Health New Zealand|Te Whatu Ora
General Practitioner, Dr B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01043)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Health New Zealand|Te Whatu Ora (Health NZ) and Dr B at a medical centre. The following issues were identified for investigation:

   - *Whether Health NZ|Te Whatu Ora provided Mr A with an appropriate standard of care from August 2019 to May 2020 (inclusive).*
   - *Whether Dr B provided Mr A with an appropriate standard of care from October 2018 to May 2020 (inclusive).*

2. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

3. The parties directly involved in the investigation were:

Mr A	Consumer
Health NZ|Te Whatu Ora	Provider
Dr B	Provider

4. Further information was received from the medical centre.

5. In-house clinical advice was obtained from general practitioner (GP) Dr David Maplesden (Appendix A).

Information gathered during investigation

Introduction

6. This report considers Mr A's complaint that there were delays in the diagnosis of a lesion on his right index finger as a squamous cell carcinoma (SCC) (a type of skin cancer). Following the diagnosis, he required amputation of his finger, removal of lymph nodes, and radiation therapy.

7. Mr A had multiple chronic and complex health conditions and attended the medical centre for at least 10 years. He said that prior to 2017 he had seen GP Dr B at the medical centre monthly for 12–15 years to obtain prescriptions and had asked Dr B about the lesion on his right finger for at least eight years. Mr A said that Dr B kept telling him that it was a wart and treated it with liquid nitrogen.

8. Mr A transferred to another GP practice between February 2017 and September 2018 and returned to the medical centre on 18 September 2018. He was then aged in his fifties.

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Cryotherapy

9. The first entry in the clinical records after Mr A's return is dated 18 September 2018 and states that he was seen by Dr B and that Mr A was off all medications and appeared well.

10. However, Dr B undertook a clinical audit and stated that he saw Mr A on 9 October 2018 for the first consultation on his return to the medical centre and he referred Mr A to the local psychiatric services for a specialist assessment as Mr A was struggling with mental health issues at that time. Dr B said that the finger lesion was not mentioned at that consultation. HDC was not provided with an entry in the clinical records for 9 October 2018.

11. Dr B said that Mr A first brought the finger lesion to his attention on 30 October 2018. Unlike his previous clinical notes, which were more fulsome, a brief note in Mr A's clinical records dated 30 October 2018 states: 'Liq N2 [liquid nitrogen] to finger wart. Given SPOe [single point of entry] 0-800 number. Otherwise seems well.'

12. Dr B told HDC:

> 'My notes indicate this lesion has appearances of a benign keratotic[1] wart and it was treated with cryotherapy[2] at that time on one occasion. The lesion was not mentioned again (or noticed by me) until 20/08/19. He was referred for a plastic surgical opinion after this consult.'

13. Dr B stated that Mr A indicated that the finger lesion had been present for many years and he was wondering about treatment options. Dr B said that due to the benign appearance of the lesion and its longevity, his initial approach was a course of cryotherapy applied every two to three weeks. He said that he considered that a surgical approach was a secondary option as it would have required a skin graft to close the surgical wound and, considering the poor nature of Mr A's circulation, it was likely that this would result in graft failure and finger amputation. Dr B acknowledged that his decision-making process is poorly documented in his notes.

14. Mr A told HDC that when the lesion was treated with cryotherapy for the last time, it caused a large hole that needed to be dressed regularly by the practice nurse. Dr B said that he has been unable to find any nursing notes relating to Mr A's post-cryotherapy nursing care, and Mr A may have attended as a 'walk in' patient (with no appointment) and had the wound dressed. Dr B said that this would result in a nursing intervention note being recorded, but it may have been overlooked inadvertently, depending on what else was happening at the time in the medical centre. He stated: 'If this was the case this was an error on our part.'

15. Dr B also stated: '[I]t was always going to require a series of cryotherapy sessions to try and treat this lesion, but this never really eventuated.' He said that Mr A was next seen on

[1] An area of skin with an overgrowth of horny tissue.
[2] The use of extreme cold to freeze and remove abnormal tissue.

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20 November 2018 for a review of his psychiatric evaluation, and the finger lesion was not mentioned.

16. Dr B stated that he had only sporadic consultations with Mr A after 30 October 2018, and there was a six-month period with no contact between February 2019 and August 2019. Dr B told HDC that the contacts that did occur were centred around Mr A's extensive psychiatric and social issues and associated referrals, and he does not recall any concerns about Mr A's finger lesion over that time.

Referral

17. At a consultation on 20 August 2019 Mr A told Dr B that he thought his finger lesion had increased in size, and Dr B decided that a surgical review was warranted.

18. Dr B's notes dated 20 August 2019 state: 'WINZ Also a longstanding finger lesion. For referral to plastics.' The referral letter from Dr B to the plastic surgery service at Health NZ is dated 23 October 2019 and is marked urgent. The referral includes a photograph of Mr A's finger lesion with a provisional diagnosis of '?SCC finger' and the history noted as: 'He has a 12/12 [12 month] or more of this attached lesion on the dorsum (back) of his index finger. He does feel it is enlarging. Not really practical for biopsy …' The photograph shows an obvious hole at the site of the lesion.

