Medical Officer, Dr A
District Health Board

A Report by the
Health and Disability Commissioner

(Case 17HDC01139)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 7 April 2018, 13-year-old Master B (who has attention deficit hyperactivity disorder) was taken to the Emergency Department (ED) of a public hospital (the DHB) by his mother, Ms B. Ms B had concerns about a bleeding and growing lesion on Master B's back.

2. Master B was seen by Dr A. Dr A told HDC that he offered Ms B two options for treatment — the first being painkillers and an urgent referral to the Dermatology Department, and the second to remove the lesion in ED that evening. He said that Master B and his mother opted to have the mass removed.

3. Dr A told HDC that he explained what the removal process would entail, and that Ms B gave verbal consent for the procedure. He stated that he used lidocaine with adrenaline and ethyl chloride spray as anaesthesia to remove the lesion. However, according to Ms B, only a spray was used. After applying the anaesthesia, Dr A removed the lesion and sutured the wound.

4. Dr A told HDC that an urgent referral to the Dermatology Department was made. However, Ms B told HDC that she was not contacted by the Dermatology Department.

Findings

5. The Commissioner considered that the ethyl chloride spray and lidocaine used to remove Master B's lesion would not have had any appreciable anaesthetic effect, and was inappropriate for the procedure.

6. In addition, Dr A failed to provide full and comprehensive notes about the care he provided to Master B. No rationale is provided for the procedure; there is no explanation as to why the mass was treated in ED; there are no details about the consent process; there is no record of a discussion with Ms B and Master B about the options available; there is no record of the anaesthesia used; and there is no record of a referral to the Dermatology Department.

7. By failing to provide appropriate anaesthesia during the removal of the skin lesion, and failing to document the care provided adequately, Dr A did not provide Master B with services with reasonable care and skill. Accordingly, the Commissioner found Dr A in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

8. It is recommended that Dr A provide a written apology to Master B and Ms B.

9. It is recommended that the DHB:

   a) Consider whether Dr A would benefit from ongoing collegial support and mentoring with respect to his documentation and clinical decision-making within the ED context.

   b) Report back to HDC on its progress in implementing an e-referral process.

10. It is recommended that the Medical Council of New Zealand consider whether a review of Dr A's competence is warranted.

Complaint and investigation

11. The Commissioner received a complaint from Ms B about the services provided to her son, Master B, by Dr A. The following issues were identified for investigation:

- *Whether the DHB provided Master B with an appropriate standard of care in April 2017.*
- *Whether Dr A provided Master B with an appropriate standard of care in April 2017.*

12. The parties directly involved in the investigation were:

Dr A	Provider/medical officer
Master B	Consumer
Ms B	Complainant
DHB	Provider

Also mentioned in this report:

Dr C	Emergency practitioner

13. Independent expert advice was obtained from a rural hospital medicine specialist, Dr Jennifer Keys (**Appendix A**).

Information gathered during investigation

Background

14. This report relates to the care provided to Master B, aged 13 years at the time. Master B has attention deficit hyperactivity disorder (ADHD).

15. In March 2017, Master B experienced a bleeding and growing lesion on his back.[2] Master B's general practitioner (GP) had attempted to remove the lesion by freezing it but, despite three or four treatments, this had not been successful.

16. Ms B, Master B's mother, became concerned about the appearance of the lesion and the fact that it was bleeding. On 7 April 2017, she took Master B to the ED at the public hospital. Master B was seen in ED that evening by Dr A,[3] who was the sole doctor available in the department.

Consultation with Dr A

17. There is disagreement about Master B's level of stress when he first spoke to Dr A. Dr A told HDC: "[Master B] appeared to be very anxious when I saw him in ED."

18. Ms B told HDC: "[Master B was] anxious but not overly anxious when we first saw the [doctor], in fact he was dozing on the chair beside me." Dr A conducted a physical examination before inspecting the lesion on Master B's back, which he considered to be superficial. Dr A told HDC:

> "It measured approximately 2 cm, fairly soft, dark colour, with defined limits (but didn't look like a cyst). It was attached to the skin by a pedicle[4] that measured approximately 1 cm long and 0.3 cm in width. There was a small amount of blood coming from the base of the pedicle."

