General Practitioner, Dr C
Medical Centre

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01906)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man in 2020 by a locum general practitioner (GP) at a medical centre in relation to the management of a melanoma diagnosis following receipt of the histology results.

Findings

2. The Deputy Commissioner found the GP in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that the GP failed to interpret the histology report correctly, and that as a result, the man did not have correct or complete information on which to base his decision to defer follow-up treatment. The Deputy Commissioner was also critical that safety-netting advice was not documented and was critical of the clinic's response to the GP's error in misinterpreting the histology results.

Recommendations

3. The Deputy Commissioner recommended that the GP provide a written apology to the man, receive peer mentoring in relation to the management of histology results, and present an anonymised case study to his peers. The Deputy Commissioner also recommended that the Medical Council of New Zealand undertake a competence review of the GP.

Complaint and investigation

4. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided to her father, Mr A, by Dr C, a locum GP working at a medical centre. The following issues were identified for investigation:

- *Whether Dr C provided Mr A with an appropriate standard of care on 15 May 2020 until his melanoma[1] diagnosis.*
- *Whether the medical centre provided Mr A with an appropriate standard of care on 15 May 2020 until his melanoma diagnosis.*

5. This report is the opinion of Deputy Commissioner Deborah James and is made in accordance with the power delegated to her by the Commissioner.

6. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs B	Consumer's daughter/complainant
Dr C	Locum GP/provider
Medical centre	Provider

[1] A form of cancer that begins in melanocytes (cells that make the pigment melanin).

7. Further information was received from:

Te Whatu Ora (formerly a district health board)[2]	DHB
Dr D	GP/provider
RN E	Registered nurse/provider

8. General practitioner Dr F is also mentioned in this report.

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

Information gathered during investigation

Background

10. This report concerns the management of a melanoma diagnosis in 2020 by GP Dr C[3] at a medical centre.[4] Dr C was employed by the medical centre on 13 April 2020 as an independent contractor for a period of 16 weeks.[5]

11. At the time of these events, Mr A was aged in his seventies. Mr A's regular GP at the medical centre was Dr D.

12. Mr A had a lesion removed from his left forearm by Dr C in May 2020. Histology results found that the lesion was a nodular melanoma[6] and that a specialist referral was required. During a follow-up consultation, Mr A was advised by Dr C that he thought that the lesion was a melanoma in situ,[7] and on the basis of this advice, Mr A declined a referral.

April–May 2020

13. On 30 April 2020, Mr A had a telephone consultation with Dr D as he was concerned about a lesion on his left forearm. The telephone consultation took place during public health

[2] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to the DHB now refer to Te Whatu Ora.
[3] Dr C is a general practitioner who qualified overseas. Since 2012, Dr C has worked as a locum general practitioner both overseas and in New Zealand.
[4] The medical centre is a charitable trust and is a provider of primary healthcare services.
[5] The contract for services between Dr C and the medical centre ended on 3 July 2020 when Dr C returned home.
[6] A nodular melanoma is an invasive form of melanoma in which the lesion presents as a nodule (lump) that has been rapidly enlarging over the previous weeks to months.
[7] Melanoma in situ is an early form of primary melanoma in which the malignant cells are confined to the tissue of origin, the epidermis. It is also known as in-situ melanoma and level 1 melanoma.

restrictions during the COVID-19 pandemic,[8] and Mr A was seen in the ambulance bay at the medical centre by Dr D, who recorded the following notes for the consultation:

> "Worried about growing lesion on arm.
>
> Looks like a little bruise on his arm, been present too long, bigger all the time. Blood blister appearance?
>
> **4 months duration.**
>
> He cannot take a phone [picture] and send, will come to ambulance bay at clinic and I will review, take [picture], and organise treatment if needed.
>
> …
>
> Patient seen in parking lot in ambulance bay. Photo taken and attached to record.
>
> Firm nodule left forearm, no fluctuance,[9] blue area.
>
> Asked [Dr C] his opinion, agrees needs removal.
>
> Patient booked for tomorrow."

14. Mr A returned to the medical centre on 1 May 2020 for removal of the lesion by Dr C, who recorded:

> "Came for review [with a] suspicious area on forearm with a [firm] subcutaneous nodule and a dark appearance non vascular.
>
> Consent obtained, procedure explained
>
> 1% Lig with ad[r]enaline, p[e]n marked are at least 5mm margin all around
>
> Excision and submission of pathology …"

15. Dr C told HDC that the lesion was assessed rapidly and appropriately given the restrictions in place due to the COVID-19 public health restrictions, and an appropriate wide margin excision (5mm) was used as per the guidelines from Dr C's home country. The lesion was then sent for histology.[10]

Histology results

16. The histology report was provided to the medical centre on 11 May 2020. The results reported that due to the lack of connection with overlying epidermis,[11] the lesion might

[8] A four-tier alert level system was in place during the COVID-19 pandemic in New Zealand between March 2020 and December 2021, with levels 3 and 4 being forms of lockdown. A level 3 lockdown was in place from 27 April 2020 until 13 May 2020 (ie, at the time of Mr A's consultation with Dr D).
[9] A tense area of skin with a wave-like or boggy feeling when examined by touch.
[10] Study of the cells of the lesion under a microscope.
[11] The outermost of the three layers that comprise the skin.

represent a metastasis of melanoma[12] or a primary nodular melanoma[13] in this area. The report stated: "[C]linical correlation and thorough examination of the patient is essential."

15 May 2020 consultation

17. On 15 May 2020, Mr A had a follow-up consultation with Dr C to discuss the results of the histology report. Dr C recorded:

> "Came for review and discussion and explained the nature of the histology, and the element of doubt, I believe it is melanoma in situ and complete wide excision is treatment of choice.
>
> We discussed possible referral or second opinion and he was happy and pleased with the report and no further action at this time
>
> Full skin evaluation did not find any other abnormal lesions, although there [were] one or two [acanthoma[14]].
>
> He has got through bowel cancer and does not wish any further investigation …"

18. Dr C's notes also refer to a discussion about a referral for a "[Dupuytren's contracture[15]] of [the left] little finger", and that Mr A would "think about our comments". However, it is unclear whether "our comments" relates to the discussion regarding a referral for the Dupuytren's contracture or the lesion.

