COMMUNICATIONS BETWEEN GENERAL PRACTITIONERS AND HOSPITAL DOCTORS IN THE CANTERBURY AREA

REPORT OF A PILOT STUDY

by

J.M. Bevan, K. Sheridan Dawes
W. Hughes Jones, J. Jenkins

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Health Services Research Unit
University of Kent at Canterbury

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Summary

A study of the communications between the medical staff of the Kent and Canterbury Hospital and the general practitioners referring patients to this hospital was carried out by means of questionnaires addressed to the doctors concerned, and designed to elicit information about the channels of communication, the circumstances surrounding such communications and their timing in relation to significant events. The postal questionnaire approach resulted in a good response from consultants, a fair response from general practitioners and a disappointingly poor response from junior hospital doctors.

Methods, speed and nature of communications were found to be related more to personal decisions than to any policy of the hospital or the specialty. Even the usual time taken for letters to go through the post, particularly by second class mail, resulted in information being received too late, in the opinion of some of the general practitioners.

Most family doctors in the survey appeared generally satisfied with communications from the hospital though considerable concern was expressed about the communications in respect of the discharge or death of an inpatient. Many consultants felt the state of communications between the hospital and the general practitioner to be less adequate than they would desire and attributed the shortcomings primarily to the lack of secretarial assistance.

The study confirmed the findings of other studies carried out over the past decade and it is recommended that experiments to eliminate the deficiencies commonly found in the hospital/general practitioner communications system should now take place. In particular, more importance should be attached to discussion of communications problems and proposed changes between hospital doctors, administrators and family doctors. Newly appointed junior hospital doctors should be familiarised with current procedure in the hospital; the use of modern dictating and recording machines as well as a return to personal secretaries should be more thoroughly examined.

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1. Introduction

This enquiry arose out of a letter, dated 9th April, 1969, from Mr. J.B. Cornish of the Department of Health and Social Security to one of us (J.M.B.). Mr. Cornish asked whether the passage of all forms of clinical information between hospital and general practice (and vice versa) would be a feasible subject for the research team then in existence in the Faculty of Social Sciences at the University of Kent at Canterbury.

Subsequent discussion indicated that delays in the communication of items of information between hospitals and general practitioners were of concern to the Department - particularly where they related to the discharge of patients from hospital. It was agreed that the research team should mount a pilot survey based on the Kent and Canterbury Hospital.

The study had as its object the identification of the channels of communication existing between the medical staff of the hospital and the general practitioners whose patients used the hospital. The intention was to discern the circumstances in which communications took place and to investigate the methods used. It was also proposed to make some assessment of the effectiveness of the communications, arrangements and customs observed - if only by ascertaining the degree of satisfaction with which they were viewed by the doctors involved.

The project took the form of a series of postal surveys addressed to all consultants and other full-time medical hospital staff working at the Kent and Canterbury Hospital and all family doctors practising in a broadly defined catchment area of the hospital.

The study, within the limits of the methods of enquiry used, thus sought to provide a comprehensive picture of the arrangements for, and customs relating to the communication of clinical information between the hospital, medical staff and family doctors in the catchment area, as seen by the doctors involved. It is important to bear in mind, however, that what follows is the report of a pilot study - a major aim of which was to establish the feasibility of the general approach adopted and to test the adequacy of the research techniques and documents used.

Some preliminary work took place in the first half of 1970. During this period, the approval of the medical committee of the Kent and Canterbury Hospital was obtained for an approach to be made to the doctors it represented, and an examination of the literature on hospital/general practitioner communications was commenced. Work also commenced on the development of the questionnaires to be used in the study.

The Department formally notified the University of its intention to provide financial support for the study in July 1970, and the research associate (W.H.J.), working on a half-time basis on the project took up her appointment on 1st July 1970.

The remainder of the year was mostly occupied with questionnaire development; field work took place during the period December 1970 - June, 1971.

2. Hospital/general practitioner communications - some preliminary remarks

A patient's contact with the hospital service in respect of a particular spell of illness may at its simplest, be confined to a single attendance at an outpatient clinic. It may, however, be a much more complex matter involving one or more outpatient attendances or a consultant may make a domiciliary consultation in the home of the patient, followed by a spell as an inpatient in one or more hospitals and/or parts of a particular hospital - perhaps including operations or other special procedures. The patient may then be discharged from the ward but continue attending the outpatient department of the hospital.

The flow chart (Diagram 1) indicates various possible sequences of contacts with the hospital and specialist services which a patient may follow in the course of a spell of illness - from the time he seeks medical advice from the general practitioner until the conclusion of any hospital treatment or until his death. Communication between the hospital and the general practitioner (or vice versa) may at least in principle, occur whenever the patient moves from one contact or event in the system to another.

To appraise the effectiveness of a communications system such as that linking hospitals and general practitioners, one must consider how far it serves the information needs of the complex which it serves. Each participant in the information system requires certain information from other parts of the right

sort at the right time and in the right place - primarily in order to provide timely and effective care to their patients. The working of the information system has, however, to be considered in the context of the other activities of the complex.

Most of the participants will be concerned with providing information and they will be anxious that this process should not become excessively time-consuming or stressful. Conflicts of interest may arise as one individual may not accept the stated needs of another. Indeed, he may not think it expedient to provide the information required - knowledge is a prerequisite of power, or at least independence.

The objective of the communication system under consideration is, therefore, a matter of establishing reasonable standards and resolving conflicts - of aiming at a stable equilibrium which fulfils as much as possible of everybody's needs or at least the 'justifiable' needs of everybody who 'matters'. This involves, to some extent, a subjective assessment of priorities in two respects, the perceived needs of the person receiving the information and the resource outlay and wants of the person supplying the information.

Except in the case of some emergency admissions or attendances at casualty departments, the general practitioner will initiate the sequence of contacts with the hospital by requesting an appointment for a patient at an outpatient clinic or by asking that a patient be admitted directly as an inpatient. Such a request will normally be accompanied or followed by a communication to the appropriate hospital clinician of such clinical information as the general practitioner thinks appropriate.

Where the contact is confined to one or more outpatient attendances, the patient will remain more or less entirely in the community and may also be seeing his general practitioner about the same spell of illness, either for treatment in conjunction with what is being done in the hospital or simply for explanation about what is happening. In either event, the general practitioner will need certain information in order to provide treatment and/or explanation, especially at the conclusion of the sequence of contacts with the hospital when the patient has returned to his sole care.

Where a domiciliary consultation takes place, the general practitioner may be present (this involves communication to fix a mutually convenient time for the consultant and general practitioner). Whether or not the general

practitioner is present, he will wish to hear of the findings of the domiciliary consultation.

Where a decision is taken to place a patient's name on the waiting list for admission to hospital following an outpatient attendance, the general practitioner will, presumably, wish to know in good time when the admission is likely to be. He will also need to be acquainted with the plan of action proposed for the inpatient spell in order to prepare the patient and/or his relatives (the same will be true in the case of direct emergency admissions). Once in the hospital, the general practitioner will wish to be kept informed sufficiently to perform his duty as a family doctor to that person. Where treatment proceeds according to plan, he may not need information whilst the patient is in hospital but he may wish to be informed of any unexpected transfer of the patient to another specialty, of complications or transfer to another hospital, to keep the patient's family informed and to prepare a plan of action when the patient is discharged from the hospital. The general practitioner will wish to know of the discharge of his patient from hospital and will generally require information about various aspects of the patient's care provided by the hospital. He will require to be informed at the earliest opportunity if one of his patients dies in hospital.

In most sequences of hospital contacts, the general practitioner initiates the associated exchange of information at or about the time he requests the hospital or specialist service to take some action in respect of his patient and he may provide further information by way of elaboration or elucidation as the hospital treatment proceeds.

The flow of information back from the hospital to the general practitioner may be related to one or both of two of the latter's functions. It firstly may be necessary to the general practitioner's purely clinical activities as, for example, when he resumes treatment on discharge of a patient or undertakes treatment in collaboration with the consultant. In these circumstances failure to receive relevant information in good time may prejudice the patient's health in an obvious way. The general practitioner, however, also has the role, as the patient's personal physician, of explaining what is going on to the patient or his family and in comforting or sustaining them, especially in the case of the patient suffering from life-threatening or distressing conditions. To do this job properly, he needs to be kept sufficiently in the picture in a timely fashion about the hospital's treatment (and its expected outcome for his patient). Though, in many

cases, absence of information may not so much directly hazard the patient's health as inhibit the general practitioner's capability to relieve unhappiness and plan constructively for the future of the patient and his family.

It is clear that it is no easy task even to describe the informal and formal communications existing between hospital doctors and general practitioners let alone evaluate any particular set of arrangements other than in a fairly primitive manner.

In the "Report on communications and relationships between general practitioners and hospital medical staff" (Shaw 1963), a number of possible assertions and recommendations were made, the report being based on the cumulative experience of general practitioners and hospital doctors rather than on factual data, but serves to pinpoint areas of difficulty.

Considering the accepted importance of the subject of communications, a surprisingly small number of studies have examined aspects of hospital/general practitioner communications. Some have done this as part of much wider ranging investigations of medical care, e.g. Cartwright (1964), and Forsyth & Logan (1968); some surveyed consultants e.g. De Alarcon & Hodson (1964), and others surveyed general practitioners e.g. Wessex Regional Hospital Board (1964). Other studies which concentrated on the receipt of information about patients discharged from hospital e.g. De Alarcon, de Glanville & Hodson (1960), Evans & McBride (1968), and Lockwood & McCallum (1970), and one looked at communications after outpatient attendance (Ross, Carmichael & Stevenson (1963)).

Most of these studies have been concerned to some extent with the quality of communications, usually as judged by either the consultants or the general practitioners involved, but sometimes, as in the case of Forsyth & Logan's study, on the basis of an external assessment.

At the time the present study was mounted, what seemed to be lacking was a study in which both hospital doctors and general practitioners associated with a particular hospital were asked to describe and comment upon the speed, method of transmission and quality of communications associated with the various clinical events which might give rise to the exchange of information (i.e. looking at the same situation from a number of different viewpoints).

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3. The Study - a description of its setting and the methods used

The Study took the form of three surveys, one addressed to each of the following groups of doctors: (i) the consultants rendering services at the Kent and Canterbury Hospital, (ii) non-consultant medical staff of this hospital and (iii) the general practitioners in and around Canterbury who were thought likely to refer at least some of their patients to the Kent and Canterbury Hospital. This district general hospital is located at Canterbury and, at the time of the study had 336 acute beds, the specialties represented at the hospital were as indicated in Table 1. A list of all hospitals in the area is shown in Table 2.

The group of general practitioners approached comprised those principals, shown in the lists of the Executive Council for South-East London and Kent, as practising in the following areas: the City of Canterbury, Eastry Rural District, Sandwich Borough, Bridge/Blean Rural District, Ashford East Rural District and Elham Rural District, Faversham, Herne Bay and Whitstable. The total area included in the survey therefore extended to the coast and inland to about 12 - 15 miles from Canterbury excluding any urban areas in which a sizeable general hospital was situated, (see map). Deal was excluded, however, because the route to Canterbury was somewhat long and indirect, when compared with that to the major general hospital at Dover.

The questionnaires (see Appendix) addressed to all three groups were concerned with why, when and how communications took place between hospital doctors (consultants and others) and general practitioners in connection with outpatient consultations, inpatient admissions, the progress and discharge of inpatients and domiciliary consultations. Those approached were also invited to comment on the effectiveness of the various aspects of the communications process. The consultants and hospital doctors were asked for certain basic information about the size and workload of, and secretarial support for, the units in which they worked. Analogous information about their practices was sought from the family doctors approached. As far as possible the wording and format of the questions used were the same in the three questionnaires to facilitate the comparison of the impressions of the three groups of clinicians concerned with hospital and general practitioner communication. It was stressed throughout that the survey related to outpatients and inpatients treated at the Kent and Canterbury Hospital only.

The front page of the questionnaires addressed to consultants and other hospital doctors stressed (i) that the study was in the nature of a feasibility exercise; (ii) that where information such as the workload of a unit was requested it was accepted that answers would generally be rough estimates of magnitude only; (iii) that any answers given by individuals would be treated as confidential. Certain definitions of terms used in the questionnaire, such as 'routine' were also given.

Accompanying the questionnaire in the initial distribution to consultants and other hospital doctors were (a) a copy of the Standard Referral Form provided by the hospital to general practitioners for use in referring patients to the hospital (this was because a question was included on the value of this form to respondents); (b) a short introductory letter; (c) a stamped-addressed envelope.

The packages containing questionnaires and related material for the 32 consultants and 26 other hospital doctors involved were delivered to the Hospital Secretary[1] for distribution via the internal postal system of the hospital. This was done on 29th December, 1970. A first reminder was posted on 26th January, 1971 and a second reminder to consultants only, on 2nd April 1971. Because of the postal strike which occurred in early 1971 respondents were asked in the reminder to return their completed questionnaires in the envelope provided to the Hospital Secretary's office for collection.

The questionnaire addressed to the general practitioners did not contain a front page analogous to that used for the consultants and other hospital doctors. It was, however, accompanied by a somewhat longer letter of introduction which emphasized that the study's aim was to find out about general practitioners' experiences and views in connection with communications between themselves and the hospital. A Standard Referral Form and stamped-addressed envelope were also included with the questionnaire. The questionnaires and related material were posted to the 79 practitioners involved at the end of March 1971. The first reminder was despatched on 15th April. A final approach in the form of visits to the non-respondent general practitioners by one of us (KSD - a general practitioner himself) was undertaken in June/July, 1971 but this practice was discontinued after 12 visits as being too time consuming in a feasibility study although yielding 8 further completed questionnaires.

4. The response to the enquiries

(a) Consultants Twenty-two consultants (see Table 1) returned completed questionnaires. One of these was a replacement for a consultant who was originally approached but who retired on 31st December 1970 (i.e. just after the first approach). The latter was excluded from the count of those approached). Two other consultants who did not reply were found to have retired on 31st March, 1971. These are included in the number of those from whom no reply was received. One other of the consultants who did not reply apparently did not work at the Kent and Canterbury Hospital.

All specialties approached in the hospital except neurology were represented by those consultants who replied to the questionnaire. The average length of time since qualification of the consultants who replied was somewhat less than that for those not replying. All 10 consultants who did not reply had been qualified for 20 years or more, whereas only 13 (59%) of those replying were in this category.

(b) Junior Hospital Doctors The initial request for information to the 26 non-consultant medical staff followed by a reminder, yielded only 5 completed questionnaires and one refusal. As a result of the first reminder it was discovered that 4 of the doctors who did not reply were no longer employed at the Kent and Canterbury Hospital. The 5 respondents were drawn from the following specialties: obstetrics, urology, orthopaedics, surgery and radiotherapy. A second reminder was not sent to the junior hospital doctors who had not replied, for after consultation with consultants and the Hospital Secretary, it seemed that little would be achieved by pursuing further this rapidly changing group of doctors. The finding that this group of doctors did not appear to be strongly motivated to take an interest in communications was highly significant, for at least in respect of inpatients they play a major role in communications between the hospital and the general practitioners. They comprise a group of doctors who, in general, do not remain in one hospital for long periods of time and, in the case of the present study, appeared by their names to be of foreign extraction. These factors must have an important bearing on the efficacy of communications.

