Plastic and Reconstructive Surgeon, Dr A

A Plastic Surgery Clinic

A Report by the

Health and Disability Commissioner

(Case 14HDC00132)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of Contents

Executive summary

1. On 11 June 2012, Mr B saw plastic and reconstructive surgeon Dr A at a plastic surgery clinic (the Clinic) on referral from a general practitioner (GP). Mr B presented with lesions on his left nasal ala (nose) and scalp, and had a family history of skin cancer. Dr A considered that the lesions on Mr B's left nasal ala and scalp were suspected basal cell carcinomas (a form of skin cancer), and planned to perform surgery in the coming weeks.

2. On 8 August 2012, Dr A performed incisional biopsies of the lesions on Mr B's left nasal ala and scalp, and excisional biopsies of lesions on Mr B's left cheek and right lumbar (lower back) region, and sent the biopsies for histology testing. On Tuesday 14 August 2012, Mr B returned to the Clinic for removal of his sutures. The nursing note of the consultation states that the histology report was not available at that time and that Mr B was advised to contact the Clinic by the end of the week if he had not heard anything from Dr A. However, Mr B recalls being instructed to wait for further advice.

3. On 15 August 2012, the histology report was sent to the Clinic. The result showed that the left nasal ala and scalp lesions were basal cell carcinomas. Mr B required further follow-up, but he was not informed of the histology results and no follow-up was arranged.

4. In November 2013, Mr B consulted GP Dr C to arrange vaccinations for upcoming overseas travel. Dr C noted three areas on Mr B's scalp suspicious of basal cell carcinoma, and arranged to see the 2012 histology report. A week later, Mr B had a further consultation with Dr C, who informed him that the 2012 histology report had shown basal cell carcinoma and, following examination, Dr C referred Mr B to a skin specialist for surgery.

5. The Commissioner found that, by failing to inform Mr B of his abnormal test results, Dr A breached Right 6(1)(f) of the Code.[1] In addition, Dr A failed to provide services with reasonable care and skill by not arranging the follow-up care that Mr B required, and breached Right 4(1) of the Code.[2]

6. The Commissioner considered that the lack of safeguards in the Clinic's systems for handling patient test results directly contributed to Mr B receiving suboptimal care. By failing to ensure that its systems were sufficiently robust, the Clinic failed to provide services to Mr B with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

[1] Right 6(1)(f) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including the results of tests."
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Complaint and investigation

7. The Commissioner received a complaint from Mr B about the services provided to him by plastic and reconstructive surgeon Dr A at the Clinic. The following issues were identified for investigation:

- *Whether Dr A provided Mr B with services of an appropriate standard.*
- *Whether the Clinic provided Mr B with services of an appropriate standard.*

8. An investigation was commenced on 22 May 2014.

9. The parties directly involved in the investigation were:

Dr A	Plastic and reconstructive surgeon
Mr B	Consumer
The Clinic	Plastic surgery clinic

10. Information was also reviewed from general practitioners Dr C and Dr D.

11. Independent expert advice was obtained from plastic and reconstructive surgeon Dr Gary Duncan (**Appendix A**).

Information gathered during investigation

Background

12. On 14 May 2012, Mr B, aged 52 years at the time, visited general practitioner (GP) Dr D[3] about a bleeding patch on his scalp. The clinical notes record that Mr B presented with a lesion on his left nasal ala,[4] a lesion at the top of his scalp, and a family history of skin cancer. That day, Dr D referred Mr B to plastic and reconstructive surgeon Dr A at the Clinic[5] for further investigation and management. In her referral letter to Dr A, Dr D queried the possibility that the lesion on Mr B's left nasal ala was a basal cell carcinoma[6] or squamous cell carcinoma in situ.[7]

Biopsies — 2012

13. On 11 June 2012, Mr B had his first consultation with Dr A. The clinical notes record that, on examination, Dr A considered that the lesions on Mr B's left nasal ala and scalp were suspected basal cell carcinomas. Dr A also noted concern about lesions on Mr B's cheeks and back. He planned to undertake biopsies of the lesions in the following weeks.

