General Practitioner, Dr B

Medical Centre

General Practitioner, Dr C

Skin Clinic

A Report by the

Health and Disability Commissioner

(Case 17HDC01829)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man in 2015 for a skin cancer on the helix of his right ear, and the care provided in 2017 for a lump on his neck. The lump was a squamous cell carcinoma (SCC)[1] that had spread from the ear to the man's lymph nodes. The man received surgery and radiation therapy, but he sadly died. A number of oversights in the man's care from 2015 to 2017 contributed to delays in his treatment and misunderstanding about his diagnosis.

2. This report highlights the importance of providers communicating effectively with one another, and having good systems in place for sharing clinical information. It also emphasises the need for providers to review information carefully, and to communicate openly with the consumer.

Findings

3. The Commissioner found the man's general practitioner (GP) in breach of Right 4(1) and Right 6(1) of the Code. The Commissioner was critical that the GP (a) did not acknowledge the mention of the man's SCC history in the letter from the skin clinic GP; (b) did not refer the man in a timely manner; and (c) did not inform the man about the oversight of not sending the referral. As a consequence, there was a delay in the man receiving a first specialist appointment, and the GP's subsequent care was not provided with the knowledge of the man's high-risk diagnosis.

4. The Commissioner found the skin clinic GP in breach of Right 4(5) of the Code. The Commissioner was critical that she (a) did not co-operate with other providers to ensure quality and continuity of services to the man; (b) did not communicate effectively with the GP; (c) did not provide the GP with details of a follow-up plan; and (d) did not include details about the man's SCC history in her report of 14 April 2016. These failings contributed to the GP not being aware of the man's SCC diagnosis.

5. The Commissioner found the skin clinic in breach of Right 4(1) of the Code. The Commissioner was critical that the skin clinic's administrative processes were not sufficiently robust, and did not provide or support the timely provision of important clinical information. This contributed to the GP being unaware of the SCC diagnosis.

Recommendations

6. The Commissioner recommended that the GP, the skin clinic GP and the skin clinic provide written apologies to the man's partner.

7. The Commissioner recommended that the skin clinic (a) implement a process requiring the consumer's GP to be notified when a lesion of significance is found; and (b) undertake an audit of a sample of 30 skin cancer removal procedures to determine whether the operation report, follow-up information, and histology results have been sent to the patient's GP within a week.

[1] SCC is a common type of keratinocyte cancer, or non-melanoma skin cancer. SCC is an invasive disease that can sometimes spread to other organs, and may prove fatal.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her late partner, Mr A, by Dr B at the medical centre, and Dr C at the skin clinic. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Dr B in 2015, 2016, and 2017.*
- *The appropriateness of the care provided to Mr A by the medical centre in 2015, 2016, and 2017.*
- *The appropriateness of the care provided to Mr A by Dr C in 2015 and 2016.*
- *The appropriateness of the care provided to Mr A by the skin clinic in 2015 and 2016.*

9. The parties directly involved in the investigation were:

Ms A	Complainant/consumer's partner
Dr B	General practitioner (GP)
Medical centre	Provider
Dr C	GP
Skin clinic	Provider

Also mentioned in this report:

Dr D	Plastic surgeon

10. Further information was received from the Medical Council of New Zealand, two district health boards (DHB), and head and neck surgeon Dr E.

11. In-house clinical advice was obtained from GP Dr David Maplesden (Appendix A).

Information gathered during investigation

Background

Squamous cell carcinoma of the right ear

12. On 19 June 2015, Mr A (aged in his fifties) visited GP Dr B[2] at the medical centre.[3] Mr A advised Dr B that the top of his right ear was sore. A scab had developed but the wound was not healing. Dr B took photographs of the lesion with the intention of referring him for surgery. She said that she did not offer to remove the lesion as she felt it was beyond the

[2] Dr B is a Fellow of the Royal New Zealand College of General Practitioners, and has been in general practice for many years. She is a partner at the medical centre. Dr B has undertaken further training in skin cancers, and performs minor surgery excising skin cancers.

[3] At the time all GPs at the medical centre were directors and shareholders in the company. The GPs were self-employed but operated through the medical centre. The medical centre has been Cornerstone accredited since 2010.

scope of her expertise. Dr B stated that Mr A raised four medical problems during this appointment, and as a result it took longer than 20 minutes.

13. The referral was not made at that time, as Dr B inadvertently forgot to set a task reminder to write the referral. She did, however, set herself a recall for a different problem raised by Mr A. Dr B stated that it is her usual practice to set herself a task reminder to write referrals, as it is not possible to write referrals and consult in a 15-minute appointment. Dr B also said that her standard practice is to ask her patients to inform the practice if there is no acknowledgement of a referral within 6–8 weeks.

14. On 10 September 2015, Mr A privately consulted with Dr C[4] at the skin clinic for a free skin check. Dr C explained that these are brief checks of 1–2 lesions of concern to the patient, and are designed to let the patient know if anything further needs to be done. Dr C noted that Mr A had an obvious skin cancer on the helix of his right ear, and a nurse took a biopsy of the lesion.

15. On 17 September 2015, Mr A returned to see Dr C for a full skin cancer consultation. At that time, the biopsy results were still outstanding. Dr C stated:

> "[Mr A] asked that I not send the biopsy result or my consultation notes to his GP as he did not want her to think he was going behind her back or making assumptions about her care."

16. Dr C said that Mr A advised her that he would inform his GP.

17. Ms A, on the other hand, does not believe that Mr A would have been concerned about someone's feelings being hurt when it came to his health. She told HDC: "[I]t's not what he told me."

18. Mr A contacted Dr B's practice nurse that day and advised that the lesion needed to be excised. Dr B said that Mr A did not inform her nurse that he had had a biopsy taken. Dr B told HDC:

> "[O]n speaking to the nurse, she is clear that had she been informed, not only would she have written it into the notes, she would have checked … for the histology or at least alerted me that the result was pending."

19. During the conversation with the practice nurse, it also became apparent that the referral had not been sent following the 19 June 2015 appointment. Dr B was informed and realised her error, and immediately sent the referral to the Plastic Surgery service at DHB2. Dr B said that it was at the end of the day that her oversight was discovered, and she did not contact Mr A to apologise and inform him that she had sent the referral with a request for an urgent appointment. She stated:

[4] Dr C is a Fellow of the Royal New Zealand College of General Practitioners, and has qualifications in dermatology and skin cancer medicine and surgery. Dr C has worked at the skin clinic for over ten years.

> "It was certainly not in an effort to conceal this oversight, as in my referral … I made it clear that I had seen [Mr A] 3 months earlier and forgotten to refer him so that it was clear … that he needed an appointment much quicker."

20. DHB2 declined the referral[5] but sent it to the skin service at DHB3. DHB3 gave the referral high priority with a 1–2 week wait for an appointment.

21. On 23 September 2015, the biopsy results arrived at the skin clinic. Dr C was on leave, but asked a skin clinic nurse to contact Mr A to let him know that he had a squamous cell carcinoma (SCC)[6] on his ear that would require further surgery. The nurse advised Dr C by email that Mr A said that he had contacted his GP and found out that he had not been referred to the hospital, and was "not too happy about this".

22. Dr C told HDC that she spoke to Mr A on 25 September 2015, and he confirmed that he had notified his GP practice of the SCC result. She said that this was the end-point for the request to withhold information from Dr B. Dr C acknowledged that the histology result from 10 September should then have been sent to Dr B, as Dr B was listed on the patient label. However, it was not.

23. Mr A opted to receive private care, and had the SCC removed on 29 September 2015 by Dr D and Dr C at the skin clinic. The histology result (received on 6 October 2015) showed invasive SCC. The histology result and operation report were not sent to Dr B. Dr C said that these were given to Mr A in hard copy. She acknowledged that they also should have been sent to Dr B, and noted that Dr B was listed on the patient label. The clinic told HDC that this was an error whereby an administrative staff member did not manually tick a box to send the documents to Dr B.

24. On 14 April 2016, Mr A saw Dr C again for follow-up, and it was noted that his ear had healed. However, in response to the information gathered section of my provisional report, Ms A told HDC: "[The ear] hadn't healed. There was still a little scab [and] [Dr C] said it was probably just another little stitch but it should disappear. It didn't." Dr C planned to review Mr A again in one year's time, and set a recall in the practice management system.

25. The notes from this consultation were emailed to Dr B on 24 June 2016. The notes state that this was an "initial consultation" rather than a follow-up appointment. Dr C told HDC that she used the initial consultation template as it is more comprehensive than the follow-up template. The notes did not reference Mr A's surgery or histology result, and his "past medical/skin cancer history" is recorded as "Nil". Dr C explained that she recorded this because the SCC was a current rather than a past problem. She said that the delay in her notes reaching Dr B was a clinic systems error.

[5] The DHB2 response notes that it accepts only tertiary-level skin cancers, and many head and neck cancers are managed by DHB3 on behalf of Mr A's DHB of domicile, DHB1.

[6] SCC is a common type of keratinocyte cancer, or non-melanoma skin cancer. SCC is an invasive disease, referring to cancer cells that have grown beyond the epidermis. SCC can sometimes spread to other organs, and may prove fatal.

26. Dr B told HDC: "[Dr C's] email led me to believe [Mr A's] ear lesion was benign."

Further right ear lesion

27. On 15 September 2016, Mr A saw Dr C again and had a punch biopsy of another right ear skin lesion. The results of this biopsy showed that the lesion was benign (chondrodermatitis nodularis helicis). These results were sent to Dr B on the same day, and there was no mention in the histology report of an SCC having been excised the previous year.

