



Letters to the editor

ADDRESS LETTERS TO:

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Medical records

Dear Editor

I commend the commitment of Elliott-Smith et al to provide high quality computer medical records.¹ Their solution involved using nonmedical staff to update medical history summaries at the changeover to a paperless record system. I worry that using nonmedical staff takes the onus of producing accurate and complete records away from the GP. This is especially so if nonmedical staff continue to update records after the initial transfer of information. If GPs aren't taught or don't frequently use the important functions of a software program then they may lose the habit of recording the information altogether.

I have worked as a part-time GP in a practice that has become paperless. I struggled initially with gaps in computerised patient records because I couldn't find the 'place' on the program to store them. If I had been given a detailed tutorial about the functions within the software program (rather than a 5 minute handover) when the swap to paperless occurred, I would have eliminated these gaps quickly rather than discovering these functions often by accident or by discussion with other GPs several months down the track.

*Jan Gartlan
Hobart, Tas*

Reference

1. Elliott-Smith A. Computerisation of records: using nonmedical staff for past history summarisation. *Aust Fam Physician* 2005;34:685-8.

Failure to diagnose

Dear Editor

I read with interest the article by Sara Bird 'Failure to diagnose: subarachnoid haemorrhage' (*AFP* August). In her analysis Dr Bird points out the need for GPs to have a high index of suspicion for this rare cause of headache, and to institute appropriate systems for following up results.

I would like to hear her view about the responsibility of the consultant radiologist to communicate such an important diagnosis to the GP.

It is my feeling that sending off a fax at 4 pm on Friday afternoon is quite inadequate. Faxes do not always arrive, and when they do they may not get to the practitioner promptly. In the past it was common practice for the radiologist to ring his or her colleague directly to ensure that the urgent diagnosis was conveyed.

In my practice I have noticed that I do not get a phone call, even when there is an unexpected finding such as a recent fracture. In fact, the fracture in a recent report was mentioned in the body of the typed report but not in the conclusion. Perhaps this issue of professional responsibility could be raised with the College of Radiologists and guidelines on appropriate communication developed.

*Robert Long
Castlemaine, Vic*

Reply

Dear Dr Long

Thank you for your letter. I certainly agree with your comments about ringing colleagues directly to ensure an urgent diagnosis or result is conveyed. I recall one memorable week in general practice when I ordered cerebral CT scans on three patients (unusual enough). Two of the patients had cerebral tumours and, in each case, the radiologist personally rang me to inform me of the results. That was in the days before our practice had a fax machine. We'd never even heard of email! It seems that with the advent of modern electronic communication, the use of the phone to ensure our colleagues 'have got the message' has decreased. Perhaps we have become overly reliant on technology in some instances.

I agree that the issue of communication between health professionals should be tackled at both a college and local level. Medical defence organisations should take up the issue with the colleges as a part of their risk management strategies. We should also try to reach an understanding and agreement with the radiologists, pathologists and other specialists to whom we refer our patients about the communication of urgent diagnoses and results.

As a claims manager I am frequently surprised and dismayed with the communication breakdowns between health professionals, and this case is a good

example. As the matter did not proceed to litigation, the role of the radiologist was not explored in the article. However, if I had been the claims manager acting on behalf of the GP, I would certainly have sought contribution from the radiologist!

Sara Bird
MDA National

Training

Dear Editor

Over the past few years in my occasional role as an external clinical tutor (ECT) for the training program, I have noted that one of the commonest concerns registrars have is that of time management. This problem mostly appears in consultations with new patients or new complaints. While I was analysing the consultations with registrars I noted that in many instances they had not reached a definitive or differential diagnosis and this in turn led to uncertainty for both the doctor and the patient.

Recent reading of the learning objectives of both graduate and undergraduate medical courses shows that the word 'diagnosis' is seldom used and has been usurped by the word 'problem'. Looking also at the last marking sheet I was given for the assessment of ECTs there were eight areas of the consultation to consider and it was only in the seventh that the task of making a diagnosis was hinted at, and even then it was disguised in the word 'problem'. The terms 'patient problem/s' and 'diagnosis' are not synonymous. The undergraduate and graduate teaching in recent years has painted the role of the GP as being a 'problem solver in an era of holistic medicine'. Holism and problem lists are fine, but where appropriate, the first role of the GP is as diagnostician. If that role is not adequately carried out the GP fails the patient.

Despite the considerably increased complexity of the task of general practice over the years, time allowance for the average consultation has not been extended commensurately, and time management has become a burdensome issue for GPs, especially so for the less experienced.

One help toward the time management issue is the restoration of the diagnosis to a position of prime importance and of prioritising it above any collateral problems wherever possible. One consequence (among many) of the present disparity between task and time in general practice, is the tendency toward attenuated clinical medicine and the loss of its associated skills; and that is a tendency I would hope to see reversed. With the advent of specialisation within specialties the GP has to be, at least diagnostically, general physician and general surgeon as well as GP.

Frank Mansfield
Gooseberry Hill, WA

Conflict of interest

Dear Editor

I enjoyed reading Vicki Kotsirilos's article on complementary and alternative medicine – Part 2 (*AFP* August), especially the section on ethical issues. I duly noted Vicki's declaration at the end of her article 'conflict of interest: none declared'. This would seem to be the exception in the burgeoning supplement industry where doctors seem to be tempted into value adding their consultations. The practice of recommending supplements for health issues and then selling them to the patients for a profit is becoming increasingly common. I can't think of too many more direct conflicts of interest than this, yet I haven't seen any guidelines put out by ACNEM or other CAM bodies. Perhaps these will come in Part 3 or perhaps this is a problem that the CAM industry would prefer to ignore?

Scott Masters
Caloundra, Qld

Reply

Dear Editor

Thank you to Dr Masters for raising this important point. I understand this is a sensitive issue. The issue of prescribing and dispensing medicines, including complementary medicines has been considered by a number of organisations, including ACNEM and AIMA who are currently

preparing a position paper. It is important to ensure transparency between the GP and patient, including ensuring that the patient has appropriate information about the nature/benefits/risks of the treatment, and costs within the practice. The practice needs to comply with the AMA's Code of Ethics (2004) that, among other points, states:

- Ensure that your patient is aware of your fees where possible. Encourage open discussion of health care costs
- When referring your patient to institutions or services in which you have a direct financial interest, provide full disclosure of such interest
- If you work in a practice or institution, place your professional duties and responsibilities to your patients above the commercial interests of the owners or others who work within these practices
- Do not publicly endorse therapeutic goods as defined under the *Therapeutic Goods Act 1989* (C'th), contrary to the Therapeutic Goods Advertising Code
- Exercise caution in publicly endorsing any particular commercial product or service not covered by the Therapeutic Goods Advertising Code.

Furthermore, with respect to 'conflict of interest: none declared', I stand by my word, as I do not profit (after expenses) from the sale of supplements.

Vicki Kotsirilos
Clayton, Vic

AFP

The 5 domains of general practice



1. Communication skills and the patient-doctor relationship



2. Applied professional knowledge and skills



3. Population health and the context of general practice



4. Professional and ethical role



5. Organisational and legal dimensions