19. Dr A could not make a definitive diagnosis of the skin lesion as a sample needed to be sent to the laboratory to confirm the pathology. He offered Ms B two options for treatment — the first being discharge from the ED with painkillers and an urgent referral to the Dermatology Department. Dr A advised that it could take several days or a few weeks to get an appointment with the Dermatology Department, depending on the capacity of the department. The second option he offered was to remove the lesion in ED that evening.

20. Master B and his mother opted to have the mass removed that evening. Dr A told HDC that Ms B said that "she wanted a diagnosis as soon as possible, and for the removal of the mass from her son's back that day in order to stop the bleeding, the pain and the stress for her son".

[2] The length of time Master B had had the lesion on his back is disputed. Dr A told HDC and recorded in his clinical notes that the mass had been on Master B's back for approximately two weeks. Ms B told HDC that the mass had been an issue for at least two months.

[3] Dr A qualified as a doctor overseas and was an employee at the public hospital as a Medical Officer Special Scale (a non-training position for a doctor who has not yet specialised or gained a postgraduate qualification, or an international medical graduate who is not eligible for a consultant role). Dr A advised HDC that he has had basic training in the removal of lesions. Dr A holds a Master's degree in Emergency Medicine and at the time was undertaking a Certificate in Emergency Medicine with the Australasian College of Emergency Medicine.

[4] A constricted portion or stalk.

21. Dr A told Master B and his mother what the removal process would entail, including that he would make an incision and cut off the top layer of the skin, and that he would use anaesthetic/analgesia. Dr A said that Ms B gave verbal consent for the procedure.

22. Dr A told HDC that he recalled Master B saying more than once that he did not want any needles. Dr A said that he assured Master B that there would be no needles involved and, after that, his stress levels appeared to reduce.

23. Ms B told Dr A that Master B has a needle phobia, and that it is preferable for needles to be avoided. However, Ms B told HDC that if Master B had been aware of the level of pain involved with the procedure, he would have elected to receive a local anaesthesia via a needle.

24. Dr A has stated that in his view, removal of the mass was appropriate because of the pain and stress that it was causing Master B; because it was consistent with Ms B's wishes; because of the size of the incision; and because the risks of the procedure were minimal. Dr A also told HDC:

> "This was a simple procedure with no material risks that weighed against removal that day. [Master B's] stress level decreased considerably once he was advised that I would not be using any needles. Any risk of inadequate excisions margins or poor cosmetic result were minimal given the size of the incision.
>
> The reason for my procedure was to provide relief of symptoms (as per the wishes of [Master B's] mother), a diagnosis as soon as possible (as per the wishes of [Master B's] mother), and a follow up by Dermatology in case any further specialist treatment was needed (once the diagnosis of the lesion was established)."

25. Dr A told HDC that the lack of clinical standards at the DHB meant that ED doctors exercised judgement on a case-by-case basis. The removal of the lesion was straightforward, and there was no clinical disadvantage to removing it that day. Dr A said that in his view the options open to him were to proceed as he did, or to decline treatment to a distressed mother and an anxious young man with a sore and bleeding lesion, which may well have attracted a complaint and further escalated their distress.

Anaesthesia

26. There is disagreement about the type of anaesthesia used. Dr A told HDC that he used lidocaine with adrenaline and ethyl chloride spray. According to Dr A, his reasoning for this was:

> "I was conscious of not using any method that could cause [Master B] more stress, like high flow Entonox[5] in the [resuscitation area], or infiltration of local anaesthetic into the surrounding tissue (involves the use of a needle), or sedation (involves the use of a needle/intravenous cannula).

[5] A gas used for pain relief via a facemask or mouthpiece.

