The Review

Saul Miller

Who?

Times have changed. At one time, he (females in the role were rare) might not have been much in evidence but every patient knew for sure who their consultant was.

For a start, there would be his name writ large above the head of her bed. Staff would introduce themselves as working for him. And when he did grace the ward, there would be further cues: he would be the one others buzzed around like worker bees to their queen; he would possess the crispest white coat and the emptiest pockets; no name badge would be on his lapel; he would stop only near beds he owned; and half moon spectacles really were a good guide too.

Now though, white coats are out, bifocals are in, and any attempt at continuity of person has long since been abandoned in hospitals. The cult of personality that surrounded consultants has ebbed as surely as the patient record has gained in sanctity.

This has had consequences. The need to know the correct notes are being aligned with the correct patient has become ever more crucial. The patient seen without their notes has little hope of being given more of a service than the plane arriving over Heathrow without a landing slot: the best outcome is likely to be a holding pattern, a coping until the notes reappear. Few in hospital practice now expect to know their patients well enough to manage fine without.

So there are systems. NHS numbers existed for years without catching on. A name was enough, with perhaps a date of birth too if the name was a common one. But contact a hospital now — unless you are ringing, bizarrely — and you need much more than this: the address, a phone number, and certainly the NHS number. I was brought up to believe memorizing my National Insurance number was crucial to getting through life but it may soon be that not being able to reel off your NHS number will be a problem for citizens too.

Laboratory services have loved the rising possibilities of linking multiple data to each patient — though each sample now has to be labelled so well, and its request form completed in such detail that an IT system failure makes ordering tests well-nigh impossible. Scrawl on the side of a test tube? Forget it!

So, each patient and any stuff relating to them are ever more comprehensively labelled to ensure they are always correctly matched. But then comes their discharge.

A carbon copy of a two word summary, in a junior's untidy scrawl, of what has transpired may or may not be handed to the patient. It might be posted, arriving days too late, or it may never appear. It will be weeks before a useful typewritten summary appears but that will be sent to the wrong GP, not infrequently to the wrong practice. Meantime, ringing the hospital to find out what happened is not so easy either. The problem is that the consultant's name is often not there, or illegible if it is, and the patient has no idea who he or she was. And who knows where the hospital notes are anyway?

Later, when that typed letter does arrive with the wrong GP, the problems encountered on discharge will either have been managed without the relevant information or the patient — frustratingly — readmitted. Outside of hospitals, personal continuity is still sought by patients and valued by GPs, but hampered by this outdated system. I dread to think how many episodes of less-than-ideal care are consequent on it.

The National Programme for IT has failed us here too. The least we should expect by now is to have useful information about every admission at discharge, typewritten, and delivered to the correct GP.

One day, bifocals will give way to progressive lenses: perhaps we must wait until then?

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