19. Dr C told HDC that in his discussion with Mr A, he mentioned "all the possibilities of metastases", as is mandatory in any melanoma situation. Dr C recalled that Mr A had recently had an "extensive investigation" for bowel cancer and recent surgery, and felt that Mr A had made an informed decision not to be referred at the time based on the uncertainty regarding the possibility of a metastatic lesion. Dr C stated that where there is an uncertainty regarding histology, it is his practice to discuss the worst-case scenario, as he did with Mr A, and he recalled that Mr A had a good understanding of this. Dr C said that in all cases involving melanoma, he would have discussed the need for a review of the original lesion with both Mr A and Dr D.

20. The medical centre told HDC that no further action was recorded by Dr C at this time. However, Dr C advised that he is "certain" that he followed his routine practice of providing safety-netting advice.[16]

21. Dr C accepted that he made a mistake in describing the lesion as a melanoma in situ and cannot recall why he arrived at this conclusion when the histology confirmed that the lesion was a nodular melanoma and that therefore a wider excision would be required. He stated:

[12] Melanoma that has spread to other sites of the body.
[13] A type of melanoma that can grow and spread quickly.
[14] A non-cancerous skin tumour.
[15] A Dupuytren's contracture is a condition in which connective tissue in the palm of the hand becomes tight and shortened, pulling the fingers in towards the palm.
[16] Advice on what to look for and when to seek further medical assistance.

> "Given this was a nodular melanoma and not [melanoma in situ], a further wider excision was needed. Ordinarily I would refer him to the hospital to have this done. Had I made the correct diagnosis I would have explained the need for a wider excision to [Mr A]. I regret that [this] did not take place and that [Mr A] made his decision not to be referred based on incomplete information."

June–July 2020 (histology audit and Te Whatu Ora contact with medical centre)

22. On 23 June 2020, a histology audit was completed by Dr C along with a senior nurse at the medical centre. Dr C told HDC that this was completed at his request as part of good practice, and it involved a senior nurse assisting with a full audit of all his cases at the medical centre.

23. The medical centre told HDC that the audit was completed by a nurse on 23 June, and the results were provided to Dr C.

24. Dr C returned to his home country on 3 July 2020 and continued to practise there as a locum GP.

25. On 23 July, the medical centre was contacted by a melanoma clinical nurse specialist from Te Whatu Ora, who spoke to RN E about the histology results for Mr A. The clinical notes record that the nurse was concerned about the histology report from May 2020 regarding the excision of the melanoma by Dr C. It is recorded that further follow-up would be discussed with Mr A.

26. RN E told HDC that the clinical nurse specialist from Te Whatu Ora wanted to know whether there had been follow-up after receipt of the results. RN E advised that Dr C had discussed the result with Mr A, but that she would follow up with Dr F (another GP at the medical centre) for further review. RN E stated that subsequently she telephoned the nurse back and advised that Dr F had thought it "odd" that Mr A had not wanted a referral, but that this was his choice. An appointment was booked with Dr D following Dr D's return from leave, to consult with Mr A about the results.

27. RN E stated that she telephoned Mr A to advise him of the appointment, and spoke with Mr A's wife, who "firmly advised" that Mr A did not want any treatment but agreed to attend the appointment with Dr D.

Consultation with Dr D

28. Mr A had a consultation with Dr D on 31 July. The clinical notes record the following:

> "Discussed melanoma — path with complete excision however possibly not primary but a metastasis.
>
> Discussed risk/benefits/need to review thoroughly. He had declined this with [Dr C]. He admits he may not have understood the risk of metastasis.
>
> Did skin check. Photo consent on file and with verbal permission current photos obtained of two lesions on his back, both dermoscopy and regular. 7 total photos kept. He was happy to have me send these to skin cancer for f/u.

> He isn't sure whether he wants referral to a specialist or not, but willing to consider it, depending on what is recommended."

29. Dr D conducted a head-to-foot examination in addition to taking photographs. The photographs were attached to the urgent referral and sent to Te Whatu Ora on 8 August 2020 for further management of the melanoma.

August–November 2020

30. Mr A was seen by a plastic surgeon at the public hospital on 12 August 2020. The plastic surgeon conducted a full body check and located multiple lesions, and Mr A was waitlisted for urgent excisional biopsies. Mr A was seen again on 7 September 2020 by a general surgery registrar at the public hospital. Given the history and referral for the excision of multiple skin lesions, Mr A was referred for a PET-CT[17] scan on 15 September.

31. Following the PET-CT scan, Mr A met with a general surgery registrar on 25 September 2020. The registrar noted the following:

> ''The histology from the skin lesion in May is concerning and we have expressed to him today that we are very concerned that this was not referred to the hospital earlier and we have encouraged them to give formal feedback to your practice so this does not happen again. Also in the histology it is suggested that it may not be a primary melanoma but possibly a metastasis. I think it is most likely that this is a primary melanoma so we will proceed to wide local excision with sentinel node biopsy of the left axilla but this is why his other suspicious pigmented lesions that have been identified also need biopsy in case this is metastasis. I have explained this to him and his family today and they are understanding of the information."

32. The registrar reported that excision biopsies of three lesions on Mr A's forehead were also completed at the consultation. The registrar arranged for an urgent left forearm wide local excision and sentinel node biopsy as well as excision biopsies of Mr A's left upper back lesion and chest lesion, and Mr A was scheduled for surgery on 22 October 2020 at the public hospital. The subsequent anatomical pathology confirmed no evidence of malignancy in any of the lesions removed or in the lymph nodes.

33. On 25 November, Mr A was seen by a surgical registrar at the public hospital for a follow-up discussion of the results. The registrar recommended four-monthly skin checks for the next three years, then annual skin checks. Mr A was discharged back to the care of his GP at the medical centre.

Further information

Medical centre

34. The medical centre told HDC that as a result of the complaint it undertook an investigation involving a review of all clinical notes and correspondence. It stated that Dr D now reviews

[17] Positron emission tomography-computed tomography — a scan that produces images of the organs and tissues at work to help to diagnose, locate and assess a disease.

all surgery performed by locum GPs at the medical centre, and audits histology results as part of the process.

35. The medical centre told HDC that Dr C was correct in his diagnosis, as no other melanoma was found and all other biopsies have been negative. The medical centre reiterated that Mr A's outcome was good and that Dr C's judgement was correct. However, the medical centre accepted that Dr C was incorrect in his presentation of the results to Mr A, and that Dr C should have ensured that Mr A understood the risks of not pursuing further assessment and should have documented this. The medical centre stated that currently Mr A refuses any further referrals and has opted to have biopsies performed at the medical centre.

36. The medical centre told HDC that all GPs, including locums, are provided orientation on clinical pathways and policies, and can refer to these in consultations with patients. The medical centre advised that all pathways relating to melanoma are now highlighted when training locums, to ensure that specialist follow-up occurs in accordance with the guidelines.