28. On 1 October 2016, Dr C sent a letter to Dr B stating that the action plan was a biopsy of the ear to exclude keratoacanthoma.[7] The letter also stated: "Lesion on [right] ear: painful and niggling since excision of the SCC last year … Lesion superior to scar from SCC …"

29. Dr B stated that it was slightly out of order to receive the biopsy result before the letter detailing the doctor's decision-making. She said that when she read that Dr C was entertaining only possible benign diagnoses, "the fact that the lesion was benign further reinforced [her] thinking that [Mr A's] ear lesion had now been fully dealt with and was not of concern". Dr B apologised for missing the reference to SCC in the letter.

Lump on neck

30. In January 2017, Mr A noticed a lump on his neck, behind his ear lobe. He visited Dr B on 25 January 2017. Dr B did not take a biopsy of the lump, but she requested blood tests. Dr B said that if she had been aware of the SCC diagnosis at the time, she would have referred Mr A for a biopsy that day. Dr B stated that she asked Mr A to return in one month for follow-up, and that she would have told him to return sooner if the lesion changed or if he was concerned. Mr A's partner, Ms A, told HDC that she is concerned that Dr B did not take a biopsy of the lump at this time.

31. The blood tests indicated monoclonal B cell lymphocytosis with chronic lymphocytic leukaemia (CLL). Accordingly, Dr B sent a referral to the Haematology service at DHB1 on 7 February 2017. The referral mentioned the CLL diagnosis and that Mr A had an 8mm soft to firm lump behind his ear. Dr B wrote: "I think this is a benign lymph gland or reactive." The referral did not mention Mr A's history of SCC.

32. On 8 February 2017, the DHB1 Haematology service responded stating that Mr A did not need to be seen in clinic at that stage. It recommended that Dr B monitor Mr A's full blood count every three months, and refer him back if his blood counts escalated rapidly or if he developed other specific symptoms. DHB1 stated that the advice given was correct based on the information available at the time of the referral — the lymph node was small (less than 10mm in diameter), the full blood count was only slightly outside normal limits, and there were no other concerning features or information to suggest an aggressive malignancy.

[7] Keratoacanthoma is considered to be a variant of the keratinocyte or non-melanoma skin cancer SCC. Usually keratoacanthomas are treated surgically, as clinically they cannot be reliably distinguished from more severe forms of skin cancer.

33. On 10 March 2017, Mr A saw Dr B again, as the lump behind his ear had grown and he was experiencing a lot more pain. Dr B referred him to Head and Neck Surgery at DHB1 for excision of the lump. The referral included the benign biopsy results and did not refer to a past history of SCC. The referral was given priority three — to be seen "within 4 months … benign tumour". A Clinical Director from DHB1 reviewed the referral and said that the grading assigned was appropriate given the information provided. The Clinical Director said that had the information on the prior SCC diagnosis been available, the referral would have received a high priority.

34. On 23 March 2017, Ms A sought a second opinion from another GP, and surgeon Dr E was recommended.

35. Mr A did not wish to wait any longer for a hospital appointment, and on 24 March 2017 he telephoned the medical centre and asked for a referral to be sent to Dr E. Dr B sent the referral to Dr E that day. Dr E biopsied the lump on 25 March 2017. The biopsy confirmed that the lump was an SCC that had spread from the ear to Mr A's lymph nodes. It was removed surgically on 11 April 2017, and Mr A was referred for radiation therapy at DHB3. However, Mr A died the following year.

Further information

Medical centre and Dr B

36. Dr B told HDC that omitting to write the referral was an unintentional, inadvertent error. She stated: "I am at a loss as to how this could have happened and I deeply regret that [Mr A's] referral was not done on 19 June 2015." She said that this would be the first time in her many years of general practice that she had omitted to set a task for a referral to be done.

37. The medical centre submitted that if the purpose of the skin clinic's letters of 24 June 2016 and 1 October 2016 were to inform Dr B of Mr A's high-risk SCC, then it should have clearly indicated his past medical/skin cancer history as:

> "29 September 2015 — Grade 2 level 4 invasive Squamous Cell Carcinoma to Right Ear
>
> 15 September 2016 — Chrondrodermatitis Nodularis Helicis to Right Ear."

38. The medical centre submitted that it was evident that Dr B was not aware of the high-risk/invasive SCC, because her subsequent correspondence with hospital specialties and Dr E did not mention the SCC.

39. The medical centre noted that Mr A saw two other GPs on three separate occasions (15 December 2015, 4 April 2016, and 1 July 2016) for unrelated matters, and did not discuss his consultations or procedures at the skin clinic during these consultations.

40. Dr B told HDC that she has undertaken the following steps in reflecting on Mr A's case:

- She discussed Mr A's case with the other doctors and nurses at the medical centre as part of a peer review, and this allowed them to review their policy on management of test results, reports, and referrals.

- She has reviewed several articles on the management of test results and SCC.
- A plastic surgeon has been invited to the medical centre to discuss the management of skin cancers as part of continuing medical education.
- Learning from the incident highlighted the importance of good communication between the GP and the patient, and also of maintaining communication between specialists and GPs, particularly when patients self-refer.
- Dr B said that she did not receive any feedback from DHB3 that Mr A had not been seen in the skin lesion clinic. However, she noted that once she received confirmation that the referral had been received, she marked an electronic task reminding her of the referral as "complete". Dr B said that she no longer marks a task as complete or deleted until she is notified that the patient has been seen.
- Dr B now regularly prints letters and discharge summaries to read in hard copy, so as not to miss out on crucial information.

41. At the time of these events, the medical centre had a "Patient Test Results and Reports Management" policy. This states that when a referral letter is sent, a reminder is automatically generated on task manager for follow-up in six weeks' time, to check that the referral has been received. The policy also states that patients referred to a hospital or specialist are advised verbally to let their doctor know if they have not received an appointment within a specific timeframe.

42. The medical centre stated that it has undertaken the following steps since this complaint:

- It has reviewed the importance of open disclosure, and encouraged its clinical and administrative staff members to inform patients of any errors or omissions and offer options to resolve the error.
- Its GPs have discussed the article about high-risk SCC and have re-familiarised themselves with the risk factors.
- It has set up a texting service when referring patients. The text reads: "Hi, this is to confirm that a referral has been sent to the (specialty). If you have not heard within (1) month, please let our nurse know. [The medical centre]."
- Its website and waiting room now indicate that a standard consultation is 15 minutes long.
- Its GPs remind patients to seek medical attention should their condition not improve within an appropriate timeframe.
- There is increased use of the patient task tool and staff task tool in the practice management system.
- It is planning an audit to check whether referrals are being made in a timely manner.
- Automatic six-week recalls are added to appropriate referrals.

- The current practice management system does not support efficient transfer of medical photographs. However, patients who have had medical photographs taken will have a note made to remind the responsible clinician to transfer and annotate the photographs to the medical centre's secure "medical images" folder.
- Text messages and all clinical communication with patients are recorded in the practice management system.
- Summaries of discharge letters are entered into a "comment" section of the practice management system inbox.

Skin clinic

43. Dr C stated that the skin clinic's usual practice is to send a copy of all consultation and histology results to a patient's GP (except for free skin checks). The skin clinic told HDC that it does not have written policies related to the sending of patient information to GPs, but where the following criteria are met in skin clinic clinical records, the information will be sent electronically to GPs by administrative staff:

a) Referring and usual practitioners are listed

b) A checkbox stating "request for a discharge letter" is ticked, and

c) The "Dear Dr" salutation is included in the consultation notes.

44. The skin clinic said that its doctors attend regular multidisciplinary meetings to review findings from the previous six-month period, including overall numbers and types of lesions excised, margins, clinical concordance with histological findings, complications, and benign to malignant ratios. It stated:

> "We plan to present this case, anonymised, as a case study to highlight the very real risk of metastatic disease from high-risk locations, the presentation of these (regional metastatic disease in nodes) and the associated feature of immunosuppression that increases the risk of both metastatic disease and poor prognosis."

45. The skin clinic stated that it will encourage its staff (via a memo from the Chief Medical Officer) to use its printed laboratory forms from the patient management system, which have an automatic "copy to" function that picks up the patient's GP, as opposed to paper laboratory forms, which require the "copy to" field to be ticked manually.

Dr C

46. Dr C told HDC that she accepts that an oversight occurred in not providing Dr B with a management plan for Mr A.

47. Dr C stated that she has made the following changes to her practice as a result of this complaint:

- She now has 20-minute initial consultations to allow more time for reviewing past notes, performing examinations, and writing detailed notes.

- She has changed her documentation template so that "Skin Cancer History" and "Past Medical History" are separate headings.
- She has removed the word "Past" from the "Past Skin Cancer History" part of her documentation template so that all current and past skin cancers come under the same heading.
- She now writes down both positive and negative local lymph node findings (in the past, she recorded only positive findings).
- She has written the skin clinic's current guidelines for the management of SCC, basal cell carcinoma, and melanoma.
- When a patient requests that notes be withheld from his or her GP, she now advises the patient of the possible consequences, and documents this in her notes.
- She now writes in her consultation notes when she has educated patients to check their scars, regional lymph nodes, and self-check their skin on a regular basis and to return as soon as possible should they have a positive finding.

Responses to provisional opinion

48. Ms A was given an opportunity to respond to the "information gathered" section of the provisional opinion. Where appropriate, her comments have been incorporated into the report.

49. Dr B was given an opportunity to respond to the provisional opinion, and she accepted the findings and recommendations.

50. The medical centre was given an opportunity to respond to the provisional opinion, and had nothing further to add.

51. The skin clinic was given an opportunity to respond to the provisional opinion, and had nothing further to add.

52. Dr C was given an opportunity to respond to the provisional opinion. Dr C submitted that:

- her oversights were mild and compounded by procedural errors at the skin clinic, given that results and consultation reports were not sent to Dr B for months. Dr C stated that she relied on the practice having already communicated essential information to Dr B.
- she took reasonable steps to communicate and co-operate with Dr B by copying Dr B into results and correspondence, and providing Dr B with all relevant information.

Opinion: Introductory comment

53. This report highlights how important it is for providers who are involved in a consumer's care to communicate effectively with one another, and to have good systems in place for sharing clinical information. It also emphasises the need for providers to review information carefully, and to communicate openly with the consumer.

