Plastic Surgeon, Dr B

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC02380)

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Executive summary

1. This report considers the care provided by a plastic surgeon in 2018.

2. In January 2018, the plastic surgeon excised a basal cell carcinoma (BCC) on a man's left eyebrow. The histology report revealed that the BCC had been incompletely excised, and a plan was made to re-excise it. However, re-excision was never performed. Approximately one year later in January 2019, following a re-referral from the man's general practitioner (GP), the man saw the plastic surgeon again and recurrence of the BCC was confirmed. Further investigations revealed that the cancer had progressed, and subsequently it was categorised as at an advanced stage and incurable.

3. The report discusses the adequacy and appropriateness of the plastic surgeon's management of the man, including the decision not to re-excise the BCC and the ongoing monitoring and surveillance of the BCC.

Findings

4. The Deputy Commissioner found that the plastic surgeon breached Right 4(1) of the Code. The Deputy Commissioner was critical of the plastic surgeon for failing to provide written advice to the man and his GP about ongoing surveillance, and to put in place an adequate plan for monitoring and follow-up after the decision was made not to re-excise the BCC. The Deputy Commissioner was also critical that the plastic surgeon failed to ensure that the man was seen in a timely manner after he was re-referred by his GP in November 2018.

Recommendations

5. The Deputy Commissioner recommended that the plastic surgeon provide a written apology to the man, prepare an anonymised case study for sharing with colleagues, and undertake further training on communication and consent.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Dr B. The following issue was identified for investigation:

   - *Whether Dr B provided Mr A with an appropriate standard of care in 2018.*

7. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

8. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	Provider/plastic surgeon

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9. Also mentioned in this report:

Dr C	Oculoplastic surgeon
Dr D	Plastic surgeon
Mr E	Lawyer for Dr B

10. Further information was received from a district health board (DHB).

11. Independent expert advice was obtained from plastic and reconstructive surgeon Dr Sally Langley (Appendix A).

Information gathered during investigation

Introduction

12. This report considers the care provided to Mr A, aged in his eighties at the time of events, by plastic surgeon Dr B,[1] and, in particular, the management of a basal cell carcinoma (BCC).[2]

January 2018

13. In January 2018, Mr A was referred by his GP to Dr B for the management of a BCC on his left eyebrow.

14. Mr A had an initial consultation with Dr B on 18 January 2018. In his clinic letter to Mr A's GP, dated 18 January 2018, Dr B noted that the BCC on Mr A's eyebrow was "longstanding", having been present for the last one to two years, and that it "ble[d] occasionally and stain[ed] his pillow".[3]

15. Mr A told HDC that at the time of this consultation, Dr B seemed more concerned with a lentigo maligna[4] on his left cheek, rather than the BCC on his eyebrow, and booked him for the excision of both the following week.

16. Dr B told HDC: "I was indeed more concerned about the Lentigo Maligna as it is often more serious and life threatening than the BCC."

17. In his clinic letter, Dr B noted the "probable BCC" on Mr A's eyebrow, but noted:

> "[M]ore importantly he has a patch of lentigo maligna in his left cheek. … I have booked him to have both the lentigo maligna and the BCC excised under a light general anaesthesia."

[1] Dr B is vocationally registered in plastic and reconstructive surgery.
[2] A common, locally invasive type of skin cancer.
[3] This investigation relates solely to the care provided by Dr B. The care provided by Mr A's GP has not been considered as part of this investigation.
[4] An early form of melanoma in which the malignant cells have not yet spread.

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18. On 25 January 2018, Dr B excised both the BCC on Mr A's eyebrow and the lentigo maligna on his cheek.

February 2018

19. On 13 February 2018, Dr B saw Mr A for follow-up. In his clinic letter to Mr A's GP, Dr B noted that the histology from the excised lentigo maligna indicated that an in situ[5] melanoma had been incompletely excised at the 12 o'clock margin, which coincided with the lower eyelid. He also noted that the BCC on the left eyebrow had been incompletely excised at the deep margin.

20. Dr B told HDC that during the consultation he explained the histology results to Mr A, and "showed [Mr A] pictures from Anatomy books to demonstrate the proximity of the nerves (supra orbital nerve) to the BCC scar, and thus the need for excision and how surgery is the first option in this case". However, Dr B did not document the details of this conversation.

21. Dr B said that at that time they agreed to the following plan:

> "[T]o observe the lentigo maligna (rather than undergo near-total lower eyelid reconstruction with all its attending complications) and intervene surgically if there was evidence of clinical recurrence.
>
> Re-excise the BCC as it would have been a simple easy procedure at the time.
>
> Depending on the results, Radiation was to be considered *if it was still incompletely excised,* which was a possibility."

22. In his clinic letter to Mr A's GP, Dr B primarily discussed the lentigo maligna. In relation to the BCC, he documented:

> "The other lesion excised from the left eyebrow area was a basaloid carcinoma and is focally incompletely excised at the deep margin.
>
> PLAN:
> I have booked [Mr A] to come back for a deeper excision of the eyebrow area, as this is a simple procedure without potentially functional consequences. He will also have what is likely to be an early SCC excised from the left lateral arm."

23. Dr B told HDC that "[t]he re-excision plan was clearly decided and planned", and was documented in his clinic letter. Dr B said that Mr A agreed to the plan, and subsequently was booked to have the BCC re-excised, together with the lesion on his left arm. Dr B told HDC:

[5] The cancer cells have not spread.

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> "[At that time] I was clearly concerned enough to see [Mr A], discuss the results, explain why he needs another surgery (wide local excision) and to schedule him for further surgery."

24. Mr A told HDC that he has no recollection of being shown pictures from an anatomy book but agrees that during this appointment Dr B told him that the BCC had not been excised completely. However, Mr A has provided two slightly different accounts about what was planned at that time. In Mr A's original complaint to HDC, he said that a plan was made to re-excise the BCC, and that Dr B mentioned the possibility that radiotherapy might be required. However, in subsequent correspondence, Mr A said that he does not recall re-excision being planned at that time. In response to the "information gathered" section of the provisional opinion, Mr A said that the confusion regarding what he understood to be the plan at that time may be the result of his confusion between the treatment for the lentigo maligna and that of the BCC, which were discussed at the same time. Mr A stated: "Hence the decision to observe and monitor was [his] understanding of a consultative decision on both." Mr A said that while a definitive plan may well have been clear to Dr B, it was "not at all clear" to him, as he thought that the appointment scheduled for 4 April 2018 was for the lesion on his left arm only.

April 2018

25. On 4 April 2018, Mr A presented for the surgery as planned. Dr B told HDC that prior to commencing the surgery, when he was going through the consent, Mr A questioned why the BCC was being excised again when the scar had healed and there was nothing to see. Dr B said that he explained to Mr A the need to try to get as much clearance around the excised BCC as possible, but that there would still be no guarantee that the excision would be complete this time either. Dr B said that Mr A then questioned the point of the surgery if success could not be guaranteed. Dr B stated:

> "It was only then that I mentioned the alternative and to my mind, less than ideal option of observation/surveillance as an alternative, and this was his preferred option, despite him being aware, as had just been explained, why a re-excision had been recommended and planned. In the face of his decision not to proceed with the planned surgery on his forehead, only the left arm skin cancer was cut out that day."

26. Dr B said that this was a 3–5 minute conversation. Dr B documented the discussion briefly in his handwritten notes, as well as in his more detailed operation note, which states:

> "The procedure was discussed and explained to the patient and verbal consent obtained. The plan with [Mr A] was to excise the lesion in the left arm plus to do a deeper excision of the incompletely basaloid carcinoma in the left brow. … However, [Mr A] expressed his wish to just observe the forehead lesion if possible, as there are no signs of clinical recurrence I think this is not unreasonable and I was happy to do that as [Mr A] is going to be on surveillance for the incompletely excised lentigo melanoma in the left lower lid …"

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27. In contrast, Mr A denies that he elected just to observe the BCC, rather than re-excise it. Mr A said that it was his understanding that this appointment was to excise only the lesion on his arm, and that there was no plan to re-excise the BCC on his left eyebrow at that time, "and as such may well have questioned why the forehead procedure was also scheduled". He stated that at this appointment he questioned Dr B about the lump and tingling sensations he was getting around the eyebrow area, and Dr B told him that there are a lot of nerve endings in the area. Mr A said that there was no discussion or suggestion of further treatment at that time.

28. Mr A told HDC:

> "I have always asked the professional what their recommendation would be throughout any treatment I have had, and have followed this knowing that I am not qualified nor experienced to make an informed decision."