Dr C

37. Dr C told HDC that he is sorry for the error and distress that this has caused. He accepts that he incorrectly described the lesion as a melanoma in situ when it was clear in the histology report that it was a nodular melanoma. Accordingly, a wider excision was required.

Responses to provisional opinion

The family

38. Mrs B was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. She told HDC that she appreciated that Dr C had apologised and had openly admitted and accepted his error, and that he has reflected and updated his knowledge in this area. She considered that it was reassuring that as a result of the complaint, the medical centre had completed a review of the incident and put in place procedures to ensure that this would not happen again.

39. Mrs B considered that the medical centre's remarks were incorrect — in particular, the comment that Dr C was correct in his diagnosis as no other melanoma was found and all other biopsies have been negative, and the outcome was good. She said that had the clinical nurse specialist not alerted the medical centre to Mr A's histology results, there would not have been any further investigations. As a result, Mr A was very lucky that all results came back negative.

40. Mrs B does not accept the medical centre's comment that Mr A refuses any further referrals, and is concerned that this comment makes Mr A sound "stubborn and impolite". She says that her father has a "limited understanding of medical terms and comes from a generation where he does not like to cause a bother, or waste doctors and hospital time, knowing how overworked our health system is".

Dr C

41. Dr C was provided with an opportunity to comment on the provisional opinion.

42. Dr C accepted the finding that he breached the Code of Health and Disability Services Consumers' Rights (the Code) for failing to interpret the histology report correctly, and said that he is very sorry for the distress that this has caused Mr A and his family. Dr C advised that as result of this case, he refreshed his knowledge of melanoma and the local guidelines, and he believes that this mistake will not be repeated.

Medical centre

43. The medical centre was provided with an opportunity to comment on the full provisional opinion, and it advised that it had no further comments to make.

Opinion: Dr C — breach

44. Dr C had a duty to provide services in accordance with the Code. Right 4(1) of the Code provides that every consumer has the right to have services provided with reasonable care and skill.

45. Mr A was seen at the medical centre on 30 April 2020 during the COVID-19 lockdown. Given the concerns about the lesion on Mr A's left forearm, identified by both Dr D and Dr C, Mr A was scheduled for an appointment with Dr C on 1 May 2020 to have the lesion removed. The histology report was received on 11 May 2020 and noted that the lesion might represent a metastasis of the melanoma or a primary nodular melanoma. The report concluded that clinical correlation and thorough examination of the patient was essential.

Consultation and discussion of histology results

46. Following receipt of the report, Mr A had a consultation with Dr C. Dr C incorrectly advised Mr A that he believed the lesion was a melanoma in situ. On the basis of this advice and because Mr A had recently recovered from bowel cancer, he declined further investigation. The error was not identified in a subsequent self-audit conducted by Dr C and a nurse at the medical centre. Dr C has accepted that he incorrectly described the lesion as a melanoma in situ when it was clear in the histology report that it was a nodular melanoma.

47. My in-house clinical advisor, GP Dr David Maplesden, stated:

> "It appears [Dr C's] impression the lesion may have been a SSM[18] remained following provision of the excision audit results … It appears [Dr C] made an error in his interpretation of the histology results as being suggestive of SSM or metastasis rather than nodular melanoma or metastasis and it is difficult to understand how this occurred. I cannot assume that [Mr A] would have agreed to specialist referral if he had been given the full and correct information regarding his histological diagnosis, but the

[18] Superficial spreading melanoma — a form of melanoma in which the malignant cells tend to stay within the epidermis ("in situ" phase) for a prolonged period (months to decades).

fact remains he based his decision to defer follow-up on incorrect or incomplete information provided to him by [Dr C]."

48. Dr Maplesden noted that Dr C is an experienced GP but is unable to explain why he interpreted the histology result as being suggestive of SSM. Dr Maplesden said that it is concerning that Dr C failed to recognise his error when completing the audit. Dr Maplesden concluded that he would be "at least moderately critical" that the information presented to Mr A was erroneous and did not in fact enable Mr A to make an informed choice regarding his future management.

49. The medical centre had a Patient Test Result Management Policy (see Appendix B), which Dr C was required to follow. The purpose of the policy is to ensure that patient investigations are managed appropriately. The policy states that the ordering clinician has the ultimate responsibility for following up on patient test results and ensuring that the patient is aware of the process. The policy highlights the importance of significant results being followed up and includes a direction that all significant test results should be communicated either by letter or telephone consultation confirming that the patient is aware of the results and that they have a suitable clinical follow-up and management plan. A record of this contact needs to be documented in the patient's file. In addition, I note that the guidance on melanoma management from the regional Community HealthPathways (see Appendix 2 of Dr Maplesden's advice) states that for diagnosed melanoma, an urgent non-acute skin care assessment is needed.

50. Dr C described the lesion in his notes as a melanoma in situ, which he accepts was a mistake as it was clear in the histology report that it was a nodular melanoma or a metastasis of a melanoma. He told HDC that had he made a correct diagnosis, he would have explained to Mr A the need for a wider excision and referred him to the hospital to have this done. Dr C stated that he cannot recall the reason he concluded that the lesion was a melanoma in situ.

51. I am critical that Dr C misinterpreted the histology report, and that as a result, Mr A did not have the correct or complete information on which to base his decision to defer follow-up treatment. In a subsequent appointment with Dr D, Mr A indicated that he may not have understood the risk of metastasis when he discussed the results with Dr C. I am also concerned that Dr C did not document any advice he provided to Mr A, notwithstanding the fact that he may have provided verbal safety-netting advice.

Conclusion

52. Overall, I consider that Dr C failed to provide Mr A with an acceptable standard of care, by failing to interpret the histology report of Mr A's lesion correctly. The consequence of this was that Mr A received incorrect information when making a decision about his future treatment. Accordingly, I find that Dr C breached Right 4(1) of the Code.[19] I remind Dr C of the importance of reviewing histology reports carefully before discussing the results with a patient.

[19] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Opinion: Medical centre — adverse comment

53. The medical centre was responsible for providing services to Mr A in accordance with the Code. Dr C was employed as a locum GP from 16 April 2020 to 3 July 2020. The medical centre was advised of the histology results by a clinical nurse specialist from Te Whatu Ora. Following the notification from Te Whatu Ora, the medical centre arranged an appointment for Mr A with his regular GP, Dr D. Dr D conducted a full body check and made an urgent referral to Te Whatu Ora.