> As I wanted to respect the wish of [Ms B and Master B], I discussed the option of using a combination of local ethyl chloride spray (for pain) and local lidocaine [with] adrenaline (for pain and bleeding). I explained that ethyl chloride would be applied to the skin with a spray and drops of lidocaine would be applied with a syringe. The goal was to provide analgesia to the base of the pedicle (0.3 cm width) and to the area where I was going to apply suture.
>
> [Master B's] mother agreed with this. Before giving him analgesia, I used the ethyl chloride spray on my own arm, to show him that there would be no needles and it wasn't painful, and then I did the same with local lidocaine/adrenaline. I showed him the syringe and the liquid in it and drew his attention to the fact that there would be no needles used."

27. According to Ms B, only spray was used. Ms B told HDC:

> "The only thing he used was a cold spray. The can looked exactly like the can of Instant freeze that you can get at the supermarket."

The procedure

28. After applying the anaesthesia, Dr A removed the lesion. He held the lesion with his left hand, and performed an incision on the base of the pedicle on the surface of the skin. He then put the tissue into the container to be sent to the laboratory.

29. There is disagreement about the number of stitches applied to close the wound. Dr A advised HDC, and documented in the clinical notes, that he used only one stitch and a Steri-Strip. According to Ms B, two stitches were used.

30. Dr A stated that, given the circumstances of this case, the scale of the incision, Master B's past medical history, his fear of needles, and his wishes, he believed he used appropriate local anaesthesia, and that this was the only option to provide sufficient effect without using needles. As ethyl chloride was removed from the Emergency Department only after the complaint, Dr A submitted that it was therefore considered an available option at the time the procedure took place.

31. There is disagreement about the level of distress Master B displayed during the procedure. Dr A told HDC that neither Master B nor his mother asked him to stop during the procedure, and that Master B did not appear to be aware when he "started the stitch", which gave him confidence that the local anaesthetics were working. Dr A stated:

> "I recall [Ms B] was giving her son a hug during this time.
>
> … Throughout his attendance at ED, I talked to [Master B] directly. He didn't complain of pain or discomfort during the procedure and did not appear to be distressed during the procedure or when he was being discharged. As a matter of my practice, I would not let a patient leave my care/ED if they were in distress …"

32. The registered nurse in triage that day also does not recall any untoward observations. He told HDC that his usual practice is to document any and all observations of a patient's demeanour or behaviour.

33. However, Ms B told HDC that while Dr A was cutting the lesion, she observed Master B crying and screaming, and she was holding him to keep him still. According to Ms B, when Master B left the room he was hyperventilating.

34. After the procedure had been completed, the nurse provided wound cleaning and dressing. Master B was discharged, and the tissue was sent to the Pathology Department for analysis.

35. Dr A documented in the clinical notes: "[M]ass removed from back. Sent to lab. 1 x stitch, steristripped, dressed."

Referral to Dermatology Department

36. Dr A told HDC that an urgent referral to the Dermatology Department was made, and that Ms B was advised to call the public hospital and ask about an appointment if the referral centre had not called her in a week's time. According to Ms B, she received no contact from the Dermatology Department.

37. Dr A informed HDC that there were ongoing issues with the reliability of the public hospital's fax machine, and that a radiographer had confirmed that referrals were known to go missing. The radiographer told HDC:

> "It is not uncommon for an ED Doctor or Triage Nurse to come to the department and ask if we have received a referral for a patient, as they have not yet received their imaging. In most instances this is because we have not received the referral. In most instances the referrer will confirm that they believe they have faxed the referral and can produce the referral. This occurs a number of times each week and is not dependent on the clinician or the fax machine in ED that has been used."

38. The DHB told HDC that an investigation did not find any evidence of a fax being received in the DHB Referral Centre transmitted from the ED during the time period indicated, and the DHB was also unable to locate the yellow referral form in the patient's clinical file.

39. However, it is the DHB's understanding that from time to time there have been issues with faxing from the ED. In the future, there will be electronic orders available for all Radiology internal referrals, including the ED.

40. Dr A did not document in the clinical notes that a referral for Dermatology review had been sent.

Subsequent events

41. In the days following the treatment, the lesion regrew. On 23 April 2017, Master B underwent surgery for removal of the lesion under general anaesthetic.

