**Is No News Good News? Build a More Reliable Follow-up System for Test Results (**Annual Rural and Remote Medicine Conference, April 4, 2019)

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## How effective management of test results improves patient safety

*There is growing evidence that effectively managing the results of test and diagnostic imaging reports improves patient safety.*

## The bottom line

- Physicians should have an effective system in place for managing follow-up on the results of investigative tests.
- Physicians ordering diagnostic tests have a duty to communicate the results to the patient and to make reasonable efforts to ensure appropriate follow-up is arranged.
- Physicians who receive an abnormal report, even incidentally, may have an obligation to appropriately respond to it or to redirect it, even if the patient is no longer, or never was, in their care.
- Physicians should document their review of tests results and what follow-up action they initiated.
- When away on vacation or absent for a long period of time, physicians should establish a process for follow-up.

With the advent of technology, diagnostic capabilities have been bolstered. Now there is an opportunity for healthcare providers to achieve corresponding improvements in the management of the results of tests and diagnostic imaging reports.

In today's complex healthcare environment, managing the follow-up to results is difficult. Exchanges of information take place between multiple providers, using a mix of electronic and paper-based processes. As results take different forms and are communicated in different ways, the risk associated with miscommunication or follow-through is always present. The introduction of interdisciplinary care and expanding scopes of practice further compounds this issue. Recognizing that failure to follow-up on investigative results may contribute to poor clinical outcomes for patients and potential medico-legal difficulties for physicians, this article highlights effective strategies to enhance the management of results.

The CMPA reviewed its closed legal and medical regulatory authority (College) complaint case files (2006–2010) where the management of results of tests and diagnostic imaging reports in a doctor's office was alleged to have contributed to a delayed diagnosis. Seventy-six cases were identified of which 43 were College cases and 33 were legal cases. These legal cases have a high rate of settlement on behalf of physicians, hospitals, and laboratories. Family physicians were the group most frequently named in both the legal and College cases. They were distantly followed by physicians practising in general surgery and emergency medicine.

More than 50% of the cases reviewed involved patients with neoplasms. The types of cancer included lung, breast, digestive, cervical, prostate, as well as others. Patients with injuries and fractures were involved in 15% of the cases, and those with diseases of the circulatory system were involved in 7%.

These cases emphasize the importance of having clearly defined procedures and effective systems to follow-up on results.

## Issues identified

Failure to follow-up on test results or diagnostic imaging reports was one of the most frequent issues identified in this review. There was either a delay in follow-up, no follow-up, or inadequate processes for follow-up.

The following areas were highlighted in the data and demonstrate where there is a need to improve systems and prevent failures in follow-up:

- booking tests and investigations that have been recommended by a physician
- following up on patients who cancel or fail to show up for an appointment
- following up on investigations that have been completed, but no report has been received
- date stamping and initialing reports as they are received in the office
- flagging reports to be reviewed by physicians before they are filed
- requiring that reports be read completely so all key information is captured
- flagging abnormal results (i.e. blood tests, X-rays, CT scans) and identifying those patients who require urgent or routine follow-up
- communicating test results to patients and others such as consultants
- scanning or placing test results into patient files
- arranging for continued care when a physician leaves for an extended period (i.e. maternity leave or vacation) or moves

While this review of CMPA cases focuses on managing the results from tests and diagnostic imaging reports in a doctor's office, physicians and their office staff were not the only healthcare providers involved. In many instances, other healthcare professionals, institutions, and facilities played a role. For example, in one case a system tracking issue with both the hospital and the physician's office resulted in a lack of follow-up on the X-ray of a patient with cancer. Hospitals, laboratories, other health professionals and their staff are also responsible for communicating results and facilitating follow-up. Every member of the team is accountable for the care he or she provides.

However, it is confirmed by an established legal precedent and by the policies of a number of Colleges that the ordering physician is responsible for the timely and appropriate follow-up on the results of investigative tests. The courts have determined that when ordering an investigative test, the physician must be satisfied systems are in place, in the office and the laboratory or facility, to reasonably ensure the results are received in a timely manner. The protocol or system must also provide for appropriate steps to be taken to report the results to the patient and to arrange necessary follow-up. The system must flag or allow the review of clinically significant results for a test or other diagnostic study physicians have ordered.

In urgent situations, or when caring for a patient who is at a higher risk of receiving a clinically significant result, it is prudent to follow-up more closely.

It is not uncommon for physicians to receive investigative results ordered by other physicians and other healthcare providers for patients they are no longer actively following or, in some cases, who have not actually been under their care. When physicians receive an abnormal report — whether they ordered it or not — they may have an obligation to respond or redirect it, even if the patient is no longer or never was in their care. In these circumstances, physicians can reduce possible problems in follow-up of clinically significant results and findings by notifying:

- the ordering physician, the laboratory, or the hospital
- the current healthcare provider
- the patient, in extreme cases

Written notification to the laboratory or testing centre involved may decrease the likelihood of future results being misdirected. While the report to patients is usually the duty of the ordering physician, when he or she is not available the laboratory or facility may be expected to take necessary steps to notify patients in urgent cases.

## Strategies to improve follow-up of investigative test results

The first step in addressing follow-up issues in a physician's office is to map out the flow, sources, and formats of results, and to validate the effectiveness of the management system.

Such an examination will assist physicians in determining how to improve the management of investigative results, which ultimately improves patient care.

When seeking to develop and improve systems, some physician leaders have looked to the airline industry where there is also little room for error and where the consequences of not complying with systems can be disastrous. The following suggestions and methods can be considered in healthcare settings: [1, 2]

- **Foster a culture of safety.** Make it the responsibility of all office staff to identify and report follow-through issues. Look for weak links in procedures and try to anticipate system failures. Create an environment where comments are welcomed and input encouraged.
- **Standardize and simplify processes and procedures as much as possible.** Ensure compliance and knowledge of established procedures. Checklists, flow sheets, and tracking or monitoring systems may be helpful.
- **Consider new technologies with built-in systems such as reminders, alerts, and documentation tools.** Recognize that systems are only effective when there is a commitment to using them.
- **Consider prioritizing test results with "urgent," "critical," "action needed," or "pending results."** A coding system may heighten awareness and trigger necessary follow-up.
- **Engaging patients in their own care may strengthen follow-up systems.** Discussing why an investigative test has been ordered allows patients to recognize its importance to their clinical situation.
- **Avoid using the "no news is good news" approach for dealing with test results and diagnostic imaging reports.** Unless the systems used to manage these results are significantly exacting, this practice may not provide enough protection for patients. A number of Colleges have specifically cautioned physicians against using this approach.

## References


1. Lippman, H. Davenport, J. “Sued for misdiagnosis? It could happen to you.”, Journal of Family Practice (2010) Sept. Vol. 59, no 9, p489.
2. Wahls, Terry, "Diagnostic errors and abnormal diagnostic tests lost to follow-up, A source of needless waste and delay to treatment," *Journal of Ambulatory Care Management*, (2007) Vol. 30, no. 4, p341.