19. With reference to the two-month delay in sending the referral, Dr B said:

> 'The delay here was partly due to an administrative oversight on my part in following up the referral process when we had problems attaching photos to the referral (8 weeks) and for this I am truly sorry.'

20. Dr B stated that normally he adds patients who need specialist referrals to an electronic list and deletes them after completion, but clearly that did not happen in this case.

21. Mr A stated that in January 2020 he was advised by a surgeon at Hospital 1 that he needed to get his finger wart looked at. The Clinical Director of Hospital 1 said that there is no reference to Mr A's finger lesion in his Hospital 1 notes. The Clinical Director stated:

> 'The focus of our service has been on looking at [other] issues. If I have prompted him to get his fingers checked it may have been a verbal discussion, certainly it has not been made obvious on looking at my letters.'

Plastic and reconstructive surgery service

22. On 4 November 2019, the referral from Dr B was accepted by the plastics and reconstructive surgery service as 'high suspicion of cancer, < [less than] 100 days'. A letter of acceptance of referral dated 4 November 2019 was sent to Mr A and copied to Dr B. The letter contained the safety-netting advice that Mr A should contact his GP if his condition worsened. In response to the provisional opinion, Health NZ noted that it was relevant that Dr B had not done a biopsy, and the triaging surgeon at Health NZ did not request a

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biopsy, and, even if this had been done, the process that followed would have been identical to what occurred.

23. Mr A was a patient of consultant plastic surgeon Dr C from March 2020. Mr A's first specialist appointment (FSA) with Dr C was on 9 March 2020 at the minor surgery clinic at Hospital 1.

24. Dr C found that Mr A had an infected 1.5cm diameter probable SCC and he did not have axillary lymphadenopathy (swelling of lymph nodes in the armpit). He was given the antibiotic flucloxacillin and underwent an immediate biopsy, which was positive for SCC.

25. Mr A was triaged as semi-urgent and booked for surgery to excise the skin cancer on 6 April 2020. However, this appointment was cancelled due to COVID-19, and he was rebooked for 18 May 2020.

26. Following the biopsy, the lesion became infected and did not heal. Mr A presented to the Emergency Department (ED) at Hospital 2 on 12 April 2020 in pain with multiple infected skin lesions and was treated with antibiotics. His discharge summary notes the secondary diagnosis as delayed healing of an infected right finger, and the primary diagnosis as cellulitis of a right calf wound, with follow-up care for the leg wound to be provided by his GP.

27. On 21 and 24 April 2020 Mr A presented to the medical centre for wound review and dressings. Possible re-biopsy and re-referral for his finger lesion were discussed, and on 28 April 2020 medical centre staff confirmed that Mr A's surgery had been scheduled for 18 May 2020.

28. Mr A presented to the ED at Hospital 2 again on 7 May 2020 because of pain in his finger lesion. It was noted that he picked at the wound daily. The clinical notes record:

> '[A]pproximately 10x10mm wound on the dorsal aspect back of his right index finger at the level of the PIPJ (the middle joint). This wound has been present for approximately 4/12 (four months) following cryotherapy for SCC … [H]e stated that he wanted to amputate his finger to finally resolve the issue.'

29. Mr A left the department before he could be reviewed medically.

30. Mr A's surgery on 18 May 2020 had been booked at the minor surgery clinic at Hospital 1, but due to the COVID-19 lockdown at that time, this was changed to a day surgery unit.

31. On arrival at the unit, Mr A was unwell. He was in severe pain and was shaking. Dr C said that the lesion was then 20mm in diameter and Mr A had an obvious infection related to the lesion on his finger, and multiple other sites of cellulitis (skin infection). Dr C attempted to undertake the procedure, but it was abandoned because Mr A was unable to cope. He was transferred to Hospital 2 for intravenous antibiotics, and on 19 May 2020 he underwent excision of the lesion down to the tendon.

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32. The histology report showed that the lesion was a moderately differentiated (intermediate grade) SCC, 4.2mm thick, with perineural invasion (invasion into the space surrounding a nerve) 0.1mm from the deep margin and incomplete at the deep margin, which was the extensor tendon (on the back of the hand). Mr A was discharged on 22 May 2020.

33. Dr C saw Mr A at a plastic surgery outpatient clinic (the clinic) on 26 May 2020 and discussed the diagnosis with him. Dr C said that the advice given was to perform a ray amputation of the finger (amputation of the whole index finger, including the knuckle), and Mr A agreed to that plan. He was admitted to Hospital 2 that day to undergo the ray amputation under general anaesthetic the following day.

34. Dr C told HDC that Mr A did not attend the clinic on 9 June 2020 for post-surgical follow-up and review. Mr A attended the clinic on 16 June 2020, at which stage he was healing well, and the sutures were removed. No further SCC was found in the finger amputation specimen. Mr A was booked for a three-month follow-up on 15 September 2020, but he did not attend. Dr C wrote to Dr B stating that Mr A had not attended the clinic, but Dr C still wished to see him, and another appointment was sent for one month's time.

