

By Richard O'Keefe

# The DUTY of medical practitioners to FOLLOW UP

Medical practitioners' capacity to actively manage and follow up patients to ensure appropriate investigations are undertaken and acted upon has been enhanced in recent times with the development and promotion of detailed comprehensive software programs for the storing of patient information. Medical practitioners' capacity to screen and monitor patients for serious conditions such as cancer has also developed significantly during the last decade, with the advent of, among other things, screening tests in relation to a multitude of medical conditions.

In this article, two aspects of medical practice are considered – the follow-up of patients and opportunistic screening for latent disease. Although determining what the duty of care requires is a matter addressed on the particular facts when considering breach,<sup>1</sup> some general guidance may be found in case law.

**PROACTIVE FOLLOW-UP**

Medical practitioners now have access to sophisticated software for maintaining clinical records. Such software enables them to flag review dates for patients, and to maintain a comprehensive record of test results and other information.

The duty to maintain detailed records is a statutory obligation.<sup>2</sup>

The Royal Australian College of General Practitioners (RACGP) has been motivated to prepare guidelines for general practices that emphasise the medical practitioner's obligation to maintain comprehensive records. In its *Standards for General Practice*, the RACGP states that a general practice must have a system that provides for 'following up on tests and results that are expected to be, but have not yet been, received by the practice; and 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'.<sup>3</sup>

However, the Australian Medical Association (AMA) has a more restricted position. The *AMA Position Statement on Patient Follow-up and Tracking* emphasises that medical practitioners should provide patients with enough information about the necessity of tests, specialist appointments and further consultations (and about the consequences of not pursuing these things) so that the patient is able to make an informed decision for themselves.<sup>4</sup> The *Statement* affirms that it is the responsibility of the patient to act upon medical advice for referrals and tests, but that the medical practitioner is duty-bound to inform patients of any clinically significant test results.<sup>5</sup>

Several articles in *Australian Family Physician*, the official journal of the RACGP, advise medical practitioners of their obligation to contact patients with test results (particularly when a delay could have serious health consequences) and that practices need to have proper systems for following up recommendations made to patients.<sup>6</sup>

These sources suggest that there is no consistent medical practice in relation to patient follow-up.

The common law imposes upon medical practitioners an obligation to maintain accurate records and to take a proactive approach to following up patients to ensure that they are made aware of relevant medical information. The medical practitioner's duty to follow up is 'being firmly established as part of the legal landscape'. The South Australian case of *Kite v Malycha*<sup>7</sup> has been described as the 'genesis' of the duty to follow up, but several other cases before and since can be characterised as 'follow-up' cases.<sup>8</sup> As might be expected, the content of the duty seems to be very circumstance-specific.<sup>9</sup>

**Kite v Malycha**

Mr Malycha was a specialist breast surgeon who performed a biopsy on a lump in Mrs Kite's left breast in December 1994. Mrs Kite was instructed to telephone for the results of the biopsy and return for a follow-up appointment in January 1995, but she failed to do either. The cytology report, which Mr Malycha claimed never to have received, indicated that the specimen was highly suspicious of underlying carcinoma. Mr Malycha did not record in patient records having performed the biopsy, or any attempt to track down the results or contact Mrs Kite when she missed her follow-up appointment.

The court held that Mr Malycha should have recorded the biopsy and should have made some enquiry to find out what happened to the cytology report when it was not promptly received. At worst, according to Perry J, Mr Malycha should have become aware of the missing report after he reviewed the file when Mrs Kite missed her appointment in January 1995. Mr Malycha was thus found to have breached the duty of care he owed to Mrs Kite. Justice Perry stated that it was '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' when the simplest of systems would have provided an easy way to follow-up.<sup>10</sup>

On the issue of contributory negligence, Perry J allowed that Mrs Kite did have a duty to exercise reasonable care for >>


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her own health. However, he held that her failure to call for the test results or attend the follow-up appointment did not amount to a breach of this duty as Mrs Kite was 'entitled to assume that if the cytology report was adverse, she would be told about it'.<sup>11</sup>

