General Practitioner Dr A

Case 99HDC11494

7 May 2001

Information for this investigation was obtained from the general practitioner, Dr A, the consumer, Mrs B, the practice nurse, Ms C, and a public hospital. I also obtained advice from an independent general practitioner, Dr D.

In my opinion Dr A did not breach Right 4(2) but did breach Right 4(4) of the Code of Rights for delaying several weeks before following up Mrs B's diagnostic mammogram results. My reasons for reaching this conclusion are as follows:

Clinical concern
Dr A referred Mrs B for a mammography and ultrasound after she had complained of a slightly painful right breast mass that could not be aspirated. Mrs B had a history of fibrocystic disease and recurrent breast cysts, for which Dr A had previously referred her to a surgeon, Dr E. Dr A advised that she was "suspicious of other pathology".

History of delay
When Dr A wrote to the public hospital radiology department referring Mrs B for mammography, she requested that a copy of the results be sent to the surgeon, Dr E. Dr A advised that she did this as a safety net precaution because she had in the past experienced delays in receiving results from the hospital radiology department.

Patient assumption of contact
Dr A advised that the standard practice at the Medical Centre is that "[p]atients are also encouraged to contact us if they have not heard of their result rather than just assuming that no abnormalities were found. Patients are contacted by letter if their test results come back with no abnormality, and are phoned directly when any abnormality is found. Patients are encouraged to contact us if a specialist appointment or test result has not been received." Mrs B advised me, however, that she was not told anything at the Medical Centre about receiving her results. Mrs B also advised that she enquired about results at the radiology department at the time of her mammogram, and was told that her general practitioner would advise her.

Mrs B further advised that she did not know when the test results would be available but understood that Dr A would contact her if anything were "wrong". Mrs B also advised that she took the silence of the first few weeks as meaning "nothing was wrong". Mrs B said that she made the first call to the Medical Centre only after it "played on her mind" that the radiographer had called in a doctor to view the mammogram and she was then sent through for an ultrasound.

Systems
There is a system in place at the Medical Centre to respond to patient enquiries and prompts. This system was utilised on 8 June 1999 when Mrs B called to enquire about her mammogram results. Nine weeks had passed since the mammogram was taken on 6 April 1999. Dr A should have received the result within three weeks if it

had been sent by ordinary post. I accept Dr A's advice that it had not arrived. The practice nurse, Ms C, advised me that following Mrs B's call she telephoned the radiology department requesting the mammogram report. The radiology department has no record of this call, but states that it is possible that not all calls are recorded. Mrs B made a second call to the Medical Centre on 5 July 1999. Ms C contacted the hospital the same day and obtained the results. Dr A advised Mrs B of the results on 6 July 1999. Thirteen weeks had now passed since the mammogram was taken. Dr A advised that she had no formal bring-up system for overdue results other than patient prompts.

Independent Advice

My general practitioner advisor stated: "[At] present, in general practice, these systems remain somewhat haphazard and cannot be matched to results which are not, for a variety of reasons, returned to the practice. [Dr A] cannot, therefore, be expected by current practice standards, to have realised that [Mrs B's] results had not returned to her practice."

My advisor also stated that the matching of patient referrals for tests "may be done for some areas e.g. for cervical smears or for individual patients in whom this is felt warranted". Mrs B was referred for a mammogram to investigate a clinical suspicion of "other pathologies". That suspicion was well founded. Mrs B underwent a mastectomy with removal of axillary lymph nodes on 5 August 1999.

Commissioner's Opinion

No Breach – Right 4(2)

Right 4(2) requires that a patient be provided with services "that comply with legal, professional, ethical, and other relevant standards". It seems that under current professional standards Dr A could not be expected to have realised that Mrs B's results had not been returned. In my opinion Dr A did not breach Right 4(2).

Breach – Right 4(4)

Right 4(4) requires that patients be provided with services in "a manner that minimises the potential harm to, and optimises the quality of life of, that consumer". Mrs B's mammogram/ultrasound results were finally obtained 13 weeks after the mammogram was performed. Dr A referred Mrs B to the hospital radiology department for a mammogram because she was suspicious that Mrs B's breast lump might be cancerous. In my view, any test ordered where the doctor has reason to suspect a diagnosis of cancer requires proactive follow-up by the referring doctor. In failing to have a system that ensured follow-up of Mrs B's test result, Dr A did not provide services that minimised the potential harm to Mrs B's life. An earlier referral to Dr E would have resulted in earlier cancer treatment. Accordingly, my opinion is that Dr A breached Right 4(4) of the Code.

Actions

I understand that since this complaint was made, Dr A has further computerised the Medical Centre. I recommend that a bring-up system for follow-up of overdue results in appropriate clinical areas be put in place to minimise the likelihood of such an event occurring again.

I recommend that Dr A apologise to Mrs B by sending a letter to my Office, which will be forwarded to Mrs B.

A copy of this opinion will be sent to the Medical Council of New Zealand. An anonymised copy of this opinion will be sent to the Royal New Zealand College of General Practitioners, for educational purposes.