54. I would like to express my sympathies to Ms A and her children for the loss of Mr A. In my opinion, a number of oversights in Mr A's care journey from 2015 to 2017 contributed to delays in his treatment and misunderstanding about his diagnosis. These are set out below.

Opinion: Dr B — breach

Standard of care

Failure to write referral after 19 June 2015 consultation

55. Following Mr A's consultation with Dr B on 19 June 2015, Dr B forgot to write a referral for surgery to remove the lesion on the top of Mr A's right ear, despite this being her intention. Dr B noted that this consultation took longer than 20 minutes because Mr A discussed four medical problems with her. Dr B's usual practice is to set herself a task reminder to write a referral after a consultation, but on this occasion she forgot to do so. She said that her standard practice is also to ask her patients to inform the practice if there is no acknowledgement of a referral within 6–8 weeks. Dr B realised her error on 17 September 2015 when Mr A contacted her practice nurse, and she sent the referral immediately once she became aware of her oversight.

56. My in-house clinical advisor, GP Dr David Maplesden, advised:

> "While acknowledging the delay in sending the referral appears to be the result of human error, the failure to make a timely referral for a patient with a suspicious skin lesion must be regarded as a moderate departure from expected standards of care."

57. Dr Maplesden commented that there are mitigating factors, including Dr B's intention to make an appropriate referral, and the otherwise good standard of the consultation in question. I accept Dr Maplesden's advice. While I acknowledge that this was a human error, and Dr B had intended to make the referral, I am critical that Dr B failed to set herself a task reminder and make the referral in a timely manner. This meant that there was a delay in Mr A obtaining a first specialist appointment for the suspicious lesion on his ear.

Standard of care from 17 September 2015 until 1 October 2016

58. Dr B did not receive correspondence from the skin clinic regarding Mr A's care until 24 June 2016. The letter Dr B received on this date referred to Mr A having been seen for an initial consultation on 14 April 2016, and did not make any reference to the surgical

removal of his SCC. Dr B said: "[Dr C's] email led me to believe that [Mr A's] ear lesion was benign."

59. Dr B then received a histology report on 15 September 2016 relating to a further lesion on Mr A's ear. The result stated that this was chondrodermatitis nodularis helicis — a benign lesion. Dr C then wrote a letter to Dr B, which was received on 1 October 2016, and this referenced the SCC history (discussed further below).

60. Dr Maplesden commented:

> "There was little communication from [the skin clinic] regarding [Mr A's] subsequent management and what was received prior to September 2016 I feel was falsely reassuring and somewhat misleading … Until receipt of the letter from [the skin clinic] on [1 October 2016], I think it was reasonable for [Dr B] to assume [Mr A's] ear lesion was benign and had either resolved spontaneously or responded to non-invasive treatment at [the skin clinic] (with reference to the [skin clinic] report received on 24 June 2016)."

61. I accept this advice, and I am satisfied that until 1 October 2016, it was reasonable for Dr B to have assumed that Mr A's ear lesion was benign.

Failure to acknowledge mention of SCC in report 1 October 2016

62. On 1 October 2016, Dr C sent a letter to Dr B relating to the consultation with Mr A on 15 September 2016. The letter stated that the action plan was a biopsy of the ear to exclude keratoacanthoma. The letter also stated: "Lesion on [right] ear: painful and niggling since excision of the SCC last year … Lesion superior to scar from SCC …"

63. Dr B commented that it was out of order to receive the biopsy result before the letter detailing Dr C's decision-making. Dr B said that when she read that Dr C was entertaining only possible benign diagnoses, "the fact that the lesion was benign reinforced [her] thinking that the ear lesion had now been fully dealt with and was not of concern". Dr B apologised for missing the reference to SCC in the letter.

64. Dr Maplesden advised that "the picture was somewhat confusing for [Dr B] with no previous information having been received regarding a possible SCC diagnosis or treatment". However, he commented that the report from Dr C was not lengthy, and there were two references to SCC that were not buried in the report. He stated:

> "There was reference to right ear SCC history in the report and it is critical to subsequent events that [Dr B] apparently did not recognise or acknowledge the history, did not record it in [Mr A's] clinical notes as a coded diagnosis, and did not consider the information in subsequent consultations or provide it in subsequent referrals ... I am moderately critical that [Dr B] failed to acknowledge the reference to [Mr A's] history of SCC on receipt of the [skin clinic] report."

65. I accept this advice. As Mr A's GP, Dr B had a responsibility to carefully review correspondence she received from other providers about his care. In my opinion, it was a serious oversight that Dr B failed to acknowledge the references in Dr C's letter to Mr A

having SCC. This oversight meant that during her subsequent care of Mr A, Dr B was not cognisant of the diagnosis.

66. However, I note that Dr Maplesden considered that Dr B's subsequent care of Mr A was clinically reasonable given that she was not aware of his history of SCC of the right ear. Dr Maplesden also noted that Mr A's new diagnosis of CLL was a significant distractor. Dr Maplesden stated:

> "[Dr B's] subsequent management of [Mr A] was influenced by her perception there was no history of skin malignancy … Management of [Mr A's] neck lump (< 1cm) in January and February 2017 was consistent with expected practice. She investigated with blood tests, determined a possible cause of the lump (lymphadenopathy related to CLL) and referred for specialist haematology advice which she followed ... Had [Dr B] been aware of [Mr A's] history of right ear SCC, I would have expected prompt referral for surgical review when [Mr A] first presented with his neck lump on 25 January 2017. The lesion was eventually biopsied by [Dr E] two months later. It is unclear to what extent the up to eight week delay (assuming there was likely to be a wait for review even if referral had been made in January 2017) had on [Mr A's] subsequent clinical course."

67. I accept this advice. While I am concerned that Dr B failed to recognise the reference to SCC in Dr C's letter, I consider that her subsequent management of Mr A was appropriate based on her belief that his right ear lesion was benign.

Conclusion

68. Dr B had a responsibility to provide services to Mr A with reasonable care and skill. In my opinion, she did not do this, because she failed to initiate a referral in a timely manner after the 19 June 2015 consultation, and she failed to acknowledge the mention of Mr A's SCC history in the letter from Dr C received on 1 October 2016. These oversights meant that there was a delay in Mr A receiving a first specialist appointment for his suspicious right ear lesion, and that Dr B's subsequent care was not provided with the knowledge of his high-risk diagnosis. Accordingly, I find that Dr B breached Right 4(1) of the Code.[8]

Open disclosure

69. On 17 September 2015, Mr A telephoned Dr B's practice nurse, and at that point it was discovered that Dr B had not made the referral as intended after the 19 June 2015 appointment. Dr B said that her oversight was discovered at the end of the day, and she did not contact Mr A to apologise and inform him that she had sent the referral with a request for an urgent appointment. She stated:

> "It was certainly not in an effort to conceal this oversight, as in my referral … I made it clear that I had seen [Mr A] 3 months earlier and forgotten to refer him so that it was clear … that he needed an appointment much quicker."

70. Dr Maplesden advised:

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

> "Had [Dr B] contacted [Mr A] directly to apologise for the delayed referral and to clarify an ongoing management strategy before completing the referral (which I think was a reasonable expectation under the circumstances), it is possible she would have been more fully informed regarding the preceding biopsy and the fact a result would be available and would be valuable to the clinician assessing the referral."

71. Dr Maplesden considered this to have been a moderate departure from accepted practice in the circumstances described, regardless of whether such disclosure would have altered Mr A's subsequent management.

72. I accept this advice. Right 6(1) of the Code states that every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. In my opinion, a reasonable consumer in Mr A's circumstances would expect to be told about the oversight of not sending the referral as intended, and to be given an apology. Notwithstanding Dr B's appropriate action in immediately generating the referral once she became aware of her oversight, I consider that she breached Right 6(1) of the Code by failing to inform Mr A of her error.

73. I am satisfied that the actions taken by Dr B in reflecting on her involvement in Mr A's care are appropriate.

Opinion: Medical centre — no breach

74. Dr B was working at the medical centre. As stated above, I have found Dr B in breach of the Code for failing to provide an adequate standard of care to Mr A, and for failing to openly disclose to Mr A her error in forgetting to make the referral.

75. I consider that Dr B's failure to initiate a task reminder to make the referral following the 19 June 2015 appointment was an individual error. I note that the medical centre had in place a "Patient Test Results and Reports Management" policy, which guided its doctors on the process for making and following up on referrals. My expert advisor, Dr Maplesden, stated:

> "I have viewed the practice policy on management of test results and clinical correspondence and this appears consistent with similar policies I have reviewed from other practices. It is apparent the delay in sending the referral was the result of human error (failure to initiate the referral/automatic tracking process) rather than a systems failure in this case and it is difficult to know how such an error can be avoided."

76. I accept this advice and am satisfied that the policy was appropriate. I am pleased that the medical centre has also made a suitable change to its practice to introduce a text message service whereby a message is sent to the patient once the referral has been completed,

with instructions for the patient to contact the practice if he or she does not hear back in a specific timeframe.

77. I consider that Dr B's failure to recognise the mention of SCC in Dr C's letter, received on 1 October 2016, and her failure to openly disclose her error in forgetting to make the referral following the appointment of 19 June 2015, related solely to Dr B's individual judgement, and were not contributed to by the systems and processes at the medical centre. I support the medical centre's initiative in discussing with its staff the importance of open disclosure of errors or omissions.

78. I am satisfied that Dr B's failures do not relate to any systems or organisational issues at the medical centre. Accordingly, I do not find the medical centre in breach of the Code.

