Dermatologist, Dr B

A Report by the Deputy
Health and Disability Commissioner

(Case 18HDC02251)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by a dermatologist, and highlights the importance and basic requirement of undertaking appropriate site identification checks to ensure that surgery is performed at the correct site.

2. The woman was referred to the dermatologist for Mohs surgery[1] on a confirmed basal cell carcinoma (BCC) lesion on her forehead. Before surgery, the dermatologist assessed the woman's forehead with his magnifying loops and identified what clinically appeared to be the biopsy-proven BCC. However, he failed to confirm the site with the patient by holding a mirror and reviewing the previous photograph of the skin cancer site.

3. Approximately 24 hours after the surgery, when the woman's dressings were being changed, it was discovered that the dermatologist had performed the surgery at the incorrect site — on an old chickenpox scar above the actual confirmed BCC lesion.

Findings

4. The Deputy Commissioner found that by failing to confirm the site of surgery correctly, and then subsequently performing the surgery at the wrong site, the dermatologist failed to provide the woman with an appropriate standard of care, in breach of Right 4(1) of the Code.

5. The Deputy Commissioner considered that the events in this case indicated an individual error, and are not indicative of any wider systemic or organisational issues at the dermatology clinic and, as such, she did not find the dermatology clinic in breach of the Code.

Recommendations

6. The Deputy Commissioner acknowledged the changes that have been made to both the dermatologist's and the dermatology clinic's practice, and the apology letter that the dermatologist sent to the woman after the events. In addition, she recommended that the dermatologist arrange for an audit of the next three months of Mohs surgeries he performs, to ensure that the new additions on both the consent form and intra-operative theatre record are being used.

[1] Mohs surgery is a precise surgical technique used to treat skin cancer. During Mohs surgery, thin layers of cancer-containing skin are removed progressively and examined until only cancer-free tissue remains.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by Dr B at a dermatology clinic. The following issues were identified for investigation:

- *Whether the dermatology clinic provided Mrs A with an appropriate standard of care in November 2018.*
- *Whether Dr B provided Mrs A with an appropriate standard of care in November 2018.*

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

9. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Dr B	Provider/dermatologist
Dermatology clinic	Provider/skin care clinic

10. Independent expert advice was obtained from a dermatologist and Mohs specialist, Dr Harvey Smith (Appendix A).

Information gathered during investigation

Background

11. Mrs A, aged in her forties at the time of events, had a medical history that included a bleeding disorder, a history of high sun exposure, Fitzpatrick type 3 skin,[2] and a family history of melanoma[3] and other skin cancers.

12. On 28 August 2018, Mrs A presented to her general practitioner with a lesion on the left-hand side of her forehead. It was noted that the lesion was sensitive when applying creams, but did not bleed. Additionally, the lesion had been identified as "requiring action" in a mole map undertaken a month earlier.

13. In light of Mrs A's family history, and the mole map recommendation, her general practitioner referred her to dermatologist Dr B at the dermatology clinic for management of a potential basal cell carcinoma (BCC).[4]

[2] Skin type 3 on using the "Fitzpatrick classification" refers to darker white skin that tans after an initial burn.
[3] Melanoma is the most serious type of skin cancer. It develops in the skin cells that are found in the deeper layers of the skin.
[4] BCCs are the most common form of skin cancer. They tend to be slow growing and rarely spread to other parts of the body.

14. Mrs A saw Dr B on 1 October 2018, and a biopsy of the lesion was taken, measuring 3 millimetres in diameter and 4 millimetres in depth. The biopsy was reviewed and reported later that day by an anatomical pathologist, and was found to show "[n]odular basal cell carcinoma (BCC)[5]". A photograph of the biopsied site on Mrs A's forehead was also taken on this day, as per Dr B's usual process.

15. On 9 October 2018, Mrs A saw Dr B again for removal of the sutures of the biopsied area, and, with the confirmation that the lesion was a BCC, Mrs A was booked in for "Mohs surgery" at 8.15am on 6 November 2018.

Dermatology clinic and Dr B

16. The dermatology clinic is a private clinic, where clinicians operate as individual practitioners rather than employees. Dr B had access and operating rights at the dermatology clinic (although there was no written agreement in relation to this). However, he provides medical and consulting services to patients and operates from the centre as an employee of a company. The policies, equipment, and ancillary staff were provided by the dermatology clinic.

