Tracking of results and specialist referral
(13HDC00903, 4 February 2016)

General practitioner ~ Medical centre ~ District health board ~ Laboratory ~ Smear test results ~ Referral ~ Tracking of results ~ Right 4(1)

A woman with a history of high grade cervical abnormality, duplicate cervixes and a bicornuate uterus, enrolled at a new medical clinic. The woman required annual cervical smears. Four years later, after the woman complained of inter-menstrual bleeding, her GP performed a smear test for the woman on each cervix and noted that the larger left cervix bled on being touched and had a lumpy appearance.

The GP sent two specimen referral forms and two specimens to a laboratory for testing. Previously, when conducting annual smears for the woman the GP had sent two samples but only one form, and had only ever received one result. The GP received a smear test result from the laboratory, which documented that the result was normal. While the result form had an identification number, there was nothing to indicate which cervix the result related to, or that this was result one of two. As the woman had symptoms of inter-menstrual bleeding, the GP sent a referral to a gynaecology clinic for colposcopy with the normal result attached. The referral set out details of the woman's relevant cervical history and current history. The gynaecology clinic placed the woman on the colposcopy waiting list assigning her a grading of "low grade" with a follow-up time of within six months. The clinic acknowledged that, based on the information it had received, the woman was incorrectly graded and should have been graded as semi-urgent, with a follow-up timeframe of one to three months.

The medical clinic received the second smear test result relating to the woman. Again there was nothing to indicate the specific specimen site or that this was result two of two. The specimen result was abnormal but this result was mistakenly filed as a duplicate by an unknown person and the GP was not expecting a second result. No action was taken regarding the abnormal smear result.

A few months later, the woman asked the GP to refer her to a private gynaecologist as she did not want to wait six months. Subsequently, the woman was diagnosed with cervical cancer and she underwent a hysterectomy.

It was held that, despite her history, the GP had failed to discuss with the woman any option of specialist involvement prior to her complaining of inter-menstrual bleeding, and failed to ascertain whether there should have been two results after sending two specimens with two forms. Accordingly, the GP breached Right 4(1).

While the primary responsibility relating to the tracking of the woman's smears lay with the GP, the medical centre did not have in place an adequate laboratory test result tracking system; there was no system in place to alert staff of abnormal test results; there was no record of who filed a particular result; and a result could have been filed without the ordering clinician being made aware of it. Accordingly, the medical centre breached Right 4(1).

Criticism was also made of the DHB for incorrectly grading the patient's referral, and of the laboratory for inadequately recording on the result forms which sample the result related to.