Opinion: Dr C — breach

Initial withholding of information from Dr B

79. On 10 September 2015, Mr A privately consulted with Dr C at the skin clinic for a free skin check. Dr C noted that Mr A had an obvious skin cancer on the helix of his right ear, and a nurse took a biopsy. Mr A returned a week later for a full skin cancer consultation, and at that time, the biopsy results were still outstanding. Mr A requested that Dr C not provide the biopsy result or consultation notes to Dr B, and Dr C understood that Mr A would inform Dr B himself. On 23 September 2015, the biopsy result confirmed that Mr A had SCC. Dr C told HDC that she spoke to Mr A on 25 September 2015, and he confirmed that he had notified his GP practice of the SCC result. She said that this was the end-point for the request to withhold information from Dr B.

80. Dr Maplesden advised that it was reasonable for Dr C to withhold correspondence from Dr B in line with Mr A's wishes. Dr Maplesden also considered that it was reasonable for Dr C to assume the veracity of Mr A's statement regarding informing Dr B of his biopsy results. However, Dr Maplesden stated:

> "I believe the situation should have been documented and [Mr A] made fully aware of the importance of sharing critical health information between providers, particularly once the nature of his lesion was revealed."

81. In these circumstances I am not critical of Dr C for withholding the initial biopsy result or consultation notes from Dr B in line with Mr A's request, and I consider it reasonable for her to have accepted Mr A's explanation that he had informed Dr B of the results. I note that Dr C now advises her patients of the possible consequences of withholding information from their GP, and documents this in the notes.

Failure to provide Dr B with recommended follow-up plan 29 September 2015

82. Mr A had the SCC removed on 29 September 2015 by Dr D and Dr C. The histology result (received 6 October 2015) showed invasive SCC. The histology result and operation report

were given to Mr A in hard copy, but were not sent to Dr B because of an administrative error at the skin clinic.

83. Dr Maplesden noted that following this surgery, Dr B was not advised of a follow-up plan for Mr A. Dr Maplesden stated:

> "While it was reasonable for [Dr C] to assume [Dr B] had received a copy of the 29 September 2015 operation note and would receive a copy of the histology report, given the nature of [Mr A's] SCC (a GP without special interest in skin cancers might not be aware of the high risk nature of the lesion) I think it was a reasonable expectation that the GP would be notified of the intended or recommended follow-up plan, with reference to the significance of this histology result and anatomical site of the lesion as placing [Mr A] in a comparatively high risk group for recurrence."

84. Dr Maplesden referenced Clause 48 of the Medical Council of New Zealand publication *Good Medical Practice*, [9] which states:

> "Once you have the patient's permission to share information, you must provide your colleagues with the information they need to ensure that the patient receives appropriate care without delay."

85. Dr Maplesden noted that this had been an accepted principle long before the 2016 update of the publication, and advised:

> "I believe the failure by [Dr C] to provide [Dr B] with [Mr A's] intended and recommended follow-up plan (after receipt of his histology result), including discussion of the high risk nature of his tumour, was a mild to moderate departure from accepted practice."

86. I accept this advice. I acknowledge Dr C's submission that there were procedural issues at the skin clinic, and that the skin clinic failed to provide Dr B with a copy of the operation note and histology result. However, I do not accept that those procedural errors at the skin clinic diminished Dr C's individual responsibility to communicate with Dr B, who was Mr A's primary care provider, about the nature of his SCC and an intended follow-up plan after the surgery of 29 September 2015 and on receipt of the histology result on 6 October 2015 showing that the SCC was invasive. I also note that Dr C considered that the end-point for withholding information from Dr B was only a few days previously, on 25 September 2015.

Deficiencies in 14 April 2016 report

87. On 14 April 2016, Mr A saw Dr C again for a follow-up appointment. A letter summary of this appointment was sent to Dr B on 24 June 2016. It states that this was an "initial consultation" rather than a follow-up appointment. Dr C told HDC that she used the initial consultation template as it is more comprehensive than the follow-up template. The notes also did not reference Mr A's surgery or histology result, and his "past medical/skin cancer history" is recorded as "Nil". Dr C explained that she recorded this because she considered

[9] https://www.mcnz.org.nz/assets/standards/85fa1bd706/Good-Medical-Practice.pdf Accessed 15 August 2019.

that the SCC was a current rather than a past problem. Dr C stated that the delay in her notes reaching Dr B was a skin clinic systems error.

88. Dr Maplesden advised that the letter in relation to this consultation was misleading in the following respects:

> "[R]eferring to the review as an initial consultation, skin cancer history recorded as 'Nil' ([Dr C] states this was because she regarded [Mr A's] SCC diagnosed six months previously as a 'current' rather than 'past' history) and no reference to [Mr A's] actual diagnosis of SCC (high risk) anywhere in the report, or to assessment for local lymphadenopathy. The documented follow-up plan at this stage was annual review recommended but it was not clear whether this was to be undertaken by [Dr B] or by [the skin clinic]."

89. In Dr Maplesden's opinion, the deficiencies in this communication to Dr B represent a mild to moderate departure from acceptable standards. I accept this advice. Although Dr C submitted that she took reasonable steps to communicate and co-operate with Dr B by copying her into results and relevant correspondence, providers should ensure their communication is of an appropriate standard, by including necessary and complete information. As noted above, a follow-up plan was not communicated and I am particularly concerned that the report did not reference Mr A's SCC history. In my view, the wording of the letter led to Dr B's impression that Mr A's ear lesion was benign.

Conclusion

90. Dr C had a responsibility to co-operate with other providers to ensure quality and continuity of services to Mr A. In my opinion, she failed to communicate effectively with Dr B, did not provide Dr B with details of a follow-up plan after Mr A's surgical removal of the SCC on 29 September 2015, and failed to include details about Mr A's SCC history in her report of 14 April 2016. In my view, these failures contributed to Dr B not being aware of Mr A's SCC diagnosis. I find that Dr C breached Right 4(5) of the Code.

91. I am satisfied that the actions taken by Dr C as a result of this case are appropriate.

Opinion: Skin clinic — breach

92. Despite Mr A having received care at the skin clinic from 10 September 2015, the first information received by Dr B from the clinic regarding Mr A's care was a letter from Dr C received on 24 June 2016 regarding the consultation on 14 April 2016. There were a number of deficiencies in the communication from the skin clinic to Dr B as follows:

- The histology result from 10 September 2015 was not sent to Dr B once the end-point for withholding information from Dr B had passed on 25 September 2015, despite Dr B being listed on the patient label.

- The operation report and histology result from 29 September 2015 were not sent to Dr B despite Dr B being listed on the patient label. The skin clinic accepts that this was an administrative error whereby a staff member did not manually tick a box to send the documents to Dr B.
- The report from the consultation of 14 April 2016 was not sent to Dr B until 24 June 2016.
- The report from the consultation of 15 September 2016 was not sent to Dr B until 1 October 2016.

93. Dr C stated that the skin clinic's usual practice is to send a copy of all consultation and histology results to a patient's GP (except for free skin checks). The skin clinic told HDC that it does not have written policies related to the sending of patient information to GPs, but where particular criteria are met in the skin clinic's clinical records, the information will be sent electronically to GPs by administrative staff.

94. Dr Maplesden advised:

> "[Dr C] … quite reasonably assumed that [Dr B] would receive copies of the histology and operation note from 29 October 2015 as this was normal practice at [the skin clinic]. However, it appears there were a number of separate administrative issues which resulted in none of this information being passed on to [Dr B]. I think [the skin clinic] must accept responsibility for not having sufficiently robust processes in place to prevent this type of oversight/omission, and I note this was not a single error but three errors on two separate occasions (failure to send on a copy of the 10 September 2015 histology result, failure to send on a copy of the operation report, failure to send on a copy of the 29 September 2015 histology result …) ... I think it is fair to say that timely provision of important clinical information (as this was) to the GP is accepted practice for an organisation such as [the skin clinic] and the failure to do this was a moderate departure from such practice."

95. I agree with this advice and I am concerned that the processes at the skin clinic did not provide or support the timely provision of important clinical information to Dr B, and that this contributed to Dr B not being aware of Mr A's SCC diagnosis. The skin clinic had a responsibility to provide Mr A services with reasonable care and skill, and I consider that it failed to do so by not providing the information and by not having in place sufficiently robust administrative processes. I find that the skin clinic breached Right 4(1) of the Code.

96. I accept Dr Maplesden's advice that appropriate remedial measures have since been implemented at the skin clinic.

Recommendations

97. I recommend that Dr B provide a written apology to Ms A for the failings identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

98. I recommend that Dr C provide a written apology to Ms A for the failings identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

99. I recommend that the skin clinic provide a written apology to Ms A for the failings identified in this report. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

100. I also recommend that the skin clinic undertake the following within three months of the date of this report, and report back to HDC:

a) Implement a process that requires the consumer's GP to be notified when a patient is found to have a lesion of significance at a free skin check, provided the consumer consents to this sharing of information.

b) Undertake an audit of a sample of 30 skin cancer removal procedures at the skin clinic over the preceding three months to determine whether the operation report, follow-up information, and histology results have been sent to the patient's GP within a week of that information becoming available. A summary of the actions taken to address any significant findings from the audit should be shared with HDC.

Follow-up actions

101. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of the names of Dr B and Dr C in covering correspondence.

102. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Royal New Zealand College of General Practitioners and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from HDC's in-house clinical advisor, GP Dr David Maplesden:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [Ms A] on behalf of [Mr A] (dec); responses from [Dr B]; GP notes and relevant policy documents [the medical centre]; response from [the skin clinic] including responses from [Dr C] and relevant clinical notes; response from surgeon [Dr E] and relevant specialist reports; response from [DHB3]; response and clinical notes from [DHB1]; response from [DHB2].

