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Doi 10.4066/AMJ.2009.62

Jiwa, M. & Ward, P.R., 2009. Will the need for effective communication between doctors redefine primary care? *Australasian Medical Journal*, 2(4), 1-9.

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*Will the need for effective communication between doctors redefine primary care?*

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Please cite this paper as: Jiwa M, Ward PR. Will the need for effective communication between doctors redefine primary care? AMJ 2009, 1, 4, 1-9. Doi 10.4066/AMJ.2009.62



The medical profession differentiated into specialities decades ago.<sup>1</sup> Most doctors are no longer able to serve everyone who might seek medical advice. Put simply surgeons are not expert in psychiatry. Therefore all doctors regularly refer patients to colleagues in other specialties. Geography and logistic considerations determine that doctors seldom 'talk' to one another when seeking opinions or advice. To date the main medium of communication between doctors is the traditional 'letter'.<sup>2</sup> There are numerous studies reporting the impact of this communication and most conclude that doctors often fail to pen enough information when they write to each other.<sup>3</sup> Why articulate people don't seem to communicate 'effectively' on paper and increasingly on line, is the subject of this editorial.

We begin by looking beyond medicine at an example where written communication has been the cause of conflict between two different professional groups. Palmeri reported discord between nurses and lawyers at a law firm in relation to reports written to support claims for malpractice.<sup>4</sup> The documents that are most central to the mission of their employer related persuasive narratives of how a health care facility's failures to uphold medical or nursing standards caused a patient to suffer injuries and or death. Even though nurse consultants and attorneys shared a concern for narrative, they have very different conceptions of these narratives. In particular, nurse consultants and attorneys disagreed about how these narratives should be told (discursive conflict), the standards of evidence that should inform the crafting of these narratives (epistemological conflict), and the ways in which the technical terms in these narratives should be defined (bypassing). In general, nurse consultants tended to value writing that was objective, copiously detailed, and informal grammatically, whereas attorneys preferred reports that were persuasive, concise, and grammatically correct. Whereas nurse consultants tended to write appeals focused on logos (logical scientific facts), attorneys recognized the equal importance of appeals to pathos (emotion) designed to provoke a judge or a jury to feel anger about the injuries a client suffered as a result of a health care provider's 'negligence'.



The preceding case-study highlights both the importance and problem of communication for the smooth running of systems. The focus here is the 'medical system'. In helping us to understand, explain and potentially respond to the 'problems' of communication, we need a theoretical framework which attends to the issues of 'communication within and across systems'. We also need a framework which defines communication as 'social' as opposed to the purely technical transfer of information. One possible theoretical framework in this vein is Niklas Luhmann's social systems theory.<sup>5,6</sup> In brief, Luhmann's theory sets out to understand/explain society in terms of the structure and function of the social systems that compose it (e.g. the economic system, the medical system, the legal system, the system of the family etc.) What makes these systems 'social' is the idea that they only exist by virtue of the communication that define them. So, for the medical system, communication centres on the detection, diagnosis, treatment and management of disease. As soon as the communication moves into the costs, legal or ethical aspects of treatment, this is no longer being undertaken within the system of medicine, but rather in other distinct social systems. For Luhmann, a social system is defined by a boundary between itself and its environment (e.g. between the system of medicine, and everything else that is not involved with communication around disease). Communication within a social system operates by selecting only a limited amount of all information available outside the system, and the criterion according to which information is selected and processed is 'meaning'. In other words, a particular social system will choose which information to select, and will then translate this into a language (semantics) which makes sense within its own internal reference. For example, when thinking about the management of patients with a particular chronic condition, the semantics in the medical system may revolve around chronic diseases, reduction in morbidity etc, semantics in the economic system may focus on costs to the healthcare system, costs to society, financial trade-offs in resource allocation etc, semantics in other healthcare professions may focus on care for the people and carers etc. This is a crucial point to understand when thinking about the validity of this theory to understanding communication issues between medical specialities or between different health care professionals. The theory helps us to understand the distinctions between different social



systems, on the basis of the communication with the systems. It may also help those of us who complain at the lack of political action on issues we (in our particular medical system) see as vitally important. Luhmann makes specific reference to the ‘problem of communication’ between social systems, and does not posit a neat answer, unlike Habermas, who states that social systems are striving for what he calls the ‘ideal speech situation’ in which both ‘sides’ of the communication reach a point of relative happiness in the outcome.<sup>7</sup> For Luhmann, the analogy of ‘black boxes’ is useful – social systems are like two black boxes which do not know the internal workings of each other, and we can therefore not predict how and whether a particular social system will select a particular piece of information. Again, we can see this in terms of the ‘research transfer’ literature, whereby we can produce extremely important research findings (at least, important within the social system of science) but they are not taken up (or selected) by policy makers.

Thus far we have treated medicine as a one system, why is there miscommunication within a seemingly homogenous system? The answer may be that General practitioners, who represent a speciality within the medical profession, operate within a distinct social system; ‘meaning’ in this ‘system’ is moderated by the training and the perspective of the practitioner. When the GP determines that further assessment of the patient’s problem warrants a referral to a specialist, that specialist is a member of another ‘social system’, another ‘black box’. Therefore the GP would be required to communicate by “structural coupling”. In other words to reframe the patient’s problem so that they have meaning in psychiatry, surgery, gynaecology etc. To develop the thesis further we will consider the founding principles of general practice.

