Taking a good history

Good communication is the cornerstone of the doctor–patient relationship. Yet, as with all interactions between two people, possibilities abound for misunderstanding and incorrect assumptions. As noted by William Osler, taking a good history from a patient is an essential skill for any doctor. A recent general practice case illustrated the pitfalls in relying on summaries and not asking key questions of a new patient.

A tragic death

This case involved Mrs A, a woman in her thirties seeking treatment for a migraine. She had attended a medical centre on several occasions as a casual patient and had recently transferred her notes there as Dr X's patient, but had not seen Dr X since doing so. As Dr X was not available until later in the day, Mrs A and her husband decided to see another doctor at the medical centre, Dr Y. By this stage Mrs A's notes had arrived at the medical centre, been given a number and filed. The cover sheet had been filled in with some basic information about Mrs A. The only medical information included on the cover sheet was a tetanus vaccination in 1997.

During Mrs A's appointment, Dr Y either did not have, or did not refer to, Mrs A's file. Dr Y did, however, refer to the cover sheet. Dr Y took a history from Mrs A regarding her migraines and asked Mr and Mrs A a number of questions. These questions did not include a specific enquiry whether Mrs A had asthma. This assumed vital importance in light of Dr Y's decision to prescribe Mrs A propranolol, a medication for which asthma is a contraindication. Mrs A had a history of asthma and, not long after taking the prescribed propranolol, she experienced breathing difficulties which progressed to respiratory arrest. Tragically, Mrs A died a month later. The Coroner found that Mrs A died as a result of a pulmonary embolism.

A husband's complaint

Mr A complained to HDC about Dr Y's care of his wife, seeking an investigation so that he and his family could "obtain closure and begin to rebuild [their] lives".

I commenced an investigation into Mr A's complaint and notified Dr Y and the medical centre. In her response, Dr Y said that she was devastated by Mrs A's death. She provided an account of the consultation and stated: "One issue that concerns me greatly is why I did not get an answer from Mrs A that directed me to a past history of asthma." Dr Y speculated that the fact that Mrs A had taken Voltaren in the past may have "blocked" her from asking. Dr Y also described her experience of patients usually volunteering information about an asthmatic condition.

Dr Y pointed out that there was no mention of asthma on the apparently completed cover sheet for Mrs A's file. Dr Y described her own practice of reviewing the files of any new patients, highlighting important information and recording it on the file cover sheet. The first page of Mrs A's records included a list of prescriptions of asthma medications.

I obtained expert advice from Dr Jim Vause and considered advice provided to ACC (which accepted a claim for "medical error") by Dr Ian St George and Dr David Henry. These GP experts were unanimous that it was inappropriate to prescribe a beta-blocker to an asthmatic. Dr Vause noted that as Dr Y had not established this

contraindication from Mrs A's records, she was dependent upon obtaining the information directly from Mr and Mrs A. Dr Y needed to ask what Dr Vause described as "the critical question", namely, did she have asthma or any other significant lung problem.

HDC opinion

I concluded that, in prescribing a beta-blocker to an asthmatic, Dr Y failed to provide services with reasonable care and skill. Dr Y knew that beta-blockers are contraindicated for asthmatics, but failed to establish that this contraindication was present in this case. Accordingly, in my opinion Dr Y breached Right 4(1) of the Code.

In terms of the information available to Dr Y on the cover sheet, I noted that, irrespective of her own usual practice, Dr Y knew Mrs A was another doctor's patient. Dr Y acknowledged that she could not influence how other doctors practise when summarising key patient information. In these circumstances, I concluded that it was not safe for Dr Y to assume that the cover sheet was complete and reliable.

There can be distractions or "red herrings" during consultations that divert a doctor from a line of questioning. However, it remains a fundamental part of a doctor's role to establish whether there are any contraindications to proposed treatment. Patients cannot be relied on to volunteer all relevant details, and indeed do not have the training and experience to know what may be important. They rely on their GP to elicit key information.

Shared GP practices

Although it was Dr Y's duty to obtain necessary information from Mrs A, in my view her fellow GPs also had a responsibility to ensure that important patient information was readily available to other practitioners who might care for their patient. Mrs A's case highlighted the risk of a patient falling through the cracks. There was no single legal entity responsible for the running of the separate, co-located practices. A site visit also raised some issues about the way in which the doctors worked together. The GPs maintained that, notwithstanding the shared premises and facilities, they were all completely independent from each other. In their view, safe practice was an entirely individual matter.

I found this an unsatisfactory situation. Regardless of the legal framework adopted by practices, patients naturally expect a level of co-ordination and co-operation between GPs working in close proximity. I endorsed the sensible recommendations by Dr Vause:

- Consistent practice policy on the transfer of information from previous notes, defining the responsible person and a timeframe for completion.
- Audit of the system (by an administrator or practice manager) to ensure that it is sufficiently reliable for the GPs to be assured that critical data is not missing.
- Recording of all patient medical information held in the medical centre in one file, with progress notes recorded contiguously.

Obviously computerised medical records would assist co-located practices to achieve these steps.

In conclusion, this tragic case study highlights the crucial importance of taking a good history and asking key questions to ensure that all relevant information is obtained from a patient.

Ron Paterson
Health and Disability Commissioner

New Zealand Doctor, October 2006