General Practitioner, Dr B

A Report by the
Health and Disability Commissioner

(Case 19HDC01050)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a general practitioner (GP) between February 2018 and March 2019 for a melanoma on a man's arm. A number of oversights in the man's care contributed to a delay in his treatment.

2. The report highlights the importance of providers making referrals in a timely manner. It also emphasises the need to document examination findings and to provide consumers with information on expected timeframes for appointments, and safety-net information on what to do if symptoms change.

Findings

3. The Commissioner found the GP in breach of Right 4(1) of the Code. The Commissioner was critical that the GP did not initiate a referral in a timely manner, did not document his findings, and did not make the man aware of the timeframe in which he could expect to receive an appointment. As a consequence, there was a delay in the man receiving a first specialist appointment and treatment for his melanoma.

4. The Commissioner acknowledged the otherwise high standard of both documentation and clinical practice in other clinical documentation by the GP, and commended him for his open disclosure of the omission to send the referral.

Recommendations

5. The Commissioner recommended that the GP provide a written apology to the man, and implement the use of a PMS reminder system as soon as the intention to make a referral has been confirmed, to reduce the risk of intended tasks being overlooked.

Complaint and investigation

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

- *Whether Dr B provided Mr A with an appropriate standard of care between February 2018 and March 2019 (inclusive).*

7. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	General practitioner (GP)/provider

8. Also mentioned in this report:

Dr C	GP

9. Further information was received from the medical centre, the district health board (DHB), and ACC.

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

Information gathered during investigation

Background

11. This report concerns the delayed referral of Mr A by Dr B to the DHB for a suspicious skin lesion. Mr A was later diagnosed with a malignant melanoma on his arm, which was removed.

12. Mr A has a complex medical history, including type 2 diabetes, ischaemic heart disease (IHD)[1], angina, hypertension, and gastro-oesophageal reflux with oesophagitis. He requires multiple medications and regular three-monthly GP review.

Reviews by Dr B

2 February 2018

13. On 2 February 2018, Mr A, then aged in his fifties, was reviewed by his GP, Dr B, at a medical centre. This was a lengthy consultation addressing multiple health issues. The clinical notes indicate a review of his angina, diabetes, and hypertension.

14. Mr A had a skin lesion on his right upper arm that his wife suggested he get checked. Dr B examined it and considered that the lesion was a wart. He recorded in the notes: "13 x 7mm roughly oval seborrhoeic wart by dermatoscopy with few darker patches within it in medial right upper arm." Dr B had recently completed a weekend dermoscopy course and was confident that the skin lesion was a seborrheic keratosis.[2]

15. Dr B told HDC that he cannot recall accurately what he told Mr A about what to do if the appearance of the lesion changed. Dr B said that his usual approach is to provide safety-netting advice that includes telling the patient to return if symptoms change. There is no record of this in the notes.

16. Mr A felt reassured by Dr B's advice and was not concerned when the lesion began to change colour. On four subsequent consultations at the medical centre, when he saw different staff members, Mr A did not mention the skin lesion. He told HDC: "[T]he reason I didn't say anything about the melanoma was that I thought it was a wart after the first time [Dr B] looked at it."

[1] Damage or disease in the heart's major blood vessels.
[2] A wart.

14 December 2018

17. On 14 December 2018, Mr A had a consultation with Dr B relating to chest pain, diabetes control, hayfever, and GORD.[3] There is no reference to Mr A's skin lesion in the notes. Dr B told HDC that he recalls seeing the lesion on Mr A's arm when he was taking his blood pressure. The upper arm lesion had changed significantly since the review in February, and Dr B was concerned by its change in appearance.

18. Dr B told HDC that he took photographs of the lesion on his phone. He cannot recall exactly what he discussed with Mr A, but believes he would have explained why he was taking photographs, and that he was concerned about the appearance of the lesion and thought that it might be a melanoma.

19. Mr A told HDC that when Dr B noticed the lesion, he was concerned and offered to remove it for a fee or make a referral to the hospital. Mr A chose to be referred to the DHB for removal of the lesion.

20. Dr B omitted to upload the photographs to Mr A's file or to complete the referral form. He said that the consultation was complex with multiple important health issues reviewed and discussed. The consultation started about 40 minutes after the scheduled time, and was the last of the morning.