42. The lesion was later identified as a lobular capillary haemangioma, which is a benign vascular lesion of the skin.

The DHB

43. The DHB advised that there is no policy for removal of skin lesions in the Emergency Department, as this is not considered to be an emergency procedure.

44. Dr C, the Clinical Lead of the Emergency Department, responded on behalf of the DHB. Dr C told HDC:

> "Having such a mass would be unpleasant and worrying, but it is not an emergency condition requiring immediate removal. Late on a Friday evening when working as a solo doctor in an ED does not place the practitioner in an ideal position for attending to such a problem."

45. In reference to the anaesthesia used, Dr C stated that it would have been a better approach to arrange elective removal in an environment in which anaesthesia/analgesia and procedural sedation could be used to allay anxiety and provide optimal pain relief.

46. Dr C apologised for ethyl chloride having been used in these circumstances, and has removed ethyl chloride as an option for anaesthesia in ED.

47. In relation to Dr A's clinical records, Dr C has discussed with Dr A the imperative for recording all treatments given (including the type of anaesthesia used). She stated that it is best practice to record the response to treatment, and the outcome of the procedure.

Further information

48. Dr A has advised that he discussed the situation at length with the Clinical Director of the public hospital. Dr A told HDC:

> "[The clinical director] agreed with the way I took care of [Master B], and commented that my documentation should be more detailed in order to provide more specific details about this and other cases in general, to have an even better level of communication with patients and relatives."

49. Dr A stated that having reviewed his clinical notes and reflected on the situation, he now recognises that the level of his documentation could have been better. He has apologised and said that he will allow more time to complete detailed accounts for all patients he sees. Dr A said that the nature of Emergency Department shifts is that clinicians are busy, but that he will endeavour to balance the needs of patients as much as possible.

Responses to provisional opinion

Ms B

50. Ms B was given an opportunity to comment on the "information gathered" section of the provisional opinion.

Dr A

51. Dr A was given an opportunity to comment on the provisional opinion. Where relevant, his comments have been incorporated into the report.

The DHB

52. The DHB was given an opportunity to comment on the provisional opinion. It advised that it accepts the proposed recommendations and is confident that Dr A has learnt a great deal from this complaint. It will continue to support him in his ongoing learning.

Opinion: Dr A — breach

53. On 7 April 2017, Master B, accompanied by his mother, Ms B, received care from Dr A in the ED. Master B presented with an identified mass causing discomfort and distress for Master B and his mother.

54. After examining the mass and having initial discussions with Master B and Ms B, Dr A offered removal of the mass in ED as a treatment option. Dr A applied anaesthesia and proceeded to remove the mass.

Treatment of the mass

55. The DHB advised HDC that it does not consider the removal of a skin lesion to be an ED procedure, and the choice to remove it was questionable. Dr A stated that he considered removal of the mass in ED to be appropriate as the procedure was straightforward and the incision was completely superficial.

56. While Ms B expressed a preference for immediate removal of the lesion, and the wishes of Ms B and Master B were important, the options presented to them needed to be subject to appropriate clinical decision-making. My expert advisor, Dr Jennifer Keys, advised that "it is uncommon for a mass to be removed in an emergency department but it may be reasonable for this to occur, on occasion".

57. Dr Keys further advised:

> "I looked for objective evidence which would suggest that [the incision] was superficial or deeper. The only suggestion was given by [Dr A], who describes using a single suture at the site of the excision of the lesion. This would strongly suggest that the wound was not extremely superficial — if it had been then either no suture would be required or glue or a steristrip would have sufficed."

58. I note Dr A's submission that Emergency Department doctors at the DHB exercise judgement on a case-by-case basis, and I note the matters he considered when deciding to proceed with the procedure. In all the circumstances of this case, I accept that the decision to remove Master B's lesion may have been reasonable.

Anaesthesia

59. Dr A used both ethyl chloride spray and topical lidocaine with adrenalin to anaesthetise the area prior to removing the lesion from Master B's back.

