Patient Test Results

Concerns about the communication to patients of test results arise frequently in the complaints received by HDC. The Commissioner has previously said doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal results[1]. An essential element of effective communication with patients is to discuss in advance whether patients will only be notified if the result is abnormal, will be advised of the result in any event, or should contact the practice themselves to obtain the test result.

Information about test results should be communicated in a manner that enables the patient to understand the significance of the information. In some cases, the actual report or result may not be particularly helpful to the patient. An explanation of the significance of the result and advice about any recommended investigations or treatments may be more meaningful Knowledge of test results enables patients to be partners in their own healthcare and provides a layer of protection should other systems fail and the required follow up be overlooked.

This is a recurring theme in HDC cases and it arose again in a recent decision.[2] In that case a man attended his general practice in March 2010 and had a consultation with his general practitioner, who removed a mole from the man's right thigh. The subsequent histology report showed that the mole was "an atypical compound nevis amounting to in situ melanoma". The doctor said he was reassured by the report that he had completely excised the lesion and because it was melanoma in situ with no evidence of invasion, he was sure that the margin of excision was adequate.

The patient said he was never informed that the mole was a melanoma in situ. He said he thought that if the test results were serious, the doctor would call him.

The doctor was certain the patient was informed of his results but he also noted that the patient did not return to have his sutures removed so the opportunity to discuss the result may have been lost. As the results did not warrant further follow-up at that time, the Commissioner accepted that they were not considered serious and the doctor was not found to have breached the Code by failing to ensure the patient knew about the result.

Subsequently, in May 2012, the patient saw the doctor about a lump in his right groin. The doctor thought the lump might be a lymph node or femoral hernia and ordered an ultrasound of the lump. The ultrasound report stated that the lump was "probably a reactive [lymph] node" and that options for further management would include an FNA biopsy at that time or a follow-up ultrasound scan four weeks later. The report further stated that if the lump remained abnormal following a follow-up ultrasound, "then FNA biopsy would definitely be indicated".

When the patient returned for a further consultation the doctor told him that he had a reactive lymph node and advised him to return if he had any concerns. The doctor said he also prescribed antibiotics but there is no record of any such prescription. The patient said the doctor told him that the lump was benign and should resolve in three to four months and did not recall being prescribed antibiotics. The doctor did not inform the patient that the ultrasound report suggested follow-up investigations — namely an FNA at the time, or a

---

[1] 10HDC01419 (5 April 2012).

[2] 13HDC00031 (20 March 2014).

follow-up ultrasound four weeks later. The Commissioner considered that the level of uncertainty about the diagnosis was information that a reasonable consumer in the patient's circumstances would expect to receive. The expert advisor said that, on seeing that ultrasound report "any GP should be putting cancer on his/her differential diagnosis list".

About four months later the man noticed that the lump had grown and become painful and consulted a different doctor. A subsequent ultrasound noted "Significant growth and change in the echotexture in the right groin node. It looks malignant and urgent FNA is required." The man was referred to a specialist for treatment for metastatic melanoma and sadly died in 2013.

The Commissioner found that the failure to communicate the ultrasound result and follow up recommendations in May 2012 was a breach of Right 6(1) of the Code. The failure to arrange an immediate FNA, follow-up ultrasound or follow-up consultation was suboptimal and a breach of Right 4(1) of the Code.

Doctors need to have an efficient system for notifying patients of test results including a bring-up component. The expected process should be discussed with patients and they should be encouraged to call if they want confirmation of the normal result or have any questions.

Dr Cordelia Thomas

NZ Doctor, 6 May 2014