MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 16 NOVEMBER 2016 AT 6.15 P.M.

THE TOPIC:
PATIENT CENTRED CARE AND PATIENT ADVOCACY - STRENGTHS AND WEAKNESSES

SPEAKERS: MR PHILIP GREENWOOD SC
DR KAREN LUXFORD

QUESTIONS

MS KEELY GRAHAM: I am very interested in the low information retention rate of patients and the fact that what they do retain is about 50 per cent incorrect, particularly when its information about themselves. That is golden material when you are defending doctors against claims that they failed to warn a patient of a risk. I would like to obtain some of those source studies from you.

We have time for a couple of questions if anybody has anything they would like to ask the speakers.

DR PENNY BROWNE: I am a general practitioner. I am the senior medical officer of AVANT. It is really more of a comment than a question. I feel I need to defend the role of general practitioners here. I think that a lot of that role of a good family practitioner who has known the patient for a long time, is actually value added by the practitioner with (a) hopefully a good, effective referral letter and (b) importantly, following up with the patient, following the specialist consultation to reinforce the messages and the information. That actually would work well within the current system.

The second comment is that I totally agree with you and I think that there are other mechanisms within our modern day society to actually help if somebody does not have a support person. There are trials in relation to people doing videos, particularly of emotionally charged consultations, such as a first oncology consultation. People are being encouraged to do a video recording to aid the retention and the accuracy of the information that is being shared.

MR PHILIP GREENWOOD SC: Can I respond. There are two things and the first one is I think you are absolutely right. The trusted, long term GP provides a wonderful role and can provide a bridge to a lot of this. However the reality is we have so few of those GPs. These days with many medical practices people go and see one doctor one time, a different doctor another time and so there is not the continuity of care that there used to be.

DR PENNY BROWNE: But they are supported more in our community.

MR PHILIP GREENWOOD SC: I agree that is one factor. In terms of the other ways of doing things, audio recording has also been studied. However it is not embraced by the profession at all. In fact everybody is a little anxious about video recording, particularly with phones these days. It is so easy, and yet everybody is anxious about it. Hence those two alternatives you raise are great ideas but in practice they are not taking off.

EDWANA: I am Edwana. I am an occupational therapist and I was interested in the REACH number. Is that person who is the outreach critical care person, in the organisation or external to the organisation?

DR KAREN LUXFORD: The phone number is a local phone number within the hospital and the respondent is a local staff member, who is within the hospital. Who the respondent is depends on the facility and we have to be flexible with that. For some of the smaller rural facilities it might be the after hours nurse manager or an outreach Clinical Nurse Consultant. In some of our large metropolitan facilities it is the Medical Emergency Team that comes.

DR BRUCE CONNOLLY: I am a surgeon who tonight is speaking as a patient about support persons. I, for one, do not like to upset my doctor. I have had so many doctors the last eight months, you would not believe it. None of them did I want to upset in any way. I took my support person, my wife Joyce, on several occasions and she shared the same view. We have great doctors. However one time I took my daughter, who is very outspoken, and after having had some treatments which nearly killed me, the daughter said, "Dad, can I speak?" I said, "Yes, but go gently". She said to the oncologist, "If you continue to give my father this treatment, this will be his last consultation, because he won't make it". With her involvement, we all woke up to the fact that what our daughter was observing of me was disastrous but it took her, rather than Joyce and me to say anything.

MR PHILIP GREENWOOD SC: It is really surprising, to the rest of us, to hear you say that. It just reinforces the point so dramatically that even people who are confident, capable, and know all about what is going on, are not comfortable about saying something because it is about them.

DR GILES: I enjoyed the presentations very much. Surgeons are not known for taking long histories and taking a lot of

time because we are generally sent all the information by referring doctors.

I would like to say, there are different situations in medicine which might require different techniques. My best friend was an endocrinologist, now retired. He was also a great general physician on the staff at Royal North Shore Hospital. He received all the difficult cases to work out when no one else could. He told me these patients were always the same. They came with three or four support people who took over and they had huge piles of test results. So, what he did was to usher the accompanying people politely to the waiting room, take the tests and put them aside, sit the person down and say to him or her, "Now please tell me when you were last well?" He said the patients could always relate to that and would say, "No one has ever asked me that, doctor. I clearly remember last year, I was with the family, I was fantastic" and then the history would come out and he would solve the problem. It was just a different technique - horses for courses!

DR KAREN LUXFORD: Can I just make a comment on that? That was a great piece of information because I think that one of the things that is connected to that is we do not necessarily ask patients what their expectations are. "What are you aiming for?" or "What are you trying to achieve?" They want to get better but if we do not ask people what that expectation and that goal is, we do not know whether they necessarily know. I love the approach of sitting down and listening to what the patient is wanting to tell you, because some of the other research that we know is that in a typical consultation with a doctor, the doctor interrupts the patient in the first 18 seconds. That is well-known and has been shown in a number of studies.

In a similar vein, we have been looking at this at the Clinical Excellence Commission in relation to mis-diagnosis. We have found if you let the patient talk for just a couple more minutes, you just about find out everything you need to know. However most people are interrupted in the first 18 seconds.

DR GRANNER: I can definitely see the advantage in this model in the bio-medical environment. However when you are treating a patient in a psycho-social environment, an advocate can be a negative, because their advocacy could be part of the problem. You will not know that until you are a long way into the consultation, and that may be very much a negative.

I think we have to look at those situations where an advocate is most appropriate.

MR PHILIP GREENWOOD SC: Good point.

MEETING CONCLUDED