Oral and Maxillofacial Surgeon, Dr B

Whanganui District Health Board

A Report by the

Health and Disability Commissioner

(Case 14HDC00828)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In October 2011 Mr A first noticed a painful lesion on his tongue. Mr A was referred by a general practitioner to an oral and maxillofacial surgeon, Dr B, in December 2011. On 14 December 2011 Dr B undertook a biopsy of the lesion on Mr A's tongue. The histology report indicated no definite evidence of dysplasia(proliferation of cells of an abnormal type).

2. Following the biopsy, Dr B monitored Mr A at intervals of two to four months. On 16 May 2012, Dr B referred Mr A for further dental work. After the dental work was carried out, the patient management system discharged Mr A, and he was not rebooked with Dr B. Mr A contacted Whanganui DHB, and the error was identified and another appointment scheduled for 5 September 2012.

3. On 5 September 2012 Dr B reviewed Mr A and noted in the clinical record that there continued to be a white lesion in Mr A's mouth. Mr A was booked for a tongue biopsy and removal of an impacted tooth 38, under general anaesthetic.

4. On 27 February 2013 Mr A underwent the biopsy and removal of the impacted tooth. The histology report indicated squamous cell carcinoma in situ, incompletely excised at the nine o'clock margin.

5. Following the biopsy, Dr B continued to monitor Mr A, with follow-up appointments on 13 March 2013, 24 April 2013 and 7 August 2013.

6. On 7 August 2013 Dr B recorded in the clinical notes that the white lesion had returned, and that an additional biopsy would need to be performed under general anaesthetic. Mr A underwent a third biopsy on 23 October 2013. The histology results again showed squamous carcinoma in situ, this time extending to the right excision margin.

7. Following the biopsy on 23 October 2013 Dr B continued to review Mr A, and saw him on 30 October 2013 and 27 November 2013. On 27 November 2013 Dr B referred Mr A to the Radiation/Oncology Clinic at another hospital for additional follow-up.

8. During his care of Mr A, Dr B kept minimal, and largely illegible, clinical records and operation notes.

Findings

9. By failing to indicate semi-urgent priority for Mr A's second biopsy on the booking form, failing to undertake a further biopsy or refer Mr A to a multidisciplinary team following the second biopsy and, following the biopsy procedures, failing to question Mr A about pain in his tongue, Dr B breached Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code).

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

10. By not adhering to professional standards regarding documentation, Dr B also breached Right 4(2)[2] of the Code.

11. For failing to provide Mr A with information that a reasonable consumer would require in the situation, including an appropriate explanation of the biopsy results and an explanation of the management options available, Dr B breached Right 6(1)[3] of the Code. Without this information, Mr A was not in a position to make informed choices and provide informed consent for his further treatment. It then follows that Dr B also breached Right 7(1)[4] of the Code.

12. Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

13. By failing to have a system to monitor Dr B's compliance with its policies and procedures, particularly those relating to documentation, and having an inadequate booking system that allowed Mr A to be discharged inappropriately from its system, Whanganui DHB failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code. Criticism is also made about Whanganui DHB's clinical documentation system not allowing photographs to be retained on a patient's clinical record.

Recommendations

14. It was recommended that Dr B provide an apology to Mr A, and undertake further training on the importance of, and expectations for, clear, full and accurate documentation.

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

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[2] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."
[3] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"
[4] Right 7(1) states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."

Complaint and investigation

16. The Commissioner received a complaint from Mr A about the services provided by Dr B at Whanganui District Health Board. An investigation was commenced on 17 April 2015. The following issues were identified for investigation:

- *Whether Dr B provided an appropriate standard of care to Mr A between December 2011 and May 2014.*
- *Whether Whanganui District Health Board provided an appropriate standard of care to Mr A between December 2011 and May 2014.*

17. The parties directly involved in the investigation were:

Mr A	Consumer, complainant
Ms A	Complainant's partner
Dr B	Oral and maxillofacial surgeon
Whanganui District Health Board	Provider

Also mentioned in this report:

Ms C	Clinical Manager Oral Health
Ms D	Dental assistant
Dr E	Principal Dental Officer
Dr F	Oral and maxillofacial surgeon

18. Independent advice was obtained from an expert oral and maxillofacial surgeon, Dr Jacobus Erasmus (**Appendix A**).

Information gathered during investigation

Mr A

19. On 18 November 2011 Mr A attended a medical centre and was seen by a general practitioner (GP). The GP noted in the clinical record that Mr A had had a sore tongue for two months and had noticed an ulcer two months before the appointment. The GP noted that Mr A did not feel unwell and had never smoked. The GP recorded: "White plaque underneath L [left] side of the tongue. No palpable submandibular[5] and cervical LNs [lymph nodes]. Leucoplakia.[6] Referred to maxillofacia[l][7] for possible excision biopsy."

[5] Major salivary glands located beneath the floor of the mouth.
[6] A mucous membrane (epithelial tissue that secretes mucus) disorder characterised by white patches, especially on the cheek, tongue and other regions.
[7] A surgical speciality for treating diseases, injuries and defects in the head, neck, face, jaws and the hard and soft tissues of the mouth (oral) and jaws/face (maxillofacial) region.

20. That same day, the GP wrote a referral letter to oral and maxillofacial surgeon Dr B, stating: "[Mr A is] obviously worried about tongue cancer and I wonder if you could kindly consider him for an excision biopsy of this leucoplakia." The GP's referral letter was sent to Dr B's clinic at another district health board (DHB2) on 18 November 2011.

Dr B

21. Dr B qualified as a general dental practitioner and obtained a Fellowship in Dental Surgery. He has been registered in New Zealand as a general dental practitioner and as an oral and maxillofacial surgery specialist for a number of years.

22. Dr B works between a number of different places.

23. Dr B attends Whanganui DHB as a visiting oral and maxillofacial surgeon for the DHB's dental service. Dr B's responsibilities at Whanganui DHB involve weekly oral and maxillofacial surgery outpatient clinics. At the time of the events in question, Dr B also carried out list surgeries on a fortnightly basis.

Ms A

24. Mr A's partner, Ms A, was in attendance at all of Mr A's appointments with Dr B at Whanganui DHB. All parties recall Ms A's attendance.

Ms D

25. Dental assistant Ms D has worked with Dr B since 2012, and was at appointments with Mr A during that time.

Referral and initial assessment

26. On 2 December 2011 Mr A was reviewed by Dr B at DHB2. The clinical notes are brief and report: "R/V [review] white patch L [left] tongue." At that appointment Dr B recommended that a biopsy on Mr A's tongue under local anaesthetic be completed at Whanganui DHB. That day, Dr B wrote himself a referral from DHB2 to Whanganui DHB to arrange an appointment for Mr A for a half-hour biopsy. The referral was triaged by the dental unit at Whanganui DHB on 5 December 2011 as urgent.

Dr B's clinical notes

27. Dr B's clinical notes, supplied by Whanganui DHB, are brief and largely illegible. HDC requested that Dr B transcribe his clinical notes for the purposes of the investigation. As such, the clinical notes recorded in the following sections are Dr B's transcription.

First biopsy — 14 December 2011

28. On 14 December 2011 Dr B undertook a biopsy of the lesion on Mr A's tongue under local anaesthetic. According to Dr B, his clinical notes record: "Lignocaine[8] with adrenaline 180000 2 cartridges incisional biopsy lesion tongue, closed vicryl 30 sutures." The histology report states that a 4mm biopsy was taken, and notes:

[8] A synthetic local anaesthetic used in dental surgery.

"Sections show pieces of squamous mucosa consistent with tissue from the tongue. There is hyperkeratosis[9] and parakeratosis[10] but no definite evidence of dysplasia[11]." In the summary of the diagnosis, the report states: "HYPERPLASIA WITH HYPERKERATOSIS AND PARAKERATOSIS" (Emphasis in original).

Follow-up from first biopsy

29. Following the biopsy, Dr B reviewed Mr A on 21 December 2011. According to Dr B, the clinical note records:

> "Review with pathology. Pathology reported as hyperkeratosis no dysplasia. Arrangements made for review in three months' time. Query galvanic reaction from gold amalgam[12] in his lower left mandibular 1st and 2nd molars."

30. On 7 March 2012 Mr A attended an appointment with Dr B. According to Dr B, his clinical note records: "Reviewed. Recurrence of area left tongue. Try replacing amalgam with plastic filling."

31. On 30 March 2012 Mr A was seen by Clinical Manager Oral Health Ms C. The clinical records state:

> "37 — was removed — root canal evident — treatment still intact. — Placed kalsogen and fuji. [Local anaesthetic] 3.0 ml [lignocaine]."

32. On 16 May 2012 Mr A attended an appointment with Dr B. According to Dr B, his clinical notes record:

> "Marked improvement, but sharp cusps on mandibular left second and third molars. Treatment advised, permanent restoration not amalgam and smooth cusps on the tooth 2nd molar and 3rd molar."

33. On 18 June 2012 Mr A was seen again by Ms C, who "cut down [glass ionomer cement]"[13] on tooth 37.

Possible discharge from Dr B's care

34. After the 18 June 2012 appointment with Ms C, Mr A was discharged from Dr B's clinic in error. Ms C told HDC that it was always the plan for Mr A to be referred back to Dr B, but that its patient management system did not recognise referrals from dental therapists and, as such, she did not have the power to make the referral to Dr B. There was no other system in place to ensure that Mr A was referred back to Dr B following this appointment. However, Ms C told HDC that that was always the plan, and that it was communicated to Mr A.

