College response to HDC

The Health & Disability Commissioner (HDC) Ron Paterson addresses a case in his comment that raises several key issues. College president Jim Vause provides a GP viewpoint as concerns about Patient Test Results extend into Specialist Referrals.

One of the challenges facing modern general practice is that even the best GPs may receive a complaint. The likelihood of that complaint proceeding further through the system is dependent on several factors – not the least on how well it is managed.

In this case, the HDC, Ron Paterson, postulates that a simple written apology, and an assurance that her practice had instituted systems to ensure timely follow-up of specialist referrals, could have avoided the stress of protracted investigation and litigation, and the harmful publicity. This is an important indication from the Commissioner and one that all GPs, on receipt of a complaint, must consider when weighing up further action.

While it is always advisable to contact your indemnity advisor very early, often the non-incriminatory soft word of sympathy, of apology for any discomfort experienced, may take the heat out of the situation. Any further progression can be influenced by other factors but there is a significant commonality to many complaints that focuses on doctor/patient communication – or rather the lack of it – following a 'significant event'.

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To manage such a process, the College recommends two resources on complaint and significant event management, both available free to members.[1,2]

A culture of safety in which the GP is encouraged and supported to report and remedy problems they have identified is developing in New Zealand but requires further work. Rae Lamb[3] has produced some very interesting work on this in relation to hospitals in America,[4] while last year the Australian Council for Safety and Quality in Health Care launched their open disclosure standard.*

Expert advice and use of guidelines

The conflicting expert advice in this case is worthy of note. There is some difficulty in determining the appropriate standards of care that would apply to the GP as the event in concern occurred during the late formative stages of the *Early Detection of Breast Cancer Guideline*. Even were it to be applicable, the document is a 'best practice' guideline and there remain a number of issues to be considered in judging whether the expected standard of care should be best practice or reasonable or minimum standard.

College has already identified this and a number of other issues for the HDC and ACC medical advisors. They must be knowledgeable of and able to source the relevant standards of care, understand the different types of standards and their relationship to evidence and opinion and, in addition, be knowledgeable of current thinking on error and quality issues. There is clearly a need for investigating bodies to provide training and professional development opportunities for their advisors, such as setting up peer review groups, and providing feedback on their reports.

System problems

Another issue the Commissioner identifies is the need for the follow-up of specialist referrals – especially if the patient's need for specialist assessment has become more urgent.

This extends from the Commissioner's stance on patient test results. The need for an audit trail of significant test results cannot be denied and, on superficial consideration, the same applies to specialist referrals. Alas, implementation of both is a different story.

Theoretically, it is possible to provide a patient test result trail, either manually or by computer. Manual systems impose a significant staff workload considering the number of tests a doctor may order in a day. Documentation needs to cover test initiators, a process for identifying missing significant results, patient notification, staff responsibilities and follow-up actions, and acknowledgement of receipt from the provider. Some of these are easier to achieve than others, particularly as time frames for tests differ according to both the test and also the provider, sometimes even for the same test.

* Open disclosure standard: A national standard for open communication in public and private hospitals, following an adverse event in health care, ACSQH, July 2003.

An example is the difference in waiting time for a chest x-ray done privately compared with that done at a public hospital, if you can get one. As for acknowledgement systems, these may work but more often are of little value, assuming you can even get one.

Extending this to specialist referrals

As time frames may range to an 18-month wait for a consultation from a referral to a specialist, as different hospital departments deal with referrals in a different manner, as GPs may be referring to three different hospitals plus private hospitals and private specialists; we consequently have an exceedingly complex system desperately in need of national consistency.

The College has lobbied fellow specialist Colleges on the matter of patient test results. If referrals are added there must be an emphasis on the quality of hospital internal communication. We must applaud DHBs such as Counties-Manukau for their electronic acknowledgement of receipt of GP referrals but how do you get others to adopt similar systems?

Relief may be just over the horizon. The Health Information Standards Organisation is now seeking sector support/views for the provision of such a system. They already have DHBNZ support.* The College hopes to be actively involved.

The HDC suggestions need to be implemented in an integrated manner across the primary/secondary divide and the Commissioner's lobbying can only help the cause of better patient care.

If you have a capable PMS system, and if the referral receivers send a compatible acknowledgement message, computerisation is the answer. Provider ability in this area currently ranges from excellent to luddite.

Then there are the patients

To this broth of IT and provider behaviour we add the patient. It is common for patients not to get tests done or to not push for a specialist appointment. My own list as a 5/10ths GP stands today at 28 patients overdue for x-rays or lab tests. For some patients it is a lack of volition, or a lack of control of external factors, whereas others have been put on waiting lists (e.g. a five-month wait for ultrasound). Theoretically, specialist referrals can be put on an audit trail but the range of referral receivers is a lot greater than test results and their IT enablement wildly divergent.

Food for thought

Cases such as this highlight areas that we GPs must consider for our practice, our systems and for our approach to complaints.

Jim Vause
President, RNZCGP

* The WAVE recommendation No 17 states: '*DHBs should implement capability for connectivity between hospitals and health care providers including that for electronic interchange of Referral letters and Discharge summaries and other useful information (e.g. Emergency Department attendance notification) between hospitals and healthcare providers within two years.*'

References

1. RNZCGP. Managing complaints: process and strategies. Wellington: RNZCGP; 2003.
2. RNZCGP. Significant event management – A general practice guide. Wellington: RNZCGP; 2002.
3. Health Reporter, Radio New Zealand.
4. Lamb RM, Studdert DM, Bohmer R, Berwick DM and Troyen A. Brennan Hospital Disclosure Practices: Results of a National Survey Health Affairs, March/April 2003.