Doctor in General Practice, Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 19HDC02131)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a doctor in general practice in respect of a melanoma on a man's back. A number of failures by the doctor contributed to a delay in specialist care and treatment for the significant lesion that had a high risk of metastasis. The report highlights the importance of informing consumers of the outcome of test results and following through on recommendations made in histology reports, and of accurate documentation.

2. The doctor first saw the man at a medical centre and examined the lesion on his back. The doctor excised the lesion and sent a histology request to the laboratory. The histology report was received a few days later. It noted that the lesion was an invasive superficial spreading primary melanoma, and recommended a wider excision. After the report was received, the man had multiple follow-up appointments with the doctor, but the doctor failed to inform the man of the histology results, and did not perform a further excision or recommend or offer referral to a specialist.

Findings

The doctor

3. The Deputy Commissioner found the doctor in breach of Right 4(1) of the Code for not ensuring that the man was informed of the histology results, and not performing a wider excision, and because the frequency of follow-up reviews that the doctor advised was inconsistent with accepted practice. In addition, the Deputy Commissioner found that the doctor breached Right 6(1) of the Code by failing to inform the man that the lesion was skin cancer and that a specialist referral was warranted after the histology results were received.

The medical centre

4. The Deputy Commissioner found that the medical centre was not vicariously liable for the actions of its employee, the doctor, and that the medical centre was not directly in breach of the Code. The Deputy Commissioner considered that the errors identified were individual failings and did not indicate broader systems or organisational issues.

Recommendations

5. The Deputy Commissioner recommended that the doctor provide a written apology to the man, and that should the doctor re-apply for a practising certificate in New Zealand, the Medical Council of New Zealand consider whether a review of his competence is warranted.

6. The Deputy Commissioner recommended that the medical centre complete an audit of the skin lesions excised by the doctor, and audit a sample of the histology reports ordered by the doctor, to check whether these were managed appropriately. These recommendations have been completed.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms C about the services provided to her nephew, Mr A, by Dr B. The following issues were identified for investigation:

- *Whether Dr B provided Mr A with an appropriate standard of care in 2019.*
- *Whether the medical centre provided Mr A with an appropriate standard of care in 2019.*

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:

Mr A	Consumer
Dr B	Provider/doctor in general practice
Ms C	Complainant/consumer's aunt
Provider/medical centre	

10. Also mentioned in this report:

Enrolled Nurse (EN) D	Enrolled nurse
Dr E	Consultant surgeon
Dr F	General practitioner (GP)

11. Further information was received from:

District Health Board (DHB)
Accident Compensation Corporation

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

Information gathered during investigation

Background

Mr A

13. At the time of events, Mr A was in his twenties. He has Asperger's syndrome[1] and is high functioning, and has congenital deafness in one ear.

[1] Asperger's syndrome is an autism spectrum disorder that is characterised by impaired social interaction, repetitive patterns of behaviour and restricted interests, normal language and cognitive development but poor conversational skills and difficulty with nonverbal communication, and often above-average performance in a narrow field against a general background of impaired functioning.

Dr B

14. In 2017, Dr B[2] commenced employment in the role of Family Doctor GP for the medical centre. Dr B trained overseas and prior to this event had worked in New Zealand as a doctor in general practice for 11 years. He is not vocationally registered as a GP.[3]

5 April 2019 — first consultation for skin lesion

Review by enrolled nurse

15. On 5 April 2019, Mr A presented to the medical centre for the first time. He was seen by EN D, who documented Mr A's family, medical, and social history, including that his mother had a history of cancer. EN D also noted that Mr A's reason for presenting was: "Had a mole on back that had change[d] in size and tearing and bleeding a lot. First started 1 month ago."

16. As part of her assessment, EN D recorded Mr A's vital signs (all of which were within normal range,[4] except for a slightly elevated blood pressure (BP) reading of 140/90mmHg[5]). EN D also reviewed the mole on Mr A's back and documented:

> "Lesion on back is 3cm by 2cm very large purple/deep red in colour. This is growing in size and changing shape. Plan for Urgent [review] today with [Dr B] as ? very suspicious lesion ? melanoma."

Review by Dr B

17. Following EN D's review, Mr A was reviewed by Dr B. Dr B documented:

> "Large fulminating [meaning sudden and severe] lesion 3cm x 3cm on mid lower back. Central dark area. Has all the features of a keratoacanthoma.[6] Came up about a month ago and has been growing rapidly since. Laterally an area of hyperkeratosis[7] noted. Bleeds [occasionally]. Discussed lesion/Possibility of [cancer]/Advised of options/ Happy to get it done [here]/Consent form signed To be booked."

18. That day, Mr A signed a "Consent for Minor Surgery" form. The form noted the minor surgery procedure as "excision lump on back".

19. Dr B told HDC that he remembers offering Mr A a referral to a specialist, but that Mr A declined this and opted for removal at the medical centre. However, Mr A told HDC that he has a good recollection of this appointment, and Dr B did not offer specialist referral. Mr A also said that he asked Dr B if he should go to the "mole map place" (i.e., to a clinic that

[2] Dr B was awarded a general scope of practice in 2008. His practising certificate expired in 2020.
[3] The Royal New Zealand College of General Practitioners believes that all doctors working in general practice should have completed or be undertaking vocational training; however, it notes that around 25% of doctors working in general practice are not vocationally registered or undertaking vocational training: https://rnzcgp.org.nz/RNZCGP/Advocacy/Position_statements/Vocational_Training.aspx
[4] Respiratory rate 16 breaths per minute; heart rate 98 beats per minute; oxygen saturation 98% on room air.
[5] Normal adult BP is less than 120/80mmHg.
[6] A common type of cutaneous squamous cell carcinoma (skin cancer).
[7] Thickening of the stratum corneum layer of the skin.

provides skin checks for the purpose of detecting skin cancer) to get the lesion checked, but Dr B told him that he could remove it more cheaply.

12 April 2019 — excision of skin lesion

20. On 12 April 2019, Mr A returned to the medical centre. Dr B excised the lesion, assisted by EN D. Dr B documented that he obtained informed consent prior to the procedure, and applied local anaesthetic to the skin. He also documented his advice to Mr A about caring for the wound, and that Mr A would return to the medical centre in three days' time for a wound check, and again in two weeks' time for removal of the sutures used to close the wound.

