HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to take patient history and consider differential diagnosis in treatment of man with persistent ear condition

1. Mr A had a background of Crohn's disease[1] and basal cell carcinomas (BCCs[2]). On 4 April 2016 Mr A's general practitioner (GP) referred Mr A to a private ear, nose and throat (ENT) surgeon, Dr B,[3] for review of Mr A's 'left ear fullness and discomfort'. Dr B saw Mr A several times over the course of a year. Mr A is concerned that Dr B did not monitor his ear adequately, leading to a delayed diagnosis of cancer and significant hearing loss.

Background

2. Between 12 April 2016 and 4 April 2017, Mr A had eight appointments[4] with Dr B, who cited left otitis externa[5] as the predominant diagnosis. Dr B states that Mr A was 'specifically' referred to him for treatment of otitis externa, and that the referral did not mention any skin malignancies.

3. In addition, Dr B told HDC that he was 'not made aware of [Mr A's] possible immunosuppression from Crohn's disease treatment by [Mr A's GP], nor [Mr A]', and he did not receive any correspondence from other healthcare providers involved in Mr A's care (apart from the initial referral).[6] He also did not have access to Mr A's clinical records. Dr B said that therefore, he was unaware that Mr A was experiencing ENT issues other than his recurring otitis externa in his left ear (which, according to his records, had completely resolved at the last consultation on 4 April 2017).

4. During the initial appointment, Dr B documented that the 'external auditory canal[7] was slightly oedematous[8] and a small bleeding ulcer was visible' on the bottom side of the left ear canal. The ulcer was not documented again for any of Mr A's subsequent appointments.

[1] Bowel disease that causes inflammation in the digestive tract. Mr A was on immunosuppressant medications, including methotrexate and prednisone, at the time of events.
[2] A common, locally invasive type of skin cancer.
[3] Dr B told HDC that he has since retired from clinical practice.
[4] 12 April 2016, 27 April 2016, 8 November 2016, 17 January 2017, 31 January 2017, 15 February 2017, 27 March 2017 and 4 April 2017.
[5] Inflammation or infection affecting the external ear and ear canal. Symptoms may include ear pain, itchiness and swelling.
[6] Dr B told HDC that he was made aware of the course of care provided by other healthcare providers (between December 2016 and December 2017) only because of HDC's investigation.
[7] The passageway that connects the external ear to the eardrum. It plays a key role in directing sound waves towards the middle ear for hearing.
[8] Swollen or inflamed.

5. Over the course of the eight appointments, Dr B did not document any findings in relation to the right ear or left pinna (the external ear), and he did not document any differential diagnoses. Dr B also did not document any patient history other than that associated with the presenting complaint.

6. Dr B discharged Mr A from his care on 4 April 2017. Dr B told HDC that at this stage 'the clinical appearance of the ear canal returned to normal with no apparent disease of the whole of the [left] external ear'.

7. Mr A was also under the care of a dermatologist, Dr C, for management of his Crohn's disease and multiple BCCs on other areas of his body. In December 2016 Dr C confirmed a BCC on Mr A's right ear and referred Mr A to a plastic surgeon, Dr D. On 1 May 2017 Dr D excised the right ear BCC, alongside a subsequent BCC (which Dr C found on Mr A's left external ear under the antihelix[9] on 24 March 2017).

8. Mr A told HDC that because of his frustration of experiencing ongoing ear pain, he attended a local ear clinic in August 2017 to have his ear syringed. During this appointment, the ear nurse expressed concern about the appearance of his left ear and referred him back to his GP. After a series of unsuccessful specialist referrals,[10] Mr A was referred to a head and neck surgeon, Dr E. In December 2017 Dr E performed a lateral temporal bone resection[11] to clear a BCC from Mr A's left ear.

