Of visions, systems, and recurring themes

Greetings. It is a privilege to be the Health and Disability Commissioner. I appreciate this opportunity to share with you, six months in, some of my thinking as I reflect on this first period of my tenure.

In this note I will reflect on visions old and new for the health sector, some important themes arising in those visions and captured in our own Code of Health and Disability Services Consumers' Rights, and some recurring themes arising in the matters before my Office.

New Zealand has a health and disability system of which it can be rightly proud. Our system successfully treats or engages with health and disability consumers on millions of occasions every year[1]. Advocates assist with 3500 queries a year and this office receives some 1500 complaints.

These consumer stories provide us with important opportunities to learn, to improve system safety and quality, and thus to strengthen the system that serves us all.

Visions old and new

In 1988 Judge Cartwright advocated a system 'which will encourage better communication between patient and doctor, allow for structured negotiation and mediation, and raise awareness of patients' medical, cultural and family needs. The focus of attention must shift from the doctor to the patient.'[2] Judge Cartwright went on to say: 'Health professionals need to listen to their patients, communicate with them, protect them, offer them the best healthcare within their resources, and bravely confront colleagues if standards slip.'[3]

Twenty years on another voice speaking of a modern health care system articulated the following vision: 'We envision a culture that is open, transparent, supportive and committed to learning; where doctors, nurses and all health workers treat each other and their patients competently and with respect: where the patient's interest is always paramount; and where patients and families are fully engaged in their care. We envision a culture centred on team work, grounded in mission and purpose, in which organisational managers and boards hold themselves accountable for safety and learning to improve.'[4]

The similarities are striking. US thought leaders Leape Berwick et al go on to discuss five transforming concepts relevant to the delivery of that vision. Three of these – transparency, the integrated care platform, and consumer engagement – are themselves current themes in the New Zealand system and are echoes of our own Code.

---

[1] 'For example, acute hospital discharges exceed 370,000 per annum, primary care interactions exceed 15 million consults per annum'. Source: Ministry of Health

[2] Cartwright, SR: *The report of the committee of inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital and into other related matters*. Auckland Government printing office 1988.

[3] Ibid

[4] L.Leape, D Berwick et al*; Transforming Health Care: A Safety Imperative*, qual saf healthcare 2009: 18; 424-428

A quality and safety approach rightly places 'what happened' before 'who did it'. It encourages the open disclosure of information and the genuine willingness to transparently disclose and discuss events that go wrong.

My approach will be first to seek the learning and to understand fully what happened in the consumer stories that come before me. Consumers commonly say to me that their purpose in complaining is to ensure that 'this does not happen to anyone else'.

There has been and will be no jurisprudential earthquake in the opinions being issued. Decision-making will reflect the precedents set in the last fifteen years. In resolving complaints I am interested to reduce repetition of errors – exploring system cause and context, and strengthening system delivery. The themes of resolution, protection, and learning continue, as do the themes of being fair and expecting professionals to take responsibility for their practice[5].

Avoiding repetition – how well do we learn as a system?

If we can understand the systems within which events occur, we can also understand causation, learn, and avoid repetition.

Any conversation about a learning system connotes questions of culture. In a highly complex and busy system, learning is a challenge. One thought-provoking aspect of the stories before me in these last six months has been not that they occurred at all, but the frequency with which the same themes recur.

Getting the basics right – recurring themes

Patient safety begins with getting the basics right. It is in the ordinary that we spend most of our time, and it is in the ordinary that issues arise. I group some of these under the rubric: 'Read the notes, ask the questions, talk to the patient'.

In this and other fora, I will be discussing these recurring themes. A broad series of issues fall within each area – some examples are outlined below.

Read the notes

Issues concerning notes appear frequently – are they comprehensive, accurate, contemporaneous? Do they quickly collect diagnostic results, do they support continuity of care, and are they read?

Consider the woman with shoulder pain who consulted five different doctors at a medical centre over a period of seven months[6]. Each consultation was poorly documented and the notes provided little assistance to doctors at subsequent consultations. After a failure to follow up on referrals and test results, the woman was eventually diagnosed with cervical stenosis and myelopathy.

[5] Opinion 08HDC04311
[6] Opinion 08HDC06359.

In another case, the notes were appropriate, but were not read by the next provider (who had them). Harm was avoided as a friend fortuitously advised the consumer to have a free mammogram independently of her GP practice. The mammogram confirmed the previously palpated lump was suspicious for cancer, subsequently confirmed.

Ask the questions

Another recurring theme is omitting to ask questions about either history or what else may be going on. In one case a GP diagnosed his female patient, whom he saw on a series of visits, with iron deficiency anaemia and gastritis without performing an abdominal or rectal examination. When iron supplements failed to improve her health he undertook no further investigations. The woman eventually sought a second opinion, revealing a primary tumour in her caecum and secondary cancer in her liver.[7]

'Ask the questions' also raises cultural issues about our system – the ease with which we can ask questions and our comfort in doing so. Co-operation and teamwork ensure that the many different skill sets of individuals can be combined to provide more efficient, effective and safer care[8].

Cases suggest team members can be hesitant to step out of the hierarchy, or to question decisions. The story of a 2½ year old boy illustrates this. The child was admitted to hospital with a moderately severe exacerbation of asthma. He was transferred to a paediatric ward later that day, initially improved but overnight experienced increasing respiratory distress. He suffered cardio respiratory arrest early the next morning and ultimately died. In that case, the attending house officer did not recognise the severity of the child's condition and failed to respond appropriately. Senior nurses present expressed concern; but even so, specialist assistance was not sought early enough.[9]

The communication theme, in many forms, echoes through cases past and present. How effectively do we work, as teams, among providers, and is it easy to raise a concern or step up or outside the hierarchy when concerns grow?

Talk to the patient

It is important that consumers are equipped with information that a reasonable person in that consumer's circumstances might wish to know. Communication of risk is one recurring dimension of this.

A patient who was undergoing innovative robot-assisted surgery was not advised of the surgeon's limited experience and the time he had previously taken when carrying out this surgery. The patient was not aware of the risks should the operation be prolonged. The surgeon was found in breach as the patient did not give informed consent to the operation.[10]

---

[7] Opinion 10HDC00253.
[8] Weller J, Thwaites J, Nhoopatkar H, Hazell W., "Are doctors team players, and do they need to be?" New Zealand Medical Journal 2010: 123 (1310)
[9] Opinion 08HDC04311.
[10] Opinion 08HDC20258

In a case of a testicular torsion, incorrectly but reasonably diagnosed as infection, the patient was informed of the risk of the differential diagnosis of torsion. He chose to go back to work rather than walk into the room next door and have the free ultrasound, which was the only certain way to exclude the differential diagnosis. The consumer felt he wasn't given sufficiently clear information about the severity of the consequences of the differential diagnosis.

Conclusion

Recurring themes within the 'getting the basics right' rubric will be the subject of ongoing discussion and engagement with the system. We have a strong system. It works well the vast majority of the time. Improving that system is a worthy challenge.

Anthony Hill
Health and Disability Commissioner
Medical Council newsletter, February 2011