Communicating Critical Values in Anatomic Pathology

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Critical values in anatomic pathology are usually information sensitive, whereas most such values in laboratory medicine are time sensitive. However, there is an important time element in anatomic pathology as well. Pathologists should be aware that many medicolegal actions against radiologists are based on failure to communicate “abnormal” results in a timely manner. Are pathologists the next group that will be targeted? Pathologists can spend much time trying to communicate important data that will affect patient care to someone who will accept the information. This is not an efficient use of pathologists’ professional time. Most important, what are our obligations to patients to communicate “critical” abnormal results to the treating physician? What results need to be so communicated? Are pathologists obliged to contact the patient directly if there is a failure to communicate the critical results to a clinician? We explore these questions to promote discussion of these important issues as they relate to pathologists’ liability and to patient care.

(Arch Pathol Lab Med. 2006;130:641–644)

The title of this article implies that we as pathologists have defined critical values (see “Critical Values in Anatomic Pathology” by Silverman and Pereira1 in this issue of the ARCHIVES) and have established how pathologists communicate results to the treating physicians in a timely fashion. The convening of the Symposium on Errors, Error Reduction, and Critical Values in Anatomic Pathology indicates that neither of these is operative.

Critical values in anatomic pathology are information sensitive (meaning that the content is of major importance but may not require immediate action), whereas, by contrast, most critical values in laboratory medicine are time sensitive; however, time issues are important in anatomic pathology as well. Pathologists should be aware that many medicolegal actions against our radiologist colleagues are based on failure to communicate “abnormal” results in a timely manner. In fact, in 10% of medicolegal radiology cases, the written report was issued in an untimely or unsuitable manner, affecting the clinical outcome in 75% of these cases.2 Are pathologists the next group that will be targeted?

Physicians who order specific tests or who perform fine-needle aspirations or biopsies generally want to follow up regarding the diagnostic results. Similarly, in the Internet age, many patients are anxious about the results and about the therapeutic or prognostic import of their diagnoses. Should pathologists expect our clinical colleagues or patients to contact us about such results? If patients do so, should we respond? Shall we bypass the clinician who is fully informed about the patient’s history and medical condition (comorbidities)? The patient’s history and condition may influence the recommended therapies such that any therapeutic advice given by the pathologist (who is unaware of the clinical condition of the patient) directly to the patient may be inappropriate and, indeed, injurious.

Among internal medicine physicians, tracking laboratory results is problematic on many ordered tests for their patients. Most physicians who order laboratory or radiology tests write the orders, but the patient’s insurance coverage dictates which laboratory or radiology service performs the test. In addition, the timing of the test is left to the discretion of the patient and the laboratory or radiology service. So when can physicians check for the test results? When are the results abnormal, resulting in the dismissal of the executive director of the medical center?3 According to city officials, the failure of the medical center stemmed from placing a single clerk in charge of scheduling appointments and of notifying thousands of patients of their test results, an administrative decision made 16 months before the discovery of the mix-ups regarding notification of the Papanicolaou test results.4 This illustrates how communication breakdown can occur not only through professional carelessness but also through administrative negligence. Although the pathologists were not implicated in the situation, we need to exercise vigilance in monitoring laboratory communication systems and protocols.

What obligation, if any, does the laboratory have to communicate test results? Is the existence of a signed type-written report or an electronically verified report sufficient? Can the report be in electronic form only, or is a hard copy necessary? Does the laboratory rely on a com-
puter system or on the mail? How rapidly must a report be received?

The major problem is clear: how and to whom do pathologists communicate “critical” information? It seems obvious that we should telephone or e-mail (if compliant with privacy issues) the data to the attending physician who is in charge of the patient’s care. This is easier said than done. Multiple scenarios can occur, and many pathologists have experienced them.

Sometimes, the physician who performed the procedure was simply a “third-party intermediary.” A surgeon may have performed a lymph node biopsy to rule out lymphoma, and the node shows caseous granulomas and acid-fast organisms. The pathologist telephones the surgeon, who refers the pathologist to the patient’s oncologist; that physician, who does not treat infections, refers the pathologist to the patient’s internist or primary care provider, who may or may not know that the biopsy had even been performed. Another possibility involves a physician who refuses to accept the test results because he or she is no longer an attending physician on the service. The pathologist has now spent much time trying to convey important data that will affect patient care to someone who will accept the information. This is not an efficient use of pathologists’ professional time.

