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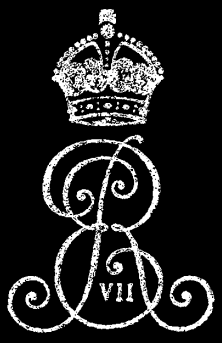

Report on Communications and Relationships between General Practitioners and Hospital Medical Staff

34 KING STREET, LONDON, E.C.2

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PREFACE

This report is the outcome of an enquiry sponsored by King Edward's Hospital Fund and undertaken by Dr. Maurice Shaw into the subject of relationships between General Medical Practitioners and Hospitals. It is not the product of intensive field work; it results from a purely practical and introductory enquiry undertaken by a Consultant Physician of many years standing, within the terms of reference mentioned above. Its object is mainly to draw attention to the problem of communication between Hospitals and General Practitioners and make any general recommendations which seem indicated.

Dr. Shaw had the assistance and advice during his enquiry of a small panel of doctors which included General Practitioners from different parts of the country, and this report takes into account their comments and suggestions. The King's Fund is grateful for their invaluable help and for that of the many hospital workers, medical, nursing and others who co-operated in providing the information on which the report was based, especially Professor Titmus for advising Dr. Shaw on the general plan of the investigation.

The Fund may well decide to pursue this matter further by closer enquiry into particular aspects of the problem, but in the meantime it is hoped that Dr. Shaw's report may be of interest to Hospital Management Committees when considering their own methods of keeping in touch with local doctors. In any case their comments and suggestions will be welcomed.

REPORT ON COMMUNICATIONS AND RELATIONSHIPS BETWEEN GENERAL PRACTITIONERS AND HOSPITAL MEDICAL STAFF

This report is an investigation which has been carried out during the past year into the present state of relationships and communications between medical men engaged in hospital practice and those in general family practice.

The method adopted has been for the investigator, a retired hospital consultant, to visit a number of hospitals and practices of various types in different parts of the country and to question all grades of medical and non-medical staff.

Nature of Communications

Communications may be by letter, by telephone or direct. The general practitioner needs to communicate with hospitals (a) for an out-patient appointment; (b) for an admission; (c) for information about a patient; (d) for a domiciliary consultation; the latter does not require to be considered in detail as a very large number of appointments for domiciliary consultations are made through the consultant's private secretary.

Out-patient appointments can be made by letter, by telephone or by a personal call at the appointments office by the patient. There is an increasing tendency for hospitals to provide general practitioners with special forms of application which vary greatly in content as well as in size. These forms are completed by the practitioner, and the patient brings them or posts them to the hospital. Hospital administrators are generally in favour of these forms as they save time by making it possible for the registration of the patient and the completion of the necessary details on the out-patient notes to be done before the patient arrives for consultation. Some general practitioners like these forms but there is a large number which prefers to use ordinary note paper. This preference is shared, on the whole, by doctors' secretaries who find the form unsuitable for easy and rapid typing. In a town of some size, with several hospitals

which have different forms for different clinics, the general practitioner has to have a large stock in his surgery and may have to carry them with him on his rounds. Some of the forms seen have a space for completion by the patient which cannot be sealed and remains visible. A recent circular from an Executive Council has expressed the opinion that these details have met with no objections from patients; but the area involved was part of Greater London where the postal services are more impersonal than in rural districts. It is likely that patients in village communities would object to the postmaster and his staff knowing that they were attending hospital and that they had previously attended, e.g. the gynaecological department—and their age—all details which have to be filled in on the back of the envelope. It is true that an outer envelope is provided for those who object, but it would seem better, if such forms are to be used, for all the information to remain confidential. It has been pointed out that some of the forms in use, even when folded and sealed, are made of insufficiently thick paper to prevent the inquisitive from reading some of the contents. This is only one of the many instances where practices suitable in a densely populated urban area are not so appropriate for rural and sparsely populated communities.

Cost of Postage

The cost of posting letters applying for out-patient appointments may be a problem. Some hospitals provide prepaid forms and these are very welcome to general practitioners. In other cases, where the letter is on a printed form or on the general practitioner's own paper, the cost must be borne either by the doctor or the patient, unless the patient or a relative or friend can take the letter to the hospital. This can often be done when the patient lives within a short distance of the hospital but is impracticable when cost of public transport is involved.

Appointments by Telephone

In many cases the appointment is made by telephone, either by the doctor from his surgery or by the patient. In one hospital where this matter was specifically investigated it was shown that the majority of telephone requests for out-patient appointments came from the patients. Many general practitioners have complained of

the difficulty of making rapid contact with appointment clerks by telephone and this may be an increasingly serious problem with the introduction of S.T.D. (Subscriber Trunk Dialling). Although some enquiries have been made, no area in which investigations have taken place had had S.T.D. long enough for its impact on telephone communications to be assessed: it is, however, generally agreed by both hospital and general practitioners that it may well be a problem on both sides. Some hospitals have a separate telephone for appointment clerks and so avoid incoming calls for appointments passing through the hospital switchboard. Whichever system is used, however, it is quite common for delays to occur and many general practitioners have said that, although they get an immediate reply from the appointment clerk, they are then kept waiting while the clerk deals with some other problem. It would seem mainly to be a question of adequate staffing to secure a quick response to enquiries for out-patient appointments.