21. That day, Dr B sent a request to the laboratory for histology of the lesion.

15 April 2019 — wound review and dressing change

22. On 15 April 2019, Mr A returned to the medical centre for a review of his wound and a dressing change, which was performed by EN D. EN D noted that the wound was healing well and recorded: "[Dr B] happy reviewed wound/happy with same."

17 April 2019 — histology report received

23. On 17 April 2019, the histology report was received by the medical centre. The histology report stated:

> "Diagnosis: Primary melanoma, invasive/Subtype: Superficial spreading melanoma/ Tumour thickness (Breslow):[8] 8.9 mm/Level of invasion (Clark): III[9]
>
> … A wider excision is recommended
>
> … SUMMARY / Skin mid back — Primary cutaneous [of the skin] melanoma, invasive, superficial spreading."

24. Dr B annotated the histology report as "superficial spreading melanoma" in the notes. Dr B told HDC that he appreciated that the diagnosis was a serious one. However, the medical centre told HDC that Dr B did not document any further action or follow-up, and there was no evidence of any contact with Mr A at this point.

26 April 2019 — alternate sutures removed

25. On 26 April 2019, Mr A returned to the medical centre for removal of alternate sutures by EN D. EN D noted: "Wound healing very well." EN D also recorded that she made an appointment for Mr A with Dr B for the following week to "go over results/remove remaining sutures". She told HDC:

[8] Breslow thickness is the measurement of the depth of the melanoma from the surface of the skin to the deepest point of the tumour. In general, the thicker the melanoma measures, the greater its chance of spreading.
[9] The Clark scale is used to determine how many layers of the skin the tumour has grown into. Clark Level III means that the melanoma has reached the third layer of the skin (the reticular dermis).

> "… I could see that [Mr A's] results had returned showing they were abnormal/ melanoma. I questioned [Mr A] if he had heard from [Dr B] regarding his results, he advised he had not heard anything. [Dr B] was not available on this day to see [Mr A]. The policy for these kind of test results is for the doctor to disclose these results to the patient so that a treatment plan can be formed — it is not for the nurse to disclose these results or refer to specialists. I told [Mr A] that he needed to see the doctor for these results ..."

26. Dr B told HDC that his usual practice was to join the patient at the time of suture removal and to inform the patient of the histology at that time. He also stated: "I have no doubt that I would have spoken to him also about the seriousness of the lesion." However, EN D told HDC that Dr B was not available when the sutures were being removed, so Dr B did not see Mr A that day. EN D said that she spoke to Dr B at some point after she saw the histology results (although she cannot recall when) to let him know that she had made an appointment at the soonest available time for Dr B to discuss the results with Mr A.

30 April 2019 — consultation with Dr B

27. On 30 April 2019, Mr A returned to the medical centre. He was first seen by Dr B, who noted that Mr A's wound looked clean and was healing well. Dr B also documented:

> "Advised re histology / At excision when one of margins recognised to be close to edge additional sliver of tissue removed and included in specimen / At this stage no further excision to be done / Will be reviewed in 3 months / Both axillae [armpits] checked and free of glands [lymph nodes]."

28. Dr B told HDC that he recognised that the lesion required referral to a specialist. He stated that he has a "vague recollection" that Mr A declined further referral and was happy to be monitored at the medical centre despite Dr B's advice. However, Mr A told HDC that he also has a good recollection of this appointment, and Dr B did not offer specialist referral. Mr A said that had Dr B offered a referral, he would have taken up this offer. There is no record in the notes that Dr B advised Mr A about a possible referral or that Mr A declined such a referral.

29. On the same day, Mr A had his remaining sutures removed by EN D.

2 August 2019 — three-month review

30. On 2 August 2019, Mr A returned to the medical centre for the three-month review with Dr B. Dr B documented:

> "Here for rev[iew] of wound 3m[onths] after excision / superficial spreading melanoma R[ight] lower back / Wound healed Minimal scar tissue / No sign of recurrence / Advised rev[iew] in 6 months and if ok thereafter yearly for 3 years."

31. Mr A told HDC that after receiving this follow-up care from Dr B, he "believed his treatment had ended". Mr A understood that Dr B had told him that the mole was non-malignant.

27 September 2019 — review of lump in armpit

32. On 27 September 2019, Mr A returned to the medical centre for review of a lump in his right armpit, which had become painful three days earlier. He was seen by Dr F, who documented in the notes a possible diagnosis of cancer of the lymphatic system[10] (lymphoma) or some other pathology. That day, Dr F referred Mr A urgently to the General Surgery Department at a public hospital for assessment of the lump.

Subsequent events

33. Samples were taken of the mass in Mr A's armpit on 23 October 2019 at the public hospital. The histology report showed that the mass was cancerous (metastatic melanoma).

34. Mr A was seen by consultant surgeon Dr E on 4 November 2019. Dr E noted in her clinic letter that when the histology of the excisional biopsy was reported in April 2019, Mr A was "never referred for a sentinel node biopsy[11] or wider excision". Dr E told HDC that, at that meeting, Mr A told her that he was not aware that the skin lesion was cancer. She stated:

> "[Mr A's] chance of having lymph node involvement at diagnosis was 32% according to the Memorial Sloan Kettering Nomograms [a clinical prediction tool used to calculate the likelihood that the cancer has metastasised (spread)]. He should have been referred at diagnosis for a sentinel node biopsy and complete staging [determining the extent of a cancer]. An earlier referral may have resulted in a different outcome. Although it is now evident that [Mr A] has a very aggressive melanoma."

35. On 11 November 2019, Mr A was also seen by a medical oncologist. The oncologist wrote in her clinic letter that following excision of the lesion in April 2019: "[Mr A] recalls asking [his GP] whether there was any cancer after the excision and he was told there was not and that no further treatment was required at that time."