Most important, what are our obligations to patients to communicate critical abnormal results to the treating physician? What are the test results that need to be so communicated? Is the pathologist obliged to contact the patient directly if there is a failure to communicate the critical results to a clinician? A Westlaw search revealed a dearth of case law that specifically involved pathologists in the communication of critical anatomic pathology results, reflecting that most pathologists make appropriate efforts to communicate time-urgent information. However, this is far from reassuring. Although pathologists have not been hit with a flood of litigation, the problems that radiologists face may be a harbinger of pathologists’ liability. To provide some protection, we should articulate the rationale of communicating results.

The first step is to understand the elements of a malpractice suit. For a patient to prevail, he or she must prove first that the physician has some relationship or duty to act in a certain way, that this duty was not met by the actions of the physician, that the patient experienced some damage or harm as a result, and that there is a causal relationship both in law and in fact that links the breach with the injury. However, the application of these simple rules to physicians is more fluid.

In theory, a duty is imposed on a physician not just because he or she is best positioned to prevent such harm. Duty is conferred when the pathologist’s actions intersect the social concerns that govern tort law; namely, whether there is a treating or referring physician, whether the physician has the means to identify and locate the patient, and whether there are any contractual limitations on the physician’s duty. There appears to be a trend toward finding that a physician’s duty starts when he or she is in a position to prevent future harm, without giving other factors much consideration. Many courts are not performing a traditional tort analysis and are using the physician to shoulder the burden of adverse outcomes.

Much is said about the standard of care, but when courts look at preventing future harm, how do we discern what the standard of care is concerning communication? With national accreditation of laboratories and national specialty board examinations, the standard of care in medicine has evolved from one of a reasonable practitioner in a particular locale to one almost devoid of provincial boundaries. There may be a fine line between medical practice and communication of test results. An Indiana court case illustrates the importance of recognizing when the pathologist is using medical judgment. In this case, the pathologist waited to receive all of the outside consultation reports before issuing a revised pathology report. The clinician was informed of the revised diagnosis the next day. The patient argued that the pathologist should have communicated the results of each consultation report to the clinician as it was received. The court held that the pathologist exercised medical discretion in gathering and reviewing several outside consultation reports before issuing a revised pathology report; however, the transmission of the final pathology report was determined to be an administrative act. This distinction is important because the formation of the pathology report is a medical act that is generally subject to national standards of care, whereas the transmission of this information is an administrative one. Does this mean that there is a different standard when judging communication? That remains to be seen, and practice habits differ. Clinicians in Bismarck, ND, may be accustomed to having every malignant diagnosis telephoned to them by the pathologist, whereas clinicians in Philadelphia may never expect such telephone calls. The proliferation of practice standard guidelines should bring some uniformity to these communication issues.

What if the clinician receives the pathology report, but the pathologist did not alert him or her to the results in the report by a telephone call or another means? One could argue that the pathologist’s obligation is discharged on the clinician’s receipt of the results. Frequently, medical consultants complete their duty to inform by recording their conclusions in the medical record or by sending a letter to the referring physician. Are pathology reports any different? In a New York case, the patient’s expert witness claimed that there was a departure from the standard of care when the pathologist did not verbally communicate details to the clinician. The pathologist’s oral report to the obstetrician was that the results of an amniocentesis were normal, while the written report stated that one cell was missing an X chromosome and that the pregnancy should be monitored by ultrasonography, although such a finding was most likely a cultural artifact. The case was based on the patient’s expert witness, a family practitioner, who thought that the manner in which the pathologist reported the results was inappropriate. However, the court held that it is a legal question, not a medical one, whether there is a duty to communicate results in a particular manner to the clinician and thereby to the patient. An expert witness cannot establish whether there is a duty or not—that is up to the courts. The expert witness can only attest to medical decision making. Although this may be a reassuring result in legal reasoning, the reality is that a jury could perceive a pathologist’s actions in a similar situation as being callous.

The standard of care, as a matter of law, is not defined by professional guidelines or by codes of ethics; however, there appears to be a predisposition to use guidelines as such. In an Arizona case, the lower appellate court held that a radiologist had a duty to report abnormal findings...
directly to the patient if “there is no referring physician or the referring physician is unavailable,” relying largely on section V of the Standards of the American College of Radiology (2001) (concerning the communication of diagnoses), section VII (B)(2)(b) of the American College of Radiology’s Standards for the Performance of Screening Mammography (2000), and the American Medical Association’s Ethical Opinion E-10.03 (June 1999). However, the court’s logic meshed the concept of duty with the standard of care. The Arizona Supreme Court declined to place so much weight on professional society guidelines, emphasizing that, while these can aid in defining the standard of care, they are not dispositive of it and do not establish a duty as a matter of law. This underscores the standard of care, they are not dispositive of it and do not establish a duty as a matter of law. However, the court’s logic meshed the concept of duty with the standard of care. The Arizona Supreme Court declined to place so much weight on professional society guidelines, emphasizing that, while these can aid in defining the standard of care, they are not dispositive of it and do not establish a duty as a matter of law.11 This underscores the importance of professional guidelines in establishing a standard of care, and as various pathology societies develop such communication guidelines, it would be prudent to keep the guidelines flexible for the practitioner. Although guidelines can be a burden, they can provide protection from litigation if the pathologist follows specific procedures. As a result, guidelines should perhaps indicate what efforts are not necessary as well.