### Other 'follow-up' cases

The duty in *Kite* was expanded in *Tai v Hazistavrou*.<sup>12</sup> Dr Tai was found negligent for failing to follow up the recommendation he made to Mrs Hazistavrou to have a D & C operation to rule out cervical cancer. He planned to perform the procedure himself, but the time and date were to be organised by the hospital. The hospital lost the admission form and Mrs Hazistavrou did not enquire into the delay. The court agreed with the findings of the trial judge, ruling that Dr Tai should have followed up Mrs Hazistavrou when she did not appear on his operating schedule after a reasonable period.<sup>13</sup>

In *Samios v Repatriation Commission*, a hospital was found to be negligent for not recognising the seriousness of a patient's condition and for sending him home to think over (for six weeks) the necessity of an operation.<sup>14</sup> Relevantly, the hospital was also found to be negligent for not following up the patient after the six weeks had expired.

In *Thomsen v Davison*, a medical practitioner carried out tests on a patient that caused him to doubt the patient's state of health.<sup>15</sup> He requested that the patient attend a laboratory to have further tests carried out, but afterwards failed to ascertain the results of those tests or advise the patient of the results. The court held that the medical practitioner's duty of care required him to take all reasonable steps to inform himself of the result of the tests.<sup>16</sup>

In *Kalokerinos v Burnett*, Mrs Burnett saw her GP with symptoms indicative of cervical cancer and received a referral to a specialist gynaecologist in another town.<sup>17</sup> She returned to the medical practitioner later that day to ask for a referral to a closer specialist, as she was unable to make travel arrangements. Dr Kalokerinos reassured Mrs Burnett, advising that she should see the specialist when she could. Mrs Burnett never saw the specialist and waited another year before seeking alternative medical advice. The court held that Dr Kalokerinos was negligent in not providing a referral to another specialist or, alternatively, not following up Mrs Burnett to ensure that she had seen the specialist. The court also made a finding of contributory negligence of 20 per cent against Mrs Burnett for failing to seek alternative advice.

In the recent NT case of *Young v Central Australian Aboriginal Congress Inc*,<sup>18</sup> the patient, Mr Impu, saw a medical practitioner at a shared practice, complaining of chest pains. The medical practitioner ordered a cholesterol test to rule out ischaemic heart disease and referred Mr Impu to a specialist. Mr Impu did not take the test or attend the specialist appointment. He subsequently saw several other medical practitioners at the practice for different complaints, but none of them followed up either the test or the appointment. Several months after the initial consultation, Mr Impu suffered a heart attack and died. The court found that, in failing to have an adequate system of follow up, the medical

practice breached its duty of care to Mr Impu.<sup>19</sup> Although the practice did not have computerised system to pick up patients who missed appointments, the court observed:

'the first defendant had a responsibility to put administrative procedures in place for the situation that arose in this case where a patient fails to attend for a fasting cholesterol test which is part of the treatment plan for a potentially serious condition.'<sup>20</sup>

The trial judge did not find the individual medical practitioner who ordered the test liable for the failure to follow up, because the medical centre was responsible for devising a system to ensure that patients were followed up when necessary.<sup>21</sup>

The court assessed the late Mr Impu's contributory negligence at 50 per cent.

### The scope of the duty to follow up

One commentator has outlined a two-tiered test for finding a duty to follow up.<sup>22</sup> According to this model, the duty arises where the medical practitioner 'knows (or ought to know) that the patient has failed to submit for treatment; and knows (or ought to know) or suspects that the patient may require further treatment'.<sup>23</sup>

The courts articulate the duty to follow up as an element of the medical practitioner's broader comprehensive duty of care, emphasising that decisions like *Kite* are 'well within the orthodox field of negligence'<sup>24</sup> and that failure to follow up is, in effect, failure to complete the treatment process.<sup>25</sup>

This is consistent with medical orthodoxy, which obliges the medical practitioner to pursue investigations until such time as a diagnosis is made for a particular complaint.

