

More about...Practice management

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Communication between colleagues

This short article outlines the minimum information that should be transferred between doctors during the referral/consultation process. Websites for downloading MSWord templates are provided below. An electronic 'dropbox' is described that can be used by doctors to organise and (securely) transfer patient data. This free service not only improves efficiency, but also cuts practice costs associated with printing and mailing letters to colleagues.

For optimal patient care, the minimum set of information that needs to be transferred between colleagues is well established and is recapped below. Moving these data efficiently and inexpensively and keeping reports organised and easily accessible has been a challenge that has only recently been solved.

Minimal information that should accompany the referral or consultation process

- From
 - a. Doctor's name
 - b. Doctor's address
 - c. Doctor's HPCSA number (required for electronic routing).
- To
 - a. Doctor's name
 - b. Doctor's address
 - c. Doctor's HPCSA number (required for electronic routing).
- Patient
 - a. First name
 - b. Last name
 - c. Date of birth (day/month/year)
 - d. Gender
 - e. ID number
 - f. Address.

To this must be added the following core clinical information:

- Clinical information for referrals (download an MSWord template from www.bluebird.co.za/Downloads/referral.doc)

- a. Problem
 - b. History of the problem
 - c. Allergies
 - d. Medication
 - e. Past medical history
 - f. Past surgical history
 - g. Relevant laboratories
 - h. Relevant imaging
 - i. Purpose of the referral.
- Clinical information for consultations (download an MSWord template from www.bluebird.co.za/Downloads/consult.doc)
 - a. Problem
 - b. History of the problem
 - c. Allergies
 - d. Medication
 - e. Past medical history
 - f. Past surgical history
 - g. Relevant laboratories
 - h. Relevant imaging
 - i. Assessment
 - j. Plan.

How can a practice move these data to a colleague efficiently and inexpensively?

The standard way of moving clinical information uses paper that is either mailed or carried by the patient. The former is expensive, the latter often mislaid. There is a service (available to doctors who utilise electronic laboratory results) that will move this information to medical colleagues without charge. All that is required is a PC that is connected to the Internet. Most practices (70%) use EDI and therefore already have this infrastructure.

More information is available on www.bluebird.co.za/Downloads/dropbox.doc – a few conditions apply.

What happens if the recipient wants paper?

The service will print and deliver the paper on his/her behalf.

Why is the archive such a valuable service?

Paper stored in filing cabinets is an expensive, cumbersome and archaic way of storing clinical information. Electronic

storage is cheap and instantly accessible – no more searching for that elusive paper report! The service discussed above keeps all electronic correspondence (together with laboratory results and radiology reports) on a secure site accessible in the same manner as on-line banking.

Is your pathologist serious about patient confidentiality?

This article examines the manner in which pathology reports are delivered to South African physicians and raises concerns regarding patient confidentiality. The importance of an audit between ordered and received pathology tests is explored.

A strong argument is made for secure, encrypted, electronic transmission to replace the sometimes cavalier approach to patient privacy.

Confidentiality of pathology reports has always been important: the advent of HIV has merely highlighted an issue that should have been addressed years ago.

Very few practices have an audit process whereby each ordered test is ticked off once returned. Most doctors assume that all ordered tests *will* be returned and have no way of monitoring missing reports (sometimes found weeks later under the courier's *bakkie* seat). If that test were a positive screening test, done as part of a routine yearly physical, often neither doctor nor patient realises that something is missing – sometimes with catastrophic results.

In such cases, is the ordering doctor or the laboratory liable?

Some years ago, in my own practice I did a screening test for Down's syndrome. The test was not returned and I didn't have any system that would alert me to the fact that I had not seen that particular result. It was positive. The patient returned for her next antenatal visit 4 weeks later. This prompted me to look for the result of her Down's

screen. She was now too late to be offered therapeutic termination.

Pathology reports are generally delivered by courier, fax, e-mail and, recently, by an encrypted, secure, auditable electronic system similar to the more familiar on-line banking model.

There are international guidelines concerning these delivery methods.¹

Faxes

Generally one should *not* fax sensitive personal information. If faxing is the only timely method available, the following precautions are required:

- Rules concerning the type of personal information that can be faxed from the laboratory must be documented. The laboratory must check regularly to confirm that employees are following the rules.
- The fax machine must be located in a secure area and access controlled to prevent unauthorised persons viewing faxed information. When faxing sensitive information, the machine must be monitored during the faxing process.
- Phone ahead to confirm the practice fax number before sending personal information. Confirm the recipient's security arrangements for receiving faxes. Ask the intended recipient to call as soon as possible to confirm receipt of the fax.
- Use encryption technology to fax sensitive personal information.

Transporting of reports by courier

It is essential to ensure that the courier company implements the following security safeguards:

- Physical security in offices and vehicles.
- Restricted employee access to personal information. Sealed envelopes.
- Staff must sign confidentiality agreements.
- Ensure that drivers are insured.
- Set driver guidelines and policy to ensure that personal information is kept secure while in the vehicle.
- Ensure that the courier company tracks the shipment and collects the *signature of the receiver* when the delivery is made.
- The sender should record an itemised description of the documents being transported in case of disagreement about what documents were received, or in case missing documents need to be identified.

Practically, we are all aware that this does not happen, but is it reasonable to keep ignoring the potential to harm our patients when there is a better way?