Letters from General Practitioners

The content of general practitioners' letters has been investigated both by inspection of their letters and by questioning consultants. While it is clear that a minority do not come up to the standard which might be reasonably expected most of them are at least adequate and many excellent. Consultants on the whole seem to agree that the standard of general practice has been improving over the years and, although there are not infrequent criticisms of general practitioners' letters, and of occasional abuse of the out-patient service, these do not appear to present a serious problem in most areas. A criticism of general practitioners' letters which is certainly justified is that they so often omit any reference to treatment already given. A letter containing an excellent history together with the results of a careful physical examination which can, however, be obtained by the consultant himself, should not omit one of the things which the consultant can neither know nor find out without being informed. Patients are usually quite ignorant of the nature of the drugs they are taking although they are ready enough to say the number and colour of the pills consumed daily. The social background and the personality of the patient are other things which the consultant cannot know unless the information is supplied to him by the practitioner referring the case.

Letters from Hospital Staff

While criticisms of general practitioners' letters by consultants are often heard there is, on the other side, a good deal of criticism of the replies sent by consultants and other medical members of hospital staffs. One of the most serious is the not very rare delay in the receipt of these replies and the occasional complete absence of them. A careful study of this has been made. From hospital records it is clear that the trouble can be due to delay either in the dictation of the reply or in its typing and despatch. But even when the carbon copies filed with the notes suggest that the reply has been sent on the day of the clinic, the date on the letter does not necessarily indicate the date of posting. Although practices vary in different hospitals, most secretaries date their letters on the day of typing although in some cases the date of the clinic may be typed on a letter which is in fact transcribed some days later. In one busy general practice it was possible to watch the morning mail being opened and it was clear that the postmarks on the envelopes were often several days later than the dates on the letters. Administrators attribute these failures to shortage of staff and there is no doubt that this is a factor, especially in holiday periods or during epidemics which both diminish the secretarial staff and increase the number of patients. But there are also faults on the consultant side. It seems that some consultants, presumably owing to their other commitments, only dictate twice (or even once) a week. Thus a letter about a patient seen on a Friday may not be dictated until the following Monday or even later. If there is any hold up in the typing from the causes mentioned above it may be a week or more before the general practitioner gets a report. It is true that in cases of real urgency the telephone is often used or the patient may be given a handwritten note to take to his doctor but in such cases no record is kept—or, at any rate, very rarely—so that it is impossible to determine retrospectively by reference to the notes whether this has been done.

Failures in Out-Patient Communications

The complete absence of a reply to a general practitioner who has written about an out-patient is infrequent but does occur and there appear to be several reasons. One of the commonest is the

fact that the patient is admitted to a ward direct from the out-patient department. In such cases it is common practice for the notes to be taken to the ward with the patient so that when the consultant comes to dictate at the end of his clinic the notes are not on his desk and no letter gets written; the first thing the general practitioner receives is the discharge letter or summary which may be sent some time after the patient's discharge. Some consultants, familiar with this hazard, always keep the doctor's letter separate from the folder containing the patient's notes so that, if the latter are removed from his desk for any purpose whatever, the doctor's letter remains and receives attention; but it may easily get lost. There can, however, be no doubt that this particular type of breakdown in communications is largely overcome if the secretary who types the letter is given some executive responsibility for the correspondence. In some clinics it is the secretary's duty to check the letters she has taken against the appointments list and it is her responsibility to see that such breakdowns do not occur; in the case cited such a secretary would, on finding that no letter had been dictated, get the notes from the ward and enquire from the consultant what he wished done. A telephone message or a brief note advising the general practitioner of the admission of his patient might be all that was required for the moment and this could be done by the secretary herself. In hospitals where the letters are taken down by members of a typing pool the typist takes down what is dictated and has no further responsibility. In this connection it should be pointed out that some Records Officers prefer the typing pool system because then the secretaries are responsible only to them; but one hospital administrator suggested that a system of personal secretaries combined with a sort of tactical reserve of pool typists to ease the pressure wherever it was greatest might prove the most effective organisation in a large hospital. There is almost complete unanimity among consultants in favour of the personal secretary even though, in most hospitals, one may have to serve two or even more clinics. In a large cardiological clinic visited the secretary had complete charge of the notes in her office in the block housing the clinic, but such a system would not be very popular with most Records Officers. Even in this very efficient clinic it was noticed, on going through the notes, that an out-patient with a diagnosis of cardiac infarction had been admitted to the ward and the first communication the referring doctor received was the letter sent on the patient's discharge from the ward. But the

best systems will sometimes fail through human error and this particular failure does not invalidate the principle that a personal secretary with a greater degree of responsibility for the correspondence than is usually assumed by a pool typist makes for greater efficiency in the matter of both written and of telephonic communications.

Internal References

Another common cause of failures in out-patient communications results from the reference of the patient to another clinic in the same, or even in another, hospital. In such a situation practices vary. Sometimes the first consultant, especially if the colleague whose advice he seeks is holding his clinic at the same time, simply writes on his notes "Will Dr. X kindly see" and sends both patient and notes direct to the other clinic. In some hospitals a form has to be filled in inviting a colleague to see a patient and this is often used when the clinic to which the patient is referred is held on another day. In the case where the first consultant sends his notes to his colleague, the second opinion may be recorded by hand in the notes and this may not be seen by the first consultant until his next visit; or the consultant whose opinion has been sought may dictate an actual letter to his colleague but it is not a universal practice to send a copy of this letter to the general practitioner. A patient may thus wander from clinic to clinic with notes passing between hospital colleagues without the general practitioner knowing what is happening until some weeks (or months) later when he gets a report—possibly from the psychiatrist! It seems that some routine procedure is needed for dealing with a situation which is by no means infrequent. In one clinic it was the custom for the consultant referring a patient to a colleague to write to the general practitioner and to send a copy to his consultant colleague and this may well be the best practice. An experienced personal secretary would (or should) see that such a situation did not arise but some of the younger secretaries interviewed said that they would not send copies of correspondence to anyone unless expressly ordered to do so. Some consultants would probably not welcome a general instruction to all medical secretaries to send copies of all correspondence to the patients' doctors although they would have no objection to copies of letters to patients' doctors being sent to their consultant colleagues. It should be mentioned

here that one general practitioner expressed the view that no hospital out-patient should be referred to another clinic without the general practitioner being consulted. The reasons given for this view are not without substance. It was pointed out that such a practice would never be tolerated in the case of a private patient and what was right for a private patient ought to be right for a hospital one. It is, of course, true that some general practitioners would prefer their patients not to be seen by certain consultants for varying reasons but the saving of time resulting from the immediate reference to the appropriate clinic must be balanced against the advantages of delaying the appointment in order first to consult the patient's general practitioner.

