MIEC

MIEC LOSS PREVENTION

Managing Your Practice

Advisory 16

No news is good news ... an unsafe policy

INSIDE

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"No news is good news," is a policy that invites patient injury and increases liability exposure. Developing notification systems within your practice will increase patient safety by reducing the possibility of patient injury stemming from failure to review and act on lab results that were filed prior to physician review, and delayed patient notification. This newsletter offers suggestions for developing a tracking system to reduce the frequency of delayed or missed diagnoses due to overlooked lab reports, and ensuring patient notification of test results.

A number of patient injuries in malpractice cases are traced to physicians' failure to review and act upon positive lab results and X-ray reports. There is no guarantee that filing the results in the chart will facilitate physician review. In fact, just the opposite may occur: When results are filed in the chart before physician review, information needed for diagnosis and treatment may be overlooked and patient injury may result. Developing a system that ensures no lab or X-ray results are filed before physician review will reduce the possibility of patient injury. The following examples illustrate just how important and invaluable a reliable tracking system can be for your practice.

"Dr. Fredericks" and her five partners, all obstetricians and gynecologists, emphasize cancer prevention for their patients. They do periodic breast examinations, mammograms, Pap smears and other studies as appropriate. Because of the high volume of test results received in the office each week, some patients are told they will be contacted only if the results suggest that further follow-up is needed. Other patients are advised, "No news is good news. If you don't hear from us, the tests were negative." This system appeared to have worked well until recently, when a 48-year-old mother of four came to see Dr. Fredericks for breast tenderness. The doctor opened the patient's chart and saw a Class III Pap smear report dated 18 months earlier. The doctor checked with her staff. "Did anyone call Mrs. Crimmins to tell her about this report?" None of the medical assistants recalled phoning the patient. No one could explain how the report could have been overlooked. Neither could the jury in the malpractice suit that ensued. Despite defense claims that the delay in diagnosing cancer was not the proximate cause of Mrs. Crimmins' death, the jury awarded the patient's husband and children substantial damages.

"Dr. Lockman," a general practitioner, called Ed Johnson when he

received the report of a suspicious mass in Ed's left lung, which the radiologist thought warranted additional studies. "This could be serious, Ed," the doctor recalled saying.

"I'll get to it as soon as I can, Doc," the patient supposedly responded.

Two months later, the doctor called Mr. Johnson again. "I don't think this is something you should put off, Ed," the doctor reiterated.

"After the holidays, Doc. The kids and grandkids are here and this isn't a good time."

Dr. Lockman testified about each of these phone calls in the lawsuit that the Johnson family filed against him after Ed died of lung cancer. "Can you show the jury one bit of evidence, anything that supports your claim that you told Mr. Johnson he needed to have his chest X-ray repeated?" the Johnsons' attorney asked at the doctor's trial. Mr. Johnson apparently had told his family Dr. Lockman had given him a clean bill of health. The documentation in Mr. Johnson's chart did not reflect the telephone calls or discussion, which made it difficult for the defense attorney to prove that Mr. Johnson had been warned regarding his medical condition.

Both of these situations could have had dramatically different outcomes if Dr. Fredericks' practice had an effective system to ensure that all lab and X-ray reports were reviewed by a physician before they were filed, and had Dr. Lockman documented those conversations with Mr. Johnson about his test results. A system failure can cause as much damage as an overtly negligent act and therefore should be monitored to ensure accuracy, compliance and consistency. Lack of documentation may compromise the credibility of the care rendered. Good documentation is evidence of the care provided.

Rationalizations for unsafe policies

Common reasons regarding why lab and X-ray results are filed before physician review or patient notification include:

- **Not enough staff -** This reason is the least defensible. Successful notification systems do not require increased staff, just increased attention to detail. A simple tracking system that is monitored at least weekly, will increase patient safety and defensibility.
- **Too many results to track -** If you think you have too many results coming back to track, then chances are you do need a system that helps you monitor returned results so you are able to notify patients in a timely manner. A tracking system will ensure that what goes out comes back in.
- **Results are filed in my "out-box" -** Simply placing a result in your "out-box" is an insufficient system of advising staff that the information has been reviewed and can be filed. Many malpractice cases have been lost because unreviewed results made it to the out-box, were filed prior to physician review, and the patient suffered an injury as a result.
- **Results are reviewed during follow-up visit -** This reason increases the potential for patient injury. If the patient doesn't return as advised, significant findings may be discovered too late to prevent patient injury.
- **MAs review results and notify patients -** This reason may encourage medical assistants to practice outside of their certification and in some cases, practice medicine without a license. Medical assistants do not possess the training, licensure or knowledge to identify nuances that differentiate between values, nor the clinical experience to recognize diagnosis and treatment information, nor the ability to answer patients' clinical questions.
- **Patients don't want to know benign results -** This reason presumes that patients don't care about their health. All patients have a right to know their test results; it is a physician's obligation, with his/her staff's assistance, to inform patients of their test results. Timely notification of negative and positive results reduces anxiety and enables patients to continue their daily functions without having to wonder if they are okay.
- **"I've been doing it this way for years and never had a problem." -** This philosophy is

an accident waiting to happen and a recipe for disaster. With demands on physicians' time at an all time high, and patient expectations equally high, the need for change cannot be ignored.