(c) General Practitioners Forty-five of the 79 general practitioners returned completed questionnaires (Table 3) representing between them 26 out of 37 practices involved. (In certain cases it was stated that one doctor had completed the questionnaire on behalf of the practice, though all practitioners were approached). The response from all 9 partners of a large group practice (Table 4), resulted in this practice producing one-fifth of all general practitioner responses. The age of the doctors replying as reflected by the years since registration suggested that they were typical, in this respect, of the population under study (Table 5). The doctors who responded also appeared typical in respect of number of principals (Table 3), number of patients in their practices (Table 6), and distance of their main surgery premises from Canterbury (Table 7).

The Representativeness of the Response Doctors - Summary

The consultants who replied tended to be younger than those who did not, but between them represented virtually all specialties to be found at the Kent and Canterbury Hospital. The general practitioners seemed typical of the population under study as far as years since registration, numbers of principals in their practices and patient list sizes were concerned.

It seems reasonable to conclude that the results obtained from the surveys of consultants and general practitioners may be fairly representative of the population under study, of which they constituted self-selected samples. At worst they constitute the response of majorities of the categories of doctors involved.

The handful of junior hospital doctors who completed the questionnaire cannot, of course, be regarded as representative. Their answers, however, are presented as the experiences and views of 5 relatively young individuals who are actively involved in hospital/G.P. communications.

5. Some characteristics of the respondents

(a) General practitioners

(i) Personal characteristics Forty-three out of the 45 respondents were male and just over half had been fully registered medical practitioners for less than 20 years, hence were probably less than 45 years of age.

Six had been registered for 30 years or more and so were almost certainly over 55 years old. Two-thirds of the respondents had been 10 years or more in general practice (Table 8), and, overall, three-quarters had entered general practice within 6 years of registration and 19 (24%) within 3 years of registration (Table 9).

(ii) Practice premises and secretarial/receptionist assistance

Forty-two of the 45 respondents practised from one main surgery. Just under half of these also worked from a branch surgery. The remaining three doctors practised from three premises.

The use of the word secretary in general practice is often used to describe a receptionist who by reason of her duties became involved in clerical work. For this reason it was decided to use "secretary/receptionist" to describe all clerical assistance employed by the general practitioner.

Forty-one doctors employed full-time secretary/receptionist assistance at their main surgery (that is, such assistance was available at all surgery sessions). One of the remaining 4 employed no secretary/receptionist staff at all in his practice - the remainder relied on part-time cover. Of the doctors with branch surgeries, 6 employed full-time help at these.

(iii) The role of the secretary/receptionist in practice/hospital communications

Just under half the doctors used their secretary/receptionist to type most of their outpatient referral letters and to telephone for most outpatient appointments. A further 8 used the secretary/receptionist to type outpatient referral letters; but only to a limited extent, if at all, to telephone for outpatient appointments.

Of the remainder, 6 did not use secretary/receptionists at all to type letters or telephone for appointments (Table 10).

(iv) The distance of the doctor's main premises from the Kent and Canterbury Hospital and the proportion of admissions and outpatient referrals which were made to the Kent and Canterbury Hospital

About one-quarter of the respondents practised within 3 miles of the Kent and Canterbury Hospital, but more than two-thirds lived 7 or more miles distant (27% ten miles or more distant) (Table 7).

All general practitioners who replied to the questionnaire referred some patients to the outpatient department of the Kent and Canterbury Hospital and almost three-quarters referred over 60% of their patients to this hospital (Table 11). We have used 60% of referrals to the Kent and Canterbury Hospital as the criterion for regarding the Kent and Canterbury Hospital as the doctors' main hospital because they were asked about all types of hospitals, including mental, so that they could not possibly refer all patients to the Kent and Canterbury Hospital (The question concerning referrals was designed in bands of 0, 1-19%, 20-39%, 40-59%, 60-79%, 80-100%).

As one would expect, those general practitioners whose surgery premises were located some distance from Canterbury tended to refer a smaller proportion of their outpatients to the Kent and Canterbury Hospital. The situation for admission to hospital of respondents' patients was almost exactly similar. Within a radius of 6 miles, all respondents mostly used the Kent and Canterbury Hospital. Beyond this circle, the proportion who mainly used the Kent and Canterbury Hospital dropped to just over one-half.

From information gained from the responding general practitioners' comments, it appeared that the nearest general hospital to the patient and/or practice was used except in special circumstances. The reasons given for referring patients to other hospitals may be grouped together in three categories:-

(1) The reputation of other departments or hospitals - usually the selection being that of the general practitioner's teaching hospital (mentioned by 17 doctors).

(2) The absence of appropriate local facilities (mentioned by 15 doctors) - almost always in conjunction with (1).

(3) Shorter waiting time for appointment (mentioned by 7 doctors).

The problem of communications was not mentioned by any of the respondents.

(b) Consultants

(i) Age and sex All but 2 of the consultants who replied were male. as mentioned earlier, 13 of the responding consultants had been fully registered for more than 20 years and of these 6 had been qualified for more than 30 years.

(ii) The 'units' within which the consultants worked The specialist units and their medical staffing are shown in Table 12.

(iii) Secretarial assistance Three consultants indicated that they had a personal secretary - the remainder shared a secretary with one or more colleagues in the unit, (as opposed to using a secretarial pool).

(iv) The consultant's outpatient workload at the Kent and Canterbury Hospital One consultant attended only one outpatient session every 2 weeks, whilst 11 attended 2 or more sessions per week (Table 13). The variation in attendance was seen both within and between specialties. The average number of patients seen in an outpatient session by respondents, as stated by the respondents in the questionnaire, ranged from 9 patients per session to 70 patients per session (Table 14).

(c) Junior hospital doctors Three of the 5 who replied were men, only one of whom appeared to be of foreign extraction, and all but one had been qualified for 5 years or more.

As more than half the non-respondents could not be traced in the Medical Directory 1972, we are unable to draw any firm conclusion about their date of qualification, in particular whether they largely comprised recently qualified doctors, although this probably was so.

Entry of a doctor's name in the Medical Directory is purely voluntary and is dependent each year on the ability of the editor to trace the doctor concerned. The high mobility of this group of young doctors increases the difficulty of contact.

The respondents described their positions and specialties as follows: Medical assistant in radiotherapy, Senior orthopaedic registrar, Surgical registrar, Urological registrar, Obstetric house surgeon. All indicated that they had the shared use of a secretary as opposed to having a personal secretary or having to rely on a secretarial pool.

Respondents working in Urology, General Surgery and Orthopaedics attended one or two outpatient sessions per week. The obstetric house surgeon attended four (ante-natal) sessions per week). The radiotherapist felt that he could not describe his outpatient work in terms of sessions per week and numbers seen. With the occasional exception of the urologist whose load per week was extremely variable, all the respondents saw on average at least 20 patients per session.

6. Results from the survey

In this section communications between general practitioner and the hospital and specialist services are considered under the following headings:-

(a) making appointments for outpatients attendances (b) the outpatient consultation and its immediate aftermath (c) admission to hospital (d) communications relating to inpatients whilst they are in hospital (e) death in hospital (f) communications relating to discharge from hospital (g) domiciliary consultations.

(a) Making appointments for outpatient attendances and the associated communication of clinical information

Delays in obtaining appointments and in admission to hospital may affect communications adversely. General practitioners were asked whether they experienced difficulties in obtaining appointments for patients in particular specialties in reasonable time. Eighty per cent of the respondents said they did.

It appeared that physical medicine, gynaecology and, to a lesser extent, general medicine and urology were the specialties in which delays were most frequently encountered (each of these was mentioned specifically by about a quarter to a third of those with difficulties and if one includes the blanket response of "all specialties" given by some respondents, the proportion goes up to between one-third and a half). Paediatrics, E.N.T. and dermatology were seldom mentioned in this context. Surgery, however, received favourable mention from 5 of those who had difficulties with other specialties. Broadly

speaking, just under one-quarter of the respondents experienced delays with most or all specialties, and a further quarter with several specialties (three or more). The remainder either had no difficulties at all or with only one or two specialties. These different experiences did not appear to be related to age of respondents, distance from Kent and Canterbury Hospital and extent of usage of the Kent and Canterbury Hospital.

Making contact by telephone with the hospital appointments clerk did not generally appear to present any difficulties to general practitioners in the study.

In general, how did the respondents make appointments for their patients to attend an outpatient clinic (other than for emergencies)? Table 15 shows the method most commonly used, by each of the general practitioners replying, to make appointments and convey related clinical information. The standard referral form appeared to be slightly more popular than the telephone.*

Most of the remaining doctors usually make appointments via a letter delivered by post. Of the 2 doctors giving other methods, one held a clinical assistantship in the hospital and delivered information and made appointments personally when at the hospital. The other general practitioner only "used" the Kent and Canterbury when his patients were transferred by consultants from the adjacent Thanet group of hospitals.

The method of making an outpatient appointment used by a general practitioner did not appear to be related to his age or number of years in general practice, nor was there any association between method of communication and the amount of secretarial/receptionist help in the practice, or the location of general practitioner, the extent to which he referred patients to the Kent and Canterbury hospital or whether he held a clinical assistantship at the hospital.

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* When the telephone was used clinical information was usually sent in a letter given to the patient for delivery at the hospital on the occasion of his outpatient consultation.

What factors did then affect the general practitioner's choice of method for making appointments? The standard referral form has obvious attractions from the point of view of economy and convenience. (They are issued free of charge by the hospital and pre-paid envelopes are provided on request.*) These were in fact almost invariably the reasons given for using the standard referral form. There were criticisms, however, especially of the revised form. Many thought the form had insufficient space for clinical information; and contained a section on personal details on the outside of the form which the patient had to complete - several doctors thought that the amount of such information required was 'ridiculous' and that some of it bordered on the offensive to the patient. One doctor mentioned that the new form was too flimsy for use on an electric typewriter and another that it looked very 'grotty' in patients' notes after sealing and opening again - a point also made by a consultant.

Telephoning for an appointment meant that the doctor knew when the appointment was going to be and could query long delays, especially if undesirable for the patient (7 doctors remarked about this). Arrangements could then be made to send up-to-date clinical information in a letter delivered to the hospital at the time of the outpatient consultation. A personal letter, as opposed to the standard referral form was used usually because the doctors preferred to be unfettered by the constraints imposed by the layout of a form; sometimes because they felt it was more personal. Two respondents stated that they had not received any standard referral forms.

Most consultants said that clinical information from general practitioners arrived by post. Approximately half of the consultants remarked that the general practitioners, with whom they were in contact, usually sent them a personal letter and the other half said that general practitioners usually sent a standard referral form. Personal (face to face or telephone)

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* A copy of the standard referral form in use at the hospital was enclosed with each questionnaire. These standard referral forms were issued to us by the hospital secretary, but it became obvious from telephone calls received and by subsequent comments on the questionnaires that a revised form had been introduced by the hospital. The comments from the general practitioners related to the standard referral form enclosed, to the revised standard referral form and to comparisons between the two forms. It was also commented that the revised form had been introduced without either prior warning or consultation with the general practitioners.

contact between the general practitioner and the consultant over referrals was not usual but in the psychiatry and radiotherapy specialties personal contact was involved in up to a quarter of referrals received. Consultants thought that the number of patients referred to outpatient departments without any form of clinical communication from the general practitioner was very small, and only one consultant believed the proportion of such patients to be as high as 10 - 15%.

The consultants were requested to state which method of conveying clinical information they preferred general practitioners to use. There was no marked preference either for standard referral form or letter and indeed many consultants did not answer the question.

Among the junior hospital doctors, one respondent thought that all clinical information from the general practitioner arrived by post. Two others thought that about half arrived by post and half by hand and one that nearly all such information came by hand. The remaining one said that the mode of delivery of written material was unknown to him. It may be, of course, that many of the consultants and other hospital doctors experienced difficulty in answering this question as they might receive written communications already removed from the envelopes in which they were delivered, especially in the case of the revised standard referral forms. As to whether the information was contained in a letter or the standard referral form, two thought that it came mostly by letter. Two thought that the letter and standard referral form were equally common and one thought that standard referral forms were mostly used. As with the consultants, the junior hospital doctors were agreed that virtually no patients were referred to them by general practitioners without any form of clinical information.

Four of the five junior hospital doctors preferred a letter to the standard referral form, only one preferred the latter. Generally the preference was not associated with explicit criticism of the standard referral form as used in the Kent and Canterbury Hospital. That is, standard referral forms in general were less acceptable to the respondents than were letters. The only explanation offered for the preference for letters was that the standard referral form "did not cover all types of information needed in a particular case" - though this may be a reflection of the amount of space allowed for an unstructured letter on the standard referral form.

(b) The outpatient consultation and its immediate aftermath Were patients seen by the consultant, as opposed to one of his staff, to whom they were referred by general practitioners who took part in the survey? In the case of general medicine and dermatology, the general practitioners thought that the patients were almost invariably seen by the consultant to whom they were referred. At the other extreme, in the case of obstetrics and gynaecology, there was thought by the general practitioners to be a high probability of patients being seen by someone other than the consultant to whom they were referred and in the case of general surgery and 'other' specialties, the general practitioners felt there was some chance of this happening. The reported experience of the general practitioners appeared to be unrelated to the number of years spent in general practice.

Since generally it will be the junior hospital doctor who sees new referrals if the consultant does not, how far does the experience concerning the number of first referrals they see correspond to the impressions of the general practitioners in the survey? The obstetric house surgeon appeared to see at least as many new referrals as the consultant obstetrician, thus corroborating the views of the general practitioners.* The surgical registrar who replied seemed to see relatively few new patients compared with the consultant surgeon, and indeed the orthopaedic senior registrar reported as large a volume of new referrals as the consultant. The urological registrar reported that he saw very few new patients. The medical assistant in radiotherapy stated that the arrangements for seeing patients could not be expressed in terms of a sessional basis.

An outpatient consultation at a hospital department may give rise to one or more of the following actions - the patient may be admitted to the hospital, put on a waiting list for admission, transferred to another specialty, asked to return for a second outpatient appointment or referred back to the care of the general practitioner. To what extent and in what manner were the general practitioners kept informed of decisions to take any of these actions?

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* It must be remembered that in many cases patients are referred to the obstetric department merely for booking for confinement, not for consultant opinion.

The consultants and junior hospital doctors were almost unanimous in the view that they informed the general practitioner when his patient was transferred to another specialty within one week of the relevant consultation. This impression was corroborated by the general practitioners - nearly half of whom indicated that they were not merely informed but consulted about such a decision. (Table 17).

In the case of patients admitted directly from the outpatient department, all consultants said that as a routine they informed the general practitioner while the patient was still in hospital (Table 18).

In the case of the junior hospital doctors, the surgical registrar said general practitioners were informed as a routine within 24 hours. The urological registrar and medical assistant in radiotherapy said they informed the general practitioners within 2 to 3 days, and a senior registrar in orthopaedics said this was done only after discharge. In the case of obstetrics the house surgeon stated that the general practitioner was only notified (and then within 24 hours) after a patient was admitted as an abnormal case following the first ante-natal attendance.

Of the general practitioners replying, about half felt that they were informed in the case of all specialties except 'other' within three days of a direct admission from the outpatients department. However, 8 to 10 doctors, in respect of each specialty, (i.e. about 20% of those replying) indicated that they were only informed after the discharge of the patient.