29. Further, in response to the "information gathered" section of the provisional opinion, Mr A stated:

> "Had [Dr B] been adamant that [re-excision of the forehead BCC] was highly recommended to be done, as he was with the [lentigo maligna] at the first consultation, there is nothing to suggest that I would have refused this advice. I would not have gone against a clear operation treatment plan."

30. On 18 April 2018, Mr A was seen at the clinic for removal of the sutures in his arm. However, Dr B did not review Mr A at that time.

August 2018

31. On 7 August 2018, Mr A saw Dr B for a follow-up appointment. Dr B told HDC that at that time there was no clinical evidence of reoccurrence of the previously excised BCC on Mr A's left eyebrow, and the cheek flap where the lentigo maligna had been excised was also clear, but there was a new BCC evident on Mr A's right forehead.

32. In his clinic letter, dated 7 August 2018, Dr B stated:

> "The left cheek reconstruction from the melanoma excision appears to be doing fine with no signs of recurrence and so is the scar above the left eyebrow with the incompletely excised basosquamous skin cancer. [Mr A] is still keen to keep an eye on things rather than intervene with a wider excision."

33. In contrast, Mr A said that at that appointment he told Dr B that he was still concerned about the previously excised BCC on his left eyebrow, but he "again took [Dr B's] advice to keep an eye on it".

34. Dr B acknowledged that no follow-up plan was documented, and no follow-up was arranged.

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35. On 22 August 2018, Dr B excised the new BCC on Mr A's right forehead. Mr A told HDC that at that time he again expressed his concern about the lump on his left eyebrow, which he said was getting bigger, but that Dr B took no notice of it.

36. The clinical records contain no reference to the BCC on Mr A's left eyebrow, or to any follow-up relating to that appointment.

November 2018

37. On 21 November 2018, Mr A's GP sent a letter to Dr B raising concerns about a new lump and tingling at the site of Mr A's left eyebrow BCC. In the letter, Mr A's GP noted: "[Mr A] has asked for this appointment."

38. Mr A told HDC that following the initial surgery in January, he became increasingly worried "about the lump which was growing, and the sensations around it", which is why he went back to his GP.

39. Dr B said that the referral was received during the "end of year rush", which is the "worst & busiest time of the year", and, as such, an appointment was not scheduled for Dr B to see Mr A until 17 January 2019, approximately eight weeks after the referral letter was received.

40. Dr B acknowledged that this was a long delay, and accepts "with hindsight more could have been done to squeeze [Mr A] in before the end of the year".

17 January 2019 — CT scan/referral to the DHB

41. Dr B reviewed Mr A on 17 January 2019, and confirmed the reoccurrence of the left BCC.

42. Dr B said that he then referred Mr A for a CT scan to plan for surgery to excise the BCC. The scan revealed that the tumour was in the left orbit (eye socket) and abutting the eyeball. Dr B told HDC: "[F]or that particular finding (proximity to the eyeball): operating on it by myself would be out of my scope of expertise."

43. Accordingly, on 25 January 2019 Dr B referred Mr A to an oculoplastic surgeon, Dr C, "in the hope that it results in a surgical procedure, which would be a definitive step that can obviate need for radiotherapy". In his referral letter to Dr C, Dr B stated:

> "Back in January 2018 [Mr A] had excision of a large lentigo maligna of the left cheek, which was reconstructed with a cheek rotation flap with good effect. He had a few other skin cancers, most notably a basaloid cancer in the left brow that was excised at the same time but seems to have extended to the deep margin of the excision and thus was incompletely excised. The area has been observed and followed up but more recently in late 2018 he was referred back from his GP with a lump below the left eyebrow. He has also been having symptoms of tingling in the forehead and scalp, indicating perineural invasion. CT scan performed last week shows extension of that subcutaneous mass into the left orbit abutting the globe."

44. Dr B said that from this point, Mr A's care transferred to Dr C, and he had no further involvement in Mr A's care.

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Ongoing care

45. Mr A was reviewed by Dr C in January 2019.

46. A CT carried out at the time revealed a large mass extending into the superior orbit of the left eye. A decision was made not to undertake further surgery, and Mr A was treated with radiotherapy.

47. Unfortunately, the cancer progressed and subsequently was categorised as at an advanced stage and incurable.

Further comment from Dr B

48. Dr B acknowledged that Mr A has no recollection of their discussion on 4 April 2018 when the decision was made to observe the BCC rather than to re-excise it. Dr B noted that Mr A has a number of conditions that can affect cognition and memory. Dr B stated: "Thus, whilst it is clear that [Mr A] does not remember some of the conversations that we had, it is possible that this is related to problems with his recall and memory."

49. In relation to the management of the BCC, Dr B told HDC:

> "If re-excision was to be done in April '18, things *may* have taken a different turn, *perhaps I should have pushed [Mr A] to go ahead with surgery* that day? Mind you that would have meant I could potentially get into trouble if anything goes wrong as I would have [been] seen as going against patient wishes." (Emphasis in original.)

50. In relation to the lack of a documented follow-up plan, Dr B told HDC:

> "The follow-up plan documentation is indeed not found in our computer records — this is unfortunate, I can only assume that the computer system deleted the Nov/Dec appointment. As there was now a new GP letter — Nov 2018, this could have occurred in the process of triaging the new letter to re-plan the consultation session."

51. Finally, Dr B stated:

> "I am very sorry that [Mr A] is upset at the way he has been treated by me. At all times I felt that I treated him with the utmost respect, listen[ed] to his concerns, provided him with all relevant information and accommodated his wishes."

Opinion from Dr D

52. Dr B obtained his own advice from plastic surgeon Dr D, who has practised as a consultant in plastic and reconstructive surgery for many years.[6]

53. Dr D noted that from review of the clinical images, at the time of Mr A's initial presentation to Dr B, Mr A's BCC appeared to be "an extensive and neglected infiltrating BCC". Dr D considers that Dr B's initial management of the BCC "seems entirely appropriate".

[6] Dr D's full reports are included at Appendix B.

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54. Dr D advised that the subsequent plan to re-excise the site once histology showed that the lesion had not been excised completely also "seems entirely reasonable".

55. Dr D commented on his understanding that Mr A declined to proceed with re-excision when the plan was discussed immediately prior to the surgery in April. Dr D stated: "If a patient declined to go ahead with a procedure, the surgeon is unable to continue as he had planned and I believe it is unfair to criticize [Dr B] on this point." Further to this, Dr D stated:

> "Although a deep margin excision was later not done, because of the wishes of the patient, a 'watch and see' policy of regular and frequent follow-up given the patient's age and medical status, is entirely reasonable in this clinical case."

56. Dr D considers that after the decision was made not to proceed with re-excision in April, Dr B's follow-up plan was appropriate. Dr D stated:

> "The patient declined surgery to the left supraorbital region and subsequently regular follow-up was instituted including further skin cancer excisions of an extremity and the right paramedian forehead. There was a clear and transparent plan of surveillance which was followed by [Dr B]."

57. In relation to the timeliness of Dr B's follow-up after the re-referral from Mr A's GP was received in November 2018, Dr D said that "a significant local recurrence was a possibility if not a certainty and that urgent review was indicated". However, Dr D noted that the referral came at a very busy period, and Dr B was unable to see Mr A for another eight weeks. Dr D considers that in the circumstances, Dr B "perhaps should have seen [Mr A] earlier" following the GP referral, but advised that, in his opinion, this would unlikely have changed the outcome.

Family meeting

58. On 6 September 2019, Dr B met with Mr A, and two members of his family, to discuss Mr A's concerns about the management of his BCC.

59. In a summary of the meeting sent to Mr A's GP, Dr B recorded in relation to why further surgery was not performed following the initial excision in 2018:

> "My reasoning was the complexity and difficulty of the surgery, given its proximity to the supraorbital nerve … I discussed and mentioned to [Mr A] on more than one occasion the reason for not operating and the potential other options, such as observation given that clinically there were no signs at the time that the lesion was recurring. In April 2018, when I saw [Mr A] for a follow up visit where there was a small skin cancer in the left lateral arm, the options for surgery to the left supraorbital area was brought up again, focusing on the potential complications and comorbidities versus continuing to observe. [Mr A] opted for observation and was happy to do that as well at the next follow up visit in August 2018.
>
> Should I have done the wider excision locally in the forehead, I would have probably ended up with another incomplete excision at the deep margin … This would have been

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> questioned by the medical and surgical community … There was clinical recurrence on the left forehead in January 2019 …"

Further comment from Mr A

60. Mr A told HDC:

> "Prior to this I was fit and active, playing outdoor bowls 3–4 times per week, living alone, cooking, washing & ironing, looking after my house and large section and growing a vegetable garden all year round. My doctor assured me that I was in excellent health which far belied my chronological age."