Factors that may be important in determining the extent of any obligation to follow up, drawn from the above cases, include: the seriousness of the patient's condition; the duration of the doctor:patient relationship; diagnosis being provisional or treatment being incomplete; the patient being advised of the importance of subsequent tests or appointments; and the ease with which follow up could have been accomplished.<sup>26</sup> It may also be relevant that the medical practitioner has handed responsibility for reaching a diagnosis to a specialist.

The dynamic of the doctor:patient relationship may also be considered when a court is deciding whether a medical practitioner has breached a duty to proactively follow up, despite the patient's responsibility to take care for his or her own health. In *Kite*, *Tai*, *Kalokerinos*, *Thomsen* and *Samios*, the evidence showed that the medical practitioner's silence led the patient into a false belief about the (un)importance of a test, procedure or results. In effect, the medical practitioner's failure to follow up led the patient to believe that further action on their part was not required. In *Young*, the finding of 50 per cent contributory negligence was expressly linked to the fact that the initial medical practitioner impressed upon the patient the seriousness of ischaemic heart disease and the importance of seeing a specialist.<sup>27</sup> Thus the subsequent failure to follow up could not have led the patient to reasonably believe that the test and appointment were unnecessary.

**The effect of civil liability legislation**

Civil liability legislation, introduced across Australia, may affect the applicable standard of care in failure to follow up cases. Legislation in all states provides that medical practitioners are not negligent if it can be shown that they act in accordance with peer professional opinion.<sup>28</sup>

Importantly, however, in NSW, s5P of the *Civil Liability Act 2002* (NSW) provides that the modified *Bolam*<sup>29</sup> test does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death, of or injury to a person, associated with the provision by a professional of a professional service. While a medical practitioner's failure to follow up could be considered a part of either 'treatment' or 'advice', the failure to follow up a patient is more likely to fall squarely within the exception concerning advice. Similar exceptions apply in Victoria and Queensland.<sup>30</sup>

**OPPORTUNISTIC SCREENING**

To what extent is a medical practitioner required to inform a patient of, and offer screening tests for, potentially serious disease?

Screening involves testing members of the community for a specific disease even though they do not have symptoms of it. The term 'screening' specifically excludes the investigation of people with symptoms.<sup>31</sup>

Medical practitioners may owe a duty to offer screening such as mammograms, Pap smears, and faecal occult blood testing to patients who have not requested these tests and have attended the GP for a different reason. There are guidelines published by relevant medical colleges and public health institutions in relation to specific tests, including testing for colorectal cancer, cervical cancer and breast cancer.<sup>32</sup> Controversy exists in relation to screening for melanoma<sup>33</sup> and prostate cancer.<sup>34</sup>

Recently, medical practitioners have been encouraged to offer patients general health checkups, giving the opportunity to discuss available testing. However, at present no such check up is fully funded by Medicare.<sup>35</sup>

Claims relating to opportunistic screening have two aspects: it must be established both that the test is acknowledged to be an appropriate and effective screening tool, and that it should be offered to the particular patient.

The medical profession has published a significant volume of material in relation to opportunistic screening. The RACGP publishes *Guidelines for Preventive Activities in General Practice*, which outlines the screening appropriate for each gender, age group and some specific risk groups. The *Guidelines* state that it is appropriate to provide such screening opportunistically according to 'age and risk status'.<sup>36</sup>

The courts have to date, however, not been troubled with cases concerning this issue, with the exception of one decision from the ACT.

***Koziol v Anasson*<sup>37</sup>**

This case was an appeal from the Supreme Court of the ACT. Mrs Anasson saw Dr Koziol on a one-off basis in 1987 and was diagnosed with post-pill amenorrhoea. She was told to

return in two months if her symptoms had not resolved. Mrs Anasson returned as directed, and was referred to a gynaecologist who carried out a Pap smear and found a pre-cancerous lesion. Mrs Anasson then had a hysterectomy, which necessarily involved the termination of her existing pregnancy. The trial judge found that Dr Koziol had been negligent in not carrying out opportunistic screening in the form of a Pap smear at the first consultation, before Mrs Anasson became pregnant.