[9] Abnormal thickening of the outer layer of the skin.
[10] The presence of nucleated keratinocytes (or skin cells that are still dividing).
[11] The enlargement of an organ or tissue by the proliferation of cells of an abnormal type as an early stage in the development of cancer.
[12] A liquid mercury and metal alloy mixture used to fill cavities caused by tooth decay.
[13] A dental cement used in restorative dentistry.

35. Furthermore, Ms C told HDC that Mr A's discharge would eventually have been picked up by the receptionist, who goes through all the patient lists and booking sheets. Mr A told HDC that some time after his appointment with Ms C he called Whanganui DHB to arrange an additional appointment with Dr B, and was informed that he had been discharged. Mr A queried this discharge, and an appointment with Dr B was arranged for 5 September 2012.

36. There were 11 weeks between Mr A's appointment with Ms C and his next appointment with Dr B.

Decision to undertake second biopsy

37. On 5 September 2012 Mr A was seen by Dr B. According to Dr B, the clinical note reads: "Review, still white patch. Treatment — extract the mandibular left 3rd molar and biopsy the tongue under day case general anaesthesia."

38. Mr A recalls Dr B telling him that it was his third molar that was causing his tongue pain, and that he would remove the tooth at the same time as doing the biopsy.

Pre-admission documentation

39. On 5 September 2012 Dr B also completed a Whanganui DHB operation booking form for Mr A. On the form, Dr B wrote the diagnosis: "[Impacted] 38 white patch L [left] lateral tongue." The intended procedure was stated as: "[E]xtract 38 biopsy tongue." No priority code or score was given, although there is a place on the form for both to be indicated. Dr B advised HDC: "[A]t that stage I had no input into when people were booked, how they were booked or what priority they were given." Dr B noted on the form that the operation would occur under general anaesthetic and take 40 minutes, and that Mr A was healthy.

40. Principal Dental Officer Dr E, the Health Manager, and Ms C all refuted Dr B's statement that he did not have control over his surgical lists. Instead, they stated that the majority of patients placed on Dr B's waiting lists were either seen by Dr B himself, or Dr B was aware of these patients and had consented by signature on the patient records that they should be added to his surgical lists. According to Whanganui DHB staff, Dr B usually confirmed patients by a signature or a notation made on the patient booking form, which indicated that Dr B had agreed to the particular patient being placed on the waiting list. Equally, if a patient was thought to need urgent treatment, this was noted in the patient booking form by Dr B, and he could therefore expedite a patient obtaining a theatre date.

41. On 5 October 2012 Mr A had an appointment with a registered nurse (RN) and underwent a pre-admission nursing assessment. The form outlines that Mr A's current problems were "impacted wisdom tooth, [and] white lesion on tongue". It was noted that Mr A was independent and used paracetamol[14] at home, and that his general health was good. Mr A was asked to call if he became unwell in the week prior to his surgery. The nursing action on the form states: "[C]ommence + follow pre-op week visit." On a pre-admission supplementary administrative note, the RN recorded: "Pt

[14] A medication used to treat pain and fever.

[patient] well to book … Can come anytime, would prefer towards the end of year if possible."

42. Mr A's biopsy was scheduled for 27 February 2013. Dr B told HDC that he would have preferred the biopsy to have been earlier, although, as stated above, he felt he had no control over his operating lists. On 26 February 2013 a registered nurse from Whanganui DHB called Mr A and recorded: "Pt [patient] phoned + advised of tomorrows 0800. NBM [nil by mouth] from 2400. Pt well."

Second biopsy — 27 February 2013

43. On 27 February 2013 Mr A was admitted to the Day Surgery Unit for an extraction of tooth 38 and a biopsy and excision of the tongue lesion. Dr B hand wrote an operation record that is largely illegible. The date is not recorded, nor is the time, the anaesthetist's name or the assistant's name. According to Dr B, the operation note reads: "Lignocaine with Adrenaline x3. 38 elevated. Excisional biopsy lesion tongue. Vicryl 3/0. Post operation 1) Home this [afternoon] 2) Outpatient review [two weeks]."

44. On 27 February 2013 Mr A stayed at the hospital until 3.40pm. In recovery Mr A complained of pain and was given tramadol.[15] Mr A was discharged with a prescription for codeine.[16]

45. The histology report of 5 March 2013 outlines that the lesion was sized 22 x 20 x 10mm. The report stated:

> "Sections show squamous mucosa[17] with underlying skeletal muscle and fat consistent with tongue. This includes a plaque of severe epithelial dysplasia amounting to squamous cell carcinoma in-situ.[18] Multiple levels have been performed and there is no evidence of invasive malignancy. The in-situ carcinoma extends to involve the 9 o'clock radial margin. The background mucosa show irregular acanthosis[19] as well as widespread abnormal hyperkeratosis and parakeratosis. The 3 o'clock margin appears free of dysplasia by at least 1 mm."

46. The report identifies:

> "SQUAMOUS CELL CARCINOMA IN-SITU, INCOMPLETELY EXCISED AT 9 O'CLOCK MARGIN. NO EVIDENCE OF INVASIVE MALIGNANCY. BACKGROUND MUCOSA SHOWS PARAKERATOSIS." (Emphasis in original.)

[15] An opioid pain medication used to treat moderate to severe pain.
[16] An analgesic drug derived from morphine.
[17] Mucous membrane.
[18] An uncontrolled growth of abnormal cells arising in the squamous cells, which compose most of the skin's upper layers.
[19] Thickening of the skin.

Follow-up after second biopsy

47. On 13 March 2013 Dr B reviewed Mr A. According to Dr B, the clinical note records: "Review following the biopsy. Pathology shows carcinoma in situ clear of margins, review in six weeks." Dr B told HDC: "[M]y understanding of the biopsy report was that it was clear of carcinoma in-situ but that there was dysplasia in the margins." Dr B also told HDC that, in light of the tongue appearing otherwise healthy apart from the margins on one side, he decided to continue to monitor Mr A. Dr B told Mr A that "he would be kept under close review", and that these reviews were normally six weeks to three months apart.

48. On 24 April 2013 Dr B reviewed Mr A. According to Dr B, the clinical note records: "Review, all good, no problems, no nodes and made arrangements for review in four months' time."

49. In contrast, Mr A told HDC that he recalls that at that time he was still experiencing a lot of pain, which he reported to Dr B. Mr A also said that he was having difficulty extending his tongue. He said that Dr B made no comment to him when he reported these symptoms.

Lead-up to third biopsy

50. On 7 August 2013 Dr B reviewed Mr A and, according to Dr B, the clinical note states: "Small area — same place. Arrange under GA [general anaesthetic] biopsy."

51. Mr A told HDC that he recalls telling Dr B again about his ongoing pain and his inability to extend his tongue properly.

52. Also on 7 August 2013 Mr A completed a Whanganui DHB Preassessment Adult Questionnaire. The form asked whether Mr A had been in the hospital previously and, if so, for what and when. Mr A stated: "Feb 2013. Removal of dysplasia on tongue."

53. On 4 September 2013 Mr A was reviewed as part of the pre-admission clinic. Notes from the clinic state that Mr A had a "good understanding of procedure" and that he had "panadol and codeine at home". The notes of the discussion with Mr A record that he was given educational information about anaesthetics. Originally the biopsy was booked for 23 October 2013, but the date was then brought forward to 9 October 2013.

Cancelled biopsy — 9 October 2013

54. On 9 October 2013 Mr A was admitted to the day unit, but his biopsy was cancelled. A pre-admission and theatre supplementary administrative note records: "Pt [patient] cancelled due to out of surgical time — [Dr B] needed to get away on time & list had started late. Pt told by [Dr B] — Tea & sandwiches given. Pt booked in two weeks time." Mr A recalled: "After being fully prepared for theatre and with just 10 minutes before going into surgery I was informed by [Dr B] he had an appointment [at another place] and my operation would be rescheduled for the original date of 23/10/2013."

Third biopsy — 23 October 2013

55. On 23 October 2013 Mr A had the third excision and biopsy of his tongue, again under general anaesthetic. Mr A signed a Request and Agreement to Treatment Consent Form in which he agreed that he had "received a reasonable explanation of intent, and likely outcome of the operation/treatment of 'excision lesion L [left] tongue'".

56. Dr B completed a brief clinical record of the surgery. Again there is no indication on the form of the date, time, assistant or anaesthetist. According to Dr B, the operation note reads: "Excisional biopsy tongue left. Lignocaine with adrenaline 1:80,000 x 2. Excision of lesion, vicryl 3/0. Post [operation] 1) home this [afternoon] 2) [outpatient department] 1 week." The 25 October 2013 histology report states that [Mr A's] excision measured 30 x 12 x 8 mm, with an "ill defined roughened pale tan lesion measuring 15 x 15 mm". The report states:

> "Sections show squamous mucosa including skeletal muscle elements, consistent with tissue of the tongue. The epithelium shows widespread features of carcinoma in-situ. There is no evidence of invasive carcinoma. The area of in-situ change extends to widely involve the right excision margin. …
>
> MUSCOSA, LEFT SIDE OF TONGUE: SQUAMOUS CARCINOMA IN-SITU EXTENDING TO INVOLVE THE RIGHT EXCISION MARGIN." (Emphasis in original.)

Follow-up after third biopsy

57. On 30 October 2013 Mr A attended a follow-up appointment with Dr B. According to Dr B, the clinical note records: "Review with pathology. Carcinoma in situ advised Manuka honey and review in four weeks' time." Dr B told HDC that the manuka honey was suggested to be "used as a balm not to treat the white patch".

