

## Communication and Test Results

As has been discussed in previous articles, doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal results. In this article we will consider two recent cases that consider whose responsibility it is to follow up test results.

*Coles Medical Practice in New Zealand* (2013) states a number of principles for doctors, including:

- All the relevant parties should understand their responsibilities clearly.
- If you are responsible for conducting a clinical investigation you are also responsible for ensuring that the results are communicated appropriately to those in charge of conducting follow-up, and for keeping the patient informed.
- If you order investigations, it is your responsibility to review, interpret and act on the results. If you go off duty before the results are known, you should alert the incoming doctor that there are results outstanding. Furthermore, you should check the results when you are next on duty.
- It should be the responsibility of the clinician who has ordered the test to ensure that the results are reviewed, the patient is informed, and any necessary action is taken.

When multiple clinicians are copied in on a request form for a test, the results will be sent to each clinician. GPs may receive results for patients without knowing the clinical rationale for the tests, and in some cases when they have had no recent contact with the patient. It needs to be clear to each clinician whose responsibility it is to follow up the test results.

In a recent HDC decision (15HDC01204, 30 June 2017), a 67-year-old man presented to an emergency department because he had developed left-sided chest pain. He had felt ill since the previous day, and had shortness of breath and a chronic cough. An SMO reviewed the man and ordered a chest X-ray. The SMO diagnosed pneumonia and recommended admission, but the man declined. On discharge the man was told to follow up with his GP, but no timeframe was specified. The discharge summary was sent to the man's GP. The chest X-ray was reported on the following day, and the findings were "a dense pneumonic consolidation" in the left upper lobe of the lung. The report recommended a follow-up X-ray in 10–14 days' time. Both the SMO and the GP received the chest X-ray report but neither took any action in respect of it. The SMO stated that at that DHB, usually follow-up X-rays were handled by GPs, and it would be very unusual for an ED clinician to order a follow-up X-ray at 10–14 days.

HDC was critical that the SMO did not communicate with the GP about follow-up to ensure co-ordination of care. Unless communication has been received about who is responsible, clinicians copied into test results should double check that the result has been actioned and the patient has received appropriate follow-up. In this case, the GP was not proactive in confirming his assumption that the ED doctor would organise the follow-up chest X-ray. HDC's expert advisor, GP Dr David Maplesden, stated that it would have been prudent for the GP to use a reminder system so that he would be aware if the expected result had not been received within a reasonable timeframe. Dr Maplesden pointed out that the case illustrates the lack of clarity that surrounds the handling of results when tests are ordered by secondary care providers with copies going to primary care (or vice versa). He stated:

"There appears to be different assumptions by the various providers, and these assumptions lead to the risk of abnormal results 'falling through the cracks'. I think it is unreasonable to expect primary care providers to have to check with their secondary care colleague as to who is taking responsibility for management of every significantly abnormal result originating from secondary care that they are copied into. A more reasonable expectation is

that the clinician ordering the test and receiving the result manages that result in an appropriate fashion (which includes notification of the patient where appropriate) which might include formally deputising management of the result to a third party verbally or in writing (with that action recorded). I feel that in any case where a potentially significant result has been received and there remains doubt as to who is managing it, both the requester and those in receipt of the result have a responsibility to ensure it is managed appropriately.”

In another case (15HDC01387, 16 June 2017), a GP requested blood tests for a 78-year-old man. The results showed that the man had a moderate number of reactive lymphocytes. The GP referred the man to the medical outpatients clinic at a hospital because of this symptoms, and attached to the referral letter the blood test results and a note that a further report was to follow from a pathologist. However, the referral letter did not refer to the man’s high lymphocyte levels or that the GP was awaiting a supplementary report. Subsequently, further blood tests were taken, and the results were consistent with chronic lymphocytic leukaemia (CLL). The GP did not forward that information to the outpatients clinic or discuss it with the man. The GP stated that it was his expectation that the results of the investigations he had included would be reviewed by the medical team, and that further investigations referred to in the laboratory result would be available to the clinic because they shared the same laboratory service. He stated that he thought that as he had made an appropriate referral to the medical outpatients clinic he had deputised the clinic to follow up on the man’s condition. As the GP had made no formal referral to the clinic, the Commissioner did not consider that the GP had deputised the outpatients service to follow up on the man’s test results, and said that it was not a reasonable expectation that the DHB staff would proactively search the community laboratory database when there was no obvious reason to do so. The Commissioner stated that the GP had a responsibility to communicate the diagnosis of CLL and the related blood test results directly to the DHB and to the man himself.

The management of test results, and in particular the issue of who is ultimately responsible for following up test results, continues to create problems. There is often a lack of agreement and consistency between the parties as to what is reasonable, in particular when multiple clinicians are involved in the management of a patient between primary and secondary care. Fundamentally, this is an issue of effective communication between providers, which is essential to maintain a seamless service and ultimately to ensure the well-being of the patient.

Dr Cordelia Thomas, Associate Commissioner  
*NZ Doctor*, 31 January 2018