



Missing test results and failure to diagnose

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Case histories are based on actual medical negligence claims, however, certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved. Medical negligence claims alleging 'failure to diagnose' are a common cause of claims against general practitioners. In these claims, there is often an underlying weakness in the practice's test result and patient tracking systems. This article outlines a method of analysing 'near misses' in general practice with the aim of minimising the risk of an adverse incident, complaint or claim arising from failure to diagnose.

Case history

The group practice was an extremely busy metropolitan general practice comprising four full time and six part time GPs. To keep up with the increasing practice administrative demands, Mrs Mary Jones was appointed in March 2003 as an additional reception staff member. Mary's youngest child had just started primary school and this was her first job in 10 years. On 6 April 2003, Mr George Brown was seen by Dr Britten, one of the part time GPs in the practice. Mr Brown complained of a 2 week history of a productive cough with yellow sputum. He had had an episode of haemoptysis on the day before the consultation. Dr Britten noted that Mr Brown was a heavy smoker. Physical examination was unremarkable. Dr Britten made a provisional diagnosis of lower respiratory tract infection. She prescribed a course of antibiotics, ordered a chest X-ray and asked the patient to return if his symptoms did not settle. Dr Britten and Mr Brown also discussed a strategy for the patient to give up smoking. On 8 April 2003, Mr Brown attended the local radiology practice for the chest X-ray. The X-rays were delivered to the practice the following day. The films and report noted a mass in the left upper lobe suggestive of a malignancy. One of Mary's tasks was opening and sorting the mail. In her zeal to impress and look efficient, Mary immediately filed all test results and reports in the patients' medical records, including Mr Brown's X-ray report. She placed the films in the pile of uncollected X-ray films. Over the next few weeks, when the practice manager had some spare time, Mary was gradually taught the practice policies and procedures. It was after this training that she realised that the GPs were required to read and sign all test results before filing. As it had only been a few weeks since she had commenced work, she thought the results that she had already filed would not matter. Mr Brown's symptoms settled promptly with antibiotics. He assumed that his chest X-ray had been normal and did not contact Dr Britten or one of the other GPs for his results. When Mr Brown returned to the practice on 15 June 2003 with a further episode of haemoptysis, the GP noted the previous history and X-ray report from April 2003. Further investigations confirmed a diagnosis of lung cancer.

Medicolegal issues

In this case, Dr Britten relied solely upon the practice's system of managing test results and reports to ensure that she was able to follow up and recall patients with abnormal test and imaging results. In view of the patient's history of smoking and haemoptysis, she was concerned that Mr Brown may have had an underlying cancer as the cause of his symptoms. However, she did not want to cause the patient any undue concern and simply recommended he have a chest X-ray

to look for evidence of infection. Because she only worked at the practice one morning a week, Dr Britten did not have many of her 'own' patients and she tended to see the patients with acute problems who could not see their 'regular' GP. Dr Britten assumed Mr Brown would see one of the other GPs for the results of his test. On his part, Mr Brown thought 'no news was good news'. Mr Brown assumed Dr Britten would review the results of the chest X-ray that she had ordered and let him know if there were

any problems. While the 2 month delay in diagnosing the patient's lung cancer did not affect his treatment or long term prognosis, Mr Brown was angry and disappointed that he was not diagnosed earlier.

Discussion

It has been estimated that up to 50% of the medical negligence claims arising in general practice result from a failure to diagnose a patient's condition.¹ The three most common clinical presentations leading to allegations of

failure to diagnose include:

- trauma and orthopaedic conditions
- infections, and
- malignancy.

An Australian study into incidents of potential or actual harm to general practice patients revealed that 34% were related to 'diagnosis' problems.² The most common contributory factors to these incidents were poor communication between patients and health care professionals and actions of others (23%) and errors in judgement (22%).

The Royal Australian College of General Practitioners *Standards for General Practice* recommends that general practices have a system for reviewing, acting upon, and incorporating in the medical record all pathology results, diagnostic imaging reports and clinical correspondence received.³ The intention of this recommendation is to ensure that all results and correspondence relating to a patient's clinical care are reviewed by a GP and acted upon.