Nineteen out of the 22 consultants responding and 4 of the 5 junior hospital doctors (the fifth, the obstetric house surgeon, said there was no waiting list) indicated that they informed the general practitioner as a routine within one week when a patient of his was placed on the waiting list for admission. The general practitioners' answers supported this view. More than 80% of those who answered the relevant question agreed in respect of each specialty that they were so notified within one week of the patient being seen by the consultant or other hospital doctor. (Tables 19a and 19b).

Markedly fewer hospital doctors (consultants and other) and general practitioners replied that general practitioners were notified within a week of the fact that a second outpatient appointment had been arranged for the patient.

Again 19 out of 22 consultants and all of the junior hospital doctors replied that as a routine when patients were returned to the care of their general practitioners, the latter were informed within a week of the decision. Between one-quarter and one-third of the general practitioners (depending upon the specialty concerned), however, stated that they usually did not hear of this decision by the hospital doctors until more than a week at best from the relevant outpatient consultation. Nearly all the rest felt that they were informed in less than a week. No one indicated that they were not informed at all.

Thus, by and large, the great majority of general practitioners felt that they were informed fairly promptly (at least within a week) of a decision to take any of the actions discussed above. If there was an operationally weak link in the communications chain, it was in the case of notification to the general practitioner that his patient had been returned to his care.

The specialties listed by name in the questionnaire were regarded as following very similar procedures in respect of communications with general practitioners about matters arising from outpatient attendances. However, the 'other specialty' category was consistently rated worse than the names of specialties by the general practitioner respondents and this was supported by the answers given by the consultants to the same question.

How were general practitioners informed of decisions made at outpatient consultations other than direct admissions to hospital? Consultants, junior hospital doctors and general practitioners were virtually unanimous that the routine method of communication was in writing - though the telephone was predictably used sometimes with or without written communication, especially in the case of urgency.

The consultants and junior hospital doctors were asked whether a proforma would be of value for notifying the general practitioners of an admission direct from the outpatient department. Only 3 of the 22 consultants, and 2 of the 5 junior hospital doctors considered such a proforma would be of help. One of the junior hospital doctors commented that "it might obviate the oversight".

(c) Admission to hospital Almost all the consultants and junior hospital doctors indicated that as a routine they informed general practitioners within 3 days when a patient was admitted directly from the outpatient department. About half the general practitioners said they were informed within 3 days of such an event occurring. About one quarter of those replying to this question, however, heard only after the discharge of the patient (in the case of patients who were admitted for 3 days or more).

It must be remembered that even though the consultant or junior hospital doctor may dictate a letter immediately after seeing a patient, the process of conveying the information - typing, posting and delivering of the mail, may mean that several days elapse before the general practitioner receives the information.

The hospital secretary reported that a routine existed in the Kent and Canterbury Hospital for informing the family doctors when a patient was admitted from the outpatient department, and for telling general practitioners of an emergency admission. However, the situation in the latter case was in marked contrast to that for patients admitted directly from an outpatient department. Eighty per cent of the general practitioners replying to this question said they heard of an emergency admission only after discharge, and this applied to all specialties. Eight of the consultants, however, said they, themselves, informed family doctors as a routine while a patient of theirs was in hospital following an emergency admission; though 13 said they only informed the general practitioner after the discharge of the patient. In the case of the junior hospital doctors, only the medical assistant in radiotherapy indicated that family doctors were informed by him as a routine of emergency admissions. The house surgeon in obstetrics made the point that most emergency admissions in her specialty were in fact sent by the general practitioner. This consideration may explain the lack of communication to the general practitioner concerning emergency admissions of patients, though as the final decision to admit a patient is that of the hospital doctor, there would appear to be a need for notification to be made.

Turning to patients admitted from the waiting list, most consultants, junior hospital doctors and general practitioners were agreed that in all specialties general practitioners were not informed of an admission till after discharge.

This section suggests that general practitioners are likely to hear that a patient has been admitted directly from the outpatient department while the patient is in hospital but not likely to hear in the case of other admissions including the possibly important case of emergency admissions until after the discharge of the patient (for which there was said to be a routine procedure but hardly any of the clinicians seemed to be involved in this and the general practitioner certainly did not seem to get much information from whatever routine procedure was in operation).

(d) Communications relating to inpatients which take place whilst they are in hospital

Whilst the patient is in hospital, the general practitioner may wish to follow his progress. One way of doing this is to call at the hospital and look at the case notes of patients. Virtually all the general practitioners who answered the relevent question indicated that they had direct access to case notes in the case of all specialties.

However, a large number of doctors - between one-third and one-half, depending on specialty - did not answer this question, possibly because they had had no occasion to test the matter. Thirteen consultants stated that they allowed access to the case notes as a routine, five sometimes allowed access, and one refused access.

Four out of the five junior hospital doctors agreed that the general practitioners had access to case notes - one said that they never had free access to the notes, this being a specialty other than that of the consultant mentioned above.

The transfer of an inpatient to another specialty or hospital is something which will obviously be of interest to the general practitioner. About 80% of the general practitioners answering the question in the case of each specialty, felt that they were usually informed of such a transfer (Table 20). (It will be recalled that nearly all doctors felt that they were informed, if not consulted, when their patients were transferred to another specialty at the outpatient level). Twelve of the consultants said that they themselves usually notified the general practitioner of an inpatient transfer. Five said they sometimes did this and four that they never themselves took this action. Three of the junior hospital doctors said that they themselves usually informed general practitioners of inpatient transfers; one that he sometimes did and one that he never took this action.

Note that in the question put to the doctors, we did not distinguish between transfers within a hospital and those to other hospitals. Apparently, it is a routine at the Kent and Canterbury Hospital for the office staff to notify general practitioners if the patient is transferred to another hospital - since from the point of view of the hospital, the patient has been discharged.

Some of the comments of consultants and general practitioners indicated that the hospital doctors were more likely to inform the general practitioner of transfers to another hospital; for example, a rehabilitation or general practitioner hospital. However, there is no hospital routine for informing the general practitioner of an inpatient transfer within the hospital; this is left to the discretion of the consultant.

The general practitioners were asked whether, in the event of a decision to operate on one of their patients, following admission to the Kent and Canterbury Hospital for observation or investigation, they were informed of this before or soon after the operation. The majority of those replying were clear that they were not informed at any stage before discharge. Five thought that they were usually informed three days or more after the operation (but before discharge) but not as a rule any earlier. A number (up to 12, depending on specialty) believed that they were sometimes notified but only three days or more after the operation had taken place. The consultant surgeons concurred with the general practitioners in this matter in that they themselves seldom informed the latter about their intention to operate or of the outcome of such an operation before discharge. However, consultants occasionally contacted the general practitioner if there had been a post-operative complication which would require his attention when the patient returned to him. Of the four junior hospital doctors who replied to this question, one indicated that as a routine he informed the general practitioner two or three days after the operation - the others never (or at most sometimes) informed family doctors about an operation before discharge.

Concerning interim reports (other than those discussed above) relating to patients, the great majority of the general practitioners in the survey were of the opinion that they never received such reports, and only in two specialties did as many as eight (20%) believe that they were sometimes provided with interim reports on their patients' progress whilst in hospital. The consultants' and junior hospital doctors' answers supported this opinion.

From the comments of the consultants and general practitioners relating to this question, the impression was gained that a stimulus either in the form of an enquiry from the general practitioners or the need for further information on the part of the hospital tended to be a prerequisite for an interim report to be given to the family practitioner.

By and large it would appear that apart from inpatient transfers the general practitioner would probably receive no information on the progress of his patients prior to the patient's discharge or death.

(e) Death in hospital On the death of a patient, the normal practice is for a proforma to be sent by the office staff to the general practitioner. Subsequently, a houseman sends a handwritten note to the general practitioner giving clinical details. It can be seen from Table 21 that just under one half of the general practitioner respondents reported that they did not usually receive such a note from the hospital doctor. Furthermore, it appeared that occasionally general practitioners received no notification from any hospital source.

Four consultants felt that the telephone was the usual method used to notify a general practitioner of his patient's death, eight a letter from the consultant or junior hospital colleague, and seven a proforma (three others stated that the method varied with circumstances).

Of the junior hospital doctors, two said that a standard proforma was the method used as a routine for informing general practitioners; one a letter from a hospital doctor (other than himself) and one that doctors were notified by telephone. (One did not know, but thought that the telephone was used in special cases). (Table 22).

Table 23 shows the amount of time elapsing between the death of a patient in hospital and his general practitioner receiving any notification. Depending on specialty, 20-30% of the general practitioners heard within a day and about a further third heard within 24 to 48 hours; the remaining third did not hear of their patient's death for 2 days or more. Note - in the above discussion the number of "not answered" responses on the part of general practitioners varied between 3 in the case of general surgery and general medicine and 16

in the case of dermatology, (in each case out of a total of 45 respondents) presumably reflecting the general practitioner's experience (if any) of communication in the event of a patient's death from the respective specialties.

With regard to the evidence of a post mortem, under half of the consultants usually informed the general practitioner about this, and about the same proportion sometimes told the general practitioner. One consultant indicated that he never imparted post mortem evidence to a general practitioner. Consultants in the same specialty did not necessarily follow a consistent course.

Three of the five junior hospital doctors said that post mortem findings were sent as a routine to the general practitioners; one said probably never, though he was not sure, and one replied that he did not know.

The most significant result emerging from this part of the enquiry was that around 40% of the general practitioners answering the relevant part of the questionnaire usually did not hear of a patient's death for two days or more after this had occurred, and this appeared equally so for all specialties. Five doctors also reported that they were sometimes not informed at all.

Allowing for delays within the secretarial system and time for delivery by the post office, there is an inevitable delay of between 24 to 48 hours before any written communication is received by a general practitioner. A delay of 48 hours or more may well be regarded by general practitioners as very unsatisfactory from the point of view of their role vis-a-vis those bereaved.

(f) Communications relating to the discharge of inpatients from hospital

When a patient was discharged from hospital, most consultants (20) reported that a note was routinely sent by post to the family doctor (Table 24). Two consultants usually handed the note to the patient, and 4 other consultants stated that they sometimes used this method. Of the junior hospital doctors, 2 said that notes were sent by post as a rule; one that a note was sent by hand with the patient, and 2 said that they adopted various procedures including a note of some kind or a telephone call.

According to the consultants, the discharge note (defined in our questionnaire as "a short letter to the general practitioner at the time the patient is discharged") was usually written by the junior hospital doctor in half of the specialties involved. Otherwise the consultant wrote the letter, except in chest diseases and dermatology where it was the ward sister who wrote the discharge note. In obstetrics and gynaecology, the ward sister and the junior hospital doctor were said to combine in writing the note. The junior hospital doctors, in respect of their own specialties, confirmed the opinions of their consultants.

Eleven consultants in 9 specialties said that the discharge note was written on the day of the patient's discharge. The remainder reported that the note was written 2 to 3 days following discharge. Two of the junior hospital doctors said that the discharge note was usually written on the day of discharge; one that it was usually written 2 to 3 days after discharge and 2 stated that the interval elapsing before a discharge note was written varied according to circumstances - for example, workload of secretarial staff or how hard pressed the house surgeon was, or how important was the case.

Among the general practitioners responding, 41 doctors (90%) felt that they were usually informed of patient's discharge from hospital by post, though 37 thought that the telephone was at least sometimes used and 28 that the notes were at least sometimes sent by hand with the patient. Just under half reported that they usually received a discharge note within 2 or 3 days of the discharge in the case of general medicine, general surgery and E.N.T., compared with between one-quarter and one-third in respect of gynaecology and obstetrics and dermatology and "other", (Table 25). In the case of all specialties except obstetrics, virtually all the remainder of those replying said they usually heard within two weeks. In obstetrics, however, 18% said they did not usually receive notification of a patient's discharge

for more than 2 weeks after the event. As the length of stay in hospital following confinement is usually predictable and the district midwife is informed of discharges after delivery, the obstetric unit may feel that adequate notification has been given. Sometimes the general practitioner had been informed of a patient's discharge by the relatives, the patient or the district nurse before the discharge note had arrived.

The general practitioners were asked whether the discharge note gave adequate information about a number of aspects of the patient's care in hospital and his needs once discharged - namely, the patient's clinical condition; treatment in hospital; quantity and types of drugs and/or dressings given to the patient on discharge; recommended treatment and return visit to hospital.

In the case of each of these aspects (see Table 26), about a half of the family doctors felt that the discharge note **usually** gave adequate information. Though there was little difference in the replies covering each aspect, it appeared that the general practitioners were marginally less satisfied as to the adequacy of information on patients' clinical condition and hospital treatment than they were about more "practical" matters which might have an immediate bearing on the future care of the patient - that is, further treatment recommended, drugs and dressings given and return visit arranged. In the case of each individual aspect, between 5 and 7 general practitioners expressed the opinion that the discharge note never gave adequate information, only one respondent being wholly dissatisfied with the discharge note; the remainder said it sometimes did. More generally the comments of the general practitioners on this subject suggested that there was a good deal of dissatisfaction about notification of discharge. Criticisms ranging from legibility to incompleteness. A few made suggestions as to how the situation might be improved, e.g. by using a structured discharge note, sending a note with patient on discharge or merely by typing the note.

The general practitioners were asked in a further question, whether they were notified if a patient had to make more than one return visit to the hospital after being discharged from the ward. Between one quarter and one third, depending on the specialty, thought that they usually were, but almost one-quarter in the case of each specialty said that they were in fact never informed about this matter.

Generally, with regard to return visits to hospital by the patient, it seemed to be accepted by the general practitioners that further communication was not necessary on the part of the hospital for routine follow-up visits. Clearly, sometimes general practitioners did not know whether their patients were receiving hospital treatment.

The general practitioners were asked to estimate the proportion of patients who failed to return to them after being instructed to do so when discharged from hospital. About two-thirds of the doctors thought that the proportion was less than 20% and most of the rest that it was between 20 - 40%. Two suggested that the figures might be as high as 80 - 100% (similar figures to these were also given for discharges from outpatient departments and from the accident centre).

The discharge note (or telephone call) serves to alert the general practitioner to the fact that his patient has been discharged from hospital and ideally at least should enable him to take appropriate action in the period immediately following discharge. A fuller report of the patient's stay in hospital - a clinical summary - is however, usually sent to the general practitioner in due course. Four of the consultants indicated that the discharge summary was usually completed by themselves; 13 that it was usually completed by another hospital doctor. Apart from the two psychiatrists, the consultants who wrote their own discharge summaries were a different group from those who usually wrote their own discharge notes .

There were exceptions to the procedure of writing a discharge note followed by a discharge summary. One consultant wrote a letter which replaced both note and summary; one consultant said that he did not write summaries and 2 others said that they did not do so for routine cases. Among the junior hospital doctors, 2 observed that the discharge note and summary were the same document and the other three that it was, as a routine, either completed by a junior hospital doctor (himself or someone else) or a consultant.

Over half the consultants (12) and 3 of the junior hospital doctors (including one who said a discharge note and summary were the same documents) said that summaries were written within a week and correspondingly about two-thirds (31) of the general practitioner respondents said that they

usually received the clinical summary within 2 weeks of the discharge of the patient. Delays however, were not infrequent. Five general practitioners reported that they sometimes waited more than 3 weeks for discharge summary. The general practitioners accounted for this by the pressure of work on junior hospital doctors, the frequency with which they change, and their lack of secretarial services. Some departments were specifically criticised for delays. Obstetrics/gynaecology and paediatrics were each mentioned by 6 general practitioners (including 3 who mentioned both specialties). Sometimes obstetric summaries did not arrive apparently in time for the post-natal examination (circa 6 weeks after delivery) and one doctor complained that paediatric summaries could take 3 months).