The elements of tort law should concern the pathologist even if one concludes that there is a duty to contact the clinician in a time-sensitive manner or, in an extreme circumstance, to contact the patient directly. A pathologist is liable only for what he or she does but also for what he or she does not do. Issues communicated during a telephone call can be misconstrued by the clinician or by the patient. The exigencies of time may not allow a busy pathologist to discuss a full account of the findings in the final pathology report. If the pathologist determines that an oral communication is necessary, the encounter should be documented. A lack of documentation can be used in court to imply that the critical nature of the findings was not directly conveyed to the clinician. Even if an official pathology report has already been dictated, an addendum to the report should be issued for documentation of oral communication. If it is important or urgent enough to warrant a telephone call, the communication is worthy of memorialization. Extensive documentation not only protects the pathologist but also underscores the nature of the patient’s condition.

If the pathologist decides to contact the patient, he or she needs to be sure that the patient understands that treatment or further evaluation (or at least follow-up with a clinician) is necessary. The final impression a patient should have is that the pathologist is monitoring the clinical situation. Furthermore, the pathologist should impress upon the patient the urgency with which he or she must pursue follow-up. It is prudent for the pathologist to make sure that the patient is capable of contacting his or her physician and for the pathologist to brief the clinician of the diagnosis if this clinician is not the ordering physician. Failure to do so may incur liability against the hapless pathologist.

In the age of technology, in which almost everyone carries a pager, a cell phone, or other communication device, it should be easy to communicate critical data to the responsible therapist. We know how difficult it is in reality. Therein lies a business opportunity, and companies have developed communication systems that can ease the burden on the data provider to interact with the client clinician; these systems also electronically document the communication and its receipt. Laboratory information systems could be implemented that convey alerts for “panic values,” not only for laboratory results but also for anatomic pathology reports by identifying designated panic words or phrases in an anatomic pathology report. The system could then automatically notify the clinician of the report via e-mail, fax, pager, cell phone, or telephone according to predetermined criteria. Such a system allows the clinician to define the algorithm and escalation process. If the clinician did not acknowledge the first alert within a specific time frame, the system would proceed to a second alert, perhaps in a different manner. Flexible laboratory information system parameters determined by the clinician increase the chances that information is conveyed in a manner most amenable to the clinician. Moreover, this places the “ball” of liability in the clinician’s court. Such systems would save precious time in attempts to contact the clinician, and failing that, could prompt the pathologist to consider directly contacting the patient if the situation necessitates it. The success of these ventures awaits their widespread use but may potentially offer at least some relief to communication dilemmas.

It is obvious that we need to tell the clinician about results that are abnormal and unexpected. What are the major categories of critical diagnoses? A short list would include unexpected diagnosis of malignancy, vasculitis, organ transplant rejection, and tissue-invasive infectious agents. However, as stressed by Pereira et al,15 the pathologist’s discretion is as important as any list. Hence, in some practices, notification may seem appropriate for the finding of fat in an endometrial curettage specimen or in the case of a discrepancy between frozen section and permanent section diagnoses.

With national pathology organizations developing guidelines for definition of critical values in anatomic pathology, the next step should be implementing methods to effectively communicate the information in a timely fashion to the patient’s physician. In practices or laboratories, pathologists should formulate a consensus with their clinician colleagues and clients as to what types of diagnoses are deemed critical, and policies should be developed by laboratories in conjunction with their parent institutions and medical boards. Some of these diagnoses will be individualized to the clinical service (eg, fat in an endometrial curettage specimen), although others will be common to all services (eg, an unexpected malignancy).

Some of the literature cited herein has provided the opening salvo to this discussion in pathology. However, the radiology literature is replete with examples and warnings about communication of radiographic results. To comply with national recommendations to avoid “medical errors” and to serve patients in an efficient and judicious fashion, the discussion needs to be broadened within our specialty and recommendations developed.

References

8. Stryczek v Methodist Hospitals, 694 NE2d 1186, 1187–1192 (Ind Ct App 1996); see also Keene v Methodist Hospital, 324 F Supp 233, 233–235 (D Ind 1971).
11. Supra note 5.