

Communication between colleagues - pitfalls and practical solutions

It is impossible for a family doctor to make a fully informed decision without timely access to reports from all doctors involved in the care of that patient. Waiting weeks for a report from a consulting specialist is an unacceptable standard of care. Perhaps as important as timely access to current reports, is a simple mechanism that organises and facilitates quick access to past consultations. In this article, collegial communication is discussed, problems are highlighted, and a practical solution is suggested.

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Background

While GPs, in particular, often experience delayed access to consultation reports, it is also unreasonable to expect specialists to do their jobs efficiently without the following information:

- history of the problem/s leading to the referral
- relevant lab and imaging data
- purpose of the referral.

Many doctors are frustrated at not having access to information previously documented by colleagues. The current system is not only archaic and inaccurate, but dangerous, time consuming, and extremely expensive. To optimise safe and cost-effective care, relevant, historic, clinical information must be readily available to the current doctor treating that patient. As the core coordinator of patient care, it is important for the family doctor to be able to access pertinent clinical information previously documented by a range of specialists quickly and easily.

We are all aware of existing shortcomings in communication between colleagues, but it is educational to briefly review common processes and to look at some failed solutions.

Referrals

These may be brief notes, scribbled in shorthand, on a prescription pad and handed to the patient. Besides often not reaching the specialist, the information, if legible, is seldom sufficiently detailed to greatly assist the consultation. The more dedicated referring doctor will attempt to phone the consultant, but that brings its own set of problems (telephone tag, quick notes scribbled by the consultant on pieces of paper which are then mislaid, and so forth).

Consultations

Ideally, each time a specialist sees a patient, a note should be forwarded to the family doctor. Commonly, these notes are dictated, transcribed, checked for mistakes, printed and snail-mailed. In many practices this process is measured in weeks rather than hours.

Besides the time delay, the process (excluding physician time!) is expensive for the specialist practice:

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| • transcription cost | R35.00 for 15 minutes |
| • printing, paper, envelope | R 3.50 |
| • stamp | R 2.00 |

Assuming 20 patients /day this adds a minimum of R200.00 to the daily practice overheads.

Are electronic medical records the solution?

Ever since the advent of the internet, many have believed that electronic medical records (EMR) would solve the problem of communication between medical doctors. Not only could legible data be moved quickly between colleagues, but there would be no need for data capture by the recipient.

While there *are* compelling reasons to consider using an EMR system (see the article on p. 24), the tantalising promise of improved communication has failed miserably.

Besides the crippling fact that relatively few practices have thus far adopted EMR (think of isolated fax machines), there is an even greater problem – most EMR systems are incompatible and cannot exchange data electronically.

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While many, including the author, have worked hard in attempts to standardise the links between different sources of electronic medical information, the following statement probably summarises the net result of these efforts thus far: 'I love medical standards, there are so many to choose from...'

Part of the problem is that technology advances rapidly and newer EMR systems incorporate features (including the latest communication 'standard') that older EMR systems, almost by definition, cannot access.

However, it is not just data standards: a whole layer of complexity is added by the need to ensure confidentiality of patient data, as well as assured and audited delivery. This, incidentally, is why it is totally unacceptable to use unencrypted e-mail to communicate patient identifiable information. Even encrypted e-mail (subject to the vagaries and inconsistent anti-spam policies of various internet service providers) is problematic and frequently results in total loss of patient information. PDF attachments have multiple drawbacks, not the least of which is that this is a poor way to protect your patient's confidentiality.

It is important to allow every doctor (including those with minimal infrastructure) to communicate with every other doctor. However, it is certain that, in the foreseeable future, not all doctors will adopt compatible EMR systems. This will not solve the communication conundrum.

Shangri-La – the ideal situation

- The consulting specialist always has access to a formal referral note.
- Documentation of any medical encounter is available to the referring doctor within 24 hours without a major change in the way either practice currently operates and without major cost. Documentation is accessible from anywhere (the rooms, home, even when on the move) without special hardware or software.
- Cumulative organisation of referrals, consultations, lab work or imaging allows

the doctor quick access to historic patient information.

- Patient confidentiality is assured.

A proposal for the real world

While I believe it is important to work hard to ensure adoption of clinical document and communication standards and to promote the widespread use of digitalised clinical notes, waiting for those initiatives to mature before addressing a fundamentally broken process is doing our patients a major disservice.

It seems that a middle entity, a translator and facilitator, inserted into the process, could immediately accomplish the following:

- Accept all mainstream forms of medical communication from both referring and consulting doctors. That entity should work with whatever the doctor currently produces (faxed paper reports, word documents, web templates, even voice). To facilitate this process, it is useful to work from templates that stipulate the minimum subset of data required for collegial communication. It would also be ideal if EMR vendors offered a free 'lite' version of their EMR that incorporated these minimal requirements (see the accompanying 'More About' communication article which gives links to a Dropbox solution and MS Word templates for referral or consultation reports).
- Convert the original documents so that they are:
 - organised in a database

- easily, but securely accessible by the physician/s involved (without special hardware or software)
- able to exchange information (using industry standards such as XML and ODBC) with a variety of mainstream EMR systems, i.e. transform data formatting so that it is available in a range of medical 'standards' – this would protect the doctors' investment in their current, or future, EMR.

- Display the documents on a secure website accessible only to the doctor sending the report and to the doctor/s to whom the document was addressed. This website would use the internet banking model to ensure security. A working example can be found at <http://zeus.bluebird.co.za> – use 'demo' as both account name and password.
- Ensure patient confidentiality. This really needs to be 'information with integrity'. A data repository where any doctor has access to any patient's medical information is not only ethically unsound; it also undermines the implicit trust contract in the patient/doctor relationship, which in turn undermines the doctor's ability to ensure optimal patient care. This is an important concept and must trump the convenience of any doctor having access to any other doctor's notes on a patient they are about to see. In a sophisticated environment arguably the patient should have the final say as to who has access to his or her medical record.

A solution such as the one proposed not only facilitates timely interchange of data between otherwise incompatible health record systems but, by storing and organising clinical documents, and providing secure and simple access, it means that communication between colleagues becomes simple, inexpensive and extremely efficient. As a medical community, we have the responsibility to grasp such an opportunity and, in so doing, dramatically improve patient care.

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In a nutshell

Current communication between medical colleagues tends to be archaic and time consuming and doesn't always provide the information that is necessary in a referral.

Electronic medical records (EMR) should start to solve some of the problems inherent in the present system, but lack of standardisation is a major problem.

An ideal system would:

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- Display the documents on a secure website accessible only to the doctor sending the report and to the doctor/s to whom the document was addressed.
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single suture ***Inappropriate prostate cancer screening***

Researchers say that many elderly men in the USA are being screened inappropriately for prostate cancer. The very old and those in poor health are unlikely to live long enough to enjoy the potential benefits of screening. But the harms are immediate – including anxiety, false positive tests followed by repeated needle biopsies and lifelong serious side-effects from invasive treatments. Researchers looked at routine data from Medicare claims and the Veterans Affairs provider, which showed that 56% of nearly 600 000 men older than 70 had a PSA test in 2003. None of these men had symptoms or a history of prostate cancer. There is very little evidence that a PSA test can save your life at any age or state of health. But even those in favour of screening say that the test should be reserved for men with a life expectancy of at least 10 years.

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