[3] Dr D was not Mr B's regular GP.
[4] The lateral surface that flares out from the opening of the nose.
[5] Dr A is a director of the Clinic.
[6] A common type of skin cancer that only rarely spreads to other parts of the body.
[7] A common type of skin cancer derived from the squamous cells, the flat cells that make up the outside layer of the skin, and confined to the epidermis, the top layer of the skin.

14. On 8 August 2012, Dr A performed incisional biopsies[8] of the lesions on Mr B's left nasal ala and scalp, and excisional biopsies[9] of lesions on Mr B's left cheek and right lumbar (lower back) region. The biopsies were performed under local anaesthetic, and removal of the sutures was scheduled for the following week. The excised tissue was sent for histology testing.

15. On 14 August 2012, Mr B returned to the Clinic for removal of his sutures. The nursing note of this consultation records that the wounds were clean and dry with no signs of infection. It also states that the histology report was not available at that time and that Mr B was advised to contact the Clinic by the end of the week if he had not heard anything from Dr A.

16. In contrast, Mr B told HDC that he "was instructed to wait for further advice if the biopsies showed up anything requiring further action and was assured they would contact me if necessary".

17. The following day, on 15 August 2012, the histology report became available. It showed that the left nasal ala and scalp lesions were basal cell carcinomas.[10] Although Mr B required further surgery, he was not informed of the results, and there is no record that he had any further contact with Dr A or the Clinic.

Subsequent treatment — 2013

18. On 13 November 2013, Mr B presented to GP Dr C at an accident and medical clinic to organise vaccines for upcoming overseas travel. According to the clinical records, Mr B told Dr C that he had "some pre cancerous things cut out [of his] scalp a year ago, one bleeds still". Dr C recorded that, on examination, there were three areas on Mr B's scalp suspicious of basal cell carcinoma. Dr C recorded that he would request the 2012 histology report before seeing Mr B again for a thorough skin cancer check.

19. On 15 November 2013, Dr C recorded that he had reviewed the 2012 histology report and text messaged Mr B to let him know that he would require a full examination and skin cancer treatment.

20. On 20 November 2013, Mr B had a consultation with Dr C, who informed him that the 2012 histology report had showed basal cell carcinoma and, following examination, Dr C referred Mr B to a skin specialist. The skin specialist subsequently performed Mohs surgery (microscopically controlled surgery used to treat common types of skin cancer). Mr B later underwent further surgery and, at the time he made his complaint, anticipated that future surgery would also be required.

[8] A surgical procedure where a small part of a lesion is removed to identify its composition/abnormality.
[9] A surgical procedure where an entire area of abnormality is removed.
[10] The other lesions were benign and did not require further follow-up.

Systems in place at the Clinic

Usual practice in 2012

21. Dr A advised HDC that he uses the software systems Incisive Specialist Practice Manager[11] as his practice management software, and EDI (Electronic Data Interchange)[12] to manage patient test results and correspondence. He explained that, when test results become available, they need to be signed off electronically (at which point they are entered into the patient's electronic clinical notes), and that he is the only person authorised to sign them off. He said that, in 2012, his practice was to assess test results when he signed them off and, if the patient required further treatment, to print out the test results, call the patient to explain the results, and fill out a Surgical Plan Sheet detailing the follow-up required. He further stated that, if the test results were available at the time of suture removal, the nurse normally informed the patient of the results, and that he (Dr A) was usually on site to discuss abnormal results at that time.

22. Dr A told HDC that there were no written policies regarding informing patients of, or following up, test results at the Clinic at the time of these events.

Mr B's histology results

23. Dr A said that he cannot remember or explain what happened regarding Mr B's histology results. Dr A stated that he signed off the histology results, but said that the relevant software does not enable him to see when he did so. He explained that he was out of the office at a conference at the time of these events and that he may have signed off the histology results remotely. He stated:

> "That being the case, the report would have been printed out at [my office] and ready for my attention on return … I may have omitted to print the report out and did not act on it as I should have on my return to [the office]. Alternatively, I may have printed the report out and then it was misfiled. Either way, I should have ensured that proper practice was followed and that the necessary further surgery was arranged."

