



Who's Bothered

Duty and Decision (8)



The previous blog explored the conditions that would justify a professional moving from the exchange circle to a more proximal position in a person's network of support. These set of considerations were framed as answering the question of 'so what?' This being short hand for an analysis of risk and impact on wellbeing. Perhaps paradoxically, this blog addresses a question that needs to precede considerations of impact and risk. In Care Aims this is referred to as the question of 'who is bothered?'

The 'who is bothered' question seeks to identify the 'primary requestor'. This is the person most close (proximal) to the patient who is concerned about possible impact or is noticing impact in the patient. The rationale being that it is not possible to evaluate risk (i.e. the so what?) without first identifying the person who is observing and reporting it (i.e. who is bothered?).

Traditionally, a referral is seen as a transfer of care – “please can you provide 'X' care for 'Y' patient.” The presumption under this mode of practice being that it is always the patient who requires assistance. This has led clinicians to short-cut triage and jump straight into assessment or intervention with the identified patient.

Within the Care Aims framework a referral is framed as a request for help. The first question in triage being who is it that is requesting assistance? This question is relatively easy to answer when the request is received directly from the patient (i.e. the person in the middle of the circle). In this situation it is obvious that they are 'bothered', and it is them we need to speak with to answer the 'so what' question about impact or risk to wellbeing?



In current practice requests for assistance are often passed through an intermediary.

Commonly this involves someone raising a concern with a GP. The GP then requests the assistance of another health professional. In many such situations the GP can be thought of as a 'secondary referrer'. In that they are simply acting as the messenger for someone else's concern. In this situation, the first task in triage is to identify the primary requestor. As noted above this is the person closest to the patient who is expressing concern. In many instances this person will be the identified patient.

It is important to note that contact with the identified patient at triage does not imply a duty of care or duty to assess. There is no transfer of care at referral, as is often assumed. Instead, the duty at triage is to make a decision about whether or not there is a need for the team receiving the request to become more proximal. This decision includes considering whether more proximal people making up the existing circle of support (which includes the referrer) are currently able to manage risks or impacts. It also includes judging whether the provision of advice, signposting, support, or consultation to the referrer will be sufficient to enable the more proximal circle to cope. Another important part of the duty at triage is to communicate decisions and provide any support to the referrer in a timely way.

There are times when the identified patient is not the one who is bothered. These situations are considered in the next blog.