9. Mr A told HDC that this 'was a major operation [that has left him] with no hearing in [his] left ear whatsoever'. In response to the provisional opinion, Dr B noted that Mr A was fitted with a left bone-anchored hearing aid, which he considered indicated that some hearing in the ear was preserved. However, in response to the provisional opinion, Mrs A noted that Mr A had trialled a cochlear hearing device without success and believes that 'this lesion did in fact result in a malignancy that meant [Mr A] completely lost his hearing in his left ear and has suffered a significant loss of quality of life over the past 7 years'.

Independent clinical advice

10. Independent clinical advice was provided by an otolaryngologist, Dr Michel Neeff (Appendix A). In summary, the following advice was provided:

- The failure to consider differential diagnoses and associated conditions is a departure from the standard of care. If Dr B did not recognise the skin lesion, or if he missed the skin lesion, this would constitute a severe departure.
- An insufficient level of clinical documentation and comprehensive history-taking constitutes a moderate departure from the standard of care.

[9] The Y-shaped cartilage within the external ear.
[10] In the first instance, Mr A was referred to Dr C, who re-referred Mr A to Dr D. Dr D was unable to operate as the cancer was too large, and subsequently he referred Mr A to Dr E.
[11] A surgical procedure in which a portion of a bone on the side of the skull is removed.

Response to provisional decision

Mr and Mrs A

11. Mr A was provided with an opportunity to respond to the provisional decision. Mrs A, on behalf of her husband, told HDC that she believes there was a severe departure from the standard of care in this case and that the failings discussed in this report did directly result in a delayed diagnosis of Mr A's cancer. Mrs A stated that '[h]ad [Dr B] carried out his role in providing the expected care and treatment by a specialist of his calibre and consulted with peers for an alternative method of treatment, an earlier diagnosis could have been made with less disastrous results'. Further comments made by Mrs A have been incorporated into this report where relevant.

Dr B

12. Dr B was provided with an opportunity to respond to the provisional decision. Dr B told HDC that he believes this case highlights the consequences of a lack of communication between treating specialists. However, Dr B acknowledged that he did not take a comprehensive history of Mr A and accepted responsibility for his part in Mr A's delayed treatment. Dr B also accepted the findings in my report. Further, he stated that he has since reflected on his practice and 'sincerely regret[s]' his role in the delayed referral and treatment. Dr B also identified that there were opportunities for earlier referral and management of Mr A's BCC following his May 2017 operation — which was after Dr B had discharged Mr A from his care and, therefore, outside Dr B's control. Further comments made by Dr B have been incorporated into this report where relevant.

Decision

13. I am satisfied that as at the 27 March and 4 April 2017 consultations with Dr B, Mr A had a new basal cell carcinoma on his left ear under the antihelix. This had been noted by Dr C at an assessment on 24 March 2017 (only three days earlier). In his most recent response (prior to the issuing of the provisional opinion), Dr B did not accept that he ignored any skin lesions on Mr A's ear. He asserts that Mr A was referred specifically for otitis externa, and therefore Dr B believes that he 'was not engaged to diagnose or treat any other ENT issues'. He stated further that he would have undertaken a more comprehensive examination had he been informed of the skin lesions by other practitioners or Mr A. However, Dr B also asserted in his first response to my Office that for the whole period Mr A was under his care, there was no apparent abnormality of the entire external ear canal and the pinna.

14. In addition, Dr B commented that he was provided with limited information about Mr A's clinical history and that he was unaware that Mr A was experiencing other ENT issues.

15. While I acknowledge Dr B's submission that he was managing Mr A's otitis externa only, I am concerned that he was unaware of the skin lesion on both 27 March and 4 April 2017, and moreover, that throughout the whole period of care he was wholly unaware of Mr A's other problems, including his other ear (an 'obvious' and 'ulcerating' BCC of the right ear from February 2017); his relevant clinical history, including that Mr A was under the care of other specialists; that Mr A was immunocompromised; and that Mr A had a background of skin lesions, including BCCs. I concur with the opinion of my clinical advisor, Dr Neeff, that comprehensive medical history-taking is the cornerstone in managing medical and surgical

patients, and it guides the practitioner towards an effective examination, diagnosis, and treatment plan. It is an expected and fundamental standard of care. I also concur with Dr Neeff that it is the responsibility of the doctor to take that history, and it is not the patient's task to volunteer such information relevant to the problem with which they present.