Changes made

24. Dr A advised HDC that he had had concerns in the past about how robust the system was for following up patient test results, and had requested that changes be made to the software so that, when test results were signed off, a dropdown menu appeared with three options ("no further treatment required", "recall for further treatment" and "phone patient to discuss"). Dr A said that the modifications were not able to be integrated into the computer software. He stated that, as an alternative, he instituted a rubber stamp process (discussed further below).[13]

25. Dr A told HDC that the following changes have now been made to the Clinic's systems for managing patient test results:

[11] Software used for managing specialist practices.
[12] An electronic method for computer systems to exchange information.
[13] This system was introduced shortly after these events occurred but before Dr A became aware that Mr B had not received his test results or required follow-up.

a. All test results are copied to the patient's GP or referring doctor.

b. All test results are printed irrespective of whether the patient requires further treatment.

c. Dr A now signs off test results only from the office (rather than remotely), in order to ensure that they are appropriately printed and actioned.

d. The practice nurse stamps the printed test results with a rubber stamp, which has tick boxes titled "No further action", "Recall" and "Phoned", along with a space to write comments. The stamped and printed test results are then given to Dr A to determine the further action required.

e. Test results that have been stamped and completed with instructions are scanned into the patient's electronic clinical records.

f. The Clinic now receives a printed copy of test results from the laboratory itself, and the printed copy is either given to the patient at the time of suture removal or sent to the patient.

g. At the time of these events, a handwritten logbook was used to keep a record of every specimen taken and sent for testing. The logbook now includes a further column to document whether the test results have been seen and actioned appropriately. A practice nurse checks the logbook weekly.

26. These processes are set out in the Clinic's written policy titled "Policy for Handling, Care and Reporting of Surgical Specimens" (the Policy), which has been introduced since these events occurred.

Further information

27. Dr A told HDC:

> "I am very sorry for the failure to follow up on [Mr B's] results and the subsequent surgery and reconstruction that he has had to undergo … I have made the changes described [above] and I believe these provide several safeguards to avoid similar such problems in the future."

Response to provisional report

28. Dr A and the Clinic accepted the findings and recommendations made in the provisional report in relation to the care they provided.

29. Having reviewed the "Information gathered during investigation" section of the provisional report, Mr B made a number of comments, which have been taken into account in my consideration of this investigation.

30. Mr B also stated:

> "…the failure to be notified of required surgery in a timely manner meant far more invasive, painful and time-consuming processes were required to correct the situation."

Opinion: Dr A

Clinical care provided at the time of biopsies — No breach

31. Mr B presented to Dr A in June 2012 on referral from Dr D for lesions suspicious of basal cell carcinoma. Dr A reviewed Mr B and, in August 2012, performed excisional and incisional biopsies of a number of lesions.

32. In assessing the care provided by Dr A, I sought independent expert advice from plastic surgeon Dr Gary Duncan. Dr Duncan advised me that the clinical care provided by Dr A when he assessed Mr B and performed the biopsies was appropriate, and I accept that advice.

Test result requiring follow-up — Breach

33. On 15 August 2012, Mr B's histology report became available. It showed that the left nasal ala and scalp lesions were basal cell carcinomas. As acknowledged by Dr A, Mr B should have undergone further surgery at that time. However, he was not informed of the results and no follow-up was organised. It was not until over a year later, when another doctor requested the histology results from the laboratory, that Mr B became aware of the results and appropriate follow-up was organised.

34. As this Office has stated on numerous occasions, doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal results. Primary responsibility for that duty of care lies with the clinician who ordered the test, in this case, Dr A.[14]

35. I note that, whereas the clinical notes record that at the time his sutures were removed on 14 August 2012 Mr B was told to contact the Clinic if he had not heard from Dr A by the end of the week, Mr B recalls that he was assured he would be contacted if further action was required. In my view, it is important that patients are encouraged to be partners in their own care and to call a medical practice if they have any questions about their treatment. However, irrespective of what Mr B was told about whether or not to contact the Clinic, the responsibility to follow up test results lies with the referring clinician rather than the patient.[15]

36. Dr A does not dispute that he should have informed Mr B of his histology results and organised further surgery. While Dr A does not remember how the error occurred, he stated that it is likely that he signed off the test result remotely and either did not print the histology report as would be his normal practice, or he printed the histology report and it was subsequently misfiled. In any event, Dr A accepts that he signed off the histology report but did not take further action in that Mr B was not informed of his abnormal test results and did not have appropriate follow-up organised.