35. On 14 October 2020 Mr A was seen in the clinic by Dr C's registrar, who found that Mr A had a right axillary (armpit) mass and ordered investigations. A fine needle aspiration cytology (cell examination) was performed, which showed SCC. Mr A had a CT (computed tomography) scan, which showed no other significant findings.

36. Mr A told HDC that on 10 November 2020 he was scheduled to have surgery the following day, and that 'the prognosis was not good'. He explained that the cancer had spread to his lymph nodes, and he was expected to be in hospital for two to three weeks.

37. Dr C said that Mr A underwent a right axillary lymph node dissection on 11 November 2020, and he was discharged from hospital on 17 November 2020 with follow-up care in place. Health NZ noted that the histology report from the surgery showed SCC in 4/26 of Mr A's lymph nodes.

38. Mr A's support person told HDC that Mr A had 24 lymph nodes removed, causing a big wound, and he had issues with healing, which delayed the start of his radiation therapy three times. Subsequently, Mr A underwent radiation therapy five times a week for several weeks.

Further comment

Dr C

39. Dr C stated that the COVID-19 lockdown occurred during Mr A's care. He was seen just before the lockdown, but his definitive surgery was deferred due to the lockdown. Dr C said:

> 'It is unfortunate that [Mr A] had the long delay from October 2019 through to March 2020 before he was seen about the aggressive squamous cell carcinoma of his right

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index finger. We have many referrals coming through our service and most skin cancers are indeed triaged as semi-urgent, to be seen <100 days.'

40. Dr C said that the plastic surgery service is not able to comply with that target due to the service's heavy workload. Dr C commented: 'We currently see the most urgent patients within a shorter period of time, e.g. melanoma and aggressive squamous cell carcinoma if we are able to identify them.'

41. Dr C said that as at December 2020, the wait time for standard skin cancer patients was four to five months. Dr C stated that the service relies on patients and their GPs advising them of any change, deterioration, or concern, and they can then try to book the patient sooner than the approximately four to five months.

Health NZ

42. Health NZ acknowledged the concerns about the timeliness of services provided to Mr A and recognised that it would have been ideal for him to be seen earlier. However, several factors affected the timing of Mr A's care, including patient factors and the COVID-19 pandemic. Health NZ stated: 'Those are relevant under Clause 3 of the Code and support our overall view that our service to Mr A was reasonable in all the circumstances.'

43. Health NZ also stated that while it recognises HDC's mandate to consider its referral triage process and communication with patients while they are on the waitlist, questions relating to allocation of resources and access to services fall within the remit of the Ministry of Health rather than HDC.

Medical centre policies

44. The 'Procedure for cryotherapy treatments' policy includes the following:

'• All lesions must be seen by the patient GP initially with instructions for cryotherapy (either verbal or written).

- Generally up to x 3 treatments (with a x 2 week gap) under protocol.
- If the patient does not return for additional treatments and more than x 1 treatment is required the nurses or practitioner must recall patients.
- Nurses ensure notes under short key are added in Medtech:

  [discuss with] Patient/Guardian/benefits vs risks/adverse effects, opportunity for questions given,* no *[contraindications]. Verbal consent gained for Liquid Nitrogen. Post Procedure Advice Given.

- If there is no response to treatment, nurses are to refer back to the provider for review and instructions.'

45. The 'Patient Records' policy includes the following:

'• Each patient record at this practice is a complete, accurate, and up-to-date clinical record.

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- All services provided to a patient by our practice are added to their patient record in the PMS, including assessments, investigations, and referrals.
- Assessment, management, progress, and outcomes are documented in a way that enables another team member to continue the patient's health care. Patient records are updated by the clinician treating the patient at the time of consultation or within 24 hours.
- Clinical staff enter clear and accurate information that is objective and non-judgmental.
- All clinical records: identify the clinician (GP, nurse, or care provider) making [sure] the entry [is] dated, accurate, and legible (if handwritten) [and] provide a permanent record (ink or electronic) [using] only approved abbreviations.'

Responses to provisional opinion

46. Health NZ, Dr B, the medical centre, and Mr A were given the opportunity to respond to relevant sections of the provisional opinion. The medical centre and Mr A did not submit any comments to HDC. Dr B advised that he accepted the findings and did not have any further comments. Health NZ responded with clarifications and considerations, which have been incorporated into this report where relevant.

Opinion: Dr B — adverse comment

47. At the outset, I express my sympathy to Mr A for the difficult treatment journey he has experienced. There are substantial variations between his and Dr B's recollection of events, as discussed below.