At this point it may be worth mentioning a complaint often heard from general practitioners as to the enormous volume of correspondence which accumulates, in particular concerning their more neuropathic patients. The N.H.S. envelopes get filled to bursting point, but too much information is preferable to too little and a good deal of superfluous correspondence could probably be destroyed and replaced by a brief note on the patient's record card.

Local Authority Patients

In addition to these causes of breakdown in out-patient correspondence one must consider the cases referred to hospital by the local authority—usually the school medical officer or his deputy. In some places the general practitioners say that the medical officers of health are sufficiently co-operative not to permit reference of any of their patients to hospitals without prior consultation, but in many areas patients are, in fact, referred to hospital by the local authority without their doctor being informed; and it can well happen that a child is sent to an E.N.T. clinic and later admitted for tonsillectomy without the general practitioner knowing about it. This is particularly obnoxious to many general practitioners who may have quite strong views on removal of tonsils and resent this being carried out not only without their knowledge but contrary to their wishes. While copies of letters from hospital consultants to local authority doctors are sometimes sent to general practitioners there seems to be no common practice in this matter with the result that failures in communications are by no means infrequent. It has been noticed that in the case of

many patients referred by the local authority the name of the general practitioner has not been recorded on the hospital notes although there is always a space for this.

In addition to local authority patients, there may be letters written by hospital medical staff to solicitors, insurance companies or to employers. It is not usual practice for copies of these to be sent to the patient's doctor, although it would seem desirable that he should receive a copy of any such reports. It is more debatable whether reports on such things as abortions or attempted suicides should be reported to the patient's general practitioner but there will probably be no objection to this being done with the patient's consent and it may be of considerable importance for a patient's doctor to know of such incidents.

Cases do occur where, on admission, a patient's doctor is not known as, for example, in the case of a patient admitted unconscious. The patient, however, will ultimately be identified whether he recovers or not and it should be possible to inform the general practitioner of the outcome. In some cases patients are referred directly to another hospital (e.g. an infectious disease hospital) from the casualty department, in which case the responsibility for communicating with the doctor falls upon the hospital ultimately admitting him.

Personal Continuity in Out-Patient Departments

A fairly common complaint from general practitioners is that their patients are not always seen by the consultant to whom they have been referred, even when a personally addressed letter has been sent. The reply may come from a deputy who does not always have his status and qualifications typed under his name. It is reassuring for the general practitioner to read "M.D., M.R.C.P." or "F.R.C.S." under the signature rather than a name unknown to him belonging, for all he knows, to quite a junior officer. It would almost certainly be appreciated if the status as well as the qualifications of deputies were always typed beneath their signatures. Moreover the reason why the consultant has not seen the patient himself is often not stated. In straightforward cases—routine hernias, etc.—this does not matter much and is accepted, but where

a particular consultant's opinion is wanted for a special reason, either because of his specialised knowledge or because he is considered the best person to handle a difficult patient, the transfer of the patient to other and less experienced hands may well be resented by both patient and doctor. Enquiries have been made of administrators as to whether this difficulty, when due to a consultant's absence, could be overcome. It is often routine practice to notify local doctors of consultants' holidays but this is not enough. The service which would be appreciated by general practitioners is one which would notify them, either when or after the appointment is made, that the chosen consultant will not be available. In some cases this would be difficult and it happens at some hospitals that the absence of a consultant at short notice may involve the cancellation of the clinic, in which case every patient booked for an appointment must be communicated with by letter or telephone. It may seem a little surprising that, apart from illness, such unexpected absence should happen at all and it is difficult to estimate their frequency; but they certainly do occur. It seems to be a matter for Medical Committees to consider and to devise some scheme by which prospective absences are notified sufficiently far ahead to avoid the difficulties which these absences involve.

In some hospitals out-patients are routinely shared between the consultant and an assistant. This practice enables a greater number of patients to be handled at the clinic and often diminishes the waiting time for an appointment, but the practice may have certain disadvantages. A patient telephoning, on the instructions of his doctor, for an appointment with Dr. X may merely get one with Dr. X's Clinic. The consultant's personal list may be full and the late applicants will then be allocated to the assistant who is, in some cases, a relatively junior medical officer. The general practitioner is rarely asked whether he has any objection to this arrangement, but the most serious problems arise when a patient from the country is referred to a London hospital and an appointment made with a consultant of European reputation who may, in fact, never see the patient at all. Appointment clerks do not usually disclose, and indeed may not know, that Dr. X will be away on the allotted day. It has been said that at one important special hospital in London a general practitioner was told, when telephoning for an appointment, that he could not have an appointment with a

named specialist; moreover the appointment clerk was apparently forbidden to state the name of the consultant who would be seeing out-patients on a specific day. In some cases of this sort the doctor may actually accompany his patient to the hospital and, in order to so do he may elect to give up his half-day. In such a situation he naturally wishes to know with which consultant the appointment is being made. In some special hospitals, especially those in London attached to the post-graduate institutes, it seems to be common practice for a new patient to be seen first by an assistant (admittedly of some experience and standing) who filters through to the consultant only those thought suitable for post-graduate teaching. Such practices are frustrating to general practitioners who may have told their patients that they are going to see the most famous specialist in England only to find that they have been fobbed off on to a registrar after a long and possibly expensive journey. That sort of thing does little to maintain good relationships between those in general and hospital practice. Another complaint which is often voiced by general practitioners, and indeed by many patients, is that they so often see a different doctor on each visit to the hospital—especially at teaching hospitals. This naturally involves letters from several different people and tends to spoil the continuity of the various reports which the general practitioner accumulates in his files.