16. Dr Neeff further advised that because Mr A was immunocompromised, infections such as otitis externa can take longer to settle and can occur more frequently. Hence, in the context of otitis externa recurrence, Mr A's clinical history, and the finding of an ulcer in the ear canal at his initial presentation, alternative diagnoses and associated conditions should have been considered.

17. Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), consumers have the right to have services provided with reasonable care and skill. In my view, Dr B breached that right. Specifically, while ultimately the presenting complaint was considered to be otitis externa, Dr B needed to bring his specialist skills to bear on Mr A's ongoing presentations with recurrent infection. In this respect, it would be expected practice for Dr B to have taken an adequate clinical history, which I am satisfied he did not, and he should also have considered alternative diagnoses and associated conditions when Mr A's symptoms did not settle completely. These were departures from the expected standard of care, and therefore a breach of Right 4(1).

18. Lastly, I am critical of Dr B's documentation, which I consider is both brief and insufficient.

19. While acknowledging Mr and Mrs A's views about Dr B and the extent to which an earlier diagnosis could have been made, it is important to state that I am unable to determine whether the failures discussed in this report directly resulted in a delayed diagnosis of Mr A's cancer.

Recommendations

20. I recommend that Dr B provide a formal written apology to Mr A for the breach of Right 4(1) of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mr A, within three weeks of the date of this report.

21. Noting that Dr B is retired from clinical practice (although he provides advice to an organisation), and given the time that has elapsed since the provision of care, no further recommendations will be made.

Follow-up actions

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

23. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, will be placed on the HDC website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following clinical advice was obtained from otolaryngologist Dr Michel Neeff:

> 'I have been asked to provide an opinion to the Commissioner on case number **C21HDCO1332.**
>
> I have read the HDC "Guidelines for Independent Advisors". In my response I will follow these guidelines.
>
> I was awarded a Fellowship in Otolaryngology, Head and Neck Surgery with the Royal Australasian College of Surgeons (RACS) in 2005 and gained further training in Neurotology and Skull base Surgery during my Fellowship in 2006. I have been a Consultant Surgeon at [Health NZ], Auckland City and Starship Hospitals, and in private practice in Auckland since 2007, sub-specialising in Otology and Neurotology.
>
> **Expert advice requested**
> I received the following instructions by the Commissioner (HDC letter dated 16 March 2023):
>
> Please review the enclosed documentation and advise whether you consider the care provided to [Mr A] by [Dr B] was reasonable in the circumstances, and why.
>
> In particular, please comment on:
>
> 1. The reasonableness of continuing [Mr A's] treatment in the same manner when issues reoccurred, and whether any alternative courses of action should have been considered;
> 2. Whether you would expect an ENT specialist to consider lesions on the skin as part of an assessment of the ear;
> 3. The quality of [Dr B's] clinical documentation, including whether [Dr B's] notes provide sufficient detail; and
> 4. Any other matters relating to [Mr A's] ENT treatment that you consider relevant to comment on.
>
> For each question, please advise:
>
> 1. What is the standard of care/accepted practice?
> 2. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
> 3. How would it be viewed by your peers?
> 4. Recommendations for improvement that may help to prevent a similar occurrence in future.

If you note that there are different versions of events in the information provided, please provide your advice in the alternative. For example, whether the care was appropriate based on scenario (a), and whether it was appropriate based on scenario (b).

Summary:
From the medical and surgical notes provided:

The patient, [Mr A], has a background history of Crohn's Disease, and is on multiple medications for this, including immunosuppressants such as methotrexate and prednisone.