21. Dr B feels that the time pressures contributed to his oversight in not uploading Mr A's images, which would have prompted the need to complete the referral. Mr A told HDC that he believes the mistake was caused by a heavy workload, and added that he does not hold any animosity towards Dr B, and still holds him in high regard as a doctor.

8 March 2019

22. On 8 March 2019, Mr A had his three-monthly review with GP Dr C at the medical centre. Dr C was concerned by the appearance of the lesion and was unable to confirm that a referral had been sent. Dr B was called in to see Mr A immediately. Dr B acknowledged the omission to send the referral, took new photographs, and actioned an urgent referral.

23. The referral included the following information:

> "[The skin lesion] now measures 15 x 10mm and bleeding from soft dmed part in inferior end. not sore. ?melanoma.
>
> (for some reason I forgot to write note re having taken photos and was to arrange SOPD referral for excision when first saw it on 14/12/18, when was being reviewed for all regular medications re IHD and diabetes etc)
>
> plan: taken more photos now and for BPAC referral marked high suspicion of cancer — BPAC ref[e]rral sent at 2.53pm."

[3] Gastro-oesophageal reflux disease.

24. The referral, with photographs, was immediately sent by Dr B to the DHB and marked as a high suspicion of cancer. The referral was acknowledged as having been received by the DHB. Dr B noted on the referral that he had omitted to make the referral in December 2018.

Treatment

25. On 19 March 2019, Dr B received a letter from the DHB advising that the referral had been triaged as urgent. The excisional biopsy of the lesion was performed under local anaesthetic at the DHB on 28 March 2019.

26. On 9 April 2019, Mr A was reviewed in clinic at the DHB. The excision site had healed well, and the histology report dated 2 April 2019 confirmed that the lesion was a malignant melanoma. Mr A had a wide local excision and sentinel node biopsy on 2 May 2019. There was no evidence of residual malignancy or metastatic disease.

27. Mr A told HDC that he was concerned about the possible serious outcome of the delay in referral and treatment of the melanoma, and hoped to see changes made to the assessment process so that this does not happen to others.

Further information

Dr B

28. Dr B apologised for omitting to send the referral to the DHB on 14 December 2018 and for the length of time that elapsed between this date and the referral being sent in March 2019. He said that the omission was an unfortunate oversight, and he apologised to Mr A at the time.

29. Dr B provided his reflection on how he believes the omission occurred. He said that many patients present with multiple issues in the 15-minute consultation time, and usually he completes a note and assigns himself tasks for completing referrals after the consultation has ended. On 14 December 2018, Mr A's appointment was scheduled for 11.45am but commenced about 12.25pm and lasted for about 45 minutes. The consultation was long and ran over time, covering extensive health issues.

Actions taken — Dr B

30. After these events, the following key improvements were implemented:

a) Provision of multimedia education notices to patients.

b) Education of administration staff in advising patients on the duration of appointment times booked.

c) Education of GPs in being proactive in explaining their limit on what can be done for the patient within 15 minutes.

d) Exploration of ways to subsidise extended consultation for high-needs patients with limited means.

e) Implementation of nurse triage appointments prior to doctor appointments to save the doctor time and reduce the doctor's work pressure.

f) Reduction in Dr B's patient consultation sessions.

31. The medical centre is also undertaking the following:

a) Reviewing the 15-minute consultation time, as it is inadequate for dealing with the review of patients with multiple health problems.

b) Actively recruiting for more doctors to help with resourcing.

32. Dr B commented that recruiting more doctors is "not a quick or easy process" in provincial general practice.

Policy

33. The "[Medical Centre] Management Policy patient test results, urgent referrals, clinical correspondence and other investigations" outlines the policy and procedures related to the processes involved in the management of patient test results and medical reports.

34. The section on "Correspondence" states:

> "Follow up appointments will be made as requested by the interpreting Physician or as per another clinical policy …
>
> Correspondence re clinic and Specialist referral: It is documented in the clinical notes how, and when, the referral has been sent. A referral acknowledgment is received into the Results box from [the DHB] when a referral is sent via an BPAC e-referral (accessed via 'Overview, BPAC, … e-referral'). Acknowledgement and waiting times are scanned in the doctor's Inbox who will 'file' them.
>
> …
>
> All urgent referrals are saved in the PMS system. Any clinical BPAC (electronic) referral has an acknowledgement sent back from [the DHB] directly into our PMS once received. The clinician follows up as appropriate."