2. [Ms A] complains about delays in the management of a squamous cell carcinoma (SCC) of [Mr A's] right ear, and subsequent delays in the management of a lump behind his right ear which was eventually removed by [Dr E] and was found to be metastatic SCC. She states [Mr A] saw [Dr B] in August 2015 with the right ear lesion and [Dr B] advised she would send an oncology referral. When no response had been received from the hospital a month later, [Ms A] checked with the hospital ([DHB3]) and established no referral had been received. [Ms A] states she contacted [Dr B] who *said she did not agree to refer.* [Mr A] then attended [the skin clinic] for a free skin check on 10 September 2015 and saw [Dr C] then and again on 17 September 2015. [Ms A] describes an appointment being made by [Dr C] for 'Radiology' and attending an appointment for 'Radiology' on 21 September 2015. On 23 September 2015 the diagnosis of SCC was confirmed and [Dr B] *received info about squamous and said she'd try to get [Mr A] into [DHB3] but I had already at this stage scheduled private surgery due to her previous comments about not agreeing to referral.* Surgery was performed at [the skin clinic] on 29 September 2015 with removal of sutures 8 October 2015 and follow-up consults with [Dr C] on 14 April and 15 September 2016 with small bump at the original operation site. On 12 January 2017, [Mr A] noted a small lump behind his right ear and attended [Dr B] on 25 January 2017. [Ms A] states [Mr A] was diagnosed with chronic lymphocytic leukaemia (CLL) and *told not to worry. Back to GP following weeks complaining about painful lump and causing disruptive sleep. Still told not to worry and that it was probably a cyst that was pushing against the bone and would just go up and down and was stress related. No referral made.* On 23 March 2017, [Ms A] states she sought an opinion from another GP and was advised to make an appointment with surgeon [Dr E]. On 25 March 2017 [Dr E] biopsied the lump and subsequent result indicated this was metastatic SCC. [Mr A] required major head and neck surgery but the tumour went on to involve his facial nerve causing facial palsy and complicating subsequent radiotherapy treatment. Sadly, [Mr A] succumbed to his disease [the following year]. [Ms A] is of the opinion that the delays in the management of [Mr A's] initial cancer and subsequently delays in managing the lump behind his ear have been severely detrimental to [Mr A].

3. [Dr B's] response includes the following points:

(i) [Dr B] saw [Mr A] regarding his right ear lesion in June 2015 rather than the August as stated by [Ms A]. It was [Dr B's] intention to refer [Mr A] immediately for excision of the lesion (plastic surgical service) and she took a clinical photograph and advised [Mr A] of the plan. [Dr B's] usual practice is to set a task reminder to do the referral but on this occasion she omitted to do so and then forgot to write the referral. She states she did set a recall to review the outcome of the referral in four months, confirming her intention to refer. [Dr B] states that the oversight regarding completion of the referral was *an unintentional, inadvertent error. I am at a loss to how this could have happened, and I deeply regret that [Mr A's] referral was not done on 19 June 2015.* In subsequent correspondence, [Dr B] clarified she has seen [Mr A] for a benign appearing thigh lesion at the same time as the ear lesion and the recall set for four months was for review of the thigh lesion. She explained that once an electronic referral is generated (as was intended for the ear lesion) a task is automatically set for review of the referral in six weeks. However, as [Dr B] omitted to complete the referral, there was no task set to monitor the outcome of the referral.

(ii) [Dr B] states that on 19 June 2015, as is my usual practice, I would have told [Mr A] to contact my practice nurse if he did not hear back from the DHB following my intention to refer him. [Mr A] contacted the practice on 17 September 2015 and spoke to [practice nurse who] conveyed to [Dr B] the message that [Mr A] had been seen by [Dr C] at [the skin clinic] and advised to have his ear lesion excised, and that there was no record of a referral having been received at the hospital. [Dr B] reviewed [Mr A's] notes and realised her oversight with regard to the referral. She immediately generated an electronic referral for [DHB2] plastic surgical service which she felt would offer [Mr A] the most prompt service. A photograph was attached. [Dr B] denies speaking with [Mr A] or advising that she would not complete a referral and the practice has no record of contact between [Dr B] and [Mr A] in this regard or any request for [Dr B] to telephone [Mr A].

(iii) [Dr B] states she did not receive any information from [the skin clinic] or the laboratory regarding [Mr A's] procedures in September 2015 (biopsy and removal of right ear lesion) or his follow-up at [the skin clinic] on 8 October 2015. The first correspondence received from [the skin clinic] was an e-mail from [Dr C] on 24 June 2016 which did not refer to [Mr A's] history of SCC but appeared to indicate review of a most likely benign ear lesion. [Dr B] had not received any information from [DHB2] that [Mr A's] appointment there had been cancelled or not attended, and remained under the impression his ear lesion had been dealt with as was felt clinically appropriate at the time, and that it was most likely benign given the absence of any information to the contrary. This belief was further strengthened when on 15 September 2016 [Dr B] was copied in to a histology report indicating a benign lesion (chondrodermatitis nodularis helicis) biopsied on the right ear. On 1 October 2016 [Dr B] received a letter from [Dr C] in relation to assessment of [Mr A's] right ear lesion in September 2016 and belief this was most likely benign but a biopsy was performed. The letter did not refer to the result of the biopsy or any follow-up and [Dr B] believed

the lesion had most likely resolved spontaneously (which CNH lesions can do[1]) or had been removed with the biopsy. There was no indication a malignant lesion was suspected or confirmed on this occasion, **but the letter did briefly refer to [Mr A's] previous SCC removal.**

(iv) [Dr B] states that when she next saw [Mr A] in January 2017 with a lump behind his right ear, she was under the impression his ear lesion(s) had been benign. She questioned [Mr A] regarding symptoms suggesting a sinister cause for lymph node enlargement (such as lymphoma) and checked for any other lymphadenopathy. She ordered blood tests to try and find a cause for the lump and advised [Mr A] to return for review in one month and would have told him to return sooner, as is her usual practice, if the lump changed. She did not feel it was clinically appropriate, based on her understanding of [Mr A's] current history, to remove the lump or refer without further preliminary investigations.

(v) Blood results were suggestive of CLL and [Dr B] felt the lump was most likely related to this diagnosis. She conveyed the result to [Mr A] on 7 February 2017 and a haematology referral was agreed and undertaken that day. Written advice was received from the haematology service stating [Mr A] did not need to be seen or treated unless he became more symptomatic (including development of bulky lymphadenopathy), but his blood count should be monitored regularly. This information was conveyed to [Mr A] by phone and confirmatory letter which included a blood test form. [Dr B] notes there was no advice from the haematologist to biopsy or arrange removal of the neck lump. She states: *As is my usual practice, I would have asked* [Mr A] *to see me if he noticed any change or any symptoms or concerns.*

(vi) [Mr A] returned for review on 10 March 2017. The neck lump had grown and was causing [Mr A] significant discomfort. [Dr B] felt the lump was suspicious for malignancy and referred [Mr A] to the DHB ENT service the same day for review and removal of the lump. The reason for referral was documented as '*suspicious lump in neck'.* [Mr A] asked about the possibility of a link between his blood condition and the lump and, based on the haematologist advice, [Dr B] explained the blood condition itself was not a concern at this stage. On 24 March 2017, [Dr B] provided a referral letter to [Dr E] at [Mr A's] request as he did not wish to wait any longer for a hospital appointment. As [Dr B's] impression was that [Mr A] had only ever had a benign ear lesion treated, this information was conveyed in the referral letters to the DHB and [Dr E], together with [Mr A's] haematological diagnosis, haematologist advice and a photograph of the lump.

4. [Dr C's] response includes the following points:

(i) [Dr C] first met [Mr A] at [the skin clinic] on 10 September 2015 when he attended for a [free skin check]. These are brief encounters to identify whether a lesion of concern to a patient requires specific management. They do not generate GP letters

[1] https://www.dermnetnz.org/topics/chondrodermatitis-nodularis-helicis/ Accessed 7 February 2018

as the check is usually the result of a self-referral, but standard practice is to send letters and histology results of all other consultations.

(ii) [Mr A] had an obvious skin cancer on his right ear. Management options were discussed (including referral back to the GP) and [Mr A] requested immediate biopsy at [the skin clinic] which was undertaken by [Dr C]. [Mr A] informed [Dr C] that [Dr B] was aware of the lesion and had referred him to the hospital but he was yet to get an appointment.

(iii) [Mr A] returned to [the skin clinic] on 17 September 2015 for a formal skin cancer review (whole body). The biopsy result was not yet available. [Dr C] states: *[Mr A] asked that I not send the biopsy result or my consultation notes to his GP as he did not want her to think that he was going behind her back or making assumptions about her care.*

(iv) Biopsy results were received on 23 September 2015. [Dr C] was on leave and advised the [the skin clinic] clinic manager to advise [Mr A] of his result, that he would require further surgery, and that [Dr C] would contact him on her return from leave later in the week to discuss management options. The clinic manager later e-mailed [Dr C] to say [Mr A] had contacted his GP and was advised he had not been referred to the hospital but the GP was waiting to see how the lesion progressed and he was 'not too happy about this'. [Dr C] understood [Mr A] had informed his GP of the biopsy result and need to expedite his referral which was why he was disgruntled with the outcome. Excision of the ear lesion was undertaken at [the skin clinic] on 29 September 2015 (plastic surgeon [Dr D] and [Dr C]).

(v) Hard copies of the operation note and histology result were provided to [Mr A]. [Dr C] states: *They should also have been sent to [Mr A's] GP after he had made contact with his GP regarding skin clinic's involvement. [Mr A's] GP was listed on the patient label but not cc'd.* [The skin clinic] now use[s] computer generated laboratory forms which automatically cc the GP. Following the audit which led to these changes (date not recorded) *the 2016 follow-up letters and results did reach [Mr A's] GP*.

(vi) [Dr C] states [Mr A's] ear was well healed when review was undertaken on 14 April 2016 and a copy of the review letter was provided to [Dr B]. [Mr A] attended [the skin clinic] again on 15 September 2016 with a painful right ear lesion separate to the original excision scar. This was biopsied and shown to be a benign lesion. A clinic report and copy of histology were forwarded to [Dr B]. The clinic report included references to [Mr A's] previous SCC (see summary below).