Content of Consultants' Letters

A number of criticisms of the content of consultants' letters has been made by many general practitioners. The most important of these and one which has been shown to be justified by inspection of the letters themselves is that they often do not *answer* the general practitioners' letters. They tend to be reports rather than letters in answer to specific queries. Many examples could be quoted but a typical one was the case of a general practitioner who sent up a patient with symptoms which he thought might be connected with Paget's disease and put this as a question to the consultant who ignored it completely and did not even mention Paget's disease in his reply. This sort of thing is by no means uncommon and probably arises from the fact that the general practitioner's letter is read by the consultant before he sees the patient and is not referred to again when the reply is being dictated. The consultant's letter

thus tends to be a report composed from his own notes rather than an answer to the letter accompanying the patient. Another criticism is that the consultant often repeats at length a history which has already been fully given by the general practitioner (this again may be due to the letter not being re-read before the answer is dictated). Such repetitions may, however, be valuable for the record and at least one general practitioner interviewed said that he (having no secretary himself) welcomed the receipt of a neatly typed repetition of his own findings for his own records. It is relevant to point out at this point that comparatively few general practitioners have secretaries and, such as do, often employ them part time. A more universal use of secretaries by general practitioners would greatly improve communications both written and telephonic but only some of the larger practices can at present cope with the expense.

In some hospitals it is the custom to collect all the letters and reports going to an individual doctor or practice into one envelope, presumably to save postage. In more than one practice, however, the complaint has been made that such packages were insufficiently stamped, involving the practice in some extra expense.

Dictating Machines

At this point it may be pertinent to say something about the use of dictating machines. These are now widely used but it seems that they will not be in universal use until the prejudice against them, shared by most secretaries and many hospital doctors, is overcome. The typist or secretary has two main objections, the fear of losing her shorthand speed; and her dislike of spending her time typing with no personal contact with those for whom she is working. If the secretariat is organised on a basis of personal secretaries with responsibilities beyond those of the purely mechanical act of typing this latter objection would be largely overcome. The first will probably die a natural death as shorthand is gradually replaced by mechanical sound recording in one form or another. The use of machines is, of course, a great time saver. Dictating can be done as each patient is seen without the necessity of the secretary being present in the clinic or even in the hospital. Quite a number of hospitals now have remote control recording apparatus which relays the

letter direct to the secretary's office. This latter practice certainly eliminates a good many of the breakdowns of communications which occur.

Reports on Casualties

In addition to the reports on out-patients there is the problem of the casualty department. "Casualties" frequently arrive at hospital without the knowledge of their own doctors who have probably not been consulted for the injury or other emergency which takes them to the casualty department. The practice of different hospitals varies greatly. Most have printed forms for completion by the casualty officer but these are not always used or, if they are, are used selectively, being mainly confined to patients in whose case the co-operation of the general practitioner is required. The form is quite often given to the patient to take to his doctor but a fairly frequent custom is for the patient to be asked to report to his doctor without any written communication being sent. That this habit is undesirable is illustrated by an action which was brought in 1955 (Chapman v Rix) in which a widow sued a hospital doctor because he had told a patient (who subsequently died) to report to his own doctor. The action for negligence was partly on the grounds that the hospital doctor had been negligent in not writing to the patient's doctor. The High Court Judge held that this omission amounted to negligence and awarded heavy damages to the widow. It is true that this judgment was reversed by the Court of Appeal and that the House of Lords upheld the Appeal Court's decision. But a letter, which would have taken at the most a few minutes to write, would have saved an enormous amount of subsequent time and money. Where a "pro forma" is used, a carbon copy is not usually kept in the hospital notes and it is therefore difficult retrospectively to know whether any written communication has, in fact, been sent to the patient's doctor. Some patients are referred from the casualty to the out-patient department in which case a report to his doctor (if known) is usually sent, but a proportion of casualties, especially road accident cases, occur at a distance from the patient's home. If the patient is admitted the usual discharge letter will be sent when the patient goes home, provided again that the name and address of the doctor is known. If, as sometimes happens, the patient says he has no doctor, he should

be urged to apply forthwith to be put on the list of a doctor practising in his neighbourhood. This would go some way to avoid the unfortunate situation which arises when a doctor is called in emergency to a patient recently discharged from hospital about whom nobody knows anything. It is important that the telephone number as well as the name and address of the patient's general practitioner should be clearly written on the notes.

Notification of Admissions

Somewhat different problems of communications arise when a patient is admitted, whether as an emergency, from out-patients or from the waiting list. A system much appreciated by the general practitioners and carried out at some, but probably few, hospitals is for a card to be sent to the doctor immediately on the admission of one of his patients. This may serve no very useful purpose in the case of a direct admission at the request of the general practitioner but it does tell him in which ward to find his patient if he wants to visit him. It is very useful in the case of emergency admissions which have not passed through the doctor's hands e.g. sudden illness or accident at work, and particularly in the case of patients admitted from the waiting list. Doctors are informed from Out-patients that a patient's name is being put on the waiting list but they have no idea when the admission will be and without such notification the patient may be in and out of the ward before his doctor knows anything about it. For reasons already given it may be thought unwise for these notifications to be sent on an open postcard, especially when the patient comes from a small village where all postcards can be read by post-office staff. There is no doubt that notification of admissions is welcomed by general practitioners.