Relevant standards

35. Cornerstone Accreditation standards[4] include the following:

> "[Indicator 21.1 states:] Patient records contain information to identify the patient and document: the reason(s) for the visit, relevant examination and assessment, management, progress and outcomes (management/risk factors/screening/ continuity/referral/tests/investigations).
>
> …
>
> [Indicator 23.4 states:] The practice can demonstrate how they identify and track potentially significant investigations and urgent referrals. [The practice has a] policy

[4] RNZCGP. Aiming for Excellence. The RNZCGP standard for New Zealand general practice (2016).

that describes how the practice identifies and tracks significant investigations and urgent referrals."

Responses to provisional opinion

36. Mr A was given an opportunity to respond to the "information gathered" section of the provisional opinion. He commented: "I truly believe it was work pressure that caused the mistake and I feel that [Dr B] is a very good gp."

37. Dr B was given an opportunity to respond to the provisional opinion and accepted the proposed recommendations. Dr B submitted that many provincial general practitioners in New Zealand are facing the issue of an increasing workload and difficulty in attracting and retaining quality GPs to provincial areas.

Opinion: Dr B — breach

Introduction

38. This report highlights the importance of providers making referrals in a timely manner. It also emphasises the need to document examination findings and to provide consumers with information on expected timeframes for appointments, and safety-net information on what to do if symptoms change. In my opinion, a number of oversights in Mr A's care contributed to a delay in his treatment. These are set out below.

Reviews

2 February 2018

39. On 2 February 2018, Dr B saw Mr A at a regular three-monthly GP review for multiple health issues. During the consultation, Mr A asked Dr B to check a skin lesion on his upper right arm. Dr B examined the lesion and told Mr A that he thought that the lesion was a wart.

40. My in-house clinical advisor, GP Dr David Maplesden, considers that Dr B was conscientious in applying his recent dermoscopic training in his review of the lesion. Dr Maplesden was unable to determine whether Dr B erred in his diagnosis or impression of Mr A's lesion at that time, and explained that melanoma can mimic seborrheic keratosis,[5] and seborrheic keratosis-like melanomas can be clinically and dermoscopically challenging to detect. Dr Maplesden advised that biopsy remains the definitive diagnostic tool for melanoma, and is indicated once a threshold of suspicion is obtained.

[5] Izikson L et al, "Prevalence of Melanoma Clinically Resembling Seborrheic Keratosis: Analysis of 9204 Cases". *JAMA Derm* (2002) 138(12): 1562–1556.

41. Dr Maplesden stated:

> "Best practice would be to document features of a pigmented skin lesion (ABCDE mnemonic[6]), particularly evolution and size of the lesion, although I do not commonly see this degree of documentation in files I have reviewed. An increasing number of GPs will photograph pigmented skin lesions but I would not regard this as expected practice."

42. Dr Maplesden advised that it is important to use the review of a skin lesion, even if apparently benign, to inform the patient of potentially concerning features such as rapid growth, bleeding, or change in colour, and to report any such features promptly. Dr B told HDC that he cannot recall accurately what he told Mr A, although his usual practice is to provide safety-net information. This information is not documented in the notes. Dr Maplesden considers that if such advice was not given by Dr B, this would be a mild departure from accepted standards.

14 December 2018

43. Between February and December 2018, Mr A attended the medical centre on four occasions and saw different staff members. He did not mention the skin lesion at these consultations, as he felt reassured by what Dr B had told him at the February review.

44. On 14 December 2018, Mr A had a consultation with Dr B for multiple health issues, not including the skin lesion. While taking Mr A's blood pressure, Dr B saw the skin lesion on Mr A's arm and was concerned by its change in appearance.

45. Dr B told HDC that he took photographs of the lesion and had a discussion with Mr A, but cannot recall exactly what he said. No reference to Mr A's skin lesion was recorded in the notes. Mr A told HDC that Dr B offered to remove the lesion for a fee or to make a referral to the hospital. Mr A chose to be referred to the hospital for removal of the lesion.