37. By failing to inform Mr B of his abnormal test results, Dr A breached Right 6(1)(f) of the Code.

[14] See, for example, 10HDC01419 and 12HDC00413, available at www.hdc.org.nz.
[15] As previously stated in, for example, 10HDC01419, available at www.hdc.org.nz.

38. In addition, Dr A failed to provide services with reasonable care and skill by not arranging the follow-up care that Mr B required, and breached Right 4(1) of the Code.

Opinion: The Clinic

Systems for handling patient test results — Breach

39. Medical practices have a responsibility to ensure that they have effective systems in place for the handling of incoming patient test results and follow-up. In my view, it is essential that those systems are robust and support clinicians in providing good quality care.

40. Dr A told HDC that there were no written policies regarding informing patients of, or following up, test results at the Clinic at the time of these events. He stated that his usual practice was to print test results that required further action at the time he signed them off, and to organise follow-up at that stage. He also stated that patients were advised of histology results at the time of suture removal if they were available which, in this case, did not occur.

41. It appears that a number of factors may have contributed to the failure in this instance, including:

    a. The histology results were not available at the time Mr B's sutures were removed and, therefore, the practice nurse was unable to inform Mr B of the results at that time.

    b. Dr A was away at a conference when the histology results became available and, therefore, at the time he signed them off, either he did not print them or he printed them and they were misfiled.

    c. Once Dr A signed off the histology report, there was no additional process or safeguard in place at the Clinic at the time to check and confirm that the patient had been informed of the result and appropriate follow-up had been organised.

42. In my view, the systems in place at the Clinic at the time of these events were insufficiently robust. In cases such as Mr B's, where the histology result was not available at the time of suture removal, the Clinic's systems were largely reliant on Dr A taking appropriate action at the time he signed off the results. There was no alert or recall placed on Mr B's electronic patient records, and no system in place that required Dr A or another staff member to check that patients requiring follow-up had received it. As such, there were no safeguards in place to ensure that if an error did occur at one point during the process (eg, the histology report was not printed at the time of sign-off or the printed histology report was misfiled), it was picked up at another point in the process.

43. In my view, the lack of safeguards in the Clinic's systems for handling patient test results directly contributed to Mr B receiving suboptimal care. I consider that, by failing to ensure that its systems were sufficiently robust, the Clinic failed to provide

services to Mr B with reasonable care and skill and, therefore, breached Right 4(1) of the Code.

44. Dr Duncan noted that written policies do not, on their own, guarantee good care, and I agree. However, I do consider that written policies can assist in ensuring that processes are clear and readily accessible to all staff which, in turn, can support clinicians in providing good care. The Clinic has made a number of changes to its systems for handling patient test results, including introducing a comprehensive written policy, since these events occurred. I note Dr Duncan's view that the systems in place at the Clinic now "meet the highest standards of care" and that no further changes are required.

Recommendations

45. In accordance with the recommendation made in the provisional report, Dr A provided a written apology to Mr B for his breaches of the Code, which has been forwarded to Mr B.

46. I recommend that the Clinic provide a written apology to Mr B for its breach of the Code. The apology should be sent to HDC for forwarding to Mr B within three weeks of the date of this report.

47. I recommend that, within three months of the date of this report, the Clinic conduct an audit of its patient records to ensure that all patients who have had abnormal test results since August 2012 have been informed of those results and, if necessary, had appropriate follow-up organised, and report back to HDC on the outcome.

Follow-up actions

48.
- 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 the District Health Board, and they will be advised of Dr A's name.

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

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from plastic and reconstructive surgeon Dr Gary Duncan:

"My name is Gary Malcolm Duncan, MBChB, FRACS (Plastic). I have been asked to provide an opinion to the Health and Disability Commissioner on case number 14/00132 ([Mr B]). I have read and agreed to follow the Commissioner's guidelines for independent advice.

[…] I am a duly registered medical practitioner currently holding an annual practising certificate. I hold vocational registration in the section of Plastic and Reconstructive Surgery. I trained from 1974 to 1979 in plastic and reconstructive surgery in Australia and New Zealand and attained my Royal Australasian College of Fellowship at the end of 1979. I then completed four years of post graduate training in Australia and the United Kingdom. I have been employed as a Consultant Plastic Surgeon at the Wellington Regional Plastic Reconstructive and Burns Unit since 1981 and have been in part time private practice since 1984, practising within the entire spectrum of plastic surgery.