Treatment of finger lesion

48. Mr A said that he had drawn Dr B's attention to the lesion on his finger over many years. He said that prior to the period in 2017–2018 during which he did not attend the practice, he had seen Dr B at the medical centre monthly for 12–15 years to obtain prescriptions, and he had asked about the lesion on his right finger for at least eight years. Mr A said that Dr B kept telling him it was a wart and treated it with liquid nitrogen. However, there is no reference in the clinical records to Dr B having seen a finger lesion, or any treatment for a finger lesion prior to 30 October 2018, and Dr B said that that consultation was the first time the lesion was brought to his attention. I note that the referral Dr B completed on 23 October 2019 indicates that the lesion had been present for 12 months.

49. I accept Mr A's account that the lesion had been present for some years, but contemporaneous evidence indicates that it was not treated at the medical centre or by Dr B prior to 30 October 2018.

50. Mr A said that the lesion was treated with liquid nitrogen on several occasions. However, Dr B said that the only liquid nitrogen treatment was on 30 October 2018, and the planned

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subsequent treatments did not eventuate. My in-house clinical advisor, GP Dr David Maplesden, advised that best practice would have been for Dr B to have documented some details regarding the lesion being treated (which side, which finger, duration, size, evolution), informed consent to cryotherapy, and provision of safety-netting advice to Mr A to return if the lesion persisted or progressed after treatment. Dr Maplesden said that Dr B's standard of clinical documentation could be improved in this regard. I agree. There is no reference in Mr A's clinical records as to why Dr B did not arrange additional treatments. I note that the 'Procedure for cryotherapy treatments' policy required him to give instructions for cryotherapy (either verbal or written) for up to three treatments, with a two-week gap between treatments.

51. I accept that the lesion on Mr A's finger was treated with liquid nitrogen at least once, but I am unable to make a finding that there were further treatments, as Mr A has alleged. However, I would be concerned if there were other treatments that are not recorded.

Referral letter

52. When Dr B saw Mr A on 20 August 2019, he recorded that Mr A had a longstanding finger lesion and would be referred to 'plastics'. The referral letter from Dr B to the plastic surgery service is dated 23 October 2019 and is marked urgent. Dr B said that the delay occurred because he failed to add the referral to his electronic list of patients who needed specialist referrals. He stated that this may have related to difficulties with the 'photo add' system for plastics referrals, which may have distracted him from the correct processes over the referral.

53. Dr Maplesden is mildly to moderately critical of the delay in submitting the referral. I accept this advice.

54. Dr Maplesden advised that the referral for suspected cancer should have been tracked in accordance with recommended practice, which may have led to earlier recognition that submission of the referral had been delayed. He noted that it is not possible to determine from the clinical documentation what actually prompted the completion of the referral on 23 October 2019. There is no documentation in the GP notes suggesting that Mr A sought review of his finger lesion between August and October 2019. In my view, when Dr B saw Mr A on 20 August 2019, he should have informed him of the steps he should take if he was not contacted by the plastic surgery service, such as contacting the practice or the plastic surgery service. There is also no evidence of any open disclosure to Mr A regarding the delayed referral. In my view, Dr B should have contacted Mr A and explained the delay.

Conclusion

55. Overall, although I am critical that Dr B failed to submit the referral letter in a timely manner, I note that he has since changed his practice to avoid delays occurring again. Further, I note that at the time, Dr B was supporting Mr A with multiple other concerns, and I have taken into account that the poor standard of clinic notes on 30 October was not Dr B's usual standard, and that his other clinical records were of a good standard. As such, I have made adverse comment regarding the lack of safety-netting advice, open disclosure, and poor record-keeping related to this episode of care and have made recommendations

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to Dr B (see below). However, I do not consider that Dr B breached the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: Health NZ — adverse comment

56. Dr B's referral of Mr A to the plastics and reconstructive surgery service is marked urgent and dated 23 October 2019. The referral was for a skin lesion '?SCC' on the dorsum of the index finger. The service sent Mr A a letter of acceptance of the referral dated 4 November 2019 and copied it to Dr B.

57. The Faster Cancer Treatment (FCT) indicators and guidance aim to help coordinate timely access to appointments and tests for people with a high suspicion of cancer. However, SCCs were not included within the FCT programme.[3] Consequently, the referral fell within the Elective Services Patient Flow Indicators (ESPFIs) framework. The ESPFIs measure whether the providers are meeting the required performance standard at several key decision or indicator points on the person's journey through the planned care system.

58. Mr A's referral was acknowledged and triaged as semi-urgent, to be seen within 100 days, and the letter dated 4 November 2019 was sent to Mr A within 12 calendar days of the date of the referral letter. This was within the ESPFI timeframe that services appropriately acknowledge and process more than 90% of all patient referrals in 15 calendar days or less.

59. The letter of 4 November 2019 stated that Mr A would receive an appointment by 23 March 2020. This is a gap of 152 calendar days and outside the ESPFI parameter that all patients accepted for FSA should be seen within four months (120 days) of the date of referral. The letter contained safety-netting advice for Mr A to continue seeing his GP and let the GP know if his condition worsened.

60. Mr A had an FSA and biopsy on 9 March 2020 (a calendar gap of 138 days from referral to FSA). This is outside the ESPFI 120-day parameter. The histology report was available on 16 March 2020.