(vii) Further follow-up was arranged for [Mr A] for April 2017. [Mr A] did not reply to the recall and a further recall was issued. (By this stage [Mr A] was under the care of [Dr E].)

5. Summary of clinical notes and responses

Date	Event	Comment
19/6/15	Consult [Dr B]	[Mr A] noted as having lesion on right pinna (antihelix), photographed, *refer for excision.* Benign lesion noted left thigh — for review in 5 months.
10/9/15	Consult [the skin clinic] — [Dr C]	*Lesion on rt ear, present a few months and GP referred to hospital for surgery. So far hasn't heard anything.* Suspected SCC or BCC and biopsy performed same day.
17/9/15	Consult [the skin clinic] — [Dr C]	Full skin check performed and cryotherapy to some facial actinic keratosis. ROS from biopsy site. *Discussed him chasing up public referral, but that would get a quote for ear surgery performed by [the skin clinic].*
17/9/15	TC [Mr A] to [the medical centre]	Practice nurse notes: *skin clinic ([Dr C]). Agrees should have excision of lesion R) antihelix. [Mr A] has called hospital. No referral for lesion.* Info conveyed by patient to [Dr B] who completed referral (Plastics). There is no reference to what information was conveyed back to [Mr A].
17/9/15	Referral to [DHB2] plastic surgical service from [Dr B]	*I would be grateful if you could see this gentleman who has an ulcerating lesion on the antihelix of the right ear. I saw him in June and forgot to send the referral.* Lesion photograph attached.
21/9/15	Communication [DHB2]→[the medical centre]	Acknowledgement of receipt of referral which had been forwarded to [DHB3] surgical service on 18/9/15[2]
23/9/15	Histology result [the skin clinic]	Biopsy histology results received showing SCC. Practice nurse e-mailed [Dr C] who advised patient to be notified and check if hospital appointment has been received. Nurse notes include: *GP nurse advised [Mr A] has not been referred into the public system yet as GP was waiting to see how lesion progressed.* There is no reference to copy of result to GP.
24/9/15	Communication [DHB3]→[the	Confirmation referral prioritized as 1–2 weeks (P1-A)

[2] The DHB2 response notes that they accept only tertiary level skin cancers and many head and neck cancers are managed by DHB3 on behalf of Mr A's DHB of domicile, DHB1.

	medical centre]	with surgical skin lesion clinic.
29/9/15	[the skin clinic] — [Dr D]	[Mr A] had evidently been referred by [Dr C] to surgeon [Dr D] for excision of the ear lesion. This was undertaken at [the skin clinic] on 29/9/15.
6/10/15	Histology result [the skin clinic]	Result received and annotated by [Dr C] as *Grade 2 SCC, clear margins, review 6/12.* Maximum tumour thickness was 3.5mm and anatomic level IV (invades reticular dermis). There is no reference to copy of result or preceding operation note being forwarded to GP.
8/10/15	[the skin clinic]	Nurse consult for wound review — healing well. Results discussed (content not recorded) and noted FU apt in 6/12.
14/4/16	[the skin clinic] consult — [Dr C]	Consult recorded as 'Dear Doctor' letter. Noted ear healed with skin reaction right conchal fossa. Actinic keratosis face treated with cryotherapy. No specific reference to check of local nodes. Plan for review in one year with annual review recommended.
24/6/16	Letter [Dr C]→[Dr B]	Discharge summary as per consult above sent to [Dr B] including: *Your patient was seen on 14/04/16 for an Initial Consultation at [skin clinic]… for skin cancer consultation … ear healing well, but gets a sharp sensation at times from scar …* Management provided (as referred to above) is recorded but there is no specific reference to [Mr A's] surgery (date/nature) or histology result. Personal skin cancer history is recorded as *nil.*
15/9/16	[skin clinic] consult — [Dr C]	Consult recorded as 'Dear Doctor' letter noting history: *Lesion on rt ear: painful and niggling since excision of the SCC last year.* No reference to assessment of local nodes. Lesion described as *core removed … heaped up keratin peripherally.* Biopsy was performed to differentiate possible stitch reaction vs recurrence or other pathology.
21/9/16	Histology result [the skin clinic] (cc [Dr B])	Histology reported a benign lesion chondrodermatitis nodularis helicis. [Dr C] annotated result: *CDHN R ear. I have e-mailed [Mr A] with results.* [Dr B] had received an e-copy of the result on 20/9/16.

22/9/16	[the skin clinic] (nurse consult)	Removal of sutures. Apparently healing well. No follow-up arranged.
1/10/16	Letter [Dr C]→[Dr B]	Consult notes from consult dated 24/6/16 received from [Dr C]. There is no reference to the histology result or follow-up although on this occasion [Dr B] had been cc'd into the histology result.
25/1/17	Consult [Dr B]	10/7 hx of lump behind R ear. Asymptomatic otherwise. *8mm soft to firm lump behind the tragus, nil elsewhere … no lymphadenopathy in groin or axilla … I think this is a benign lymph gland or reactive. To return for rv in 1m.* Blood tests ordered.
26/1/17	Blood results [the medical centre]	Initial blood results received showing lymphocytosis with cell markers report concluding: *Provided there is no lymphadenopathy and organomegaly, associated autoimmune disease or systemic symptoms of a B lymphoproliferative disorder, the findings indicate the presence of a Monoclonal B cell Lymphocytosis (MBL) with CLL phenotype.* Benign nature of the condition was emphasized with follow-up blood count recommended in 3–6 months.
6/2/17	Blood results [the medical centre]	Further bloods received from tests undertaken on 2/2/17. No additional pathology detected.
7/2/17	Referral to DHB Haematology from [Dr B]	Referral notes [Mr A's] recent development of post-auricular lump R side and blood results. Results forwarded include benign histology from 15/9/16 but [Dr B] was unaware of previous SCC histology results from 29/9/15 and these were not included.
7/2/17	Communication DHB→[the medical centre]	Acknowledgement of referral and note specialist advice would follow but no appointment.
14/2/17	Letter DHB→[the medical centre]	Letter from DHB haematologist recommending 3-monthly blood count monitoring in community. Reference is made to ear lump as: *You state he had an 8mm lump behind his tragus which may or may not be related.*
16/2/17	Letter [the medical	Letter included a copy of note from haematologist and form and instructions to repeat blood tests in April, but to come in sooner if symptomatic including

	centre]→ [Mr A]	swollen glands.
10/3/17	Consult [Dr B]	[Mr A] re-presented as the ear lump had grown and was now tender. Described as *firm to hard regular lump of about 12mm diameter, there is also an overlying pigmented naevus over this lump … refer to ENT for excision.* Photograph taken.
10/3/17	Referral to DHB ENT service from [Dr B]	Referral describes *suspicious lump in neck.* Growth of lump over two months noted (8mm→13mm). Recent CLL diagnosis noted and comment: *There was a lesion removed from the R antihelix last year but this was a chondrodermatitis helicis.* Histology report of that lesion attached. As noted previously, [Dr B] was unaware of previous SCC histology results from 29/9/15 and these were not included.
15/3/17	Communication DHB→ [Dr B]	Acknowledgement of ENT referral priority P3 — *within 4 months — Head & Neck — Benign Tumour*[3]
24/3/17	TC [Mr A] to [the medical centre]	[Mr A] spoke to practice nurse requesting private referral to [Dr E] with whom he had made an appointment for the following day. E-referral sent from [Dr B] 24/3/17 with history similar to the previous ENT referral and photo attached. Histology report attached as per ENT referral above.
25/3/17	Consult [Dr E]	[Dr E] biopsied [Mr A's] lump. Operation note reads: *Suspicious lesion behind ear, B-cell tumour of blood. I suspect this is a deposit of B-cell, it certainly looks malignant.*
4/4/17	Histology result [Dr E]	Histology reported as SCC probably related to the previous ear lesion (I suspect this is when [Dr E] first became aware of [Mr A's] history of SCC removal from his R pinna).
6/4/17 onwards	CT scan and further management	[Dr E] organized CT scan 6/4/17 which showed metastatic nodal disease in the right post-auricular region. Wide excision, flap and extensive lymph node dissection was undertaken on 11 April 2017 followed by radiotherapy. It was felt [Mr A's] co-diagnosis of CLL predisposed him to more aggressive tumour behaviour, but the CLL was not amenable to treatment currently.

[3] The response from DHB1 notes that higher priority would have been given to assessment of the lump if the previous history of SCC had been disclosed.

6. Comments on [Dr B's] management

(i) There were delays in [Mr A] receiving a first specialist assessment of his right ear lesion in 2015 which can be attributed primarily to the failure by [Dr B] to send the specialist referral when intended following the consultation of 19 June 2015. Because the referral was never completed there was no tracking or reminder activated although [Dr B] states she would have instructed [Mr A] to let her know if he did not receive an appointment (time frame not specified). I have viewed the practice policy on management of test results and clinical correspondence and this appears consistent with similar policies I have reviewed from other practices. It is apparent the delay in sending the referral was the result of human error (failure to initiate the referral/automatic tracking process) rather than a systems failure in this case and it is difficult to know how such an error can be avoided. A degree of 'safety-netting' can be provided by giving the patient some idea of expected time frame for receipt of an appointment and for the patient to contact the GP if an appointment is not received. I note that in 2016, the HQSC reviewed some cases of delayed treatment or diagnosis resulting from 'lost' referrals and advised: *These cases emphasise the importance of involving patients in the expected next steps of their care, so they can provide a further 'safety net' to ensure actions planned take place. Ideally, written information would be given to the patient stating the expected follow up timeframe, and who to contact if follow up does not occur*[4]. [Dr B] states it is her usual practice to do this although I note [Mr A] did not contact the practice until three months after the referral was meant to have been sent. While acknowledging the delay in sending the referral appears to be the result of human error, the failure to make a timely referral for a patient with a suspicious skin lesion must be regarded as a moderate departure from expected standards of care, a mitigating factor being the documented intention to make the referral.