Risk management strategies

A useful method of analysing the underlying causes of a 'near miss' is to construct a cause and effect diagram. This provides a structured method of identifying the causes of a near miss, with the aim of preventing its (re)occurrence. The purpose of the cause and effect diagram is to consider a wide variety of possible contributors to the incident, with a view to identifying the key sources that contributed the most. These sources are then targeted for improvement. Cause and effect diagrams are also called 'fishbone' diagrams, as they resemble a picture of the bones of a fish, attached to the spine of a fish (*Figure 1*). It is probably most effective to construct a 'fishbone' diagram as a group, for example at a staff meeting.

Step 1: Take a sheet of paper and in the middle of the page draw a horizontal line (which will be the main bone of the fish skeleton).

Step 2: Write down the 'problem' (near miss) at the right hand end of the horizontal line (at the head of the fish). It is important to get the definition of the problem as clear as possible and to describe the problem in behavioural terms if possible.

Step 3: Identify the major causes of the near

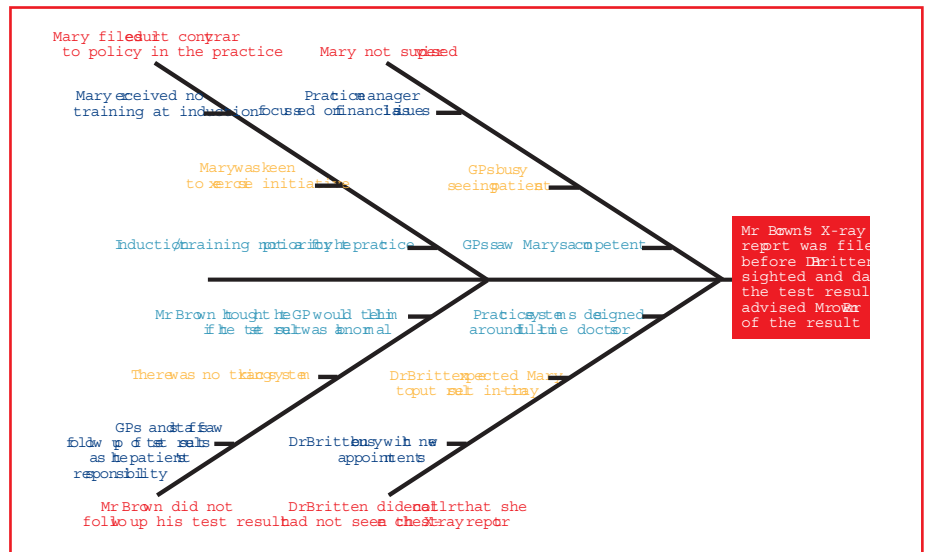


Figure 1. Cause and effect diagram

miss. The key to constructing the diagram is to have 3–6 main categories that encompass all possible influences or causes. Draw a line like a backwards slash (the fishbones) for each cause identified and label the lines.

Step 4: Write down the underlying causes of each of the major causes.

Step 5: See if there are identifiable causes for these causes.

Step 6: Review the 'fishbone' and decide where the common causes lie. Decide which 'root causes' are likely to merit investigation. Try and identify causes that might be easy to fix and ones that will make a substantial impact.

If there is a possibility of legal action arising out of a 'near miss', it is recommended that GPs seek advice from their medical defence organisation before undertaking a cause and effect analysis. In this case, the practice decided their priority 'causes' were a more comprehensive test result tracking system and supervision of non-GP staff members. The practice manager and one of the GPs asked other local practices about their tips on test result tracking and discovered some useful strategies to improve their approach. Six months later, the practice manager undertook an audit of the number of test results not 'signed off' by a GP. The practice was happy with the results, and decided to tackle the issue of improvements in their training of part time practice

staff.

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Summary of important points

- Claims alleging 'failure to diagnose' account for up to 50% of the medical negligence claims against GPs.
- Failure to diagnose claims commonly arise from a failure in a practice's test result and patient tracking systems.
- GPs and their staff can use a cause and effect diagram as a tool to analyse the underlying causes of a 'near miss' with a view to assisting to ensure a timely diagnosis.

Conflict of interest: none declared.

References

1. Green S, Lee R, Moss J. Problems in general practice: delay in diagnosis. The Medical Defence Union, 1998.
2. Bhasale AL, Miller GC, Reid SE, Britt HC. Analysing potential harm in Australian general practice: an incident monitoring study. *Med J Aust* 1998;169:73–76.
3. The Royal Australian College of General Practitioners. *Standards for general practice*. 2nd edn. Melbourne: the RACGP 2000;39.

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