Referrals trip up GPs and DHBs

The responsibility of GPs to follow up patient test results has been the subject of extensive discussion in the past. Follow-up of specialist referrals raises similar issues. Doctors who refer patients to a specialist need to take reasonable steps to follow up the referral, especially if the patient's need for specialist assessment has become more urgent following the referral. As stated by Judge Beattie some years ago in a District Court case:

> "In all the circumstances I find that the acts and omissions of Dr H on 21 January and following, when she failed to identify the degree of urgency that was required to have [Mrs P] seen by the appropriate specialists and thereby given over to the appropriate treatment without delay, was inexcusable and constitutes a falling below the standard of care expected in the circumstances. I cannot emphasise too much that the circumstances of this case were that of a life-threatening disease and which any competent general practitioner ought to have identified and taken far more direct action and follow-up if necessary."

Judge Beattie did not think it too onerous to expect a GP to telephone the hospital to speed up an appointment given the suspected malignancy in that case and the fact time was of the essence. He said "[a] degree of aggression" was called for in following up the referral.

In a more recent case, a medical centre did not have an automatic reminder system in place to ensure referrals were followed up, preferring to leave it to the individual doctors to manually set up reminders on a case-by-case basis. The GP prepared a referral letter but forgot to print and send it. The GP also failed to enter an alert on her computer which would have reminded her by way of a pop-up on her computer screen to follow up the referral if she had not heard back from the DHB within a nominated time frame.

As a result, no colonoscopy appointment was arranged for the patient and it was only after the patient complained to HDC that the GP realised she had failed to send the referral letter. As I stated in the opinion:

"Medical providers need to have robust systems in place to ensure mistakes and omissions are identified at an early stage to prevent harm being caused to the patient.

One simple precaution providers can take to ensure referrals are being actioned in a timely manner is to allow for automatic alerts to appear on their computer screen at a nominated interval after a referral letter has been generated, alerting them to follow up if they have not heard back from the clinician by that time...

"Another precaution providers can take is to ask the patient to contact the clinician to whom they have been referred directly if they have not heard from them within a certain time frame. A provider who explains to the patient the purpose of the referral and its importance, not only ensures that the patient is adequately informed, but also encourages the patient to be vigilant in following up if the referral appointment is not received."

It was found the GP did not provide the patient with services with reasonable care and skill and so breached Right 4(1) of the Code. In addition, I consider practices should have policies in place regarding the use of reminder systems.

DHBs also have a duty of care

DHBs also owe patients a duty of care in handling referrals from GPs within the district and from other DHBs. A specific aspect of the duty of care is the duty to cooperate with other providers to ensure continuity of care under Right 4(5) of the Code. A DHB must have robust systems for managing referrals so the referred patients do not fall through cracks in the system.

In another recent case, a man was referred to DHB 1's cardiology department for an angiography by his respiratory physician at DHB 2. The respiratory physician telephoned DHB 1 and then faxed his referral letter to DHB 1, attaching a copy of the man's exercise tolerance test (ETT) results. The referral needed to be assessed to determine whether its priority was urgent, semi-urgent or routine.

The information contained in the man's ETT results was significant and warranted an urgent priority or immediate admission to hospital. However, the triaging cardiologist at DHB 1 was unable to decipher the ETT results as they were too faint to read. Neither the triaging cardiologist nor the staff at DHB 1 followed up to obtain a legible copy of the results. The man was given a semi-urgent grading based on the information contained in the referral letter. Sadly, the man died of a heart attack before the appointment allocated.

I made adverse comment about the actions of the cardiologist in failing to ensure the illegible ETT was followed up and the triage decision reconsidered. The triaging clinician had assumed, if the matter was serious, the referring doctor would have called him and the letter would have reflected the level of seriousness. Making such assumptions creates a significant risk for the patient.

The referral letter did contain the information that indicated the seriousness of the patient's condition, but the ETT results attached to the letter were illegible.

As I stated in the report "seamless patient care requires that clinicians act to ensure their concerns are being appropriately actioned. The DHB should have policies in place to ensure such follow-up occurs". If a referral does not contain sufficient information to make an accurate triage assessment, further information should be sought from the referrer, rather than relying on incomplete information or assumptions.

DHB 1 was found to have breached Right 4(1) of the Code because it did not provide the man with services with reasonable care and skill. Adverse comment was made about the failure of the referring DHB to have an appropriate system to ensure referrals have been received and the receiving DHB has accepted care of the patient.

If the referring clinician had followed up the referral to check the fax had been received and was legible, and the urgency and risk had been acknowledged, he would have been aware the ETT results were illegible and been able to take steps to remedy the situation.

In addition, DHB 1 was unable to provide any evidence it had notified referring clinicians of its expectation that referring clinicians will make direct telephone contact with the on-call registrar if a patient is considered an urgent priority or high risk. Patients have a right to cooperation among

providers to ensure quality and continuity of services. DHB 1 was found to have breached Right 4(5) of the Code because it did not communicate effectively with DHB 2.

A receiving DHB should acknowledge receipt of the referral, promptly notify the patient (with a copy to the patient's GP and the referring DHB) of an approximate time frame for an appointment, and then notify the patient (again, with a copy to the GP and referrer) of a specific appointment time.

In this case, no letter of acknowledgement was generated or sent to the patient and so DHB 1 was found to have breached Right 6(1)(c) of the Code.

Referrals a two-way process

Referrals involve a two-way process of communication. The referring clinician must ensure the referral contains adequate information and is sent to the appropriate recipient. The referring clinician should have processes in place to ensure the referral is followed up to check whether appropriate action has been taken. The receiving clinician or DHB should take appropriate and timely steps and communicate these to the patient and the referring doctor or DHB.

A key session at HDC's Medico Legal Conference to be held in Auckland on 17 October and in Wellington on 18 October will be "Lost in transition: exploring continuity of care through HDC complaints". The conference theme this year is "Creating a consumer-centred culture", and I am very much looking forward to this great opportunity to engage in discussion with the medical practitioners and others who will be attending.

I hope to see many *New Zealand Doctor* readers there. Contact jphillips@hdc.org.nz or phone 04-494 7904 to find out about the programme and to register.

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