Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Mismanagement of melanoma diagnosis

20HDC01906

The Deputy Health and Disability Commissioner has found a locum GP breached the Code of Health and Disability Services Consumers' Rights (the Code) in his management of a man's melanoma diagnosis.

Deborah James found the GP breached Right 4(1) of the Code by failing to interpret the histology report of the man's lesion correctly. The consequence of this was that the man received incorrect information when making a decision about his future treatment.

The breach concerns the GP's management of a melanoma diagnosis after a lesion was removed from the man's arm. Test results of the lesion showed an invasive melanoma which could be either a primary or metastasised (secondary) melanoma. A specialist referral was recommended for further investigation.

The GP advised the man that he believed it was a melanoma in situ (primary and localised) and recommended excision as treatment. The man declined a referral for further examination based on that advice.

The medical centre arranged an appointment with another GP after it was contacted by a melanoma clinical nurse specialist from Te Whatu Ora/Health New Zealand. The GP examined the man and made an urgent referral request to Te Whatu Ora.

Subsequently, the man had other lesions were biopsied. No evidence of further cancer was found. The locum GP has admitted his error and apologised to the man and his family.

"Dr C failed to provide Mr A with an acceptable standard of care by failing to interpret the histology of Mr A's lesion correctly. … Mr A received incorrect information when making a decision about his future treatment," said Ms James.

Ms James also made adverse comment about the medical centre in relation to their view that the GP had been correct in his diagnosis, as no other melanoma was found. Ms James reminded the clinic of the importance of ensuring that its staff manage significant histology results appropriately.

Ms James recommended the GP provide a written apology to the man and arrange for peer mentoring on interpreting histology results. She also recommended the GP

present this case as an anonymised case study to peers. Evidence of both actions must be supplied to HDC within six months of this report.

She further recommended the Medical Council of New Zealand undertake a competence review of the GP.

4 September 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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