Simple solutions

Systems that ensure that results are received and patients are notified are simple to implement and, if used consistently, will increase patient safety and satisfaction while reducing physician liability exposure. Consider the following:

- **Physician review -** Develop a policy to ensure that no result is filed before being reviewed and initialed or signed by a physician.
- **Consistent review -** Use a consistent and recognizable method of documenting your review of the results, such as, initials, signature, rubber-stamp, or other method. ***(See Figure 1 below.)***

Report reviewed by: _____
Phone report to patient?
☐ *Yes* ☐ *No*
Phoned to: _____
Comments: _____
_____
_____
Date/Time: _____
By: _____

Figure 1

- **Mail notification -** Have patients address a notification envelope before they leave the practice, file the envelope in the chart or tickler file, and mail a copy of the results or a results form to patients once the information has been received. ***(See Figure 2 on next page.)***
- **Tracking log -** Design a log to track studies that are sent out, and establish a time period for follow-up if results are not received when anticipated. ***(See Figure 3 insert.)***
- **MA notification -** If medical assistants are responsible for reporting negative lab results to patients, write a protocol that clearly establishes what your MA can and cannot communicate to patients. **Note:** We recommend that only licensed healthcare providers notify patients of positive or abnormal results as physicians, nonphysician clinicians and nurses are better able to answer patient's questions about the results.
- **Involve staff -** Direct staff members to advise physicians when lab or X-ray results have been received and/or have not been initialed or signed. Doing so adds a layer to your notification system and encourages team spirit among your staff.
- **Document, document, document -** When anyone communicates lab or X-ray results to patients by phone, it is important to document the conversation in the medical chart, in the progress record, on the actual lab result, or in a section of the chart dedicated to telephone messages. The documentation should include the date, what was discussed, what was recommended, if anything, and who communicated the information. If a staff member calls on behalf of a physician, documentation should include "per Dr. X." Contemporaneous documentation is paramount to the defense of a medical malpractice lawsuit.

Don't wait until a patient is injured or until you are sued to revisit your patient notification policy. We hope this newsletter is helpful in encouraging you to develop a notification policy, or to improve your existing system. Please call the Loss Prevention Department if we may be of further assistance in this process.

Get advice from MIEC

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Visit MIEC on the Internet:
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Date _____

Dear _____:

Your laboratory evaluation ordered at this office on _____ has been reported as follows:

Normal	Abnormal		Normal	Abnormal	
_____	_____	Blood sugar	_____	_____	Uric acid
_____	_____	Total Cholesterol	_____	_____	Blood Count
_____	_____	HDL	_____	_____	Thyroid Function
_____	_____	LDL	_____	_____	Prostate Antigen (PSA)
_____	_____	Triglycerides	_____	_____	Sed Rate
_____	_____	Liver Function	_____	_____	Occult Blood in Stool
_____	_____	Kidney Function	_____	_____	Urinalysis
_____	_____	Potassium	_____	_____	Pap Smear

Comments: _____
_____
_____
_____
_____

Next office visit: _____

Next comprehensive exam:_____

_____
Name of Doctor

_____
Name of person who completed form

_____
Date

Figure 2

A Log to Track Referrals and Test Results

Patient injuries and subsequent liability for physicians may result when:

- patients fail to follow their physician's advice to have tests or see a specialist;
- consultants' letters or test results that require follow-up fail to reach the referring physician's attention;
- the referring physician lacks a system to track referrals to ensure follow-up.

The log form on the next page helps physicians and staff track referrals to labs, radiology departments, and specialists. When the doctor refers a patient for tests or exams, a staff member enters the patient's name, the date, and the referral destination. When the report or consultation letter returns, staff records the date it is received and follow-up action taken (e.g., "patient called w/ negative results, JH," or "f. u. appt made for 10/10/200x, CD"). If the person monitoring the log sees that a report has not been received in a timely manner (determined by the doctor for each type of referral), he or she should find out why (e.g., "called ortho, transcription delay, report next week, Dr. Lee advised, CD"; or "TC, 3/18, pt doesn't want test, appt 3/20/200x to discuss w/ Dr. Lee, JH").

Patients may be injured if physicians do not see reports that contain significant findings before the reports are filed and appropriate action is taken. To prevent such errors, doctors should initial reports to indicate they have reviewed them before the reports are filed by staff.

When: (1) physicians document their referral intentions and recommendations clearly in their progress notes; (2) their staff keeps track of the referrals and results in a log, and; (3) physicians initial incoming reports before they are filed, there is less likelihood that patients who require follow-up will "slip through the cracks" and be injured.

Figure 3, Page 1

Sample Patient Referral Log

Patient Name Chart #	Referred to: (lab, radiology, consultant)	Date Referred	Date Report Received	Follow-up

Page_____

Figure 3, Page 2