General practitioners were asked how adequate were the clinical summaries with regard to information about the following aspects of the patient's care: the patient's clinical condition, treatment received in hospital, quantity and type of drugs and/or dressings given to the patient on discharge, treatment recommended and return visits to hospital.

More than two-thirds of the general practitioners reported that they usually found the information on clinical condition and further treatment recommended adequate. Slightly fewer (but still about two-thirds) found the summary provided adequate information on drugs and dressings given and return visits arranged, (Table 27).

Information on hospital treatment was least likely to be regarded as adequate and it was in respect of this aspect only that any respondent declared himself never satisfied with the information provided. (5 were in this situation).

Generally, about half the general practitioners did not usually appear to receive any notification that the patient had been discharged until 3 days or more had elapsed and very possibly the patient called to see them; (which the great majority of people were believed to do at some stage, at least, when advised to do so by the hospital authorities). The answers of the consultant and other hospital doctors suggested that they were conscious of the size of these delays if not their consequences to the general practitioner. Even when the discharge note arrived, only about half the doctors thought it usually gave adequate information on the care, past or proposed, of the patient. By contrast, the fuller clinical summary, which

appeared usually to arrive within a fortnight of the patient's discharge, was judged rather more favourably by the doctors as to the adequacy of the information it contained. Delays which were of concern to to the general practitioners were mentioned in respect of obstetrics and paediatrics; (in obstetrics this feeling seemed to be at variance with the information in the replies of the junior hospital doctor and the consultant).

Generally, the survey suggested that there was, on the part of the general practitioners, considerable interest in, and concern about, the quality and timing of information relating to the discharge of their patients from hospital.

(g) Domiciliary consultations

A domiciliary consultation under the National Health Service consists of a visit to the patient's home by a consultant at the request of the general practitioner in order to advise on the diagnosis and treatment of a patient who is considered by the general practitioner to be incapable of attending as an outpatient but does not require admission to hospital.

The attendance of the general practitioner on these occasions is not obligatory, but the domiciliary consultation does allow face to face communication between the consultant and the general practitioner about a patient and his illness.

Considerable variation was found in the number of domiciliary consultations carried out by different consultants, both within and between different specialties. Less than one domiciliary consultation per month was carried out by 9 of the consultants; one per week was carried out by 8 consultants and 2 per week by the remaining 5 consultants.

Variation was also observed in the proportion of domiciliary consultations at which the consultants reported the general practitioner to have been present. Seven consultants stated that they were always or nearly always accompanied by the general practitioner when making domiciliary consultations, while at the other extreme were eight consultants who were never or only rarely accompanied by the general practitioner. The remaining consultants were in an intermediate position in this respect. Differences were observed within specialties, in fact in one specialty one of the consultants stated that he was accompanied by the general practitioner at 75% of domiciliary consultations whilst his colleague in the same specialty was only accompanied on 5% of occasions.

These impressions were to some extent at variance with those of the general practitioners in the survey (Table 28). For example, whilst 25 of the 39 general practitioners answering the relevant question said that

the general surgeons never made a domiciliary consultation without their being present; 3 said this frequently happened and 11 that it sometimes did. The general practitioners moreover felt that a very similar situation obtained in the case of three other specialties. The consultants in these specialties reported varying practices.

The general practitioners were asked to give their reasons for not accompanying the consultant on a domiciliary consultation and of the 27 replies received, 16 stated that it was sometimes difficult or impossible to arrange a mutually convenient time and 6 stated that the consultants were unable to specify a particular time for the consultation. Four general practitioners gave the preference of the consultant to consult the patient alone as the reasons for the practitioners' non-attendance and one general practitioner merely stated that he only requested 7 domiciliary consultations a year and was not usually present. The general impression received was that general practitioners were perfectly content that some domiciliary consultations should take place, especially those relating to non-urgent problems, without the general practitioner being present.

The general practitioners and the consultants in the sample were asked to state the methods of communication used by the consultant to inform the general practitioner of the outcome of a domiciliary consultation in those cases when the general practitioner was not present. The replies are shown in Table 29.*

The general practitioners were somewhat more likely to regard communication by letter, as opposed to telephone or other personal contact, as the usual method of conveying information in these circumstances - however, it was clear that in this situation, communication by telephone or personal contact was rather more common than was the case for exchanges of information in relation to other forms of, or stages, in hospital and/or specialist care.

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* No evidence was elicited concerning the possibility of further communication occurring if domiciliary consultations had taken place with the general practitioner present.

(h) General comments of respondents

The three groups of doctors were asked if they had any comments to make on any aspect of hospital/general practitioner communications.

Replies to this question came from 22 of the 45 general practitioner respondents, and in general there appeared to be a favourable impression of the communications system. No single respondent appeared to be dissatisfied with every aspect of the system, nor was there an obvious group of general practitioners who were more critical than the others. A typical comment was "By and large our communications with the hospital are fairly good".

Criticisms were usually related to the discharge of inpatients from hospital, e.g. "It would be a great help if patients or their relatives were given a letter to the G.P. from the house officer on discharge from the wards. After all, patients frequently take communications from the G.P. to the hospital. General office information is particularly misleading and a great waste of money except that one does at least know a patient has been in hospital. I find it particularly difficult when patients are receiving drugs and clinical information is not available within a week. This causes great frustration in my office as the secretary has to spend a long time on the telephone trying to obtain information".

As mentioned earlier in the report (see P. 29) the section of the questionnaire dealing with the discharge of inpatients provoked a considerable response from the general practitioners and was a subject about which the general practitioners expressed most interest and concern.

The replies to this request for comments from the consultant respondents were rather different in that they expressed somewhat less satisfaction with the system:- e.g.

"Communications are often inadequate and take too long.

(1) Telephone calls take no longer than writing a letter
(2) Medical secretaries are too few and too busy
(3) Letters may wait 24 hours before signature
(4) There are no facilities for immediate dictation on ward rounds and in operating theatres
(5) Economically it is unreasonable to report by letter every operation and complication to G.P.
(6) Much of the criticism we get from G.Ps. occurs when our routine procedure breaks down"

Whereas no mention of personal communication was made in the comments from the general practitioners, this aspect was the subject of four consultants comments:- e.g.

"Direct, personal doctor to doctor communication desirable. This is possible:-

(a) through a weekly case conference to which all G.Ps. are invited

(b) meetings and meals at Post-graduate Medical Centre

(c) improved personal contact between specialties

(d) on domiciliary visits it is preferable for G.Ps. to be present more frequently "

Only two of the five junior hospital doctors made comments, one of whom suggested that "much greater trained secretarial help for all is required", while the other commented on the good communications which existed when ante-natal care was shared between the hospital and the general practitioner, and went on to say, "otherwise he (the general practitioner) is only informed in cases where help is needed from him in the care of a patient".

Discussion

Most general practitioners in the survey appeared reasonably satisfied with the communications system though there was widespread concern about the arrangements for providing information relating to the discharge of their patients from hospital. The consultants tended to view the system with less satisfaction and expressed concern at the lack of resources, particularly of secretarial assistance, which prevented them from providing the information service that they would have wished.

The general impression obtained was that the hospital doctors and general practitioners took a sympathetic view of one another's information needs. On specific aspects of the communication system, their reports as to what they believed normally happened were, broadly speaking, compatible - the main area of apparent disagreement being the time taken to communicate with the general practitioners following significant events. This may, however, be at least partly explained in terms of delays in the post.

The individualistic behaviour of consultants in respect of communication with general practitioners was a recurring theme of the findings; variations between consultants in the same specialty were found to be as great, if not greater than those found between specialties. This partially supports the findings of Forsyth and Logan (1968) who pointed out that wide variations existed within specialties though they considered that there were correlations between the specialties of different hospitals sufficient for the authors to conclude, "the relationship suggests a factor operating over and above the influence of each individual consultant and peculiar to that hospital's pattern of work".

As far as the general practitioners who responded to our questionnaire were concerned, most of their criticism was directed toward the timing of the notification of the discharge of inpatients. The necessity, in many cases, that the general practitioner be in possession of such information before the patient or the patient's relatives contact the general practitioner implies that it should be available as soon as possible after the decision to discharge. Almost all the consultants in our survey normally communicated this information by post which involves an inevitable delay before the general practitioner receives this information and this delay could be as much as one week after the consultant or other hospital doctor has dictated the letter. In the study by Cartwright (1964), 12 per cent of the general practitioners complained

that discharge information did not arrive soon enough and studies by De Alarcon (1960), Evans and McBride (1968) and Lockwood and McCallum (1970) reported that discharge notes could arrive at the doctor's surgery any time between twenty four hours and three weeks after the discharge of the patient from hospital. Lockwood and McCallum also stated that of their patients who had been discharged from hospital and made contact with the surgery, 22 per cent arrived before any communication had been received from the hospital. South and Rhodes (1971) noted in their study how rapidly the value to the general practitioner of the discharge letter dropped after forty eight hours. Eighty four per cent of the general practitioners in the study said it was very useful if received within forty eight hours but the comparable proportion was 41 per cent if it arrived four days after discharge. (This was a discharge letter for maternity cases).

The content of the discharge note gave rise to less criticism by the general practitioners who responded to our questionnaire. More than half considered the note gave adequate information about the clinical condition, treatment in hospital, further treatment to be carried out, whether return visit to hospital had been requested and what drugs had been given. Cartwright's study showed similar findings. Moreover, a greater proportion of the general practitioners who responded to our questionnaire appeared satisfied with the somewhat longer discharge summary. The delay in notification of the death of a patient in hospital was particularly noted by the general practitioners. These and other general practitioners complained of delays in communication by the hospital doctors when a patient ceased to attend outpatients.

The most important aspect of communications as perceived by the general practitioners in the study was that of their need to be supplied with appropriate information by the hospital when they resume the care of their patients. The general practitioner requires to have such information for the obvious reason that he must continue any treatment required but he also, as a family physician, needs to transmit information to the patient and his family.

In those circumstances where communication between the hospital and the general practitioner could occur, but where the hospital is continuing the care of the patient, little irritation appeared to be felt by the general practitioner at any lack of information. Thus, when a patient was transferred to another hospital or to another unit in the same hospital, the general practitioners appeared to be less interested in receiving information about such events at the time they occurred. The lack of information provided by the hospital

doctor to the general practitioner in cases of emergency admission was, however, of concern to the general practitioners who responded to the questionnaire.

Standard referral forms, for use by the general practitioners, were available for outpatient referrals. Both the hospital doctors and the general practitioners displayed some variety in their opinions as to the desirability of having a standardised format for such purposes. However, the introduction of a modified standard referral form by the hospital at the time of the survey without consultation with the general practitioners concerned was the source of some irritation to them, especially as the form was thought by some to be unsatisfactory, both in format and content.

In general, the survey appeared to confirm other studies particularly in respect of complaints by general practitioners about certain areas of communication. That these findings have been reported over a number of years without change suggests that the problem at the present time is not one of eliciting further detailed or more geographically widespread information but of implementation of measures to correct the already well known lacunae in the communication system and of monitoring such experiments as are devised to improve communications.

In respect of the feasibility aspect of the study, the method of approach by questionnaire appears to suffer from one serious disadvantage in that the junior hospital doctors who are specifically concerned with the major part of communications in respect of inpatients and their discharge showed a particularly poor response rate. This has been suggested as being a result of their high mobility and lack of identity with the hospital and to their infrequent contact with the group of general practitioners practising in the area of the hospital. The same factors seriously hindered their being integrated into the communications system and developing the necessary skills in this sphere, and suggest that more attention should be given to instructing them on matters relevant to the effective dissemination of information.

The somewhat unsatisfactory response rate of the general practitioners may have been partly due to the fact that they felt unable to provide adequate quantitative data of the kind requested, through lack of records and partly due to the complexity and length of the questionnaire. In over one quarter of the partnerships approached the questionnaires were completed by only some of

the partners. An attempt at interviewing the general practitioners who had not responded to the questionnaires was found to be extremely time consuming though quite profitable in terms of response. A few general practitioners were found to be, for various reasons, unavailable at the time of the interview or were unwilling to grant an interview because of shortage of time available. Among those who completed the questionnaires, most completed them fully except for some of the matrix type questions. Many doctors made helpful comments on the forms.

Recommendations

1. That further efforts to gain information about communications between hospitals and general practitioners are unlikely on their own to prove fruitful as a means of improving the system, as the problems inherent in the existing system are now well-documented and have remained unchanged during the period the various studies have been carried out.
2. Implementation of experimental schemes to improve the communications system should be instituted and monitored, for example:-
   (a) Representatives of the local general practitioners should discuss the problems identified in this study with representatives of the local consultants, junior hospital doctors and medical records officer. The reorganisation of the N.H.S. in 1974, through the district medical committee which contains representatives of the hospital and general practitioners should improve the facilities for concerted action on communications.
   (b) Junior hospital doctors should, as part of their introduction to a new hospital receive instruction concerning the needs for and the methods of communication of relevant information between hospital and general practitioners.
   (c) Further experimental studies, not only in the use of telephone answering machines and other automated facilities, but also in the personal allocation of secretaries to consultants could be carried out.

