Communicating test results

Q. Can x-ray interpretations of an urgent nature be reported to the referring doctor by a radiologist, or can the radiologist have a staff person do it? Can the information be given to the referring doctor’s staff, if the referring doctor is not available?

A. Ideally, the radiologist or pathologist should report urgent test interpretations (including “panic values” on lab studies) to the referring physician, who often will have questions that only can be answered by a radiologist or pathologist. If the referring physician is not available, it is acceptable for the information to be given to a staff person.

Whether the call is from physician-to-physician or from physician-to-staff, follow these safeguards: (1) the caller should document the date and time of the phone call, AND the full name of the person to whom the information was given; (2) if the information is given to a staff person, the caller should state the degree of urgency for communicating the message to the referring physician; (3) in their dictated reports, radiologists should summarize the message reported by telephone, the full name of the person who took the message, and the date and time of call; similar documentation should accompany the final report of stat or urgent lab tests that were telephoned to the referring physician’s office. Some labs use a rubber stamp template to document this information on the lab report.

Q. Can significantly abnormal X-ray reports or lab panic values be transmitted to the referring physician by fax or e-mail?

A. A person-to-person phone is always recommended for reporting urgent test results. Faxing or e-mailing urgent data is not advisable, as the sender has no assurance that the recipient will receive it in a timely manner, or at all. E-mail messages can be delayed in cyberspace for a variety of reasons, and faxes can be inadvertently sent to the wrong number. Even if the information promptly arrives in the correct office by fax or e-mail, its presence might not be promptly noted by the receiving doctor or his/her staff. You may fax or e-mail reports of test results after a person-to-person contact.

Q. What should our laboratory do when tests produce “panic” values and the referring doctor’s office is closed and no one is on call for the referring doctor?
A. This situation is a reason pathologists and radiologists recommend that referring physicians include the following on all requisitions for outpatient X-rays and lab tests: the patient's name, address and telephone number. If the referring doctor is unavailable, then the pathologist or radiologist can attempt to contact the patient directly to advise him/her to immediately go to an emergency department for medical attention. We know of one instance in which a pathologist, unable to reach a referring physician to informed him/her of test results that indicated a life-threatening condition, saw the patient’s address and phone number on the requisition and promptly called the local police, who went to the patient’s house and transported him to the hospital for life-saving treatment.

Q. We sometimes receive reports of abnormal test results and X-rays from the emergency department for patients the ED referred to us, but who never contacted our office. What should we do with the results?

A. Many emergency departments have a system for notifying patients of delayed, abnormal test and X-ray results, but some do not. Although the referral by the ED may not have established a doctor-patient relationship between you and this new patient, consider taking an action that could prevent injury to the patient or save his life: (1) contact the patient by phone to report that you are in receipt of the abnormal results, advise the patient to come in promptly for the follow-up recommended by the ED – and be sure to emphasize whatever degree of urgency exists; or (2) if you do not know how to reach the patient, notify the emergency department and request that the ED locate the patient and report the results. Document the date and time of your call and the name of the person with whom you spoke. Again, be sure to emphasize to the recipient of your call how urgent it is to reach the patient. (Incidentally, when you receive the medical record of a patient who was referred to your office by the ED and the patient never contacts your office, we suggest that after a reasonable time, you inform an ED physician that the patient did not follow up as directed. Document the call.)

Liposuction claims

Q. A number of liposuction cases have made national headlines recently. Does MIEC have any information about the frequency of liposuction (lipoplasty) cases and the severity of the claims? What has been MIEC’s claims experience?

A. According to a study by the Physician Insurers Association of America (PIAA), lipoplasty claims are infrequent, but result in indemnity payments to patients more often than other types of claims. Between January 1995 and June 1998, 292 lipoplasty claims were reported to the PIAA Data Sharing System. Of the total reported claims, 263 have been closed, 116 (44.1%) of these with an indemnity payment. The PIAA reports, “The ratio of paid [lipoplasty] claims is higher (44.1%) than the ratio of all malpractice claims (31.8%).” However, the average payment for a lipoplasty claim is significantly lower than all other claims in the database ($94,534 versus $157,126, respectively).

The low severity of the patients’ injuries may account for the lower average indemnity payment. In 36% of the lipoplasty claims, the patient suffered a minor temporary injury, 23% had an insignificant injury, 15% a major temporary injury and 13.6% a minor permanent injury. Patients died in seven cases, and the indemnity payment to the decedents’ families averaged $150,000 per claim.

Additional findings in the PIAA lipoplasty study:
- Plastic surgeons were the primary defendants in 86.3% of the claims.
- The most common allegation against defendant-physicians was “improperly performed procedure.”
- In 47% of the claims, the surgery was entirely elective.
- Two-thirds of the procedures were done in a hospital operating room, and 21% in a physician’s office. “Failure to diagnose post-operative infection” was the leading allegation in claims stemming from an office-based procedure.

MIEC has had 20 liposuction/lipoplasty claims; total indemnity of $103,839 was paid in four claims (average indemnity $25,960); 12 were closed with no payment to the patient, and four remain open. Expenses for the 20 cases was approximately $446,000. Operating beyond the scope of the patient’s informed consent was a secondary allegation in one claim. Patients were dissatisfied with their results in 12 of the 20 claims.
In-office sale of health-related products

Q. To supplement my income, I want to sell health-related products to my patients. What advice does MIEC offer?

A. Review the American Medical Association’s (AMA) policy on the sale of non-prescription health-related products, adopted in June 1999.

