Mavis' Story

Mavis has had a fall, but the consulting doctor in the emergency department won't supply a letter or x-ray report for her GP, telling her to just report the details herself. Mavis has Alzheimer's.

Mavis, seventy-six and suffering from Alzheimer's, normally resides in Ballarat, supported by her daughter. Her mobility is average, and she has a history of osteoporosis. She was visiting her son and his family in Tasmania. Her granddaughter had escorted her to help her deal with the flights, as she gets anxious easily.

During her visit she had a fall and broke her wrist. Though initially she said she was fine, the next day Mavis said that her wrist was a bit sore and swollen. With her family she went to the emergency department of the local hospital, where she was diagnosed with a hairline fracture of the radius. The family were advised to buy a wrist splint, as a plaster would be difficult for her to deal with and potentially upset her balance further.

As Mavis was due to fly back to Ballarat the next day, her daughter-in-law, who is a nurse, asked the consulting doctor for a letter and x-ray report for Mavis's GP. The doctor stated that this was unnecessary and that Mavis could tell her doctor what had happened. After being reminded that Mavis suffers from short-term memory loss due to Alzheimer's, the daughter tried again to ask for some documentation, at which time the doctor said to Mavis, "you will be able to talk to your doctor won't you?" Mavis responded, "Of course". It should be noted that Mavis is unable to remember the name or address of her GP.

On return to Ballarat, an appointment was made with the GP, and the daughter spoke to the receptionist at the clinic. A request was made for the x-ray report, and the daughter contacted the radiology department at the hospital in Tasmania, who promised to fax the report to the GP clinic once it had been typed later that day. The receptionist at the GP clinic was also given the phone number of the hospital's radiology department and said she would follow up if the report hadn't been received.

The next day at 5 p.m. Mavis turned up for her appointment, but her GP had not received the report. Neither the hospital's radiology department nor the GP clinic had followed up. By now Mavis was unsure of where the pain was, in her wrist or forearm. Without the hospital x-ray report, the GP had a duty of care to identify the cause of her pain, and justify his treatment regime. The result was that Mavis had to have another x-ray—which proved she had a hairline fracture of the radius—and return the next day for the result.

Can we do better?

Poor communication, accountability, and no follow-up documentation resulted in an unnecessary repeated x-ray and an unnecessary additional appointment with the GP.

How could these processes have been improved?