54. Dr Maplesden advised that the initial management and excision of the lesion by Dr D and Dr C was conscientious management of a suspicious skin lesion during the COVID-19 lockdown in 2020, and I accept this advice. I note that the medical centre responded appropriately and quickly in arranging an appointment for Mr A and a subsequent referral once the medical centre was contacted by the clinical nurse specialist following up on the histology results. I accept Dr Maplesden's advice that Dr D was conscientious in undertaking a full skin check and photographing a number of suspicious skin lesions, and providing an urgent referral. I accept that Dr D's management of Mr A was consistent with accepted practice.

55. Dr Maplesden noted the following in relation to the medical centre:

> "I believe the practice orientation and auditing processes in place at the time of the events in question were very reasonable and there was no systemic practice related issue contributing to the incident in question."

56. Dr Maplesden also commented that the medical centre's Patient Test Result Management Policy is consistent with accepted practice, and I accept this advice.

57. As a result of the incident, the medical centre undertook an audit of the histology of all lesions removed by locums, to ensure that recommended practice had been followed. The medical centre stated that all GPs, including locums, are provided orientation in clinical pathways, and it now ensures that pathways relating to melanoma are highlighted in the training of locums. I commend the medical centre for taking such steps.

58. However, notwithstanding the positive steps taken subsequent to these events, the medical centre told HDC that Dr C was correct in his diagnosis, as no other melanoma was found, and all Mr A's other biopsies have been negative. The medical centre said that Mr A's outcome was good, and that Dr C's judgement was correct. While I accept that the final outcome was positive for Mr A, the fact remains that Dr C did not interpret a significant histology result appropriately and, as a consequence, Mr A did not receive correct information when making decisions about his future care. I am concerned by the medical centre's remarks and remind it of the importance of ensuring that its staff manage significant histology results appropriately.

Changes made

59. Dr C told HDC that he has reflected on the melanoma management guidelines and has reviewed the Australian and New Zealand guidelines for the management of melanoma disease, which included updating himself on the latest research around causality, risk and prevention. Dr C stated that he has learnt about the need for appropriate follow-up in addition to the new techniques and appropriate use of the PET scan alongside the MRI,[20] and understands that melanoma remains an important cause of death in older males. Dr C said that in future he will confer with a colleague to confirm the exact type or stage of a new lesion in order to be certain that local guidelines are followed where appropriate. Dr C concluded that he would reflect on every consultation as part of good medical practice.

Recommendations

60. I recommend that Dr C:

a) Provide a written apology to Mr A for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.
b) Arrange to receive mentoring from a peer regarding the interpretation of histology results. Evidence that this has been arranged is to be provided to HDC within three months of the date of this report, and the outcome of the mentoring is to be provided to HDC six months later.
c) Present this case as an anonymised case study to his peers. Evidence that this has been done is to be provided to HDC within six months of the date of this report.

61. I recommend that the Medical Council of New Zealand undertake a competence review of Dr C.

Follow-up actions

62. 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 New Zealand, and it will be advised of Dr C's name in covering correspondence.

63. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Royal New Zealand College of General Practitioners and Te Tāhū Hauora | Health Quality and Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[20] Magnetic resonance imaging — a scan that produces detailed images of the organs and tissues in the body.

Appendix A: In-house clinical advice to Commissioner

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

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs B] about the care provided to her father, [Mr A], by [Dr C] 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 [Mrs B], daughter of [Mr A]
- Response from [the practice manager] with input from [Dr C]
- GP notes [the medical centre]
- Clinical notes [DHB/public hospital]
- **Responses to this advice were received from [Dr C] and [the medical centre] in July 2022 and this information has been incorporated as addenda (bolded) in relevant sections of the report.**

2. The complaint relates to delayed follow-up of an invasive melanoma. The melanoma was removed from [Mr A's] left forearm by locum GP [Dr C] on 1 May 2020 (see timeline below). [Dr C] has since returned to [his home country]. It appears [Dr C] felt the lesion removed was a melanoma-in-situ (MIS) and that based in part on this information, [Mr A] declined follow-up. Routine audit of histology results by [the DHB's] melanoma clinical nurse specialist in July 2020 led to review of [Mr A's] management and subsequent wide local excision of the previous excision scar, sentinel node biopsy and excision biopsy of other possible pigmented lesions. The formal histology results are included as Appendix 1. Accepted management of suspected and confirmed melanoma is presented in Appendix 2 as extracts from relevant [regional] Community HealthPathways.

3. 30 April 2020 (Covid alert level 3): Phone triage ([Dr D]) noting [Mr A's] concerns regarding a lesion growing on his left forearm over the preceding four months. [Mr A] seen in ambulance bay by [Dr D], photographs of the lesion taken and second opinion obtained from colleague [Dr C]. Agreed that excision required and booked for following day.

Comment: This was conscientious management of a suspicious skin lesion during a period of stress and uncertainty in general practice due to the requirement for Covid precautions.

4. 1 May 2020: [Dr C's] notes record lesion removal as:

Came for review with a suspicious area on forearm with a firm subcutaneous nodule and a dark appearance, non-vascular.

Consent obtained, procedure explained

1% Lig with adrenaline, pen marked are at least 5mm margin all round

Excision and submission of pathology, sutures times 8 Mattress ROS 1/52 or later depending on appearance

Has thin slightly leathery skin

Written consent obtained (form viewed). Nurse notes record dressing and provision of wound care and follow-up advice. On 8 May 2020 — removal of sutures (practice nurse). Wound well healed. Histology not yet available.

Comment: Recommended NZ practice for excision of a suspected melanoma is excision with 2mm margins, adopting a vertical or oblique orientation on a limb if possible (see Appendix 2). This makes later wide local excision of the scar (if required) a less complex process. I note [Dr C] chose to take 5mm margins. Orientation of the excision is not clear from the notes. [Dr C] may not have been familiar with local guidance having trained in [another country]. Relevant … guidance states:

1.6.1 Consider a clinical margin of at least 0.5 cm when excising stage 0 melanoma.

1.6.2 If excision for stage 0 melanoma does not achieve an adequate histological margin, discuss further management with the multidisciplinary team.

1.6.3 Offer excision with a clinical margin of at least 1 cm to people with stage I melanoma.

1.6.4 Offer excision with a clinical margin of at least 2 cm to people with stage II melanoma.

Noting [Dr C] followed [overseas] guidance (assuming he suspected a superficial melanoma) I am not critical of his decision to plan a 5mm excision margin. I note both [guidance from NZ and Dr C's home country] recommend offering re-excision with at least 2cm margins to patients with confirmed stage 2 melanoma (see below). There were no apparent complications with the surgery which appears to have been carried out with appropriate care. Whether it was reasonable, on the basis of pre-excision examination, to assume this was clinically a MIS is debatable noting there was a 'firm sub-cutaneous nodule' present. However, not having viewed or examined the lesion I am unable to comment further on this aspect of care.