46. Dr B omitted to upload the photographs to Mr A's file or to complete the referral form, and made no record in the notes of the skin lesion. Dr B told HDC that the consultation had been long and complex, and he had been under time pressure.

47. Dr Maplesden advised:

> "[Dr B] failed to document his examination findings in regard to [Mr A's] skin lesion, and there was no record of the provisional diagnosis or intended management plan. This must be regarded as a moderate departure from accepted practice with respect to clinical documentation, taking into account the circumstances of the oversight including: complex consultation, time pressure, photographs taken and the fact that [Dr B's] standard of clinical documentation was otherwise consistently very good and more detailed than many clinical notes I review. It appears the omission on this occasion was an exception to his usual high standard and a direct result of time pressure."

[6] https://www.dermnetnz.org/topics/abcdes-of-melanoma/ accessed 12 September 2019.

48. I agree with Dr Maplesden that Dr B's omission to document his examination findings is a departure from accepted practice, even taking into account the mitigating factors referred to above.

49. Dr B also omitted to upload the photographs of the lesion to Mr A's file, and I am concerned that both omissions contributed to him then forgetting to make the referral for Mr A. Dr Maplesden advised:

> "The failure to initiate appropriate timely management of [Mr A's] skin lesion suspicious for melanoma (by completing/tracking an appropriate referral) I regard as a moderate departure from accepted practice, taking into account there was an intention to make the referral which was discussed with [Mr A], and photographs were taken to attach to the referral."

50. Dr Maplesden reviewed the relevant practice policy regarding referrals, and advised that it is robust and fit for purpose. He stated:

> "[A]ccepted practice would be for the referral to be completed in a timely fashion and, given the high suspicion of cancer (HSCAN), for the referral to be tracked to ensure [Mr A's] definitive management was also undertaken in a timely manner."

51. In this case, Dr B did not follow the practice policy, and omitted to make the referral.

52. I am concerned that Dr B did not inform Mr A of the expected time frame in which he should expect to receive an appointment. Dr Maplesden advised that it would be accepted practice to provide this information to the consumer. He stated:

> "(HSCAN) accepted practice is to inform the patient of when an appointment is likely to be received, and what to do if the appointment has not been received within a defined time frame."

53. Dr Maplesden considers that failing to provide this information to the consumer, particularly when the lesion was felt to be suspicious, is a mild to moderate departure from accepted practice. I agree with this advice and am concerned that safety-netting information was not provided by Dr B.

8 March 2019

54. On 8 March 2019, Mr A had his three-monthly review with another GP at the medical centre. The GP saw the skin lesion and was immediately concerned and called in Dr B. On realising his oversight, Dr B immediately acknowledged the omission to send the referral, took new photographs, and actioned an urgent referral. This open disclosure and prompt action by Dr B is to be commended.

Conclusion

55. I acknowledge the comments by my expert advisor on the high standard of both documentation and clinical practice in other clinical documentation by Dr B. I note Dr B's comments about the high workload, that it can be hard to recruit to provincial general

practice, and that he is making changes to manage his workload better. I commend Dr B for his open disclosure of the omission to send the referral.

56. However, Dr B had a responsibility to provide services to Mr A with reasonable care and skill and, in my opinion, he did not do this. Dr B failed to initiate a referral in a timely manner after the 14 December 2018 consultation, he failed to document his findings, and he did not make Mr A aware of the timeframe in which he could expect to receive an appointment following the referral. These oversights meant that there was a delay in Mr A receiving a first specialist appointment and treatment for his malignant melanoma. Accordingly, I find that Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[7]

Recommendations

57. In the provisional opinion, I recommended that Dr B provide a written apology to Mr A for the failings identified in the report. Dr B has provided an apology, which has been forwarded to Mr A by HDC.

58. I recommend that Dr B implement the use of a PMS reminder system as soon as the intention to make a referral has been confirmed (rather than once the referral has been generated) to reduce the risk of intended tasks being overlooked.

Follow-up actions

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

60. 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.

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

Appendix A: In-house clinical 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 [Mr A]; response from [Dr B]; GP notes [medical centre]; clinical notes [DHB].

