EDITORIAL

Diagnostic tests and litigation

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The most common category of litigation against general practitioners is an allegation of diagnostic error. This accounts for approximately 45% of the claims against Australian general practitioners, based on analysis of MDA National's data since 2000. A study of medical negligence claims in which patients alleged a missed or delayed diagnosis in the ambulatory setting found a median of three errors in the diagnostic process. The most common errors were:

- failure to order an appropriate diagnostic test (55%)
- failure to create a proper follow-up plan (45%)
- failure to obtain an adequate history or perform an adequate physical examination (42%)
- incorrect interpretation of diagnostic tests (37%).[1]

The underlying causes of diagnostic error are complex and multifactorial. They typically involve both cognitive and system-related factors.[2]

Cognitive errors involve faults in the clinical reasoning process. The cognitive factors related to investigations generally involve either a failure to consider the correct diagnosis, or a failure to order the appropriate investigation as part of the diagnostic process. A common example of a claim arising from a cognitive error is a failure to consider pulmonary embolus in the differential diagnosis of a patient presenting with dyspnoea. This results in a failure to order appropriate diagnostic tests to confirm or exclude this diagnosis. Another example is a patient presenting with a breast lump who has a normal mammogram, but the doctor fails to order fine needle aspiration cytology as part of the recommended 'triple test' process.

System-related factors generally involve either a failure to follow up the performance or receipt of an investigation, or a failure to inform the patient of a clinically significant test result. These errors often arise when there is not an explicit discussion or shared understanding about how the patient will obtain the results of their investigations. A common example of this type of error is when a prostate specific antigen test is ordered as part of a screening process, but the patient does not contact or attend the practice to obtain the result. If the prostate specific antigen is markedly elevated and there is a breakdown in the recall system in the practice then the patient will not be informed of the abnormal result or provided with recommendations about further investigations.

The courts have confirmed that if a patient undergoes a diagnostic test ordered by a doctor, then it is the doctor's responsibility to review the results and consider if further action is required. The case of *Kite v Malycha* [1998] involved an allegation of failure to diagnose breast cancer in a 31-year-old patient. The surgeon performed fine needle aspiration cytology which revealed cancer, but as a result of a system-related error, the fine needle aspiration result was not received and reviewed by the surgeon. The court found that 'irrespective of any initiative taken by the patient, [the surgeon] owed a duty to find out what the outcome of the pathological examination of the fine needle aspiration was … it is unreasonable for a professional medical specialist to base his whole follow-up system, which can mean the difference between death or cure, on the patient taking the next step'.[3]

If the result of an investigation is clinically significant for the patient, a medical practitioner has a legal duty to follow up or 'recall' the patient to inform them of the result and any recommendations for future management. Notwithstanding a patient's failure to contact the practice or return for a follow-up appointment, it is ultimately the medical practitioner's responsibility to inform the patient. The number and types of attempts to recall the patient will depend on the circumstances. Depending on the likely harm to the patient, three telephone calls at different times of the day and follow-up by mail may be needed.[4]

Importantly, the courts have also found that in some circumstances general practitioners and their staff have a duty either to ensure a patient undergoes a recommended investigation, or to satisfy themselves that the patient has made an informed decision not to undergo the recommended investigation. In

From the Editor

Current prescribing patterns suggest that long-acting beta agonists are being overused in childhood asthma. Peter van Asperen discusses where these drugs fit in therapy.

Cystic fibrosis is a less common respiratory disease, but has many complications. Phillip Masel reviews the current treatments.

Like cystic fibrosis, endometriosis can contribute to infertility. Kirsten Black and Ian Fraser say that infertility is usually an indication for referring a woman with endometriosis to a specialist.

The diagnosis of endometriosis is often delayed. Similar delays in the diagnosis of cancer may have medicolegal implications, as discussed by Sara Bird. It will therefore be important to follow up the results of tests for the tumour markers reviewed by David Faulkner and Cliff Meldrum.

Young v Central Australian Aboriginal Congress Inc [2008] a general practice was found negligent in failing to follow up a patient who had been referred by a general practitioner for blood tests and also referred to a specialist within the practice for investigation of suspected ischaemic heart disease. When the patient failed to attend the appointment for a stress test, the practice did not follow up the patient due to a system-related error, where the medical record of another patient with the same name was reviewed. Interestingly, in this case the general practitioner who provided the patient with the referral for the investigations was found not to have been negligent because the court concluded the general practitioner had 'explained the potential seriousness of ischaemic heart disease and the importance of the follow-up appointments'. The court also found the patient had contributed to the outcome because he 'failed in his own interests to attend either the appointment or to ever raise the issue of these tests when he subsequently attended [the practice] for other unrelated conditions'. The compensation awarded was reduced by 50% to account for the patient's contributory negligence.[5]

Once a patient has been properly informed of their results and the management recommendations, it is up to the patient to decide whether or not to follow this advice. The law recognises that there is legally effective informed consent, but also legally effective informed refusal.

So what does this mean for medical practitioners? The law does not impose a duty to ensure patients undergo all of the investigations a doctor has ordered. If the patient does undergo the recommended tests, then there is a duty on the doctor to review the results and consider what action, if any, is required. While there is some evidence that Australian medical practitioners order more tests as a result of medicolegal concerns,[6] the key to minimising litigation related to investigations should involve attention to cognitive factors, such as ordering the correct investigations during the diagnostic process, and having rigorous recall systems to ensure the appropriate follow-up of patients and their test results.[4] The importance of good communication to ensure the patient understands the reasons for, and the consequences of not, undertaking a recommended investigation and also how to obtain their investigation results cannot be overemphasised. Good documentation is also essential. ◀

Conflict of interest: none declared

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Dental note

Diagnostic tests and litigation

General practice dentists in Australia usually undertake any diagnostic tests within the confines of their clinic and the results are immediately relayed to the patient. Simple vitality testing, percussion tests and intra-oral radiographs are usually sufficient for immediate diagnosis and treatment planning. Occasionally there is a need for further investigations, such as an orthopantomogram or cone-beam CT and conveying these results to patients should be done in a timely manner. When dentists order a test it is their responsibility to ensure that the result, with interpretation, is directly communicated to the patient.

Of concern is our professional responsibility when referring patients for further specialist investigation and care, particularly for the management of a potentially malignant oral lesion. On the one hand, there can be a failure in thoroughly examining patients and not recognising abnormalities. However, this can be greatly compounded if there is a lack of communication, emphasising the importance of the recommended referral and following up to ensure the patients proceed with our recommendations. Simple procedures for referral, communication with the specialist practice and documenting communication should not delay diagnosis which could adversely affect the outcome for the patient.

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