(ii) There was apparent miscommunication between practice staff and [Mr A] on 17 September 2015 when [Mr A] contacted the practice to say he had seen [Dr C] at [the skin clinic] and she agreed the ear lesion required removal. At this stage the biopsy result was not available and it appears [Dr B] was not made aware [Mr A] had had a biopsy performed. [Mr A] was apparently given the impression the initial plan was to observe his ear lesion rather than make a referral and this may have been the result of misinterpretation of GP notes by the practice nurse communicating with [Mr A] (the observation plan related to a thigh lesion). [Dr B] completed the referral on 17 September 2015 and this was managed appropriately by the relevant DHBs given the content of the referral (no mention of biopsy having been undertaken). It is unclear whether [Mr A] was notified the referral was being sent that day and I would be moderately critical if there was not open disclosure regarding the delayed referral and the fact a referral was being completed. Had [Dr B] contacted [Mr A] directly to apologise for the delayed referral and to clarify an ongoing management strategy before completing the referral (which I think was a reasonable expectation under the circumstances), it is possible she would have been more fully informed regarding the

[4] https://www.hqsc.govt.nz/assets/Reportable-Events/Publications/Open-book/OB-ensuring-referrals-happen-Feb-2016.pdf Accessed 7 February 2018

preceding biopsy and the fact a result would be available and would be valuable to the clinician assessing the referral.

(iii) There was little communication from [the skin clinic] regarding [Mr A's] subsequent management and what was received prior to September 2016 I feel was falsely reassuring and somewhat misleading (see later comments). Until receipt of the letter from [the skin clinic] on 15 September 2016, I think it was reasonable for [Dr B] to assume [Mr A's] ear lesion was benign and had either resolved spontaneously or responded to non-invasive treatment at [the skin clinic] (with reference to the [the skin clinic] report received on 24 June 2016).

(iv) On 1 October 2016 [Dr B] received a report from [the skin clinic] noting [Mr A] had been seen for follow-up on 15 September 2016. There is reference within the report to [Mr A's] previous surgery and diagnosis as: *Lesion on rt ear: painful and niggling* ***since excision of the SCC last year*** *…* ***Lesion superior to scar from SCC*** *…* The new lesion identified at this consultation was biopsied and confirmed as benign with [Dr B] receiving a report of that histology some time before receiving the clinic letter (having not received any previous histology reports in relation to the SCC diagnosis). I think the picture was somewhat confusing for [Dr B] with no previous information having been received regarding a possible SCC diagnosis or treatment, but a lesion biopsied on this occasion shown to be benign and histology report now provided (ie no consistent approach by [the skin clinic] in provision of clinical information). Nevertheless, there was reference to right ear SCC history in the report and it is critical to subsequent events that [Dr B] apparently did not recognise or acknowledge the history, did not record it in [Mr A's] clinical notes as a coded diagnosis, and did not consider the information in subsequent consultations or provide it in subsequent referrals. If she was unsure about the content or relevance of the information contained in the letter, clarification could have been sought at the time including accessing Testsafe to determine if previous histology reports were available. Taking into account the sub-optimal communication from [the skin clinic] (which is discussed further below), I am moderately critical that [Dr B] failed to acknowledge the reference to [Mr A's] history of SCC on receipt of the [the skin clinic] report.

(v) [Dr B's] subsequent management of [Mr A] was influenced by her perception there was no history of skin malignancy and this is taken into account in my subsequent comments (ie I would be more critical of her subsequent management if she had been aware of the SCC history). Management of [Mr A's] neck lump (< 1cm) in January and February 2017 was consistent with expected practice. She investigated with blood tests, determined a possible cause of the lump (lymphadenopathy related to CLL) and referred for specialist haematology advice which she followed. The DHB advice was appropriate based on the information provided by [Dr B]. When the lump continued to grow, a timely referral was made for ENT review. It could be argued a 'high suspicion of cancer' priority should have been assigned by [DHB1], even without the history of previous SCC being provided, given the mass was now >1 cm and was increasing in size[5]. Nevertheless, there was no further delay in treatment as [Mr A]

[5] Ministry of Health. Faster Cancer Treatment: High suspicion of cancer definitions. April 2016

promptly accessed appropriate care in the private sector which led to his diagnosis of metastatic SCC. Had [Dr B] been aware of [Mr A's] history of right ear SCC, I would have expected prompt referral for surgical review when [Mr A] first presented with his neck lump on 25 January 2017. The lesion was eventually biopsied by [Dr E] two months later. It is unclear to what extent the up to eight week delay (assuming there was likely to be a wait for review even if referral had been made in January 2017) had on [Mr A's] subsequent clinical course.

7. Comments on communication from [the skin clinic]

(i) [Dr C] states it is not usual practice to inform GPs when a patient has been seen for a free skin check following self-referral. I think if a patient is determined to have a lesion of significance following such a check, the GP should be notified (with patient consent) but if no abnormality is detected such correspondence would not be required. The service provided to [Mr A] on 10 September 2015 (lesion biopsy) fell outside the definition of a 'free skin check' service and I believe [Dr B] should have been notified in a timely fashion of the service provided, and copied in to the biopsy result. This should be the default position unless the patient does not consent to provision of such information. [Dr C] refers to [Mr A] declining consent for communication with his GP at a later consultation (see below) and it is not clear if this was the case on 10 September 2015. If [Mr A] had not formally requested on 10 September 2015 that information be withheld from his GP, I would be mildly critical that [Dr B] was not notified of the skin biopsy and copied in to the results at the time the procedure was undertaken, acknowledging there was likely an intention to send a more complete record once the biopsy result was available and management plan agreed.

(ii) [Dr C] has clarified that [Mr A] discussed with her on 17 September 2015 that he did not wish [Dr B] to receive correspondence regarding his ear lesion management. Under this circumstance it was reasonable that correspondence was withheld although I believe the situation should have been documented and [Mr A] made fully aware of the importance of sharing critical health information between providers, particularly once the nature of his lesion was revealed. It appears [Dr C] was reassured by [Mr A] that he would communicate relevant information to his GP and this may well have been a reasonable assumption.

(iii) At some point [Mr A] evidently consented to [Dr C] communicating with [Dr B] and a follow-up report was received by [Dr B] on 24 June 2016 in relation to [Mr A's] consultation with [Dr C] on 14 April 2016. I believe this communication was deficient for the following reasons:

- The consultation was listed as an initial consultation rather than follow-up
- There was no specific reference to [Mr A's] SCC diagnosis
- There was no specific reference to [Mr A's] previous SCC removal (other than oblique reference to 'ear healing well' and 'stitch reaction rt conchal fossa')

https://nsfl.health.govt.nz/system/files/documents/publications/high_suspicion_of_cancer_definitions_0.pdf

- Under the heading 'Skin cancer history' is the notation 'nil' further implying the previously treated ear lesion was not malignant

I think if [Mr A] had now granted consent to communication with [Dr B], it was important that [Dr B] was provided with adequate background information including a copy of the operation note and previous histology reports. If [Dr C] established beyond doubt that [Mr A] had provided such information to [Dr B] himself, I would be mildly to moderately critical of the standard of the communication above. If [Dr C] did not establish these facts I would be at least moderately critical of the standard of inter-provider communication on this occasion.

(iv) The communication dated 15 September 2016 was adequate in that there is some reference to [Mr A's] previous SCC excision, and [Dr B] was copied in to results of the lesion which was biopsied (benign). However, there is no follow-up plan evident.

(v) The actual clinical management and follow-up of [Mr A's] SCC is outside the scope of this report. Given the involvement of a surgeon (Dr D) in the definitive management of the cancer (and presumably advising on follow-up once he was aware of the histology report), if further information is to be sought in this regard it would be best obtained from a plastic surgeon following a response from [Dr D]. In that case, [Dr D] should be asked to clarify his role in [Mr A's] management including whether he was aware of the histology results of the excision he undertook with [Dr C], whether these results were discussed with [Dr C] and what was the recommended follow-up/surveillance plan."

The following further advice was received from Dr Maplesden:

"1. Thank you for providing further information on this file. Comments made below in relation to this information should be read in conjunction with my original advice dated 30 August 2018. The documents reviewed are:

- Response from [Dr C] dated 2 April 2019
- Response from [skin clinic] dated 3 April 2019
- Response from [Dr B] dated 15 April 2019
- Response from [the medical centre] dated 15 April 2019

2. [Mr A's] consultation with [Dr B] on 19 June 2015: [Dr B] emphasises this was a complex consultation which ran significantly over time. Multiple issues were addressed including painful knee (physiotherapy referral completed), repeat of long-term medications, opportunistic updating of tetanus immunisation status (referred to nurse for immunisation) and review of two skin lesions (thigh and ear). The ear lesion was identified as requiring plastic surgical referral. Photographs were taken, offer made of private referral (declined as [Mr A] did not have insurance) and DHB referral discussed and agreed. Possibly due to time pressure, [Dr B] inadvertently omitted to set a task reminder to complete the plastic surgical referral and omitted to complete the referral itself. No additional new information has been provided in relation to the

consultation (see section 3(i) of original advice). I remain of the view, stated in my original advice (s 6(i)) that while acknowledging the delay in sending the referral appears to be the result of human error, the failure to make a timely referral for a patient with a suspicious skin lesion must be regarded as a moderate departure from expected standards of care. Mitigating factors are the intention to make an appropriate referral, and the otherwise good standard of the consultation in question. The processes [the medical centre] had in place at the time of this incident in relation to handling of clinical documentation (including referrals) were consistent with accepted practice. However, [the medical centre] has since added an additional action which might further reduce the risk of inadvertently missed referrals — that being a SMS message sent to the patient once the referral has been completed and instructions for the patient to enquire if the message has not been received by a week after the consultation. If this initiative proves effective, it might be considered for implementation by other practices. [The medical centre] is also encouraging patients to use the patient portal which gives them direct access to their results and clinical correspondence. These are appropriate remedial actions.

