Follow up of test results after hours

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This article examines a recent Coronial inquest in which the Coroner made recommendations to general practitioners regarding the process of notification by pathology practices of abnormal and life threatening results and how GPs respond to such notifications. An addendum to the *Standards for general practices* provides guidance for GPs and their staff on the systems to manage the follow up of test results outside normal general practice opening hours.

Case history

The patient, 34 years of age, attended a medical centre on 25 March 2004 complaining of low retrosternal and epigastric discomfort. The pain was worse when the patient was lying down and she often had a bitter taste in her mouth. There was no past, or family, history of any significant illnesses. Physical examination was normal, apart from some tenderness in the epigastrium. An electrocardiogram (ECG) was performed which was normal. The general practitioner made a provisional diagnosis of 'hyperacidity with mild oesophageal regurgitation'. The patient was given a prescription for Losec. She was asked to re-attend for review in 1 week or earlier if she experienced any additional symptoms. The patient returned at 10 am on 26 March 2004 and saw another GP at the medical centre. She complained of epigastric discomfort and vomiting overnight. Physical examination was normal, apart from the previously noted tenderness in the epigastrium. Another ECG was performed which revealed sinus bradycardia of 60 bpm, but no other abnormality. The GP ordered blood tests including cardiac enzymes. The patient was asked to return to discuss the results of the tests or to re-present if the symptoms worsened. The blood tests were reported at 8.35 pm on 26 March 2004 and the results were faxed to the medical centre by the pathology practice at 8.37 pm. The results revealed an elevated troponin. The test results were placed in the GP's in tray but were not seen by the GP until he was next on duty on 28 March 2004.

In the interim, the patient had presented to the local emergency department (ED) at 12.51 pm on 26 March 2004. She complained of chest pain, stating that she had suffered burning pain in the chest since 22 March 2004. The patient advised the triage nurse that the pain occurred mainly at night and was nonradiating. She gave a history of having vomited on three occasions over the preceding 12 hours. The patient said she had had an ECG, which was normal and the Losec she had been prescribed had been ineffective. The patient's blood pressure was noted to be 122/86, her pulse rate was 86 bpm and her temperature was 37.2. The patient was triaged category 3. At 2.30 pm the patient's name was called by one of the ED medical officers. The patient did not answer and the file was marked 'did not answer call'. At approximately 2.45 pm the patient was found dead in the toilets in the waiting room of the ED. The death was reported to the Coroner. An autopsy revealed that the patient had died from an acute myocardial infarction (AMI).

In November 2005, the case proceeded to a Coronial inquest (hearing).[1] The Coroner was not critical of the consultations by the two GPs at the medical centre. He opined that the GPs were entitled to form the view that the pain was gastrointestinal in origin, having taken a history, and performed a physical examination and an ECG. However, the Coroner was concerned that there was a delay in reviewing and taking appropriate action by the medical centre upon receipt of the pathology results which were suggestive of an AMI. The Coroner concluded that there was a failure in the systems in place at the medical centre for the patient's test results to be accessed, assessed and appropriate action taken, although he noted that in this case the failure had not made any difference to the outcome for the patient. At the inquest, one of the GPs gave evidence that systems had since been introduced into the practice to ensure that there was some follow up of pathology results.

At the conclusion of the inquest, the Coroner made the following recommendation: 'That the Royal Australian College of General Practitioners and the Royal College of Pathologists of Australasia review the process of notification by pathology services of clinical significant abnormal test results (sic) to GPs and the response to such notifications by GPs'.

Discussion and risk management strategies

Criterion 1.1.4 of the *Standards for general practices* states: 'Our practice ensures reasonable arrangements for medical care for patients outside our normal operating hours'.[2]

On 1 July 2007, The Royal Australian College of General Practitioners produced the following addendum to the explanation for this criterion: 'The successful follow up of abnormal life threatening results outside the normal opening hours of the general practice relies on general practices having robust and reliable systems for contact. Failures in these processes in pathology follow up have been the subject of criticism, and recommendations for improvement in recent Coroner's inquests, where patients have been harmed through the lack of robust ways to convey urgent information.

General practices need to have after hours arrangements in place to allow abnormal and life threatening results identified by pathologists to be conveyed to a medical practitioner who will ensure that an informed appropriate medical decision is made and acted on promptly.

If the general practice uses another service (eg. a cooperative, medical deputising services [MDS], hospital) then the general practice must have a defined, reliable means of access for the deputising practitioner to patient health information and to the practice in exceptional circumstances. This places an obligation on the general practice to establish this means of contact (eg. a contact telephone number for one or more of the practice doctors). It also places an obligation on cooperatives and MDS to contact the general practice in exceptional circumstances.

General practices need to clarify what is expected of the deputising doctors in cases of urgent and life threatening results being communicated to the deputising doctor in lieu of the GPs in the general practice, and vice versa. Ideally, this will be outlined in a formal agreement between the general practice and the after hours care provider'.

Conflict of interest: none.

References

1. Inquest into the death of Sharon Brophy. Westmead Coroner's Court, Sydney. 9 November 2005.
2. The Royal Australian College of General Practitioners. Standards for general practices. 3rd edn. Melbourne: The RACGP, 2005.

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