Further information

Mr A and Ms C

36. Ms C told HDC that Mr A's prognosis is terminal but he is still able to work part time and is doing okay. In response to the provisional opinion, Ms C clarified that Mr A had been working full time up until his surgery, but he now works four hours a week when he is well enough. She also stated: "[O]ur family are concerned this could happen to another patient if [Dr B] is not held accountable." Mr A told HDC that he underwent further surgery to remove new tumours in April 2021.

Dr B

37. The medical centre told HDC that Dr B went on annual leave in early August 2019, and was due to return in early September 2019. However, when a staff member went to his house to hand over the work car, the staff member found a different person living there. The medical centre stated that it sent Dr B a number of emails, left voice messages, and filed a

[10] The tissues and organs that produce, store, and carry white blood cells, which fight infections and other diseases. This system includes the bone marrow, spleen, thymus, lymph nodes, and lymphatic vessels (a network of thin tubes that carry lymph and white blood cells).

[11] A surgical procedure used to determine whether a primary tumour has spread to the lymph nodes.

missing person report with the Police; however, the Police told the medical centre that Dr B had not returned to New Zealand. The medical centre said: "Disappointingly, [Dr B] did not respond to any of our attempts to engage him."

38. The medical centre also told HDC that when Dr B was first recruited to work at the medical centre, he had been recommended by another GP also working at the medical centre. The medical centre said that it "worked diligently with [Dr B] to highlight our systems, approaches, and policies".

39. Dr B told HDC that he is now overseas.

Medical centre

40. The medical centre told HDC:

> "[The medical centre] is deeply remorseful that this is [Mr A's] experience. We know early detection and effective results management is key to improved outcomes. Within the last year we have invested in developing an effective method of managing test results to reduce error … We extend our apologies to both [Mr A] and his family."

41. The medical centre achieved Cornerstone accreditation[12] in 2017.

EN D

42. EN D told HDC:

> "I would like to take this time to express my sincere condolences to [Mr A] and his family. I cannot express my sorrow enough that [Mr A] was not cared/treated for appropriately through the service at [the medical centre]. My thoughts and prayers are with [Mr A] and his family."

ACC claim

43. A treatment injury claim was made to ACC, and the claim was accepted. The ACC treatment injury report stated that ACC concluded that "the metastatic melanoma was caused by the failure to treat/follow-up by the GP".

Responses to provisional opinion

44. Mr A and Ms C, Dr B, and the medical centre were all given the opportunity to respond to relevant sections of my provisional opinion. Where appropriate, their responses have been incorporated into this report.

45. In addition, Mr A noted the impact his diagnosis has had on his mother, who "unexpectedly became [Mr A's] primary caregiver while still having to hold down a full time job as she is single. [Mr A's mother] is employed in a support work role and had to take time off during

[12] Cornerstone accreditation is a programme specifically designed by the Royal New Zealand College of General Practitioners to improve the quality of care provided to patients by general practices in New Zealand by setting standards relating to practice systems, practice and patient information management, quality improvement, and professional development.

the lockdown to protect [Mr A] even though she was an essential worker." Mr A added that since his diagnosis, his mother has been unable to travel to visit family like she used to, and that his mother attends all appointments with him, which requires her to take time off work.

46. Ms C commented:

> "We are very grateful for the support [Mr A] has received from [the public hospital] oncology and district nursing, along with support from ACC. [H]owever we also believe [Mr A] could have had the opportunity for a better outcome if he had received an appropriate standard of care."

47. Disappointingly, Dr B did not provide a response.

48. The medical centre told HDC that it found the contents, findings, and recommendations in the provisional report to be a "fair summation" of the case. It added:

> "The Board, Management, and Staff of the medical centre and in particular those staff of the medical centre, our general practice, have been deeply impacted, distressed and saddened for [Mr A]. … We again, extend our most sincere apologies to [Mr A] and his whānau for the level of care he experienced under [Dr B]. We are indeed, truly deeply sorry."

Opinion: Dr B — breach

Introduction

49. This is a sad case about a young man whose prognosis is now terminal after being diagnosed with an aggressive melanoma. As noted by my in-house advisor, GP Dr David Maplesden, it is not possible to determine conclusively whether specialist referral in April 2019 would have changed Mr A's subsequent clinical course. However, I have significant concerns about the care that Dr B provided to Mr A. I outline these concerns below.

Appropriateness of Dr B excising the lesion

50. After Dr B's initial assessment of the lesion, Mr A returned to the medical centre on 12 April 2019 to have the lesion removed by Dr B. Dr B said that he had offered Mr A a referral to a specialist for removal of the lesion, but Mr A had declined and opted for removal at the medical centre. Mr A said that specialist referral was not offered. Dr B documented: "Advised of options/Happy to get it done [here]."

51. My in-house advisor, GP Dr David Maplesden, commented:

> "I believe if [Dr B] was confident he could achieve primary closure of the excision having achieved 2mm margins it was reasonable to proceed with the excision in primary care. I believe many of my colleagues would have referred [Mr A] to a plastic surgeon or GP with special interest and experience in skin cancer for the excision given the size and

> nature of the lesion, but it seems likely [Dr B] had surgical skills given his clinical background."

52. Owing to the conflicting statements, and the notes indicating that there was some discussion about the options for management of the lesion, I cannot make a finding as to whether Dr B offered specialist referral at this first consultation on 12 April 2019. If specialist referral was offered, and Mr A had declined referral, then Dr B should have documented this. In any case, however, I accept Dr Maplesden's advice and consider that it was reasonable for Dr B to excise the lesion himself.

Dr B's actions following receipt of histology

53. The histology result, received at the medical centre on 17 April 2019, stated that the lesion was an invasive superficial spreading primary melanoma. The tumour thickness was 8.9mm and the Clark level of invasion was III. The histology also recommended a wider excision.

54. Dr Maplesden advised that this histology result was "significantly abnormal". He explained: "This is a significant lesion with high risk of sentinel lymph node metastasis (31% in Mr A's case according to a recognised prediction tool[13])." Dr Maplesden advised:

> "It is the responsibility of the clinician ordering the test ([Dr B]) to convey the result to the patient unless that responsibility has been explicitly passed on to another staff member … I believe best practice would have been notification to [Mr A] of his result as soon as it was received but acceptable practice would be to notify and discuss the result at the time of removal of sutures. If [Dr B] had no intention to inform [Mr A] of the result, this would be a severe departure from accepted practice. If [Dr B] had an intention to notify and discuss the result at the time of removal of sutures, I am mildly critical this intention was not documented in the clinical notes."