5. 11 May 2020 — histology reported (see Appendix 1). This was a nodular melanoma with Breslow depth 4.7mm (at least Stage II) and unknown status regarding distant metastases or lymph node involvement although there were favourable findings of absent ulceration and no signs of local lymphovascular invasion. However, the absence of any atypical melanocytic proliferation in the epidermis raised the possibility this might be a metastasis rather than a primary lesion. Diagnosis of MIS is confirmed by

histological examination of the tumour and finding malignant melanocytes confined to the epidermis and epidermal adnexal structures. Breslow thickness is not reported for MIS and MIS is often reported as a Clark level 1 melanoma. MIS is considered Stage 0 in the American Joint Committee on Cancer (AJCC) staging guidelines[1]. The absence of atypical melanocytes in the epidermal layer, and the significant vertical invasion as shown by Breslow depth and Clark level (4) meant this was not a MIS. I do not believe there was any clinical basis for [Dr C] to suggest [Mr A's] lesion was a MIS when confronted with the histology report on file. In order for [Mr A] to make an informed choice, appropriate information to be presented included: this was an invasive melanoma of significant depth and risk of metastasis; recommended management in [both guidelines] is wide local excision (WLE) with at least 2cm margins; recommended local management is referral to [the DHB's] skin cancer service (non-acute) for WLE and discussion of other procedures that might influence prognosis or ongoing management (sentinel node biopsy, staging imaging); there was an additional complication regarding the possibility this might be a metastatic rather than primary lesion which (in my opinion) increased the need for specialist input.

6. 15 May 2020: Discussion of histology and skin check ([Dr C]). Notes include:

Came for review and discussion and explained the nature of the histology, and the element of doubt, I believe it is melanoma in Situ and Complete wide excision is treatment of choice. We discussed possible referral or second opinion and he was happy and pleased with report and no further action at this time. Full skin evaluation did not find any other abnormal lesions, although there [are] one or two acanthomata.

He has got through bowels cancer and does not wish any further investigation.

We discussed the possible referral for Dupytrenes contracture of L little finger, some changes on the R. He will think about our comments.

A disease code has been recorded as: *Malignant melanoma of skin (B32.00) — Melanoma In Situ — wide excision completed.*

7. In the provider response, [Dr C] has noted:

At the follow up discussion with the Histology report present I went through the 'uncertainty' presented by the report and discussed this with [Mr A] in the context of his other recent illness. He appeared to understand this, indeed reflected back the decision making process with me and decided that he did not want referral. He fully understood that this decision was able to be revisited should he wish, or to discuss this with another practitioner should he wish. I naturally shared the words 'metastatic' with him, explaining what this might mean along with the fact that this was 'uncertain'. I feel that [Mr A] made an informed and competent decision.

[1] https://dermnetnz.org/topics/melanoma-in-situ/ Accessed 17 May 2021

Comment: While there was uncertainty over whether the lesion represented a primary or metastatic lesion, it was certain this was not a MIS. The fact [Dr C] has documented the diagnosis of MIS in two separate places in the clinic note raises the possibility (or likelihood) the discussion with [Mr A] was undertaken in the context of MIS being the likely diagnosis which had quite different prognostic implications and management advice compared with the actual diagnosis of stage 2 invasive melanoma or metastasis from an unknown primary. If this was the case (diagnosis of MIS and the relatively low risk implications of this histology presented to [Mr A]) I would be **at least moderately critical** that the information presented was erroneous and did not in fact enable [Mr A] to make an informed choice regarding his future management. If [Mr A] was presented with the diagnosis of likely stage 2 invasive melanoma, and the information as discussed in section 5, and despite this information he chose to decline or defer a decision regarding further intervention, I would not be critical of [Dr C's] management. However, both [Dr C's] contemporaneous notes and [Mr A's] subsequent recollections (see section 13) appear to support the former scenario. Mitigating factors are that it is documented an option of referral was discussed and further wide excision may have been discussed although the notes are ambiguous in this regard (the recorded comment: *I believe it is melanoma in Situ and Complete wide excision is treatment of choice* could be interpreted as meaning an adequately wide excision had already been undertaken for MIS, and this appears to have been [Mr A's] interpretation (see s13)). However, [Dr C] was conscientious in undertaking a full skin check and although the lesions he identified as benign were subsequently identified as suspicious by other clinicians, final histology showed them to be benign. It is not clear from the notes what formal follow-up skin check schedule was advised (if any) and this may represent a mild deficiency in clinical documentation, or a mild to moderate deficiency in clinical practice if there was no appropriate advice given in this regard.

Addendum 20 July 2022

[Dr C] has provided further information regarding his management of [Mr A] including the following comments:

- **The possibility of metastatic disease was discussed with [Mr A] — *The conversation I had with [Mr A] was done in the context of his recent and extensive investigation for Bowel Cancer, and recent surgery and his own present state of health and overall well-being. He made an informed decision not to be referred at that time (based on the uncertainty regarding the possibility of a metastatic lesion), and as mentioned he confirmed this decision with me and the fact that he could seek a second opinion from another practitioner or change his mind.***

- ***I have clearly described the lesion in the notes as MIS, and this is a mistake on my behalf. I acknowledge that this lesion was a nodular melanoma. I cannot now recall the reason I concluded that this was a MIS. It is clear that in the histology report it is a nodular melanoma. I sincerely apologise to [Mr A] for this error.***

- ***Given this was a nodular melanoma and not MIS, a further wider excision was needed. Ordinarily I would refer him to the hospital to have this done. Had I made the correct diagnosis I would have explained the need for a wider excision to [Mr A]. I regret that [this] did not take place and that [Mr A] made his decision not to be referred based on incomplete information.***

- **[Dr C] notes that he would have encouraged [Mr A] to have periodic review of the original lesion site to be undertaken by [Mr A's] usual GP.**

