

Managing patient test results

In complaints to HDC about the mismanagement of patient test results, I am often asked: “What about the patient’s responsibility?” This was a key topic of discussion at a recent MCNZ Branch Advisory Body meeting and is highlighted in a new HDC decision.

Notifying results

There is no doubt that doctors and DHBs owe patients a duty of care in handling patient test results and following up recommended tests. The devil is in the detail!

HDC has seen the full gamut of cases over the years. In case 00HDC07636 (8 March 2001) a GP was found in breach of the Code for failing to inform a patient of her test results. An Asian woman presenting in her 14th week of her second pregnancy had an abnormal result for syphilis serology (negative TPHA and positive RPR). The GP had intended to discuss the results with her at the next antenatal visit (scheduled for 20 weeks) and arrange further testing, but she did not attend. At 27 weeks she delivered a stillborn fetus, which had died from chronic fetal infection. The woman was found to have active syphilis infection.

Doctors are free to make clear arrangements that patients will only be notified of concerning test results. Unless there is clear evidence that such an arrangement has been made, patients need to be told all their results. In case 02HDC18949 (29 July 2004), Mr A was warned that following a vasectomy, he needed to continue with other forms of contraception until two consecutive semen analyses showed no sperm. The first test result indicated a low sperm count, but Mr A was not advised (in accordance with clinic policy). Mr A was informed that the second test result was clear and that a further test was required. The third test result revealed numerous sperm, and the GP and his practice nurse attempted, unsuccessfully, to contact Mr A several times by telephone. The GP then forgot about the matter. Six months later he wrote to Mr A advising that he was still fertile. Six weeks after receipt of the letter Mrs A discovered she was 13 weeks pregnant.

Follow-up of missing results

What if the medical centre never receives the results of a recommended investigation? In case 99HDC11494 (7 May 2001), a woman with a slightly painful breast mass that could not be aspirated, and a history of fibrocystic disease and recurrent breast cysts, was referred by her GP for mammography and an ultrasound scan. The report was expected within three weeks. Nine weeks after the mammogram, the patient contacted the medical centre to enquire about her results, despite being assured by her GP that she would be contacted if there was something wrong. The practice nurse then chased up the report. A month later, having still heard nothing, the patient called the medical centre again — 13 weeks after the mammogram. The practice nurse contacted the testing facility that day, obtained the results (which were abnormal), and notified the patient. I stated: “In my view any test ordered where the doctor has reason to suspect a cancer diagnosis requires a proactive follow-up by the referring doctor.” I recommended that the medical centre implement a bring-up system for follow-up of overdue results in appropriate clinical areas. The ruling prompted a lot of discussion

in the profession, and led the RNZCGP to develop its guidance paper “Managing Patient Test Results — Minimising Error” (updated in 2005).

Key principles

A number of key principles can be stated, based on the duty of care and the duty to provide information affirmed in Rights 4(1) and 6(1) of the Code of Patients’ Rights.

- At the time any test is proposed, patients have a right to be told by their doctor *why* the test is recommended, and *when and how* they will be informed of the results.
- If a doctor or medical centre has a standard practice of not notifying normal test results, patients must be informed and their consent obtained to non-notification in such circumstances.
- It must be made clear to patients that they are entitled to be notified of *all* test results, and that even if they agree to be notified only of abnormal results, they are welcome to call the medical centre and check whether their results have been received and what they are.
- In the absence of any other arrangement being made, when results are received by a medical centre, the patient must be informed. This is especially important if the results raise a clinical concern and need follow-up.
- A doctor is responsible for having an efficient system for identifying and following up overdue test results.

New HDC case

In case 08HDC06165 (3 October 2008), a 70-year-old man, Mr C, consulted his GP with symptoms suggesting mild prostatic enlargement. A prostate examination revealed a “soft, smooth, [moderately] large, benign feeling prostate”. His PSA was mildly elevated at 10.8µg/l and the laboratory advised follow-up for this level. The GP decided to repeat the test in three months’ time. Mr C was not advised of the raised PSA, or its significance. Three months later the GP clinic sent Mr C (although he has no recollection of receiving it) a letter saying “you are now due for a blood test”, enclosing a laboratory request form for another PSA test.

Ten months later Mr C consulted his GP after noticing blood in his urine, and a further PSA test was done. During the prior ten months, Mr C was seen at the GP clinic on three occasions — once for chest pain where he was admitted to hospital for treatment for a myocardial infarction, and once with blood in the urine, which was attributed to anticoagulant therapy and insertion of a urinary catheter during the admission. The PSA test was not discussed or followed up.

The PSA result came back with a raised level of 67µg/l and Mr C was referred to the urology service at his local DHB. Unfortunately, the referral was “misplaced”, resulting in a delay before his first specialist appointment. A subsequent biopsy (18 months after the first PSA test) showed adenocarcinoma of the prostate, and a bone scan revealed widespread metastatic disease.

Following an investigation, I concluded that the GP clinic breached Right 6(1) of the Code by failing to properly inform Mr C about the need for the PSA tests and the result of the first test. There was no evidence that Mr C was told what a PSA result means or of the significance of his raised level. The GP believed that he would have

tried to contact Mr C by telephone and invite him in for a face-to-face consultation (since PSA results are complicated to explain), but he did not document this.

Keeping patients well informed is fundamental to good medical practice. Patients need information if they are to be partners in their own care. I stated: “This approach recognises their autonomy — that it is ultimately the patient’s choice whether to follow medical advice and have a test. Knowing when and how results will be notified is reassuring for patients, and also provides an important safeguard. A patient who knows that a test is being undertaken because of a clinical concern, and that the results should have been received by a certain date, can play a valuable backstop role by checking with the medical centre if that date has passed and they have heard nothing further. In a complex health system where results sometimes go astray, patients are right to assume that ‘no news’ does not necessarily mean ‘good news’.”

What about the patient’s responsibility?

The “elephant in the room” in some of these cases (such as the vasectomy case) is the patient’s responsibility. In the recent PSA test results case, I commented: “Doctors are often quick to talk about patient responsibility and patient compliance. Of course patients have a key responsibility for taking steps to look after their own health. But a 70-year-old patient who does not know why he needed to have a blood test, nor what the results were, can hardly be held responsible for not having a follow-up test on the basis only of a standard form letter.” To his credit, the GP accepted full responsibility for the failure to properly inform the patient.

I am aware that there are varying opinions in relation to systems to manage patient test results. In this case, although Mr C was sent a request form to have the PSA test repeated, he did not have the second test performed. The GP clinic took no action to follow up the matter when no further PSA test result was reported. The GP clinic now has a system that will track every blood test requested, with automatic follow-up after two weeks has elapsed with no results reported. I commended the clinic on these changes and on its commitment to high standards of patient care, which possibly now exceeds what the law requires.

Conclusion

This review of HDC cases illustrates the responsibility of GPs and medical centres in managing patient test results. The case of Mr C highlights the importance of keeping patients well informed about why they are having a blood test, the significance of the results, and when and how results will be notified. The provision of information is vital if patients are to be true partners in their own care.

Ron Paterson
Health and Disability Commissioner

New Zealand Doctor, 5 November 2008