6 November 2018

Pre-surgical procedure

17. On presentation to the dermatology clinic, Mrs A was given a consent form to read and sign. The consent form, dated 6 November 2018, was for "MOHS Micrographic Surgery" for treatment of a "BCC forehead". The risks outlined in the consent form included bleeding, infections, and scarring.

18. Dr B told HDC that prior to coming to surgery, Mrs A had explained that this would be a very stressful situation for her, and so Dr B arranged for Hypnovel, an anti-anxiety sedative, to be given to her as soon as she was admitted.

19. The "intra-operative nursing record" for Mrs A's surgery documented that she was administered Hypnovel at 7.30am. Mrs A's blood pressure was then checked, and she was taken to the operating theatre.

20. Dr B told HDC that once Mrs A was in the operating theatre, he assessed her forehead with his magnifying loops. He stated that, as with all Mohs cases, at times it can be difficult to identify the lesion, and so he stretched her skin laterally and identified what clinically appeared to be the biopsy-proven BCC. This lesion was documented to be 1cm by 1cm in size.

21. Dr B told HDC that his usual practice, once the patient presents to surgery on the operating day, is to confirm the site together with the patient, holding a mirror and reviewing the previous photograph of the skin cancer site. However, neither of these practices occurred in this case. Dr B stated that he "reviewed the photograph at the prior site in a different

[5] A nodular BCC is the most common type of facial BCC and appears as a shiny or pearly nodule with a smooth surface.

room, not in the operating room where [Mrs A] was present", and he "deeply regrets" that he did not follow his usual process.

22. Dr B also noted that once Mrs A was given anti-anxiety sedatives at the time of her arrival in the waiting area, her cognition was impaired. He stated that therefore, her ability to participate in identification of the site was limited.

Surgery

23. Once Dr B had identified what clinically appeared to be the site of the biopsy-proven BCC, he proceeded to treat the area with anaesthesia. Surgery began at approximately 8.30am.

24. During surgery, Dr B scraped an area of 1.7x1.9cm, and believed that the lesion extended significantly outside its clinical margins. He stated that such a finding would be strongly suggestive of a BCC. A first layer of skin was then taken from the site, and a dressing was applied whilst Dr B reviewed the histology of the specimen.

25. Dr B told HDC that the histological examination revealed no extension of tumour in the margins, either deeply or at the edge. Consequently, after this pathology had been reviewed, he proceeded to close the wound.

26. As Mrs A had limited laxity of skin, the wound was closed with a "pedicle flap" — a skin graft technique in which a piece of skin from a nearby area is reattached over the area that needs to be covered. Dr B stated that a skin graft could have been an alternative possibility, but that usually this would not produce the same aesthetic result as a flap.

27. Both the surgery and wound closure were completed uneventfully, and there was no excessive bleeding at the site. In view of the complexity of the wound closure, and to ensure that the wound would heal as well as possible, an appointment was made for Mrs A to be reviewed by Dr B on the morning of 9 November 2018.

Subsequent events

28. Approximately 24 hours after the surgery, the dermatology clinic was contacted by Mrs A, who expressed concern that the wrong lesion had been operated on. Mrs A's mother had been changing the dressings when she noticed that the surgery had been performed on an old chickenpox scar above her daughter's actual confirmed nodular BCC.

29. A meeting was held on 7 November with Dr B, Mrs A, and her parents, where Dr B explained that he could not confirm whether the site of the surgery was just a chickenpox scar, or whether it was a chickenpox scar with an associated BCC. At this meeting it was also noted that the pedicle flap from the surgical site had impaired blood supply, and its viability was looking poor. Mrs A was booked for a review with Dr B for 9 November 2018, but subsequently she cancelled this.

30. With the help of her general practitioner, Mrs A completed an ACC treatment injury form for the surgery performed by Dr B, and subsequently she was referred to a plastic surgeon for further management.

31. On 12 November 2018, Dr B wrote a letter to Mrs A apologising for the excision of the wrong lesion, as well as the suboptimal healing of the pedicle flap.

Further information

Dermatology clinic policies and procedures

32. At the time of these events, the dermatology clinic had a policy entitled "Policy and Protocol for Surgical Patients", for the prevention of "wrong site, wrong procedure and wrong person surgery". The policy outlines the procedure to be undertaken for pre-procedure verification, to ensure the correct identity of the patient.

33. The policy also stipulated that the surgeon would mark the site of the surgery "in the theatre, in discussion with the patient [and] directly onto the skin with skin marker" prior to the surgery being performed.