61. The ESPFI parameter is that all patients given a commitment to treatment should receive it within four months. Mr A was admitted on 18 May 2020 and underwent excision of the lesion on 19 May 2020. The histology report dated 21 May 2020 showed SCC and Mr A underwent a right index finger ray amputation on 28 May 2020. The histology report showed no residual SCC. In total, Mr A received FSA and first treatment within 209 days of the 23 October 2019 referral. He underwent his first treatment within 71 days of the FSA (and his subsequent treatment within 10 days of that), which was within ESPFI timelines.

[3] https://nsfl.health.govt.nz/system/files/documents/publications/fct_tumour_specific_guidance_v2.0_jan17_0.docx

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62. The COVID-19 lockdown occurred during the time Mr A was under Dr C's care. He was seen just before the lockdown, but his definitive surgery was deferred due to the lockdown. Dr C said that it was unfortunate that Mr A had a long delay from October 2019 through to March 2020 before he was seen about the SCC of his right index finger.

63. Dr C said that the plastic surgery service is not able to comply with the 100-day target due to the service's heavy workload and, as at December 2020, the wait time for standard skin cancer patients was four to five months.

64. Health NZ acknowledged the concerns about the timeliness of services provided to Mr A and recognised that it would have been ideal for him to be seen earlier. However, it pointed to several factors that affected the timing of Mr A's care, including patient factors and the COVID-19 pandemic. Health NZ stated: 'Those are relevant under Clause 3 of the Code and support our overall view that our service to Mr A was reasonable in all the circumstances.'

65. I acknowledge that booking routine SCCs outside the ESPFI of four months is not uncommon. However, when issues cause delays, there should be transparent communication to patients and referrers regarding expected timelines and safety-netting advice, especially in the event that a condition deteriorates, so that patients can make informed choices about their care, and referrers can provide adequate advice.

66. Although the time from referral to FSA was outside ESPFI timeframes, I have taken into account the pressures on the system at that time, including the COVID-19 public safety measures in place and the information provided to Mr A, which included safety-netting advice, and I have not found Health NZ in breach of the Code.

67. Health NZ stated that while it recognises HDC's mandate to consider Health NZ's referral triage process and communication with patients while they are on the waitlist, it considers that questions relating to allocation of resources and access to services fall within the remit of the Ministry of Health rather than HDC.

68. While I agree that HDC cannot compel access to services and does not have jurisdiction over the clinical thresholds for access to services, HDC does have a clear mandate to ensure that consumers are sufficiently informed of services to which they do have access and highlight where these services are under pressure to meet demand, potentially causing harm in the community as a result.

Opinion: Medical centre — adverse comment

69. Mr A told HDC that when the lesion was treated with cryotherapy for the last time, it caused a large hole that needed to be dressed regularly by the practice nurse at the medical centre. The record of the consultation on 30 October 2018 refers to a finger wart having been treated with liquid nitrogen, but there is no record of any dressings having

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been undertaken. Regarding the potential treatment options, Dr B acknowledged that the decision-making process is poorly documented in the notes.

70. Dr B has been unable to find any nursing notes relating to Mr A's post-cryotherapy nursing care. He stated that Mr A may have attended as a 'walk in' patient (with no appointment) and had a dressing done, and, although normally that would result in a nursing intervention note being recorded, this may have been overlooked inadvertently, depending on what else was happening at the time in the medical centre. Dr B stated: 'If this was the case this was an error on our part.' I am unable to make a finding as to whether Mr A received post-cryotherapy nursing care.

71. My in-house clinical advisor, GP Dr Maplesden, advised that ulcers can form at the site of cryotherapy to benign lesions, and delayed healing can be due multiple factors. Dr Maplesden noted that malignancy may need to be considered in the differential diagnosis if there is prolonged ulceration or progressive ulceration at the site of cryotherapy, or if a lesion that usually would be responsive to cryotherapy is not responsive.

72. Dr Maplesden advised that if Mr A presented to the medical centre with delayed wound healing at the site of his cryotherapy and required dressings and/or GP review, he would expect these presentations to be documented, and the failure to do so would represent a severe departure from expected standards of clinical documentation. I agree.

73. I note that the photograph of Mr A's finger that accompanied the referral shows an obvious unhealed lesion, but there is no record of when the photograph was taken. I am unable to establish whether or not Mr A returned to the medical centre for follow-up care after the cryotherapy on 30 October 2018. If he did, the presentations should have been documented. If he did not, I am critical that medical centre staff did not recall him, as required by the 'Procedure for cryotherapy treatments' policy.

Changes made and update

74. Dr B said that he has improved referral processes by adding to the electronic list at the same time as the referral decision is made.

75. The medical centre has reviewed its clinical policy regarding the cryotherapy service. Clinicians will now set up a recall for any patients who require cryotherapy, if the process includes more than one episode.

76. The medical centre has improved its protocol and instructions to clinicians on uploading photographs of patient images to referrals.