60. My expert advisor, Dr Keys, advised that "neither ethyl chloride or topical lignocaine would have any appreciable effect as an anaesthetic". Dr Keys added that lidocaine does not penetrate intact skin unless it is applied in very specific formulations or mixtures, and even then it may take 30 minutes to have an effect.

61. Dr Keys further advised:

> "Accepted practice for analgesia or anaesthesia for any procedure on a child is to minimise discomfort to the child … Accepted practice for removal of a skin lesion would be a subcutaneous injection of local anaesthetic. If a subcutaneous injection will be difficult then adjuncts may be considered, including intranasal or oral sedating or analgesic medication."

62. Dr Keys does not consider the anaesthesia given on this occasion to have been sufficient for the removal of a skin lesion, as neither the ethyl chloride spray nor the application of lidocaine with adrenalin would have had any appreciable effect. Dr Keys advised that whether or not Master B was visibly distressed, she considers that the anaesthesia provided was inappropriate, and that the removal of a skin lesion from a child without appropriate anaesthesia is a significant departure from normal practice.

63. I note Dr A's submission that as ethyl chloride was removed from the Emergency Department only after this complaint, it was therefore considered an available option at the time the procedure took place. However, I do not consider the fact that ethyl chloride spray was available in ED meant that it was an option for this procedure.

64. I accept Dr Key's advice that the use of ethyl chloride spray and lidocaine would not have had any appreciable effect, and consider that their use as anaesthesia to remove Master B's lesion was inappropriate.

Level of pain

65. I have been provided with conflicting accounts about the level of pain Master B suffered. It is not necessary for me to make a finding about how much pain Master B experienced. Dr A stated that neither Master B nor his mother asked him to stop during the procedure. However, it is not apparent that during the procedure Dr A checked with Master B whether he was in pain, and, in my view, Dr A should consider taking such steps in future.

Record-keeping

66. Dr Keys advised that Dr A's documentation is an incomplete record of the clinical findings, the reasoning for the procedure, and of the procedure itself. She also advised that the notes contain no description of the skin lesion or of consent having been obtained for the

procedure. Dr Keys considers Dr A's documentation to be a "moderate departure" from accepted standards.

67. I further note that although Dr A told Ms B that he would refer Master B to the Dermatology Department, Ms B did not receive any contact from the department. The DHB undertook investigations and found no record of a fax referral having been received during the timeframe specified by Dr A, and Dr A's notes do not document whether a Dermatology referral occurred. I do not make a finding as to whether or not a fax was sent, but I am critical that there is no record of a referral having been made for Master B.

68. Clinical records are central to ensuring safe, effective, and timely care, and are essential to continuity of care. Dr A's clinical records lack sufficient detail. There is no rationale provided for the procedure, and no explanation as to why the mass was treated in the Emergency Department. There are no details about the consent process or the discussion that Dr A had with Ms B and Master B about the options available. There is also no record of the anaesthesia used or the discussion that Dr A had with Ms B and Master B about the anaesthesia that he proposed to use, and no record of a referral to the Dermatology Department. I am critical that Dr A failed to provide full and comprehensive notes.

Conclusion

69. By failing to provide appropriate anaesthesia during the removal of the skin lesion, and failing to document the care provided adequately, Dr A did not provide Master B with services with reasonable care and skill on 7 April 2017. Accordingly, I find that Dr A breached Right 4(1) of the Code.

Opinion: the DHB — no breach

70. As a healthcare provider, the DHB is responsible for providing services in accordance with the Code. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994, an employing authority is vicariously liable for any acts or omissions of its employees. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the public hospital. In considering what steps the DHB could have reasonably taken to prevent these events, such as a guiding policy, I consider there to have been no need for a policy on the appropriate anaesthesia for the removal of skin lesions, as this was not an Emergency Department procedure. Therefore, I consider that the DHB did not breach the Code directly or vicariously.

71. I consider it appropriate that the DHB has removed ethyl chloride as an option for anaesthesia in the Emergency Department.

Recommendations

72. I recommend that Dr A provide a written apology to Master B and Ms B. The apology is to be sent to HDC within one month of the date of this report, for forwarding to the family.