55. Dr B said that his usual practice was to inform patients of histology results when the sutures were removed. However, I note EN D's account, together with her contemporaneous note, that during the consultation for removal of the alternate sutures, Dr B was not available, and she had to make an appointment with Dr B to discuss the results with Mr A several days later. In my opinion, it was clear that Dr B did not inform Mr A of the histology results when the alternate sutures were removed on 26 April 2019.

56. I accept Dr Maplesden's advice and I am critical that Dr B did not inform Mr A of the histology result during this consultation or, if he was unavailable, ensure that another staff member did so. I also agree with Dr Maplesden that Dr B should have documented his intention with respect to informing Mr A of the histology results. In the context of a significantly abnormal histology result, these issues are concerning.

[13] https://www.mskcc.org/nomograms/melanoma/sentinel_lymph_node_metastasis Accessed 7 December 2020.

Discussion of histology results with Mr A

57. Dr B stated that he discussed the histology results with Mr A on 30 April 2019. Dr B documented, "Advised re histology …", but he did not document any details as to what was discussed. He noted that no further excision was required, and that Mr A was to return for a review in three months' time.

58. Dr B said that he vaguely recalled offering specialist referral at this stage; however, Mr A said that specialist referral was not offered. There is nothing documented about a possible referral or Mr A having declined that referral. I note Dr Maplesden's comment that a failure to document Mr A having declined the recommended specialist referral would be a severe departure from accepted practice. In any case, given that there is no documentation of a specialist referral being offered, and Dr B has said that he only "vaguely" recalls offering one, I prefer Mr A's account, and find it more likely than not that Dr B did not offer specialist referral at this consultation.

59. On the basis of that finding, I note Dr Maplesden's advice that Dr B's management of Mr A's confirmed diagnosis of high-risk melanoma "would be met with severe disapproval". Dr Maplesden advised:

> "[I]f the lesion was described as being non-malignant this was clearly an error. I would expect my colleagues to recognise this was potentially a high risk lesion that required specialist referral for wider excision, possibly preceded by sentinel node biopsy, and further management. I would expect a colleague who was unsure how to manage the lesion to seek specialist advice or consult local guidance (HealthPathways). I would expect the patient to be informed this was a skin cancer (melanoma) which requires urgent specialist review to discuss further management, and for referral for specialist care to be made with urgency and tracked to ensure timely management. … There was no referral made for specialist input. Review was advised in three months which could be regarded as a mitigating factor."

60. Dr B stated that he recognised the seriousness of the lesion. However, he failed to make a referral to a specialist and specifically documented that no further excision was required (when the histology report clearly recommended wider excision). These factors indicate that Dr B either failed to take sufficient care when reading the report, or did not appreciate the significance of the histology findings.

61. In addition, Mr A came away with the impression that his lesion was non-malignant. This implies that Dr B did not convey critically important information or, if he did communicate the histology results, it was not done so effectively in a manner that enabled Mr A to understand the information provided. The DHB's oncologist documented in November 2019 that Mr A said that he was told by Dr B that there was no cancer after the excision, and that no further treatment was required. If Dr B had appreciated the seriousness of the lesion, then he should have explained this to Mr A clearly, and told him that it warranted intensive monitoring and follow-up. I acknowledge that Mr A has Asperger's syndrome and is deaf in one ear — this made it even more important that Dr B explain clearly that the lesion was

cancerous and that specialist referral was recommended, and also for Dr B to check that Mr A understood the information he was being given.

62. However, notwithstanding my comments on the importance of effective communication, on the evidence before me, I find that Dr B did not inform Mr A that the lesion was skin cancer (melanoma).

63. I accept Dr Maplesden's advice and I consider that Dr B's management of Mr A's melanoma at this stage amounts to poor care. As a result, Mr A was denied the opportunity to receive timely and appropriate specialist input into what was a significant and, ultimately, aggressive disease.

Follow-up review

64. Dr B saw Mr A again on 2 August 2019 for a three-month review. Dr B documented advising Mr A to return for a further review in six months' time, and to have yearly reviews thereafter for three years. Again at this consultation, Dr B did not refer Mr A to a specialist.

65. Dr Maplesden noted that Mr A had at least a Stage IIc[14] disease at the time (stage IIc means (among other things) that the tumour presents an intermediate to high risk for spread or metastasis of the disease). Dr Maplesden also noted that local guidelines[15] recommend that patients with stage II or III disease are reviewed every four to six months for five years (other Australasian guidelines[16] recommend three- to four-monthly reviews for five years) and yearly thereafter. Dr Maplesden advised:

> "I am moderately critical that the advice provided to [Mr A] regarding follow-up was inconsistent with accepted practice, a mitigating factor being that some advice was provided. This consultation represents a missed opportunity to recognise that specialist referral should have been undertaken three months previously."

66. I accept Dr Maplesden's advice, and agree that Dr B should have advised Mr A to have more frequent follow-up reviews in line with the guidance. I also agree that this review represents a missed opportunity to recognise, and address, the earlier failures in Dr B's care. Had Dr B recognised the earlier failures, or at least recommended the appropriate frequency of follow-up reviews, Mr A may have received the requisite specialist input and treatment earlier than he did.

67. Dr Maplesden also advised that he would be moderately critical if Dr B did not examine the lymph nodes in Mr A's armpit (perform an axillary palpation) at this review. Dr B has not commented on whether he performed axillary palpation, and the clinical notes contain no documentation of palpation having been performed. In the absence of any documentation

[14] https://www.aimatmelanoma.org/stages-of-melanoma/stage-ii/ Accessed 7 December 2020
[15] HealthPathways section "Melanoma (Cutaneous)".
[16] Australian Cancer Network Melanoma Guidelines Revision Working Party. Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand. The Cancer Council Australia and Australian Cancer Network, Sydney and New Zealand Guidelines Group, Wellington (2008): https://www.health.govt.nz/system/files/documents/publications/melanoma-guideline-nov08-v2.pdf

recording this, I find that Dr B did not perform this examination. This is yet another concerning failure to take adequate care.