In-Patients and the General Practitioner

While his patient is in hospital the doctor may want to visit him and the facilities available for such visits have been the subject of enquiry by talks with members of medical staffs, with sisters and with nurses. It seems that in most hospitals doctors are welcomed at any time and given all the information they want including permission to read the notes. This practice is not universal and it was perhaps a little surprising to find that at one large teaching hos-

pital the consultants expressed the view that access to the notes by the general practitioners should not be allowed in the absence of a medical member of the hospital staff. This arrangement would not be very acceptable to general practitioners as they have not the time to wait while a house officer or registrar is summoned. The reason for the attitude of the consultants at this hospital seemed to be a fear that unauthorised people such as journalists might get information the publication of which could prove embarrassing to both hospital and patient. However, ward sisters said that they personally knew most of their patients' doctors, especially in small towns, and if they did not recognise them the patient would identify them. Sisters were not keen to interrupt a consultant's ward round if the general practitioner arrived while it was in progress and some would ask the general practitioner to return at a more convenient time. Most sisters, however, said that they would personally inform the consultant of the general practitioner's presence and leave it to him to decide whether or not he would see him. Both matrons and ward sisters agreed that a junior nurse should not assume the responsibility, as she has been known to do, of turning a doctor away without reference to the sister herself or to the senior staff nurse on duty.

A number of general practitioners have said that they sometimes visit one of their patients in a certain ward only to find afterwards that another of their patients was in the same ward unknown to them, and that their failure to visit or even to recognise them has given offence. The appearance of a patient in hospital is very different from his appearance in the surgery or in the High Street and, with a view to obviate this difficulty, some wards keep a list of patients posted in a room outside the ward recording, against the patient's name, the name of his doctor; a glance at this list will tell the general practitioner which of his patients is in the ward. Even if admissions are routinely notified, as suggested above, it is still helpful to have such a list outside the ward as a visiting doctor may well forget in which ward or wards his patients are located.

Discharge Reports

The communications connected with the discharge of patients have been the subject of careful scrutiny because it is in this con-

nection that so many failures occur. Nearly all hospitals have a short printed form, to be completed by the house officer, which is posted to the patient's doctor "on his discharge"; in theory this means on the day of discharge, but in practice this ideal is rarely realised and it may not be despatched until the patient has been home for over 24 hours. A case was recently reported in the press of a death of a diabetic patient before the discharge letter from the hospital had reached his doctor. On a few (very few) occasions the form has been found still in the patient's notes a year or more after he had left the hospital, but the doctor doubtless received a full summary a week or two after discharge. Ideally these forms should be sent out on the day *before* the patient's discharge so that his doctor knows of his impending return home before he actually arrives. An administrative problem is involved as to who should be responsible for actually stamping and posting the forms. The secretary to the Firm would seem to be the obvious person and, if she is to do it, it is all the more important that they should be filled in well before the patient leaves; if, for example, they are completed by the house officer on his night round they would probably not catch the first post the next morning unless the house officer himself (or the sister, as is sometimes the case) assumes the responsibility. Most matrons whose views were sought on this question considered that sisters should not have this purely clerical work thrust upon them. Different arrangements would probably be needed in different hospitals.

The content of such forms has been criticised for giving too little information as to treatment and the clinical condition of the patient. There is usually a space for "treatment recommended", but the quantity of medicine given to the patient to take home with him is rarely if ever stated. A doctor wants to know whether his patient has enough medicine to last him a few days or a fortnight. This is especially important in connection with the other main criticism as a bed-ridden or completely immobile patient with only a few days supply of medicine will need an early visit, whereas a completely mobile patient with a fortnight's supply may be expected to visit the surgery. Only one form seen satisfactorily solves this problem and in this the patient is classified as "bed-ridden", "partially confined to bed", "ambulant" or "completely mobile"; but although there is a space for "recommendations" there is no indication of

how long any drugs given may be expected to last. This particular form is *given* to the patient to take home and this practice involves the hazard, present whenever a report is given to a patient, that it may be opened and read by the patient, and may for one reason or another not be delivered to the doctor.

Interim Reports

In none of the hospitals visited was any very serious attempt made to keep in touch with the General Practitioner while his patient was in hospital, although occasional instances were encountered when an individual consultant might arrange a meeting in the ward with the general practitioner and the almoner. Many doctors would like to be notified as to the time of consultant's visits to *their* patients, although their other commitments would often make it impossible for them to attend the hospital at the time indicated; it does seem, however, that a consultant round, with the general practitioner and the almoner present, would be useful in many, although in by no means all, cases. The importance of such meetings is illustrated by the not infrequent complaint that patients are often discharged too soon in relation to their home conditions. This is to some extent an almoner's responsibility, but the degree to which the almoner is consulted on such matters varies greatly; some consultants seem to ignore the services of the almoner while others make frequent use of her. Most general practitioners would like to be consulted themselves as to the home conditions so that they could confirm that these were appropriate for the condition of the patient.

Opinions vary as to whether interim reports, especially on long-stay patients, would be welcomed by general practitioners as a whole, but most of them would be pleased if all hospitals would adopt the system which is practised in some (but only by some surgeons) of sending an immediate report on operation findings. There are hospitals where a dictating machine is available off the theatre so that the surgeon can dictate a note as soon as he leaves the theatre after an operation. The objection to this from the administrative angle (as to so many suggestions for improvements in communications) is staff shortage. It is, however, important for general practitioners to know as soon as possible the

result of an operation on one of their patients as he is likely to be consulted by relatives who expect him to be able to give them the information they seek.