Summary

A study of the communications between the medical staff of the Kent and Canterbury Hospital and the general practitioners referring patients to this

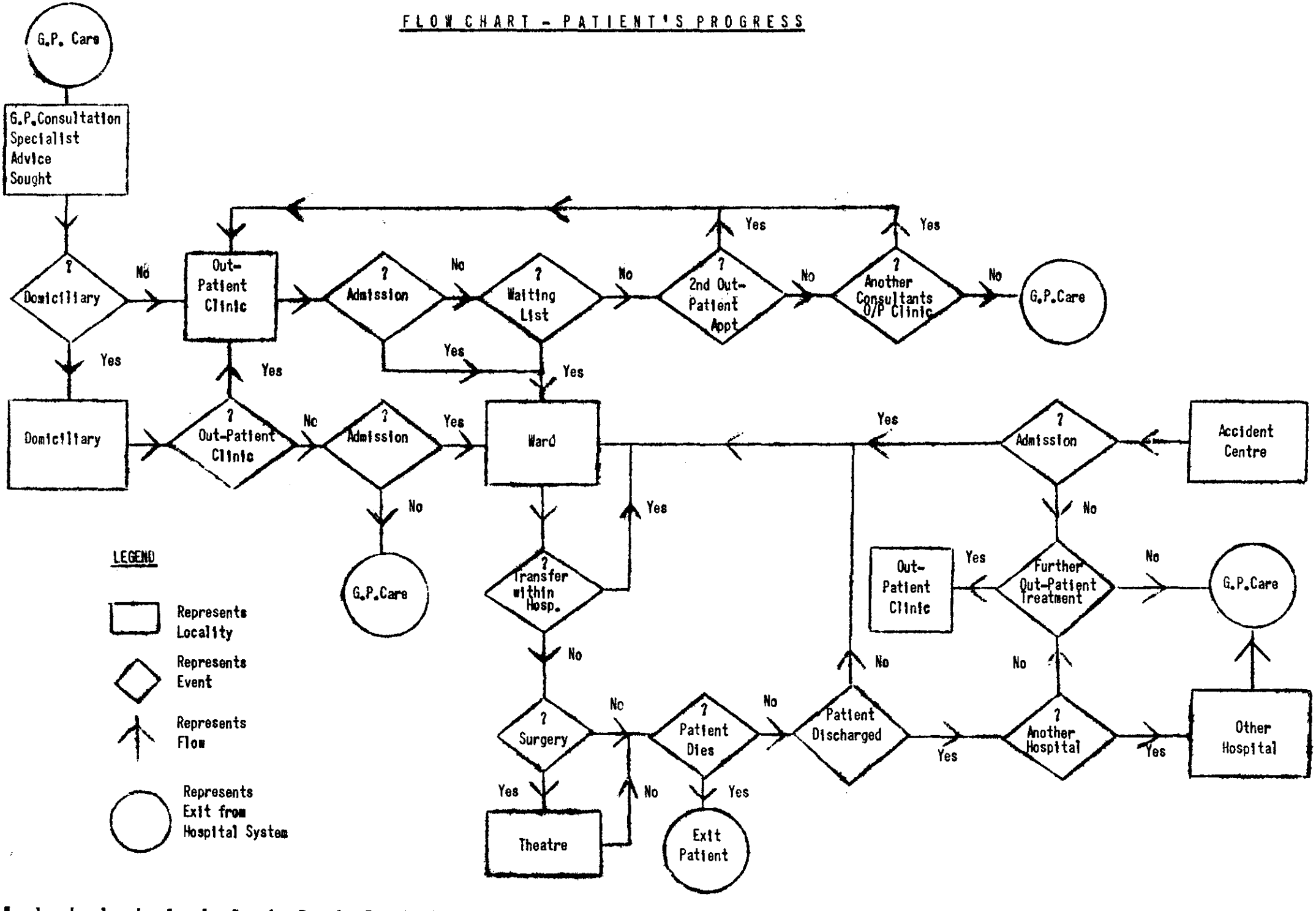
hospital was carried out by means of questionnaires addressed to the doctors concerned, and designed to elicit information about the channels of communication, the circumstances surrounding such communications and their timing in relation to significant events. The postal questionnaire approach resulted in a good response from consultants, a fair response from general practitioners and a disappointingly poor response from junior hospital doctors.

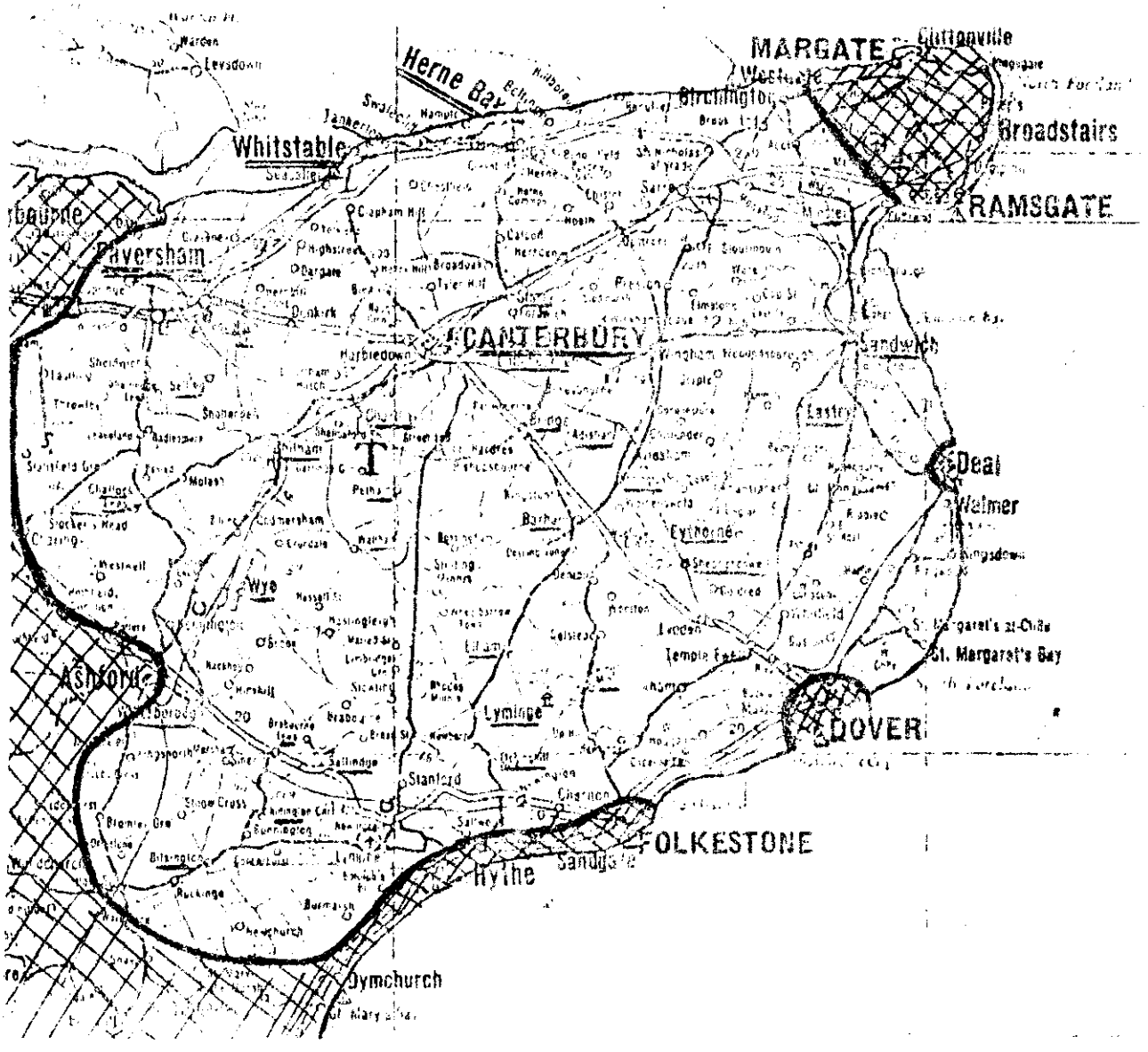
Methods, speed and nature of communications were found to be related more to personal decisions than to any policy of the hospital or the specialty, Even the usual time taken for letters to go through the post, particularly by second class mail, resulted in information being received too late, in the opinion of some of the general practitioners.

Most family doctors in the survey appeared generally satisfied with communications from the hospital though considerable concern was expressed about the communications in respect of the discharge or death of an inpatient. Many consultants felt the state of communications between the hospital and the general practitioner to be less adequate than they would desire and attributed the shortcomings primarily to the lack of secretarial assistance.

The study confirmed the findings of other studies carried out over the past decade and it is recommended that experiments to eliminate the deficiencies commonly found in the hospital/general practitioner communications system should now take place. In particular, more importance should be attached to discussion of communication problems and proposed changes between hospital doctors, administrators and family doctors. Newly appointed junior hospital doctors should be familiarised with current procedure in the hospital; the use of modern dictating and recording machines as well as a return to personal secretaries should be more thoroughly examined.

FLOW CHART - PATIENT'S PROGRESS





RINGS ARE DRAWN AT 3-MILE DISTANCES FROM CANTERBURY

TABLE 1

LIST OF SPECIALTIES AT KENT AND CANTERBURY HOSPITAL

	Number of consultants involved	Respondents
General medicine	3	3
General surgery	3	3
Gynaecology & obstetrics	3	1
Paediatrics	1	1
Orthopaedics	4	2
Physical medicine	1	1
Otorhinolaryngology	3	1
Ophthalmology	4	2
Urology	1	1
Dermatology & venereology	2	2
Radiotherapy	2	1
Chest diseases	1	1
Psychological medicine	2	2
Plastic surgery	1	1
Neurology	1	0
Total	32	22

TABLE 2

HOSPITALS IN EAST KENT

HMC Group	Hospital	Type	No. of beds	Location
10 Canterbury Group H.M.C.	Kent & Canterbury	Acute	336	Canterbury
	Dane John Hostel	Radiotherapy	11	"
	Mount	T.B. & Chest	30	"
	Whitstable & Tankerton	Acute	38	Tankerton
	Queen Victoria Memorial	Acute	46	Herne Bay
	Faversham Cottage	Acute	20	Faversham
	Herne	Chronic	129	Herne Bay
	Nunnery Fields	Long stay	109	Canterbury
	St. Helier's Maternity	Obstetric	15	Tankerton
	Bensted House	Joint user	98	Faversham

TABLE 2 (contd.)

HOSPITALS IN EAST KENT

HMC Group	Hospital	Type	No. of Beds	Location
11 Isle of Thanet H.M.C.	Isle of Thanet District (Margate Wing)	Acute	211	Margate
	Isle of Thanet District (Ramsgate Wing)	Acute	106	Ramsgate
	Haine	Mainly acute	100	Ramsgate
	Royal Sea Bathing	Srg.,T.B. etc.	215	Margate
	Princess Mary's Rehabilitation	Rehabilitation	229	Margate
	Hill House	Chronic	190	Ramsgate
	Westbrook Day Hospital	Geriatric	50 places	Margate
	Diabetic Convalescent	Pre-convalescent	57	Birchington
	Lanthorne & Hospital Day School for Handicapped Children	Mental Handicap & Psychiatry	35 - 40	Broadstairs
12 S.E.Kent H.M.C.	Royal Victoria	Acute	154	Folkestone
	Royal Victoria	Geriatric	33	Dover
	Victoria, Deal, Walmer & District	Acute	57	Deal
	Willesborough	Acute	109	Nr. Ashford
	Buckland	Acute	198	Buckland
	Warren	Isolation	14	Ashford
	Dover Isolation	Isolation	34	Dover
	Ashford	Acute	115	Ashford
	Hothfield	Geriatric	135	Nr.Ashford
	Eastry	Mental Handicap	205	Nr. Sandwich
	St. Mary's	Geriatric	200	Nr. Folkestone
	Eversley House	Mental Handicap	25	Hythe
24 St. Augustine's H.M.C.	St. Augustine's	Mental Illness	1339	Nr. Canterbury
	St. Martin's	Mental Illness	185	Nr. Canterbury

Source: Hospital Year Book 1972

TABLE 3

RESPONSES OF GENERAL PRACTITIONERS BY PARTNERSHIP SIZE

No. of partners in practice	No. of doctors approached	No. of respondents
1	12 (100%)	8 (67%)
2	34 (100%)	18 (53%)
3	15 (100%)	8 (53%)
4	4 (100%)	2 (50%)
5	5 (100%)	0
9	9 (100%)	9 (100%)
Total	79 (100%)	45 (57%)

% across rows and rounded to whole numbers

TABLE 4

DISTRIBUTION OF PRACTICES BY PARTNERSHIP SIZE AND LEVEL OF RESPONSE

Number of partners of in practice	Number of practices approached	Number of practices by level of response		
		One partner responding	Two partners responding	All partners responding
1	12	-	-	8
2	17	4	-	7
3	5	2	3	-
4	1	-	1	-
5	1	-	-	-
9	1	-	-	1
Totals	37	6	4	16

TABLE 5

GENERAL PRACTITIONERS BY YEAR SINCE REGISTRATION

Number of years since registration	Total number of doctors approached	Respondents
	No.	No.
0 - 9	15 (19%)	10 (22%)
10 - 19	23 (29%)	15 (33%)
20 - 29	26 (33%)	14 (31%)
30 +	15 (19%)	6 (13%)
Totals	79 (100%)	45 (100%)

% rounded to whole numbers

TABLE 6

DISTRIBUTION OF PRACTITIONERS BY NUMBER OF PATIENTS ON LIST

Number of Patients on G.P's list	Total number of doctors approached	Number of respondents
0 - 1599	14 (18%)	7 (15%)
1600 - 2599	24 (30%)	13 (29%)
2600 - 3799	38 (48%)	24 (53%)
3800 +	3 (4%)	1 (2%)
Total	79 (100%)	45 (100%)

Source: Executive Council for S.E. London and Kent

% down columns and rounded to whole numbers

TABLE 7

GENERAL PRACTITIONERS BY DISTANCE OF SURGERY PREMISES FROM KENT & CANTERBURY HOSPITAL

Distance from hospital	Total number of doctors approached	Respondents
0 - 3 miles	21 (26%)	11 (24%)
4 - 6 "	4 (5%)	3 (7%)
7 - 9 "	29 (37%)	19 (42%)
10 +	25 (32%)	12 (27%)
Total	79 (100%)	45 (100%)

TABLE 8

NUMBER OF YEARS SPENT AS GENERAL PRACTITIONER

(Respondents only)

Number of years as General Practitioner	Number of doctors
0 - 9 years	15 (33%)
10 - 19 "	19 (42%)
20 - 29 "	8 (18%)
30 +	3 (7%)
Total	45 (100%)

TABLE 9

DIFFERENCE IN YEARS BETWEEN REGISTRATION AND ENTRY TO GENERAL PRACTICE

(Respondents only)

Difference in years	Number of doctors
0 - 3	19 (42%)
4 - 6	15 (33%)
7 - 9	6 (13%)
10 - 12	2 (4%)
13 - 15	1 (2%)
16 - 18	2 (4%)
Total	45 (100%)

TABLE 10

ESTIMATED PROPORTION OF OUTPATIENT REFERRALS IN WHICH THERE IS INVOLVEMENT OF FULL-TIME SECRETARY/RECEPTIONIST STAFF

Proportion of outpatient referrals in which Secretary/Receptionist telephones for outpatient appointment	Proportion of Outpatient Referrals in which Secretary/Receptionist types referral letter			
	0	1% - 39%	40% - 79%	80% - 100%
0	7*	1	-	4
1 - 39%	2	2	1	-
40 - 79%	1	-	-	4
80 - 100%	2	-	-	21

* Includes one doctor with no secretary/receptionist

TABLE 11

RESPONDING GENERAL PRACTITIONERS' ESTIMATES OF OUTPATIENT REFERRALS TO KENT AND CANTERBURY HOSPITAL BY DISTANCE OF SURGERY PREMISES FROM KENT AND CANTERBURY HOSPITAL

Proportion of patients referred	Number of referring doctors				Total
	0-3 miles	4-6 miles	7-9 miles	10+ miles	
1 - 19%	-	-	1	3	4
20 - 39%	-	-	5	2	7
40 - 59%	-	-	3	0	3
60 - 79%	3	-	3	5	11
80 - 100%	8	3	7	2	20

TABLE 12

MEDICAL STAFFING OF HOSPITAL SPECIALIST UNITS

(as at January 1971)

Specialty	No. of consultants	No. of junior hospital doctors	No. of clinical assistants
Plastic surgery	1	0	0
Psychiatry	2	1	1
Chest Diseases	2	1	0
Radiotherapy	2	1	1
Dermatology	2	0	0
Urology	1	4	2
Physical medicine	1	1	0
Ophthalmology	3	1	1
E.N.T.	3	2	0
Orthopaedics	4	8	1
Obstetrics	3	4	0
General surgery	3	3	0
General medicine	3	2	1
Paediatrics	2	1	1

TABLE 13

NUMBER OF OUTPATIENT SESSIONS PER MONTH ATTENDED BY CONSULTANTS - AS STATED BY RESPONDENTS

	Number of sessions per month							
	2	3	4	5	6	7	8	9 or more
Number of Consultants	1	0	8	1	1	0	8	3

