A GP's duty to follow up test results

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Medical negligence claims alleging 'failure to diagnose' are a common cause of claims against general practitioners. In these claims there is often an underlying weakness in the GP's test result and patient tracking systems.

This article discusses the duty of care of a GP to follow up patients and their test results. Guidance is provided on how to establish an effective test result tracking system in order to minimise the possibility of a claim arising from 'failure to diagnose'.

Case history[1]

On 2 December 1994, Mrs K presented to Dr M for review of a tender lump in her left axilla. The lump had been present for about nine weeks. The 31 year old patient was 12 weeks into her third pregnancy at the time of presentation. Mrs K advised Dr M that there had been a similar lump in her left armpit about one year ago, but it had gone away after it was treated with antibiotics. On examination, there was no abnormality of either breast but there was some subdermal thickening in the left axilla that appeared to be beyond the tail of the left breast. Dr M advised the patient that he thought it was an area of hidradenitis but, just to be certain, he performed a fine needle aspiration biopsy (FNAB) of the area. The medical records noted the history, examination findings and the provisional diagnosis but there was no reference to the FNAB in the records. At the conclusion of the consultation, Dr M reassured Mrs K that he thought the condition was most likely to be hidradenitis, a benign condition. She was asked to ring the practice later that day for the biopsy results and arrangements were made for a follow up appointment on 3 January 1995.

The patient did not telephone the practice, nor did she attend the follow up appointment. Dr M never received the FNAB report which concluded that 'the features are those of an atypical epithelial proliferation highly suspicious of an underlying carcinoma'. When the patient failed to attend her follow up appointment, Dr M reviewed the patient's medical records but, as there was no notation of the FNAB, he concluded that there was no need to contact the patient as she had hidradenitis.

Following the delivery of her third child, Mrs K re-attended Dr M in September 1995. It was now 10 months after the initial consultation. The lump was larger and more tender. Subsequent open biopsy of the lump revealed a breast cancer with metastatic spread to the axillary lymph nodes. In spite of undergoing further surgery and chemotherapy, by October 1997 Mrs K had developed liver and bony metastases.

Mrs K commenced legal proceedings against Dr M alleging a delay in the diagnosis of her breast cancer.

Medicolegal issues

In her Statement of Claim, Mrs K alleged Dr M, having performed a FNAB, failed to take proper steps in response to the pathology report indicating a likelihood of cancer. In his defence to the proceedings, Dr M denied any negligence and claimed, in any event, it would not have made any significant difference if Mrs K's breast cancer had been diagnosed and treated 10 months earlier. Dr M also pleaded that Mrs K was guilty of contributory negligence in that she failed to contact the practice to obtain the FNAB result and failed to attend the follow up appointment. Three and a half years after Mrs K's initial consultation with Dr M, the claim proceeded to trial.

The court found that Dr M was negligent in failing to follow up and obtain the FNAB report and to act on it in a timely manner. In reaching this conclusion, the judge criticised Dr M's failure to establish a foolproof means of checking whether reports had been forwarded to his practice. The judge concluded that: 'All that would have been needed was a simple running sheet, recording that a report had been requested, with provision for the particular

entry to be ticked off when the report was received. He had no such system. Mrs K's failures to ring him...or to attend for the follow up appointment does not excuse the breach of duty of care imposed upon him in that respect. Irrespective of any initiative taken by the patient, he owed a duty to find out what the outcome of the pathological examination of the fine needle aspiration was...it is unreasonable for a professional medical specialist to base his whole follow up system, which can mean the difference between death or cure, on the patient taking the next step'.

The court also rejected the plea of contributory negligence. In this regard, the judge concluded: 'In general terms, Mrs K owed a duty to exercise reasonable care for her own safety and wellbeing. But her conduct must be judged in light of the circumstances as a whole. Dr M concedes that he reassured her as to her condition when she saw him on 2 December 1994. Very likely his reassurance would have led her to believe that a follow up consultation was not so important as it might otherwise have been. As I have said, irrespective of whether she rang up about it, she was entitled to assume that if the outcome of the testing of the biopsy gave cause for concern, she would be informed. No doubt she would then have sought further advice'.

Mrs K was awarded damages of more than $500 000.

Discussion

General practitioners commonly ask patients to phone or attend for test results. Reliance on this as the only system of follow up can lead to problems if, as in this case, the results are misplaced or the patient fails to contact the practice. While the patient may decide not to attend for a test or follow up, it remains the responsibility of the GP to know if this has occurred and consider whether further action is required in the circumstances.

A recent review of incidents of potential or actual harm to general practice patients concluded that: 'Lack of protocols for ensuring action on results of tests and investigations meant that important results were filed unseen or left until the GP who ordered the test was next in the surgery. Recall systems were often inadequate, preventing recall of patients for follow up tests and investigations and resulting in missed or delayed diagnosis or management'.[2]

Risk management strategies

The RACGP Standards for General Practices[3] recommends that general practices have a system for reviewing, acting upon, and incorporating in the medical record all pathology results, diagnostic imaging reports and clinical correspondence received. The intention of this recommendation is to ensure that all results and correspondence relating to a patient's clinical care are reviewed by a doctor and acted upon.

The standards also specify that there should be a system for follow up and recall of patients with abnormal test and imaging results. The indicators for this are:

- the doctor(s) can describe the procedure for follow up and recall of patients with abnormal test and imaging results
- the practice has a system (paper or computer based) to recall patients with significantly abnormal test and imaging results
- the practice has a written policy to follow up and recall patients with significantly abnormal test and imaging results.

The guidelines for interpretation of this recommendation state: 'While practices are not expected to contact patients with the results of every test or investigation undertaken (it is the patient's responsibility to seek such results), there may be significant patient risk in not following up abnormal results. An abnormal result must be reviewed by a doctor to determine its significance to the ongoing care of the patient'.[3]

What are the essential elements of a test result tracking system?

When instituting a test result tracking system:

- determine which tests are 'significant' and require tracking – 'significant' tests are those where subsequent follow up is essential and the risk to the patient of not following up is high, eg. breast and other tissue biopsy results, diagnostic mammograms, INR tests
- devise a method whereby significant test requests are centrally recorded to determine whether the:
  - test you ordered was actually performed
  - results have been received by your practice
  - results have been seen by you, eg. signed and dated
  - results have been reported to the patient
  - results have been acted upon
  - report has been filed in the patient's medical records.

Electronic medical record systems will facilitate the tracking of test results, but the elements of the system remain the same regardless of whether you use a computer or paper based tracking system.

SUMMARY OF IMPORTANT POINTS

- 'Failure to diagnose' claims commonly arise from a failure of a GP's test result and patient tracking system.
- Establish an efficient practice system which helps you and your staff to keep track of significant test results.
- Don't wait for the patient to act. You have an obligation to contact a patient, particularly in circumstances where any delay could place their health in jeopardy.

References

1. *Kite v Malycha* [1998] 71 SASR 321.
2. Bhasale A L, Miller G C, Reid S E, Britt H C. Analysing potential harm in Australian general practice: an incident monitoring study. Med J Aust 1998; 169:73–76.
3. The Royal Australian College of General Practitioners. Standards for General Practices. 2nd edn. Melbourne: RACGP 2000; 39.

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