Full Discharge Summaries

After the patient has left hospital there is sent, at widely varying time intervals, a full summary of his investigations and treatment. Although some such summaries may reach the general practitioner within a few days of his patient's discharge, most of them take a week or more—sometimes even months. Their content, too, is often unsatisfactory as they contain either too much or too little information—more often too much from the general practitioner's point of view—although few general practitioners seem to agree as to what exactly is required. Most of them welcome full details of investigations as they find these educationally valuable, but few, if any, want a detailed account of the steps in a surgical operation. Naturally the requirements vary from case to case. Simple routine operations only need the briefest report—"RIH; repair; satisfactory", would satisfy most general practitioners, but in a difficult case all the steps leading to a diagnosis would be appreciated. This raises the question as to who should write these summaries. Again current practice varies enormously. Some consultants write their own—the ideal procedure—but in many hospitals this is left to a more junior officer who may be anything from a registrar downwards. A house officer probably has too little experience to be sufficiently selective and tends to make a complete summary—sometimes a copy—of the notes. If the consultant cannot do his own summaries they should be delegated to the most senior officer available with full knowledge of the case.

The long delay in the completion and despatch of discharged summaries is due to a number of causes. If they are left to a junior house officer whose tenure of office is only six months, he may well leave the hospital before he has completed the work. His successor, in trying to catch up, may neglect his predecessor's notes in favour of those of his own patients with whom he is more familiar, and in this way it sometimes happens that no report at all is sent until a request is made by the general practitioner. It is common enough to find a cumulative pile of notes awaiting discharge summaries, and staff shortages on the secretarial side may

be partly responsible. It would almost certainly improve the situation if this work was never entrusted to any medical officer below the status of registrar, although it has been said by a senior consultant at one large teaching hospital that the registrars there would not have the time; but, if it is considered essential to good communications that the registrars should be responsible for summaries, any necessary adjustments in their duties should be made to enable them to have the time for this important work. The very common delays which occur in sending out discharge summaries seem to be matters for discussion between medical and administrative staffs.

Communications after Discharge

The sending of a report to the general practitioner on the discharge of his patient, with recommendations as to future treatment, does not necessarily mean that the patient will now remain under the sole care of his own doctor, and the (allegedly unnecessary) retention of patients by the hospital is a common cause of adverse comment by the general practitioners. Opinions vary as to the role of the general practitioner in the continued treatment and supervision of his patients who are attending hospital, but it is probably true to say that most general practitioners want to look after their own patients, even though from time to time they may have to attend hospital for a check. This is not the place to discuss the question of whether the general practitioner or the hospital consultant has the overall care of the patient while the latter is attending hospital, but it is quite clear that the general practitioner requires to be informed of what is going on, as he may have to deal with an emergency. Moreover, it is pointed out by general practitioners that if they are to keep themselves abreast with advances in the investigation and treatment of disease, they must have the closest contacts with the consultants who are supervising treatment at hospitals and should be able themselves to carry out a great many of the treatments recommended. Some consultants, impressed by the lack of co-operation of a few of the local general practitioners, take the view that they cannot risk their patients being neglected and/or improperly treated by their own doctors and, in the alleged interest of the patient, insist on keeping all the treatment, including the prescription of drugs, in their own hands. General prac-

titioners retort that although there may be a very small proportion of "bad" general practitioners, the assumption by the hospital of complete charge of their patients is likely to lead to more "bad" doctors as the keen ones will lose heart and become disillusioned if they are only to act as distributors and not as an essential part of the service. There is truth on both sides of this argument. It is generally agreed that what have been, for brevity, called "bad" doctors are relatively few and that their numbers are diminishing. While it is admitted that the interest of the patient must be a first consideration, the gradual improvement of standards of general practice is one of the surest ways of benefiting the patient and it can be argued that it is not the duty of the hospital consultant to do anything which will limit the legitimate sphere of action of the family doctor and so impair his usefulness to the community. Briefly the problem is, should hospital practice be geared to co-operate with good or bad general practice? The answer must surely be, with good general practice, although special steps may have to be taken to protect the patient against rare cases of neglect by his general practitioner.

Unnecessary retention of patients in out-patient departments involves further breakdowns in communications, since the volume of patients handled makes it impossible to keep the general practitioners informed of their patients' progress. One surgical consultant said that he saw 50-60 old patients at every clinic and it was quite impossible to write, even briefly, about most of them owing to lack of time and secretarial facilities. Moreover, if reports on all these patients were sent, the volume of letters would be an embarrassment to the recipient. An argument sometimes used by consultants to defend the practice of keeping patients at hospital is the increasing complexity of treatment, much of which is considered outside the scope of the average general practitioner; but keeping the general practitioner ignorant of what is going on and not allowing him to play some part in complex treatment increases rather than solves the problem. It is, however, admitted on both sides that there is a need for some patients to attend hospital frequently.

A practice which tends to overload out-patient clinics is the routine booking of an appointment for every patient leaving a ward.

The patient with, for example, chronic bronchitis or heart failure is rarely benefited by a visit to Out-patients and, indeed, is often made worse. It is much better for him to remain under the care of his doctor, in whose hands should lie the decision as to whether further consultation at hospital is necessary.

