SUMMARY

DR. DAVID ALBERT FOSTER ELLIS (CPSO #20915)

1. Disposition

On March 22, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered otolaryngologist and head and neck surgeon Dr. Ellis to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Ellis to:

- Attend and successfully complete the next available session of a course acceptable to the College, offering a minimum of one hour of instruction on melanoma – diagnosis and management
- Review the clinical practice guidelines on the following areas:
    - Biopsy of a Suspicious Pigmented Lesion
    - Pre-operative and Pre-treatment Investigations for Melanoma
    - Referral and Follow-up Surveillance of Cutaneous Melanoma
    - Optimal Excision Margins for Cutaneous Melanoma
    - Specimen Collecting and Tissue Handling Instructions
- Prepare written summaries of the above-noted guidelines and submit them to the College to ensure completeness of the review.

In addition, the Committee required Dr. Ellis to appear before a panel of the Committee to be cautioned with respect to the appropriate examination, diagnosis and processing of lesions. This includes taking an appropriate history, performing an appropriate physical examination and reaching a differential diagnosis of cutaneous lesions, as well as the use of appropriately wide excisions for melanoma.

2. Introduction

The patient complained to the College that Dr. Ellis failed to appropriately manage his melanoma from May to July 2016. The patient expressed concern that Dr. Ellis failed to consider his immunosuppressed condition or properly process biopsy samples.

The patient indicated that Dr. Ellis removed a number of moles from his back and the back of his head and placed them all in one vial before sending them for pathology analysis. One of the seven moles tested positive for melanoma but, as Dr. Ellis had not separated or labeled the specimens, it was impossible to know where the melanoma had come from. This required Dr. Ellis to re-excise the moles. The seven excisions tested negative for malignancy, but the patient expressed concern that the melanoma could still be in his body because there is no way to know which lymph node to check.

Dr. Ellis responded that the moles he removed from the patient's back and neck were not suggestive of melanoma. He understood that the patient wanted the moles removed for cosmetic reasons and did not believe a full excision procedure to be in the patient's best interest. He indicated that he considered it reasonable to place the specimens in one vial.

The patient denied that the mole removal was for cosmetic reasons and indicated that the kidney transplant team advised him to have the moles removed.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee noted that the patient informed Dr. Ellis at the initial consultation that he had received a kidney transplant six months earlier and that he was on anti-rejection medication. This

is important, as the anti-rejection medication increased the patient's relative risk for cutaneous malignancies.

Among the specimens Dr. Ellis removed from the patient's back and neck were several nevi, a seborrheic keratosis and an intermediate-thickness melanoma. The appropriate management for intermediate-thickness melanoma would be a wide excision and elective lymph node dissection and biopsy.

The Committee found Dr. Ellis's decision to send the specimens to pathology together in the same container to be concerning. Any isolated lesions that have the potential for malignancy must be sent individually for histopathologic analysis. If a number of specimens are sent together, in the rare event one lesion turns out to be melanoma or another type of skin cancer, it is impossible to know where to perform the wider excision with elective lymph node dissection.

Dr. Ellis carried out wider excisions on the areas of the patient's lesions but failed to document the extent of the margin he used for the eight areas where he performed wider excision. Pathology testing did not identify melanoma in the excised areas, but this is not reassuring as it is not possible to determine whether Dr. Ellis did a sufficiently wide resection of all of the sites.

In light of Dr. Ellis's response, the Committee questioned his ability to distinguish melanomas in a skin examination. While it is possible to mistake a nevus for a melanoma, it is not acceptable to remove lesions and fail to separate them so that they cannot be identified. Nor is it acceptable to fail to clearly document the extent of the margins on second excisions.

In the Committee's view, Dr. Ellis's response to the complaint did not reassure the Committee that he had insight into his poor judgement in this case. The Committee concluded that the two-fold disposition described above was warranted.