My interpretation of [Dr C's] additional response is that he discussed with [Mr A] that there was uncertainty whether the lesion was a metastasis or a SSM. If it was a metastasis then further investigation was required. If it was a SSM, then the management undertaken was appropriate but regular checks of the excision site were required. Following this discussion, and in light of his recent treatment for bowel cancer, [Mr A] elected to defer any specialist referral. It appears [Dr C's] impression the lesion may have been a SSM remained following provision of the excision audit results (see below). It appears [Dr C] made an error in his interpretation of the histology results as being suggestive of SSM or metastasis rather than nodular melanoma or metastasis and it is difficult to understand how this occurred. I cannot assume that [Mr A] would have agreed to specialist referral if he had been given the full and correct information regarding his histological diagnosis, but the fact remains he based his decision to defer follow-up on incorrect or incomplete information provided to him by [Dr C]. I remain of the view that my peers would be at least moderately critical of this situation. [Dr C] is an experienced GP and he is unable to explain why he interpreted the histology result as being suggestive of SSM. It is also of some concern that he failed to recognise his error when completing the audit discussed below. [Dr C] has since undertaken further education in melanoma management as outlined in his response and apologises to [Mr A] for his failure to diagnose the nodular melanoma. He states: *I will also, in future, confer with a colleague to confirm the exact type or stage of a new lesion, in order to be certain that the local guidelines are followed where appropriate.* These are reasonable remedial actions and I have no further comments in this regard.

8. 23 June 2020: Practice nurse note stating: *Conducted a histology audit for [Dr C] on this file.*

Comment: The provider response suggests this may have been a self-audit (ie performed by [Dr C]) and this may require clarification. If it was a self-audit, it is not surprising the apparent erroneous assumption by [Dr C] that [Mr A's] lesion was a MIS was not detected. Since the events in question, senior permanent clinical staff at the facility now regularly audit the histology of all lesions removed by locums to ensure recommended practice has been followed. This is an appropriate remedial action, but I do not believe the apparent failure of the existing audit system to detect [Mr A's] delayed follow-up represents a systemic issue given self-auditing is an accepted practice in primary care. The primary reason for the delay in [Mr A's] follow-up appears likely to relate to [Dr C's] apparent mis-interpretation of the histology result which may have affected the information provided to [Mr A] regarding his diagnosis. I presume all locum

GPs are made aware of the ClinicalPathways resource as part of their practice orientation. Given the high prevalence in NZ (compared to many other countries) of conditions such as melanoma and rheumatic fever, it may be worth considering emphasizing these pathways as 'samples' for locums to view as part of their orientation process.

Addendum 20 July 2022: The [medical centre's] response notes the audit was undertaken by a practice nurse on behalf of [Dr C] with the results provided to [Dr C] and reviewed by him. The [medical centre's] locum orientation process includes training in ClinicalPathways. There will be emphasis placed on the suspected melanoma and rheumatic fever Pathways in the future.

I believe the practice orientation and auditing processes in place at the time of the events in question were very reasonable and there was no systemic practice related issue contributing to the incident in question. The practice response also includes the repeated statement: *[Dr C's] judgement was correct … the patient outcome was good.* I believe this statement is made with the benefit of hindsight rather than accurately reflecting the contemporaneous management.

9. 23 July 2020: Practice nurse note recording contact with [the DHB's] melanoma clinical nurse specialist (CNS): *concerned re-pathology report dated 01/05/2020 — following excision of melanoma by [Dr C]. [Mr A] seen back in clinic and results relayed to him — he was happy with report and did not wish for any further action. I will contact [Dr F] to go over report and/or contact [CNS] to clarify results and if further F/U is necessary. Further note later that day: D/W [Dr F]: plan get patient to F/U with [Dr D] if he wishes to ensure [Mr A] is aware fully of implications of path report (metastatic disease). If no metastatic disease it would be beneficial to have F/U … Appointment made with [Dr D] 31/07/2020 @ 09:40.*

Comment: There was appropriate and timely action undertaken in response to the call from the CNS.

Addendum 20 July 2022: The practice nurse involved in this communication states she spoke with [Mr A's] wife on behalf of [Mr A] and confirms that [Mrs A] *firmly advised that [Mr A] did not want any treatment but agreed to attend the appointment with [Dr D].*

10. 31 July 2020 (Friday): Review with [Dr D]. Notes include:

Presents feeling well, no concerns. Discussed melanoma — path with complete excision however possibly not primary but a metastasis. Discussed risk/benefits/need to review thoroughly. He had declined this previously with [Dr C]. He admits he may not have understood the risk of metastasis. Did skin check. Photo consent on file and with verbal permission current photos obtained of two lesions on his back, both dermoscopy and regular. 7 total photos kept. He was happy to have me send these to skin cancer for f/u.

He isn't sure whether he wants referral to a specialist or not, but willing to consider it, depending on what is recommended.

Comment: The content of the consultation does reflect some doubt in [Mr A's] mind regarding his desire for specialist review of his situation despite apparent more detailed and appropriate discussion from [Dr D] although in hindsight, it appears [Mr A's] impression may have been that treatment had been completed if the lesion was not a metastasis 'complete excision', but follow-up was required if it was a metastasis and this is where the uncertainly lay. However, specialist follow-up was recommended whether or not the lesion was a primary or secondary melanoma as has been discussed previously. The fact excision appeared complete did not obviate the need for specialist input. [Dr D] was conscientious in arranging further full skin check and photographing a number of suspicious skin lesions, then providing an urgent referral and images once they had been uploaded to the PMS (see below). I believe [Dr D's] management of [Mr A] was consistent with accepted practice.

Addendum 20 July 2022: [Dr D] has provided a statement which is consistent with the clinical record. She notes that at the consultation of 31 July 2020 *we reviewed the histology report which does indicate the lesion might be a metastasis not a primary because it was not connected to the overlying epidermis. [Mr A] was not sure he wanted specialist review but did allow photos. He was willing to consider the referral depending on what was recommended. He did mention that he didn't realise the risk of the lesion being a metastasis.* [Dr D] notes that following the subsequent work-up through [the DHB's] plastic surgical service (see below) [Mr A] has declined subsequent plastic surgical referral for new skin lesions and prefers management (biopsy, regular skin checks) to be undertaken in the practice.

11. 4 August 2020: Skin lesion photographs uploaded onto PMS ready for sending. 8 August 2020: Urgent referral by [Dr D] to DHB skin cancer service including images of other lesions observed at recent assessment. Referral is of good quality. Includes: *Met with patient, explained concern, he is willing to pursue this now. He did not understand that he had risk for a primary lesion elsewhere.* 8 August 2020: Referral triaged by [plastic surgery MOSS] and appointment made for review in clinic.

12. 12 August 2020: Clinic review Waitlisted for urgent excisional biopsies of several lesions. 7 September 2020: Scheduled date for removal of lesions identified at preceding clinic but registrar identified need for possible imaging prior and after discussion with surgeon [Mr A] was referred for PET-CT scan. 15 September 2020: PET-CT performed. No evidence of metastatic melanoma. Indeterminate nodule right lung with follow-up CT recommended in three months.