2. [Mr A] complains about delays in the diagnosis of a malignant melanoma recently removed from his right upper arm. He states he attended [Dr B] in February 2018 with a lesion on his right upper arm that his wife had suggested he get checked. [Dr B] examined the lesion and felt it was just a wart. [Mr A] felt reassured by the diagnosis and was not particularly concerned when the lesion began changing in colour. However, [Dr B] reviewed the lesion in December 2018 and informed [Mr A] that the lesion required biopsy and this would be arranged through the DHB. In March 2019 [Mr A] states he saw another GP at [the medical centre] who was concerned at the appearance of the lesion and was unable to confirm a referral had been sent. She got [Dr B] to see [Mr A] immediately. [Dr B] admitted having forgotten to send the [previous] referral, took photos of the lesion and sent in a new referral. [Mr A] was subsequently diagnosed with a melanoma.

3. Clinical notes have been reviewed from February 2018. [Mr A] has a complex medical history including ischaemic heart disease with previous PCI but ongoing angina, hypertension, type 2 diabetes on insulin, obstructive sleep apnoea and gastro-oesophageal reflux. He requires multiple medications and regular GP review. On 2 February 2018 [Mr A] was reviewed by [Dr B] for repeat of usual medications. Notes indicate review of angina and diabetes control with symptom of visual floaters also addressed and antihypertensive regime adjusted. Prescriptions were provided for hayfever and GORD symptoms. Blood tests forms were provided for cardiovascular risk monitoring. There are additional notes relating to review of a skin lesion coded as seborrheic keratosis: *13x17mm roughly oval seborrheic wart by dermatoscopy with few darker patches within it in medial right upper arm that his wife wanted checked.*

Comments:

(i) [Dr B] notes in his response that this was a lengthy (38 minute) consultation at which multiple health issues were addressed. [Dr B] had recently completed a weekend dermoscopy course and was confident the macroscopic and dermoscopic features of the skin lesion presented by [Mr A] were consistent with the diagnosis of seborrheic keratosis. In my opinion, this consultation is generally well documented and was complex in nature. However, best practice would be to document features of a pigmented skin lesion (ABCDE mnemonic[1]), particularly evolution and size of the lesion, although I do not commonly see this degree of documentation in files I have

[1] https://www.dermnetnz.org/topics/abcdes-of-melanoma/ Accessed 12 September 2019.

reviewed. An increasing number of GPs will photograph pigmented skin lesions for future reference, but I would not regard this as expected practice. I believe it is important to use review of a skin lesion, even if apparently benign, to inform the patient of potentially concerning features of any skin lesion (including rapid growth, bleeding or change in colour) and to promptly report any such features. It is not clear from the response or notes if such information was provided to [Mr A] but I would be mildly critical if it was not. It appears [Mr A] felt sufficiently reassured by the information provided to him on 2 February 2018 that he did not draw the attention of any health provider to the changing lesion at subsequent consultations.

(ii) While there are an increasing number of GPs incorporating use of the dermoscope into their assessment of skin lesions, I would not yet regard this practice as expected in primary care. However, [Dr B] was conscientious in applying his recent dermoscopic training in this case. Research suggests use of the dermoscope by primary care clinicians with appropriate training improves identification of melanoma compared with 'naked eye' identification, and reduces unnecessary biopsies of benign lesions[2]. Biopsy remains the definitive diagnostic tool for melanoma. However, biopsy must be used judiciously as unnecessary biopsies contribute to health care costs and leave scars, which can have psychosocial implications. With benign nevi outnumbering melanoma about 2 million to 1, biopsy is indicated once a threshold of suspicion is obtained[3]. It is recognised that melanoma can mimic seborrheic keratosis[4] and seborrheic keratosis-like melanomas can be clinically and dermoscopically challenging to detect. A 2017 study[5] discusses dermoscopic clues that might help differentiate between the lesions improving the rate of correct diagnosis. Without having viewed [Mr A's] lesion or dermoscopic images of the lesion from February 2018, I am unable to state (without the benefit of hindsight) that [Dr B] erred in his diagnosis or impression of [Mr A's] lesion at that time. However, [Dr B] might like to review the cited reference 5 as an adjunct to the dermoscopic training he has already undertaken.

4. [Dr B] states in his response that [Mr A] was seen on four occasions during 2018 in relation to his chronic medical conditions (locum GP once, GP trainee once and nurses on two occasions). He did not mention any issues with his skin lesion on these occasions. (I have not reviewed notes related to these consultations but [Mr A] concurs with the response in this regard, as he felt reassured by [Dr B] that the skin lesion was 'just a wart').