58. In regard to administering manuka honey, Mr A advised HDC that he applied manuka honey to his tongue on Dr B's recommendation, and that Dr B advised him to apply "Activated Manuka Honey" to the sore area several times a day, hopefully to cure the problem. Mr A told HDC that using the manuka honey was painful, so he stopped using it.

59. On 27 November 2013 Dr B reviewed Mr A. Both dental assistant Ms D and Ms C recall being in attendance, as well as Mr A's partner, Ms A. Mr A recalls that it was only himself, Ms A and Dr B present at the appointment.

60. According to Dr B, the clinical note records: "Review area distal aspect of left lateral tongue. No ulceration. Transfer to [DHB3] re. further opinion regarding squamous cell carcinoma."

61. Dr B told HDC that all the histology reports stated that there was no invasive carcinoma but, because of the ongoing dysplasia, he decided to refer Mr A to DHB3 for further assessment.

62. According to Mr A, Dr B told him that he was "unsure why [Mr A's] tongue wasn't responding to treatment but as they had a larger team they may know what the cause of the problem was and its treatment". Mr A said that Dr B never mentioned cancer or that he was referring him to the oncology clinic.

63. In contrast, Ms C recalls Dr B telling Mr A that the lesion was "something nasty" that needed further investigation. Ms C is unsure whether Dr B used the word "cancer", but said that normally he would use this word. Ms C thinks that Dr B told Mr A that he was referring him to the "head and neck clinic" at DHB3.

64. Dr B, Ms D and Ms C all recall that while Mr A and Ms A were still in the room Dr B rang the Radiation/Oncology Clinic at DHB3 to make the appointment for the following Friday. All three recall Dr B telling Mr A that there would be many people present at Mr A's first appointment at DHB3, and that the clinic was likely to be overwhelming.

65. In contrast, Mr A and Ms A told HDC that they were not in the room when Dr B called the Dental Unit at DHB3 to book an appointment for Mr A.

DHB3

66. On 6 December 2013 Mr A was seen by the Regional Cancer Treatment Service at DHB3. On 3 January 2014 Mr A had a wide local excision of the left side of his tongue and a buccal flap reconstruction[20]. Mr A also had an MRI[21] and CT[22] scan. The initial histology from the excision confirmed squamous cell carcinoma. Mr A went on to have radiation therapy and ongoing monitoring of his tongue.

Dental imaging

67. At no time during Mr A's care at Whanganui DHB were clinical photographs taken. Dr B advised: "We don't have the facilities in Whanganui to take clinical photographs — it is as simple as that. And even if we had the ability to take them, storage, access [and] security are incredibly difficult."

68. In contrast, Whanganui DHB told HDC that clinical photographs can be taken and stored in the hard copy of the patient's clinical records, and that this has been the process for many years. At the time of these events it did not have the facility to store clinical photographs electronically.

Advice on carcinoma in situ

69. Mr A stated that he was never informed by Dr B that he had carcinoma in situ, and that Dr B did not discuss with him options for managing the lesion. Mr A said that he asked Dr B frequently, and specifically after each biopsy, if he had cancer. Ms A confirmed Mr A's recollection that Mr A often asked whether he had cancer.

[20] Portion of the cheek used in a graft over the wound on the tongue.
[21] Magnetic resonance imaging (MRI) — a technique that uses a magnetic field and radio waves to create a detailed image of the organs and tissues within the body.
[22] A computerised or computed tomography (CT) scan involves an X-ray procedure that combines many X-ray images to create cross-sectional views.

70. However, in contrast, both Dr B and Ms D deny that Mr A asked whether he had cancer.

71. Dr B told HDC that it is probable that he never informed Mr A of the carcinoma in situ, but instead likely described it, after the 27 February 2013 biopsy, as "no real nastiness in terms of invasive carcinoma".

72. Ms D also confirmed that she does not recall Dr B informing Mr A that he had carcinoma in situ, but that it was likely Dr B would have used words/phrases like "nasty" or "I think you've something nasty brewing there" or "I don't think it's anything nasty but we need to investigate", because he used those phrases in similar circumstances.

73. There is no documentation regarding the information that was provided to Mr A regarding diagnosis or the options available to him for managing the lesion.

Pain management

74. Mr A told HDC that he was often in pain, and that this increased throughout his treatment with Dr B. Mr A said that before the third biopsy he was in "extreme discomfort", and this impacted on his ability to eat. Mr A is very clear that he told Dr B of this, but that Dr B never prescribed him any pain medication. Mr A's partner confirms Mr A's recollections.

75. In contrast, Dr B does not recall Mr A informing him of pain. Similarly, Ms D stated to HDC: "I don't recall [Mr A] ever talking about any pain that he was having." Ms D considered it possible that Mr A mentioned irritation.

76. In response to the "information gathered" section of the provisional opinion, Mr A noted that it is his belief that the reason Dr B decided to remove his 3rd molar on 5 September 2012 was because he thought that this might be the cause of Mr A's pain. Mr A believes that this demonstrates that Dr B was aware of his ongoing pain problems.

77. Dr B did not prescribe pain medication for Mr A between December 2011 and December 2013. In addition, there is no reference in the clinical records to Mr A reporting pain.

Action taken by Whanganui DHB with regard to clinical notes

78. The Health Manager told HDC that prior to Mr A's complaint:

> "I had not been previously aware of any concerns around [Dr B's] documentation or communication. And prior to receiving the complaint from [Mr A], I did not personally have concerns about [Dr B's] communication or documentation. When I prepared [Mr A's] clinical notes to send to our external reviewer, it was clear to me for the first time that [Dr B's] notes were not adequate in this case."

79. From January 2013, Whanganui DHB employed a dentist and dental specialist in public health dentistry, Dr E, as the Principal Dental Officer for the DHB. Dr E's role

involves providing clinical advice and leadership for the Dental Unit. Dr E also provides clinical services in general dentistry, both within the hospital and supporting the community oral health service.

80. Dr E told HDC that on 17 July 2013 he was emailed by Whanganui DHB about the standard of Dr B's operation records and, in particular, that they were illegible, and so typed records could not be made. At this time Dr E was told that dictated reports were not being provided by Dr B.

81. On 30 July 2013 Dr E spoke to Dr B by telephone about his operation notes. Dr E told Dr B that the DHB requires a clear operation note that can be typed and filed for each patient.

82. Following Dr E's discussion with Dr B, Dr B received training on the use in theatre of the DHB's medical dictation system. According to Dr E, he checked whether this was being used by Dr B, and typing staff indicated that dictated operation notes were being received.

Additional comment — Dr B

83. With regard to the decision to monitor Mr A following the second and third biopsies, Dr B advised HDC that his decision was because "none of the biopsies showed invasive carcinoma". Dr B said that "the subsequent biopsies [the second and third] did not show invasive carcinoma therefore the decision based on these reports was not to have CT or MRI scanning as this would have added little information".

Whanganui DHB

External Case Review

84. Whanganui DHB commissioned an External Case Review (the review) into Mr A's complaint and the care provided by Dr B. The review was carried out by oral and maxillofacial surgeon Dr F. Dr F's report highlighted a number of concerns about the care provided to Mr A. These concerns are summarised as follows:

- Quality of documentation: Dr F noted that Dr B's written notes were illegible, that there were inadequate handwritten records, and that there was no typed correspondence from Dr B's outpatient clinics or operation notes.

- Quality of care: In relation to communication, Dr F observed that there appeared to have been inadequate and/or ineffective communication between Mr A and Dr B. Dr F considered that time pressure (ie, short appointment times) may have played a role in the inadequacy of the communication. In relation to Dr B's clinical judgement, Dr F was critical of the delay Mr A experienced between the listing of his first biopsy under general anaesthetic and the actual surgery (five months). Dr F considered that the booking should have been given a clinical priority score or degree of urgency. Dr F also considered that following both biopsies under general anaesthetic, where there was evidence of carcinoma in situ extending to the margins, further local excision should have been considered and discussed with Mr A. In the case of the third biopsy, Dr F advised that there was

no scientific evidence supporting the suggestion of manuka honey, and that strong consideration should have been given to further wider local excision or referral to an appropriate person/team for further management. Dr F noted that Mr A was referred to DHB3 five weeks after the third biopsy.

- Systems and processes: Dr F observed that Dr B's outpatient clinics were busy and appointments with Dr B were brief. Dr F noted that often Dr B arrived late to clinics. Dr F also noted that Dr B felt that his surgical lists were not under his control, as other dentists added patients to his surgical lists. In addition, Dr B considered that the operating lists at Whanganui DHB were under pressure, often starting late and needing to end on time. Finally, Dr F observed that, Dr B['s] specialty as an oral and maxillofacial surgeon, [and the time of year in which he took leave], contributed in this occasion to a significant delay in surgical lists over that time.

85. In addition, Dr F noted in his report: "Surgeons working in relative isolation can risk having limited peer support and experience difficulties in maintaining adequate continuing medical education and professional development."

Review recommendations

86. Dr F's report made a number of recommendations to address the concerns raised. These recommendations included the following:

- Documentation: Ensuring Dr B had appropriate training and support to allow him to dictate all clinic and operating notes on all patients, encouraging Dr B to maintain comprehensive records, encouraging Dr B to document discussions with patients, including risks, possible complications and consent, and consideration of clinical photographs of oral lesions in patient records.

- Quality of care: Facilitating Dr B's participation in an appropriate communication course, undertaking patient satisfaction surveys, encouraging Dr B to strengthen peer contact, and facilitating Dr B in appropriate continuing medical education activities (including management of head and neck oncology).