3. Contact between [Mr A] and [the medical centre] on 17 September 2015: [Dr B] clarifies that she was not informed [Mr A] was to have (or had had) a biopsy of his ear lesion at [the skin clinic], and the practice nurse taking the call was not informed of the procedure. Had either of them been informed, processes to track the result of the biopsy would have been implemented. The plastic surgical referral intended for 19 June 2015 was made that day and sent with urgency to [DHB2] (who then forwarded it to [DHB3]). [Dr B] was notified on 24 September 2015 that [Mr A] would be seen within 1–2 weeks. The delay in sending the referral and current management plan was not openly disclosed to [Mr A] at this time and I remain of the view this was a moderate departure from accepted practice in the circumstances described regardless of whether such disclosure would have altered [Mr A's] subsequent management. However, the urgent referral was an appropriate action. The practice has since undertaken full staff discussions regarding the importance of open disclosure of errors or omissions where appropriate.

4. Consultation at [the skin clinic] on 10 September 2015: [Mr A's] punch biopsy was performed by a nurse who also informed [Mr A] of the biopsy result following its receipt on 23 September 2015 (according to the initial response [Mr A] was also provided with a hard-copy of the result). At a consultation with [Dr C] on 17 September 2015, [Mr A] requested that information related to his contact with [the skin clinic] thus far be withheld from his GP. On 25 September 2015 [Dr C] telephoned [Mr A] to confirm the management plan for his biopsy-proven SCC. She states [Mr A] *confirmed … that he had notified his General Practice of the SCC result. The phone call to his general Practice by [Mr A] was the end-point for the request to withhold information.* [Dr C] states: *The histology result from the 10/09/15, the operation note/report, and histology from 29 October* [should be September] *2015 should have gone to his GP.* My general comments in relation to these events as per s 7(i) and (ii) of my original advice remain unchanged except that I withdraw any criticism of the failure to provide to the GP any documentation of the consultation of 10 September

2015 noting it was reasonable practice to provide a complete report once the histology result had been received, and on 17 September 2015 [Mr A] declined consent for information to be sent to his GP. I think it was reasonable for [Dr C] to assume the veracity of [Mr A's] statement regarding his informing his GP of the biopsy results although it is now apparent there was no such contact from him (either verbally conveying the results or providing the practice with a copy of the histology results). [Dr C] also quite reasonably assumed that [Dr B] would receive copies of the histology and operation note from 29 October 2015 as this was normal practice at [the skin clinic]. However, it appears there were a number of separate administrative issues which resulted in none of this information being passed on to [Dr B]. I think [the skin clinic] must accept responsibility for not having sufficiently robust processes in place to prevent this type of oversight/omission, and I note this was not a single error but three errors on two separate occasions (failure to send on a copy of the 10 September 2015 histology result, failure to send on a copy of the operation report, failure to send on a copy of the 29 September 2015 histology result (although the result was cc'd in to the Cancer Registry)). Should this type of error be regarded as of lesser severity or consequence than [Dr B's] oversight in not promptly completing her intended referral form? I think it is fair to say that timely provision of important clinical information (as this was) to the GP is accepted practice for an organisation such as [the skin clinic] and the failure to do this was a moderate departure from such practice. Appropriate remedial measures have since been implemented as outlined in [the skin clinic's] response.

5. It appears [Mr A] did not discuss his ear surgery or histology results with [Dr B] subsequently, and he did not present to [medical centre] providers any issues related to his ear surgery until the consultation with [Dr B] on 25 January 2017. This consultation was in relation to a recently noted lump behind the ear which had been operated on, but there was no specific reference to the previous ear surgery raised by [Mr A] at this consultation. The [medical centre's] response noted [Mr A] saw other providers at [the medical centre] on 15 December 2015, 4 April 2016 and 1 July 2016 and there was no issue raised in relation to ear symptoms or his previous surgery.

6. [Dr C] received [Mr A's] histology result on 6 October 2015 and advised formal review in six months (high risk SCC due to anatomical site). [Mr A] had his sutures removed on 8 October 2015 with results and management plan discussed with him. [Dr B] was not informed of [Mr A's] follow-up plan and no reason has been provided for this oversight. While it was reasonable for [Dr C] to assume [Dr B] had received a copy of the 29 September 2015 operation note and would receive a copy of the histology report, given the nature of his SCC (a GP without special interest in skin cancers might not be aware of the high risk nature of the lesion) I think it was a reasonable expectation that the GP would be notified of the intended or recommended follow-up plan, with reference to the significance of this histology result and anatomical site of the lesion as placing [Mr A] in a comparatively high risk group for recurrence. Clause 48 of the Medical Council of New Zealand publication

'Good Medical Practice'[6] states: *Once you have the patient's permission to share information, you must provide your colleagues with the information they need to ensure that the patient receives appropriate care without delay*. This has been an accepted principle long before the 2016 update of this publication. I believe the failure by [Dr C] to provide [Dr B] with [Mr A's] intended and recommended follow-up plan (after receipt of his histology result), including discussion of the high risk nature of his tumour, was a mild to moderate departure from accepted practice. I would expect [Mr A] to have been made aware of the high risk nature of his disease in the discussion with [Dr C] regarding his histology results. According to guidelines relevant to the timeframe in question[7], it is recommended that *all patients* [with high risk disease] *should be instructed in self-examination of the surgical scar site, local skin and lymph nodes and should receive written information sheets giving clear instructions and actions to take should they suspect recurrent disease*. I am unable to determine if [Mr A] was adequately informed in this regard, but note he did not discuss the possible link between his cancer and the ear lump he had developed when he saw [Dr B] in January 2017.

7. The next critical point in [Mr A's] management was the follow-up consultation with [Dr C] on 14 April 2016. Even though this was a follow-up consultation, [Dr C] chose to use the 'Initial Consultation' template because it was more comprehensive than the follow-up template. As noted in my previous advice, the letter in relation to this consultation was not received by [Dr B] until 24 June 2016 and in my opinion was misleading in a number of respects including referring to the review as an initial consultation, skin cancer history recorded as 'Nil' ([Dr C] states this was because she regarded [Mr A's] SCC diagnosed six months previously as a 'current' rather than 'past' history) and no reference to [Mr A's] actual diagnosis of SCC (high risk) anywhere in the report, or to assessment for local lymphadenopathy. The documented follow-up plan at this stage was *annual review recommended* but it was not clear whether this was to be undertaken by [Dr B] or by [the skin clinic]. I acknowledge [Dr C] was under the reasonable impression [Dr B] had received the histology and operation reports from September 2015. However, I remain of the view that [Dr C's] standard of clinical documentation on this occasion was mildly to moderately deficient (see section 7(iii) of my original advice). No explanation was given regarding the delay in providing the information to [Dr B]. Since this incident, [Dr C] has made appropriate changes to the assessment template to clarify past versus present history of skin cancer, and she will record appropriate negative clinical findings as well as positive findings.

8. On 15 September 2016 [Mr A] was reviewed at [the skin clinic] by [Dr C] and a hyperkeratotic area on his right ear was biopsied. The result was benign (chondrodermatitis helicis nodularis) and [Dr B] was copied in to the result which she

[6] https://www.mcnz.org.nz/assets/standards/85fa1bd706/Good-Medical-Practice.pdf Accessed 15 August 2019

[7] Motley R, Preston P, Lawrence C. Multi-professional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma. British Association of Dermatology, 2009. (Update of the original guideline which appeared in Br J Dermatol 2002; 146: 18-25.) http://www.bad.org.uk/library-media%5Cdocuments%5CSCC_2009.pdf Accessed 15 August 2019

received and filed. A short time later a letter from [Dr C] was received by [Dr B] and filed. [Dr C] has emphasised she was under the impression [Dr B] had previously received [Mr A's] operation note and histology reports from September 2015 and she was therefore aware of [Mr A's] history of SCC involving his right ear. Taking this into account, I believe the report she sent to [Dr B] relating to the consultation of 15 September 2016 was reasonable apart from the absence of follow-up recommendations and my comments in this regard remain unchanged (s 7(iv) of original advice)). I note [Dr C] has recently developed guidance for surveillance of patients following skin cancer excision based on a number of current international guidelines and this document appears fit for purpose.

9. [Dr B] failed to detect the references to [Mr A's] SCC history when she reviewed the letter from [Dr C] received on 1 October 2016. I agree the letter referred to 'SCC' rather than squamous cell carcinoma, and there was no specific reference to the site and high risk nature of the lesion (although the site was implied). I note also that [Dr B] had received the benign histology result before she received the letter from [Dr C]. However, the report from [Dr C] was not lengthy and there were two references to SCC. These references were not 'buried' in a complex lengthy report. I remain of the view that the failure by [Dr B] to recognise or acknowledge [Mr A's] SCC diagnosis on this occasion was a moderate departure from accepted practice, with factors taken into consideration regarding this opinion detailed in section 6(iv) of my original advice.

10. I remain of the view that [Dr B's] subsequent management of [Mr A] was clinically reasonable for a patient without recognised history of SCC of the right ear (see section 6 (v) of original advice), particularly taking into account the new diagnosis of chronic lymphocytic leukaemia which was a significant distractor. [Dr C] has pointed out that the scar from [Mr A's] previous ear surgery should have been readily apparent on assessment of the area of the right peri-aural lump with which [Mr A] presented in January 2017. However, having not viewed the scar myself I am unable to comment further on this aspect of [Mr A's] care. It remains unclear to me why [Mr A] did not raise with [Dr B] the issue of his previous ear surgery and possible relationship with the new right peri-aural lump in January 2017, particularly if he had received appropriate follow-up information regarding self-surveillance (as discussed above).

11. The remedial measures outlined in the various responses appear appropriate and I have no further recommendations in this regard."