Systems, Patients, and Recurring Themes

I am pleased to have this opportunity to share some of my thinking after six months as Health and Disability Commissioner. In this column I will consider some recurring themes arising in the cases that have come before my Office.

Our health and disability system works well in the vast majority of the millions of interactions with consumers that occur each year.[1] In this context HDC advocates assist with over 3,500 enquiries, and my Office receives around 1,500 complaints per year. Each represents an opportunity to learn. The human stories that are reflected in the complaints I receive often involve individual tragedies. Resolution for consumers often involves understanding what really happened, combined with the hope that the lessons learnt mean the same thing is less likely to happen to anyone else.

I have been struck by the number of complaints which relate to a failure to get the basics right. I am interested in how well we learn as a system - why errors are repeated and how to reduce repetition. If we are to have a learning system we need to understand the individual and systemic causes of error and their context.

It is in the ordinary we largely dwell and is from the ordinary the stories of harm arise. Thus here and in subsequent columns, I will be reinforcing the message 'patient safety begins with getting the basics right'. I will be discussing a range of issues grouped under the rubric 'read the notes, ask the questions, talk to the patient'. These broad concepts provide a framework for discussing some recurring themes that arise in the stories before me.

The stories tell of notes not read and notes that are incomplete or disconnected. Good clinical records are integral to providing care. They demonstrate the reasoning behind the diagnosis, set out the key information upon which decisions about ongoing care are based and can help safeguard practitioners when faced with allegations of inadequate practice. The records are also vital for enabling continuity of care and ensuring other practitioners know what decisions have previously been made and the care that has been provided. Notes need to be comprehensive, accurate, and contemporaneous. If it isn't recorded in the notes the starting point is that it didn't happen.

Consider the woman with shoulder pain who consulted five different doctors at a medical centre over a period of seven months.[2] 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.

In a similar case, a cancer diagnosis was delayed because the follow-up GP, who had good quality notes, did not read them.

It is also vital that doctors 'ask the questions' - carry out adequate examinations and consider what else might be going on.

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

[2] Opinion 08HDC06359.

In a recent case investigated by HDC3, a patient had consulted her GP on several occasions with various complaints including tiredness, low energy levels, mild lower back pain, aching upper abdomen, shortness of breath, tightness in lower chest and a feeling of passing out. The GP diagnosed the patient with an iron deficiency anaemia and prescribed iron supplements. However, her health did not improve. A blood test result included the pathologists comment "note decreased haemoglobin ? recent blood loss – monitor".

The GP failed to carry out an abdominal or rectal examination, and to adequately investigate the causes of her anaemia. Subsequently, the patient sought a second opinion from another GP who identified a swollen liver and, following a CT scan, a primary tumor was identified in her caecum and secondary cancer in her liver.

In another feature of that case, my expert advisor commented on the GP's use of the "hot key" function when recording his notes and rightly pointed out that although the use of hot keys is not uncommon, the content of the clinical notes must accurately reflect the activities that took place during the consultation.

The patient did not recall the GP carrying out a very detailed cardiovascular examination on her (including normal peripheral pulses), recorded as occurring on nine occasions, nor receiving advice on "foods, feeds and care", recorded as occurring on eight occasions. Nor did she recall receiving advice on diet and exercise, recorded as occurring on two occasions. Overall, the records were not sufficient to meet the legal requirements and the GP was found to have breached Right 4(2) of the Code.

The importance of adequate records and examination of patients is clearly demonstrated in the context of rest home care where doctors are working with other staff in multi-disciplinary teams. The communication in the clinical record should tell the whole story about the patient's care, show the observations and how they were acted on, show continuity of care, show the care delivered following the observations including medications and other treatments, specify arrangements for review and follow-up, and show how the patient responded to the care.

Many patients now see multiple providers, GPs and practice nurses within one practice, and poor note-keeping and processes interfere with continuity of care and planned follow-up. Consider the example of a fit woman in her early sixties who had been found to have significant hypertension at a routine medical examination. The plan was to monitor the blood pressure monthly for three months to gain a better picture of her levels and to further investigate and commence treatment if indicated. The patient presented to the practice nurse as directed and elevated blood pressures were recorded on each occasion but not conveyed to the doctor. At subsequent unrelated consultations over the next two years the readings were not acknowledged even though they were present in the notes. The blood pressure remained untreated and the patient died of a cerebral haemorrhage, thought to be due to untreated hypertension.

Here the lack of communication with and from the practice nurse, together with poorly structured and documented monitoring and follow-up instructions to both the practice nurse and the patient, contributed to a potentially treatable condition being neglected.

[3] Opinion 10HDC00253

I accept that many medical professionals operate under pressure of time. It is then, however, that a structured approach to the basics avoids the temptation of the shortcut. A fully documented examination, assessment and management plan is vital in order to ensure the patient is properly managed, and supports a patient-centred system. If the basics are attended to, the complaints and personal suffering I see will be reduced.

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NZ Doctor, 9 March 2011