61. Mr A said: "[M]y purpose in making this complaint is in the hope that other people do not have to experience this in the future."

62. Mr A also stated:

> "I am angry and disappointed that the whole onus for the delay is being leveled at my supposed decision, against medical advice, to 'watch and see'. What exactly was I watching and waiting for?? … There seemed to be a very casual approach to follow up, despite my concerns."

Responses to provisional opinion

Mr A

63. Mr A was provided with a copy of the "information gathered" section of the provisional opinion. His comments have been incorporated above where appropriate. In addition, in response to Dr B's suggestion that Mr A's memory may be the result of his preexisting conditions, Mr A stated:

> "If existing conditions are now being correlated with cognition/memory problems why were they not identified at the original time of consultation so steps could be taken to inform the GP or family of a potential problem in comprehension?"

64. In relation to the lack of follow-up and plan, Mr A stated:

> "There was no defined or charted follow up plan, just a watch and wait approach with the onus of responsibility on the patient, which is not acceptable particularly if the issues identified [in relation to cognition and memory] were a valid concern. Similarly, the assertion that the computer system has randomly deleted something that clearly did not exist in the first place muddies the waters, and is not in the least credible mitigation."

Dr B

65. In response to the provisional opinion, Dr B noted that Dr D, whom Dr B engaged "to provide his independent perspective on [HDC expert] Dr Langley's findings", disagreed with Dr Langley's advice on a number of points. In particular, Dr B stated:

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- Dr D considered that Dr B's postoperative surveillance of Mr A, and the written advice provided to Mr A's GP, was "reasonable, transparent, clear and faultless".
- Dr D considered that Dr B's clinical notes, including his plan and indications for a conservative approach when Mr A declined to have a deeper excision, were "very well documented and clear".
- Dr D considered that "[Dr B] took responsibility for [Mr A's] facial cancer management and subsequent recurrence" and "managed this very difficult case well and to a reasonable standard".
- While Dr D noted that in an "ideal world" Dr B would have arranged an earlier appointment for Mr A after the re-referral was received on 11 November 2018, Dr D noted a number of mitigating factors that influenced this.

66. In relation to the decision not to proceed with re-excision in April 2018, and Dr B's documentation of his discussion with Mr A about this decision, Dr B stated:

> "[T]his was a situation where a patient decided not to adopt a course of action recommended by a surgeon. … It is correct that in a situation where a patient decides to go against a recommended course of action this should be documented, and [Dr B] accepts this. This is however a *retrospective* matter not a *proactive* issue that had any influence over [Mr A's] decision not to undertake the procedure."

67. Dr B noted that while re-excision "was the preferred option", he respected Mr A's right to make his own decision with respect to his treatment, and "respected Mr A's autonomy in this case".

68. Dr B noted that Dr D was "not at all critical" of his management plan but, in relation to the response to the re-referral received in November 2018, Dr B accepted "with hindsight that he could have made efforts to see [Mr A] earlier and this is a learning". However, Dr B noted that there were a number mitigating factors, and that "the delay was not in any way influential in terms of outcome".

Opinion: Dr B — breach

Introduction

69. This report considers whether the care provided to Mr A in relation to the management and follow-up of the BCC on his left eyebrow was reasonable and in accordance with accepted standards.

70. Overall, I have concerns about the care provided to Mr A. In making my decision, I have taken into account all of the evidence gathered during the course of the investigation, which includes statements from Mr A and Dr B, Dr D's opinion, and independent expert advice

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from plastic and reconstructive surgeon Dr Sally Langley. I have outlined my concerns in more detail below.

Initial management of BCC

71. I have considered the adequacy and appropriateness of Dr B's management plan on 13 February 2018.

72. Dr Langley advised:

> "The accepted management of a patient like [Mr A] who has had an incomplete excision/transection at deep margin, of infiltrating BCC with perineural invasion and lymphovascular invasion would have been: review histology, plan and undertake surgical re-excision (standard excision or Mohs micrographic surgery), consider the role of post-operative radiotherapy and discuss at a multidisciplinary cutaneous malignancy or head and neck cancer meeting. MRI could possibly have been considered at the time of incomplete excision with perineural invasion in February 2018 or certainly later in 2018.
>
> [Mr A's] BCC was high risk ie facial location in 'H-zone'; size about 17 x 10mm (>10mm); aggressive type (infiltrating — perhaps desmoplastic) so should have been treated in accordance with the high risk features."

73. Dr Langley advised that a conservative, non-surgical approach would not be appropriate in the circumstances.

74. Dr B said that following the initial excision of the BCC on Mr A's left eyebrow, the plan was to undertake surgical re-excision of the lesion. Dr B told HDC that he explained in detail to Mr A why re-excision was "the first option in this case". Dr B's clinic letter to Mr A's GP documented the plan to re-excise the BCC, but Dr B did not document the details of his discussion with Mr A.

75. Mr A agrees that Dr B told him that the lesion had not been excised fully. However, Mr A is less clear on whether a plan was made to re-excise the lesion at that time. In his complaint, Mr A told HDC that the plan was to re-excise the lesion, and that radiotherapy might be required, but he later told HDC that re-excision was never scheduled. Mr A said that it was his understanding that the subsequent appointment scheduled for 4 April 2018 was only to excise the lesion on his arm. In response to the "information gathered" section of the provisional opinion, Mr A said that his confusion regarding the initial plan to re-excise the BCC may have been the result of both the lentigo malinga and BCC being discussed at the same appointment. Mr A stated that while the plan to re-excise the lesion on 4 April 2018 may have been clear to Dr B, it was "not at all clear" to him.

76. I have considered both accounts and the clinical documentation and, on balance, I accept that Dr B initially planned to re-excise the BCC on Mr A's left eyebrow, as it is supported by his contemporaneous clinical records and Mr A's initial statement to HDC.

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April 2018 — decision not to proceed with re-excision

77. I have considered the adequacy and appropriateness of Dr B's management on 4 April 2018 when the decision was made not to proceed with re-excision.

78. Dr B and Mr A have provided differing accounts about what was discussed regarding the decision not to proceed with the planned re-excision on 4 April 2018.

79. Dr B said that when going through consent preoperatively, Mr A questioned why they were planning to re-excise the lesion, since it had healed and success from re-excision was not guaranteed. Dr B stated that he discussed the options available to Mr A at the time, and Mr A chose not to proceed with the recommended excision, and to take a "watch and see" approach. Dr B said that Mr A was aware of the reasons why re-excision was the recommended approach, and that ultimately Mr A decided not to proceed with the surgery at the time.

80. In contrast, Mr A denies that he elected only to observe the BCC on his eyebrow, rather than have it re-excised. Although in his initial complaint he acknowledged that there was a plan to re-excise the BCC, he later said that re-excision of the BCC was not planned for 4 April 2018, but that he did raise it as a concern at the time. He said that as an explanation for why he had tingling around the area, Dr B told him that there are lots of nerve endings in the area. Mr A stated that no plan for further treatment of his eyebrow BCC was discussed at that time.

81. Dr B documented in his handwritten notes that Mr A had chosen to observe the BCC on his forehead, and described this in more detail in his operation note. However, Dr B did not document any details of a discussion of the risks of not re-excising the BCC, and what advice he provided to Mr A, including his recommended treatment approach or management plan.

82. Dr Langley advised that the appropriate management for someone with a high-risk BCC, such as Mr A, is to re-excise it, and that a conservative approach "could only be justified for an elderly patient in poor general health and that was not the case for [Mr A]". She stated:

> "[Dr B] says that [Mr A] clearly did not want to have the advised surgery. I do not know whether [Dr B] described recurrence in the orbit and the cancer tracking into the brain. This bad outcome could still have occurred despite further excisional surgery and radiotherapy."

83. In reliance on the contemporaneous documentation, I accept that there was some discussion between Dr B and Mr A about proceeding with re-excision at that time. However, given the differences in Dr B's and Mr A's accounts about what was discussed, and the lack of additional evidence to corroborate either account, I am unable to make a finding about the exact nature of that discussion. In particular, I am unable to make a finding as to whether Dr B made it clear to Mr A that a conservative approach was not recommended in the circumstances, and discussed the risks of not re-excising the BCC.

84. I note Dr D's view that if Mr A declined to proceed with the planned surgery, Dr B's plan to "watch and see" was reasonable in the circumstances.