[Mr A's] account:
[Mr A] was referred by his GP to [Dr B], ENT Surgeon in … for an ear condition in April 2016. He felt that no change in his symptoms occurred after 8 visits over 12 months. [Mr A] sought a second opinion from an ear nurse in August 2017 who expressed concern about the appearance of his left ear. His GP referred him to a Dermatologist, who referred him to a Plastic Surgeon, who finally referred him to [Dr E], Head and Neck Surgeon. [Mr A] had to undergo a lateral temporal bone resection to clear a tumour (basal cell carcinoma, BCC) from his left ear and temporal bone. His hearing has been significantly reduced since this surgery.

[Dr B's] account:
[Dr B] documented 8 visits. At presentation in April 2016, he described a left acute otitis externa and associated ear canal ulcer which initially responded to topical antibiotic drops. The patient presented with ongoing symptoms in January 2017, and was diagnosed with left fungal otitis externa. A microbiology swab was polymicrobial. The infection was slower to respond to topical treatment this time but seemed to have cleared by the time of his last visit on 4 April 2017. None of these visits documented findings in the contralateral ear or findings of the pinna. The ear canal ulcer documented in April 2016 was not mentioned again.

Chronology of other Specialist/Practitioner visits:
December 2016: referred to Department of General Surgery, … for BCC right ear, [Dr C], Dermatologist

January 2017: seen in Department of General Surgery, … ENT review recommended for lesion right ear.

February 2017: discharged from public ENT service as patient went private.

February 2017: obvious ulcerating BCC right ear, [Dr C], Dermatologist

March 2017: BCC left ear, obvious ulcerating BCC right ear, [Dr C], Dermatologist

May 2017: Excision of BCC left and right ear, positive deep margin left ear; watch and wait approach taken, [Dr D], Plastic Surgeon

June 2017: ears clear of skin lesions clinically, [Dr C], Dermatologist

August 2017: referred to GP for review of appearance of left ear canal, Ear Nurse.

October 2017: recurrent BCC left ear, [Dr C], Dermatologist

October 2017: recurrent BCC left ear to tympanic membrane, [Dr D], Plastic Surgeon

December 2017: resection BCC left ear, lateral temporal bone, [Dr E], Head and Neck Surgeon

Response:
1) The reasonableness of continuing [Mr A's] treatment in the same manner when issues reoccurred, and whether any alternative courses of action should have been considered;
A diagnosis of left otitis externa (OE) was made. The standard treatment for this would be ear suction, water precautions and topical antibiotics with or without steroids. Most patients should start to perceive an improvement in symptoms within 3 days and expect clinical resolution within 7 to 10 days (Rosenfeld RM, Singer M, Wasserman JM, Stinnett SS. Systematic review of topical antimicrobial therapy for acute otitis externa. Otolaryngol Head Neck Surg. 2006;134(4 suppl):S24–48.)

From [Dr B's] initial account there seemed to have been an acute otitis externa at presentation which settled with the treatment provided.

In patients who fail to improve within 72 hours a review of the treatment and diagnosis is recommended as per treatment algorithm below (Figure 1). The differential diagnosis then includes dermatological, systemic, and malignant conditions amongst others (Rosenfeld RM, Schwartz SR, Cannon CR, Roland PS, Simon GR, Kumar KA, Huang WW, Haskell HW, Robertson PJ. Clinical practice guideline: acute otitis externa. Otolaryngol Head Neck Surg. 2014 Mar;150(3):504. PMID: 24491310).

When symptoms and signs failed to settle down for [Mr A] a review of the symptoms and signs, and consideration of alternative diagnoses and associated conditions should have been considered. As [Mr A] was immunocompromised, infections such as otitis externa can take longer to settle and recur more frequently. But as [Mr A] also had a background of skin lesions including BCCs, this should have been considered especially given the finding of an ulcer in the ear canal at the time of his initial presentation and the presence of a BCC of the left pinna described by [Dr C] in March 2017.