[Expert advice required and list of documents relied on redacted for brevity.]

Background

On 14/5/12 [Mr B] visited his general practitioner (GP), [Dr D], about a bleeding patch on his scalp. The clinical notes record that [Mr B] presented with a lesion on his left nasal alar, the lesion on the top of his scalp and a family history of skin cancer. [Dr D] referred [Mr B] to [Dr A] at [the Clinic] for further investigation and management.

Enclosure 1 is a letter from [a medical centre] dated 4/5/12. It is addressed to 'Plastic Surgeon' and is unsigned, nor is there any indication as to who is the author. It does note that [Mr B] is not a registered patient of [this medical centre] but does not record who his registered general practitioner is.

On 11/6/12 [Mr B] had his first consultation with [Dr A]. The clinical notes record that on examination [Dr A] considered that the lesions on [Mr B's] left nasal alar and scalp were suspected basal cell carcinomata. [Dr A] also noted concern about lesions on [Mr B's] cheeks and back. He planned to undertake surgery in the following weeks.

On 8/8/12 [Dr A] performed incisional biopsies of the lesions on [Mr B's] left nasal alar and scalp and excision biopsies of lesions on [Mr B's] left cheek and right lumbar region.

In his complaint [Mr B] stated that [Dr A] and the receptionist at [the Clinic] assured him that they would contact him if the histology report following the biopsies indicated that further action was required. On Tuesday 14/8/12 [Mr B] returned to [the Clinic] for removal of his sutures. The nursing note of this consultation records that the histology report was not available at the time and that [Mr B] was advised to contact [the Clinic] by the end of the week if he had not

heard anything from [Dr A]. On 15/8/12 the histology report showed that the biopsied left nasal alar and scalp lesions were basal cell carcinomata.

The histology report confirmed that the lesions extended to biopsy margins (as expected for an incisional biopsy). The report further noted that the lesion of the left lumbar region was a compound naevus and the lesion of the left cheek was sebaceous hyperplasia.

[Dr A] advised HDC that in 2012 his practice was to electronically sign off histology results after which they were entered into the patient's clinical record. In [Mr B's] case, [Dr A] signed off the histology report but did not inform [Mr B] of the results, organise follow-up or take any further action. Over a year later [Mr B] presented to another GP who, following examination, referred him to [a skin specialist]. [The skin specialist] subsequently performed Mohs surgery. [Mr B] later required further surgery and at the time he made his complaint anticipated future surgery would also be required.

Expert Advice Required

The adequacy of the clinical care provided by [Dr A], including the appropriateness of the procedures he undertook.

The clinical care provided by [Dr A] was appropriate in the context of the clinical presentation of the patient, [Mr B], at the time of presentation (11/6/12). Where dermal lesions are considered to be basal cell carcinoma, excisional biopsy is appropriate if the lesion is small and excision would not result in significant deformity.

For larger lesions or those which would require a significant reconstruction or situated in difficult anatomical sites, incision biopsy is appropriate to confirm the diagnosis prior to undertaking more major resection. This was appropriate in this situation. The presence of sebaceous hyperplasia can make clinical diagnosis of BCC difficult. This is confirmed by the fact that the lesion from the left cheek was sebaceous hyperplasia rather than a BCC.

The lesions of scalp and nose were confirmed to be basal cell carcinomata, excision incomplete as expected for an incisional biopsy. Unfortunately the histology result was not available at the time of his postoperative visit. (I would note that this is a relatively recent development as histology results were previously available within two to three days and thus available to be discussed with the patient at their first postoperative visit. Nowadays histology results frequently take one to three weeks to be received and this has necessitated a change in procedures with patients now requiring two postoperative visits.)

It is not disputed that [Mr B] was not informed of the result of his histology, nor was any follow-up action arranged by [Dr A]. Indeed, [Dr A] notes that he has had no further contact with [Mr B] since that time.