13. 25 September 2020: Review in surgical clinic and PET-CT discussed. Scheduled for wide local excision and grafting of original excision site, L axillary sentinel lymph node biopsy and excisional biopsy of other possible pigmented lesions. Clinic report includes the following comments:

(i) [Mr A] *was told by the general practitioner at the time that this was a contained melanoma and his treatment had been completed.* [DHB melanoma CNS] *identified that this histology had not been followed up on so he came to us today for discussion of further management after having a PET CT in [a main centre] … He reports that the general practitioner that gave him the advice has now returned [home].*

(ii) *The histology from the skin lesion in May is concerning and we have expressed to him today that we are very concerned that this was not referred into the hospital earlier and we have encouraged them to give formal feedback to your practice so this does not happen again. Also in the histology it is suggested that it may not be a primary melanoma possibly a metastasis. I think it is most likely that this is a primary melanoma so we will proceed to wide local excision with sentinel node biopsy of the left axilla but this is why his other suspicious pigmented lesions that have been identified also need biopsy in case this is metastasis*.

22 October 2020: Surgical procedure undertaken as noted above. Results showed no evidence of malignancy in any of the lesions removed or in the lymph nodes. 25 November 2020: Final surgical clinic review. Results discussed and recommendation for four-monthly skin checks for three years then annual skin checks.

Comment: Despite the delays in [Mr A's] follow-up, it appears he has had a good result from his investigations and surgery and appropriate ongoing follow-up is now in place.

13. Addendum 20 July 2022

The practice 'Patient Test Result Management Policy' has been reviewed and appears fit for purpose.

Appendix 1: Synoptic report of [Mr A's] skin lesion excised 1 May 2020 (reported 11 May 2020)

CLINICAL DETAILS:

Long standing dark patch of skin subdermally, with some associated pigmentation, not BCC/SCC but might be melanoma so wide excision performed.

SPECIMEN:

SKIN LEFT FOREARM (on form)

MACROSCOPIC DESCRIPTION:

A skin ellipse measuring 57 x 20 x 3 mm in depth with an ill-defined, smooth, grey/tan, nodular lesion measuring 22 x 12 x 5 mm in height. The lesion is 5 mm away from the nearest long axis. Transversely cut. 4 in 1A. 3 in 1B. 4 in 1C. Tips remaining.

MICROSCOPIC DESCRIPTION:

Protocol for the Examination of Specimens From Patients With Melanoma of the Skin

Version: Melanoma 4.0.0.1 Protocol Posting Date: June 2017

Includes pTNM requirements from the 8th Edition, AJCC Staging Manual

Sections taken from the described skin specimen confirm the presence of melanoma of which the description is as follows:

1. Histopathologic Tumour Type: Nodular melanoma. Overlying epidermis without atypical melanocytic proliferation. There is no connection of the lesion with overlying epithelium (biopsy examined on multiple deeper levels).
2. Maximum Tumour Thickness/Depth of Invasion (Breslow): 4.7 mm
3. Anatomic (Clark) Level: Level 4 (in reticular dermis)
4. Ulceration: Absent
5. Microscopic Satellite Nodule(s): Absent
6. Excision Resection Margin Status:
   - Margins of radial component: Not applicable as no radial component observed
   - Margins of vertical component: Uninvolved. The narrowest superficial circumferential (peripheral) margin measures 3.6 mm while the uninvolved margin to the depth measures 0.4 mm.
7. Mitotic Rate: 27 mitoses/mm2
8. Lymphovascular Invasion: Not identified (supported with D2-40 and CD31 immunostains)
9. Neurotropism: Not identified
10. Tumour Infiltrating Lymphocytes: TILs Nonbrisk: Lymphocytes infiltrate melanoma only focally
11. Tumour Regression: Not identified
12. Regional Lymph Node Status: No lymph nodes submitted for histology
13. Additional Pathologic Findings: Sun damage changes of the skin present
14. Ancillary Studies: D2-40 and CD31 — no LVI [lymphovascular invasion]
15. TNM Classification (AJCC 8th Edition): pT4a, pNX, pMX

Comment: Due to lack of connection with overlying epidermis, the lesion might represent a metastasis of the melanoma or a primary nodular melanoma in this area. Clinical correlation and thorough examination of the patient is essential.

SUMMARY: SKIN BIOPSY FROM LEFT FOREARM — MELANOMA (PLEASE SEE ABOVE)"

Appendix 2: Guidance on melanoma management from regional Community HealthPathways[2]

Pigmented Skin Lesions

This pathway covers appropriate management of pigmented lesions and assessment for possible melanoma.

Background

About pigmented skin lesions

Assessment

History and examination. Include dermoscopy.

- Look for features of a melanoma using the ABCDE rule.
- Most melanoma present with an initial flat phase.
- Consider nodular melanoma, amelanotic melanoma, and acral lentiginous and sublungual melanoma, which are commonly misdiagnosed.

Management

1. Manage according to level of concern:
   - Suspected melanoma

Suspected melanoma

Punch or shave biopsies are not suitable for the diagnosis of melanoma. Do not undertake in general practice.

- Perform an excisional biopsy with a 2 mm margin.
  - Ensure the incision plane is perpendicular to the skin surface down to subcutaneous fat. Do not angle in towards the lesion.
  - Perform longitudinal or oblique excisions on limbs. When histology proves melanoma, a subsequent wide local excision will be more difficult if a transversely-oriented biopsy has been performed on a limb.
- If direct closure with a 2 mm margin is not possible, request non-acute skin cancer assessment.

   - Low concern lesion
   - Lesion of concern with no specific melanoma features
   - Patients at increased risk of melanoma
2. Management of melanoma after excisional biopsy:
   - Diagnosed melanomas

Diagnosed melanomas

For all diagnosed melanomas, request urgent non-acute skin cancer assessment.

Specialist services provide:

- further excision.
- discussion and planning for further investigations.
- comprehensive patient information.
- consideration of any suitable patient trials e.g., treatments, vaccines.

   - Melanoma in situ, including lentigo maligna

Melanoma in situ, including lentigo maligna

- If a 5 mm margin can be achieved with direct closure, arrange to excise the lesion. If outside your competency, request general practitioner colleague excision, or request non-acute skin cancer assessment.
  - This excision requires a total margin of approximately 5 mm i.e., if the initial margin is 2 mm, take another 3 mm.
  - If the initial margin is 4 mm or more, no further excision is required.
  - Refer melanoma in situ if not confident of achieving this margin with direct closure.
  - Follow up as for high-risk patients.