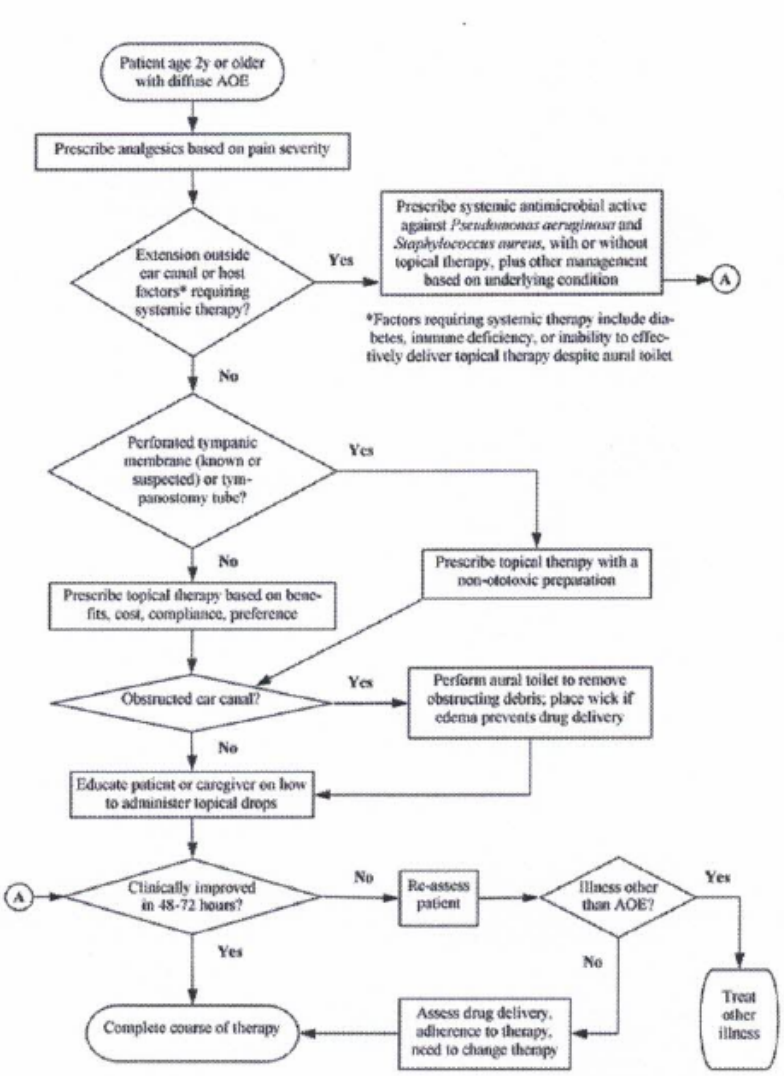


Figure 1: Treatment algorithm for acute otitis externa. *From:* Rosenfeld RM, Schwartz SR, Cannon CR, Roland PS, Simon GR, Kumar KA, Huang WW, Haskell HW, Robertson PJ. Clinical practice guideline: acute otitis externa. Otolaryngol Head Neck Surg. 2014 Mar;150(3):504. PMID: 24491310).

Failing to consider differential diagnoses and associated conditions is a departure from the standard of care. The consequence of this could be mild, e.g. if the wrong topical antibiotic drops were used in the presence of resistant bacteria, moderate, if a new diagnosis of e.g. diabetes mellitus or other immunocompromise was missed, or severe, if a malignant condition was missed.

From the clinical notes, in part due to insufficient documentation on [Dr B's] part, and from [Dr B's] response to this complaint, it is difficult to determine whether [Dr B] knew or assumed that the skin lesions of the ears were being treated by a Dermatologist and Plastic surgeon, or whether he did not recognise or missed the skin lesions. Even though there were skin lesions on the pinna, this does not mean that there was an obvious skin lesion in the ear canal.

From the notes provided it appears that the patient had an obvious BCC of the right ear (contralateral to the ear in question) documented by [Dr C] in December 2016. This had not been mentioned in [Dr B's] earlier notes from November 2016. Subsequently, a recommendation for ENT input for the management of this lesion was also advised by the General Surgery Department in … January 2017. [Dr B] did not mention this lesion or any other skin lesion in his clinical notes after this recommendation was made and there is no evidence that treatment or a referral for this lesion was offered.

