these appointments.

B Findings

The standard of care is a significant departure from the expected standard of care. The reasons for this finding are: the histology report that the BCC lesion was not fully excised should have been conveyed to [Mr A]. That the lesion was a sclerosing type of BCC made the requirement for further excision to clear the lesion even more imperative because of the increased risk of not just local recurrence but spread to the cutaneous nerves. Local recurrence without cutaneous spread with other types of BCC, nodular or superficial BCC is easily dealt with by further excision but perineural spread can cause significantly more morbidity. [Dr B] in his response stated that the usual practice was for the histology to be given at the time the patient returned for removal of sutures. This is indeed an ideal process but increasingly often histology is not available in such a timely manner now. [Dr B] then offered that his '… usual practice at that time, where there was an incomplete excision, was to ask one of my nurses to get the patient back in for a consultation to discuss referral for wider excision.' Obviously, this did not happen, and [Dr B] is not able to fully explain why adequate follow-up did not occur. He did suggest that he may have accidently filed the report before completion of the follow-up action. It is noted that [Dr B] did annotate the in-box result with 'BCC left cheek, deep margin involved' which was a good process to follow as this annotation is visible in the 'list' view of the in-box records even after the report has been filed. This annotation also indicates that [Dr B] did intend for further follow-up. Unfortunately, this annotation was not identified by [Dr B] nor any of the other staff who attended [Mr A] on subsequent visits after the report was filed. The system that [Dr B] had in place in 2012 was inadequate for histology reports. Results management for histology needs to be very robust so that there are a multiple layers of safety nets to ensure abnormal results are appropriately actioned. In this instance there was only one layer — [Dr B] himself. [Dr B] has reported that he has now instituted new processes to minimise a recurrence of this happening by generating a 'staff task for the doctor' when histology is requested. This change will assist preventing abnormal histology from not being appropriately actioned. Other steps that would help, would be to advise the patient to call for their histology if they have not received it by a certain time, in Auckland this is up to 20 days at present, obviously this 'time' would vary for each DHB region. Getting the patient involved helps backstop any issues with the reporting system and/or technology glitches that can occur from time to time resulting in the report never being received by the clinic and/or doctor. Other helpful actions would be to: transpose the 'in-box' comment into the body of the notes with actions required, so that when the notes are viewed at any time, especially at the next patient visit, the need for further action that is required for the patient is clear to all staff; nurses and other doctors that may be attending the patient not just the primary doctor, without having to open the in-box tab. If a manual consent form is used then it can be kept unfiled until the histology has been reviewed and actioned; this manual system helps negate any technology gaps. Whilst the primary responsibility for appropriate histology follow-up always rests with the attending doctor

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a multiple layer system involving the patient and all clinic staff will help close any potential gaps.

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

Yours sincerely,

Dr Gerald Young"

The following additional expert advice was obtained from Dr Young on 16 September 2019:

"**Re: C18HDC01066 — [Mr A]**

My finding of 'the standard of care is a significant departure from the expected standard of care' was based on the fact that [Dr B] had a number of opportunities to correct the oversight that the basal cell carcinoma was incompletely excised and [Mr A] was not advised, also significant morbidity to the patient resulted from the error.

I have reviewed both the 2012 and 2019 investigation results policies. I have copied the relevant section below for ease of reference:

'**MANAGEMENT OF PATIENT TEST RESULTS AND MEDICAL REPORTS'** (2012)

Tracking test results and medical records:

Do you have a system for tracking tests? — Yes.

1. Lab and Radiology requests are recorded electronically and can be viewed in patient's file. (With all the patient's data etc available)
2. The PMS automatically adds a task. Due in 1 week for Laboratory results and 3 weeks for Radiology results. When results are filed the task is automatically marked complete. If not received in that time it will show as an overdue task in the task list of the person who requested the test. Task list should not be marked complete until all the test results are received.
    a. The doctor is responsible to ensure that tests have been done and if no results received should directly contact the patient or designate someone to do this and this is to be recorded in the notes.
3. Information at receipt of result — date received, receiver, action taken, advice for patient, when and by whom (see procedure for incoming results)
4. Tests are tracked automatically

'**13.1 POLICY CLINICAL CORRESPONDENCE MANAGEMENT'** (2019)

Tracking test results and medical records:

1. Lab and Radiology requests are recorded electronically and can be viewed in patient's file. (With all the patient's data available).

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2. The PMS automatically adds a task. Due in 1 week for Laboratory results and 3 weeks for Radiology results. When results are filed the task is automatically marked complete. If not received in that time it will show as an overdue task in the task list of the person who requested the test. Task list should not be marked complete until all the test results are received.
   a. The doctor is responsible to ensure that tests have been done and if no results are received, they should directly contact the patient or designate someone to do this and this is to be recorded in the notes.
3. Information at receipt of result — date received, receiver, action taken, advice for patient, when and by whom (see procedure for incoming results).

I accept that these policies are in keeping with their network PHO recommendations and have been found to be adequate based on the RNZCGP Foundation standards. I note that [Dr B] has advised that histology requests with excisions are now linked to the 'Task Management' system in the PMS. However as documented in both the 2012 & 2019 results management policies 'when results are filed the task is automatically marked complete.'

Unfortunately this still does not prevent the human error of inadvertently filing the test result without notifying the patient, as occurred in this case, because 'when results are filed the task is automatically marked complete.' As I understand the policy it is up to the doctor to advise the patient of the result then file the result when completed. It is for this reason in my opinion, for histology results, where the result may be management critical, that a 'PMS Task Management' system used on its own is inadequate and additional safeguards should be in place for clinics that undertake excision procedures surgery.

That is why I have suggested alternative back-up processes should be in place to ensure that the patient always gets the result. The best way that I know of achieving this is to get the patient to be involved with the results process. By giving the patient written post-operative advice to call back within a certain defined period if they have not been advised of the result will be another step that helps prevent the patient from not receiving the test results. The patient should be advised they must not assume the test result is okay if they have not heard from the clinic but must call for confirmation. That the patient has been advised of the result(s) should be recorded in the clinical records so that it can be easily confirmed at the next consultation if the patient has indeed been advised of their histology results.

This step prevents the patient assuming that if they have not heard from the clinic the test result is normal or not significant, as is often the process for many laboratory tests but is not an adequate policy for histology results.

Further evidence that the system was inadequate is evidenced by the fact that [Mr A] attended [the medical centre] on 15-Aug-2012, 25-Oct-2012 and on 29-Nov-2012 which was for another excision procedure of a lesion on the right thumb. That the

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histology of the BCC incomplete excision on the L cheek was not raised with the patient at any of these appointments by [Dr B] shows a systemic problem with the results process. That [Mr A] did not raise it, suggests that [Mr A] was under the impression that the lesion was completely excised and no further action was required because he was not advised otherwise.

If the results policies are in keeping with their network PHO and have been endorsed by the RNZCGP Foundation Standards then from a general practice perspective they would be seen as adequate policies. However for a general practitioner that does minor procedures and relies on histology results for management of the lesion(s) they are only one human-error-click away from potential significant morbidity as in this case or potentially mortality if the lesion were a melanoma.

My view is that for histology results, more layers need to be inserted in the process to prevent errors in conveying histology results to patients from occurring, as incomplete management can result in significant issues. The policy as it is relies on no human error in the filing process which I find does occur when filing a long list of results.

This unfortunately occurred and with no back-up process for the histology results, this single error by [Dr B] resulted in a significant error in the provision of adequate health care to [Mr A].

Yours sincerely

Dr Gerald Young”

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