General Telephone Communications

Enquiries have been made on the general question of telephone communications between general practitioners and hospital doctors and it seems that in some areas these are not generally unsatisfactory, although in others they leave much to be desired. Increasingly the use of the pocket radio call system is being employed and there is no doubt whatever that it is extremely efficient. It can only break down if the officer required is not wearing his receiver, is out of range or occupied with work which cannot be left. In the latter case a nurse will reply and take a message. It is now mechanically possible to have a two-way radio-communication system between the switch-board operator and the officer carrying a receiver; this is not used in any hospital as far as is known but it would, if adopted, obviate a great many delays which now occur; there is, of course, the possibility of its abuse, but this could probably be controlled by appropriate regulations. Nearly all hospitals now have some internal call system and dependence on a porter or operator ringing all departments to find whoever is required is largely a thing of the past. General practitioners find that they can in many hospitals contact a doctor in a reasonable time by day, although there are still many complaints of difficulty, and night arrangements are far from satisfactory. Difficulty at night seems almost inevitable as the available staff is small and may well be engaged on duties which cannot be left: operations, emergency treatments in ward, etc. Sometimes at night a general practitioner has to talk to a porter who relays the conversation to the appropriate doctor on the internal line. Such secondhand conversations are most unsatisfactory and the ideal from the general practitioner's point of view is to be able to contact a responsible hospital doctor quickly at all hours of the day and night. This will be an increasingly important problem as S.T.D. spreads. In the daytime the presence of a full time and relatively senior admissions officer who has no duties which take him away from the telephone is a

tremendous help, and such officers exist in some hospitals. While many general practitioners say that they have no special difficulties in contacting a medical officer at *general* hospitals, some seem to have encountered great delays at *mental* hospitals. The cause of this is not clear but it is often a matter of great urgency to a general practitioner to make quick contact with a hospital psychiatrist and it seems that there is a case for a review of the facilities at some of these hospitals. In some general hospitals a periodic check is made on the time elapsing between the receipt of a call and the contacting of the appropriate officer. As far as the results of these have been seen, they have not shown any very serious delays, although these do obviously occur from time to time. Such a periodical check by hospitals themselves is a worthwhile procedure which may enable them to make good some fairly simple defect in their communication system.

In some business houses automatic exchanges are installed and this relieves the operator from handling any outgoing calls which can be dialled. With this installation the Post Office telephone can be used for internal communications and an outside number can be dialled from any instrument without using the operator. The capital expense of such an installation is considerable (around £2,500 for 100 lines) but against the expense can be set the saving of operators' wages where more than one is employed and a very much greater efficiency in telephone communications generally. There is, however, the objection to such a system in an institution like a hospital that long distance calls under S.T.D. could not be traced, but this can be met by a device which blocks all but local calls.

The use of the telephone in reporting about patients has already been referred to. There is no regularly accepted practice as to the use of the telephone but it seems that it is quite frequently used, especially in some paediatric out-patient clinics, to enable an urgent message to reach the doctor before the written report can be sent. It is, of course, sometimes used, when indicated, by other clinicians but rarely by house officers and registrars to give doctors information about their patients, although these officers may occasionally use it to get information wanted by themselves or their chiefs. A practice which has become universal at one hospital visited is the reporting

of all deaths by telephone to the general practitioner as soon as practicable after the event, thus ensuring that the doctor will know of his patient's death almost as soon as the relatives. If a patient should die during the night the general practitioner should be informed at a conveniently early hour the following morning, and it would be for each hospital to determine to whom this duty should be delegated. This is tremendously appreciated by the doctors in the area and practically all general practitioners who have been asked whether they would welcome such a scheme have answered with an enthusiastic affirmative. It is a practice which could well be universally adopted. It is perhaps only fair to record that at one provincial centre a majority of the general practitioners with whom this question was discussed did not react favourably on the grounds that their telephones rang too often and that they did not think any useful purpose would be served by early information as to the death of their patients. However, the doctors available for interview included mostly doctors living in the immediate neighbourhood of the hospital and it is probable that they therefore got the information early in any case as they would be in personal contact with the hospital daily and sometimes even more frequently. As already stated, a very large majority of doctors in most areas would welcome this service with enthusiasm. It may be noted here that no automatic record is kept of a telephone conversation comparable with the carbon copy of a typed letter. If the telephone is to be used more than at present it might be a good plan to have brief written records kept of such conversations, but it must be admitted that such an ideal may be impracticable.

Hospital—General Practitioner Relationships

There remains the question of the general relationships between general practitioners, consultants and other grades of hospital medical staff. It is quite clear that these are better in rural areas than in urban ones and that they are least close in London. In small towns every consultant seems to know every general practitioner, in some cases quite intimately. In the larger towns the relationship seems to be much better than in Central London, where a consultant may only know personally about half the general practitioners who regularly refer patients to his clinic. Indeed, it is possible, in London, for a consultant to see patients

for a general practitioner for thirty years or more without ever meeting him. He will know his handwriting and perhaps his voice, but not his face. This is probably due partly to the very wide choice of hospitals in London which can result in a general practitioner having no specially close ties with one main district hospital. The possibility of the provision of club facilities for all doctors in an area, based on the district hospital, has been discussed with both general practitioners and consultants but it was not very enthusiastically received by the former—mainly on the grounds that such facilities would not, in their opinion, be very widely used except, perhaps, by those whose practices were fairly close to the hospital. It is not intended to give the impression that the suggestion met with universal hostility as quite a number of general practitioners were much in favour of it, especially if library accommodation were also provided. If such a system were put into practice, the regions would have to be carefully selected.

It is impossible to avoid reference to cottage hospitals when discussing relationships because the establishment of personal contacts is a function of such hospitals which is universally recognised. The terms of reference do not permit the discussion of the other aspects of general practitioner hospitals but it would be fair to say that a very large majority of general practitioners and consultants who have had experience of such hospitals hold the opinion that they go a long way towards improving relationships and fostering the sort of professional and social co-operation which leads to the highest standards of general and consulting practice.