E-mail

Unencrypted e-mail is an unacceptable means of communicating confidential patient information (think of a post card). Even encrypted delivery through commercial Internet service providers (ISPs) can be a hit-and-miss affair subject to the vagaries of the anti-spam policies of various ISPs. The poor security of PDF attachments (even encrypted) merely adds to the problems.²

Electronic results

These may be sent with the proprietary system of the laboratory or by means of an independent transport hub. The independent hub has certain advantages:

- Data are carried from all laboratories in one system; the practitioner is not tethered, in perpetuity, to one laboratory.
- Other clinical data (collegial communication, radiology reports) are carried by the same system.
- The doctor has one number that can be called for help and the staff member answering that call has been trained (and has the tools) to solve the problem quickly.
- There is one interface for practice management and hospital integration.
- All historic clinical data are securely archived in one place and are accessible using a web browser (on-line banking model). A doctor can search by patient and instantly see all laboratory information, all imaging results and all consultations for that patient. This is powerful stuff!
- There is no reliance on commercial ISPs – this system allows audited and confirmed delivery to the end destination.

With the current, worldwide emphasis on patient privacy coupled with the ability of electronic ordering and delivery systems to audit that all ordered tests are returned (and to raise an alert if this does not happen) the 'old way' is increasingly difficult to defend.

References

1. The Office of the Information & Privacy Commissioner for British Columbia, Canada.
2. <http://www.password-crackers.com/crack/guapdf.html> (last accessed).

Guidelines for improved medical record keeping

It is required that all physicians keep medical records.

Given developments in society and the courts, physicians must recognise that medical records can no longer be written on

the assumption that they are for the primary physician's exclusive use. The information is the patient's; the physician is the custodian of that information. A partner, an associate, or a locum must easily be able to obtain information about the patient.

To assist Canadian physicians, 2 000 practices in British Columbia, Canada, were assessed and on the basis of this information, guidelines for the documentation of medical records were published.

This article reviews those guidelines and is published with the permission of the College of Physicians and Surgeons of British Columbia.

It was the conclusion of the Canadian study that to record anything less than that outlined below, not only exposes the patient to risk, but places the physician at risk as well.

1. Are the records legible?

2. Charts should be patient centric. Experience shows that family charts are a recurrent source of error and confusion and are not recommended. **The patient ID should include full name, address, date of birth, gender and ID number.** This basic information may also include spouse's name, medical aid plan, medical aid number, place of employment, type of work and any other information that would be helpful in assessing the patient. The information should be on the chart in a summary page or cumulative patient profile.

3. **Is a record maintained for each occasion on which the patient is seen?** The chart should record all office visits by date, but should also include a record of house calls, hospital visits, and important telephone conversations. If medical advice is provided by e-mail, that should also be retained in the file.

4. **Is the chief complaint stated?** There should be some notation as to why the patient is there. Minor complaints require relatively minor documentation, whereas more major complaints should have proportionately more documentation.

5. **Is there a history of the presenting illness?** There should be some description of the details and the length of time that the complaint has been there. This may be done by referring to a previous visit and the record pertinent to that visit.

6. **Are the findings of the physical examination noted?** This notation should include both positive and negative physical findings. This principle is especially true for complete physical examinations where all negative findings should be recorded. It provides a record of what was done as part of the examination.

More about...

7. **Are orders for X-ray or lab tests recorded and the results noted?** The fact that investigations are requested should be documented. The results may be documented in the clinical notes or may be available elsewhere in the chart.

8. **Are consultation requests noted and the reports included in the file?** Requests for consultations should be documented, preferably with the consultant's name and the date of the appointment. The request should include the reasons for the consultation and the results of any salient investigations. Referral letters and consultant's reports should become part of the permanent file.

9. **Are provisional or final diagnoses stated? Is a differential diagnosis considered?** What is the tentative diagnosis or, alternatively, what is the plan for further investigation to come to a definitive diagnosis?

10. **Is there a record of the treatment prescribed or advice given?** What is the treatment suggested? If no treatment is suggested, the record should state so. Alternatively, a description of the treatment should be described. Treatment advice

by telephone should be recorded. The advice regarding follow-up should also be recorded.

11. **Is there a record of medications prescribed, giving the date, name of medication, dose and quantity prescribed?** Repeat prescriptions by telephone should be recorded.

12. **Are there progress notes?** Repeat visits for the same complaint may refer to the previous visits. If so, has there been any change since the last visit?

13. **Are there operative notes?** If minor or major surgery is performed, is there a dictated note or an appropriate operative report?

14. **Are there pathology reports?** There should be an appropriate description or report of pathology found at surgery. This includes pathology reports on surgery performed by a consultant.

15. **Is there a résumé of hospitalisations?** Most hospitals now provide a copy of a narrative discharge summary for the admitting physician. This should become part of the permanent record.

16. **Is it possible to determine why the patient came to see the physician, what was found, and what was done about it?**

Other recommendations

Cumulative patient profiles – drug lists and problem lists in the front of the chart are very helpful and should be up to date. An incomplete drug list gives one a false sense of security.

Medication list – a list of current medications with the details of drug name and strength (often best kept in pencil, given that these will change over time).

Problem list – a list of the active medical problems being managed and a separate list of relevant resolved problems (past medical history).

Allergy notations – drug allergies should be highlighted, preferably on the front of the chart or on the inside of the chart cover.

Systematic methods of charting are recommended – e.g. SOAP (subjective, objective, analysis, plan) or similar systems.

single suture

Stop eating bushmeat

We know that HIV-1 and HIV-2 came from the chimpanzee virus SIV – simian immunodeficiency virus. However, the source of a third strain of HIV – which infects people in western central Africa – was a mystery until recently, when it was found to come from gorillas. Researchers have found the virus in the droppings of gorillas living in the remote forests of Cameroon. The infected gorillas live up to 400 kilometres apart, so researchers think that this must be an endemic virus, as SIV is in chimps. Because humans hunt and eat gorillas and use them for traditional medicine, the virus could cross yet again, forming still another strain of HIV, particularly as the growing demand for 'bushmeat' leads to more hunting.

New Scientist 2006; 11 November, p. 17.