It was accepted by the trial judge that, at the time of Mrs Anasson's consultation with Dr Koziol in 1987, it was not common practice for GPs to take opportunistic Pap smears. However, in finding Dr Koziol negligent, the trial judge held that had Dr Koziol taken a full history from Mrs Anasson at the first consultation, she would have realised that Mrs Anasson was at a high risk of developing cervical cancer.

The Federal Court disagreed with the trial judge's finding that a more complete history would have shown that Mrs Anasson was at a high risk of cervical cancer. The court emphasised that Dr Koziol's diagnosis was in fact correct, as none of the symptoms that Mrs Anasson described at the initial consultation were related to the pre-cancerous lesion. In order to find that Dr Koziol was negligent in not carrying out a Pap smear, the court would need to accept that GPs had a duty to carry out opportunistic cervical cancer screening on all women who presented with a gynaecological problem. As, in 1987, it was not common practice for GPs >>



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to carry out such screening, the court found that Dr Koziol's conduct did not fall below the requisite standard of care.

### A duty to carry out opportunistic screening?

Times, treatments and attitudes have changed since the decision in *Koziol* more than 20 years ago and, arguably, so should the common law to reflect the realities of medical practice today.

It should not be difficult to establish that medical practitioners have a duty to offer opportunistic screening. In *Koziol*, the court left open the question of the duty of Mrs Anasson's regular GP to carry out opportunistic screening. The court noted that the duty of care of her normal GP would have a 'wider ambit' than that of Dr Koziol, who saw Mrs Anasson only for a specific complaint.

This will no doubt be an important factor in the particular case – namely, the medical practitioner's responsibility for the patient's health generally – which may not be found when the patient consults only on a once-off basis.<sup>38</sup>

In pursuing a claim against a medical practitioner for failing to offer opportunistic screening, it will likely be necessary to establish that the defendant is aware that the patient is concerned about their general health (which may be more likely in the context of an ongoing doctor:patient relationship) rather than simply wanting to see a medical practitioner about a specific problem.

Based on the court's comments in *Koziol*, another fundamental factor in establishing a breach of duty will be the extent to which, at the relevant time, it was common practice to opportunistically screen for the particular disease.

One test falling into this category is prostate specific antigen (PSA) testing for prostate cancer in men. There has been much controversy surrounding the use of opportunistic PSA testing. PSA is an enzyme produced by the cells of the prostate gland. A blood test to measure PSA is the most effective currently available test for the early detection of prostate cancer. Rising levels of PSA over time are associated with both localised and metastatic prostate cancer.

An important example of the medical controversy surrounding PSA testing is (1998) 169 *Medical Journal of Australia*, which contained four articles concerning prostate cancer and PSA testing. The overall message of these was that, although no organised program for prostate cancer screening existed, and despite repeated advice from medical institutions against it, opportunistic screening had been occurring at high rates.

### Civil liability legislation

As with the duty to follow up, the civil liability legislation may also affect the content of the duty to offer opportunistic screening. If screening is characterised as a medical treatment issue, then the modified *Bolam* test may apply, such that there is no breach of duty if it is established that a body of medical practitioners do not offer such screening. Conversely, if the obligation to offer opportunistic screening is characterised as a duty to advise, then the peer professional opinion defence may not apply (though common medical practice will still be relevant).

### CONCLUSION

Medical practitioners have expressed dismay over these 'extensions' of their obligations to their patients. After the decision in *Kite*, the then South Australian AMA President, Dr Rodney Pearce, complained that 'until [*Kite*] we believed that the patient:doctor relationship involved joint obligations'.<sup>39</sup> In line with this comment, the follow-up cases discussed above have been characterised as 'courts ... placing a higher onus on health care practitioners not only to provide treatment but also to take responsibility for those patients who fail to return for treatment or results'.<sup>40</sup>

However, these developments have all arisen from changes in medical practice, and clearly the common law has been the follower rather than the leader in this respect. A duty to follow up proactively is now a recognised element of a medical practitioner's duty of care, and judicial recognition of a duty to opportunistically screen patients is likely to follow in the near future. ■

Thanks to Ms Steph Button for her contribution to this article.