Finally there is the question of "open" departments for pathology, X-ray and other ancillary investigations. These facilities seem now to be widely available at non-teaching hospitals but less so in teaching hospitals, and least of all in London teaching hospitals. The fact that the London teaching hospitals are unwilling to throw open their departments to the local practitioners may have something to do with what appears to be the lower standard of general practice in the areas served by such hospitals in London. It is feared by consultants that the service would be abused, although this is certainly not the experience of provincial hospitals where the services are available, in most cases without restriction. It is not intended that the reference to general practitioners in the environs

of teaching hospitals should imply that there are not many excellent doctors practising in these areas, although it does seem to be the general impression that there is a higher proportion of the less satisfactory type of practitioner in these parts of London and possibly in other large industrial towns with medical schools. It would be fair to say that the open department is almost universally wanted by general practitioners, who readily agree that some limitations may be necessary. It is pointed out with some truth that if X-ray and pathology were freely available, the number of out-patients would be considerably reduced.

Domiciliary visits greatly help in improving personal relationships and seem to be a very popular feature of the Health Service both with general practitioners and consultants but this aspect is, of course, nullified if the general practitioner is not present at the consultation. This does not often happen and, when it does, it is usually in the densely populated urban districts and at times of great pressure of work.

Conclusion

In conclusion, it may be stated that the general state of communications and relationships has turned out to be better than was anticipated before the survey was undertaken, but it is clear that there are a good many defects which could be put right. On the other hand, it must be recognised that many failures in communications depend on human factors which cannot be eliminated and such human factors operate both in hospitals and general practice. Although there are now more well trained and competent consultants than there were before 1948 the personal qualities, which are so necessary for the maintenance of high standards of relationships and communications, are not always those to which importance is attached in making hospital appointments. It must also be remembered that although students now often have some instruction by general practitioners, and many work for a time in a practice before qualifying, the view taken of general practice as a career and of general practitioners as doctors is often formed when the student's only medical contacts are his teachers—consultants or aspiring consultants. A number of senior students and junior house officers have been interviewed with a view to finding out what opinion they

formed of general practice and of general practitioners in general during their student and subsequent career. The answers, as may be imagined, varied greatly, but the impression was gained that teachers tended to stress the defects rather than the virtues of general practitioners. Young house officers may therefore assume their first offices rather suspicious of the abilities of the doctors who send them patients, and with little insight into the difficulties and problems of general practice. In some schools all students are obliged to spend a few weeks in their final year attached to general practitioners, thus gaining an appreciation of the conditions under which they work and of the problems with which they are faced. The fact, already alluded to, that there seems to be a larger number of practitioners of poor quality in the neighbourhood of teaching hospitals than in other areas, tends to encourage in house officers a rather hostile and suspicious attitude as they have frequent contact with such doctors (who tend to abuse the hospital service) and their view of the whole field of general practice may be distorted by the deficiencies of a very few. Moreover, the junior house officer is not often encouraged to get in touch with his patient's doctor for information which only the latter can supply and which may be of great importance in the management of the case. The young doctor on a hospital staff has a tremendously important part to play in the general relationship between hospitals and general practitioners and their training should certainly ensure that they not only have some knowledge of the conditions of general practice but that they also have inculcated into them the qualities of tact and courtesy which are so necessary in public relations generally.

General Suggestions

There follow some suggestions which, if followed, should help to improve the communications which have been the subject of this survey. It is recognised that many of them are already in operation but by no means all of them are universally followed.

In the case of Out-Patients

(1) Absence of consultants from out-patient clinics to be notified in advance to general practitioners when appointment made.

(2) Telephone and internal communications in every hospital to be equal to the demands made on them; it should be possible

for a general practitioner to contact an individual doctor within minutes, or to be told when and where he will be available.

(3) Letters from general practitioners always to include treatment already given and, in appropriate cases, some indication of social background.

(4) The consultant and general practitioner to decide between them who is to have "overall care" while the patient is attending hospital.

(5) Consultants to make sure that their reports on out-patients are also replies to the general practitioners' letters; these letters should be re-read before dictation of the reply.

(6) In the case of a deputy seeing a patient with a letter addressed to an individual consultant the reason to be stated; and the deputy to indicate his status and qualifications.

(7) A routine to be adopted whereby general practitioners are informed of action taken when a patient is referred by a Local Authority; also when patients are referred to another department of the hospital.

(8) All medical secretaries to be personal secretaries to one or more consultants and to have responsibility for seeing that breakdowns in communications do not occur.

(9) Some notification, however brief, to be sent to general practitioners in the case of casualties.

(10) Free access to all special diagnostic departments (X-rays, pathology, etc.) to be available to general practitioners.

(11) Although this suggestion is outside the scope of hospital administration it is felt that consideration might be given by the Ministry to the problem of making secretarial assistance for general practitioners more easily available.

In the case of In-Patients

(1) General practitioners to be routinely notified of all admissions.

(2) List of patients in hospital wards to include the name of the patient's general practitioner.

(3) General practitioners to have access to their patients and to their hospital notes at all times, within reason.

(4) All deaths to be notified by telephone to the general practitioner as soon as practicable after the event but written confirmation to be sent also.

(5) Interim reports to be sent in appropriate cases; in this connection operation findings are particularly important.

(6) The short discharge form to be sent off the day *before* the patient's discharge; and the form to include the clinical condition of the patient and the amount of any drugs taken out with him.

(7) Full summaries to be prepared by the most senior officer possible and sent off not later than one week after the patient's discharge.

(8) More discretion to be applied to the routine giving of out-patient appointments to patients on discharge.

(9) As in the case of out-patients the personal secretary to assume responsibility for seeing that all necessary correspondence is dealt with expeditiously.

Medical Students

The training of medical students to include instruction in the proper relationships between hospitals and general practitioners.

General Relationships

These to be fostered by meetings between hospital doctors of all grades and general practitioners at both professional and social levels, including postgraduate courses for local doctors. Much is done by B.M.A. and other society meetings. The possibility of establishing "Medical Centres" at large hospitals to be explored in the light of experience gained at those already in operation. Consideration might also be given to the place of cottage hospitals in fostering good relationships and high standards of practice.

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