[Dr C], Dermatologist first mentioned a lesion of the left ear in March 2017. [Dr B] did not describe a lesion of the left ear when the patient visited him in March 2017. A left fungal otitis externa was diagnosed instead which was said to have cleared by the time the patient was discharged on 4 April 2017. Also no mention of the lesion of the right or left ear was made at the time of discharge.

It is possible that there was no obvious lesion in the ear canal at this stage, but the lesion on the pinna described by [Dr C] should have been addressed by [Dr B].

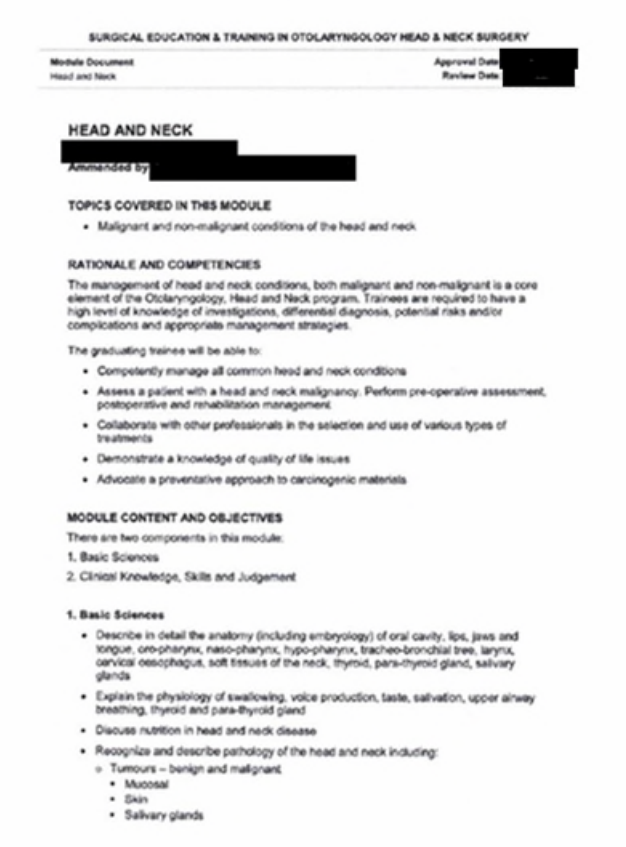
Otolaryngologists in NZ would agree that a departure from the standard of care had occurred in the management of this patient if the lesions were missed or ignored. Following the above treatment algorithm (Figure 1) closely could prevent similar occurrences in the future. Peer support by discussing this patient or requesting a second opinion when symptoms did not settle could have prevented a delay in diagnosis. Communication with the other specialties involved in [Mr A's] care could have led to an earlier diagnosis and the need for less extensive surgery.

Given the lack of documentation and the fact that [Dr B] seemingly ignored the skin lesions I estimate the departure from the standard of care in treatment and diagnosis, and in documentation quality as moderate. In making this assessment, I assumed that [Dr B] knew about the surgery the patient was having to the skin lesions and that was why he did not document them and did not treat these (benefit of the doubt).

Had [Dr B] simply ignored these lesions or had he not recognised them as malignancies, the departure from the standard of care would have been severe.

2. Whether you would expect an ENT specialist to consider lesions on the skin as part of an assessment of the ear;
The diagnosis and management of malignant and non-malignant conditions of the head and neck is regarded as core knowledge for trainees in Otolaryngology, Head and Neck Surgery in NZ. This includes benign and malignant tumours of skin. A module document describing this can be found on the RACS website. Find the relevant excerpt in Figure 2 or follow the link below (members only).