Most people agree that the ‘father’ of general practice as it is practiced in the UK, Canada and much of Australasia is Michael Balint. His ideas in the 1950s were developed on the notion that ‘context’ of the patient’s symptoms is laden with clues to cause of that distress.<sup>8</sup> Balint’s supporters claim that it is possible to identify who among the many who present to the general practitioner is ‘at risk’ and therefore which case can be managed by a generalist and which require specialists. Balint further proposed that it is the long term relationship



between the practitioners and patient that was not only a prerequisite for excellent diagnostic acumen but also a limiting factor in therapeutic success. He coined the phrase the 'drug doctor' to crystallise the idea that the doctor-patient consultation can be therapeutic but also have 'side effects' much like prescribed drugs.<sup>9</sup> In Balint's view patients engaged in a relationship with their practitioner in which their response to physical and psychological stress replayed previous unresolved psychological struggles. However Balint and his contemporaries seldom faced the threat of litigation.<sup>10</sup> Education and accreditation of practitioners began and ended in medical school. The pace of medical advance as it impacts on patients presenting with undifferentiated illness was sedate by today's standards. It would have been unusual for studies in the 1950s to report the need for time to keep up to date.<sup>11</sup> Balint was not managing patients with access to the internet and therefore almost as much information as qualified medical practitioners.<sup>12</sup> Nor were Balint's contemporaries accustomed to part-time working nor the feminisation of the medical work force. And yet in many ways one could imagine that Michael Balint would be comfortable working in the consulting rooms of the today's general medical practitioners. Many of Balint's insights and approaches are still *de rigeur*. Furthermore the value of generalists to limit the demand for expensive and potentially dangerous technical medical procedures are based on the concept of continuity of care, something that Balint and many others since then hold sacred.<sup>13</sup> These notions have become enshrined in health care systems where generalists are effectively agents for rationing scarce national healthcare resources.<sup>14</sup>

Since Balint the core activity in general practice is the consultation between doctor and patient. The function of the consultation has remained unchanged over many decades and the description by the British Royal College of General Practitioners in 1972 still applies today:

“...the ideal consultation. The doctor's attention is devoted exclusively for a short period of time to the life and problems of another human being. He is there to listen and to help. His training will have made him receptive to a wide range of distress signals and given him the means, to answer them. The occasion will be unhurried and something will be gained by both participants; a good consultation brings satisfaction to the doctor as well as to the patient.”<sup>15</sup>



The average duration of the consultation is between ten and twenty minutes. In that time the practitioner might decide to refer the patient for a specialist opinion. The patient could be an articulate professional or illiterate or unemployed. A commitment to equity, quite properly in our view, determines that no person has a greater claim to health than others and people's rights to equitable treatment by state funded medical practitioners are enforced by litigation. The effective consultation also requires attention to a series of 'tasks' including developing and maintaining the patient's trust, discovering the reason for attendance, eliciting the relevant signs and symptoms, agreeing a course of action, offering opportunistic health promotion and arranging follow up appointments.<sup>16</sup> In addition the doctor might pen or print a prescription, update medical notes, review on-going issues or perform other administrative chores such as issue certificates and of course if necessary write a letter. Some healthcare systems provide financial incentive to perform tasks that are driven by priorities set by the paymaster before the consultation. To the medical practitioner who finally determines that the patient who presents with on-going hypertension and depression requires specialist advice about their bowel symptoms the issue of the referral letter may constitute little more than a 'ticket of entry' to the test.<sup>17</sup> The specialist may be interested in a plethora of details including the amount and speed of weight lost, the nature of the rectal bleeding, the degree of anaemia and the family history, not to mention the relevant physical signs, including the presence of a palpable rectal lesion. Some of this information may be available, some of it may be recorded in the medical records, some of it will be relayed in the letter and some of it may never have been elicited. For reasons seldom reported in the literature much of this information will be lost en route. To the specialist trying to decide which cases should be seen soonest the scant details of a hastily written letter may be a source of frustration.<sup>18</sup> Luhmann's theory postulates that specialists and hospital managers have their own system of communication and the stage is set for conflict.

Doctors are seldom taught to write letters at medical school.<sup>19</sup> Technology and electronic communication offer the prospect to prompt the collection of 'relevant' information when referring the patient to another 'social system' and furthermore for the details to be relayed to be agreed beforehand. However there is limited evidence that e- letters will be widely or



quickly adopted given the seemingly insurmountable technical challenges and attendant resource implications. The computer-user interface also introduces a variety of potential confounders including a questionable impact on the consultation by increasing the focus on machine rather than patient.<sup>20</sup> Some of these issues have been researched, but more work is needed before the computer and electronic referral pathways become routine medical communication between doctors. To imagine that this will not be the path taken in the near future might be akin to proclaiming that the world wide web is a passing fad.<sup>21</sup> It may be that computers will not only become a tool for the relay of information but also change the nature of information that has meaning in the social system currently defined as general practice. If that happens it is possible that medical practitioners will become a more homogenous social system with a common language. For now the dilemma of which patient to refer and why remains a matter of opinion and for many conditions requires the exercise of a so-called sixth sense.<sup>22</sup> As the predictive value of objective tests that can be performed by GPs increase then we may begin to speak of the post-Balint era.

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