The Royal College of Pathologists
Pathology: the science behind the cure

Communication of unexpected findings, urgent reports, delayed reports and the use of Alert systems in diagnostic cellular pathology: Guidance from The Royal College of Pathologists

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Comments	This document was approved by the Specialty Advisory Committee on Cellular Pathology. In accordance with the College's pre-publications policy, this document was placed on The Royal College of Pathologists' website for consultation from 13 February to 13 March 2013. Responses and authors' comments were used to make substantial changes, including adding new advice in relation to delayed issue of a report. **Dr Suzy Lishman** **Vice-President for Advocacy and Communications**

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Purpose of guidance

Laboratory-based work is dependent not just on the issuing of a report in which there is a description of histological findings, but also on interpreting their relationship to the clinical setting. This requires the application of clinical judgment. The General Medical Council has issued guidance in *Good Medical* Practice that indicates a clinical duty to make appropriate communications to clinical teams, placing the care of patients as a first priority (Paragraphs 25 and 44a).[1]

This document provides advice in relation to concerns around implementation of systems designed to draw attention to laboratory reports, here termed 'Alert systems'. Advice is also given in relation to working with service users to establish pathways for the communication of urgent reports or reports in which there is an unexpected finding. Advice is also given around communication when it is anticipated that the issue of a written report will be significantly delayed.

An Alert system may be implemented as part of a laboratory reporting system. An Alert system is defined as any management system designed to highlight or code laboratory reports such that they are specially drawn to the attention of the clinical team. They are usually used to expedite the referral of patients through care pathways.

Systems should ensure that reports are available to service users promptly

1. Pathologists should ensure that systems are in place within the laboratory so that reports are routinely sent in a timely manner to meet clinical needs. This should include the appropriate use of technology to create written reports and electronic transmission to service users.

2. Pathologists should work with service users to optimise the service so that those who have requested a laboratory investigation receive reports upon which they can make clinical decisions. Reports should be written to comply with guidance issued by the College (cancer datasets and tissue pathways – see www.rcpath.org/publications/datasets). The use of SNOMED codes for reports can aid identification of cancer patients for multidisciplinary team (MDT) meetings.

3. Service users sending specimens should have in place systems to ensure that **all** histopathology reports are read by someone who is suitably trained and qualified to read and interpret them correctly, in the context of the patient's clinical details. Systems established with service users should ensure that histopathology/cytology reports are available promptly.

Urgent communication of a report or unexpected finding

4. Pathologists should work with service users to define a communications pathway that allows for a report to be communicated reliably and urgently in addition to routine reporting systems, when this is indicated. Systems will need to be specified that are appropriate for local use.

5. In some instances, a diagnostic finding is encountered that may be unexpected and where the pathologist believes, based on their clinical judgment, that harm may come to a patient by the delay implied in the routine reporting system. In such circumstances, the pathologist should communicate the report using the pathway defined for communicating urgent reports.

Coding reports for Alert systems

6. Pathologists may be asked to code reports as part of Alert systems. The following principles should apply:

i. Pathologists should support the implementation of Alert or coding systems as they may draw timely attention to a report to expedite a subsequent clinical management decision.

ii. In participating in the use of a coding or Alert system, pathologists should make it clear that it is the responsibility of the requesting clinician to have systems in place to ensure timely reading and the acting upon of a laboratory report. It must be clear that the Alert or coding system does not remove this primary responsibility.

iii. Coding reports requires clinical information about a case that may be lacking from a laboratory request. Pathologists must therefore inform those implementing and using an Alert system that no reliance should be placed on such a system to prevent harm coming to a patient, for example through missing reading a report, as subjective interpretation is required for the coding.

iv. It is reasonable for pathologists to code reports indicating positive cancer diagnosis or negative biopsy for purposes of managing a patient pathway. However, users of such coding should be made aware that reliance should not be placed on such a system to prevent harm coming to a patient given that clinical information may not be available to the pathologist in the request, and that subjective interpretation based on clinical information is required for the coding.

Informing service users when a delay is anticipated in issuing a report

7. Where a diagnostic finding is encountered where it is anticipated that there will be a significant delay in the preparation of a final written report (for example in waiting for additional investigations, referral to another colleague or referral to another centre), an interim report summarising the current position should be issued promptly to the relevant clinical team, so that this can be noted in the patient record. The decision when to issue an interim report is one of clinical judgment, based upon the context of the case. The case should be tracked in the laboratory to flag that a final report is still outstanding and a final written report should be issued as soon as possible.

Reference

1. General Medical Council. *Good Medical Practice*, 2013. www.gmc-uk.org/guidance/good_medical_practice.asp (accessed 30 October 2013).