(httpsi/www.surgeons.ore-Jmedia/Project/RACS/surgeons-orafiles/becoming-a-surgeon-trainees/otolaryngology/head-and-neckmodule.pdf?rey=0b9e4af522934c73blac336809460064&hash=37322A56F396E7CC0E684D5610E93B22



SURGICAL EDUCATION & TRAINING IN OTOLARYNGOLOGY HEAD & NECK SURGERY

Module Document
Head and Neck

Approval Date [redacted]
Review Date [redacted]

HEAD AND NECK

[redacted]

Amended by [redacted]

TOPICS COVERED IN THIS MODULE

- Malignant and non-malignant conditions of the head and neck

RATIONALE AND COMPETENCIES

The management of head and neck conditions, both malignant and non-malignant is a core element of the Otolaryngology, Head and Neck program. Trainees are required to have a high level of knowledge of investigations, differential diagnosis, potential risks and/or complications and appropriate management strategies.

The graduating trainee will be able to:

- Competently manage all common head and neck conditions
- Assess a patient with a head and neck malignancy. Perform pre-operative assessment, postoperative and rehabilitation management
- Collaborate with other professionals in the selection and use of various types of treatments
- Demonstrate a knowledge of quality of life issues
- Advocate a preventative approach to carcinogenic materials

MODULE CONTENT AND OBJECTIVES

There are two components in this module:

1. Basic Sciences
2. Clinical Knowledge, Skills and Judgement

1. Basic Sciences

- Describe in detail the anatomy (including embryology) of oral cavity, lips, jaws and tongue, oro-pharynx, naso-pharynx, hypo-pharynx, tracheo-bronchial tree, larynx, cervical oesophagus, soft tissues of the neck, thyroid, para-thyroid gland, salivary glands
- Explain the physiology of swallowing, voice production, taste, salivation, upper airway breathing, thyroid and para-thyroid gland
- Discuss nutrition in head and neck disease
- Recognize and describe pathology of the head and neck including:
  - Tumours – benign and malignant
    - Mucosal
    - Skin
    - Salivary glands

Figure 2: Head and Neck module document, ENT-HNS syllabus, RACS.

Skin lesions in the head and neck region in general and of the ear in particular are therefore regarded as part of the ENT assessment of the ear. If an ENT practitioner is not comfortable to manage skin lesions of the ear, a referral to a colleague managing these conditions should occur.

3) The quality of [Dr B's] clinical documentation, including whether [Dr B's] notes provide sufficient detail;

[Dr B's] notes focus on the left ear and the diagnosis of otitis externa. His initial description of the diagnosis and subsequent resolution of symptoms was in keeping with the diagnosis of acute otitis externa mentioned. It is possible that the lesion of the left pinna was not visible or present at the time. But the lesion on the left pinna was present at least from March 2017. But [Dr B] made no mention of it around that time.

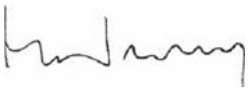
There is no description of the findings of the right ear. There is no description of [Mr A's] relevant medical or surgical history. He was on immunosuppressive therapy and had had treatment for several skin lesions at different body sites before.

Hence, the detail provided in his clinical documentation was insufficient. Furthermore, clinical letters were not copied to other Specialists involved in [Mr A's] care.

4) Any other matters relating to [Mr A's] ENT treatment that you consider relevant to comment on.
On a background of an immunosuppressed patient who had recently developed multiple skin lesions, the histological finding of a positive margin following the removal of the BCC of the left ear in May 2017 could have been managed with more vigilance. This could have involved a re-excision of the lesion when positive margins were first found. As the lesion seems to have been close to the ear canal, an early referral and input from an ENT surgeon familiar with skin lesions involving the ear canal would have been helpful.

Please do not hesitate to contact me if you have any further questions.