Dr B

34. Dr B told HDC that in 30 years of performing this procedure, this has never happened to him. He stated:

> "It is regrettable that this set of events occurred and I have no hesitation in apologising to [Mrs A] again for excising the wrong lesion and for any upset and distress caused to her as a result. I acknowledge that operating at the correct site for any surgical procedure is fundamental … This case has been a salutary lesson for me and as a result I have implemented a number of changes in my practice to avoid any such event from happening again in the future."

35. Dr B said that the following statement has been added to the consent form at the dermatology clinic: "I have identified prior to commencement of surgery, the biopsied lesion with the Mohs surgeon." He stated that the consent form will be signed only once the area to be removed has been identified by looking in a mirror with the patient.

36. The intra-operative nursing record template has also been amended at the dermatology clinic, to include a section for "verification of photographed biopsy site for Mohs surgery", where both the surgeon and the nurse are to sign that this has been done.

37. In addition, Dr B stated that while it is rare in his practice that his patients are given anti-anxiety sedatives, he has changed his practice to ensure that marking of the surgical site occurs prior to any anti-anxiety medication being given to the patient.

Responses to provisional opinion

38. Dr B was provided with an opportunity to comment on the provisional opinion, and stated that he had no comments to make on the proposed decision, recommendations, and follow-up actions. Dr B said: "I remain very sorry for [the] upset and distress caused to [Mrs A]."

39. Mrs A stated that she has had to endure further corrective surgery to her forehead, which has been very traumatic for her. She told HDC that she is trying to move on from what happened.

Opinion: Dr B — breach

40. On 6 November 2018, Mrs A presented to Dr B at the dermatology clinic for removal of a BCC on her forehead, by Mohs procedure.

41. Before beginning the surgery, Dr B identified what he thought was the biopsy-proven BCC, and then subsequently performed surgery at that site. Approximately 24 hours later, he was contacted by Mrs A, who raised concerns that the surgery had been performed on an old chickenpox scar above her actual confirmed nodular BCC.

42. My expert advisor, dermatologist and Mohs specialist Dr Harvey Smith, advised that Mohs surgery relies on starting in the correct area. He stated that without this, tracking the extensions of the tumour will not occur. Accordingly, identification of the correct site is vital.

43. Dr Smith stated:

> "Wrong-site Mohs surgery is the subject of several papers in the literature. Suggestions for minimising this event are made including photographs of the biopsy site, patient identification of the biopsy site with self-marking and joint identification with the specialist using a mirror."

44. Dr Smith advised that given the subtle nature of the clinical appearance from the photographs, and the presence of scars elsewhere on the forehead, in his view at least two methods should have been used in this case: photographic record and confirmation using a mirror.

45. Dr B told HDC that his usual practice is to confirm the site with the patient holding a mirror and reviewing the previous photograph at the skin cancer site together. In addition, the dermatology clinic had a policy for the prevention of "wrong site, wrong procedure and wrong person surgery" at the time of these events, which stipulates that the surgeon is to mark the site of the surgery "in the theatre, in discussion with the patient [and] directly onto the skin with skin marker" prior to the surgery being performed.

46. However, on this occasion, Dr B failed to follow his usual process and the above policy. He stated that he stretched Mrs A's skin laterally to identify what clinically appeared to be the biopsy-proven BCC, and, whilst he did review the previous photograph taken of the BCC site, he did so prior to the surgery in a different room to Mrs A. I also note that Mrs A was given a sedative immediately on arrival, meaning that even if Dr B had followed his usual process by confirming the site with the patient, Mrs A would not have been able to participate fully in this identification.

47. Dr Smith stated that Dr B's failure to confirm the biopsy site with Mrs A prior to the surgery was a "highly significant" departure from the standard of care, as the subsequent Mohs procedure, repair, and potential complications were accrued without benefit. I accept this advice. Mrs A was initially anxious about the Mohs surgery being performed, and the fact that the surgery was then performed at the wrong site caused her further distress, and meant that subsequently she had to undergo the procedure again to address the confirmed

BCC. In addition, it placed Mrs A at unnecessary risk of the complications of surgery, such as bleeding and scarring.

48. It is a basic requirement of any surgery that the surgery is performed at the correct site. Whilst I acknowledge that in this case there was little distinction between the biopsy-proven BCC site and Mrs A's chickenpox scar, I consider that this meant that it was even more vital for the appropriate site identification checks to be performed. The dermatology clinic had a policy for surgeons to follow to assist in this site identification, but in this case Dr B failed to adhere to both this policy and his own stated usual practice.