Conclusion

68. I have significant concerns about the care provided to Mr A by Dr B. Specifically:

- After viewing the histology results, Dr B:
  - Did not inform Mr A of the result at the time of suture removal or, if Dr B was unavailable, ensure that another staff member informed Mr A.
  - Did not document his intention with respect to informing Mr A of the results.
- On 30 April 2019, Dr B documented that no further excision was required (when the histology report clearly recommended wider excision), did not recommend or offer referral to a specialist, and failed to inform Mr A that the lesion was skin cancer.
- On 2 August 2019:
  - The frequency of follow-up reviews advised by Dr B was inconsistent with accepted practice.
  - There was a missed opportunity to recognise and correct the earlier failure to arrange specialist review.
  - Dr B did not perform an axillary palpation.

69. The cumulative effect of these failures is that Mr A did not receive appropriate or timely specialist care and treatment for the significant lesion with a high risk of metastasis — a risk that, sadly, was ultimately realised. In my opinion, Dr B's failures represent a failure to provide services with reasonable care and skill and, accordingly, I find that Dr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[17]

70. In addition, by not being informed that the lesion was skin cancer and that specialist referral was warranted after the histology results were received, Mr A was not provided with information that a reasonable consumer in his circumstances would expect to receive. Accordingly, Dr B also breached Right 6(1) of the Code.[18]

[17] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[18] 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 …"

Opinion: Medical centre — no breach

71. As a healthcare provider, the medical centre is responsible for providing services in accordance with the Code. Dr B was employed by the medical centre at the time of these events. As noted above, I have found that Dr B breached the Code.

72. My in-house clinical advisor, Dr Maplesden, advised:

> "I do not believe the deficiency in management [of Mr A's melanoma] relates to any deficiency in practice systems or processes but is rather an individual provider competency issue."

73. I also note Dr Maplesden's comments about other medical centre staff:

- EN D: "This consultation [with EN D on 5 April 2019] and associated documentation is of a high standard. [EN D] recognised the potential seriousness of [Mr A's] lesion and ensured timely review."
- Dr F: "[Mr A's] management by [Dr F] was consistent with accepted practice."

74. In this case, I consider that the errors identified were individual failings and did not indicate broader systems or organisational issues at the medical centre. Therefore, I consider that the medical centre did not breach the Code directly.

75. In addition to any direct liability for a breach of the Code, section 72 of the Health and Disability Commissioner Act 1994 (the Act) states that an employing authority is vicariously liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

76. At the time of events, Dr B was a doctor with 11 years of experience working in New Zealand as a doctor in general practice — although he was not vocationally registered. I also note Dr Maplesden's comment that the medical centre's policy on the management of test results was "adequate and, if followed by Dr B, should have resulted in timely and accurate notification of [Mr A's] result to him". In my view, it was reasonable for the medical centre to rely on Dr B's experience from working in a primary care setting in NZ for a number of years, and expect him to manage the significantly abnormal histology result appropriately. I do not consider that the medical centre, as an employing authority, could have reasonably done anything more to prevent these events from occurring. Accordingly, I do not find the medical centre vicariously liable for Dr B's breach of the Code.

77. I note with approval the changes that the medical centre has made following these events (set out in paragraph 78 below).

Changes made

78. Since these events, the medical centre has made, or will make, the following changes:

- As a priority, it is undertaking an audit of all patients who underwent a skin lesion excision by Dr B.
- Fortnightly meetings are now held for GPs (to discuss clinical case management issues), nursing staff (to discuss practice matters and education), and administrative staff (to discuss administrative processes and shared learning).
- The Test Results Policy (set out in Appendix B) was updated to include a new roster for clinical staff to check and follow up on test results, further options for annotating results, and more guidance in respect of managing potentially serious results and communicating results to patients.
- The whole practice meets for 15-minute huddles twice a week.
- It has strengthened its complaints management process.
- A new practice policy has been adopted whereby all decisions made by GPs that deviate from a specific recommendation by a specialist will be discussed with peers at a clinical meeting and recorded in the patient's clinical file.
- It will encourage a practice culture whereby any staff member should feel able to raise concerns about patient management or patient safety with any other staff member.
- It will allocate more time for orientation of locum doctors, and the duration of orientation time will depend on the past experience of the individual doctor.
- The CEO is meeting with clinicians twice annually to have a robust conversation about workloads.

Recommendations

79. I recommend that Dr B provide a written apology to Mr A for the failures identified in this report. The apology is to be sent to HDC, for forwarding, within three weeks of the date of this report.

80. I recommend that should Dr B re-apply for a practising certificate in New Zealand, the Medical Council of New Zealand consider whether a review of his competence is warranted based on the information contained in this report.

81. In response to the proposed recommendations in my provisional opinion, the medical centre:

a) Reported back to HDC on the results of its audit of the skin lesions excised by Dr B, and it detailed the steps it has taken to address issues identified.

b) Undertook and reported back to HDC on an audit of 57 histology reports that were ordered by, or reported to, Dr B to assess whether those histology results were managed appropriately, and detailed the steps it has taken to address issues identified.

Follow-up actions

82. 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.