- Systems and processes: Consideration of a DHB-wide system to allow clinical photographs to be incorporated as part of the electronic patient records, centralising all clinical notes electronically, reviewing the patient surgical booking systems, reviewing the start and finish times for maxillofacial surgery and ensuring a team meeting is held at the start of the operating list in order for the list to be reviewed and changes made if necessary.

87. To address many of Dr F's recommendations, Whanganui DHB established a programme plan with deliverables. HDC has received updates on the deliverables completed to date. In particular, the DHB has been working with Dr B to ensure that his standard of documentation improves. Furthermore, the DHB has been considering ways to allow for the electronic storage of clinical photographs. To date no solution to the clinical photographs issue has been found, and the DHB has requested that clinicians use drawings in the interim.

Whanganui DHB's Contract with Dr B

88. Dr B's Contract with Whanganui DHB, , outlined the following:

> "[…] agrees to be bound by all Whanganui District Health Board policies, procedures, rules and regulations that are in force from time to time and that it is his/her responsibility to become familiar with such policies, procedures, rules and regulations as may be relevant to this agreement and the services provided under it."

Quality control in the Dental Unit

89. When asked about quality assurance processes in the Dental Unit at Whanganui DHB between 2011 and 2013, Ms C told HDC that dental staff at the DHB, including Dr B, assisted with quality assurance measures in an unofficial way, notably through meetings where the operational processes of the unit were discussed. While Whanganui DHB advised that Dr B is an individual practitioner and is therefore responsible for complying with professional standards, in response to the provisional opinion it advised that it "unequivocally" accepts that it is accountable for the practice of all its clinical staff, including Dr B.

90. After being advised of this complaint, the Dental Council determined that an Individual Recertification Programme be established for Dr B, and that the Professional Advisor carry out a follow-up audit of compliance to practice standards at any or all of his practice locations within six months. The Dental Council advised that the recertification has now been completed, and that Dr B has fully satisfied the programme requirements.

Relevant Whanganui DHB policies

Health Records Policy (2012)

91. The Health Records Policy outlines health record requirements applicable to all Whanganui DHB employees and honorary employees. The policy states:

> "This policy applies to all WDHB employees (permanent, temporary and casual), visiting medical officers, and other partners in care, contractors, consultants and volunteers."

92. The policy also states:

> "One comprehensive integrated health record (where practical) shall be kept in respect of every patient receiving health services from WDHB's provider division … Documentation must record all assessments, a coordinated plan of care, all significant events, and all relevant records relating to that patient's health/illness episode. Records shall be concise, factual, and meet the requirements of legislation, regulation, statutory codes and health care, and professional standards."

Health Records Procedure (2012)

93. The Health Records Procedure outlines requirements for what is included in clinical records. The procedure outlines the following, of relevance:

"1.1 Health professionals must ensure that all entries in a health record are legible and made with indelible ink only …

4.4 **Patient history**
The patient's history, pertinent to the condition being treated, must be documented and will include relevant details on the following:

a) Present and past health history

b) Family history

c) Psycho-social history.

4.5 **Examination**
All assessments and clinical examinations shall be fully documented in the health record by the person undertaking that assessment, and at the time of the assessment …

4.6 **A written diagnosis**
The attending health practitioner must record a diagnosis for every patient. The diagnosis may be provisional.

4.7 **Care/Integrated Treatment Plan**
Every patient must have a documented, planned approach to their care, which must include discharge planning. The coordinated care plan should be developed in consultation with the patient/family and the multi-disciplinary team …

4.12 **Operative report**
The medical officer must record the pre-operative diagnosis prior to surgery and an operative report immediately after surgery, including a description of the findings, procedure performed, tissue removed, diagnosis, and post-operative instructions.

4.13 **Patient progress**
a) All significant events, such as an alteration in the patient's condition and response to treatment/care, must be documented … For outpatients and other patient contacts, a notation in the health record shall be made at each and every event.

…

c) Patient progress records must show evidence of regular evaluation of the care plan."

Response to provisional opinion

Dr B

94. In response to the provisional opinion, Dr B advised that since this incident he has undergone a recertification programme instigated by the Dental Council. Dr B advised that as part of this programme he has attended a workshop on oral pathology, clinical and diagnostic dilemmas.

95. Dr B also reiterated that Mr A never expressed any concerns regarding pain. He said that if he had, Mr A could have contacted him through the hospital or sought advice from his GP.

Whanganui District Health Board

96. In response to the provisional opinion, Whanganui DHB accepted that it did not provide services to Mr A with reasonable care and skill.

Mr A

97. Mr A's response to the "information gathered" section of the provisional report has been incorporated into the report where appropriate.

Relevant standards

98. The *Dental Council of New Zealand Code of Practice: Patient information and records (2006)* states:

> "2.6 The patient's treatment record must contain a record of any and all treatment or service provided within a dental practice, whether it is provided by the dentist or any other health practitioner or other employee of the dentist.
>
> 2.7 This record must include:
> …
> (f) Detail of any presenting complaint, relevant history, clinical findings, diagnosis, treatment options given, and final treatment plan agreed upon;
>
> (g) A concise description of any and all treatment or services provided; …"

Opinion: Dr B — Breach

Introduction

99. Dr B first saw Mr A on 2 December 2011. On 14 December 2011 Dr B performed a tongue biopsy on Mr A under local anaesthetic. The histology report showed no definite evidence of dysplasia. Dr B continued to review Mr A at regular intervals between 14 December 2011 and 5 September 2012. My independent advisor, oral and maxillofacial surgeon Dr Jacobus Erasmus, considered the care provided by Dr B to Mr A in the period up until 5 September 2012 to be appropriate. I accept Dr Erasmus's advice. My comments with regard to the care provided by Dr B between 5 September 2012 and 27 November 2013 are as follows.

Clinical care provided — Breach

Delay in second biopsy

100. On 5 September 2012 Mr A was reviewed by Dr B and it was noted that there was a white patch on Mr A's tongue. Dr B decided that Mr A should have a biopsy under general anaesthetic, and that tooth 38 should be removed.

101. That same day, Dr B completed an operation booking form for Mr A. The form recorded that Mr A had an impacted tooth 38 and a white patch on the left lateral side of his tongue. The intended procedures were noted to be an extraction of tooth 38 and a biopsy of the tongue. No priority code or score was given, although there was a place for both on the form. Mr A's biopsy was scheduled for 27 February 2013, five and a half months after the decision was made to perform the biopsy.

102. Dr B told HDC: "[A]t that stage I had no input into when people were booked, how they were booked or what priority they were given." I note that the operation booking form Dr B used included a place to indicate priority score. Dr B did not indicate a priority score and, as a result, the support staff at Whanganui DHB booking the procedure did not consider the booking to be semi-urgent or urgent. Whanganui DHB notes that Dr B did have the option to prioritise the urgency of the biopsy. It stated: "Whanganui DHB accepts that the delay between first and second biopsy was greater than appropriate. This appears to have been a result of a failing of the clinician [Dr B] to use the available prioritisation system rather than an absence of a decision by [Dr B] that a second biopsy was needed or of a system to prioritise the biopsy as urgent on the booking sheet."

103. Dr B agreed that the time between the booking on 5 September 2012 and the biopsy on 23 February 2013 was too long, but reiterated that this was not in his control.

104. Dr Erasmus advised that, in his opinion, the appropriate management for severe dysplasia involves monitoring every six to eight weeks, although he acknowledged that this timeframe is not followed by all clinicians, and many would consider 12 weeks between reviews to be appropriate. Nevertheless, Dr Erasmus advised me that it would have been more appropriate to perform the second biopsy within six to eight weeks after the decision was made to treat. Dr Erasmus considered:

> "[Mr A] had a recurrent lesion in a high risk area of the mouth that was suspicious enough to raise concern for a re-biopsy. This type of lesion is best managed in a *semi-urgent way*. Seen in this context it becomes clear that [Mr A's] wait of five and a half months for his second biopsy is more in keeping with that of an elective procedure rather than a semi-urgent procedure." (Emphasis in original.)

105. Dr Erasmus outlined that there may have been a false sense of security based on the benign result of the first biopsy and the fact that tooth 38 was causing frictional keratosis. Nevertheless, Dr Erasmus advised:

> "It is the responsibility of the treating clinician to provide … important information on the booking form to indicate to the clerical staff the level of urgency assigned to each case and where to place the case on the waitlist. My understanding is that [Dr B] felt he had no 'control over the system', yet at this point in time he didn't supply the appropriate information on the booking form, which would have allowed him to have 'control over the system'."

106. I accept Dr Erasmus's advice that in the circumstances Mr A's lesion should have been managed in a semi-urgent way, and the biopsy should have been completed much sooner than it was. I consider that Dr B had a responsibility to provide the necessary information to enable surgical bookings to be prioritised appropriately.

Decision to monitor following second biopsy

107. On 27 February 2013 Dr B performed a biopsy on Mr A's tongue under general anaesthetic. As outlined above, the histology report, available one week after the biopsy, stated that there was squamous cell carcinoma in situ, incompletely excised at the 9 o'clock margin.

108. Following the biopsy, Dr B decided to monitor Mr A. Mr A was seen by Dr B on 13 March 2013 (two weeks' post surgery), 24 April 2013 (six weeks since the previous review) and 7 August 2013 (15 weeks since the previous review).