77. Health NZ told HDC that on 17 March 2023, the status of the skin cancer waiting list was worse than it was in March to May 2020. It has been unable to improve its service further because it is already working at capacity. In 2022 an extra surgeon was working in the unit,

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and in the previous two years, no surgeon had taken extra leave. However, despite that, the number of patients waiting for treatment remained high. Health NZ said that to manage this, it adheres closely to its triage criteria and process and accepts skin cancer referrals strictly as per its health pathways.

78. Since February 2023, non-melanoma skin cancers outside the head and neck region have been seen in plastic surgery only when they require reconstruction because the cancers cannot be excised and closed directly. Health NZ was unable to offer any dermatology service for 18 months, which increased the skin cancer burden in the population.

79. A new dermatologist started work in February 2023. However, the dermatology service remains extremely limited in the context of significant unmet need for dermatology and skin cancer services. The plastics and reconstructive surgery service highlighted its concerns regarding long waits for skin cancer to both the previous CEO and the current management of Health NZ.

Recommendations

80. Although Health NZ indicated that it is not HDC's role to question access to services or allocation of resources, on the basis of the concerning information regarding the status of the dermatology and skin cancer service in the region, I have written to Health NZ National and advised it of my concerns. I have asked Health NZ National to provide HDC with a comprehensive workplan, within six months of receipt of this report, to address these issues.

81. I recommend that Health NZ, Dr B, and the medical centre each separately apologise to Mr A for the criticisms identified in this report. The apologies are to be sent to HDC within three weeks of the date of this report, for forwarding.

82. I recommend that within six months of the date of this report, Dr B undertake a random audit of 25 of his clinical files to ascertain the quality and accuracy of his clinical records. The audit should be conducted as per the RNZCGP clinical notes audit module guidelines, with results and plans for improvements as needed submitted to HDC for review.

83. I recommend that within three months of the date of this report, staff at the medical centre are reminded of the importance of accurate and detailed record-keeping and the updated clinical policy regarding the cryotherapy service. The medical centre is to provide HDC with evidence of this having occurred and staff attendance.

84. In the provisional opinion I recommended that Health NZ consider establishing a single point of contact system for FSA waiting-list patients in the plastics and reconstructive surgery service. Health NZ considered the recommendation and advised that it could be achieved only with additional funding, and therefore at this time it is not feasible.

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85. I recommend that Health NZ review the circumstances of those patients identified as having been harmed by systems failure in the plastics and reconstructive surgery service to ensure that ACC treatment injury claims have been supported as appropriate and report to HDC on the outcome and any remedial actions, within six months of the date of this report.

Follow-up actions

86. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Medical Council of NZ.

87. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to Te Aho o Te Kahu|Cancer Control Agency and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from GP Dr David Maplesden:

'**DATE:** 13 October 2020; **Addenda 7 April 2021 (bold — s6 & s10)**

1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided to him 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 [Mr A]
- responses from [Dr B]
- GP notes [medical centre]
- responses and clinical notes [Hospital 2]

2. [Mr A] complains about delays in the diagnosis of a lesion on his right index finger as squamous cell carcinoma (SCC). He states his GP has been treating the lesion with liquid nitrogen over the past eight years after diagnosing it as a wart. Another clinician advised him the lesion did not look like a wart and he was referred to a plastic surgeon. He has since required amputation of his finger following the diagnosis of SCC.

3. [Dr B] notes in his response that [Mr A] has attended [the medical centre] intermittently over the past 10 years. He transferred to another practice between February 2017 and September 2018. The finger lesion was first brought to [Dr B's] attention on 30 October 2018. [Dr B] states: *My notes indicate this lesion has appearances of a benign keratotic wart and it was treated with cryotherapy at that time on one occasion. The lesion was not mentioned again (or noticed by me) until 20/08/19. He was referred for a plastic surgical opinion after this consult.*

4. On review of the available notes, there is a brief note dated 30 October 2018: *Liq N2 to finger wart. Given SPOe 0-800 number. Otherwise seems well.* Notes dated 20 August 2019 are: *WINZ Also a longstanding finger lesion. For referral to plastics.* In [the DHB] notes is a referral letter from [Dr B] dated 23 October 2019 (marked urgent) to [the DHB] plastic surgical service. The referral includes a photo of [Mr A's] finger lesion with provisional diagnosis of *?SCC finger* and history noted as: *He has a 12/12 or more of this attached lesion on the dorsum of his index finger. He does feel it is enlarging. Not really practical for biopsy …*

5. In a response to HDC, [Hospital 1] notes [Mr A] has been under the care of [Hospital 1] since [an incident in] February 2017 which resulted in multiple … fractures. There is no reference in any of [Mr A's] hospital letters to him presenting a finger lesion or written advice being provided related to his finger lesion, but he cannot exclude the possibility verbal advice was provided regarding the lesion.