73. I recommend that the DHB consider whether Dr A would benefit from ongoing collegial support and mentoring with respect to his documentation and clinical decision-making within the ED context. The DHB should report back to HDC on the outcome of its consideration within three months of the date of this report.

74. I recommend that the DHB report back to HDC on its progress in implementing an e-referral process. The DHB should report back to HDC within three months of the date of this report.

75. I recommend that the Medical Council of New Zealand consider whether a review of Dr A's competence is warranted.

Follow-up actions

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

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from a rural hospital medicine specialist, Dr Jennifer Keys:

"Report for Health and Disability Commissioner 23rd March 2018

My name is Dr Jennifer Keys. I have been asked to provide an opinion on case 17HDC01139**.** I have read the Guidelines for Independent Advisors from the Office of the Health and Disability Commission and agree to follow them.

I qualified MBChB in 1991 from the University of Dundee, Scotland. My postgraduate qualifications are MRCP(UK), MRCGP, MSc (Remote Healthcare) and FDRHMNZ. I work as a Rural Hospital Doctor and Clinical Leader at Lakes District Hospital, a rural hospital, in Queenstown. In addition, I am Chair of Council of the Division of Rural Hospital Medicine.

At least 50% of my current day-to-day practice is in the Emergency Department of Lakes District Hospital. As part of my training in General Practice in Fort William, Scotland I spent half a day each week with a surgeon in the local hospital gaining experience in the removal of skin lesions. During the five years in which I worked as a locum general practitioner I regularly removed skin lesions.

I have been asked to advise whether I consider the care provided on this occasion to [Master B] by [Dr A] was reasonable in the circumstances, and why.

In particular, I have been asked to comment on:

1. The appropriateness of removing [Master B's] mass at ED.
2. Whether the anaesthesia used was appropriate and sufficient. Including, whether using lignocaine/adrenaline on gauze or droplets from a syringe (without a needle) was an appropriate method of local anaesthetic for this type of procedure.
3. [Dr A's] standard of documentation including whether, in your opinion, the documentation is an accurate reflection of [Dr A's] recollection of events.
4. Any other matters in this case that you consider warrant comment.

I have been provided with the following documents, which I have reviewed.

1. Letter of complaint dated …
2. [The DHB's] response including brief response from [Dr A] dated 26 July 2017.
3. [Dr A's] further more detailed response dated 25 January 2018.
4. Note of telephone call with [Ms B] dated 13 March 2018.
5. [The DHB's] further response dated 26 January 2018.
6. Clinical records and relevant ED policies from [the DHB].

Background

On 7 April 2017, the complainant [Ms B] and her 13 year old son [Master B] presented to the emergency department (ED) of [the public hospital]. [Master B's] attendance to ED was due to a growing and bleeding mass on his back. [Ms B] advised [Dr A] that their GP had attempted to freeze the mass to remove it between two to three times, however this had been unsuccessful. It is understood that the GP advised [Ms B] and her son to attend ED for further evaluation however there was no formal referral to the hospital. [Ms B] also advised [Dr A] that her son had ADHD. During the ED presentation, [Dr A] attempted to remove the mass from [Master B's] back. A sample of the mass was sent to the lab.

Other than the facts above, [Ms B] and [Dr A] have different recollections about the ED presentation. Each of their versions of events are outline below.

[Dr A's] recollection

[Dr A] advised HDC that:

1. [Master B] appeared to be anxious when he saw him in ED.
2. [Ms B] asked that no needles be involved as this would cause more stress to her son.
3. [Master B] refused needles a few times. Therefore, [Dr A] used a combination of local ethyl chloride spray (for pain) and drops of local lidocaine/adrenaline (for pain and bleeding) applied with a syringe. [Dr A] told HDC that the mass was attached to the skin by a pedicle that measured approximately 1 cm long and 0.3 cm in width. To remove the mass, [Dr A] held the lesion with his left hand and performed an incision on the base of the pedicle on the surface of the skin. The incision was superficial.
4. [Master B] did not appear to be aware when [Dr A] started to stitch and [Ms B] was giving her son a hug during this time.
5. He completed a dermatology referral and faxed it to the referral center.
6. He told [Ms B] to call [the public hospital] and ask about the appointment if the referral centre did not call her in a week's time.

