



## NEW ZEALAND MEDICAL ASSOCIATION

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Debbie Davies  
Clinical Leadership Group Facilitator

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Dear Debbie

### **High Level Requirements for the Transfer of Care between Health Practitioners – Focusing on the Transfer of Care from Secondary to Primary Health Practitioners (Discharge Summaries)**

The NZMA is New Zealand's largest medical organisation and has a pan professional membership. We have around 4500 members who come from all areas of medicine.

The NZMA aims to provide leadership of the medical profession, and promote:

- professional unity and values;
- the health of New Zealanders.

The key roles of the NZMA are to:

- provide advocacy on behalf of doctors and their patients;
- provide support and services to members and their practices;
- publish and maintain the Code of Ethics for the profession; and
- publish the New Zealand Medical Journal.

While we are disappointed not to have been included in the original list of organisations to be consulted we are pleased to now have the opportunity to comment, albeit within a very short timeframe. In particular we are concerned that consultation with the General Practice sector has been limited with insufficient discussion being had with those organisations that represent general practice.

Turning to the proposal itself we support this in principle. We believe it is important that there is a nationally agreed standard for this process; something that is particularly important when information is being shared across DHB boundaries. The need for national clinical leadership is critical as we already have too many examples

of attempts to generate IT solutions that either do not fit, or even worse, impose obstacles to normal clinical behaviour.

There are however a number of issues that need to be worked through:

### **Cultural Changes**

One key factor that the clinical leadership group needs to consider is the need to develop a culture in which the health care user feels comfortable with the controlled access of the available data, and a process that maximises the possibility that information that may inform a health care decision is easily available to the decision maker at the time they make that decision. The proposed "transfer of care" project appears to be a step in the right direction.

### **Data Format**

Health Practitioners need formats that are both reliable (in the electronic transfer of that information) and fit with the majority of the clinician's work practice. Best utility will come from the information being provided by all those with useful knowledge and which can be accessed by all who need to know at the time they make a decision; we need to move away from siloed "ownership" of the record.

The proposed format for the electronic discharge summaries is quite complex and will be excellent for a patient who has been admitted acutely to a secondary service, but it seems a little cumbersome for a patient who has had an uncomplicated elective admission for surgery.

We have also heard informally that the Auckland DHBs are proposing to do these as PDFs. We are concerned that if this happens it will severely strain general practice systems as the data storage implications are significant.

### **Highlighting changes**

The most important information in the discharge summary is always any change made to the management of the patient, particularly in respect of medication, that occurred during the secondary care interaction. A common concern raised by general practitioners is that they do not know if why medication changes were made; for example were they mistakes, omissions, or intended and if so, why these changes have been made. We believe these changes need to be highlighted and explained.

### **Length of Discharge Summary**

In respect of hospital based Registrars the NZMA is concerned about the amount of time it will take to complete the form if all fields are completed; something that may not be feasible given that there are already high demands on their time.

Also, while it may be outside the parameters of this consultation, we think that a registrars time could be better utilised if the task of completing discharge summaries for patients that have had simple procedures (e.g. an elective colonoscopy) and which have no results to review, could be given to a different health practitioner (such as a Peri-operative nurse).

Similarly we are concerned that if general practitioners are required to read a three page discharge summary, much of which is simply a repeat of information from the General Practitioner's record, or documentation of what happened, there is a risk that some things could be missed. The system will certainly need prompts within it to update the General Practitioner in respect of the record of medications, adverse reactions, new diagnoses and recalls / tasks. If this could be assured it would be an extremely useful tool, but much would be dependant then on the writer of the discharge summary.

**Discharge from Outpatient Service**

The other aspect of transfer of care which is not mentioned is the situation where a patient has had a period of outpatient treatment in a secondary institution over a period of months or years and is then discharged back to the primary care physician. While we appreciate that the patient will have continued to be under the care of their general practitioner during that time, they may subsequently be required to furnish prescriptions and arrange ongoing laboratory surveillance testing/screening as per the advice of the secondary institution. We think that the system needs to also ensure that the information held by the secondary institution is shared with the general practitioner.

We trust you find our comments helpful.

Yours faithfully

A handwritten signature in black ink, appearing to read 'Peter Foley', written in a cursive style.

Dr Peter Foley  
**Chair, NZMA**