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85. Although Mr A had the right to decline recommended treatment, I would be critical if Dr B did not explicitly inform Mr A of the risks of that decision, and that it was not the recommended course of action. This is information that a reasonable consumer, in Mr A's circumstances, would need to receive to give informed consent.

86. In any case, as noted by Dr Langley, in a situation such as this, when a decision is being made to depart from the recommended treatment pathway, the discussion should have been documented clearly to help inform ongoing care and management. Dr Langley advised:

> "[Dr B] has accepted to not re-excise the significantly incompletely excised BCC with perineural invasion and lymphovascular invasion following discussion with [Mr A]. This is such an important decision that it should be clearly documented and a follow-up plan made."

87. In response to the provisional opinion, Dr B acknowledged that in a situation where a patient goes against a recommended course of action, ideally this would be documented. He stated:

> "This is however a *retrospective* matter not a *proactive* issue that had any influence over [Mr A's] decision not to undertake the procedure. Nor did it have any influence on the outcome."

88. Dr B noted that while re-excision "was the preferred option", he respected Mr A's right to make his own decision with respect to his treatment, and "respected [Mr A's] autonomy in this case".

89. I disagree. There is no disputing that a conservative, non-surgical approach would not be recommended in Mr A's case. Therefore, if Mr A chose not to proceed with the recommended re-excision, it was important for him to be explicitly advised of the risks of that decision. While Dr B documented Mr A's decision not to proceed with re-excision, there is no evidence that Dr B advised him of the risks of that decision, or that Dr B clearly advised Mr A that this was recommended. I note Mr A's comment in response to the "information gathered" section of the provisional opinion:

> "Had [Dr B] been adamant that [re-excision of the BCC on Mr A's forehead] was highly recommended to be done, as he was with the [lentigo malinga] at the first consultation, there is nothing to suggest that I would have refused this advice."

90. In my opinion, Dr B should have documented the content of any discussion about the risks associated with the decision not to re-excise the BCC, and the reason(s) for not proceeding with the recommended treatment plan. I am critical that he did not do so.

Ongoing management

91. I consider that after the decision was made not to re-excise the BCC on Mr A's eyebrow in April 2018, Dr B's ongoing monitoring and management of Mr A fell below accepted standards in two respects.

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92. First, as Dr Langley advised and noted above, Dr B should have given Mr A and his GP written advice about the reasons for not re-excising the BCC, and what to look out for (thickening, lump, pain, sensory disturbance). This was important information that also should have been documented in the clinical record.

93. Secondly, as Dr B remained responsible for Mr A's follow-up of his BCC, he should have put in place an adequate plan for ongoing surveillance.

94. Dr B said that he did make a management plan for ongoing monitoring of the BCC lesion. He saw Mr A on 7 August 2018 for a follow-up appointment, at which time he noted no signs of recurrence of the BCC on Mr A's forehead. Dr B saw Mr A again on 22 August 2018 for the surgical excision of a lesion on his arm. However, Mr A does not recall Dr B assessing the BCC on his forehead at that time, and the clinical records contain no reference to the BCC on Mr A's forehead, or to any further scheduled appointments. Dr B did not see Mr A again until January 2019 at the request of his GP (discussed below).

95. I note Dr B's suggestion that an appointment had been scheduled for November or December 2018, but that this, together with the follow-up plan, was deleted when the GP referral was received in November 2018. However, Dr B has provided no evidence to support that an appointment was made. Mr A was concerned about a lump that had developed at the site of the previously excised BCC on his forehead, and attended his GP in November 2018 with the specific purpose of requesting a referral back to Dr B. That, together with the fact that there is no record of an appointment for November, and that when the referral was received an appointment was not scheduled for another eight weeks, does not persuade me that a follow-up appointment for November had been scheduled.

96. Having made that finding, I consider that Dr B's plan for follow-up of the BCC on Mr A's eyebrow was inadequate. While I note Dr D's view that Dr B's management and surveillance plan was reasonable in the circumstances, I disagree. As Dr Langley advised, Dr B should have planned to see Mr A again around November, or instructed regular review with Mr A's GP, who could refer Mr A back to Dr B if needed. As it was, beyond August there is no evidence of any plan for follow-up.

97. Dr Langley advised that if there was an appointment scheduled for November 2018, Mr A would have very likely undergone the investigations and referral earlier than January/ February 2019. Dr B's failure to arrange appropriate follow-up was therefore a missed opportunity to ensure that Mr A received timely treatment for the recurrence of the BCC.

Delay in appointment

98. I am concerned about the eight-week delay in scheduling an appointment following the receipt of the re-referral from Mr A's GP advising of the lump and tingling that had developed around the area of the BCC lesion on Mr A's left eyebrow.

99. Dr B said that the delay in the appointment being scheduled was caused by the "end of year rush", which is the "worst and busiest time of the year".

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100. I note that Dr D considers that when the referral was received, urgent review was indicated, but that it was a very busy time of year. In his opinion, earlier review would not have changed the outcome. It is important to note that my role is not to assess this case based on whether the outcome would necessarily have been any different — I am concerned about whether, with the information available to Dr B at the time, he acted appropriately and in accordance with the accepted standard of care.

101. With regard to the accepted standard of care, Dr Langley advised:

> "It is true that plastic surgery practices in private and public can be particularly busy in the pre-Christmas period but I do not accept this as justification for keeping [Mr A] waiting weeks longer than he should have. The public hospital plastic surgery department did see [Mr A] very quickly after he was referred after seeing [Dr B] emphasizing the importance of the urgency of the referral."

102. I recognise that providers cannot always control demand for their services. However, they can control how they respond to and manage the demand. The existence of systemic pressures does not remove provider accountability in addressing such issues, and it is prudent for providers to ensure that they prioritise patient follow-up appropriately based on acuity.

103. Dr Langley considers that the failure to make an appointment in a timely manner following the receipt of the GP referral was a moderate departure from accepted standards. I accept Dr Langley's advice. Both Dr Langley and Dr D agree that by the time the referral was received in November 2018, urgent review was required. I do not accept that the time of year is an excuse for not seeing a patient in a timely manner. As noted by Dr Langley, there were other options available to Dr B if he was unavailable, such as referring Mr A to another clinician. Dr Langley advised: "[I]t was unknown whether [Mr A] had a treatable condition and he was entitled to earlier review, investigation and planning than occurred."

Conclusions

104. While I accept that Dr B initially planned to re-excise the BCC when histology showed that the initial excision did not remove all the BCC, I have not been able to make a finding as to whether Dr B made it clear to Mr A the risks associated with the decision not to re-excise it, and that a conservative approach was not recommended in the circumstances. However, I would be critical if Dr B did not provide that information to Mr A, and I am critical that Dr B did not document details of the discussion that took place.

105. I am also concerned about Dr B's management of Mr A after the decision was made not to proceed with re-excision of the BCC, including:

- Failing to provide written advice to Mr A and his GP about ongoing surveillance and what to look out for.
- Failing to put in place an adequate plan for monitoring and follow-up after the decision was made not to re-excise the BCC on Mr A's eyebrow in April 2018.

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- Failing to ensure that Mr A was seen in a timely manner following the receipt of the re-referral from Mr A's GP in November 2018.

106. For the reasons set out above, I conclude that Dr B failed to provide services to Mr A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[7]

Recommendations

107. I recommend that Dr B:

a) Prepare an anonymised case study around these events, for sharing with colleagues for training purposes, within three months of the date of this report.

b) Undertake further training on communication and consent. Evidence of registration or attendance at an appropriate training session should be provided to HDC within six months of the date of this report.

c) Provide a written apology to Mr A for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, and will be forwarded to Mr A.

Follow-up actions

108. 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 Australasian College of Surgeons, and they will be advised of Dr B's name.

109. 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.

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

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Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from plastic surgeon Dr Sally Langley:

"I have been asked by [HDC] to provide further expert advice on the care provided by [Dr B] to [Mr A] between January 2018 and May 2019.

I have reviewed the previous reports and the correspondence.

I have been asked to make further comments on the following 4 questions based on the letters from [Dr B], [Dr D], [Mr E] and [Mr A] himself.

09/06/2020 Dr S Langley 1st report
25/07/2020 [Dr D] report for [Mr E]
28/07/2020 [Dr D] letter
05/09/2020 Dr S Langley 2nd report
06/09/2020 [Dr B] letter — family meeting
12/10/2020 [Mr A] letter
14/10/2020 [Mr E]
16/11/2020 [HDC Investigator] email request to comment further

My Advice from 09/06/2020 report was as follows and I will add in my further comments from today, based on the further reports, in italics.

