Delay in notification of CT colonography results (12HDC00203, 21 June 2013)

General practitioner ~ Medical Centre ~ CT colonography ~ Tumour ~ Follow-up ~ Test results ~ Electronic reminder ~ Right 4(1)

An 81-year-old woman consulted a locum general practitioner at a medical centre, complaining of tiredness. She had had a right hemicolectomy for bowel cancer in the 1990s. Blood tests showed that the woman had anaemia, and the locum GP prescribed oral iron and referred her to the Surgical Outpatient Clinic at the public hospital for a colonoscopy. The locum GP did not set a reminder on his computer for the results of the colonoscopy.

A few days later the woman's whānau requested that the woman instead be referred privately for a CT colonography. The locum GP was not working that day, so the woman's usual doctor initiated the referral. He noted the referral in the woman's clinical records, but did not communicate to the locum GP the change in the woman's management plan, and did not set a reminder on his computer for the results of the CT colonography.

The CT colonography identified a tumour in the woman's colon. She was not informed of this result of her CT colonography until nearly four months later.

There were a number of contributing factors to the delay in the woman receiving the result of her CT colonography: Neither GP followed up their referrals; the radiology service sent the result electronically to the GP at his old address at another medical centre; that medical centre advised that the result was forwarded to the GP at his current medical centre; the current medical centre advised that the result was not received; despite contact from the woman and her whānau asking after the result, staff did not follow up the result; and the woman recalled that she was told by a staff member that "everything was fine".

General practitioners who refer patients to a specialist have a responsibility to take reasonable steps to follow up the referral. It was held that the GPs and the medical centre did not take reasonable steps to follow up their referrals. Therefore, the woman did not receive services with reasonable care and skill, and the medical centre and both GPs breached Right 4(1).