

Alberta Doctors' Digest

Continuity of care

A recently published Discipline Report from the College of Physicians & Surgeons of Alberta (CPSA) underlines the risks of failing to follow up on critical test results. The investigation in question arose as a result of the failure of a specialist to review results sent to his office following a procedure ordered on a patient in 2012. The results were returned to the office, but were simply filed on the chart and not reviewed by the specialist. For reasons that are unclear, copies of the test results were also not provided to the referring family physician. In addition, subsequent visits did not reveal the existence of the results. Years later, when the patient was seen by another physician, he was made aware of the findings from 2012, but unfortunately by then, a significant medical condition was diagnosed.

The advent of NetCare in the interim has likely had a big impact on this type of problem, but there continue to be instances where reports are either missed or ignored, or there is no system in place in the office to ensure follow up with the patient. Compounding the problem is the current lack of interface between various electronic medical record systems in the province and the fact that a surprising number of physicians continue to practice using a system that is wholly or in part paper-based.

The CPSA has issued a Standard of Practice for Continuity of Care, most recently updated on June 11, 2015. A portion of that standard is dedicated to the timely follow up of test and consultation results:

In summary, the standard requires a regulated member whose practice includes established physician-patient relationships to have a system in place to review test and consultation results in a timely manner; arrange for follow up; notify the patient of any follow up date; and to document all attempts to contact the patient.

In addition, a regulated member must have a system in place to deal with the receipt and review/response to critical diagnostic test results reported after regular working hours or in the physician's absence. The system must clearly identify on the requisition when results are expected to fall in a "critical range" and ensure that the diagnostic facility is able to contact the physician or delegate.

The concept of continuity of care goes beyond ensuring that test results are reviewed and discussed with the patient in a timely manner. It extends to ensuring that where an established physician-patient relationship exists, steps are taken to provide after-hours care, either through other providers or through a service with capacity to assess care needs, and to ensure that the handover of relevant patient information is available. Where a recorded message directs the patient to another health care provider, emergency service or after-hours clinic, there must be evidence of an agreement with the designated provider or service.

In the old days, "no news is good news" meant that results have been reviewed and there's nothing to worry about. But that expression pre-supposed that all results were received and reviewed. Systems such as those mandated under the CPSA's Standard of Practice for Continuity of Care are there to ensure that the results are, in fact,

received and reviewed, and that communication with the patient occurs. I should add that the Canadian Medical Protective Association has articles and resources on its website with some strategies for following up on test results.

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