ADDRESS LETTERS TO
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A patient's duty to follow up

Dear Editor

The extraordinary case[1] recently summarised by Dr Bird (*AFP* May 2009) deserves more rigorous analysis and comment by our legal advisers.

Apparently courts have discovered a new duty: to 'follow up' – not just abnormal results, all referrals and investigations! Questions arise:

What is the logical and legal basis of this duty? Logically it seems to fly in the face of patient autonomy. A plaintiff can always say, 'Had I been given adequate information, I would have done as I was told', but the judge in this case expressly found that the doctor gave appropriate information, which leaves the duty (on the practice, not the doctor). My wife regularly leaves pathology requests on the mantelpiece for weeks before action. I suggest that this is her RIGHT and I don't know how anybody has the right, much less the responsibility, to pester her about it.

How far does the duty go? The patient having been given appropriate information, how many reminders, consultations, recalls are necessary? I'm not aware of any reason to suppose, much less any evidence that, the patient would have responded to a reminder. Or does one have to hold down her/him and take the blood by force? I frequently see patients who haven't had their cholesterol test yet, and I remind them. I don't usually make a note of this. Have I met my duty to 'follow up'? What does this term mean?

Has anyone considered the administrative burden of this duty? I flag a referral, then every week someone has to ring up and say, 'Have you been to the specialist yet?' (Obviously, it's not adequate to merely flag the patient at the next visit, they may never return.) I've worked in a number of general practices: they all had systems to act on abnormal test results, but not on every referral.

Then there are the specifics. Cardiologists opined that, if the plaintiff had had treatment, his 'life expectancy would have been extended by 12 years'. Apart from the brave extrapolation from the general to the particular, this presumably implies compliance with treatment, which we cannot assume. To suggest that a reminder from the practice would have him alive today is, I suggest, to draw a ludicrously long bow, and yet this is the basis of the negligence case. Even if we accept a breach of a duty, this breach has to cause the plaintiff's damage to enable recovery in negligence, I thought.

Finally, the award was reduced by 50% for the plaintiff's 'contributory negligence'. Surely the plaintiff's negligence wasn't 'contributory', it was central and the only cause of his problem, especially in the absence of any evidence that 'follow up' would have changed a thing.

Not being a lawyer, I have to choose my words carefully. On the basis of the information in *AFP*, I humbly submit that is a very strange, silly decision.

Brett Hunt
Rosanna, Vic

Reference

1. Bird S. A patient's duty to follow up. Aust Fam Physician 2009;38:333–5.

Reply

Dear Editor

Dr Hunt has raised some important issues arising in medical negligence claims in relation to follow up, causation and contributory negligence.

He is not alone in expressing exasperation about the legal interpretation of the duty of general practitioners to follow up patients and their test results. There is no doubt that courts are currently reluctant to make patients liable for the consequences of their own failure to follow up test results and the recommendations made by their doctors. This creates a tension for doctors between the adoption of a 'shared decision making' approach with their patients and the seemingly paternalistic approach in ensuring that patients have followed the advice that they have given to their patients.

Dr Hunt asks: 'What does follow up mean?' The RACGP *Standards for general practices* state under Criterion 1.5.4 that the term 'follow up' can have several meanings:

- following up the information: following up on tests and results that are expected to be, but have not yet been, received by the practice
- following up the patient: chasing or tracing the patient to discuss the report, test or results after they have been received by the practice and reviewed, or if the patient did not attend as expected.

The decision in any medical negligence claim will turn on its own unique set of facts. In *Young v Central Australian Aboriginal Congress Inc & Ors* [2008] NTSC 47, the clinic was found liable for not complying with their own protocol by failing to follow up the patient when he did not attend the specialist clinic as expected.

Dr Hunt also highlights the issue of causation as another problematic area of the law of negligence. In this case, cardiologists provided expert opinion with regard to causation; that is, did the breach of duty cause or contribute to the harm suffered by the patient? In order to provide an answer to this question, the medical experts and the court are required to extrapolate from the general to the particular patient. Legal causation depends on probabilities and notions of 'common sense'. However, medical causation relies on scientific proof and great care must be taken by medical experts to provide opinions that are based on appropriate medical knowledge at the time the alleged damage occurred.

Statistics are often quoted but these are usually based on data comprising the outcomes of large numbers of patients, and do not generally provide an accurate assessment of the position of an individual patient. Nevertheless, for the purpose of reaching a decision in the claim, the court must reach a definitive answer to the question of causation.

The case was significant because the court held that after being warned of the possibility of ischaemic heart disease, the patient failed to exercise reasonable care for his own health and wellbeing by failing to attend the recommended appointment and failing to inform subsequent treating practitioners of this history. On this basis, the court found that the patient had contributed to his own death, reducing his dependants' claim for damages by 50% because of this 'contributory negligence' (it should be noted that courts can reduce damages by up to 100% for contributory negligence if the court thinks it is just and equitable to do so, even if this results in the claim for damages being defeated).

For a more detailed discussion of these issues, I would encourage Dr Hunt to read a full copy of the judgment (available at www.supremecourt.nt.gov.au/old_site/doc/judgements/2008/ntsc/pdf/NTSC47%20Young%20v%20CAACI%20&%20Ors%20%5B2008%5D%2019Nov.pdf) and to also review the excellent explanation provided in Criterion 1.5.4 of the *Standards for general practices* – 'System for follow up of tests and results'.

Sara Bird
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Illegible documents and public hospitals

Dear Editor

Dr Rob Mathew (*AFP* June 2009) bemoans the poor standard of written communication from junior doctors in his local public hospitals.

As a specialist working in a public hospital, I share his frustration with lazy, illegible and unintelligible written communication. However, I would like to assure Dr Mathew that the standard of written communication is just as poor outside public hospitals as it is within them. I could provide him with many examples of letters from GPs and specialists which contain no clinical information of any use whatsoever. This includes aesthetically impressive letters produced electronically from the latest medical software.

Rather than unfairly castigating junior public hospital doctors as a whole (most of whom in my experience usually communicate precisely and effectively), perhaps Dr Mathew could join in the Sisyphean task of teaching our iGeneration medical students the dying art of effective written communication.

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