Plantar wart or melanoma?

How to record a 'simple' presentation

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This series highlights common medicolegal issues in general practice. Written by a team from medical defence organisation Avant, it is based on actual cases with details changed for privacy and some issues summarised for discussion. In this case, an action against a GP who treated a patient for a presumed plantar wart, later diagnosed as an acral melanoma, was successfully defended. It highlights the importance of including clinical descriptors, and possibly photographs, in medical records.

A medical practitioner builds a diagnosis from subjective and objective elements: patient recollection, clinical observation and empirical measurement. Good medical practice also requires making a contemporaneous record, and documenting the observations that led to that diagnosis is crucial. Some practitioners use the diagnosis as a shorthand to indicate the characteristics of a typical presentation. Even in otherwise detailed notes, specific features such as lesions may not be well described. As a recent case highlights, should a diagnosis subsequently be challenged, there are risks associated with not recording the observations supporting the diagnosis.

MedicineToday 2018; 19(5): 63-65

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Case history

Between September 2009 and May 2010, Mr White attended his GP, Dr Green, in relation to a lesion on the sole of his foot. Dr Green diagnosed a plantar wart and treated it with cryotherapy. Mr White was subsequently seen by two other GPs, in September 2010 and January 2011, respectively. Both diagnosed a plantar wart and applied cryotherapy. One of the GPs, Dr Grey, became suspicious when the lesion did not respond to treatment, and in March 2011, Mr White was diagnosed with malignant melanoma. He died the following year.

Proceedings were commenced on behalf of Mr White (the plaintiff) against Dr Green (the defendant) alleging Dr Green had breached his duty of care by failing to diagnose melanoma. This had caused Mr White harm, namely the melanoma had metastasised.

To succeed, the plaintiff had to establish that between September 2009 and May 2010 the melanoma was:

- discernible by Dr Green exercising reasonable care, and
- present but had not yet metastasised.

The crucial factor in determining both issues was the appearance of the lesion.

The factual dispute was stark. The plaintiff alleged that from the first visit, the lesion had a black centre and pigmentation. The doctors maintained the lesion did not display any indicator inconsistent with a plantar wart, including pigmentation. The judge found all witnesses gave truthful accounts; the reliability of the evidence, not honesty, was the issue.

Discussion

Standard of proof

In civil claims, the standard of proof is 'on the balance of probabilities'. Was it more likely than not that between September 2009 and May 2010, the lesion had the appearance of a melanoma?

1. RISK MANAGEMENT TIPS

- Provide some indication of your differential diagnoses or your clinical reasoning process in your notes.
- Adopt a basic framework for describing skin lesions and use it routinely even when the diagnosis appears clear and non-concerning.
- Ensure your records include the information you would need if you were taking over the patient's care.
- Consider making clinical images a routine part of the patient's file.
- Remember that clinical images form part of the medical record and should be subject to the same precautions and confidentiality and consent requirements.

The judge heard evidence from Mr White (via an affidavit sworn before his death), Mrs White and the treating doctors. Medical experts also gave evidence, but were unable to reach a consensus on the nature of the lesion or to say when metastatic disease was first present.

Mr and Mrs White's evidence

Mr and Mrs White gave evidence that from late 2009, the lesion had a black spot about the size of a match head; thinking it was a piece of black tar, Mrs White had tried to scrape it off with her fingernail. In drawings prepared by Mr White, the lesion's diameter grew from 5 mm in October 2009, to 10 mm in May 2010 and to 15 mm in January 2011. This was consistent with Mrs White's evidence that between September 2010 and January 2011, the lesion had grown from the size of a one-cent piece to the size of a five-cent piece. Mr White gave evidence that the lesion had become more raised and more asymmetrical over time. Mrs White maintained it had never contracted.

Their evidence was not entirely consistent: Mr White stated the lesion had become darker in colour; Mrs White was adamant it had always been black.

The doctors' evidence

Dr Green's medical records were brief. Typical entries recorded:

'Large (L) plantar wart → cryo

Cryo to wart'.

Dr Green's oral evidence was that 'plantar wart' was a descriptor, indicating certain characteristics such as thickening of the skin and lack of pigmentation. It was a shorthand way of indicating he had examined the lesion and been satisfied it had the typical features of a plantar wart. His usual practice was to record any unusual features. If he had observed a 'red flag', such as pigmentation, then he would not have used the term plantar wart.

The judge found Dr Green to be an intelligent and careful doctor. He accepted that Dr Green was aware of the significance of pigmentation, and that its presence would have required melanoma to be excluded.

Dr Grey made the most detailed notes. On initial presentation, she recorded the wart was 5 mm and appeared to be contracting. Two weeks later, the wart measured 10 mm in diameter. A further month after that, it appeared 'soft, painful and vascular … atypical appearance'.

Dr Grey's oral evidence was that the lesion was initially fairly symmetrical, discrete and flesh-coloured. She recalled that at a consultation some weeks later, it had changed dramatically, being purple pink and bleeding on examination.

The judge found the additional information in Dr Grey's notes persuasive in determining the appearance of the lesion.