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

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

Addendum

85. The Director of Proceedings decided to institute a disciplinary proceeding in the Health Practitioners Disciplinary Tribunal

Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from GP Dr David Maplesden:

> "Thank you for the request that I provide clinical advice in relation to the complaint from [Ms C] about the care provided by to her nephew, [Mr A], by [Dr B] of [the medical centre]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the following information:
>
> Complaint from [Ms C]
>
> Response from [the medical centre]
>
> GP notes [medical centre]
>
> Response and clinical notes [the DHB]
>
> 2. Complaint: [Mr A] attended [the medical centre] in April 2019 (aged [in his twenties] at the time) with an enlarging lesion on his back. The lesion was removed by [Dr B] at [the medical centre] on 12 April 2019 and histology result showed it to be a melanoma. When [Mr A] was informed of the results by [Dr B] on 30 April 2019 he perceived [Dr B] to be telling him the lesion was not malignant. There was no discussion regarding specialist referral or further surgery. In September 2019 [Mr A] developed a lump in his axilla and attended [the medical centre]. He was referred urgently to [the DHB] plastic surgical service and was found to have metastatic melanoma. [Ms C] is concerned that [Dr B's] management of [Mr A's] melanoma was deficient and this placed her nephew at greater risk of developing metastatic disease.
>
> 3. As guidance regarding accepted management of melanoma in New Zealand I have used the Australasian clinical practice guidelines for management of melanoma[1] and [the region's] HealthPathways section 'Melanoma (Cutaneous)'.
>
> 4. [Mr A] attended [the medical centre] for the first time on 5 April 2019. He was seen initially by [EN D] (statement provided). A 'new patient' assessment was undertaken including personal and family history (no family history of melanoma). Vital signs were recorded. The symptoms leading to presentation were: *Had a mole on back that has changes in size and tearing and bleeding a lot. First started 1 month ago … Lesion on back in 3cm by 2cm very large purple/deep red in colour.*

[1] Australian Cancer Network Melanoma Guidelines Revision Working Party. Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand. The Cancer Council Australia and Australian Cancer Network, Sydney and New Zealand Guidelines Group, Wellington (2008). https://www.health.govt.nz/system/files/documents/publications/melanoma-guideline-nov08-v2.pdf Accessed 7 December 2020

This is growing in size and changing shape. Plan for Urgent R/V today with [Dr B] as ? very suspicious lesion ? melanoma. Immediate review by [Dr B] was arranged.

Comment: This consultation and associated documentation is of a high standard. [EN D] recognised the potential seriousness of [Mr A's] lesion and ensured timely review.

5. [Dr B] reviewed [Mr A] on 5 April 2019. Consultation notes include:

Large fulminating lesion 3cm x 3cm on mid lower back

Central dark area

Has all the features of a keratoacanthoma

Came up about a month ago and has been growing rapidly since

Laterally an area of hyperkeratosis noted

Bleeds occ

Discussed lesion

Possibility of ca

Advised of options

Happy to get it done here

Consent form signed To be booked

A consent to minor surgery form was signed by [Mr A] (viewed) and removal scheduled for the following week.

Comment: The description of the lesion and its evolution was suspicious for melanoma but without having viewed the lesion I am unable to state whether or not keratacanthoma (KA) was a reasonable alternative diagnosis. Many GPs are now competent in the use of dermoscopy to assist in the diagnosis of skin lesions but I would not regard the failure to undertake dermoscopy as a departure from accepted practice. KAs are generally non-pigmented but can grow rapidly. However, most importantly [Dr B] recognised the lesion required removal. [EN D] notes in her statement that she was somewhat surprised [Dr B] agreed to remove the lesion rather than referring, given its large size and apparent nature. [Dr B] reassured her he had experience with such surgery. I note in [the medical centre's] response that [Dr B] had previously trained overseas as a … surgeon. The cited HealthPathways guidance indicates a high concern lesion or suspected melanoma should be completely excised with 2mm margins. I believe if [Dr B] was confident he could achieve primary closure of the excision having achieved 2mm margins it was reasonable to proceed with the excision in primary care. I believe many of my colleagues would have referred [Mr A] to a plastic surgeon or GP with special interest and experience in skin cancer for the excision given the size and nature of the lesion, but it seems likely [Dr B] had surgical skills given his clinical

background. The consent form does not list any specific complications of minor surgery but gives a general comment that risks have been discussed.

6. Surgery was performed by [Dr B] on 12 April 2019. Notes include:

Informed consent

LA to skin

[EN D] assisting

Lesion excision

Flap created adjacent to it and skin closed with 3/0 int nylon sutures

Advised re care of wound

No lifting stretching etc

Tcb Mon for check

Ros in 2 weeks

[EN D] assisted with the surgery and does not describe any particular issues with the procedure. The specimen was sent for histology.

Comment: The procedure is adequately documented and appears to have been undertaken in an acceptable manner.

7. [Mr A] returned for change of dressing on 15 April 2019 (undertaken by [EN D]) and the wound was noted to be healing well. He returned for removal of alternate sutures on 26 April 2019 and the wound was again noted to be healing well. [EN D] observed that the histology report was filed and was annotated by [Dr B] as *superficial spreading melanoma* [audit shows the result was received and filed on 17 April 2019]. She established [Dr B] had not communicated the result to [Mr A] and practice policy was for the GP ordering the test to convey such results. [Dr B] was not available that day and [EN D] scheduled an appointment in three days for removal of remaining sutures and discussion of the result.

Comment: The histology result was significantly abnormal (see below). [Dr B] has not provided a response and it is not possible to determine when or if he was going to convey the result to [Mr A]. It is the responsibility of the clinician ordering the test ([Dr B]) to convey the result to the patient unless that responsibility has been explicitly passed on to another staff member. In this case, there is no documentation to suggest [Dr B] requested another staff member convey the result to [Mr A], and the result appears to have been filed with no documented intention of further action. I cannot exclude the possibility that [Dr B] intended to review [Mr A] two weeks following the excision when he had his sutures removed. I believe best practice would have been notification to [Mr A] of his result as soon as it was received but acceptable practice would be to notify and discuss the result at the time of removal of sutures. If [Dr B] had no intention to inform [Mr A] of

the result, this would be a severe departure from accepted practice. If [Dr B] had an intention to notify and discuss the result at the time of removal of sutures, I am mildly critical this intention was not documented in the clinical notes. The practice policy on management of tests results (2016 version and current version) have been reviewed. The earlier version (in force at the time of the events in question) is adequate and, if followed by [Dr B], should have resulted in timely and accurate notification of [Mr A's] result to him. The revised version has more specific guidance around tracking of results and handling of results when the requestor is absent and is an improvement on the earlier version.

