

Failure to follow-up abnormal cervical smear result (14HDC01030, 29 June 2016)

Medical practitioner ~ Medical centre ~ Smear test ~ Abnormal result ~ Referral ~ Colposcopy ~ Rights 4(1), 6(1)

A woman had an appointment with a doctor for a routine cervical smear and sexually transmitted infections screening. The results, which recommended that the woman be referred for a colposcopy, were sent to the doctor's inbox. The doctor did not action the abnormal result or inform the woman of the result.

The doctor told HDC that he does not recall seeing the smear result in his inbox, but thinks he must have viewed the result on its arrival and then probably filed the result without actioning it. He said that when he was orientated on various topics and protocols, he was told that the doctors routinely did not do the smears, and that there were specific nurses who took care of that. Furthermore, he was under the impression that if he did a smear, then the results would be followed up by those nurses. He said that he was not familiar enough with the system to know that the results would not be seen by the nurses, and that the results would be filed back into the office Medtech system only through his "inbox".

The medical centre's policy however was that individual providers were responsible for management of results for all tests ordered by them (including cervical smears). This included ensuring that results were notified to the patient in an appropriate manner (whether by the ordering clinician or passed on with instructions to another staff member to undertake), and that any clinical follow-up indicated was undertaken in a timely and appropriate fashion.

The doctor's orientation paperwork records that he was orientated about "results tracking". There is no documentation on what he was told at the time.

The National Cervical Screening Programme enquired as to whether the woman's colposcopy referral had been made and the doctor subsequently made the referral. No contact was made with the woman at that time. The doctor told HDC he assumed the smear had been carried out by a nurse, and that he was just being asked to do the referral. Furthermore, he said he also assumed that the nurses "would be notifying the patient of the results of the smear and the referral".

The woman told HDC that the first time she learnt of her abnormal cervical smear was several months later, when she received a call from the colposcopy clinic on the day of her colposcopy appointment. She complained about these events directly to the medical centre and was told that her complaint would be investigated but received no further feedback about it.

By failing to establish that the cervical smear test he ordered had been followed up in a timely and appropriate way, and by failing to review the woman's clinical notes prior to making the colposcopy referral, the doctor was found to have breached Right 4(1).

For failing to ensure that he discussed the abnormal smear result with the woman, including the need for a colposcopy referral and her preferences regarding the referral (private or public), he breached Right 6(1).

Adverse comment was made about the medical centre for not ensuring that the doctor had an adequate understanding of its processes in relation to results tracking, and for failing to respond to the woman when she made a complaint and was advised that her complaint would be investigated.

It was recommended that the doctor provide evidence of the subsequent changes he has advised HDC he has made to his practice following these events, undertake a random audit of his clinical records to ensure that patient test results received in the last two years have been followed up appropriately and communicated to patients; and provide a written apology to the woman.

It was recommended that the medical centre audit clinical staff compliance with requirements for management and communication of results over a three month period to avoid a repeat of the scenario outlined in this report and provide a written apology to the woman in relation to its handling of her complaint.