1. **What is the accepted management of a patient with the type of BCC excision result presented to [Dr B] in February 2018 (infiltrating type tumour, incompletely excised with perineural infiltration)? What does the medical literature suggest might be an expected BCC recurrence rate in this scenario?**

The accepted management of a patient like [Mr A] who has had an incomplete excision/transection at deep margin, of infiltrating BCC with perineural invasion and lymphovascular invasion would have been: review histology, plan and undertake surgical re-excision (standard excision or Mohs micrographic surgery), consider the role of post-operative radiotherapy and discuss at a multidisciplinary cutaneous malignancy or head and neck cancer meeting. MRI could possibly have been considered at the time of incomplete excision with perineural invasion in February 2018 or certainly later in 2018.

[Mr A's] BCC was high risk ie facial location in 'H-zone'; size about 17 x 10mm (>10mm); aggressive type (infiltrating — perhaps desmoplastic) so should have been treated in accordance with the high risk features.

A conservative approach could only be justified for an elderly patient in poor general health and that was not the case for [Mr A]. Sometimes incomplete excision of BCC is accepted due to the patient's limited predicted lifespan and usually slow rate of recurrence for BCC. [Mr A] was in his 80s but was otherwise reasonably fit and well. Sometimes on review of histology with the pathologist it is worked out how significant

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the perineural invasion/lymphovascular invasion is and also how significant the deep margin excision is.

It is difficult to say what the recurrence rate for incompletely excised BCC with perineural invasion and lymphovascular invasion is since I could not find studies that look at this. In general people with incomplete excision BCC with perineural invasion do have some form of further treatment. I advise that the rate of recurrence would have been high. The recurrence for [Mr A] has come quickly, by about 10 months from the January 2018 excision. Also, the recurrence was already a mass of considerable size by 1 year. Usually BCC will recur more slowly.

I advise that this is a major departure from accepted standard of practice.

The lack of plan for re-excision (of BCC in H-Zone, with perineural invasion and incomplete deep excision) would be viewed with concern by plastic surgical colleagues.

22/11/2020:
[Dr D] in his letter of 25/11/2020 agrees with my comments but then supports that [Dr B] had planned re-excision and that [Mr A] declined to undergo re-excision. We do not have documentation of this discussion, advice and plan. We have [Dr B's] word only.

[Mr A] in his letter dated 12/10/2020 states that he has always taken the advice of medical professionals. With respect to the longstanding melanoma of his left cheek, [Mr A] says that he had mentioned it to his GP who was not concerned. Again, we do not have documentary evidence that that was the case but that would explain the presence of a large and obvious melanoma of the left cheek/lower eyelid. [Mr A] had not questioned the advice given by [Dr B] to surgically treat BCC left eyebrow and also melanoma left cheek/lower eyelid.

[Mr E], 14/10/2020 did not comment on this.

I uphold my advice above ie Major Departure.

2. **Please comment on the communication between [Dr B] and [Mr A] in April 2018 regarding indications for re-excision of the forehead lesion versus observation (two scenarios may need to be considered given the difference in recollection between the two parties of this communication). What would you expect to be included in such a discussion (e.g. recurrence rates, safety-netting advice regarding early signs of recurrence)?**

[Mr A] believes he was advised by the expert, [Dr B], that it was acceptable to observe his left eyebrow for BCC recurrence rather than do the further surgery. I have interpreted that [Mr A] was already living with and tolerating melanoma of his left cheek/lower eyelid when he consulted with [Dr B] for the BCC left eyebrow. [Dr B] appropriately expressed concern with respect to the melanoma of the left cheek/lower eyelid and planned surgery for both lesions. Usually melanoma is of more concern than

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BCC. [Mr A] was seemingly not concerned about melanoma but was concerned about BCC.

[Dr B] believes that [Mr A] desired for no re-excisional surgery. There is not clear documentation of the advice given by [Dr B] or received by [Mr A].

My advice is that if [Mr A] desired no further surgery for the incompletely excised BCC with perineural invasion, this should have been clearly documented by [Dr B] with the reasoning and also the advice [Dr B] gave to [Mr A]. [Mr A] should have been advised what to look out for and also the GP should have had a detailed letter explaining the reasoning around no further action and what to look out for (thickening, lump, pain, sensory disturbance). Written advice to both [Mr A] and [Mr A's] GP would have been helpful.

It is possible that [Dr B] did not believe that the BCC would recur so quickly or so badly and that he was seeing [Mr A] every few months anyway.

This is a moderate departure from accepted practice.

Plastic surgical peers would be concerned about the high possibility of recurrence and the difficulty recognizing that it was happening.

In his report of 05/09/2020 [Dr D] says that the communication between patient and surgeon seemed appropriate and that [Dr B] communicated his concern to [Mr A]. [Dr D] supports that [Mr A] wished to have a 'watch and see' policy of regular and frequent follow-up. [Dr D] says that this was entirely reasonable in this case. [Dr D] says that the re-excision surgery plan was made but the patient declined on the day, 3 months later.

In my second report dated 05/09/2020 I comment on the discrepancy between the advice that [Dr B] says he gave versus the advice [Mr A] says he received and there is no documentation of this discussion and plan. [Dr B] explains that he did make that plan and I said that I 'believed he did make that appropriate plan'. [Dr B] and [Mr A] must have had a verbal discussion which was not documented. Here we have the problem where [Dr B] believes he gave this advice to [Mr A] and then [Mr A] took the advice of the expert to adopt the 'wait and see' policy of planned follow-up. I have not seen the plan for follow-up.

I have not mentioned previously but if [Mr A] had a plan of follow-up every 3 months or so, then he would indeed have expected to be booked for a follow-up appointment in about November 2018 which is the time he saw his GP with the recurrence with worrying symptoms. If this appointment for planned follow-up had been made with [Dr B], then [Mr A] would have very likely undergone the investigations and referral earlier than January/February 2019.

[Mr E] in his letter of 14/10/2020, paragraph 4, has outlined that I have missed the point that care and follow-up was transferred to [Dr C] on 25/01/2019. This is not relevant

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since the follow-up plan that is not apparent to me was in 2018. Indeed, once [Mr A] was referred with the significant recurrence of the BCC in January 2019, his follow-up expectation was no longer with [Dr B].

Follow-up for skin malignancies is often transferred to a GP or follow-up is shared between specialist and GP. Transfer of follow-up to a GP would only be when a patient had been appropriately followed up by the specialist, was stable, the condition was appropriate for that, and referral back to specialist for concerns was readily available. This would have been part of a documented plan for follow-up.

My advice that this is a moderate departure still stands.

With consideration of [Dr B's] comments there would be no departure.

With consideration of [Mr A's] comments there is a moderate or even a major departure.

3. **Please comment on [Mr A's] post-operative surveillance by [Dr B], including documentation and written advice provided to his General Practitioner (GP).**

[Dr B's] post-operative surveillance of [Mr A] was appropriate considering the ongoing need for skin cancer removal and melanoma left cheek/lower eyelid surveillance. Also, if a course of observation was planned, appointments several months apart would have been appropriate. [Dr B] did see [Mr A] twice in August 2018 seemingly with no evidence of recurrence of the left eyebrow BCC but it was clinically apparent by November. I have not read of the plan for follow-up of the LM or the BCC beyond August 2019.

My advice is that the surveillance is mildly unacceptable, but the lack of a follow-up arrangement is of more concern. It should be clearly documented that [Dr B] wanted to see [Mr A] again in a number of months, or that he should be under regular review with his GP who could refer him back.

Please refer to the comments above under 2. The documentation of a follow-up plan is absent. Again, I state that if there had been planned follow-up [Mr A] would have been seen in about November 2018 and would not have had to see his GP and be re-referred. [Mr A] would then have undergone investigations about 2 months earlier than they did occur.

My advice is maintained that this is mildly unacceptable.

From [Dr B's] perspective there is no departure from acceptable practice.

From [Mr A's] perspective there is a moderate departure from acceptable practice.

