The Power of a Laboratory—Are We Taking Full Ownership as Hospitalists?

“Power, at the most rudimentary personal level, originates in dependence, and the power of [physicians, the professions] primarily originates in dependence upon their knowledge and competence.” With a coffee in 1 hand and a list of 20 patients in the other, the power that Paul Starr idealized in his 1984 Pulitzer Prize winner, *The Social Transformation of American Medicine*, doesn’t seem so relevant. So a long Saturday call endures, with the sole vision of power coming from that cup of coffee.

Monday morning is greeted by an urgent call from the microbiology laboratory stating that a blood culture turned positive earlier in the weekend. The laboratory originally notified the on-call fax machine located in the emergency department’s administrative office. This same notification went to the primary care’s nurse answering service but failed to reach a physician directly. As the electronic medical record is quickly sifted, slides 1 through 15 of the next Morbidity and Mortality Conference are already solidified. A 33-day-old febrile neonate was discharged from the hospital late Friday night after the respiratory viral panel resulted as adenovirus positive. After discharge, the blood culture turned positive at 26 hours. Thankfully, relief comes in the form of contamination: *Staphylococcus epidermidis*. Back to that cup of coffee.

That momentary scare followed by ease could have easily been the life of a child followed by a lawsuit. As with any profession, medicine poses the same inherent knowledge gap between expert and consumer. With this gap comes a relinquishment of “power” from the hands of patients to their physician. They put their confidence in the fact that an ordered test will be resulted, communicated, and acted on appropriately. The empowered hospitalist and hospital should have protocols in place that ensure a patient’s safety as they transition to the outpatient realm.

These errors are compounded even further for a hospitalist who is relentlessly trying to crack the barriers of communication with a primary care provider. Roy et al1 studied discharges from an adult hospital, demonstrating that primary care physicians were unaware of 65 of their patients’ 105 pending test results. Of these 65 test results, 24 were perceived to need action, and 8 required urgent action per the primary provider.

This communication disconnect is not forgiven by the court of law. Much of hospitalist legal precedent comes from the emergency department, where the same principles of effective communication and transition of care hold paramount. In 1979, *Phillips v Good Samaritan Hospital* placed the blanket of blame over all physicians involved in the missed distal humerus fracture of a 4-year-old girl. The
court stated, “It is incumbent upon these medical professionals to coordinate their efforts in a manner that best serves their patient’s well-being.”

Nearly 35 years after this defining 1979 court case, failure to notify patients about test results has become a plague in medicine.

In 2011, Gale et al. published an article documenting that malpractice payouts due to the failed communication of test results had increased from $22 million in 1991 to $91 million in 2010. Of the 306 cases studied in which test results were specifically cited as a deciding factor, 143 cases (47%) involved patients failing to receive their test results from their physician. The second most common cause of litigation was physicians never receiving the results (110 cases, 36%). Other problems included delays in reporting and test results that were filed before the clinician reviewed them.

Boohaker and colleagues have proposed 4 basic principles for managing patient tests: tracking pending test results, patient notification, documentation of notification, and successful execution of follow-up. These concepts are simple, yet the implementation of these ideals is so vastly diverse and easier said than done. It is naive to believe that a successful practice model is generalizable to a different institution. A system perfected in a primary care office is not reproducible in a hospitalist setting, just as a system built on electronic medical records may not be useful for paper-based hospitals. However, despite these fundamental differences, the same guiding principles at 1 institution can be instrumental for the success of another.

Boohaker and colleagues do miss a fundamental point pertaining to resource utilization and quality in patient care. Every ordered test should be deemed crucial for the diagnosis and management of the patient in question. Throughout the literature, unnecessary testing has been shown not only to be non-evidence-based but also to pose potential harm to pediatric patients. This is a fundamental step that needs to be addressed when it comes to laboratory ordering and its follow-up.

In 2010, the Joint Commission on Accreditation of Healthcare Organizations made an attempt to create a set of guiding principles by releasing their 8 recommendations for communicating abnormal test results:

1. Policies should be introduced with clear definitions of key terms.
2. Policies should clearly outline provider responsibilities.
3. Policies should specify procedures for fail-safe communication of abnormal test results.
4. Policies must define verbal and/or electronic reporting procedures for both critical and significantly abnormal laboratory, imaging, and other test value.
5. Policies should specify “critical tests” and acceptable length of time between their ordering and reporting.
6. Policies should define time lines between the availability of test results and patient notification, and institutions should specify preferred mechanisms for patient notification.
7. Policies must be of “real-world” value and written with feedback from key stakeholders.
8. Policies should establish responsibilities for monitoring and evaluating communication procedures.

Once again, the Joint Commission failed to address the potential harm of an ordered test that is unnecessary. Otherwise, the underlying themes seen in these recommendations can be applied to any institution or practice, regardless of its resources or facility. It is the refinement and adaptation of these recommendations that is essential.

The average pediatric hospitalist at a tertiary care center orders 7.8 chemistry, hematology, and radiology tests per patient. The number of these tests that are pending at time of discharge is not well defined in the literature. The more important questions are whether these laboratories are essential for patient care and whether every child’s hospital has protocols in place to definitively track these pending tests. It is important that hospitals implement evidence-based and practical institutional policies to guide the communication of abnormal test results. It is our duty as physicians to govern this practice. Or we can always depend on that power coming from the next cup of coffee.

REFERENCES