49. By failing to confirm the site of surgery correctly, and then subsequently performing the surgery at the wrong site, Dr B failed to provide Mrs A with an appropriate standard of care. It follows that I find him in breach of Right 4(1)[6] of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: Dermatology clinic— no breach

50. Mrs A's surgery of 6 November 2018 was carried out at the dermatology clinic. As explained above, the dermatology clinic is a private clinic, where clinicians operate as individual practitioners rather than employees. Dr B had access and operating rights at the dermatology clinic (although there was no written agreement in relation to this); however, he provides medical and consulting services to patients and operates from the centre as an employee of a company. The policies, equipment, and ancillary staff were provided by the dermatology clinic.

51. At the time of these events, the dermatology clinic had in place a policy for the prevention of "wrong site, wrong procedure and wrong person surgery", which stipulated the procedure to be undertaken for pre-procedure verification. It stated that the surgeon is to mark the site of the surgery "in the theatre, in discussion with the patient [and] directly onto the skin with skin marker" prior to the surgery being performed.

52. Dr B told HDC that he did not follow his usual practice of confirming the site with the patient holding a mirror and reviewing the previous photograph at the skin cancer site.

53. In light of the above, I consider that the events in this case indicate an individual error, and are not indicative of any wider systemic or organisational issues at the dermatology clinic. I have also not identified any issues with the centre's equipment or nursing staff. As such, I do not find that the dermatology clinic breached the Code.

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

54. I note with approval the changes that have been made to the dermatology clinic's consent form and intra-operative nursing record template, in line with my expert's advice. The changes will act as further checkpoints to ensure that the correct site has been identified.

Recommendations

55. I note the changes that have been made to both Dr B's and the dermatology clinic's practice, and acknowledge the apology letter that Dr B sent to Mrs A after the events. In addition, I recommend that Dr B arrange for an audit of the next three months of Mohs surgeries he performs, to ensure that the new additions on both the consent form and intra-operative theatre record are being used. The results of the audit are to be sent to HDC within four months of the date of this report.

Follow-up actions

56. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Dermatological Society and the Medical Council of New Zealand, and they will be advised of Dr B's name.

57. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Health Quality & Safety Commission, Skin Cancer College Australasia, the Royal Australasian College of Physicians, and the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

58. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Australasian College of Dermatologists. At this time, I will recommend to the College that it consider adopting specific measures into the syllabi for Mohs training regarding wrong-site surgery.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from dermatologist and Mohs specialist Dr Harvey Smith:

"Dear Sir/Madam

Reference: Expert opinion on care provided to [Mrs A] by [Dr B] 6 November 2018

1. I have read the guidelines for providing expert advice and agree to follow them.

2. I qualified in Medicine in 1990 and completed my specialist dermatology training in 2000. I carried out a Mohs training fellowship in 2001. I am listed as an approved Australasian College of Dermatologists (ACD) Mohs specialist. For a 10-year period I was the Chair or a member of the ACD Mohs committee. During this time, the training scheme for Mohs was formalised to Australian National Standards and Appropriate Use Criteria for Mohs were developed and then adopted by Medicare Australia. I am an author on several peer reviewed papers regarding randomised trials to reduce surgical site infection following Mohs. One of these formed part of the evidence for the World Health Organization 2016 guidelines in this area.

3. Regarding '*the overall adequacy of [Dr B's] actions during the Mohs surgery of 6 November 2018*':

   a. *What is the standard of accepted practice*?

   i. Mohs surgery relies on starting in the correct area. Without this, tracking the extensions of the tumor will not occur. The standard of accepted practice is to start at the correct site.

   ii. Wrong-site Mohs surgery is the subject of several papers in the literature. Suggestions for minimising this event are made including photographs of the biopsy site, patient identification of the biopsy site with self-marking and joint identification with the specialist using a mirror.

   b. *If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?*

   i. Highly significant as the subsequent Mohs procedure is invalidated.

   c. *How would it be viewed by your peers?*

   i. Highly significant as the subsequent Mohs procedure, repair and potential complications are accrued without benefit.

d. *Recommendations for improvement that may help to prevent a similar occurrence in future.*

i. The adoption of a series of checkpoints for confirmation of the correct site involving patient, doctor and nursing staff formally laid out in the admission and operating paperwork.

ii. The aim is to remove reliance on the doctor alone using perhaps one or two checkpoints that are vulnerable to the unique circumstances of this case.

iii. For example: a measurement from an anatomical location stated on the consent form (rather than 'forehead'); recording of the location using a photograph in the notes which can be accessed by patient, staff and doctor; during admission the staff facilitating the patient marking the location of surgery; the doctor confirming the location with the patient using a mirror and this action being confirmed by the nursing staff in the operating log beside the 'sharps count' etc.