4. **Please comment on the timeliness of the appointment offered to [Mr A] by [Dr B] given the content of the GP referral letter in November 2018. Should [Mr A], or his GP, have been given written advice to access specialist review earlier, if [Dr B] did not have the capacity to review [Mr A] for two months?**

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The letter from [Mr A's] GP sent on 21/11/2018 outlines that [Mr A] had a mass at the left eyebrow site with tingling. The presence of a lump and the tingling were worrying descriptions, 'red flags', and a prompt appointment should have been organized. The appointment was on 17/01/2019 about 2 months after the GP letter. My opinion is that [Mr A] should have been seen by [Dr B] more promptly or an appointment with another specialist who could see him quickly should have been organized. [Mr A] should have been seen, assessed, CT or MRI undertaken, MDM and plan for treatment underway before the end of 2018, certainly by about 30 days from the referral. More prompt attention might have been beneficial to [Mr A]. In fact, the 17th January is 8 weeks after the GP referral so is beyond the more acceptable waiting time. The Christmas/New Year time can make it difficult for scheduling appointments but surgeons should make sure that patient care is not compromised by delays caused by the public holidays and service closures.

I advise that this delay is a moderate departure from the standard of care. My colleagues would be quite concerned about this delay for this patient with the symptoms described by the GP on the basis of the described BCC.

My current advice is that this stands ie moderate departure.

[Dr B] defends this as does [Dr D] and would not say there is a departure from acceptable standard.

From [Mr A's] perspective this is a moderate or major departure.

5. **It is highly appropriate that [Dr B] was more concerned about the LM of the left cheek/lower eyelid initially. The photographs showed a large significant pigmented macule which could have been invasive melanoma. I and colleagues would also have had significant concern about the LM/melanoma.**

The surgery result looks very good.

Standard surgical excision as the primary treatment and as the re-excision treatment is what most plastic surgeons in New Zealand would plan. Once the histology report showed BCC with perineural invasion incompletely excised the excision method could have been by a margin control technique such as Mohs micrographic surgery (MMS). MMS has not routinely been available to patients due to limitation in number of Mohs practitioners, limited availability if at all in public hospitals, and in the private sector (and public) the considerable expense. These days MMS should be considered as the excision method if available. It is unfortunate that there is very little MMS service available in our public hospitals. Privately the cost can be prohibitive. Plastic surgeons do respect the role of MMS for certain indications such as this.

The radical surgical of orbital exenteration for periorbital BCC with perineural invasion with radiotherapy can give long term control. (Kuo)

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The cutaneous malignancy and Head & Neck Cancer multidisciplinary meetings can be available for private surgeons and patients on request.

With respect to paragraphs 7 and 8 of [Mr E's] letter, which refer to the possibility that the delay in [Mr A] getting assessment for recurrence of BCC my comment has been misinterpreted. Once [Mr A] was seen, investigated and then discussed by the group of specialists at the multidisciplinary meeting at [the public hospital] it is possible that there has been no difference in his long-term outcome. At the time that [Mr A] was presenting with his recurrence it was unknown whether he would be helped by surgery +/- radiotherapy and if they were indicated, earlier planning is likely to have been beneficial. The possibility of consequences due to delay is not known until full assessment has occurred.

I am concerned that [Mr E] in paragraph 9 has expressed concerns about the independence of my approach. [Mr E] has said that he is 'disappointed by the continuous references to [Dr B] "believing"'. My use of the word 'believing' has been rather excessive, but this is because [Dr B] has not documented findings and follow-up plans. I have had to interpret what has occurred and been planned without written documentation. That is why the word 'believe' has been used several times. I have no intention to undermine [Dr B's] credibility. I have been seeking facts and evidence of documentation.

I am also concerned about the last paragraph 10 where [Mr E] refers to [Dr D] as highly qualified and entirely supportive of the care that was provided by [Dr B]. This is not an impartial comment. [Dr D] and I would be similar for experience and competence.

I have to the best of my knowledge, based on facts where provided, made impartial comments with respect to the care that [Mr A] received for his basal cell carcinoma.

Sally Langley
Plastic and Reconstructive Surgeon"

The following further advice was provided by Dr Langley on 5 September 2020:

"I have been asked by the Commissioner to provide further expert advice on the care provided by [Dr B] to [Mr A] between January 2018 and May 2019.

I provided my report on 09/06/2020.

I have been sent [Dr B's] response and he has included a report from plastic surgeon [Dr D].

I have also been sent the screenshot of [Mr A's] appointments at [Dr B's] clinics and also the letter from the clinic attendance 17/01/2019.

[Dr B] has defended his management of [Mr A]. I accept that not all that is discussed and planned at a consultation is documented in writing. I also accept that patients do

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not always hear what is discussed correctly, interpret and understand correctly and remember the discussion and decisions.

[Dr B] believes he discussed the results, explained why further surgery was needed and scheduled [Mr A] for the further surgery for the incompletely excised eyebrow BCC. [Dr B] says that at times he feels he might have let [Mr A] down by not pushing him to have the re-excision surgery. [Dr B] believes he gave [Mr A] the options and alternatives and that [Mr A] made his own decision based on this information. [Dr B] goes on to say that [Mr A] again declined the surgical option later on when he had the recurrent BCC mass in the orbit. I do not believe that this supports that [Mr A] was well known to decline surgery. The surgery for the recurrent BCC mass would have been far more major so it is more likely that an elderly person would decline that more major surgical possibility. I believe that by the time that [Mr A's] case was discussed at the multidisciplinary meeting on 14/02/2019 all treatment options were major and difficult for [Mr A] to accept. I do not think that comparing the decline of surgery in February 2019 with the decline in April 2018 is comparable.

I have now seen the clinic letter from 17/01/2019. This letter was missing from the original file.

[Dr B] believes that he gave the advice that I have mentioned as accepted practice. [Dr B] might have done that but it is not documented. [Dr B] did plan the re-excision operation but it did not go ahead. [Dr B] believes that he did appropriately make that plan. I believe that he did make that appropriate plan.

I do see the discrepancy with respect to what [Dr B] says he advised and discussed versus what [Mr A] believed he was advised. [Dr B] verbally discussed the advice to have surgery and says that he showed [Mr A] photos of the anatomy of the area (forehead and supra-orbital nerves). [Dr B] says that [Mr A] clearly did not want to have the advised surgery. I do not know whether [Dr B] described recurrence in the orbit and the cancer tracking into the brain. This bad outcome could still have occurred despite further excisional surgery and radiotherapy. I am still unclear whether [Mr A] was advised what recurrent BCC would feel and look like. [Dr B] says that he did advise [Mr A] of this.

With respect to follow-up, I do believe that [Dr B] did not make an appropriate plan for follow-up. If the BCC was to recur it was most likely to be after many months to years. Also [Dr B] may have followed [Mr A] for the melanoma left cheek. It is common practice for the follow-up of such patients to be handed over to the general practitioner but there is no letter advising that. There was no booked follow-up after August 2019. I would have expected that under the circumstances. Many patients could be advised to re-present if concerned but we already know that [Mr A] had a large longstanding early melanoma of his left cheek for which he had not sought medical attention as far as we have been advised.

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I do not accept [Dr B's] justification for not seeing [Mr A] more promptly when he was re-referred in November 2018 with the left orbital mass. It is true that plastic surgery practices in private and public can be particularly busy in the pre-Christmas period but I do not accept this as justification for keeping [Mr A] waiting weeks longer than he should have. The public hospital plastic surgery department did see [Mr A] very quickly after he was referred after seeing [Dr B] emphasizing the importance of the urgency of the referral.

I am pleased to read that [Dr B] has made some changes in his practice related to the concerns raised with respect to the care of [Mr A]. I agree that is a difficult scenario when a patient declines advised surgery for re-excision. I am going through that with a private melanoma patient currently. I am documenting well, discussing at multidisciplinary meetings and following the patient at my clinic. I bring up the issue every time I see the patient.

I do believe that [Mr A] may have a background of avoidance of medical or surgical treatment for skin cancers. The melanoma of his left cheek was large and obvious. He must have had it for several years. The BCC left eyebrow was of moderate size, but not unusually large, before he sought attention for it. I commonly see people with BCC similar to [Mr A's] left eyebrow BCC as their first presentation. The rate of growth is not known here. [Dr B] says it had been growing for a long time. This may not be the case since the recurrence came very quickly over just a few months.

I have read the report written by [Dr D]. He is critical of my report on [Dr B].

[Dr D] has advised his 'accepted management'. [Dr D] refers to the BCC as 'neglected' but it might not have been so. [Dr D] says that the pre-operative photos show evidence of frontalis palsy but I dispute that. Also the tumour is mid-eyebrow/mid-forehead, so medial to where the frontal branch of the facial nerve enters the muscle. The nerve infiltrated here would be the supra-orbital nerve (this is a sensory nerve and runs along the superior orbit and enters the forehead around the orbital rim, medial to its mid-point). Also, even if there had been frontalis palsy present, the timeline cannot be deduced from the photo alone. [Dr D] agrees that the advice to re-excise deep margin is reasonable but that orbital exenteration would not be reasonable. [Dr D] emphasizes that [Mr A] declined the re-excision procedure.