[2] Holmes G et al. Using Dermoscopy to Identify Melanoma and Improve Diagnostic Discrimination. Fed Pract. 2018 May; 35(Suppl 4): S39–S45.
[3] Thomas L, Puig S. Dermoscopy, digital dermoscopy and other diagnostic tools in the early detection of melanoma and follow-up of high-risk skin cancer patients. Acta Derm Venereol. 2017;97(218):14–21.
[4] Izikson L et al. Prevalence of Melanoma Clinically Resembling Seborrheic Keratosis: Analysis of 9204 Cases. JAMA Derm. 2002;138(12)1562–1556
[5] Carrera C et al. Dermoscopic Clues for Diagnosing Melanomas That Resemble Seborrheic Keratosis. JAMA Dermatol. 2017;153(6):544–551. Available at: https://jamanetwork.com/journals/jamadermatology/article-abstract/2612723 Accessed 12 September 2019.

5. [Dr B] next reviewed [Mr A] on 14 December 2018. There are detailed notes relating to [Mr A's] issue with ongoing effort related to chest pain, diabetes control, hayfever and GORD. There is no reference to [Mr A's] skin lesion. In his response, [Dr B] states that while taking [Mr A's] blood pressure (sleeve rolled up) he happened to note that the upper arm lesion had changed significantly from the last time he had reviewed it: *the lesion was now smooth, rounded and black and had grown in size.* [Dr B] took photographs of the lesion with his phone and thinks he discussed with [Mr A] that the lesion was concerning *and that it may be cancerous* ([Dr B] states further in his response that he thought the lesion was a melanoma). [Dr B] states he told [Mr A] he would make a referral to [the public hospital] for removal of the lesion. Unfortunately, [Dr B] omitted to upload the photographs to [Mr A's] file or to complete the referral form. He states that [Mr A's] consultation was complex with multiple important health issues reviewed and discussed. The consultation started about 40 minutes after the scheduled time (last consultation of the morning) because of time pressures during the morning surgery. [Dr B] feels the time pressures contributed to his oversight in not uploading [Mr A's] images, that being the prompt to complete the referral (which would have the images attached).

Comments:

(i) [Dr B] was conscientious in opportunistically reviewing [Mr A's] arm lesion when it was not raised as an issue by [Mr A] himself (although this raises the question of whether [Mr A] had been previously adequately informed regarding changes in the lesion that might be regarded as suspicious). The macroscopic and dermoscopic images supplied show [Mr A's] arm lesion by now had an appearance that would have been atypical for seborrhoeic keratosis but suspicious for possible melanoma. This was apparently discussed with [Mr A] (using the term 'possible skin cancer') and it was agreed a referral would be made to [the public hospital] for the lesion to be biopsied. This was appropriate intended management. It is unclear if [Mr A] was made aware of the expected time frame in which he should receive an appointment, but it would be accepted practice to do so, particularly if the lesion was felt to be suspicious, and I would be mildly to moderately critical if no such information was provided.

(ii) [The medical centre] is Cornerstone accredited. Accreditation standards are listed in a 2016 RNZCGP publication[6]. Relevant excerpts from the publication, which represent accepted practice, are in italics below:

Indicator 21.1 states: *Patient records contain information to identify the patient and document:*

the reason(s) for the visit, relevant examination and assessment, management, progress and outcomes (management/risk factors/screening/continuity/referral/tests and investigations).

[6] RNZCGP. Aiming for Excellence. The RNZCGP standard for New Zealand general practice. 2016.

Indicator 23.4 states: *The practice can demonstrate how they identify and track potentially significant investigations and urgent referrals. [The practice has] a policy that describes how the practice identifies and tracks significant investigations and urgent referrals.*

Addendum 26 September 2019 — the relevant practice policy has been reviewed and is robust and fit for purpose. The policy was not followed in this case as is discussed later in this report.