109. However, Dr B recorded in the clinical record: "[P]athology shows carcinoma in situ clear of margins." Dr B told HDC that all the histology reports stated that there was no invasive carcinoma but that there was dysplasia in one of the margins. He said that in light of the fact that the tongue was otherwise healthy he made the decision to continue to monitor Mr A.

110. Dr Erasmus advised that Dr B's decision to monitor Mr A's tongue lesion following the second biopsy was an incorrect decision, as the biopsy results clearly showed carcinoma in situ incompletely excised. Dr Erasmus stated:

> "The key point is that [Mr A's] tongue lesion at this point contained proven residual carcinoma-in-situ, **not only dysplasia**. Regular reviews as the sole mode of treatment of a lesion known to contain residual carcinoma-in-situ … is considered to be an inappropriate action, especially in the setting where the position of the carcinoma-in-situ was clearly identified on the histology report." (Emphasis in original.)

111. Instead of monitoring, Dr Erasmus considered that a detailed examination should then have been performed, with a flexible endoscope, of the posterior aspect of the tongue, oropharynx[23] and other inaccessible areas in the upper airways, to look for other lesions. A CT scan should have been considered, and surgery planned for re-excision of the lesion at the earliest possible opportunity. Once the lesion had been excised with wider margins (5–10mm clear margins), ideally follow-up should have been six weekly for the first two years and less frequently (three monthly) thereafter for a period of two years. Dr Erasmus advised that detailed examinations and further surgery would best be performed in a multidisciplinary clinic setting with the input of Ear, Nose and Throat surgeons and Head and Neck teams.

112. Dr Erasmus said:

> "I believe [Dr B's] decision to *monitor* [Mr A's] tongue lesion following the outcome of the second biopsy, instead of performing a *wider excision or refer* [Mr A] for such surgery in a timely fashion, represents a significant departure from the standard of care." (Emphasis in original.)

113. I accept Dr Erasmus's advice and consider that Dr B did not provide appropriate care to Mr A following the second biopsy. Instead of monitoring Mr A following the biopsy, Dr B should have performed a wider excision to ensure clear margins, or referred Mr A to a multidisciplinary clinic for surgery.

Pain management

114. Mr A told HDC that frequently he mentioned to Dr B that he was in pain, but Dr B did not provide prescriptions for any pain medication. Mr A's partner, Ms A, confirms Mr A's recollections. In contrast, both Dr B and Ms D told HDC that Mr A never complained of pain. There is no documentation relating to any complaint or discussion about pain or pain management.

115. In light of the differing accounts I am unable to conclude whether or not Mr A did complain of pain. However, regardless of whether or not Mr A mentioned pain, Dr Erasmus advised that "[i]t is unlikely that perineural nerve infiltration[24] by tumour was causing the pain, as the first biopsy showed only hyperkeratosis and the two subsequent biopsies showed carcinoma in situ, but no evidence of neural involvement or perineural spread. … the post-biopsy surgical defects are quite sizeable. The tongue, being a very sensitive organ, would have been very painful after the biopsies. I think it is reasonable to expect the surgeon to enquire about postoperative pain and prescribe analgesia accordingly." I agree. I consider that regardless of what Mr A was reporting, Dr B had a responsibility to enquire and elicit the relevant information about Mr A's pain, particularly following the biopsies. There is no evidence that Dr B did this.

[23] Middle portion of the pharynx (throat) behind the mouth.
[24] When the cancer cells surround or track down the nerve.

Conclusion

116. Dr B failed to indicate semi-urgent priority for Mr A's second biopsy on the booking form and, as a result, Mr A waited five and a half months for this procedure when the nature of his lesion indicated a semi-urgent need for biopsy. Following the second biopsy, Dr B inappropriately chose to monitor Mr A instead of undertaking a further biopsy or referring him to a multidisciplinary team. Furthermore, following the biopsies Dr B did not ask Mr A about pain in his tongue. I consider that these failures demonstrate a lack of reasonable care and skill, and, accordingly, Dr B breached Right 4(1) of the Code.

Information provided — Breach

117. On 27 February 2013 Dr B performed a biopsy of the lesion on Mr A's tongue under general anaesthetic. The histology report of 5 March 2013 stated that Mr A had squamous cell carcinoma in situ, incompletely excised at the nine o'clock margin, with no invasive carcinoma. Dr B monitored Mr A following this biopsy, at intervals varying from two to fifteen weeks.

118. On 23 October 2013 Dr B performed another biopsy of the lesion on Mr A's tongue under general anaesthetic. The histology report of 25 October 2013 stated that Mr A had squamous carcinoma in situ extending to involve the right excision margin. Mr A was then seen by Dr B on 30 October 2013 and 27 November 2013, before he was referred to DHB3.

119. Mr A and Ms A told HDC that they asked Dr B about cancer on a number of occasions, and he denied that cancer was present.

120. There is no record in the clinical notes of what Dr B discussed with Mr A following the February 2013 and October 2013 biopsies. There is no record that a diagnosis or management options for the carcinoma in situ were discussed with Mr A.

121. Dr B told HDC that he does not recall Mr A asking about cancer, but it is likely that he never told Mr A about the carcinoma in situ or discussed with Mr A the histology results. Dr B advised that it is likely that he told Mr A that there was no "nastiness" in terms of invasive carcinoma. Dr B told Mr A that he would be kept under close review.

122. Based on the recollections of Mr A, Ms A, Dr B and Ms D, I consider that Dr B did not inform Mr A of his diagnosis of carcinoma in situ following the biopsies of 27 February 2013 and 23 October 2013.

123. Furthermore, Mr A told HDC that management options were never discussed. There is no documentation regarding management options. Accordingly, I find that Dr B did not discuss management options with Mr A, other than informing him that he would be "kept under close review".

124. Mr A had a right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including an explanation of his condition and the options available. Dr Erasmus advised that in these circumstances this would

include accurately informing Mr A of the diagnosis as per histology results, of the various stages of dysplasia, discussing the implications of the diagnosis in terms of further treatment and prognosis, and ensuring that Mr A understood the role and necessity of further surgery, the risks associated with a conservative (wait-and-see) approach, including recurrence rates, and the importance of ongoing surveillance. Dr Erasmus advised:

> "Accurately conveying the diagnosis and stage of cancer to a patient and ensuring that he/she understands the implications, is a basic principle of oncology …"

125. In this situation, following the biopsies of 23 February 2013 and 30 October 2013, Mr A was not given the appropriate information or options to be able to give informed consent to Dr B for monitoring the tongue instead of undertaking a further excision or referring him to a multidisciplinary clinic for surgery.

Conclusion

126. For failing to provide Mr A with information that a reasonable consumer would require in the situation, including an appropriate explanation of the biopsy results and an explanation of the management options available, Dr B breached Right 6(1) of the Code. Without this information, Mr A was not in a position to make informed choices and provide informed consent for his further treatment. It then follows that Dr B also breached Right 7(1) of the Code.

Documentation — Breach

127. As is highlighted throughout this report, Dr B's clinical notes and operation records were minimal and largely illegible, and missing key pieces of information. In particular there is no record of Mr A's presenting symptoms, complaints, concerns or changes in symptoms. There is no clear record of clinical findings or possible differential diagnoses. Nor is there any record of the size of the noted lesion or any qualitative observations such as colour, texture and margins.

128. Dr Erasmus advised: "[Dr B's] hand-written clinical records and operation notes are found to be inadequate, largely illegible with frequent use of abbreviations." I agree with Dr Erasmus and note that HDC needed to ask for transcriptions of the notes in order to be able to decipher them.

129. The *Dental Council of New Zealand Code of Practice: Patient information and records (2006)* outlines that dental records must contain "detail of any presenting complaint, relevant history, clinical findings, diagnosis, treatment, options given and final treatment plan agreed upon". Additionally, the record is to contain a concise description of any and all treatment or services provided. Whanganui DHB policies also clearly outlined requirements for clinical records and operation notes to be legible and complete. As this Office has stated on multiple occasions, the importance of adequate documentation cannot be overstated. Documentation is essential for ensuring continuity of care. By not adhering to professional standards regarding documentation, Dr B breached Right 4(2) of the Code.

Opinion: Whanganui District Health Board — Breach

130. District health boards are responsible for the operation of the clinical services they provide. Whanganui DHB had a responsibility to have adequate systems in place and appropriate oversight of staff to ensure that Mr A received appropriate care. I consider that there were a number of service failures that are directly attributable to Whanganui DHB as the service operator.

Systemic issues — Breach

"Discharge" from Dr B's care

131. On 16 May 2012 Mr A had an appointment with Dr B. Dr B then referred Mr A to Ms C for further dental work. Ms C saw Mr A on 18 June 2012. According to Ms C, following this referral the patient management system at Whanganui DHB discharged Mr A from Dr B's care.

132. After some time had passed, and Mr A did not receive an additional appointment with Dr B, he rang Whanganui DHB and was told that he had been discharged. Mr A told HDC that he queried this discharge and that an appointment was subsequently arranged for 5 September 2012, 11 weeks following his appointment with Ms C.

133. Whanganui DHB told HDC that Mr A's "discharge" from Dr B's care was simply an administrative process that occurs when a clinician (in this case Dr B) refers a patient for clinical work under another clinician (in this case Ms C). According to Ms C, because she is a dental therapist, she cannot refer patients back to Dr B electronically. The referral back must be undertaken by an administrator.

134. My expert advisor, Dr Erasmus, reviewed documentation provided by Whanganui DHB on its booking system. Dr Erasmus considered the system to be "complex and problematic". Indeed the system failed, in this situation, to ensure that Mr A remained a patient of Dr B and that he was booked for follow-up appointments.