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6. Comment: Without having viewed [Mr A's] finger lesion in 2018 it is difficult to state whether the diagnosis of a keratosis (keratotic wart) was reasonable. SCCs usually grow over weeks to months and may arise within a pre-existing actinic keratosis[1]. Cryotherapy with liquid nitrogen is an accepted treatment for actinic keratoses[2] and it is possible the lesion with which [Mr A] presented initially was an actinic keratosis which failed to respond to cryotherapy and which later transformed to a SCC. I am unable to state that [Dr B's] management of [Mr A] on 30 October 2018 departed from accepted practice. An SCC would be unlikely to evolve over many years and there is no reference in the available notes to previous cryotherapy treatment to the lesion although I cannot exclude the possibility treatment was provided by another medical centre during the period [Mr A] was not registered at [the medical centre]. Best practice would be to document some detail regarding the lesion being treated (which side, which finger, duration, size, evolution), informed consent to cryotherapy, and provision of safety-netting advice (return if the lesion persists or progresses after treatment) and [Dr B's] standard of clinical documentation could be improved in this regard. It was appropriate to refer [Mr A] for specialist review following the consultation of 20 August 2019 and noting the provisional diagnosis of SCC and clinical photograph attached I think there was sufficient information to prioritise the referral appropriately. It is unclear to me why the referral is dated 23 October 2019 and I would be somewhat critical if there was a delay of two months before the referral was sent. [Dr B] might be able to clarify precisely when the referral was provided to the DHB and, if there was a delay, the reason for the delay.'

Addenda 7 April 2021

'**I have since reviewed GP notes from 2013 to current and there is no reference to observation of a finger lesion, or any treatment for a finger lesion, prior to 30 October 2018. I acknowledge this is at odds with [Mr A's] recollection. If treatment for a finger lesion was provided by [Dr B] on other occasions and this was not documented by him, I would regard this as a severe departure from expected standards of clinical documentation.**

(ii) In a response dated 5 April 2021 [Dr B] states: *Normally I add patients who need specialist referrals to a list kept electronically and delete them after completion. Clearly this did not happen with [Mr A's] referral resulting in this delay. As previously mentioned we had some issues with the "photo add" system to the Plastics referrals which may have distracted me from the correct processes over this referral … This whole referral process has now been tightened by me by adding to this list the same time as the referral decision is made.* I believe this referral (suspected cancer) should have been tracked as per recommended practice[3] and this may have led to earlier recognition that submission of the referral had been delayed. It is not possible to determine from the clinical documentation reviewed what actually prompted

[1] https://dermnetnz.org/topics/cutaneous-squamous-cell-carcinoma/ Accessed 13 October 2020
[2] https://dermnetnz.org/topics/actinic-keratosis/ Accessed 13 October 2020
[3] Lillis S. The management of clinical investigations. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017

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completion of the referral on 23 October 2019 or whether there was open disclosure to [Mr A] of the delayed referral. I am mildly to moderately critical of the delay in submitting the referral in the circumstances described but the process [Dr B] states he now follows should reduce the risk of such an oversight in the future. There is no documentation in the GP notes suggesting [Mr A] sought review of his finger lesion between August and October 2019.

(iii) There is no reference in the GP notes to dressings being undertaken over this period. Ulcers can form at the site of cryotherapy to benign lesions and delayed healing can be due to multiple factors including impaired circulation, cigarette smoking, poor nutrition, and infection. Malignancy might need to be considered in the differential diagnosis if there was prolonged ulceration or progressive ulceration at the site of cryotherapy, or if a lesion which would usually be responsive to cryotherapy was not responsive on this occasion. If [Mr A] presented to [the medical centre] with delayed wound healing at the site of his cryotherapy and required nursing cares (dressings) and/or GP review, I would expect these presentations to be documented. The failure to do so would represent a severe departure from expected standards of clinical documentation.

7. Plastics Clinic letter dated 9 March 2020 includes: *25-year history of RIF dorsal PIPJ lesion — multiple tx with liquid nitrogen. Getting bigger lately and infected. O/E 1.5 x 1.5cm lesion with crusting and central crater — underlying minor fluctuance. No right axillary LNs.* Handwritten clinic notes include: *looks like SCC.* Biopsy was performed immediately and complete excision of the lesion with skin graft scheduled for 6 April 2020. Initial histology report was non-specific: *well differentiated squamoproliferative lesion … differential diagnoses include a benign reactive process and squamous neoplasia.* Excision was deferred because of Covid. [Mr A] subsequently presented to [Hospital 2] ED on 12 April 2020 with multiple infected skin lesions (treated with antibiotics).

8. On 21 and 24 April 2020 [Mr A] presented to [the medical centre] for wound review and dressings. Possible re-biopsy and re-referral was discussed but on 28 April 2020 [medical centre] staff confirmed [Mr A's] definitive surgery had been scheduled for 18 May 2019. He presented to [Hospital 2] ED again on 7 May 2020 because of pain associated with his finger lesion. On that occasion a somewhat different history of the lesion was recorded: *… approximately 10x10mm wound on the dorsal aspect of his right index finger at the level of the PIPJ. This wound has been present for approximately 4/12 following cryotherapy for ?SCC … he stated that he wanted to amputate his finger to finally resolve the issue.* [Mr A] left the department before he could be medically reviewed.