4. Regarding '*whether it was reasonable for [Dr B] not to confirm the biopsy site with [Mrs A] prior to the surgery*':

a. *What is the standard of accepted practice*?

i. Given the critical nature of starting in the correct place to accrue the benefits of Mohs surgery it was not reasonable for [Dr B] to not confirm the biopsy site with [Mrs A] prior to surgery.

ii. Situations where this would have been reasonable would include: visual or cognitive disability in the patient; inaccessible area such as the back or posterior to the ear; a grossly obvious tumor (2cm + in diameter, ulcerating for example).

b. *If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?*

i. Highly significant.

ii. Given the subtle nature of the clinical appearance from the photographs and the presence of scars elsewhere on the forehead at least two methods in my view should have been used in this case: photographic record and confirmation using a mirror.

c. *How would it be viewed by your peers*?

i. Highly significant.

ii. There would in my view be a range of opinion as to what measures are routine to avoid such an event. To the best of my knowledge no specific measures have been adopted by the international syllabi for Mohs training regarding wrong site surgery.

d. *Recommendations for improvement that may help to prevent a similar occurrence in future*.

i. The adoption of measures listed in 3d.

ii. The integration of these measures as a learning point into the training syllabus for Mohs by the ACD. A significant number of New Zealand Mohs specialists are listed as approved Mohs specialists by the ACD having carried out this training.

5. Regarding '*Whether it is standard practice for Mohs surgeons to seek a review from an independent pathologist before undertaking surgery*':

a. *What is the standard of accepted practice?*

i. It is usual for patients to attend for Mohs surgery having been referred by another practitioner who may or may not have taken a biopsy to confirm the diagnosis which would be reviewed by an independent pathologist.

ii. The Mohs surgeon may on review of the patient take either a biopsy prior to the Mohs surgery (which would be reviewed by an independent pathologist) to confirm the diagnosis if this had not previously occurred.

iii. It would be quite usual for a clinically obvious tumor to not have a biopsy prior to attending for Mohs surgery. The Mohs process would be likely to identify the type of tumor using frozen sections.

iv. It is usual for Mohs surgeons to have some arrangement in place to obtain a pathology opinion in the event of atypical pathology being seen at the time of Mohs surgery.

v. It would be worth noting that within the Medicare system in Australia the Mohs surgery claim item number stipulates that the pathology must be carried out by the Mohs surgeon. This is aimed at preventing additional pathology item number claims on the day of Mohs surgery.

b. *If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?*

i. I do not believe a departure has occurred. The diagnosis was confirmed with pathology prior to the surgery.

c. *How would it be viewed by your peers?*

i. Peers would regard the biopsy report obtained prior to the Mohs surgery as an independent pathology opinion. I do not believe that they would feel it was necessary prior to every case of Mohs surgery if the tumor was obvious.

d. *Recommendations for improvement that may help to prevent a similar occurrence in future.*

i. I do not think a recommendation is applicable to this point. A biopsy prior to the Mohs surgery with an opinion from a pathologist has proven the appropriateness of the surgery but does not guarantee that the correct area is operated on.

6. Regarding '*Any other matters that you consider in this case may amount to a departure from the expected standard of care or accepted practice'*:

i. When reviewing in detail a Mohs surgery case it would be usual to see a 'Mohs map' and a digital representation of the stored frozen section slides. The process of mapping where the tumor was seen down the microscope at each stage is integral to guiding the surgeon where to take the next stage. I could not find this in the clinical notes sent to me. I do not think it materially alters the opinions I have expressed above but would be happy to review if required.

ii. With regard to question 5 and [Mrs A's] extra comments. She appears to specifically ask why an independent pathologist is not utilised following surgery to confirm what was looked at rather than question 5 where the question is that of why a pathologist is not utilised prior to surgery. In Australia as per my answer 5.a.v pathologist review on the day is specifically excluded. The aim of the training standards for Mohs in Australia are to produce a specialist competent to assess the need for Mohs, to take the Mohs specimen and to identify the pathology (of a limited number of tumors) down a microscope to determine the need for further Mohs excision and then repair the defect.

Yours Faithfully

Harvey Smith MD FACD"