Follow-up of clinically significant result
15HDC00937, 1 February 2018

Consultant physician ~ Senior medical officer ~ DHB ~ Follow-up ~ Clinically significant result ~ Ovarian cancer ~ Rights 4(1), 6(1)

A woman went to a public hospital feeling unwell. She was transferred to the General Medical Service of the hospital with a suspected viral infection and an incidental finding of lower abdominal tenderness. She was placed under the care of a consultant general physician.

The consultant general physician ordered a priority ultrasound scan, and a query of ovarian cancer was listed in the "question to be answered" section of the scan request. The possibility of ovarian cancer was not discussed directly with the woman at the time due to her history of anxiety and depression.

The consultant general physician's documented plan was to discharge the woman after the ultrasound scan had been performed, with a recommendation that she follow up with her GP if her symptoms did not settle. Contrary to the plan, however, the woman was discharged by a house officer prior to the scan being carried out. The scan was changed to an outpatient scan, and the request contained no specific reference to ovarian cancer and was given normal status. The request also did not indicate that the report was to be copied to the woman's GP, although the discharge summary noted that her GP was to follow up on the result of the scan. The consultant general physician does not recall being made aware of these arrangements.

The woman's outpatient scan noted a mass likely to be of ovarian origin, and recommended gynaecological referral and tumour marker correlation. Neither the woman nor her GP received a copy of the scan or a report relating to it. The ultrasound report was viewed and accepted electronically by the consultant general physician. The consultant general physician did not take any action in relation to the findings. Over a year later, the woman was found to have a large ovarian mass, and she was diagnosed with high-grade serous carcinoma of the ovary.

Findings
For not providing the woman with the information that a reasonable consumer would expect to receive, it was found that the consultant general physician breached Right 6(1).

It was also found that by not taking any follow-up action on the woman's clinically significant test results — whether that be further investigations, or contacting her GP to ensure that someone was taking the follow-up action required — the consultant general physician breached Right 4(1).

It was found that the failings painted a picture of poorly coordinated and documented care. Accordingly, the DHB was found to have breached Right 4(1).

Recommendations

It was recommended that the consultant general physician undertake a random audit of a selection of radiology test results to ensure that the patient radiology test results he had received over the previous three months had been followed up appropriately and communicated to his patients. It was also recommended that he provide a written apology to the woman's family.

It was recommended that the DHB provide a report regarding the steps taken to facilitate systems to enable patients to receive a copy of their results directly; use this case as an anonymised case study for the education of staff, particularly around oversight of junior clinicians, communication, and documentation; provide a report regarding the status of the recommendations made during the Root Cause Analysis; and provide a written apology to the woman's family for its breach of the Code.