9. [Mr A] had excision of his right finger lesion on 18 May 2020 (left open while awaiting histology) together with biopsy of a scalp lesion. He required IV antibiotics prior to surgery as the lesion was infected and was noted to have enlarged significantly since previous Plastics review. Histology of the finger lesion showed moderately differentiated SCC, incompletely excised at the deep margin with some

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evidence of perineural invasion. In view of this ray amputation of the index finger was undertaken on 27 May 2020 with no residual tumour identified on histological examination of the finger.

10. Comment: There was a four-and-a-half-month delay between receipt of [Dr B's] urgent referral for [Mr A] and first specialist appointment (FSA) assuming the referral was sent on 23 October 2019, and it was over six months since [Dr B] had noted his intention to refer. National skin cancer service provisions appear to refer primarily to melanoma rather than non-melanoma skin cancer (NMSC). The burden of NMSC in New Zealand is significant and many DHBs do not have the resources to provide optimal management (in terms of timeliness) although some are transferring part of the burden back to primary care via schemes using GPs with special interest in skin cancer (GPSI). The DHB could be asked for comment on the delay (although the time between FSA and excision was undoubtedly impacted by the Covid crisis) and what steps have been taken to improve FSA waiting times for NMSC.

The DHB notes the primary reason for the delay between receipt of the referral and FSA is a resource issue. [Mr A's] lesion was felt (on the basis of the history and photograph supplied) to be most likely a SCC. Extremities (hand and feet) are "high risk" sites for SCC. The referral was appropriately classified as high suspicion of cancer with a goal of <100 days for FSA. Patients are advised to see their GP for review if their lesion progresses or changes while awaiting FSA, and there was no information received from the GP requiring consideration of re-prioritisation of the referral over this period. The goal of <100 days was not met (136 days). Once [Mr A] was reviewed and biopsy results received he was placed on the semi-urgent waiting list for excision of his lesion. The original surgery date (6 April 2020) appears reasonable allowing for histology reporting. Deferral of [Mr A's] surgery during Covid alert level 4 (community) was consistent with the National Hospital Response Framework[4] recommendations and his surgery was carried out within a reasonable timeframe once alert levels dropped. I do not believe the resource issues encountered by [Health NZ] with respect to management of NMSC are localised to this [Health NZ district] and steps to improve access to secondary care services are planned as part of the Health and Disability System Review[5]. In the meantime, the triage and management processes outlined in the DHB response appear designed to limit as much as possible the adverse effects of a constrained resource.'

'**Addendum**

DATE: 16 November 2022

I have reviewed the response from [Dr B] dated 13 November 2022. [Dr B] reiterates his impression that [Mr A's] finger lesion appeared benign at the time of his first assessment of the lesion and I am unable to state there was any deficiency with this

[4] https://meras.midwife.org.nz/wp-content/uploads/sites/4/2020/03/National-Hospital-Response-Framework-4pm.pdf Accessed 7 April 2021
[5] https://systemreview.health.govt.nz/

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assessment as discussed in my original advice. [Dr B] has reflected on the quality of his clinical documentation and I believe it is reasonable to recommend he undertake a two-pass audit of his clinic notes per the RNZCGP clinical notes audit module[6] with results and reflections submitted to the Commissioner for review. There is no admission that [Mr A] had multiple undocumented applications of liquid nitrogen to his finger lesion, although [Dr B] refers to an expectation more than one application was likely to be required but *this never really eventuated.* I remain of the view that the delay in [Dr B] submitting [Mr A's] plastic surgical referral, due in part to a failure to track the referral, represents a mild to moderate departure from accepted practice but note [Dr B] has undertaken appropriate remedial measures in this regard.

I have no additional comments, recommendations or changes to my original advice.'

'**Addendum**

DATE: 27 November 2023

I have reviewed the response dated 13 November 2022 [Dr B] has provided after he has reviewed my updated advice dated 7 April 2021. There is nothing in the response that alters the comments in my advice regarding [Dr B's] management of [Mr A]. I have reviewed the response from [the medical centre] dated 15 May 2023 including copies of cryotherapy and clinical notes policies. I recommend the cryotherapy policy refers to a need to align with the clinical notes policy in terms of documenting administration of cryotherapy (including site of administration) in addition to documenting that verbal consent was obtained. I remain of the view that if [Mr A] was seen by nursing staff for change of dressings to his finger following the application of liquid nitrogen on 30 October 2018, and there was no documentation kept of this service, this represents a severe departure from accepted standards of clinical documentation and is also inconsistent with the practice clinical notes policy. However, I am unable to confirm that [Mr A] did in fact attend [the medical centre] for dressing changes in 2018.'

[6] https://www.rnzcgp.org.nz/gpdocs/New-website/quality/Record_Review_MAR-2020.pdf Accessed 16 November 2022

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