Kind regards



Michel Neeff
MBChB, FRACS'

'**Further independent clinical advice to Health and Disability Commissioner**

Complaint:	**[Mr A] | [Dr B]**
Our ref:	**21HDC01332**
Independent advisor:	**Mr Michel Neeff**

I have been asked to provide further clinical advice to HDC on case number 21HDC01332. I have read and agree to follow HDC's Guidelines for Independent Advisors. I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I was awarded a Fellowship in Otolaryngology Head and Neck Surgery with the Royal Australasian College of Surgeons (RACS) in 2005 and gained further training in Neurotology and Skull base Surgery during my Fellowship in 2006. I completed an MD at The University of Auckland in 2024. I have been a Consultant Surgeon at [Health NZ] Auckland City and Starship Hospitals and in private practice in Auckland since 2007 sub-specialising in Otology and Neurotology.
Documents provided by HDC:	1. Letter of response dated 14 December 2023

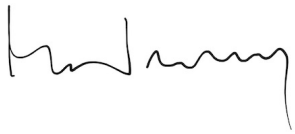
Referral instructions from HDC:	1. Whether the response provided by [Dr B] changes the findings of your original expert advice report. 2. Any other matters in this case that you consider warrant comment, if applicable.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	Please refer to my letter to HDC dated April 13, 2023 for further details. *In summary, [Mr A] received focussed treatment for a left otitis externa by [Dr B]. The presence of immunocompromise (on immunosuppressants for Crohn's disease) and the concurrent presence and treatment of skin lesions involving the ear canal in pinna of both ears was not considered or mentioned in [Dr B's] documentation.*
Question 1: Whether the response provided by [Dr B] changes the findings of your original expert advice report.	
List any sources of information reviewed other than the documents provided by HDC:	See references below
Advisor's opinion:	I reviewed [Dr B's] response to HDC dated 14.12.2023. In essence [Dr B] felt that [Mr A] had been referred for a left otitis externa which was treated adequately. [Dr B] also felt that in my report I wrongly assumed that he had had communication with other specialists involved in the treatment of [Mr A]. [Dr B] was not aware of other medical or surgical problems as he had not been advised of any. <u>My response:</u> Comprehensive medical history taking is the cornerstone in managing medical and surgical patients, and guides the practitioner towards an effective examination, formulation of a precise diagnosis, and development of a comprehensive treatment plan. It is the treating doctor's responsibility to *take* the history, not the patient's task to volunteer such information relevant to the medical problem they present with. From the notes reviewed, including [Dr B's] response, his focus appears to have been on the presenting problem only (left otitis externa). A comprehensive

	history could have provided [Dr B] with relevant and important information he missed out on, including the patient's immunocompromise and treatment received by other practitioners involved in the patient's care. Taking a comprehensive history is the accepted standard of care when managing patients. **References** 1) JR Nichol, JH Sundjaja G Nelson. Medical History. StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. 2) SM Oliver, SM Oliver (eds), "Assessing the patient: History taking and clinical examination", in Susan M. Oliver OBE (ed.), *Oxford Handbook of Musculoskeletal Nursing*, 2 edn, Oxford Handbooks in Nursing, February 2020. 3) W King. (2013). Medical History. In: Gebhart, G.F., Schmidt, R.F. (eds) Encyclopedia of Pain. Springer, Berlin, Heidelberg. 4) H Mortazavi, A Rahmani, S Rahmani. Importance, Advantages, and Objectives of Taking and Recording Patient's Medical History in Dentistry. International Journal of Medical Reviews, Volume 2, Issue 3, Summer 2015, pp 287–90.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Please refer to my letter to HDC dated 13.4.2023. The response provided by [Dr B] did not provide any information that would change my initial assessment.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Please refer to my letter to HDC dated 13.4.2023, the departure remains moderate.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Please refer to references above and in my letter to HDC dated 13.4.2023. I did not consult any peers for additional views.

Please outline any factors that may limit your assessment of the events.	None.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Even in [the] role as an advisor … thorough history taking is still important.
Question 2: Any other matters in this case that you consider warrant comment, if applicable.	
List any sources of information reviewed other than the documents provided by HDC:	See above and refer to my letter to HDC dated 13.4.2023.

Signature: 

Name: Dr Michel Neeff

Date of Advice: 21 February 2025’