8. [Mr A] returned for removal of remaining sutures and discussion of his histology result. The wound had healed well and was dressed by [EN D]. [Dr B] has documented: *Post excision rev and disc of histology. Wound looks clean and healing well. All sutures to come out today. Advised re histology. At excision when one of margins recognised to be close to edge additional sliver of issue removed and included in specimen. At this stage no further excision to be done.*

Will be reviewed in 3 months. Both axillae checked and free of glands.

9. The histology report (synoptic) is included in full as Appendix 1. The lesion was described as a superficial spreading melanoma with tumour thickness (Breslow) 8.9mm and Clark Level III invasion. *The tumour is pedunculated and invades to the neck of the stalk*. Surgical margins were clear — in-situ radial margin by 1mm, invasive radial margin by 9mm and deep margin by 12mm. An additional strip of skin provided was negative for melanoma [it is presumed based on [Dr B's] notes that this was the additional strip of skin excised from the narrowest radial margin]. The report includes: *A wider excision is recommended* with the summary statement*: Skin mid-back — Primary cutaneous melanoma, invasive, superficial spreading TNM Stage … pT4b pNx.*

10. This is a significant lesion with high risk of sentinel lymph node metastasis (31% in [Mr A's] case according to a recognised prediction tool[2]). The cited HealthPathways guidance states:

Refer all diagnosed invasive melanomas for wide local excision, even where general practitioners are capable of performing the excision. It is important that invasive melanoma are removed by a specialist to ensure:

- *discussion of sentinel node biopsy, where relevant.*
- *the appropriate margin is taken, which depends on several variables, not just Breslow thickness.*
- *comprehensive patient information is provided.*
- *any suitable patient trials are considered e.g., treatments, vaccines.*

[2] https://www.mskcc.org/nomograms/melanoma/sentinel_lymph_node_metastasis Accessed 7 December 2020

The cited Australasian guidance includes:

- *After initial excision biopsy; the radial excision margins, measured clinically from the edge of the melanoma, be: (pT4) melanoma > 4.0mm: margin 2cm.*
- *For patients with deeper invasive melanomas (> 1mm thick), referral to a specialized melanoma centre should be considered to ensure that best practice is implemented and for the collection of national outcome data. This may present logistic difficulties in regional and remote areas, but specialist care is recommended*
- *Sentinel node biopsy (SNB) is an important prognostic factor for melanoma, but there is debate about its use in treatment. SNB should be considered in patients with primary melanomas > 1mm thick or Clark IV, who want to be as informed as possible about their prognosis. SNB should be performed before wider local excision.*

11. It is not possible for me to determine how the histology result was presented to [Mr A] by [Dr B], but if the lesion was described as being non-malignant this was clearly an error. I would expect my colleagues to recognise this was potentially a high risk lesion that required specialist referral for wider excision, possibly preceded by sentinel node biopsy, and further management. I would expect a colleague who was unsure how to manage the lesion to seek specialist advice or consult local guidance (HealthPathways). I would expect the patient to be informed this was a skin cancer (melanoma) which requires urgent specialist review to discuss further management, and for referral for specialist care to be made with urgency and tracked to ensure timely management. [Dr B] appears to have reassured [Mr A] that no further surgical management was indicated despite accepted guidance indicating otherwise. There was no referral made for specialist input. Review was advised in three months which could be regarded as a mitigating factor. However, I believe [Dr B's] management of [Mr A] in relation to the confirmed diagnosis of his high risk melanoma would be met with severe disapproval by my peers. I do not believe the deficiency in management relates to any deficiency in practice systems or processes but is rather an individual provider competency issue.

12. [Mr A] returned for review after three months as advised. He was seen by [Dr B] on 2 August 2019. Notes read: *Here for rev of wound 3m after excision, superficial spreading melanoma R lower back. Wound healed Minimal scar tissue. No signs of recurrence. Advised rev in 6 months and if ok thereafter yearly for 3 years.*

Comment: The extent of [Dr B's] review of [Mr A] is unclear. I would expect palpation of axillae to have been performed in addition to checking the excision site for recurrence and general skin check. The cited Australasian guidance includes: *The main purpose of follow-up is to detect recurrences early so that early treatment can be undertaken. This assumes that earlier treatment is likely to*

result in improvements in regional disease control, quality of life and survival. Therefore, follow-up should be mainly prognosis-oriented but should also include the detection of new invasive melanomas. The reported incidence of these ranges from 2–8%. The guidance recommends instruction in patient self-examination as an important part of follow-up. While there is debate over whether formal follow-up and early diagnosis of recurrence translates into improved survival rates, the Australasian guidelines recommend patients with stage II or III disease ([Mr A] had at least Stage IIc[3] disease at this stage) are followed up three-monthly or four-monthly for five years and yearly, with HealthPathways recommending*: 4 to 6 monthly for 5 years. The prognosis within this stage varies considerably, hence the range of recommendation. All patients will then have yearly follow-up.* I would be moderately critical if [Dr B] did not perform axillary palpation as part of his assessment of [Mr A] on 2 August 2019. I am moderately critical that the advice provided to [Mr A] regarding follow-up was inconsistent with accepted practice, a mitigating factor being that some advice was provided. This consultation represents a missed opportunity to recognise that specialist referral should have been undertaken three months previously.

13. [Mr A] returned to [the medical centre] on 27 August 2019 and was seen by [Dr F]. [Mr A] had noticed a lump in his right axilla three days previously. [Dr F] palpated a 4.5 x 2.5 cm oval lump in the right axilla/upper lateral chest wall. She noted the history of melanoma and made an urgent referral for surgical review. DHB surgeon [Dr E] triaged the referral and organized urgent ultrasound of the lesion which confirmed axillary lymphadenopathy. At review by [Dr E] on 21 October 2020, [Mr A] was noted to have extensive palpable lymph nodes in his axilla and dermal recurrence near the scar from the initial melanoma excision. [Mr A] then underwent CT and CT PET staging showing disease isolated to the dermal recurrences on his back and lymph nodes in his axilla. Following MDM discussion he was offered surgery or immunotherapy as initial management. He opted for surgery (axillary clearance and excision of dermal metastases performed 13 November 2019) which maintained the option of immunotherapy should disease recur. Unfortunately, by mid-December 2019 it was evident he had recurrent dermal disease and immunotherapy was commenced. [Dr E] included the following comments in her report to HDC:

- *On 1st meeting [Mr A], he told me he was not aware the skin lesion was cancer. His recollection was that it was a benign growth, however I note the GP notes state 'melanoma'. His GP at the time brought him back for a discussion of histology and a 3 month review. No referral to Specialist services was documented.*
- *[Mr A's] chance of having lymph node involvement at diagnosis was 32% according to the Memorial Sloan Kettering Nomograms. He should have been referred at diagnosis for a sentinel node biopsy and complete staging.*

[3] https://www.aimatmelanoma.org/stages-of-melanoma/stage-ii/ Accessed 7 December 2020

An earlier referral may have resulted in a different outcome. Although it is now evident [Mr A] has a very aggressive melanoma.

