USE CASE 1

PATIENT – CLINICIAN INTERACTIONS: MAKING THEM FIT FOR THE 21ST CENTURY AND BEYOND
Outside of screening programs and public health initiatives, the majority of health care systems rely on the presentation of the citizen to the healthcare system with symptoms of one kind or another. The determination of the importance of these symptoms and the need for further medical investigation relies heavily on the patient-clinician interaction at appointments where clinical data is captured, decisions made on further investigation and information regarding this conveyed to the patient. The pressures on the healthcare systems mean that often these complex processes of data gathering, evaluation against available data, decision making and information delivery need to take place in a short appointment time of between 5 and 10 minutes. As disease comorbidity, treatment complexity and patient expectation continue to rise the current model is unsustainable. There is a well-documented increase in the population age and a coexistent multifactorial rise in demand for health care services. The capacity of the healthcare system is unable to keep up with the rising demand. The current patient journey and clinic appointment model requires disruption to embed digital technologies as experienced in almost every other aspect of our lives. The healthcare ecosystem is evolving to electronic workflow with many areas currently working with a mixed economy of structured and unstructured electronic data and some workflow still captured on paper with much of the latter scanned to an electronic storage solution. These developments have improved availability of data but in some circumstance the clinicians are hampered by difficulties surfacing the most relevant clinical information from the electronic systems for a particular patient. The parallel example stories below attempt to highlight the issues from patient and clinician perspective.

Steve (Patient)

Steve generally keeps well but recently has been feeling very tired and has started to get some abdominal pain and bloating. Things have been hectic at work and he initially thought it was all stress related but as the symptoms have continued for a while now he is starting to get a bit worried. He's spoken with a few friends and done a couple of internet searches all of which had fuelled his anxiety rather than give him the reassurance he had hoped for. He decides to see his GP asks him some more details and notes these down on the computer and arranged some tests. Steve's symptoms generally get a bit worse and he starts to notice a few more symptoms that he hadn't mentioned before. After a couple more visits to his GP he decides that he really should see a specialist. His GP has attempted to reassure him and the tests done in primary care have not suggested anything of concern. However the longer his symptoms persists the more Steve worries about them. Steve is referred to the local hospital.

Steve hears nothing from the hospital for many weeks and starts to get concerned.

Following his hospital clinic appointment, Steve is disappointed as he waited for a considerable time but the discussion was very similar to the one with the GP and the tests were the same as those done by his GP. Steve was relieved that the consultant had specifically reassured him that he didn't have cancer.

Jim (GP)

Jim is an experienced GP having been in his current practice for 11 years and had worked in Australia prior to that. His GP surgery has 8 minute appointments and often he finds it very stressful as can't have the level of detailed discussion that he would like to have with some patients. Despite that his consultations with Steve were good and he felt that he had gleaned the issues that were worrying Steve and instigated some tests which had all been reassuring. Jim knew that the longevity of Steve's symptoms with minimal change, the lack of "red flag" symptoms and the negative investigations made a significant diagnosis requiring referral very unlikely.

His preferred approach was watchful waiting and act if the clinical situation changed. He was however unable to deter Steve from seeking a specialist opinion.

Tracey (Consultant Gastroenterologist)

Tracey has been an NHS consultant for 12 years and thoroughly enjoys her work. The department is fully staffed at the recommended levels by national guidelines but despite this waiting times are significant with patients waiting many months from referral. Tracey reviewed the referral from Jim about Steve and triaged it to a routine clinic appointment. There was no contact between Steve and the hospital for 2 months when he was contacted to arrange to come it. When Tracey sees Steve in the clinic she has access to the previous tests and the detail of previous tests and contacts with the hospital along with limited information from the GP in the referral and a summary of medications. She reviews this but as the information relevant to the consultation is spread over many different places it takes her almost a third of the consultation time to assimilate this information. She then spends some time asking Steve about his symptoms creating a full clinical picture to base her decision on. Tracey comes to the same conclusion as Jim about the diagnosis and repeats Steve's blood tests before reassuring him he does not need further investigation. In the closing moments of the consultations Steve asks if this means he doesn't have cancer. Tracey had not specifically said before as she was unaware that this was Steve's biggest concern. They spend some time discussing that so Steve is reassured. However the clinic is now running 20 minutes late increasing stress and tension elsewhere.

The current system is not satisfactory for any of those involved and we seek an innovation challenge to create a more meaningful outpatient consultation for all involved