His Honour noted that the evidence from Mr and Mrs White regarding the growth of the lesion was inconsistent with the contemporaneous measurement Dr Grey made in January 2011. Mrs White's evidence that the lesion never contracted in size was at odds with Dr Grey's records. Doubt was also cast on the descriptions given by Mr and Mrs White. Dr Grey's evidence regarding lack of pigmentation until February 2011 and that the change in colour of the lesion triggered her to reconsider her diagnosis, was powerful evidence against the plaintiff's position and supported Dr Green's assessment of the lesion as a plantar wart.

Outcome

The judge was satisfied that between September 2009 and February 2011, the lesion had the appearance of a plantar wart. His Honour was unable to find, on the balance of probabilities, that a melanoma had been present at the time Dr Green reviewed the lesion. Further, if a melanoma was present, it was not discernible by the exercise of reasonable care by Dr Green. Accordingly, he had not breached his duty of care to Mr White. His Honour returned a verdict for the defendant.

Risk management

As a GP, the presentation of plantar warts is usually straightforward. However, the case of Dr Green demonstrates how things can go wrong, even years down the track, with the spotlight suddenly turned on your management and records of a 'simple' presentation. Although the court found in favour of Dr Green, there are steps that Dr Green could have taken to protect himself and potentially avoided the ordeal of a lengthy trial (summarised in Box 1).

Clinical notes

The case is a reminder of the importance of good clinical notes and the danger inherent in the tendency not to make thorough notes when we perceive the matter to be straightforward.

As practitioners will be aware, the expected standard of medical notes is addressed in *Good Medical Practice: a Code of Conduct for Doctors in Australia* (section 8.4), which outlines the standard of record-keeping the Medical Board has set down for good medical practice.[1] This includes 'Keeping accurate, up-to-date and legible records that report relevant details of clinical history, clinical findings, investigations, information given to patients, medication and other management in a

form that can be understood by other health practitioners."[1] However, even in otherwise good notes, lesions are sometimes not well documented.

In keeping notes about dermatological problems, there are several ways to describe skin lesions. However, a basic framework should include size, site, shape, colour and texture, and this framework should be used routinely.[2]

Even when the diagnosis seems obvious, there are always differential diagnoses and it is advisable to note in the records how you excluded these or which 'red flags' you ruled out. A good rule of thumb is to think about what you would want to know from the records if you were taking over the patient's care and had not spoken to the previous doctor. Such records are also of benefit from a medicolegal perspective and can help refresh your own memory. Commencing therapy such as corticosteroids or cryotherapy may also change the appearance of the lesion, and initial records may form an important reference point.

Clinical photography

Skin lesions can be difficult to describe and clinicians may interpret descriptions differently. The case of Dr Green also shows how a patient's retrospective description of a lesion can differ from that of the clinician.

Photography can provide an objective and powerful level of evidence. With the accessibility of digital photography and the ability to include images in the clinical records, photographs can provide an objective record of a lesion and be an important adjunct to the clinical notes. Photography can also aid clinical decision-making by potentially alerting the clinician to early changes in lesions, or demonstrating lesions that are not responding as expected to treatment.

In making clinical images part of the GP's standard record-keeping, there are several considerations to ensure that these photographs do not themselves become a source of risk.

Confidentiality and privacy

It is important to treat photographs as you would any other part of the patient record. They belong with the patient file and are governed by the same principles and laws of patient confidentiality and privacy.

Practice management software commonly used in general practice now often facilitates adding clinical images to the electronic record. The image should then be deleted from the camera or camera phone. For clinicians who take photographs regularly, use of a dedicated practice camera rather than a personal smartphone can help manage privacy and security issues.[3]

Wherever possible, the clinician should attempt to ensure the photograph does not have features identifiable to the patient. However, in photographing dermatological lesions, it can be useful to have indications of site and scale.

Consent

Patient consent should also be obtained with an explanation to the patient of the purpose of the photograph and the potential audience for such an image. Consent should be documented in the clinical records. Some institutions and hospitals require that consent be written, and often the use of images for educational purposes or publication requires additional consent processes.[3]

Other considerations

Resources that discuss further considerations on the use of clinical images and present guidance are listed in Box 2.[3-5] In certain circumstances, additional thought should be put into the appropriateness of clinical images: for example, in children, in adults with impaired capacity and for intimate body areas. MT

2. RESOURCES ON USE OF CLINICAL IMAGES

- Get smart: clinical images and smartphones. Avant Mutual (www.avant.org.au/news/get-smart-clinical-images)[3]
- Clinical images and the use of personal mobile devices: a guide for medical students and doctors. Australian Medical Association and Medical Indemnity Industry Association of Australia (https://ama.com.au/article/clinical-images-and-use-personal-mobile-devices)[4]
- What should health service providers consider before taking a photo of a patient on a mobile phone? Office of the Australian Information Commissioner (www.oaic.gov.au/agencies-and-organisations/faqs-for-agencies-orgs/health-service-providers/what-should-health-service-providers-consider-before-taking-a-photo-of-a-patient-on-a-mobile-phone)[5]

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COMPETING INTERESTS: None.