TABLE 14

NUMBER OF PATIENTS SEEN PER OUTPATIENT SESSION BY CONSULTANTS - AS STATED BY RESPONDENTS

	Number of patients per session			
	1-15	16-30	31-45	46-70
Number of Consultants	4	12	4	2

TABLE 15

METHOD USUALLY EMPLOYED IN MAKING APPOINTMENTS AND COMMUNICATING OUTPATIENT INFORMATION BY GENERAL PRACTITIONERS (REPLIES BY G.P'S)

Method usually employed by general practitioner	Number of G.P's
Letter delivered by post	8
Standard referral form delivered by post	19
Telephone for appointment Letter delivered by patient	16
Other	2

TABLE 16

ESTIMATED PROPORTION OF OUTPATIENTS, REFERRED BY GENERAL PRACTITIONER, SEEN BY CONSULTANT - AS STATED BY G.P. RESPONDENTS

	Proportion seen by consultant				No answer
	Under 30%	30-59%	60-89%	90-100%	
General medical	-	-	1	39	5
General surgical	-	3	0	27	5
Obst. & Gynae.	3	9	19	9	5
E.N.T.	-	-	7	33	5
Dermatology	-	-	-	40	5
Other	-	-	9	16	20
	Number of general practitioners replying				

TABLE 17

NOTIFICATION TO GENERAL PRACTITIONER OF PATIENT'S TRANSFER TO OTHER SPECIALTY (REPLIES BY GENERAL PRACTITIONERS)

	Usually consulted	Usually informed	Neither	Not answered
General medicine	17	23	1	4
General surgery	16	24	1	4
Obstet. & Gynae	16	23	2	4
E.N.T.	18	21	1	5
Dermatology	17	23	0	5
Other	9	17	0	19

(N.B. 21 of the 22 consultants and 4 of the 5 junior hospital doctors stated that they notified the general practitioner routinely)

TABLE 18

WHEN GENERAL PRACTITIONERS ARE NOTIFIED OF PATIENTS ADMISSION TO HOSPITAL

Type of admission	Replies by	While patient in hospital	After discharge of patient	No answer	Total
Emergency	Consultants	8	13	1	22
	Junior hospital doctors	2	3	0	5
	General practitioners	6	32	7	45
Direct from outpatients	Consultants	22	0	-	22
	Junior hospital doctors	4	1	-	5
	General practitioners	29	9	7	45
From waiting list	Consultants	5	15	2	22
	Junior hospital doctors	2	3	-	5
	General practitioners	5	35	5	45

TABLE 19 (a)

NOTIFICATION TO GENERAL PRACTITIONERS OF ACTION TAKEN BY CONSULTANT IN OUTPATIENTS (REPLIES OF GENERAL PRACTITIONERS)

Action taken		Time elapsing before G.P. notified			Not answered
		Within one week	More than one week	Not informed	
Patient to return for second appointment	Named specialty	27-29	10-11	3-4	3
	Other	22	6	4	13
Patient placed on waiting list	Named specialty	33-34	6-7	1	3
	Other	24	4	1	13
Patient returned to general practitioner's care	Named specialty	28-31	11-14	0	3
	Other	28	14	0	3

N.B. The variation in number of general practitioners responses in certain categories indicate the variations expressed for different specialties

TABLE 19 (b)

NOTIFICATION TO GENERAL PRACTITIONERS OF ACTION TAKEN BY CONSULTANT IN OUTPATIENTS (CONSULTANT REPLIES)

Action taken		Time elapsing before G.P. notified	
		Routinely within one week	Sometimes within one week
Patient to return for second appointment	Named specialty	8	2
	Other	9	3
Patient placed on waiting list	Named specialty	10	-
	Other	9	2*
Patient to return to G.P. care	Named specialty	9	1
	Other	10	1*

* Questions not applicable to one consultant

TABLE 20

COMMUNICATION OF INFORMATION CONCERNING TRANSFER OF PATIENT TO OTHER HOSPITAL OR SPECIALTY

Replies of	General practitioner informed			No answer	Total
	Usually	Sometimes	Never		
Consultants	12	5	4	1	22
Junior hospital doctors	3	1	1	0	5
General practitioners	30	7	1	7	45

TABLE 21

COMMUNICATION ON DEATH OF IN-PATIENT (G.P. REPLIES)

	Usually	Sometimes	Never	No answer
Telephone	0	29	6	10
Consultant letter	0	9	16	20
Junior hospital doctors letter	5	15	8	17
Proforma	33	9	0	3
Other method	0	2	9	34
Not informed	0	5	14	26

TABLE 22

ROUTINE COMMUNICATION ON DEATH OF IN-PATIENT (HOSPITAL DOCTOR REPLIES)

	Consultants' replies	Junior hospital doctors' replies
Telephone	4	1
Consultant letter	4	0
Junior hospital doctors letter	4	1
Proforma	7	2
Other method	3	1
Not informed	0	0

TABLE 23

TIME ELAPSING BEFORE G.P. NOTIFIED OF INPATIENT'S DEATH
AS STATED BY G.P. RESPONDENTS

	12 hr.	13-24 hr.	25-48 hr.	48 hr.+	Not answered
General medicine	1	9	16	16	3
General surgery	1	11	15	15	3
Obstet. & Gynae.	1	7	14	14	9
E.N.T.	2	6	11	12	14
Dermatology	0	6	11	12	16
Other	2	7	6	9	21

TABLE 24

METHOD OF COMMUNICATING WITH GENERAL PRACTITIONER
ON DISCHARGE OF PATIENT - AS STATED BY CONSULTANTS

Method used	Routine	Sometimes	Never	Not applic.	Not answered
Note sent by post	20	1	0	1	0
Note handed to patient	2	4	7	1	8
Telephone	2	13	2	1	4
Other	0	0	11	1	10

N.B. More than one method was used by some consultants

TABLE 25

TIME ELAPSED BEFORE GENERAL PRACTITIONER RECEIVED DISCHARGE NOTE
- AS STATED BY GENERAL PRACTITIONERS

Specialty	Within 2-3 days	4-14 days	15 days +	Total replies	No answer
General medicine	19 (47%)	21 (50%)	1 (3%)	42	3
General surgery	19 (45%)	21 (52%)	1 (3%)	42	3
Gynaecology and Obstetrics	10 (24%)	24 (57%)	7 (18%)	42	3
E.N.T.	17 (40%)	24 (60%)	0 -	41	4
Dermatology	12 (33%)	25 (66%)	0 -	37	8
Other	9 (32%)	13 (46%)	0 -	28	17

N.B. Percentages are across rows and are based on total answers (excluding 'no answers')

TABLE 26

ADEQUACY OF INFORMATION IN DISCHARGE NOTE
- AS STATED BY GENERAL PRACTITIONERS

	Usually	Sometimes	Never	Not answered
Clinical condition	22	14	7	2
Treatment in hospital	24	14	5	2
Further treatment	25	12	5	3
Return visit to hospital	25	12	6	2
Drugs given in hospital	26	12	5	2

TABLE 27

ADEQUACY OF INFORMATION IN DISCHARGE SUMMARY
- AS STATED BY GENERAL PRACTITIONERS

	Usually	Sometimes	Never	Not answered
Clinical condition	31	7	0	7
Treatment in hospital	24	14	5	2
Further treatment	32	6	0	7
Return visit to hospital	27	11	0	7
Drugs given in hospital	28	10	0	7

TABLE 28

HOW OFTEN DOMICILIARY CONSULTATIONS ARE CARRIED OUT WITHOUT PRESENCE OF GENERAL PRACTITIONER - AS STATED BY GENERAL PRACTITIONERS

	Frequently	Sometimes	Never	Not answered
General medicine	4	11	24	6
General surgery	3	11	25	6
Obstets. & Gynae.	1	10	23	11
E.N.T.	3	4	21	17
Dermatology	3	15	16	11
Other	5	19	8	13

TABLE 29

USUAL METHOD OF COMMUNICATING INFORMATION BY CONSULTANT AFTER DOMICILIARY CONSULTATION AT WHICH G.P. WAS NOT PRESENT AS STATED BY GENERAL PRACTITIONERS

Usual method	Replies by consultants	Replies by G.Ps.
By letter only	-	6
By letter, sometimes by telephone or personal contact	7	11
By letter and by telephone	3	1
By telephone only	2	2
By telephone, sometimes by letter or personal contact	4	8
By personal contact only	0	1
Sometimes by letter, sometimes by telephone	3	7
Not answered	3	9

UNIVERSITY OF KENT AT CANTERBURY
CENTRE FOR RESEARCH IN THE SOCIAL SCIENCES

KSD/JAA

CORNWALLIS BUILDING
THE UNIVERSITY
CANTERBURY
KENT
TELEPHONE 66822

Date as Postmark

Dear

We are conducting an enquiry (supported by the D.H.S.S.) into the communications arrangements between the Kent and Canterbury Hospital and general practitioners. The object of this study is to find out how these arrangements work in practice and to determine where improvements might usefully be made.

We are anxious to obtain information about the experiences and opinions concerning the matter of as many general practitioners as possible who refer patients to the Kent and Canterbury Hospital - including those who refer only a small proportion of their hospital cases to that hospital.

We should be most grateful if you would complete the enclosed questionnaire and return it in the stamped addressed envelope. All information you give us will be treated as confidential, and nothing will be included in any report or publication that could possibly lead to the identification of any individual doctor or practice.

We shall be glad to send you copies of reports produced as a result of this study if they would be of interest to you. Should you wish to talk to us about this research project, please let us know when it would be convenient for us to meet with you.

Yours sincerely,

(Dr. K. S. Dawes, M.B., B.S.)
Senior Research Fellow

Enc.

UNIVERSITY OF KENT AT CANTERBURY

Health Services Research Group

The main aim of the pilot study to which this questionnaire relates is to establish the feasibility of a research project into communications between hospital physicians and surgeons and general practitioners. Such a project would aim to obtain a clear description of the existing methods of communication between hospitals and the general practitioner services and to attempt to identify the causes of any failures of communication.

This questionnaire is concerned with aspects of communication between hospital medical staff and general practitioners. Where numerical answers are requested, a precise figure is not essential but it would assist the analysis of the questionnaire if an approximate lower and upper limit were given. It is certainly not intended that you should make a detailed analysis of your records before answering the questions.

For Example:

Specimen question:	How many letters do you write in an average week?
Answer:	20 - 30, rather than about 25

Glossary of terms used in this questionnaire:

a) Routine - essentially automatic procedure

b) Discharge note - a short letter to the general practitioner at the time the patient is discharged

c) Discharge summary - a full account of the patient's medical history during his stay in hospital

d) Unit - group or "firm" of doctors in a specialty

Mr. J.M. Bevan
Dr. K.S. Dawes
Dr. J.O. Jenkins
Mrs. W. Hughes-Jones

QUESTIONNAIRE

A. GENERAL INFORMATION

1. What is your specialty?

.....

2. What medical and nursing staff do you have in the unit in which you work? Please specify numbers, including yourself, in the following list:

	Number
Consultant	☐
First assistant	
Senior registrar	☐
Junior registrar	
Senior house officer	☐
House officer	
Clinical assistant	☐
Sister	
Charge nurses	☐
Staff nurses	
Nurses	☐

3. What secretarial services are at your disposal?

a) Your own personal secretary ☐

b) Shared use of a secretary ☐

c) Use of a typing pool ☐

d) Other, please specify: ☐

.....

.....

.....

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

(excluding outlying clinics or those at other hospitals)

1. How many outpatient sessions do you attend each week at the Kent and Canterbury Hospital? ☐

2. On average, how many patients do you see per session? ☐

3. Of these, what proportion are first referrals to your department?

Between ☐ % and ☐ %

4. For what proportion of these first referrals would the general practitioner do the following things?

a) complete a standard referral form only, delivered by hand

Between ☐ % and ☐ %

b) complete a standard referral form only, delivered by post

Between ☐ % and ☐ %

c) write a personal letter delivered by hand (not using a standard referral form)

Between ☐ % and ☐ %

d) write a personal letter delivered by post (not using a standard referral form)

Between ☐ % and ☐ %

e) Refer the patient without providing any clinical information

Between ☐ % and ☐ %

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

4. (contd.)

f) Provide the clinical information by by contacting you, or another member of the unit, without any written communication, e.g., by telephone

Between [ ] % and [ ] %

g) Provide the clinical information both by written communication and by other means, e.g., by telephone

Between [ ] % and [ ] %

h) Other - please state

.....

.....

Between [ ] % and [ ] %

5. Which of the procedures mentioned in the previous question do you prefer general practitioners to adopt with respect to first referrals?

.....

.....

6. Have you any criticisms of the existing standard referral form? (a copy is enclosed)

Yes [ ] No [ ]

If 'Yes', please state .....

.....

.....

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

7. Of the patients seen for the first time at an outpatient clinic by you, what proportions are: *

a) Admitted directly to the ward? Between [ ] % and [ ] %

b) Asked to return for a second outpatient appointment? Between [ ] % and [ ] %

c) Placed on the waiting list? Between [ ] % and [ ] %

d) Referred directly to a consultant in another specialty? Between [ ] % and [ ] %

e) Referred back to the general practitioner's care? Between [ ] % and [ ] %

8. In cases where outpatients are not admitted directly to the wards as inpatients (We are now referring to all outpatients seen by you not only those seen for the first time):

a) When is the general practitioner informed that a patient is asked to return for a second outpatient clinic appointment with you?

(Please tick each row)

	Routine	Sometimes	Never
Within 1 week	[ ]	[ ]	[ ]
After 1 week or more	[ ]	[ ]	[ ]
Not at all	[ ]	[ ]	[ ]

* NOTE: It is realised that these categories may overlap

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

8. (contd.)

b) When is the general practitioner informed that a patient's name has been placed on the waiting list for admission?

(Please tick each row)

	Routine	Sometimes	Never
Within 1 week	☐	☐	☐
After 1 week or more	☐	☐	☐
Not at all	☐	☐	☐

In cases where outpatients are not admitted directly to the wards as inpatients (We are now referring to all outpatients seen by you not only those seen for the first time);

c) When is the general practitioner informed that a patient is referred directly to another specialty? (Please tick each row).

	Routine	Sometimes	Never
Within 1 week	☐	☐	☐
After 1 week or more	☐	☐	☐
Not at all	☐	☐	☐

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

8. (contd.)

d) When is the general practitioner informed that a patient is referred back to the general practitioner's care?

(Please tick each row)

	Routine	Sometimes	Never
Within 1 week	☐	☐	☐
After 1 week or more	☐	☐	☐
Not at all	☐	☐	☐

9. Where you have said that you do communicate in Question 8 (a-d), please indicate how you inform the general practitioner concerned.

(Please tick each row)

	Routine	Sometimes	Never
By written communication only	☐	☐	☐
By telephone only	☐	☐	☐
By written communication and telephone	☐	☐	☐

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

10. a) When is a general practitioner informed that a patient, referred by him and seen by you, has been admitted directly to the ward from attendance at the outpatient clinic?

(Please tick each row)

		Routine	Sometimes	Never
i)	Within 24 hours	☐	☐	☐
ii)	In two to three days	☐	☐	☐
iii)	After three days or more	☐	☐	☐
iv)	Only after the discharge of the patient	☐	☐	☐

If in reference to Question 10 you ticked any of the boxes coming under the heading of 'sometimes', please say in what circumstances:

.....

.....

.....