[Dr D] believes that the communication between patient and surgeon in April 2018 was appropriate. I am unable to be so supportive since I have not seen the contemporaneous documentation. [Dr D] states that a 'watch and see' policy is reasonable.

[Dr D] also believes that the appointment in January is reasonable due to the end of a year being very busy. I do not agree with that justification. [Dr D] justifies his comment that he accepts the delay by saying that it would not have made any difference. I think that until that time it was unknown whether [Mr A] had a treatable condition and he was entitled to earlier review, investigation and planning than occurred. I agree that for

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[Mr A], in his circumstances, in retrospect, no difference in his care or tumour behaviour has occurred but that does not justify the delay. I do agree that extensive orbitocranial resection and free flap coverage was unlikely to have been offered or undertaken for [Mr A] but that decision can only be made after full review.

When patients are seen for any appointments, there is a lot of interaction that is not documented. There is variation in how the treatment advice is given by the doctor, received by the patient, understood, remembered and documented. Some treatment decisions are of more significance than others. [Dr B] has accepted to not re-excise the significantly incompletely excised BCC with perineural invasion and lymphovascular invasion following discussion with [Mr A]. This is such an important decision that it should be clearly documented and a follow-up plan made. It is unfortunate and surprising how quickly this BCC recurred as an inoperable mass.

Clarification provided by Dr Langley

'I note that your original advice specified a major departure, two moderate departures, and one mild departure from accepted practice. It appears that your original advice that there was a major departure from accepted practice (point 1 of report 1) has changed to that care was appropriate and that the major departure no longer stands — is that correct?'

I have checked my original report 09/06/20 (major departure) and what I said in my second report 05/09/20. I do sound more lenient 'I believe that he did make that plan.' However, I have not been provided with evidence to back these thoughts up, just hearsay.

'Secondly, I note on page 3 of your latest advice that you say [Dr D] believes communication between patient and surgeon in April 2018 was appropriate, but that you are unable to be so supportive since you have not seen the contemporaneous documentation. Can you please clarify for me what contemporaneous documentation you are referring to? (as I may be able to request it and provide it to you).'

I have not been provided with any documentation which would have supported [Dr D's] comment. If there is documentation I could comment further."

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Appendix B: Supporting opinion from Dr D provided by Dr B

Statement from Dr D

"25th July 2020

Dear [Mr E]

Request for independent advice — care provided to [Mr A] by [Dr B] FRACS

I have been asked to provide an opinion for the above matter. I confirm that to the best of my knowledge I do not have any conflict of interest with the parties involved.

I am a Plastic Surgeon, working within a General Plastic Surgery scope of practice. I have practised as a Consultant Plastic Surgeon in Plastic & Reconstructive Surgery for 30 years in both public, private and overseas practice.

Information provided

In preparing this advice I have been provided with copies of the following documents:

Letter of Complaint (13 December 2019)

[Dr B's] response (29 January 2020)

Clinical Records of [Dr B] FRACS January 2018–September 2019. Including clinical images

Clinical records from [the] DHB February 1918–October 2019

I have also been provided with a copy of the High Court Rules' Code of Conduct for Expert Witnesses and have followed this guidance in preparing this report.

Questions asked

You have asked me to answer a number of specific questions related to this case. I have addressed each of these below.

1. What is the accepted management of a patient with the type of BCC excision result presented to [Dr B] in February 2018 (infiltrating type tumour, incompletely excised with perineural infiltration)? What does the medical literature suggest might be an expected BCC recurrence rate in this scenario?
2. Please comment on the communication between [Dr B] and [Mr A] in April 2018 regarding indications for re-excision of the forehead lesion versus observation (two scenarios may need to be considered given the difference in recollection between the two parties of this communication). What would you expect to be included in such a discussion (e.g. recurrence rates, safety-netting advice regarding early signs of recurrence)?
3. Please comment on [Mr A's] post-operative surveillance by [Dr B], including documentation and written advice provided to his General Practitioner (GP).

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4. Please comment on the timeliness of the appointment offered to [Mr A] by [Dr B] given the content of the GP referral letter in November 2018. Should [Mr A], or his GP, have been given written advice to access specialist review earlier, if [Dr B] did not have the capacity to review [Mr A] for two months?
5. Any other observations or Matters in this case that you consider warrant a comment.

My response to the questions

What is the accepted management of a *patient with the type of BCC excision result presented to [Dr B] in February 2018 (infiltrating type tumour, incompletely excised with perineural infiltration)? What does the medical literature suggest might be an* expected BCC *recurrence rate in this scenario?*

A: The management of this patient's extreme facial BCC is guided by the size and staging at presentation and in particular the histological findings. From the clinical images, this was an extensive and neglected infiltrating BCC of his lower left forehead/supraorbital region with evidence of ulceration and frontalis muscle invasion. The original image shows partial palsy of his left frontalis muscle. The referring letter from the patient's GP suggests that the BCC was longstanding (at least 1–2 years) and had been bleeding intermittently on his pillow. This particular BCC with a desmoplastic growth pattern and histological signs of both perineural and lymphovascular invasion is a subtype with an incidence of 1–3% and associated with recurrence rates of up to 45%. They are most common in elderly males, with white skin and extensive photo-damage as in this patient. He also presented with an extensive melanoma in-situ of his left midface. The size of this is reported as 40 x 38 mm in size and the left supraorbital BCC as 17 x 10 mm in size. The initial wide excision including underlying frontalis muscle of 28 x 20 mm seems entirely appropriate. However the final histology report suggests invasion of the subcuticular frontalis muscle and transection of the deep margin. The plastic surgeon offered to perform a re-excision of the deep margin, which is accepted management for this clinical scenario, however the prognosis for this cancer is poor given the other histological evidence of focal perineural and lymphovascular spate invasion. In [a patient in their eighties] with significant co-morbidities the option of more radical surgery such as a cranio-orbital resection and free flap reconstruction is contraindicated in my view. The plan to take another margin of resection deep to the total flap used to reconstruct the original defect seems entirely reasonable, but my understanding is that after discussion, directly prior to the planned surgery, the patient declined this. If a patient declines to go ahead with a procedure, the surgeon is unable to continue as he had planned and I believe it is unfair to criticise [Dr B] on this point.

Please comment on the communication between [Dr B] and [Mr A] in April 2018 regarding indications for re-excision of the forehead lesion versus observation (two scenarios may need to be considered given the difference in recollection between the two parties of this communication). What would you expect to be included in such a discussion (e.g. recurrence rates, safety-netting advice regarding early signs of recurrence)?

A: The communication between the patient and the plastic surgeon seems appropriate with respect to the initial findings of complete radial margins but a focus of incomplete excision at a deep margin. The likelihood of recurrence based on the perineural and lymphovascular

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space invasion, as well as the desmoplastic growth pattern were clear to [Dr B] and he communicated this concern to [Mr A]. Although a deep margin excision was later not done, because of the wishes of the patient, a 'watch and see' policy of regular and frequent follow-up given the patient's age and medical status, is entirely reasonable in this clinical case. It is clearly documented that a deeper excision at the level of the periosteum of his left frontal bone was planned 3 months after the initial excision but the patient declined this on the day and elected only for wide excision of an upper extremity BCC.

Please comment on [Mr A's] post-operative surveillance by [Dr B], including documentation and written advice provided to his General Practitioner (GP).

A: This seems to me entirely reasonable, transparent, clear and faultless.

Please comment on the timeliness of the appointment offered to [Mr A] by [Dr B] given the content of the GP referral letter in November 2018. Should [Mr A], or his GP, have been given written advice to access specialist review earlier, if [Dr B] did not have the capacity to review [Mr A] for two months?

A: It was now 10 months since the original surgery and the re-referral was from a different GP in the same rural practice. I would have thought that with the signs of a recurrent lump and paraesthesia in the left frontal region that a significant local recurrence was a possibility if not a certainty and that urgent review was indicated. The end of a clinical year in plastic surgery is often characterised by a very heavy workload and in this case [Dr B] was unable to review [Mr A] until early the following year, 8 weeks later. Even if he had been reviewed earlier the outcome would have been the same. Extensive frontal bone and orbital recurrence was the problem now. Only radical cranio-orbital resection with free flap reconstruction would have been a solution and clearly this was highly risky and contraindicated. Palliative radiotherapy was an option but never a curative option in my view.