[Ms B's] recollection

[Ms B] told HDC that:

1. [Master B] was not initially anxious when they presented at ED.
2. She advised [Dr A] that [Master B] 'was anxious with needles' but she never refused needles.
3. [Master B] may have said no to needles however the extent of the pain was not explained to him. [Dr A] *only* used a 'cold spray' on the lump and 'then cut it off'.

4. [Dr A] 'tried to place two stitches in it' and during this time '[Master B] was screaming in pain, very distressed and traumatised' whilst [Ms B] tried to hold him still.
5. She never received the dermatology appointment.
6. Given the distressed state her son was in, she does not recall being advised to call [the public hospital] if she did not hear from the referral centre.

Opinion

There is some agreement between these descriptions of events but several conflicting recollections.

[Ms B] and [Dr A] both describe the removal of a rapidly growing and bleeding skin lesion in the Emergency Department (ED) at [the public hospital].

[Dr A] recalls explaining to [Ms B] that he didn't know what the lesion was and giving her a choice between removing the lesion in the ED or being referred to dermatology. He recalls [Ms B] choosing to have the lesion removed in the ED to stop the bleeding, pain and stress for her son, and to have a diagnosis as soon as possible.

Both parties recall [Master B] having anxiety related to needles. [Dr A] recalls that [Master B] stated that he didn't want needles, but [Ms B] says that that was not the case. He used topical anaesthesia to reduce [Master B's] anxiety.

[Dr A] states that he used ethyl chloride spray and drops of lidocaine/adrenaline solution and waited a few minutes. [Ms B] recalls only the spray.

After removal of the lesion either 1 ([Dr A]) or 2 ([Ms B]) sutures were placed. During this time [Dr A] recalls that [Master B] was not aware of the suturing, but [Ms B] recalls that [Master B] was screaming in pain, very distressed and traumatised.

Regarding the Commissioner's questions:

— The appropriateness of removing [Master B's] mass at ED.

It is uncommon for a mass to be removed in an emergency department but it may be reasonable for this to occur, on occasion, if the mass is very symptomatic and the patient is very keen that it be removed, if the attending doctor has the training and skills to remove it safely, if the doctor is able to provide adequate anaesthesia for the procedure, if the delay to specialist care is long and if appropriate consent is gained.

[Dr A] describes that [Master B's] mass was symptomatic and that his mother was keen to have it removed. [Ms B] does not disagree with this.

It is not clear what training or experience in the removal of skin lesions [Dr A] has. As an Emergency Physician, he will have significant experience in the repair of skin lacerations but it would be uncommon for him to have had any training in the diagnosis or removal of skin lesions.

It is not clear how long the delay to dermatology review would be, although [Dr A] describes several days or a few weeks. This is not a delay which would significantly affect the outcome of most skin lesions.

In his further response (25/1/18) [Dr A] describes verbal informed consent. I would anticipate that a doctor who is experienced in the clinical diagnosis of skin lesions would think that a rapidly growing and bleeding lesion in a teenager is likely to be a pyogenic granuloma, which may be symptomatic but is benign. He would have included the benign nature of the lesion in his informed consent. No mention is made of this in his response. He would also have noted the danger of significant bleeding during the removal of this vascular lesion and may have cautioned against removal in the Emergency Department for this reason. He does not write in his initial note or subsequent response that he described the risks of his intended procedure.

I shall discuss the anaesthesia given in response to the second question.

I can find no New Zealand standard or guideline which refers to the removal of minor skin lesions.

On balance it would seem likely that although [Ms B's] wish was that the mass be removed, with fully informed consent (including knowledge that the mass was very unlikely to be dangerous, that the delay to dermatology review would not be long, that significant bleeding may occur during its removal in ED, that a second procedure may be required for definitive management and possibly that [Dr A] did not have training in the diagnosis or removal of skin lesions) she may have requested referral rather than removal in the ED.