10. b) Do you think that a suitable proforma for this purpose would be of value to you?

Yes ☐ No ☐

If 'Yes', please give reasons:

.....

.....

.....

.....

C. INPATIENT CARE (in your unit)

1. Upon a patient being admitted to hospital, is his general practitioner informed of this by you during the patient's stay in hospital?

(Please tick each row)

	Routine	Sometimes	Never
Emergency admissions	☐	☐	☐
Other admissions	☐	☐	☐

Where you have ticked 'Sometimes', please say in what circumstances:

.....

.....

.....

2. Where you have said that you do communicate in Question 1, please indicate how you inform the general practitioner concerned?

(Please tick each row)

	Routine	Sometimes	Never
a) Dictate a letter only	☐	☐	☐
b) Write a personal letter only	☐	☐	☐
c) Telephone only	☐	☐	☐
d) Dictate a letter and telephone	☐	☐	☐
e) Write a personal letter and telephone	☐	☐	☐

Where you have ticked 'Sometimes', please say in what circumstances:

.....

.....

.....

C. INPATIENT CARE (in your unit)

QUESTIONS 3 AND 4 ARE FOR SURGICAL STAFF ONLY

3. In cases where it is decided, after a patient has been admitted for observation, that a surgical operation is necessary, is the patient's general practitioner informed, by you, before the operation is performed?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

.....

4. After a surgical operation has been performed, is a patient's general practitioner informed of the outcome, by you, before the patient is discharged from hospital? (Please tick each row).

	Routine	Sometimes	Never
Within three days	☐	☐	☐
After three days or more	☐	☐	☐
Not at all	☐	☐	☐

If, in response to Question 4, you ticked any of the boxes coming under the heading 'Sometimes', please say in what circumstances:

.....

.....

.....

.....

C. INPATIENT CARE (In your unit)

5. If a patient has to be transferred to another hospital, or to another specialty for some or all of his/her treatment, do you inform the general practitioner of this? (at or near the time of transfer).

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

.....

6. Are interim reports (other than those mentioned in Questions 3-5) on a patient's progress made, by you, to the general practitioner concerned?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

.....

7. Do general practitioners have direct access to the case notes of patients?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

D. DISCHARGE PROCEDURES (In your unit)

1. Is a discharge note written to inform a general practitioner that a patient has been discharged from hospital? (Please tick each row)

	Routine	Sometimes	Never
a) The same day	☐	☐	☐
b) In 2-3 days	☐	☐	☐
c) After 3 days or more	☐	☐	☐
d) Not at all	☐	☐	☐

Where you have ticked 'Sometimes', please specify:

.....

.....

.....

2. How is the general practitioner advised of the discharge of a patient from the hospital? (Please tick each row).

	Routine	Sometimes	Never
a) Note sent by post	☐	☐	☐
b) Note handed to patient	☐	☐	☐
c) Telephone	☐	☐	☐
d) Other	☐	☐	☐

If 'Other', please specify .....

.....

.....

.....

D. DISCHARGE PROCEDURES

3. Who writes the patient's discharge note? (Please tick each row).

	Routine	Sometimes	Never
a) Yourself	☐	☐	☐
b) Another hospital doctor	☐	☐	☐
c) Ward sister	☐	☐	☐
d) Other	☐	☐	☐

If 'Other', please specify .....

.....

.....

4. Who completes the discharge summary? (Please tick each row).

	Routine	Sometimes	Never
a) Yourself	☐	☐	☐
b) Another hospital doctor	☐	☐	☐
c) Other	☐	☐	☐

If 'Other', please specify .....

.....

.....

D. DISCHARGE PROCEDURES

5. When is the discharge summary sent to the general practitioner?
(Please tick each row)

	Routine	Sometimes	Never
a) Within 1 week	☐	☐	☐
b) After 1 week but within 3 weeks	☐	☐	☐
c) After more than 3 weeks	☐	☐	☐

Where you have ticked 'Sometimes', please specify .....

.....

.....

.....

6. How is the general practitioner notified when a patient dies?
(Please tick each row)

	Routine	Sometimes	Never
a) By standard proforma	☐	☐	☐
b) By personal letter from you	☐	☐	☐
c) By personal letter from another hospital doctor	☐	☐	☐
d) By telephone	☐	☐	☐
e) Other	☐	☐	☐

If 'Other', please specify .....

.....

.....

.....

D. DISCHARGE PROCEDURES

7. Is a general practitioner informed of post mortem findings?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances:

.....

.....

.....

E. DOMICILIARY CONSULTATIONS

1. On average how many domiciliary consultations do you undertake per week?

☐

2. In what proportion of cases is the general practitioner normally present?

Between ☐ % and ☐ %

3. When you have not been accompanied by the general practitioner on a domiciliary consultation, by what means do you communicate your findings?

(Please tick each row)

		Routine	Sometimes	Never
a)	By letter	☐	☐	☐
b)	By telephone	☐	☐	☐
c)	By personal contact	☐	☐	☐

F. GENERAL COMMENTS

1. Please state the role of the following people in respect of hospital/general practitioner communications:

(a) Yourself .....

(b) Nursing staff .....

(c) Other medical staff .....

(d) Hospital secretary .....

(e) Other .....

If 'Other', please specify .....

.....

.....

2. If you have any further comments to make on any aspect of hospital/general practitioner communications, please make use of the space below:

.....

.....

.....

.....

.....

F. GENERAL COMMENTS

3. Have you any comments about the Questionnaire?

.....

.....

.....

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Signature: _____

UNIVERSITY OF KENT AT CANTERBURY

Health Services Research Group

The main aim of the pilot study to which this questionnaire relates is to establish the feasibility of a research project into communications between hospital physicians and surgeons and general practitioners. Such a project would aim to obtain a clear description of the existing methods of communication between hospitals and the general practitioner services and to attempt to identify the causes of any failures of communication.

This questionnaire is concerned with aspects of communication between hospital medical staff and general practitioners. Where numerical answers are requested, a precise figure is not essential but it would assist the analysis of the questionnaire if an approximate lower and upper limit were given. It is certainly not intended that you should make a detailed analysis of your records before answering the questions.

For Example:

Specimen question:	How many letters do you write in an average week?
Answer:	20 - 30, rather than about 25

Glossary of terms used in this questionnaire:

a) Routine - essentially automatic procedure

b) Discharge note - a short letter to the general practitioner at the time the patient is discharged

c) Discharge summary - a full account of the patient's medical history during his stay in hospital

d) Unit - group or "firm" of doctors in a specialty

Mr. J.M. Bevan
Dr. K.S. Dawes
Dr. J.O. Jenkins
Mrs. W. Hughes-Jones

QUESTIONNAIRE

A. GENERAL INFORMATION

1. What is your specialty?

.....

2. What medical and nursing staff do you have in the unit in which you work? Please specify numbers, including yourself, in the following list:

	Number
Consultant	
First assistant	
Senior registrar	
Junior registrar	
Senior house officer	
House officer	
Clinical assistant	
Sister	
Charge nurses	
Staff nurses	
Nurses	

3. What secretarial services are at your disposal?

a) Your own personal secretary ☐

b) Shared use of a secretary ☐

c) Use of a typing pool ☐

d) Other, please specify: ☐

.....

.....

.....

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

(excluding outlying clinics or those at other hospitals)

1. How many outpatient sessions do you attend each week at the Kent and Canterbury Hospital? ☐

2. On average, how many patients do you see per session? ☐

3. Of these, what proportion are first referrals to your department?

Between ☐ % and ☐ %

4. For what proportion of these first referrals would the general practitioner do the following things?

a) complete a standard referral form only, delivered by hand

Between ☐ % and ☐ %

b) complete a standard referral form only, delivered by post

Between ☐ % and ☐ %

c) write a personal letter delivered by hand (not using a standard referral form)

Between ☐ % and ☐ %

d) write a personal letter delivered by post (not using a standard referral form)

Between ☐ % and ☐ %

e) Refer the patient without providing any clinical information

Between ☐ % and ☐ %

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

4. (contd.)

f) Provide the clinical information by by contacting you, or another member of the unit, without any written communication, e.g., by telephone

Between [ ] % and [ ] %

g) Provide the clinical information both by written communication and by other means, e.g., by telephone

Between [ ] % and [ ] %

h) Other - please state

.....

.....

Between [ ] % and [ ] %

5. Which of the procedures mentioned in the previous question do you prefer general practitioners to adopt with respect to first referrals?

.....

.....

6. Have you any criticisms of the existing standard referral form? (a copy is enclosed)

Yes [ ] No [ ]

If 'Yes', please state .....

.....

.....

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

7. Of the patients seen for the first time at an outpatient clinic by you, what proportions are:*

a) Admitted directly to the ward. Between ☐ % and ☐ %

b) Asked to return for a second outpatient appointment. Between ☐ % and ☐ %

c) Placed on the waiting list Between ☐ % and ☐ %

d) Referred directly to a consultant in your own specialty Between ☐ % and ☐ %

e) Referred directly to a consultant in another specialty Between ☐ % and ☐ %

f) Referred back to the general practitioner's care Between ☐ % and ☐ %

8. In cases where outpatients are not admitted directly to the wards as inpatients, (we are now referring to all outpatients seen by you not only those seen for the first time):

a) When is the general practitioner informed that a patient is asked to return for a second outpatient clinic appointment with you?

(Please tick each row)

	Routine	Sometimes	Never
Within one week	☐	☐	☐
After one week or more	☐	☐	☐
Not at all	☐	☐	☐

* Note: It is realised that these categories may overlap

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

8. (contd.)

b) When is the general practitioner informed that a patient's name has been placed on the waiting list for admission?

(Please tick each row)

	Routine	Sometimes	Never
Within one week	☐	☐	☐
After one week or more	☐	☐	☐
Not at all	☐	☐	☐

c) When is the general practitioner informed that a patient is referred directly to a consultant in your specialty?

(Please tick each row)

	Routine	Sometimes	Never
Within one week	☐	☐	☐
After one week or more	☐	☐	☐
Not at all	☐	☐	☐

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

8. (contd.)

In cases where outpatients are not admitted directly to the wards as inpatients, (we are now referring to all outpatients seen by you not only those seen for the first time):

d) When is the general practitioner informed that a patient is referred directly to another specialty?

(Please tick each row)

	Routine	Sometimes	Never
Within one week	☐	☐	☐
After 1 week or more	☐	☐	☐
Not at all	☐	☐	☐

e) When is the general practitioner informed that a patient is referred back to the general practitioner's care?

(Please tick each row)

	Routine	Sometimes	Never
Within 1 week	☐	☐	☐
After 1 week or more	☐	☐	☐
Not at all	☐	☐	☐

9. Where you have said that you do communicate in Question 8 (a-e), please indicate how you inform the general practitioner concerned.

(Please tick each row)

	Routine	Sometimes	Never
a) By written communication only	☐	☐	☐
b) By telephone only	☐	☐	☐
c) By written communication and telephone	☐	☐	☐

B. OUTPATIENT CLINICS AT KENT AND CANTERBURY HOSPITAL

If in reference to Question 9 you ticked any of the boxes coming under the heading of 'sometimes', please say in what circumstances:

.....

.....

10. a) When is a general practitioner informed that a patient, referred by him and seen by you, has been admitted directly to the ward from attendance at the outpatient clinic?

(Please tick each row)

	Routine	Sometimes	Never
i) Within 24 hours	☐	☐	☐
ii) In two to three days	☐	☐	☐
iii) After three days or more	☐	☐	☐
iv) Only after the discharge of the patient	☐	☐	☐

If in reference to Question 10 you ticked any of the boxes coming under the heading of 'sometimes', please say in what circumstances:

.....

.....

.....

10. b) Do you think that a suitable proforma for this purpose would be of value to you?

Yes ☐ No ☐

If 'Yes', please give reasons:

.....

.....

.....

.....

C. INPATIENT CARE (in your unit)

1. Upon a patient being admitted to hospital, is his general practitioner informed of this by you during the patient's stay in hospital?

(Please tick each row)

	Routine	Sometimes	Never
Emergency admissions	☐	☐	☐
Other admissions	☐	☐	☐

Where you have ticked 'Sometimes', please say in what circumstances:

.....

.....

.....

2. Where you have said that you do communicate in Question 1, please indicate how you inform the general practitioner concerned?

(Please tick each row)

	Routine	Sometimes	Never
a) Dictate a letter only	☐	☐	☐
b) Write a personal letter only	☐	☐	☐
c) Telephone only	☐	☐	☐
d) Dictate a letter and telephone	☐	☐	☐
e) Write a personal letter and telephone	☐	☐	☐

Where you have ticked 'Sometimes', please say in what circumstances:

.....

.....

.....

C. INPATIENT CARE (in your unit)

QUESTIONS 3 AND 4 ARE FOR SURGICAL STAFF ONLY

3. In cases where it is decided, after a patient has been admitted for observation, that a surgical operation is necessary, is the patient's general practitioner informed, by you, before the operation is performed?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

.....

4. After a surgical operation has been performed, is a patient's general practitioner informed of the outcome, by you, before the patient is discharged from hospital? (Please tick each row).

	Routine	Sometimes	Never
Within three days	☐	☐	☐
After three days or more	☐	☐	☐
Not at all	☐	☐	☐

If, in response to Question 4, you ticked any of the boxes coming under the heading 'Sometimes', please say in what circumstances:

.....

.....

.....

.....

C. INPATIENT CARE (In your unit)

5. If a patient has to be transferred to another hospital, or to another specialty for some or all of his/her treatment, do you inform the general practitioner of this? (at or near the time of transfer).

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

.....

6. Are interim reports (other than those mentioned in Questions 3-5) on a patient's progress made, by you, to the general practitioner concerned?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

.....

7. Do general practitioners have direct access to the case notes of patients?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances .....

.....

D. DISCHARGE PROCEDURES (In your unit)

1. Is a discharge note written to inform a general practitioner that a patient has been discharged from hospital? (Please tick each row)

	Routine	Sometimes	Never
a) The same day	☐	☐	☐
b) In 2-3 days	☐	☐	☐
c) After 3 days or more	☐	☐	☐
d) Not at all	☐	☐	☐

Where you have ticked 'Sometimes', please specify:

.....

.....

.....

2. How is the general practitioner advised of the discharge of a patient from the hospital? (Please tick each row).

	Routine	Sometimes	Never
a) Note sent by post	☐	☐	☐
b) Note handed to patient	☐	☐	☐
c) Telephone	☐	☐	☐
d) Other	☐	☐	☐

If 'Other', please specify .....

.....

.....

.....

D. DISCHARGE PROCEDURES

3. Who writes the patient's discharge note?

(Please tick each row)

	Routine	Sometimes	Never
a) Consultant	☐	☐	☐
b) Yourself	☐	☐	☐
c) Another hospital doctor	☐	☐	☐
d) Ward Sister	☐	☐	☐
e) Other	☐	☐	☐

If 'Other', please specify .....

.....

.....

4. Who completes the discharge summary?

(Please tick each row)

	Routine	Sometimes	Never
a) Consultant	☐	☐	☐
b) Yourself	☐	☐	☐
c) Another hospital doctor	☐	☐	☐
d) Other	☐	☐	☐

If 'Other', please specify .....

.....

.....