Any other observations or matters in this case that you consider warrant a comment.

A: There is clear evidence that the patient, after discussion with [Dr B], selected a conservative 'watch & see' approach and there was no sign of local recurrence in August 2018, 7 months after the initial wide excision, with a focus of BCC at the deep margin. Radiotherapy was never going to offer any real long-term control or cure of this extreme cancer. Basal cell cancers are not very sensitive to radiotherapy. The intent of the radiation oncologist was always going to be palliative and not curative. Orbital exenteration is mentioned, which would not have controlled the tumour spread either. He would have had to have a radical cranio-orbital resection and free flap reconstruction, which for a patient in their eighties and with significant co-morbidities, would have been a reckless and dangerous option, even in the most experienced surgical hands. The [treating radiation oncologist], who left for overseas posts in … 2019 and was not available for comment (in the DHB report), from some of his notes and correspondence is clearly prejudiced against the 'private plastic surgeon' and has in fact, contributed to the distress for the patient and family, with his views.

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Overall impression

[Dr B] managed this very difficult case well and to a reasonable standard. My only criticism is that perhaps he should have seen the patient earlier when contacted by the GP with clinical evidence of the local orbital recurrence in November 2018 (some ten months post original surgery), but then again, I am convinced that the final outcome for the patient would still have been a non-curable one. This is unfortunate but the reality is that T4 cancers of the face have a poor prognosis even with radical treatment.

Yours Sincerely,

[Mr D]

Supporting references:

1. Caroline Z. Tan. BA, Kerri E. Rieger. MD. PhD, and Kavita Y. Sarin, MD. PhD (2017). Basosquamous Carcinoma: Controversy, advances and future directions. Dermatologic Surgery 2017;43:23–31 1301: 10.10971O6SA000000000000S1S A systematic review of 39 publications at Stanford University."

Further statement from [Dr D]

"28th July 2020

Dear [Mr E]

Re: Request for independent advice — Response to Report provided by Dr S Langley

I have previously provided to you a report on the care provided to [Mr A] by [Dr B]. This is dated 25 July 2020. Subsequently you have provided me with a report written by Dr S Langley dated 11 June 2020 and addressed to the Health and Disability Commissioner.

You have also provided me with a draft response to this prepared by [Dr B] and I understand that Dr Langley has not seen this.

You have asked me to consider the matters raised by Dr Langley and advise whether this in any way alters the views I expressed in my report.

General Summary:

I disagree with Dr Langley's comments, except for the one commenting that [Dr B] should perhaps have seen [Mr A] earlier when he was referred with a local left orbital recurrence in November 2018. Her lengthy report summarises the various documents including the complaint itself and [Dr B's] clinical notes. In doing this she seems to have overlooked some critical facts including:

1. The clinical photographic evidence (see below), that the original and primary left supraorbital basal cell carcinoma was extreme and infiltrating the left lower frontalis muscle causing a partial frontalis muscle palsy (see loss of left forehead wrinkles, left

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brow ptosis, compared to right forehead) and associated with quite an extensive melanoma in-situ of his left midface.

2. That these clinical signs and the history of at least 1–2 years and 'longstanding' description by [the referring GP] raises the question of delayed referral and/or neglect by the patient in seeking medical opinion/advice.

[Original clinical images]

A cranio-orbital further excision was what was really required but his age (patient was in his eighties) and co-morbidities contra-indicated this in my view. From my review of [Dr B's] clinical notes, the plan and indications for a conservative approach, when [Mr A] declined to have a deeper excision, are very well documented and clear.

Response to specific criticisms:

Advice point 1 — I advise that this is a major departure from accepted standard of practice. The lack of a plan for re-excision (of BCC in H-Zone, with perineural invasion and incomplete deep excision would be viewed with concern by plastic surgical colleagues. (Advice point 1 page 6)

I Strongly disagree. The accepted standard practice is that every patient is assessed on their diagnosis, staging and general medical condition. A wide excision of the left supraorbital BCC including the underlying frontalis muscle was performed with local flap reconstruction, as well as excision of the melanoma in-situ of his left midface and another even more complex local flap reconstruction. Describing this as a major departure is an exaggeration and incorrect. There was always a plan by [Dr B] to attempt a re-excision of the deep incomplete margin, which would have been at the level of the left supraorbital periosteum and supraorbital boney ridge. Dr Langley seems to have overlooked this well documented fact. This was arranged and the patient presented for surgery, but then declined to proceed with the procedure that [Dr B] had suggested.

Advice point 2 — This is a moderate departure from accepted practice. Plastic surgical peers would be concerned about the high possibility of recurrence and the difficulty recognising that it was happening (Advice point 2 page 7)

Again, I Strongly disagree. Dr Langley is making several questionable assumptions in her advice. It is clear to me, that [Dr B] understood the risks of local recurrence given the aggressive nature of the primary left supraorbital infiltrating BCC with high risk histological features. However although he arranged the further surgery, he was left in a position where he could not proceed agreeing to the patient's wishes, who did not want to pursue further deep margin surgery, on the basis that success could not be guaranteed. He then communicated both to the patient and his referring GP a plan for regular clinical follow-up. This is entirely reasonable from my perspective and is the course I would have followed too.

Advice point 3 — My advice is that the surveillance is mildly unacceptable, but the lack of a follow up arrangement is of more concern. It should be clearly documented that [Dr B]

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wanted to see [Mr A] again in several months or that he should be under regular review with his GP who could refer him back. (Advice point 3 page 7)

Again, my comments would be as above. The patient declined further surgery to the left supraorbital region and subsequently regular follow-up was instituted including further skin cancer excisions of an extremity and the right paramedian forehead. There was a clear and transparent plan of surveillance which was followed by [Dr B].

Advice point 4 — I advise that the delay is a moderate departure from the standard of care. My colleagues would be quite concerned about this delay for this patient with the symptoms described by the GP based on the described BCC. (Advice point 4 page 7 and 8)

The recurrence with nerve paraesthesiae occurred ten months after the original wide excision and although there was a 2-month delay before he was seen, this in my view had no negative impact on the final outcome. The patient could have been seen more urgently in an ideal world, but the die was cast from the moment of first presentation.

This was a neglected aggressive basal cell carcinoma with characteristics of de-differentiation into a squamous cell carcinoma. Some authors believe it is in fact a collision of two different histologies in the same cancer and the incidence for this is reported as 1:10,000 BCCs. We have all seen rare cases of this.

Any other concluding comments

Coming back to [Mr A's] documented complaint: he was not prejudiced on his age and [Dr B] did take responsibility for his facial cancer management and subsequent recurrence. The fact is the patient presented late, either due to his own neglect or delay in referral by his GP.

This is perhaps the most important question in this specific case, given the knowledge and expertise in the management of skin cancer generally and the public awareness of this common acquired disease. The reasons are multiple and include: personal fear and social isolation, cultural practices such as chewing of carcinogens, lifestyle and workstyle practices, initial mis-diagnosis and or mismanagement, specific tumour characteristics, immunosuppression and or previous radiation therapy. All skin cancers of the human face initially form as small tumour burdens.

Dr Langley has throughout her opinion suggested that she believes that her colleagues would support her conclusions. For the reasons stated above and in my initial report I do not.

Yours sincerely,

[Dr D]"

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Further statement from [Dr D]

"Dear [Mr E]

Re: [Mr A] HDC Complaint — [Dr B]

I have read the response you sent me from Dr Langley.

I think it is important that I stress at the outset that when I wrote my report dated 25 July 2020, I was unaware of the position that had been taken by Dr Langley regarding the care that had been provided to [Mr A]. I did not have a copy of her original advice. I was asked to provide an opinion on the information that was supplied to me and I did. I now understand this to be the same information that was given to Dr Langley.

I was also provided with a copy of the High Court rules relating to the guidance of experts. I read this and understood my role, and I believe my reports are consistent with my obligations in that regard.

I have re-read my reports and now the further report provided by Dr Langley. There is nothing in her response that would alter the advice I provided in my letter of 25 July 2020.

I confirm my conclusion in that letter that '[Dr B] managed this difficult case well and to a reasonable standard'.

I also reconfirm my strong disagreement to Dr Langley's conclusions that find [Dr B] in breach of the appropriate standard of care.

I believe my colleagues would agree with my assessment.

On that basis, I do not see any need or purpose in responding issue by issue to Dr Langley's report. The reasons for my conclusions are set out in full in my previous reports.

I am, however, happy to answer any further questions you may have or to provide any further clarification if this would assist.

Yours faithfully,

Dr D"

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