Compliance with policies and quality control

135. Dr B was required to follow the DHB's policies and procedures. I note that Dr B's contract with Whanganui DHB outlined that he was required to follow all DHB policies and procedures. Whanganui DHB's "Health Records Policy (2012)" and "Health Records Procedure (2012)" outline requirements for clinical record-keeping at the DHB. The "Health Records Policy (2012)" states: "Documentation must record all assessments, a coordinated plan of care, all significant events, and all relevant records relating to that patient's health/illness episode." In particular, the "Health Records Procedure (2012)" outlines that the clinical records must include a patient's history, fully documented assessments, diagnoses and treatments plans. In addition, operation records must include a description of the findings, procedure performed, tissue removed, diagnosis, and postoperative instructions.

136. Throughout Dr B's care of Mr A, his clinical notes and operation records were minimal and largely illegible, missing key pieces of information. There is no record of Mr A's presenting symptoms, complaints, concerns or changes in symptoms. There is no clear record of clinical findings or possible differential diagnoses. Nor is there any

record of the size of the noted lesion or any qualitative observations such as colour, texture and margins.

137. It is clear that Dr B did not follow either the "Health Records Policy (2012)" or the "Health Records Procedure (2012)". These policies were in place to ensure that all staff involved in patient care appropriately recorded the care provided, assessments undertaken, operation records and treatment plans. As this Office has also stated previously, without staff compliance, policies become meaningless.[25]

138. I consider that it was Dr B's professional duty to follow the policies in place at Whanganui DHB. However, I also consider that Whanganui DHB had a role to play in ensuring that these policies were followed. DHBs are responsible for the services they provide, and hold responsibility for ensuring that services are carried out appropriately. In my view, Whanganui DHB should have had a system in place to ensure that Dr B was complying with its policies and procedures. I note that Whanganui DHB accepts this.

Conclusion

139. At the time of these events, Whanganui DHB had no system for oversight of Dr B's care. In particular, it had no system to monitor Dr B's compliance with its policies and procedures. Most notably in this case, the standard of Dr B's clinical documentation fell significantly below professional standards and the standard expected by the DHB. Furthermore, Whanganui DHB's booking system inappropriately discharged Mr A as a patient. It was not until Mr A rang Whanganui DHB that this error was identified. For these reasons I conclude that Whanganui DHB did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Clinical photography — other comment

140. There were no clinical photographs taken while Mr A was a patient of Dr B between December 2011 and November 2013. During this time Mr A had a lesion on his tongue that underwent considerable change.

141. Dr B told HDC that no clinical photographs were taken because Whanganui DHB does not have the facilities to store these appropriately. Whanganui DHB advised that while clinical photographs could have been stored on the patient's hard file, it confirmed that at the time of these events it did not have the facility available for the electronic storage of clinical photographs.

142. Dr Erasmus stated:

> "Clinical photographs are an important and integral part of record keeping in Medicine and Dentistry, but specifically in Oral and Maxillofacial Surgery, where pathology forms a significant component of our workload. It improves communication between clinicians and allows for accurate follow-up of pathological lesions (such as in Mr A's case). In the field of orthognathic surgery, it is a crucial element of the diagnostic process and almost impossible to do

[25] Opinion 09HDC01974 (21 June 2012).

without. Clinical photography is widely used in DHBs in other specialities, for instance Plastic and Reconstructive surgery, ENT [Ear Nose Throat], Dermatology, Ophthalmology and endoscopy (GIT [gastrointestinal tract] and joints).

Although disappointing that a valuable tool such as clinical photography was not available in the dental department in 2013, it cannot be regarded as a departure from the expected standard of care."

143. Dr Erasmus also outlined privacy and storage/appropriate access issues and acknowledged that the systems to support clinical photography are a significant capital outlay for DHBs.

144. I am guided by Dr Erasmus's advice and consider that, while not ideal, there were mitigating factors for Whanganui DHB not having the ability to capture photographs in the electronic clinical record.

Recommendations

145. I recommend that Dr B:

a) Provide a written apology to Mr A. The apology should be sent to HDC, for forwarding to Mr A, within three weeks of the date of this report.

b) Undertake professional training on the importance of, and expectations for, clear, full and accurate medical documentation, and report to HDC on the completion of this training within three months of the date of this report.

c) In response to the provisional opinion, Dr B advised that he had attended a workshop that included training on oral cancer and pathology. Dr B should provide evidence of attendance at this workshop within three weeks of the date of this report.

146. I recommend that Whanganui DHB:

a) Provide a written apology to Mr A. The apology should be sent to HDC, for forwarding to Mr A, within three weeks of the date of this report.

b) Establish formal processes to ensure quality oversight within the Dental Unit, particularly relating to staff compliance with DHB policies and procedures. Evidence of these processes should be provided to HDC within six months of the date of this report.

c) Undertake a review of the patient electronic booking system to ensure that patients are not discharged from its system when referred to another practitioner. Whanganui DHB should report back to HDC within three months of the date of this report on what steps it has taken to address this issue.

d) Undertake an audit of Dr B's clinical records and operation notes to ensure their compliance with relevant policies. Whanganui DHB should report to HDC within six months of the date of this report with the outcome of the audit.

e) Establish a formal oral and maxillofacial peer review arrangement for Dr B. The arrangement should commence within three months of the date of this report and run for a calendar year. Whanganui DHB should report to HDC within a year of the date of this report on the outcome of this peer review arrangement.

Follow-up actions

147. Dr B will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

148. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Whanganui DHB, will be sent to the Dental Council of New Zealand and DHB2, and they will be advised of Dr B's name.

149. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Whanganui DHB, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from oral and maxillofacial surgeon Dr Jacobus Erasmus:

"Re: Complaint: [Mr A]/[Dr B]

Thank you for asking me to provide advice to the Health and Disability Commissioner's office regarding the above complaint.

I, Jacobus Hendrik Erasmus, hold the qualifications BChD, MBChB and MChD in Oral and Maxillofacial Surgery (University of Stellenbosch, South Africa). I am a registered specialist in Oral and Maxillofacial Surgery, working at [a] District Health Board and in private practice at [a private] Hospital. I am a member of the Multidisciplinary Head and Neck Cancer Team at a public Hospital and have been actively involved with Oncological Surgery for the past 10 years.

I was asked by the Health and Disability Commissioner to provide my opinion on the following issues:

The care provided by [Dr B] to [Mr A]. In particular, I was asked to provide comment on:

1. The appropriateness of [Dr B's] communication with [Mr A] with regards to the results of the histology reports following his second (27 February 2013) and third (23 October 2013) biopsies.
2. The appropriateness of [Dr B's] decision to monitor [Mr A] following his second biopsy on 27 February 2013. In particular, please comment on the appropriateness of frequency of [Dr B's] reviews.
3. The appropriateness of [Dr B's] rationale for the delay in [Mr A's] second biopsy (booked in September 2012 for surgery in February 2013).
4. The appropriateness of the support systems at Whanganui DHB, in particular the DHB's supervision of [Dr B] and the DHB's ability to store clinical photographs.
5. Your consideration of Whanganui DHB's external case review by [Dr F].

For each question, I was asked to advise on the following:

(a) What is the standard of care/accepted practice?
(b) If there has been a departure from the standard of care or accepted practice, how significant a departure is it?
(c) How would it be viewed by my peers?

Documents received for my review:
1. [Mr A's] complaint of [date].
2. Summary of facts.
3. [Dr B's] statement to HDC dated 22 May 2015.
4. Transcription of an interview between HDC and [Dr B] on 15 October 2015.

5. A copy of Whanganui DHB's external case review by Oral & Maxillofacial Surgeon [Dr F] dated 2 February 2015.
6. A copy of Whanganui DHB's response to notification dated 2 June 2015, which includes the DHB's response to your preliminary expert advice (tab 8a).
7. Statement from dental assistant [Ms D] dated 23 September 2015.
8. Relevant clinical notes from Whanganui DHB between December 2011 and December 2013.

The appropriateness of [Dr B's] communication with [Mr A] with regards to the results of the histology reports following his second and third biopsies.

KEY POINTS (as per supplied documentation):

The second biopsy was performed on 27 February 2013 under general anaesthesia at [WDHB].

- *Histology report (5 March 2013) reads: SCC in-situ, incompletely excised at 9 o'clock margin, no invasive carcinoma*

Follow-up after second biopsy (13 March 2013)

- [Mr A] and his partner's interpretation of the result given to him by [Dr B]: *'Dysplasia'*. However, this statement is not reflected in [Dr B's] clinical records, which appears to remain a contentious issue.
- [Dr B's] clinic notes read: '*C in C clear*'. He later explains in an interview with the HDC (15 October 2015) that he meant 'clear of carcinoma in-situ'.
- In the interview [Dr B] stated: '*I think I probably talked about being no real nastiness in terms of invasive carcinoma. I don't know if I ever used the words carcinoma, probably not.*'

The third biopsy was performed on 23 October 2013 under general anaesthesia at [WDHB]

- Histology report reads: The epithelium shows widespread features of carcinoma-in-situ. There is no evidence of invasive carcinoma. The area of in-situ change extends to widely *involve the right excision margin. DIAGNOSIS: SCC in-situ, extending* to *involve right excision margin.*

Follow-up after third biopsy (30 October 2013)

- [Mr A's] interpretation of the result given to him: 'Dysplasia'
- [Dr B's] clinic notes appear to read: '*R/V POA e [cancer] in-situ. Admin Manuka Honey. RV 4/52*'

Advice on carcinoma in-situ (as per summary of facts)

[Mr A] advised that he was never informed by [Dr B] that he had carcinoma in-situ. [Mr A] said he frequently asked [Dr B] if he had cancer. [Ms A] confirmed

[Mr A's] recollection that he often asked if he had cancer. However, both [Dr B] and [Ms D] deny that [Mr A] asked if he had cancer.