[Mr B] was seen by [Dr A's] nurse on 14/8/12 ([Dr A] was on conference leave). The nursing notes record 'no pathology report available and advised to contact us at the end of the week if [Dr A] has not contacted him already'. [Mr B] states 'I do know categorically that they (DR and reception) assured me they would make contact if necessary'.

The failure to contact [Mr B] and to follow-up on the result of the histology reports clearly constitutes inadequate care and [Dr A] acknowledges this. Given the long delay from the events to the complaint being received, [Dr A] cannot recall 'what happened in the instance of signing off [Mr B's] histology report'. He admits that he did have concerns about the adequacy of his systems at the time and indeed had attempted to modify them without success. The change from paper base to electronic systems has required changes to clinical practice and in the period of overlap there was the possibility of error. The absence of a report is more difficult to detect than the presence of an abnormal report.

If the biopsy result had been actioned at the time, [Mr B] would have required more extensive surgery. The surgery however may have been less extensive than that required nearly eighteen months later although as no documentation was provided regarding his subsequent treatment, it is difficult to comment on that aspect.

It is not disputed that there was a failure in the clinical care provided by [Dr A] in failing to follow-up on the abnormal biopsy results.

The adequacy of relevant policies and procedures in place at [the Clinic] at the time of events complained of, including that there were not written policies at the time.

Written policies can be useful documents in defining standards of care but they do not of themselves ensure that care is adequate. In this case follow-up of an abnormal histology report (e.g. BCC) is a basic requirement of adequate surgical management of a patient and the presence or absence of written policies does not alter that fact.

Even if written policies had been available at the time, they would not automatically have prevented this omission. Clinicians I have discussed the general clinical scenario with were skeptical of the benefits of written protocols and policies. There are now so many in place that they are effectively useless.

The adequacy of the relevant policies and procedures currently in place at [the Clinic], including any further changes that you consider may be appropriate.

At the time of [Mr B's] treatment [Dr A] did not have a written policy relating to the handling, care and reporting of surgical specimens. The absence of the written policy however does not alter the fact that basic surgical care dictates that the histology result of any excised surgical specimen (particularly a specimen with a suspicion of malignancy) needs to be reviewed and appropriate action instituted.

It is clear that this is [Dr A's] normal procedure and there is no apparent reason for failure on this occasion. There were perhaps mitigating circumstances, including the delay in receipt of the histology result and the fact that he was away on conference leave at the time. There was no system for checking and confirming that the histology result had been reviewed and appropriate action instituted.

[Dr A] has clearly been devastated by the outcome in this particular case and has reviewed his policies and changed his practices in an attempt to avoid a similar event occurring in the future. He has provided an updated written six page

protocol 'Policy for Handling, Care and Reporting of Surgical Specimens'. This is a very comprehensive document with practical usefulness limited by the sheer volume of the document (and the number of other policy documents in existence).

Of more use is the change to the hand written record of all histology specimens sent for processing. In particular the addition of a column recording that any specimen taken has been processed and that the result has been sighted, signed and actioned accordingly. I do not think any further changes are required.

I would add that the hospital of my main employment (Wellington Regional Plastic, Maxillofacial and Burns Unit which is regarded as one of the country's leading plastic surgical units) does not have any written policies or protocols regarding handling and follow-up of tissue specimens.

SUMMARY:
[Dr A] completed incisional biopsies of lesions on [Mr B's] left nasal ala and scalp on 8/8/12 (plus excision of lesions of left cheek and right lumbar region). The procedure was carried out competently and met appropriate standards of care.

Histology reported that the two lesions biopsied were basal cell carcinomata with excision incomplete. That report was not communicated to [Mr B], nor was any follow-up action arranged. The lack of follow-up constitutes an inadequate standard of care. In my opinion this constitutes a moderate departure from appropriate standard of care. Other clinicians I have discussed this scenario with concur with that assessment, all noting that it was a human error that could happen to any of us.

Since this event [Dr A] has modified his practices and developed a written protocol to reduce the risk of a similar event occurring in the future. I believe the modifications mean that his practices now meet the highest standards of care.

[Information unrelated to investigation redacted for brevity].

I trust this answers all the questions raised but would be happy to discuss and clarify any aspects of the report if required.

Yours sincerely

Gary Duncan MBChB, FRACS
Consultant Plastic Surgeon"