[2] Section: Pigmented Skin Lesions. Accessed 17 May 2021

- Suspected lymph node involvement, skin, or distant metastases
- Follow-up after specialist treatment of a confirmed melanoma. See recommended schedule of follow-up for patients who have had melanoma excised.

Recommended schedule (based on a low level of evidence)

Stage	Follow-up
Stage I < 1 mm thick, with or without ulceration < 2 mm thick without ulceration	GP or private specialist, annually for 10 years.*
Stage IIa 1 to 2 mm thick and ulcerated, or > 2 mm thick	GP or private specialist, 6-monthly for 10 years.*
Stage IIb to IIc	GP or private specialist:* • 4-monthly for 2 years. • 6-monthly in the 3rd year. • Annually until the 10th anniversary.
Stage III Nodal metastases	Private or public specialist follow-up for a variable number of years, then by agreement. Agreed regime is: • 3-monthly for 1st year. • 4-monthly for 2nd year. • 6-monthly until the 5th year. • Annually until the 10th anniversary.
Stage IV Distant metastases	Private or public specialist follow-up for a variable number of years, then by agreement. Agreed regime is the same as for stage III, with additional visits as per clinical requirements.

* DHB does not provide post-melanoma follow-up services for Stage I or II.

3. Other pigmented lesions:
   - Atypical naevi
   - Congenital melanocytic naevi

Request

- Request urgent non-acute skin cancer assessment if:
  - confirmed invasive melanoma.
  - suspected melanoma, and not confident in your ability to close excision with required 2 mm margin.
  - suspicious changes in a congenital melanocytic naevus.
  - suspected lymph node involvement, skin or distant metastases.
- If patient has melanoma stage III or IV and is not already under specialist surveillance, request non-acute skin cancer assessment.
- If unsure about a lesion not of high concern, request private skin cancer assessment or seek skin cancer advice.
- Consider private skin cancer assessment for:
  - surveillance of patients at high risk of melanoma.
  - post-melanoma follow-up for stages I and II.

Appendix B: Patient Test Result Management Policy

Scope: Relevant to all employees of the Trust including its subsidiaries and affiliates.

Policy: Patient test results will be managed to ensure patient safety.

Application:

1. Process for tracking of patient test results

1.1 Where possible all patient tests will be ordered using the Patient Management System (PMS). Where this is not possible a record of the test requested will be recorded in the patient notes.

1.2 In most cases patient test results are electronically linked to their files via Healthlink. Where this is not possible and the results are received as a hardcopy the results are scanned to MedTech and stored in a dated file after being reviewed by an ordering clinician/receiving clinician.

1.3 Electronic patient test results are automatically linked with the ordering clinician (as identified by their laboratory number) via Healthlink. Where for whatever reason this is not possible then the IT team are responsible for linking these results to a receiving clinician.

2. Patient notification

2.1 Unless otherwise arranged with the ordering clinician, it is the policy of this clinic that the minimum requirement of the ordering clinician is to inform the patient of test results (laboratory tests, imaging, or other specialist test) only if they are abnormal.

2.2 If the patient test results are abnormal the ordering clinician (or authorised delegate) will attempt to notify the patient either by phone or letter to arrange follow-up care.

2.3 If attempts to contact the patient by phone or letter are not successful and there is concern about the patient's safety then the ordering clinician should contact the community services of [the medical centre] to attempt to make contact with the patient by visiting the patient at their home address.

2.4 If patient tests results are normal the ordering clinician is not obliged to inform the patient as long as this process has been clearly explained to the patient beforehand.

2.5 If the patient would like to know details of normal results they are encouraged to call the practice or can arrange with the ordering clinician to have someone notify them.

2.6 In some situations sensitive tests results will not be given out over the phone and will need to be given face to face (i.e. HIV results, STI results).

2.7 All patients will be informed by the ordering clinician (or delegated authority) of the notification process, including expected timeframes. The process of notification is available in written form if required (see appendix 1).

3. Casual patients

3.1 If test results from a casual are received and are abnormal then the ordering clinician should contact the patient (as with any abnormal result — see 1.2) and ensure that the patient's regular GP is aware of the results.

3.2 If test results of casual patient are normal then they will be treated in the same way as that of an enrolled patient (see 1.3).

4. Results received from external providers (e.g. hospital, specialist)

At times patients are seen in the hospital or by external providers. When patient test results are received by the practice it is the responsibility of the clinician charged with the patient's care to follow these up. If there is no clinician assigned to the care of the patient concerned the results will be directed to an available clinician.

4.1 All significant results will be followed up as per any significant result received (i.e. letter and/or phone contact) to ensure that there is satisfactory clinical follow-up.

4.2 The clinical management for any significant results are to be documented in the patient's notes

4.3 All normal results will not be followed up unless indicated.

5. Management of significant results

5.1 Suspicion of significant results

If after seeing a patient and ordering tests, there is a high index of suspicion of a significant result the ordering clinician should enter an electronic memo in the Patient Management System (PMS) to remind them to follow up that —

- Patients have actually gone for the investigations ordered
- The tests results are followed up by an appropriate clinician

5.2 Notification of significant results

As per 1.2 and 1.3 all significant patient test results should be communicated to the patient either by letter or phone consultation to confirm that

5.2.1 They are aware of the implication of these results

5.2.2 They have suitable clinical follow-up and a management plan.

5.2.3 Record of this contact needs to be documented in the patient's file.

6. Process for follow up of patient test results for ordering clinicians are absent

6.1 When the ordering clinician is expected to be on leave they are responsible for delegating the responsibility of follow-up on test results for their patients to another authorised clinician.

6.2 — Where clinicians are due to leave the practice they are responsible for a detailed handover of all patients with expected significant results to an authorised clinician.

6.2.1 The IT team/practice manager are responsible for ensuring that all patient test results for clinicians that are leaving the practice are redirected to another authorised clinician for follow-up.

6.3 When the ordering clinician is absent from the practice due to illness another clinician is delegated by the practice manager to be responsible for any significant patient test results for the ordering clinician concerned. Current laboratory protocols are that any dangerously abnormal results are communicated directly by the laboratory to the ordering clinician or other available clinician at the practice.

6.4 Where the ordering clinician is absent from the practice for an unexpected and prolonged period of time (i.e illness) the IT team/practice manager are responsible for redirecting all patients' results of the ordering clinician to another authorised clinician.