[Dr B] confirms that it is likely he never informed [Mr A] of the carcinoma in-situ, but instead likely described it as '*no real nastiness in terms of invasive carcinoma*'. Dental assistant [Ms D] also confirmed that she does not recall [Dr B] informing [Mr A] that he had carcinoma in-situ.

Opinion: Incompletely excised SCC in-situ at the margin of a specimen in oncological terms represents a positive margin. It is considered incorrect to interpret and record histological evidence of carcinoma-in-situ on the margins as 'clear of carcinoma-in-situ'.

The supplied documentation seems to support [Mr A's] contention that he hadn't been informed by [Dr B] of his diagnosis of carcinoma-in-situ. Not informing the patient of his/her accurate diagnosis is considered to be an incorrect action.

[Mr A's] contention that he was told all along that the lesion on his tongue was 'dysplasia, but not cancer', does not seem to be reflected in [Dr B's] clinic notes, though it has to be added that the clinic notes are found to be inadequate and largely illegible. This aspect remains a disputed point.

STANDARD OF CARE (in relation to communication):

- Accurately inform the patient of the diagnosis as per histology result.
- It is important to inform the patient of the various stages of dysplasia, ranging from mild dysplasia to invasive carcinoma AND ensure that patient understands where his/her current diagnosis fits into this spectrum of disease.
- Discuss the implications of the diagnosis in terms of further treatment and prognosis (including recurrence rates).
- It is important to ensure that the patient understands:
    - The role and necessity of further surgery
    - The risks associated with a conservative (wait-and-see) approach, including recurrence rates
    - The importance of ongoing surveillance
- It is considered good practice to have a staff member present at the discussion as well as a support person with the patient. Allow ample time for questions and a discussion around the diagnosis. It is a good principle to provide the patient with a copy of the histology result and provide literature (and/or reference) should the patient have the desire to do some research him/herself.

I believe [Dr B's] interpretation of a histological margin positive for carcinoma-in-situ as 'clear of carcinoma-in-situ' and furthermore not informing [Mr A] that he had carcinoma in-situ, is considered to be a significant departure from the standard of care.

Accurately conveying the diagnosis and stage of cancer to a patient and ensuring that he/she understands the implications, is a basic principle in oncology. I believe my peers would agree with this principle as part of the overall standard of care in oncology.

The appropriateness of [Dr B's] decision to monitor [Mr A] following his second biopsy on 27 February 2013. In particular, please comment on the appropriateness of frequency of [Dr B's] reviews

KEY POINTS (as per supplied documentation):

The second biopsy was performed on 27 February 2013 under general anaesthesia at [WDHB].

- *The specimen measured* 22 *x 20 x 10mm, which is consistent with an excisional biopsy.*
- *The wording of histology report* (*'9 o'clock margin') suggests that the specimen must have been marked to assist the pathologist with orientation of the specimen as it related to the tongue prior to the excision.*
- *The histology report* (5 *March 2013) reads: … a plaque of severe epithelial dysplasia amounting to squamous cell carcinoma in-situ. The in-situ carcinoma extends to involve the 9 o'clock radial margin.* ***DIAGNOSIS: SCC in-situ, incompletely excised at 9 o'clock margin,*** *no invasive carcinoma.*

Frequency of reviews after second biopsy

- *13 March 2013 — 2-weeks post-surgery*
- *24 April 2013 — 9-weeks post-surgery; 5 weeks since previous review appointment*
- *[Mr A] was discharged in error by the booking system at [WDHB]. [Mr A] queried his discharge and was reinstated as a patient of [Dr B].*
- 7 August 2013 — 26-weeks post-surgery; 14 weeks since previous review (clinic notes read: 'small area, same place')

Opinion:

I believe the decision to monitor the tongue lesion following the second biopsy, was an incorrect decision for the following reasons:

1. The histology clearly showed residual carcinoma-in-situ (at the 9 o'clock margin).
2. The report was produced 1-week post-surgery, and [Mr A] was reviewed 2-weeks post-surgery. This implies that the biopsy site was still in its early stages of healing and returning to the site would have been fairly easy.
3. The site of residual carcinoma in-situ was clearly indicated on the histology report (i.e. 9 o'clock margin), which implies a wide excision at this position would have been possible.
4. ***It is documented in the literature that even SCC in-situ which had been excised completely with a 3–5mm clear margin has* a *recurrence rate of***

18%[1,2]*. It can be extrapolated that incompletely excised carcinoma-in-situ will have a higher recurrence rate.*

Comments on the appropriateness of frequency of reviews:

In an interview with the HDC on 15 October 2015, [Dr B] was asked about review intervals for biopsies, to which [Dr B] replied: '*I can't remember the intervals that we were seeing but normally we see them six weeks to three months, yes at intervals like that*'.

The first review took place 2-weeks post-biopsy and the second review 5-weeks after the first. This is considered to be appropriate intervals in the setting of monitoring of *moderate–severe dysplasia.* [Mr A] was then discharged in error by the booking system, and then presented again for review 14 weeks after the previous review (i.e. 26-weeks post-surgery). The delay was less than ideal, but cannot be attributed to any action on the part of [Dr B] (ie. [Mr A] hadn't been discharged from his care).

In the setting of monitoring of *dysplasia* (in the absence of carcinoma-in-situ), some clinicians would be accepting of maximum 3-monthly reviews, which is similar to the frequency between 24.3.2013 and 7.8.2013 outlined above. However, many clinicians in oncology would lean towards 6–8 weekly reviews in the setting of *moderate–severe dysplasia.* In itself, the frequency of reviews does not constitute a departure from the standard of care by [Dr B].

The key point is that [Mr A's] tongue lesion at this point contained proven residual carcinoma-in-situ, **not only dysplasia**.

Regular reviews as the sole mode of treatment of a lesion known to contain residual carcinoma-in-situ (i.e. not considered for wider excision) is considered to be an inappropriate action, especially in the setting where the position of the carcinoma-in-situ was clearly identified on the histology report (9 o'clock margin) one week after the biopsy.

The sparse records and clinical notes makes it difficult to understand the reasoning behind [Dr B's] decision to monitor the lesion instead of proceeding with a wide excision.

KEY POINT:

- A lesion in a high risk area of the mouth that had progressed from hyperkeratosis (2011) to carcinoma-in-situ (2013) should alert the clinician to the possibility of field changes that could produce concurrent lesions further back on the posterior aspect of the tongue, which is not readily visible without endoscopic examination of that area.

STANDARD OF CARE:

After consultation with [a head and neck surgeon] we agreed that the following

actions should follow a histological diagnosis of residual carcinoma-in-situ in a tongue lesion:

- Explain to the patient that he/she has residual carcinoma in-situ and that further investigations and surgery is indicated.
- Detailed examination of the posterior aspect of the tongue, oropharynx and other inaccessible areas in the upper airways for other lesions. This can only be accomplished with the use of a flexible endoscope and is best performed in a multidisciplinary clinic setting with the input of Ear, Nose and Throat Surgeons (unless the primary surgeon is trained and familiar with flexible endoscopy).
- Consider obtaining CT scan imaging (also to confirm the status of neck lymph nodes).
- The surgeon performing the re-excision should be familiar with the principles of oncological surgery or alternatively, the patient should be referred to a multi-disciplinary Head and Neck team for further management.
- Expedite the surgery, aiming for re-excision of the lesion at the earliest possible opportunity (i.e. semi-urgent surgery).
- Re-excision of the lesion with wider margins (5–10mm clear margins).
- Follow-up intervals: ideally 6-weekly for first 2 years, then less frequently (3–monthly) thereafter for a period of 2 years.

I believe [Dr B's] decision to *monitor* [Mr A's] tongue lesion following the outcome of the second biopsy, instead of performing a *wider excision or refer* [Mr A] for such surgery in a timely fashion, represents a significant departure from the standard of care.

The appropriateness of [Dr B's] rationale for the delay in [Mr A's] second biopsy (booked in September 2012 for surgery in February 2013)

KEY POINTS:

- It was noted in the clinic notes on 5 September 2012 that a white patch was still present on the tongue and it was decided to do a second biopsy under general anaesthesia.
- The second biopsy was undertaken on 27 February 2013, some 5½ months after the decision was made to do another biopsy.
- In his interview with the HDC on 15 October 2015, [Dr B] agreed that this delay was too long before the second biopsy was undertaken.

<u>[Dr B's] rationale for the delay (as outlined in HDC interview on 15 October 2015)</u>

- The lesion reappeared in the same location as it did the first time and looked similar. The first biopsy (14 December 2011) showed only hyperkeratosis, but no dysplasia. There was a chipped wisdom tooth (38) in close proximity to the lesion and the histological picture of hyperkeratosis was attributed to frictional keratosis caused by the chipped wisdom tooth.

- He had no control over the booking system and no priority score/level of urgency was indicated on the booking form at the time the booking was made.

Contributing factors identified by [Dr F] in the External case review for the Whanganui DHB

- [Dr B] stated that at Whanganui, operating lists in the latter 2 weeks of December 'slow down' or 'stop'. However, [the Health Manager] stated that elective operating lists continue right into the week of Christmas and then stop for the Christmas/New Year period, but restart in the second week of January.
- [Dr B's leave].
- [Dr B's] operating time on afternoon elective operating lists at [WDHB] is often shortened due to a late start (the morning list often overran) and his list is stopped at the correct time.

