23rd February 2026

Dear GP Colleagues

RE: AFTER HOURS ACCEPTANCE OF ABNORMAL RESULTS

Over the last few years there has been a steady increase in abnormal blood results reported to the Pathologist on-call after hours, as the clinician responsible for the patient has not been contactable. Of particular concern is the frequency of abnormal Troponin I results needing to be dealt with by the Pathologist.

For context, when community patients have a blood test later in the working day, the results commonly become available after the conclusion of standard (GP) working hours. Pathlab has parameters for every abnormal blood test result, outside of which the responsible clinician needs to be notified immediately. For certain tests such as Troponin I, any abnormal result, no matter how far out of the reference range, the responsible clinician needs to be notified immediately.

It is concerning how frequently an attempt is made by laboratory staff to contact the responsible clinician with an abnormal result that is outside the parameters, but no one is available to accept the result. The Pathologist on-call is then notified, and often is placed in a precarious position of having to make clinical decisions about the management of a patient that they do not know. Occasionally, the patient is not contactable, and then the Pathologist needs to decide whether involving the emergency services is warranted. This is a drain on our already stretched emergency services.

In particular, the number of Troponin I tests being requested in the community setting is increasing. Whether this is an appropriate test to be requesting in the community is a separate matter for debate, but nonetheless, it is completely inappropriate for no one to be available to receive the result if abnormal.

Several attempts over the years have been made by Pathlab to encourage several GP practices to take responsibility for these after hours abnormal results, but this has been unsuccessful. The Medical Council of New Zealand policy is clear that the clinician that orders a laboratory test is responsible for receiving the test result and acting appropriately. This issue is a clinical risk, and the responsibility lies with the clinician who has ordered the test. It is our expectation that urgent steps will be taken by GP practices to attend to this issue. One suggestion is that several GP practices join together and sharing in an on-call roster to receive such results, in so doing, decreasing the burden on any individual practice or GP to nearly nothing. The roster would have to cover Monday to Saturday (inclusive), and could end at 10pm, as most abnormal results are known by that time.

I believe that efforts are being made to set up a regular GP Community Liaison meeting, and this may be the perfect forum for discussing these issues. I, along with the other Pathologists, would be more than happy to work with you on this. If this is unsuccessful, MCNZ might have to be contacted for advice.

Yours Sincerely

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PATHOLOGIST, CLINICAL DIRECTOR

Dr Justin Copeland
PATHOLOGIST