D. DISCHARGE PROCEDURES

5. When is the discharge summary sent to the general practitioner?
(Please tick each row)

	Routine	Sometimes	Never
a) Within 1 week	☐	☐	☐
b) After 1 week but within 3 weeks	☐	☐	☐
c) After more than 3 weeks	☐	☐	☐

Where you have ticked 'Sometimes', please specify .....

.....

.....

.....

6. How is the general practitioner notified when a patient dies?
(Please tick each row)

	Routine	Sometimes	Never
a) By standard proforma	☐	☐	☐
b) By personal letter from you	☐	☐	☐
c) By personal letter from consultant	☐	☐	☐
d) By personal letter from another hospital doctor	☐	☐	☐
e) By telephone	☐	☐	☐
f) Other	☐	☐	☐

If 'Other', please specify: .....

.....

.....

D. DISCHARGE PROCEDURES

7. Is a general practitioner informed of post mortem findings?

a) As a matter of routine ☐

b) Sometimes ☐

c) Never ☐

If (b), please say in what circumstances:

.....

.....

.....

E. GENERAL COMMENTS

1. Please state the role of the following people in respect of hospital/general practitioner communications:

a) Yourself .....

b) The consultant .....

c) Nursing staff .....

d) Other medical staff .....

e) Hospital secretary .....

f) Other .....

If 'Other', please specify .....

.....

.....

2. If you have any further comments to make on any aspect of hospital/general practitioner communications, please make use of the space below:

.....

.....

.....

.....

.....

.....

.....

.....

E. GENERAL COMMENTS

3. Have you any comments about the questionnaire?

.....

.....

.....

.....

.....

Signature: _____

Position or grade: _____

QUESTIONNAIRE

SECTION A

1. How many partners are there in the practice including yourself? ☐

2. In which year were you fully registered? ☐

3. How many years have you been in General Practice? ☐

4. How many patients do you have on your personal N.H.S. list?

0 - 999	☐
1,000 - 1,599	☐
1,600 - 2,199	☐
2,200 - 2,599	☐
2,600 - 3,199	☐
3,200 - 3,799	☐
3,800 or more	☐

5. From how many surgery premises do you practice? main ☐ branch ☐

6. Do you employ secretarial/receptionist help in your practice?

	main	branch		main	branch
Yes	☐	☐	No	☐	☐

a) If "Yes", are they available during all surgery sessions?

	main	branch		main	branch
Yes	☐	☐	No	☐	☐

b) If the answer to (a) is "No", please give details of when the help is available

.....

.....

.....

SECTION A

7. Do you refer patients to the Kent and Canterbury Hospital outpatient department?

Yes ☐

No ☐

If "Yes" could you say what proportion of all your outpatient referrals are to the Kent and Canterbury Hospital?

0 - 19% ☐

20 - 39% ☐

40 - 59% ☐

60 - 79% ☐

80 - 100% ☐

8. Of all your patients that are admitted to hospital, either as a result of outpatient attendance or as direct admissions, what proportion are admitted to

the Kent and Canterbury hospital ☐ %

mental hospitals ☐ %

other hospitals ☐ %

9. Please list the hospitals and clinics to which you refer your patients.

It would be most helpful if you could say in a few words the reasons for your choice.

.....

.....

.....

.....

.....

SECTION B (OUTPATIENT REFERRALS)

ALL QUESTIONS REFER TO THE KENT AND CANTERBURY HOSPITAL ONLY

1. What proportion of your outpatient appointments at the hospital are made by:-

	%
(a) Standard referral form	
(i) delivered by patient	☐
(ii) delivered by post	☐
(b) Personal letter	
(i) delivered by patient	☐
(ii) delivered by post	☐
(c) Telephone contact with hospital only	☐
(d) Written communication and telephone communication	☐
(e) Referring patient without any communication	☐
(f) Other means	☐
Please state	☐
.....	
.....	100 %
.....	

2. Which of the above methods do you prefer to adopt?

Please could you say why you prefer this method .....

.....

.....

3. (a) Where outpatient appointments are made by telephone, what proportion of these appointments are made by your secretary? ☐ %

(b) What proportion of written communications made in referring outpatients are typed by your secretary/receptionist? ☐ %

SECTION B (OUTPATIENT REFERRALS) (contd.)

4. When communicating clinical information about outpatient referrals to the hospital, in what proportion of cases do you use the following methods:-

		%
(a)	Standard referral form	
	(i) delivered by patient	☐
	(ii) delivered by post	☐
(b)	Personal letter	
	(i) delivered by patient	☐
	(ii) delivered by post	☐
(c)	Telephone contact with hospital only	☐
(d)	Written communication and telephone communication	☐
(e)	Other means	100 %

Please state .....

.....

.....

.....

5. Which of these methods do you prefer to adopt?

Please give your reasons .....

.....

.....

.....

.....

SECTION B (OUTPATIENT REFERRALS) (contd.)

6. Which of these methods does your secretary/receptionist prefer that you adopt?

Please give your reasons .....

.....

.....

.....

7. Please indicate below any comments you may have about the Standard Referral Form (copy enclosed)

.....

.....

.....

.....

8. Do you experience difficulties in making contact, by telephone, with the Hospital Appointments clerk?

Yes ☐

No ☐

If "Yes" please specify .....

.....

.....

9. Have you experienced difficulty in obtaining appointments for patients in particular specialties in a reasonable time?

Yes ☐

No ☐

If "Yes" please specify .....

.....

.....

.....

SECTION C (OUTPATIENT CARE)

ALL QUESTIONS REFER TO THE KENT AND CANTERBURY HOSPITAL ONLY

1. What proportion of patients, referred to the hospital by you, are seen by the consultant to whom they were referred as distinct from one of his staff?

Please tick the appropriate box in each column.

	Gen. Med.	Gen. Surg.	Gynae & Obst.	E.N.T.	Skins	Other
90% - 100%	☐	☐	☐	☐	☐	☐
60% - 89%	☐	☐	☐	☐	☐	☐
30% - 59%	☐	☐	☐	☐	☐	☐
Under 30%	☐	☐	☐	☐	☐	☐

2. Are you usually consulted or informed, by the specialist to whom your patient was initially referred, should that patient be referred to another specialty?

	Gen. Med.	Gen. Surg.	Gynae & Obst.	E.N.T.	Skins	Other
(a) Usually consulted	☐	☐	☐	☐	☐	☐
(b) Usually informed	☐	☐	☐	☐	☐	☐
(c) Usually neither (a) nor (b)	☐	☐	☐	☐	☐	☐

SECTION C (OUTPATIENT CARE) (contd.)

3. In cases where outpatients are not admitted directly to the wards from outpatient attendance:-

(a) When are you usually informed that a patient had been requested to return for a second outpatient appointment?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(i) Within one week	☐	☐	☐	☐	☐	☐
(ii) After one week or more	☐	☐	☐	☐	☐	☐
(iii) Not at all	☐	☐	☐	☐	☐	☐

3. (b) When are you usually informed that a patient's name has been placed on the waiting list for admission?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(i) Within one week	☐	☐	☐	☐	☐	☐
(ii) After one week or more	☐	☐	☐	☐	☐	☐
(iii) Not at all	☐	☐	☐	☐	☐	☐

3. (c) When are you usually informed that a patient has been referred back to your care?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(i) Within one week	☐	☐	☐	☐	☐	☐
(ii) After one week or more	☐	☐	☐	☐	☐	☐
(iii) Not at all	☐	☐	☐	☐	☐	☐

SECTION C (OUTPATIENT CARE) (contd.)

4. Where you have indicated in Question 3 (a) - (c) that you are informed of what is happening to your patient who is not admitted directly from out-patients, please could you say which method is used to communicate this information?

Please tick the appropriate box in each column

		Routine	Sometimes	Never
(a)	By written communication	☐	☐	☐
(b)	By telephone only	☐	☐	☐
(c)	By written communication and by telephone	☐	☐	☐

SECTION D (INPATIENT CARE)

ALL QUESTIONS REFER TO THE KENT AND CANTERBURY HOSPITAL ONLY

1. What is the usual length of time to elapse between your patient being admitted to hospital and your receiving this information from the hospital?

(a) When admitted from the waiting list

		Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(i)	Within 24 hours	☐	☐	☐	☐	☐	☐
(ii)	In 2-3 days	☐	☐	☐	☐	☐	☐
(iii)	After 3 days but before discharge of patient	☐	☐	☐	☐	☐	☐
(iv)	Only after discharge of patient	☐	☐	☐	☐	☐	☐

SECTION D (INPATIENT CARE) (contd.)

1. (b) When admitted directly to the ward from outpatients

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(i) Within 24 hours	☐	☐	☐	☐	☐	☐
(ii) In 2-3 days	☐	☐	☐	☐	☐	☐
(iii) After 3 days but before discharge of patient	☐	☐	☐	☐	☐	☐
(iv) Only after discharge of patient	☐	☐	☐	☐	☐	☐

1. (c) When admitted from the Accident Centre, e.g. after road accident

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Ortho-paedics	Other
(i) Within 24 hours	☐	☐	☐	☐	☐	☐
(ii) In 2-3 days	☐	☐	☐	☐	☐	☐
(iii) After 3 days but before discharge of patient	☐	☐	☐	☐	☐	☐
(iv) Only after discharge of patient	☐	☐	☐	☐	☐	☐

2. When it is decided to operate on one of your patients, following admission for observation or investigation, when do you receive notification of this?

	Usually	Sometimes	Never
(a) Before the operation	☐	☐	☐
(b) The day the operation takes place	☐	☐	☐
(c) In 2-3 days after the operation	☐	☐	☐
(d) After 3 days but before the discharge of the patient	☐	☐	☐

SECTION D (INPATIENT CARE) (contd.)

(3) Excluding information about operations, do you receive interim reports, while the patient is still in hospital, about their inpatient progress?

Please tick the appropriate box in each column

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(a) Usually	☐	☐	☐	☐	☐	☐
(b) Sometimes	☐	☐	☐	☐	☐	☐
(c) Never	☐	☐	☐	☐	☐	☐

If you have ticked "Sometimes" could you please state in what circumstances

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4. If you visit a patient in the hospital, do you have free access to the case notes?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(a) At any time	☐	☐	☐	☐	☐	☐
(b) Only in the presence of a member of the medical staff	☐	☐	☐	☐	☐	☐
(c) Under no circumstances	☐	☐	☐	☐	☐	☐

SECTION D (INPATIENT CARE) (contd.)

5. If a patient has to be transferred to another hospital, or to another specialty for all or some of their treatment, are you informed of this?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(a) Usually	☐	☐	☐	☐	☐	☐
(b) Sometimes	☐	☐	☐	☐	☐	☐
(c) Never	☐	☐	☐	☐	☐	☐

If you have ticked "Sometimes", please would you say in what circumstances

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SECTION E (DISCHARGE OF PATIENTS)

ALL QUESTIONS REFER TO THE KENT AND CANTERBURY HOSPITAL ONLY

1. How are you advised of the discharge of a patient from the hospital?

	Usually	Sometimes	Never
(a) By post	☐	☐	☐
(b) By hand (delivered by patient or relatives)	☐	☐	☐
(c) By telephone	☐	☐	☐
(d) By other means	☐	☐	☐

If "other" please specify .....

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SECTION E (DISCHARGE OF PATIENTS) (contd.)

2. Could you roughly estimate the proportion of patients who fail to report to you, after being instructed to do so, when they are discharged from:-

(a) Inpatient admission ☐

(b) Outpatient attendance ☐

(c) Accident centre attendance ☐

3. What is the usual length of time which elapses between the discharge of an inpatient and your receiving a discharge note?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(a) Same day	☐	☐	☐	☐	☐	☐
(b) In 2-3 days	☐	☐	☐	☐	☐	☐
(c) In 4-14 days	☐	☐	☐	☐	☐	☐
(d) In 15-21 days	☐	☐	☐	☐	☐	☐
(e) Over 21 days	☐	☐	☐	☐	☐	☐

4. Do discharge notes give adequate information for your needs as to:-

	Usually	Sometimes	Never
(a) The patient's clinical condition	☐	☐	☐
(b) Treatment received in hospital	☐	☐	☐
(c) Quantity and types of drugs and/or dressings given to the patient on discharge	☐	☐	☐
(d) Recommended treatment	☐	☐	☐
(e) Return visits to hospital	☐	☐	☐

Have you any comments to make on this subject

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SECTION E (DISCHARGE OF PATIENTS) (contd.)

5. When your patients are discharged from hospital, do you receive clinical summaries:-

	Usually	Sometimes	Never
(a) Within one week	☐	☐	☐
(b) Between 8 and 14 days	☐	☐	☐
(c) Between 15 days and 3 weeks	☐	☐	☐
(d) After 3 weeks or more	☐	☐	☐

If you have ticked "Sometimes" please give details:-

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6. Do clinical summaries give adequate information for your needs as to:-

	Usually	Sometimes	Never
(a) The patients clinical condition	☐	☐	☐
(b) Treatment received in hospital	☐	☐	☐
(c) Quantity and types of drugs and/or dressings given to the patient on discharge	☐	☐	☐
(d) Recommended treatment	☐	☐	☐
(e) Return visits to hospital	☐	☐	☐

SECTION E (DISCHARGE OF PATIENTS) (contd.)

7. Are you notified if a patient has to make more than one return visit to the hospital after being discharged from the ward:-

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(a) Usually	☐	☐	☐	☐	☐	☐
(b) Sometimes	☐	☐	☐	☐	☐	☐
(c) Never	☐	☐	☐	☐	☐	☐

If you have ticked "Sometimes" please give details:-

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8. If a patient dies in hospital, are you initially informed by:-

	Usually	Sometimes	Never
(a) Telephone	☐	☐	☐
(b) Personal letter from consultant	☐	☐	☐
(c) Personal letter from another hospital doctor	☐	☐	☐
(d) Standard proforma	☐	☐	☐
(e) Other	☐	☐	☐
(f) Not at all	☐	☐	☐

SECTION E (DISCHARGE OF PATIENTS) (contd.)

9. What is the usual time to elapse between the death of a patient in hospital and your receiving this information?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(a) Up to 12 hours	☐	☐	☐	☐	☐	☐
(b) Between 13 & 24 hrs.	☐	☐	☐	☐	☐	☐
(c) Between 25 & 48 hrs.	☐	☐	☐	☐	☐	☐
(d) Over 48 hours	☐	☐	☐	☐	☐	☐

SECTION F (DOMICILIARY CONSULTATIONS)

ALL QUESTIONS REFER TO THE KENT AND CANTERBURY HOSPITAL ONLY

1. How often does a consultant make a domiciliary consultation, at your request without your being present?

	Gen. Med.	Gen. Surg.	Gynae. & Obst.	E.N.T.	Skins	Other
(a) Frequently	☐	☐	☐	☐	☐	☐
(b) Sometimes	☐	☐	☐	☐	☐	☐
(c) Never	☐	☐	☐	☐	☐	☐

If you have ticked "Frequently" or "Sometimes" in any column, would you please specify in what circumstances:-

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SECTION F (DOMICILIARY CONSULTATIONS) (contd.)

2. When you have not accompanied a consultant on a domiciliary consultation, by what means are his findings reported to you?

	Usually	Sometimes	Never
(a) By letter	☐	☐	☐
(b) By telephone	☐	☐	☐
(c) By personal contact	☐	☐	☐

continued overleaf

1. If you have any further comments to make on any aspect of hospital/ general practitioner communications, please make use of the space below:

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2. Have you any comments about the questionnaire?

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Signature .....