Advising the Commissioner

Initial thoughts

After five months in the job as in-house clinical advisor to the Health and Disability Commissioner, I am relieved to say that most of my colleagues still speak to me. In fact collegial interaction has taken on added value as I seek the views of my peers on the (anonymised) content of some of the cases with which I am presented. The experience to date has been highly educational (as I gain knowledge researching the content of some complaints), at times humbling (both as I read of the incredible trials that some patients have endured but also as I see how truly compassionate and dedicated some of my colleagues are) but at other times somewhat disturbing (as I attempt to pass an opinion on the content of a consultation when the notes consist of five words). I have learned how important it is to place oneself in the "provider's chair" without the benefit of hindsight regarding the final outcome (and often the source of complaint) of the incident in question. And, in keeping with the focus of the Commissioner, I have tried to see opportunity in every complaint for learning and quality improvement in primary care at either an individual or professional level.

Horses and zebras

The majority of complaints made against providers will never make my desk. Many are appropriately resolved by interaction between the provider and complainant with or without the contribution of an external advocate or a specific mediation process. Some complaints I see could have been resolved at this level but, often for want of an apology without admission of responsibility, the complaint escalates. Many complaints appear to be the result of poor communication rather than any clinical competency issues, but such miscommunication can lead to poor health outcomes and breaches of the Code. A very broad review of the cases I have encountered so far indicates that about 60% have a "missed diagnosis" issue as the focus of the complaint while the remainder are for more general clinical management and communication issues. Of the missed diagnoses, cancer features prominently with bowel cancer (particularly in younger males) being the most frequent. Other diagnoses feature more commonly than their prevalence would predict including Steven-Johnson syndrome, septicaemia and "trash foot" (which I'm not ashamed to say I had to look up). And, after receiving two complaints in a week about missed neck fractures (odontoid peg) in rest home clients, a bit of research showed me that this is a not uncommon consequence of forced hyperextension (often mild force, eg, falling and striking the forehead on a bed head) in an elderly person with marked degenerative cervical spine disease. Beware the rest home client with a persistently sore neck after an unwitnessed fall!

Rest homes …

The source of complainants is interesting in that over 20% of complaints I have seen have related to rest home patients. On examining the various issues that come up in these complaints it becomes obvious just how fraught this area of primary care can be. Some of the relevant issues pertinent to the rest home environment, and which require special consideration, are:

1. Often there is no established relationship between the GP and the patient or the patient's family. Issues of privacy are raised when one family member has enduring power of attorney (EPO) but other family members request confidential information. I have frequently seen evidence of family dysfunction that ultimately involves the GP or rest home staff in issues of miscommunication. Conflicting opinions on management

options (eg, intervention versus comfort cares) between family members can make management complex, as can conflict between the wishes of a mentally sound patient and a concerned family member. It is important to establish and maintain clear lines of communication with relevant family members when dealing with those patients lacking the mental capability to make informed decisions on their own clinical management.

2. The clinical environment is often unfamiliar in terms of clinical processes, availability of resources and knowledge of staff capabilities. Yet rest home patients should expect the same standard of care they might receive had they attended the GP surgery. It is no less acceptable to examine a rest home patient in the public dining area than it would be to examine a patient in a full waiting room. Visiting GPs are often expected to see multiple rest home patients in a short period of time, and the GP must ensure that he or she has adequate time and resources to offer a standard of care that fulfils both patient and provider expectations.

3. Of the files I have examined, clinical documentation in rest home notes appears to be somewhat briefer in general than for in-surgery consultations. Notes are often hand-written (and legibility is an ongoing problem). Some providers will make brief notes at the rest home and more comprehensive computerised notes at the surgery. There is often an assumption made that history or vital signs do not need to be recorded because nursing notes will have documented these — however, the standard of nursing notes is highly variable, as is the extraction of relevant history. Again, it seems reasonable for GP documentation in rest home notes to be at least as comprehensive as in-surgery notes, particularly as there is an increased likelihood of multiple providers accessing notes in a rest home.

4. The characteristic of the patient base in a rest home makes it a more complex and riskier population to manage. Co-morbidities and polypharmacy are common, making meticulous medication management a necessity in order to minimise adverse effects and interactions. Acute disease or injuries may present in a subtle or atypical fashion (eg, odontoid peg fractures after a fall — both patients in the complaints mentioned above complained of a "sore neck" but there were no neurological signs or symptoms), and unwell patients may rapidly become dehydrated. History taking may be compromised by concurrent deafness, dementia or delirium. So a timely and detailed assessment in an unwell rest home patient is vital, as is a clear management plan and structured follow-up.

5. The incidence of falls and pressure areas is high in rest home patients. Falls are often unwitnessed and a high index of suspicion for significant injury is warranted. I have seen complaints arise from missed diagnoses of hip fracture, particularly in demented patients, where some mobility is retained (although difficult) in spite of the fracture. The main issue that appears to feature in complaints concerning pressure areas is persistence of conservative management (including repeated courses of antibiotics) despite ongoing deterioration of the area, and ultimately extensive surgical debridement, or even amputation, has been required once specialist referral is made. Often quoted by complainants are the alleged comments of secondary care providers that "this should have been seen to months ago" or words to that effect.

Summary

In summary, my first five months as HDC clinical advisor have been a voyage of discovery and learning. The experience has inevitably led me to reflect on my own practice and apply learnings I gain from reviewing complaints. I acknowledge that being the subject of a complaint is a stressful process, and many of the complaints I see are not, on review, the result of departure from expected professional standards. But there are lessons to be learned from every complaint — lessons that can contribute to quality improvement for the profession as a whole.

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