To put the waiting times for surgery into context, we could look at the yardstick provided by the Ministry of Health, which all DHBs in New Zealand have to adhere to. The MoH's required timeframe for treatment for elective surgery (ESPI 5) for [WDHB] in February 2013 was 6 months.

[Mr A] had a recurrent lesion in a high risk area of the mouth that was suspicious enough to raise concern for a re-biopsy. This type of lesion is best managed in a *semi-urgent way.* Seen in this context, it becomes clear that [Mr A's] wait of 5½ months for his second biopsy is more in keeping with that of an elective procedure rather than a semi-urgent procedure.

However, it is imaginable that a false sense of security existed based on the benign result of the first biopsy and the fact that a local cause for frictional keratosis (tooth 38) was identified in close proximity to the tongue lesion. It is reasonable to argue that this set of circumstances lowered the sense of urgency to repeat the biopsy more urgently.

I am not familiar with the booking system and wait listing process (specifically for Oral and Maxillofacial Surgery) at [WDHB], but according to the documentation supplied, it appears that a paper form exists that allows the clinician to assign a booking date, priority score (level of urgency) and diagnosis to each case booked. This would be in accordance with current practice in other DHBs in New Zealand.

It is the responsibility of the treating clinician to provide this important information on the booking form to indicate to the clerical staff the level of urgency assigned to each case and where to place the case on the waitlist. My understanding is that [Dr B] felt he had no 'control over the system', yet at this point in time he didn't supply the appropriate information on the booking form, which would have allowed him to have 'control over the system'.

The key to 'control' is management of the waitlist. The DHB expects all Senior Medical Officers to:

a) Comply with Ministry of Health's required timeframe for treatment
b) First specialist appointment (ESPI 2) waiting time of no longer than 6 months [in 2013]
c) Elective surgery (ESPI 5) waiting time of no longer than 6 months [in 2013]
d) Be familiar with the number of patients waiting in each category
e) Be familiar with the diagnosis of each case on the waitlist.

STANDARD OF CARE:

- Comply with the Ministry of Health's required timeframe for treatment for ESPI 5 for *elective surgery*.
- *Semi-urgent cases* should be done more urgently in a timeframe that reflects the more serious nature of the condition.
- It is considered to be appropriate to review cases of severe dysplasia 6–8 weekly (although this timeframe is not set in stone and some clinicians may push this out to 12 weeks).

Opinion: the 5½-month delay between booking and performing the biopsy is considered to be excessively long.

It would have been more appropriate to perform the second biopsy within 6–8 weeks after the decision was made to treat.

I accept [Dr B's] explanation that the recurrence of the lesion could possibly have been attributed to frictional keratosis caused by the chipped wisdom tooth against the background of a previously benign histology report, which effectively lowered his guard. I also accept that there were multiple factors that contributed to the inappropriate 5½-month waiting time for the second biopsy, some of which were outside [Dr B's] control (reduced operating time, Christmas period).

However, the key factor that provides control to each surgical SMO over his/her destiny within the DHB system, namely effective management of his/her individual waitlist, had not been utilised by [Dr B], which left him feeling 'not in control of the system'.

From the discussion above, I would regard the 5½-month delay between booking of the biopsy and actually performing the surgery as excessively long and undesirable. However, the discussion also highlights the various reasons for the delay; some of the most important 'tools' were indeed under [Dr B's] control but were not fully utilised at the time (I understand from the documentation supplied to me that he has since started to use the booking form to prioritise cases).

Although it is possible to take a more grim view on the delay, I feel that taking all of the above factors into consideration, [Dr B's] rationale for the delay should be regarded as a *moderate* departure from the standard of care.

The appropriateness of the support systems at Whanganui DHB, in particular the DHB's supervision of [Dr B] and the DHB's ability to store clinical photographs

To the best of my knowledge, [Dr B] was not working under direct supervision at [WDHB] between 2011 and 2013. He functioned as part of a team of visiting dentists, but no formal supervision was in place until January 2013. All medical and dental staff would normally report professionally through the chief medical officer (CMO). My understanding is that [Dr E] commenced as Principal Dental Officer (PDO) at Whanganui DHB in January 2013, to whom [Dr B] is now reporting professionally.

SUPPORT SYSTEMS AT [WDHB]

Shortcomings during the 2012–2013 period identified in the supplied documentation:

It has to be noted at this point that the shortcomings have also been outlined in [Dr F's] report dated 26/2/2015 and remedial action has since been undertaken by the Whanganui DHB.

1. **Clinical records and documentation**
   a. Clinical records (in the dental department) were done by hand as part of a paper-based filing system in 2013
   b. Dictation was not utilized by [Dr B] for clinical notes or operation reports
   c. Being paper-based, no remote access was possible to clinical records
   d. [Dr B's] hand-written clinical records and operation notes are found to be inadequate, largely illegible with frequent use of abbreviations.
      i. Opinion: The DHB has a responsibility to ensure that operation notes and clinical records are legible, preferably typed. Illegible operation reports, notes and prescriptions lead to confusion and miscommunication between members of the health care team.
   e. No typed operation notes or letters were done (in [Mr A's] case) to the referring practitioner
   f. No facility for taking or storing of clinical photographs existed in the dental department (see point 4).

2. **Booking system**
   a. There appears to have been a problem with [the patient management system] which resulted in [Mr A's] discharge in error.
   b. The inter-referral of patients between various practitioners within [the patient management system] was complex and problematic.
   c. [Dr B] didn't supply adequate information on the booking form to enable clerical staff to accurately waitlist [Mr A] according to the diagnosis and level of urgency.
   d. Of concern is the fact that [Dr B] in 2013 felt that his own operating list wasn't under his control as patients placed on the waiting list were largely determined by clinicians other than himself. However, [staff members] don't appear to be in agreement with this statement. They feel that the majority of patients placed on the waiting list were either seen by [Dr B] himself or at least he was aware of these patients.
   e. My impression from reading the supplied documentation was that the

booking system was complex and problematic, which was partly due to the clerical staff not receiving good information from the incomplete booking form.

f. Problems with the booking system have an impact on accurately assigning waiting times to patients, which has a flow-on effect to the case-mix of the elective operating lists and calculation of operating time needed to complete the list.

g. Against the background of operating lists that were under time pressure due to frequent late finishing of the morning operating lists, and problems with the booking system and case-mix, this could lead to significant inefficiencies in theatre utilization and suboptimal use of a scarce and valuable resource.

3. CME and peer contact

[Dr B] works in a [region], which makes regular peer review and CME activities difficult. He has in the past interacted with [an Oral and Maxillofacial Surgery group in another region, but meetings are infrequent]. I could not find any evidence or reference in the supplied documentation that [Dr B] regularly attends, or is involved with, CME activities specifically pertaining to Head and Neck Oncology. It is noted that [Dr B] recently attended an [oncology workshop] which should be commended.

4. Clinical photography

Clinical photographs are an important and integral part of record keeping in Medicine and Dentistry, but specifically in Oral and Maxillofacial Surgery, where pathology forms a significant component of our workload. It improves communication between clinicians and allows for accurate follow-up of pathological lesions (such as in [Mr A's] case). In the field of orthognathic surgery, it is a crucial element of the diagnostic process and almost impossible to do without. Clinical photography is widely used in DHBs in other specialties, for instance Plastic and Reconstructive surgery, ENT, Dermatology, Ophthalmology and endoscopy (GIT and joints).

Although disappointing that a valuable tool such as clinical photography was not available in the dental department in 2013, it cannot be regarded as a departure from the expected standard of care.

The issues around general use of photography in the DHB environment relate to:

a. Privacy. This is dealt with by informed consent and an appropriate consent form being signed by the patient and clinician to indicate the intended use of the photographs.

As a final comment, I would like to briefly respond to [Dr E's] response dated 27 May 2015 to my first report. It is pointed out several times that I interpreted [Dr B's] handwritten notes incorrectly as saying 'clear in the margins', when it actually said 'clear or C in C'. As my interpretation was factually incorrect, I

would like to unreservedly apologise for the inaccuracy. Bearing in mind that I had to decipher [Dr B's] clinic notes and operation report without the added benefit of a partially deciphered 'summary of facts', which I now had to my disposal for this report, it again highlights the confusion and inaccuracies brought about by illegible notes, as it leaves the note open to interpretation.

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2.Van der Waal, Isaac. Review: Potentially malignant disorders of the oral and oropharyngeal mucosa; terminology, classification, and present concepts of management. Oral Oncology 2008"

Amendment 21 March 2016

HDC requested additional information from Dr Erasmus regarding pain, and about enquiring about pain. On 21 March 2016, Dr Erasmus advised:

"[Mr A] initially presented with a white lesion and pain in the tongue. The first biopsy showed hyperkeratosis, which in itself is not a cause for pain. The pain did not dissipate after the first biopsy, but persisted until the wide excision was performed by […] on the 3rd of January 2014.

Pain in relation to the lesion: It is unlikely that perineural nerve infiltration by tumor was causing the pain, as the first biopsy showed only hyperkeratosis and the two subsequent biopsies showed carcinoma in situ, but no evidence of neural involvement or perineural spread.

Pain in relation to the biopsy sites: the post-biopsy surgical defects are quite sizeable. The tongue, being a very sensitive organ, would have been very painful after the biopsies. I think it is reasonable to expect the surgeon to enquire about postoperative pain and prescribe analgesia accordingly."