(iii) [Dr B] failed to document his examination findings in regard to [Mr A's] skin lesion, and there was no record of the provisional diagnosis or intended management plan. This must be regarded as a moderate departure from accepted practice with respect to clinical documentation, taking into account the circumstances of the oversight including: complex consultation, time pressure, photographs taken and the fact that [Dr B's] standard of clinical documentation was otherwise consistently very good and more detailed than many clinical notes I review. It appears the omission on this occasion was an exception to his usual high standard and a direct result of time pressure. I think any general practitioner can recall instances of clinical notes being inadvertently omitted or curtailed during a busy practice session, and many practices have an audit process for detecting when no notes have been written in relation to a consultation (although such a process would not have detected [Dr B's] omission as he had already made detailed entries in relation to the other issues addressed at the consultation). It is important to take these factors into account in relation to [Dr B's] oversight.

(iv) Once the management plan of referral for excision biopsy of the arm lesion had been agreed, accepted practice would be for the referral to be completed in a timely fashion and, given the high suspicion of cancer (HSCAN), for the referral to be tracked to ensure [Mr A's] definitive management was also undertaken in a timely manner. As previously discussed, in the circumstances (HSCAN) accepted practice is to inform the patient of when an appointment is likely to be received, and what to do if the appointment has not been received within a defined time frame (the same principles that apply to significant investigation results and that are discussed in detail in the cited RNZCGP document). This acts as a safety 'backstop' in addition to formal tracking of the referral using the PMS. The failure by [Dr B] to complete the referral inevitably meant there was no formal tracking of the referral (generally initiated once the referral is sent) so the two issues cannot be separated. The failure to initiate appropriate timely management of [Mr A's] skin lesion suspicious for melanoma (by completing/tracking an appropriate referral) I regard as a moderate departure from accepted practice, taking into account there was an intention to make the referral which was discussed with [Mr A], and photographs were taken to attach to the referral. I note again that [Dr B's] other clinical documentation suggests a high standard of both documentation and clinical practice, and [Dr B] has recounted the time pressures that contributed to the oversight. [Dr B] has noted in his response some changes he is making to both practice and individual processes to better manage the increasing primary care workload (increasing in both volume and

complexity) and current and an evolving primary care workforce crisis, and these appear appropriate. Use of a PMS reminder system as soon as the intention to make a referral has been confirmed (rather than once the referral has been generated) might also reduce the risk of intended tasks being overlooked during a busy surgery.

6. On 8 March 2019 [Mr A] was seen by [Dr C] for routine review. She was concerned at the appearance of [Mr A's] skin lesion and realised there was no referral on file. [Dr B] happened to be doing paperwork at the surgery and was contacted by [Dr C]. He saw [Mr A] immediately, acknowledged the omitted referral and re-photographed the lesion. [Dr B] sent an urgent referral (HSCAN) to [the public hospital] requesting removal of the lesion. Referral details included: *?melanoma R upper anterior arm skin … has started bleeding today from the soft nodular vertical growth in its lower pole. I have attached photos taken on 14/12/19* (sic) *— macro one without measuring tape, and dermatoscopic one without blood evident) and the two taken today. Now measures 15x10mm and bleeding from soft med part in inferior end. Not sore ?melanoma. (For some reason I forgot to write note re having taken photos and was to arrange SOPD referral for excision when first saw it on 14/12/18 when was being reviewed for all regular medications re IHD and diabetes etc …*The referral was acknowledged in a letter to [Dr B] dated 19 March 2019 with biopsy to occur within a month. [Mr A] had excisional biopsy of the lesion performed under local anaesthetic at [the public hospital] on 28 March 2019. At clinic review on 9 April 2019 the excision site had healed well and histology had confirmed a superficial spreading melanoma 2mm Breslow thickness without ulceration giving stage pT2a. [Mr A] was then booked for wide local excision and sentinel node biopsy with these being performed at [the public hospital] on 2 May 2019. There was no residual tumour evident and node biopsy was negative.

Comment: Management on this occasion was consistent with accepted practice. There was open disclosure of the referral oversight and an appropriate referral was then generated. [Mr A] was subsequently seen promptly in secondary care and appropriate definitive management of his arm lesion undertaken. It is not possible to state that the three-month delay between intended and actual referral had significant impact on [Mr A's] subsequent management or prognosis. The histological staging of his lesion placed him in the Stage I subset which carries a good prognosis[7]."

[7] https://www.ncbi.nlm.nih.gov/books/NBK481857/table/chapter6.t3/?report=objectonly Accessed 13 September 2019.