What isn't said

Feb 3, 2018 | 3 | education,humanities,ontheblogs,patient centred care,tips for internship

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Morry is a 75-year-old man with diabetes who was admitted with hyperglycaemia. The reason why he became hyperglycaemic is that he didn't understand the instructions from the diabetes educator. To tell the truth, he hasn't cared too much about his diabetes since his wife died. He is down on the EMR as a non-smoker but hasn't told anyone that he has started smoking again. The discharge summary details his hypokalaemia and his three days of slow-K, which helps garner the hospital some activity-based funding, and his difficult social situation is left out in favour of a long list of irrelevant blood tests. His GP sees him in follow up.

This scenario is familiar to most of us and it's worth thinking about why this happened.

Communicating underlying reasons for a presentation

Firstly, we as doctors often don't think about the real reason underlying our patient's presentation. Why did they develop their symptoms? Why didn't first line, out of hospital management work? As with Morry, the answers are often related to misunderstanding, misalignment of goals and/or lack of family support. Sometimes we do consider these questions, but the discussion fails to reach the intern and the discharge summary.

The second issue is that psychosocial concerns are not well identified and certainly not often reported in the discharge summary. This is partly to do with not getting to know our patients as people, partly not working effectively with allied health and partly due to a culture that focuses on technical issues.

The third issue, which is certainly non-trivial, is that copying and pasting between records in the EMR can lead to errors when information changes. Doctors should always be corroborating EMR information with our patients at every opportunity – but lack of time (and occasionally laziness) stops us from doing this.

Communicating with GPs

Of course, the problem with all this is that the scene is set for Morry to be readmitted next week with the same problem and that his GP doesn't have any of the important

information to prevent that from happening. Communication between GPs and hospitals requires us to put ourselves in the place of the GP and ask “What do I need to know to care for Morry?” Much of what is in the discharge is not fit for this purpose. So how can we address those issues above?

Employ curiosity

Understanding why a patient came into hospital is often more complicated than you think. Chronic care patients such as those known to a diabetes service or an oncology service should have plans that enable them to stay at home. It pays to adopt a “curious stance”. Cancer patients receiving chemotherapy admitted with toxicity are a good example. Why is a particular patient undergoing chemotherapy admitted with nausea and vomiting rather than managing with the self-care regimen recommended at home? Perhaps they weren’t given anti-emetics? Perhaps they were given them but didn’t take them?

Rather than label the patient as non-compliant - be curious! Why didn’t they take them? Perhaps they didn’t understand the instructions, couldn’t read them, or perhaps their family member told them not to take them because they are a naturopath. You can be amazed. Perhaps they took them but waited too long before starting their prescribed regimen or it may be as simple as they vomited the anti-emetics up. Once you understand why they came into hospital, the advice you give to the GP and the follow up you organise might change.

Mention why community care didn't work

Another good example is palliative care. Why do certain patients known to a community palliative care service get admitted to hospital for symptom control from the Emergency Department? Did they not ring them? Why not? Perhaps they are afraid of bothering them through lack of confidence, perhaps they are afraid of them, perhaps they never activated that referral, or perhaps the team did know, but the person on the phone was not helpful. The interventions and follow up plan will be different in each scenario. In any case, the GP will want to know the reason why community care did not work. The same principle applies for any type of community care.

Remember to address psychosocial concerns

Psychosocial concerns are not well documented on discharge letters and this is despite the fact that GPs are often the most suited to addressing them. A family conference will often reveal the most insightful information about why a patient is presenting to hospital. Understanding that the daughter looking after her elderly parent is having trouble at work and can’t get time off can be the most important information obtained in an admission. But how often does it go in the discharge summary? Another example is a social worker review uncovering significant financial or housing stress preventing a patient buying medications or seeing their local doctor. These aspects of the admission are often the most informative, and junior doctors should make a point to represent them in the discharge letter.

Communicating the same message for patient clarity

What the patient has been told is another unknown. Let's say the patient has been told not to drive, that most patients with their condition will live less than 12 months, or that they are in complete remission but we cannot be sure how long that response will last. This information is critical to the GP and very susceptible to misinformation. Patients get these messages mixed up and sometimes they misrepresent them intentionally – some clarity helps.

Communicating well with GPs helps patients

Overall the principle that helps is that communication is about what the patient needs to hear – not what you want to say. In the case of Morry, by addressing his psychosocial circumstances in the letter, his GP was able to refer him appropriately for psychological therapy, identify and treat his undiagnosed depression, arrange further diabetic therapy and get him back off the cigarettes. His GP was also able to keep a closer observation and anticipate hyperglycaemic episodes and stop Morry from being readmitted.

So, at the end of the day, sometimes it's what's not said in a discharge summary that can make all the difference - put yourself in the GP's shoes, think broadly about what has happened to the patient and how their care can be continued in their home and your discharge summaries will never be the same.

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