**Notes:** 1 *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540 at [106] and [192]. 2 *Medical Practice Regulation 2008* (NSW), sch 1. 3 Royal Australian College of General Practitioners, *Standards for General Practitioners* (2007, 3rd edition), s1.5.4. 4 Australian Medical Association (AMA), *AMA Position Statement on Patient Follow-up and Tracking* (2002). 5 *Ibid*. 6 Sara Bird, 'A GP's Duty to Follow-Up' (2003) 32(1) *Australian Family Physician* 45; Sara Bird, 'A Patient's Duty to Follow-Up Test Results' (2009) 38(5) *Australian Family Physician* 333. 7 (1998) 71 SASR 321. 8 Matthew Ellis, 'Patient Follow-Up: The Scope of the Duty, the Impact of Tort Law Reform and Practical Suggestions to Comply with Legal Requirements' (2007) 15 *Journal of Law and Medicine* 408, p410. 9 Victor Harcourt, 'The Doctor's Duty to Follow-Up: Legal Fiction, A Return to Paternalism or an Exercise in Risk Management?' (2001) 8 *Journal of Law and Medicine* 286, p289. 10 *Kite v Malycha*, p 337. 11 *Ibid*. 12 *Tai v Hatzistavrou* [1999] NSWCA 306. 13 *Ibid*, at [50]. 14 *Samios v Repatriation Commission* [1960] WAR 219. 15 *Thomsen v Davison* (1975) Qd R 93. 16 *Ibid*, p97. 17 *Kalokerinos v Burnett* (unreported, NSWCA, 30 January 1996). 18 *Young v Central Australian Aboriginal Congress Inc* [2008] NTSC 47. 19 *Ibid*, at [216]. 20 *Ibid*, at [165]. 21 *Ibid*, at [211]. 22 *Elis*, above n8, p417. 23 *Ibid*. 24 *Tai v Hatzistavrou*, p83 (Priestley JA). 25 *Thomsen v Davison*, p97; *Tai v Hatzistavrou*, at [101], [107] (Powell JA). 26 *Elis*, above n8, p418. 27 *Young v Central Australian Aboriginal Congress Inc*, at [257]-[258]. 28 See, for example, *Civil Liability Act 2002* (NSW), s50. 29 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118. 30 *Wrongs Act 1958* (Vic), s60; *Civil Liability Act 2003* (Qld), s22(5). 31 National Health and Medical Research Council, *Colorectal Cancer Screening – A Report of the Australian Health Technology Advisory Committee*, December 1992, p2. 32 See [cancerscreening.gov.au](http://cancerscreening.gov.au). 33 Cancer Council of Australia, protocol on screening for skin cancer, endorsed by the Australasian College of Dermatologists, August 2007. [www.cancer.org.au/positionstatements](http://www.cancer.org.au/positionstatements). 34 See [cancercouncil.com.au](http://cancercouncil.com.au). 35 See Research Australia Ltd, media release, 3 September 2009. 36 Royal Australian College of General Practitioners, *Guidelines for Preventive Activities in General Practice* (2009, 7th edition), p2. 37 *Koziol v Anasson* [1997] FCA 803. 38 John Devereux, 'Medical Law Reporter' (1998) 5 *Journal of Law and Medicine* 217, p220. 39 Thomas Faunce & Susannah Jeffreys, 'Doctor's Fiduciary Duties to Follow-Up and to Promptly Disclose Adverse Events' (2007) 79 *Precedent* 36, p38. 40 John Devereux, 'Medical Law Reporter' (2001) 8(4) *Journal of Law and Medicine* 377.

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