Comment: [Mr A's] management by [Dr F] was consistent with accepted practice. It is not possible to say with any certainty that specialist referral in April 2019, which was clinically indicated, would necessarily have altered [Mr A's] subsequent clinical course but he was denied the opportunity for earlier intervention — either surgery and/or immunotherapy.

14. Recommendations

(i) I believe there may be competency issues regarding [Dr B's] knowledge of melanoma management. I recommend consideration is given to referral of [Dr B] to the Medical Council of NZ.

(ii) I recommend the practice undertake an audit of patients who underwent a skin lesion excision by [Dr B] during his tenure to confirm there are clinically appropriate follow-up arrangements in place for those patients.

(iii) Locum doctors should be encouraged to access the local clinical HealthPathways and demonstration of the Pathways should form part of the locum orientation process.

15. Addendum 11 March 2021

[Dr B] has provided an e-mailed response dated 1 March 2021. He notes the following:

(i) [Dr B] has only sketchy recollection of [Mr A].

(ii) [Dr B's] usual practice is to convey histology results at the time the patient attends for removal of sutures and he believes he would have discussed the results, including the seriousness of the histology report, at the time alternate sutures were removed (see s7) although clinical notes indicate discussion of the results was held a few days later (30 April 2019) when [Mr A] returned for removal of the remaining sutures.

(iii) [Dr B] states in his response: *I also recognize that this needed further referral. I have a vague recollection that this man declined further referral and was happy to be monitored in the practice despite advice; remembering that he was offered referral in the first instance and he declined and opted for lesion removal in the rooms. This is not documented and might have resulted from being in a busy practice and slipping my mind walking between rooms.*

This is a critical issue. If [Mr A] made an adequately informed decision to decline specialist follow-up, [Dr B] cannot be faulted for not making a referral as this action required consent of the patient. Adequately informed consent would have included discussion of recommended practice and the reasons for this (nature of

histology result, consideration of sentinel node biopsy). This form of follow-up could not be undertaken in primary care (no facility for sentinel node biopsy). [Dr B's] clinical notes dated 30 April 2019 indicate histology was discussed at this appointment. There is no reference to the accepted recommendations for follow-up being discussed and declined by [Mr A]. Such discussion, particularly if the patient declined this important follow-up, should have been documented and the failure to do so represents a severe departure from accepted practice in terms of clinical documentation. [Mr A's] recollections of the information with which he was provided as conveyed to [Dr E] (see s13) indicate either the information regarding implications of [Mr A's] histology and appropriate follow-up were not discussed, or it was not discussed in a way that enabled [Mr A] to make an adequately informed decision.

(iv) Other than introducing alternative scenarios which have been discussed above, [Dr B's] response does not alter my initial advice."

Appendix 1: Histology report on lesion excised from Mr A's back on 12 April 2019

MACRO
Skin Mid Back.
The specimen consists of an ovoid piece of skin measuring 27 x 23 x 12 mm.
There is a raised keratotic lesion on the surface measuring 27 x 18 mm.
Also received in the same container a strip of skin measuring 32 x 3 x 12 mm.

Key to sections
A-B: Nodular lesion
C: Extra piece of skin
A. 1/ ; B. 1/ ; C. 4/TR ;
Macroscopy performed by

MICRO
Diagnosis: Primary melanoma, invasive
Subtype: Superficial spreading melanoma
Tumour thickness (Breslow): 8.9 mm
Level of invasion (Clark): III
Dermal mitotic rate: 4 per mm2
Additional comments: The tumour is pedunculated and invades to the neck of the stalk.

The additional strip of skin is negative for in situ or invasive melanoma

Ulceration: Present (extent: 8 mm)
Intermediate/late regression: Absent
Tumour-infiltrating lymphocytes: Absent
Desmoplasia: Absent
Lymphovascular invasion: Absent
Perineural/intraneural invasion: Absent
Microsatellites: Absent
Precursor naevus: Absent

Excision margins:
In-situ radial margin: Clear, closest skin edge 1 mm
Invasive radial margin: Clear, closest skin edge 9 mm
Deep margin: Clear, distance to tumour 12 mm
A wider excision is recommended.

Representative slides were reviewed with who agrees with the diagnosis.

SUMMARY
Skin mid back - Primary cutaneous melanoma, invasive, superficial spreading
TNM Stage (AJCC 8th ed.): pT4b pNx

Appendix B: Medical centre policies

Policy on management of test results

The medical centre's policy on the management of test results (the Test Results Policy) in place at the time of events stated:

> "The practitioner who orders or requests a test or investigation is primarily responsible for ensuring that the result is followed-up.
>
> … To assist in communicating with clients, once viewed, results may be annotated in one of the following ways:
>
> … TCI — (To Come In) the patient should be seen to discuss the results (a letter should be sent or a phone call made to ensure this happens)."

Following these events, in January 2020 the medical centre updated the Test Results Policy to include a new roster for clinical staff to check and follow up on test results, further options for annotating results, and more guidance in respect of managing potentially serious results and communicating results to patients.

Appendix C: Relevant standards

The Medical Council of New Zealand's publication *Good medical practice* (December 2016) states:

> "When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:
>
> - adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate
> - providing or arranging investigations or treatment when needed
> - taking suitable and prompt action when needed, and referring the patient to another practitioner or service when this is in the patient's best interests."