According to the AMA’s Council on Ethical and Judicial Affairs, selling products to patients, such as nutritional supplements, safety devices and skin care products, presents “...a financial conflict of interest, risks placing undue pressure on the patient, and threatens to erode the patient trust and the primary obligations of physicians to serve the interests of their patients before their own.” If a doctor decides to sell health-related products, the Council recommends:

- Distribute health-related products to patients free of charge or at cost (not for profit);
- Validate claims of products’ efficacy and do not rely upon manufacturer’s data;
- Do not participate in exclusive distributorships where the products are available only in the physician’s office; encourage manufacturers to make the products available in other places; and
- If the product is sold at a profit, fully disclose to patients the financial arrangement with the manufacturer or supplier, and inform patients of the availability of similar healthcare products that can be purchased outside of the practice.

MIEC recommends that physicians familiarize themselves with the Food and Drug Administration (FDA) regulations as they apply to the sale of health-related products. For example, dietary supplements may be considered “food,” the sale of which requires the doctor to obtain a seller’s permit, and may be taxable. There also may be labeling requirements. A number of considerations surrounding the sale of health-related products are summarized in a California Medical Association publication, “Implications of physicians’ selling vitamins, dietary supplements, and other items not requiring prescription.” Physicians can contact MIEC for further information.

E-mailing patients

Q. I want to encourage my patients to communicate with me by e-mail when they have basic questions or concerns. However, I realize e-mail has its limitations. How can I communicate proper “e-mail etiquette” to my patients?

A. According to Daniel Z. Sands, MD, co-author of the American Medical Informatics Association’s (AMIA) White Paper Guidelines for the Clinical Use of Electronic Mail with Patients, “Electronic mail can be very useful in patient care provided one understands its limitations and adheres to guidelines.” Dr. Sands stamps his rules on the back of his business cards, and distributes them to his patients on a selective basis. (See example in next column.)

For a copy of Dr. Sands’ white paper on the use of e-mail, visit his website at http://clinical.caregroup.org/ePCC/. Obtain Special Report MIEC Claims Alert, No. 24, “Using e-mail to communicate with patients and other professionals: What are the pros and cons?” at MIEC’s Internet website www.miec.com, or request a copy by e-mail: lossprevention@miec.com.

dsands@caregroup.harvard.edu

Please Follow These Rules to Improve Communication

1. Use alternative forms of communication for:
   - emergencies and other time-sensitive issues
   - sensitive information (do not assume e-mail is confidential)
   - situations in which my response is delayed (I may be away).
2. Be concise.
3. Put your name and [account number] in the subject line.
4. Keep copies of e-mail you receive from me.
5. I may save e-mail I send and receive in your record.
6. I may share you messages with my office staff or with consult-

Computerized medical records

Q. Do we need a paper printout of medical records that are maintained on computer?

A. We recommend that you do. If the computer storage medium permits undetectable alteration of data, some courts may not accept the computer medium version of a medical record as an “authenticated record.” While the technology exists for determining whether alterations have been made to paper documents, some experts say it is more difficult to detect alterations of electronic media, such as a hard disk, floppy disk or re-
writeable CDs. Thus, the credibility of an electronic document for which there is no paper counterpart could be an issue in litigation. If the plaintiff has evidence to suggest that a computerized medical record was altered, the physician may be required to prove that an alteration did not or could not have occurred.

MIEC also recommends that you keep hard copies of all forms signed by patients, such as consents and releases. If you decide to maintain medical records on a computer, establish a mandatory backup schedule. Keep backup disks off-site in a safe, fireproof place.

Physicians who use a computerized record-keeping system must protect both the integrity and confidentiality of the data. Ensure that your computer system is designed and maintained to minimize the risk that information will be lost, improperly altered or accessed by unauthorized persons. It is also important that you provide training and education for your staff about computerized medical records, including rules for access to and revision of these records.

**Recommended Reading**


**Conclusion:** “Investor-owned HMOs deliver lower quality of care than not-for-profit plans.”


**Conclusion:** “The presence of a pharmacist on rounds as a full member of the patient care team in a medical ICU was associated with a substantially lower rate of adverse drug events caused by prescribing errors...”


**Conclusion:** “Many general surgeons withhold pain medications to obtain informed consent. Many also withhold pain medications because of a belief about their effects on diagnostic accuracy. Since withholding pain medications may actually be a barrier to informed consent and diagnostic accuracy, these policies should be reconsidered.”


**Summary:** “A year ago, the AMA Ethics Council issued a report that strongly discouraged doctors from selling vitamins and other health-related, nonprescription products from their offices for profit. But the House of Delegates refused to approve it... “Its [Ethics Council] new report ... avoids the ‘thou shalt not’ language of the first. Reading between the lines, however, it is clear that the Council still frowns on the practice.”


**Summary:** “Delegates overrode concerns that they were ‘micro-managing’ medical practice in approving ethical guidelines for the sale of health products from physicians’ offices.”

**New informed consent resource for physicians who treat minors**

California Healthcare Association (CHA) has published a handbook about consent for the treatment of infants, children and adolescents. Topics include: consent laws that apply to minors; confidentiality and access to minors’ medical records; and child abuse reporting. The text contains a number of helpful forms. Order a copy of “Minors & Health Care Law,” from CHA Publications at 800/494-2001.

**To reach MIEC:**

Bay Area: 510/428-9411
Outside 510: 800/227-4527
Honolulu Office: 808/545-7231
Boise Office: 208/344-6378

Loss Prevention Fax: 510/420-7066
Main Oakland Fax: 510/654-4634
Honolulu Fax: 808/531-5224
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