If [Dr A] has no training or experience in the diagnosis of skin lesions he should have referred appropriately (with urgency if deemed necessary).

With regard to this question, I believe that there was a mild departure from the standard of care, and that my peers would be in agreement with this assessment.

— Whether the anaesthesia used was appropriate and sufficient. Including, whether using lignocaine/adrenaline on gauze or droplets from a syringe (without a needle) was an appropriate method of local anaesthetic for this type of procedure*.*

[Dr A] used two forms of topical anaesthesia. Ethyl chloride is occasionally used for reduction of discomfort related to venepuncture, but it is not regarded as adequate anaesthesia for surgical procedures. Its potential duration of action is a few minutes and, after waiting a few minutes, any effect would have ceased.

He also used lidocaine/adrenaline, which he dripped onto the skin, and waited for a couple of minutes for its effect. Lidocaine does not penetrate intact skin unless it is applied in particularly proprietary formulations or mixtures (for example topicaine), in which case it may take 30 minutes to have an effect when applied on a swab or under

an occlusive dressing. It would seem from his description that [Dr A] used normal lidocaine/adrenaline, which I would expect to have no effect as an anaesthetic when used in this manner.

I can find no New Zealand guidelines for the use of local anaesthesia for the removal of skin lesions, but the American Academy of Dermatology publishes Guidelines for the use of local anesthesia in office-based dermatology surgery. It describes a scarcity of available evidence but advises that the members of the working group routinely find that non-ablative laser therapy and other minor procedures (i.e curettage) may be performed in children under topical anesthesia. The procedures described are significantly more superficial than the excision which was performed by [Dr A]. The use of one or two sutures to close the wound would suggest that the incision at the base of the wound was through full skin thickness.

[Ms B] describes her son as being very distressed. This is consistent with the removal of this lesion and the subsequent suturing without adequate anaesthesia.

Accepted practice for analgesia or anaesthesia for any procedure on a child is to minimise discomfort to the child (whilst accepting that it may not be possible to cause no discomfort). Accepted practice for removal of a skin lesion would be a subcutaneous injection of local anaesthetic. If a subcutaneous injection will be difficult then adjuncts may be considered, including intranasal or oral sedating or analgesic medication.

I do not consider that the anaesthesia given on this occasion was appropriate or sufficient, particularly in an anxious child. With regard to this question, I believe that there was a significant departure from the standard of care, and that my peers would agree with this assessment.

— [Dr A's] standard of documentation including whether, in your opinion, the documentation is an accurate reflection of [Dr A's] recollection of events.

[Dr A's] emergency department note contains no description of the skin lesion and why he decided to remove it as an emergency. It makes no mention of consent and does not describe the anaesthesia used. I would regard this note as being an incomplete record of the clinical findings, the reasoning for the procedure and of the procedure.

There is nothing stated in his initial ED note which contradicts or is contradicted by his subsequent statement.

I believe that there is a moderate departure from the standard of expected documentation."

The following further advice was obtained from Dr Keys:

> "The reports from [Dr A] and [Ms B] clearly differ. I sought to make it clear that neither ethyl chloride (which, if it has any effect, is extremely short lived, and would have had no effect when time to wait for the lignocaine to work had been given), nor the topical lignocaine would have any appreciable effect as an anaesthetic.
>
> In his reply [Dr A] states that the incision was extremely superficial. I looked for objective evidence which would suggest that it was superficial or deeper. The only suggestion was given by [Dr A], who describes using a single suture at the site of the excision of the lesion. This would strongly suggest that the wound was not extremely superficial — if it had been then either no suture would be required or glue or a steristrip would have sufficed. Whilst it may be possible at times to place a single suture in a co-operative adult without local anaesthetic it would not be normal practice to do so in a child.
>
> It was for these reasons that I felt that [Ms B's] report was more plausible. I did not feel that [Dr A's] report of a child who was not bothered by the removal of a lesion and application of a suture was plausible, although it is clearly not possible to say that that was definitely not the case.
>
> Regards
> Jennifer"