

## Communication Systems

## Communication Systems

*Dr. Ranjana Srivastava, FRACP*

Medical Oncologist  
Southern Health  
Melbourne, Victoria

## Communication

*Think like a wise man but communicate in the language of the people*

William Butler Yeats (1865 - 1939)

3

## The case of Sylvia Hastings

50 year old single woman

Lived with older brother

Desk clerk at local business

4

## Sylvia Hastings

No regular GP, "never ill"

Went to a GP feeling dizzy

Diagnosed with diabetes

**GP detected large breast cancer on right**

5

## Sylvia Hastings

Urgent referral to hospital

Patient seen promptly

Planned treatment (in sequence):

- Chemotherapy
- Surgery
- Radiation therapy

6

## Sylvia Hastings

Patient commenced chemotherapy  
Finished recommended number of cycles  
Well-tolerated, minimal side effects  
Breast cancer shrunk

7

## Two years later

Patient saw same GP with high blood sugar  
GP discovered breast cancer  
Patient claimed to have completed all treatment  
Immediate referral to hospital:  
"Something is not right."

8

## A few weeks later

GP calls oncologist,  
"What's happening to the patient?"  
No appointment on system  
Oncologist makes urgent appointment  
Appointment relayed to patient by phone

9

## Seen by oncologist

Disfigured right breast  
Local spread of cancer  
Other untreated health issues

10

## What happened?

What do you mean?

11

## What happened?

Finished chemotherapy  
Saw a different doctor each cycle  
No surgeon appointment sent  
Rang hospital clinic  
Call not returned

12

## What happened?

Assumed chemotherapy effective  
No need for other modes of treatment  
Not aware of 'usual' follow up schedule  
No previous experience of cancer

13

*“If it was so important to have all the treatment, wouldn't someone have called me?”*

14

## Partially Treated Cancer

Agreeable to resuming treatment  
But no longer with curative intent  
Average survival few years  
Accepted news with sadness but resilience

15

Started oral treatment  
Good response for 10 months  
Missed 2 routine oncology appointments  
No clarification sought  
Appointment resent

16

## Meanwhile...

Call from another hospital several days after admission  
Admitted with severe kidney failure, heart failure, pneumonia  
One month in hospital  
Little liaison between doctors  
Priority of problems

17

Discharged home to another family member  
CT scan before seeing oncologist  
Radiology called patient at home number on database, not number listed on request card  
Scan delayed by weeks  
Showed progressive disease

18

Blood tests also required

Patient unable to drive

Not aware of home service

Did not have blood test

Significantly anaemic by the time blood test conducted

19

Disease progressed

Too unwell to have aggressive therapy

Concentrate on quality of life measures

Patient reluctantly agreed

20

## Readmission

Admitted to hospital unwell

Brother died suddenly

Cannot track down estranged sister

Not safe for discharge

Went home against medical advice

Oncology appointment to be sent out

21

## Post discharge

Home alone

Fell down, neighbour to rescue

Back in hospital

Breast cancer infected, bleeding, larger

Was told earliest appointment with oncology in weeks

Regular GP away

22

Call from GP

Heard of patient through neighbour

No discharge summary from hospital

Incomplete information on those sent

No single point of contact

"I want to help but..."

23

Breast cancer treated with radiation

Failed further therapy

Palliative care arranged

Discharged home as desired

Weak, managing with difficulty

GP involved

Likely to need hospice care soon

24

## How the patient saw it

Did not understand gravity of disease  
Different doctor for each episode of care  
Unreturned phone call, no appointment  
Doctors made assumptions  
Shifting blame

25

## How the GP saw it

Not the ideal patient  
Not the ideal specialists  
Not the ideal hospital system

26

## How the oncologist saw it

Patient responsibility  
Denial?  
Individual best v system best  
Sadness at incurable disease  
Frustration

27

## Single Uniting Factor

28

## Single Uniting Factor

*Failure to communicate*

29

## What went wrong?

Absent liaison between doctors  
Single-problem management  
No firm follow up plan

30

## What went wrong?

- Missing letters/errant fax
- Deficient and inattentive triaging
- Inadequate information to patient
- No single point of contact
- No accounting for significant other tragedies

31

## What went wrong?

32

## What went wrong?

### *System Errors*

33

## Addressing System Errors

- Improving exchange of information
- Electronic health records
- Universal ID
- Efficient and rapid transfer of information

34

## System Errors

- Compulsory electronic discharge summary
- Mandatory fields
- Electronic prompts for
  - allergies
  - drugs
  - appointments

35

## Addressing system errors

- More staff
- Better trained staff
- Improved triaging
- Continuity of care
- Workforce issues
- Remuneration

36

What went wrong?

37

What went wrong?

*Personal Responsibility*

38

## Personal Responsibility

The crux of medical care

Fundamental

Cannot be wholly replaced by better systems

39

## Personal Responsibility

Providing a concise plan

Ensuring next appointment in place

Emphasizing crucial aspects of care

Writing down key points

40

## Personal Responsibility

Investigating non-attendance

Talking to the GP/other carers

Quality of correspondence

Phone numbers and contacts that matter

Availability to patient

41

## The old-fashioned doctor

Compassionate

Empathetic

Respectful

Genuine investment

Often paternalistic

42

## Old-fashioned medicine

Medicine is not as an occupation  
but a vocation

43

## Back to the future

Rethinking medical training

Rediscovering the art of medicine

Listening

Caring

“Going the extra step”

What sort of a doctor would I want?

44

## Communication

*The single biggest problem in communication is  
the illusion that it has taken place.*

George Bernard Shaw (1856 – 1950)

45