MEDICAL PRACTICE

*Contemporary Themes***Usefulness of letters from hospitals to general practitioners**

WILLIAM BADO, CHRISTOPHER J WILLIAMS

Abstract

In an investigation of the communication between specialist hospital departments and general practitioners 97 general practitioners were asked to say how important selected items of information that the hospital could pass on would be for management of a patient receiving chemotherapy. In addition, the records of 68 patients were examined for coverage of these topics. General practitioners considered technical topics to be more important than social ones. Hospital letters covered technical topics well, apart from details of possible side effects, but did not do the same even for the two social topics that most doctors considered to be essential—namely, what patients have been told about their diagnosis and prognosis.

Letters from hospitals to general practitioners cover technical topics well but should include more information relating to the social aspects of the patient's disease.

Introduction

Patients receiving chemotherapy for cancer have to suffer the emotional and physical consequences of the treatment as well as those of their tumour.¹ Because of this, support from their general practitioner is particularly important. To provide this support general practitioners need to know what the hospital is thinking and doing and what the patient and his family understands of this.^{2,3} We undertook a study to see what information was given

to general practitioners in summaries and letters from hospitals and to see how this fulfilled the general practitioners' perceived needs.

Method and results

Questionnaires were sent to 97 general practitioners who had referred two or more patients to this unit. General practitioners were asked how important they considered different topics (see table) that might be covered in main summary letters written immediately after a treatment plan had been formulated. Topics could be graded as (1) essential, (2) interesting but not essential, or (3) not required and were divided into two major groups—namely, technical information and information covering social aspects of the patient's disease. The notes of 68 patients treated at this unit in the previous two years, chosen at random, were examined to see whether the topics offered in the questionnaire were adequately covered in initial summaries and letters to the general practitioners.

Seventy three general practitioners (75%) returned completed questionnaires (table). They considered technical topics (essential, mean 76%) to be more important than social topics (essential, mean 59%). When we examined the information in the hospital letters of 68 patients we found that technical topics were nearly always covered but that there was a striking paucity of information about social topics. General practitioners rated two social topics—namely what the patient had been told about the nature and prognosis of his disease—in the top 50% of important topics, but few letters covered these.

Discussion

This study underlines the failure of specialist hospital units to communicate non-technical information that many general practitioners regard as essential. Nearly all the general practitioners thought that information about technical topics was essential, and the letters almost uniformly contained this information. The one general topic that less than half the practitioners described as essential was possible side effects of treatment. Though

Cancer Research Campaign Medical Oncology Unit, Southampton General Hospital, Southampton SO9 4XY

WILLIAM BADO, medical student

CHRISTOPHER J WILLIAMS, DM, MRCP, senior lecturer

Correspondence to: Dr C J Williams.

Importance attached to selected topics by general practitioners compared with their coverage in letters from hospital

	No (%) of general practitioners grading topic as essential (n = 73)	No (%) of letters adequately covering topic (n = 68)
Technical topics:		
Diagnosis	71 (97)	68 (100)
Stage of disease	66 (90)	68 (100)
Details of drugs used in chemotherapy	60 (82)	68 (100)
Details of surgery	57 (78)	68 (100)
Details of investigations	56 (77)	68 (100)
Details of radiotherapy	50 (69)	68 (100)
Details of chemotherapy doses	49 (68)	61 (89)
Details of potential side effects	30 (41)	3 (5)
Social topics:		
What patient has been told about his disease	62 (85)	12 (18)
Prognosis given to patient	59 (81)	7 (10)
What relatives have been told about the disease	47 (64)	5 (7)
What patient has been told about his treatment	43 (59)	9 (13)
Advice given to patient on when to contact hospital	31 (43)	7 (10)
Family problems relevant to management	30 (42)	

non-specialist clinicians are likely to know of the major toxic effects, few are likely to have a detailed knowledge of these potentially important problems. Only three (5%) of the hospital letters, however, devoted space to this topic. The social topics rated as most important by general practitioners—namely,

whether the patient knew the diagnosis or prognosis—were covered by this hospital as badly as other social topics that had been less highly rated. It is a common experience, unfortunately, that hospital notes rarely mention whether the diagnosis or prognosis has been discussed with the patient.

The data from this type of hospital unit are likely to be representative of similar highly specialised hospital departments.³ Routine hospital summaries and letters contain nearly all the technical information needed by general practitioners but should also include a section covering what patients have been told of their illness and its prognosis as well as any other relevant social factors. Such an innovation would not only help general practitioners; it might also focus attention on the patient's social and emotional needs while he is in hospital.

We thank the general practitioners in the Wessex region who took the time to complete the questionnaire used in this study.

References

¹ Nerenz DR, Leventhal H, Love RR. Factors contributing to emotional distress during cancer chemotherapy. *Cancer* 1982;**50**:1020-7.
² Long A, Atkins JB. Communication between GPs and consultants. *Br Med J* 1974;*iv*:456-9.
³ De Aleron R, Glanville H, Hodsen JM. The value of the specialist report. *Br Med J* 1980;**281**:1663.

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Appropriate Technology

Epidemiology and research at low cost

PETER COX

At first sight it would seem that both research and epidemiology are high technology, high cost activities carried out by highly qualified specialists with nothing else to do except punch buttons on computers or organise well trained scientists working in well equipped laboratories. This is not so, for good epidemiological data should be the basis for all health planning from national to district level, and the more scanty the resources the more accurate the decisions must be. The data needed by the district medical officer for day to day decisions in planning the number of beds in a health centre or determining the size of a new hospital are also the bricks and mortar of the nation's statistics. The morbidity figures reported in the dispensaries make up the country's health statistics. Hence inaccurate, deficient, or out of date figures at district level may lead to poor planning and a distorted picture of the overall health problems of the country.

This article aims at encouraging those at the periphery of the health network to improve their methods of collecting data and embark on the vital basic research that only they can do. These tasks are not optional extras: they should be priorities in the schedule of every district medical officer.

Nuffield Centre for Health Service Studies, Leeds LS2 9PL
PETER COX, MD, DTM&H, lecturer in epidemiology

Establishing a baseline

One of the great difficulties in working in developing countries, especially as a newcomer to a remote district, is the lack of a baseline. What is normal? Values may vary among ethnic groups, among neighbouring districts, or even among villages as little as 30 or 40 miles apart. In one district in which I worked the serum protein concentrations showed a wide variation among four centres of population, and all these concentrations were higher than those in adjoining districts and tribes.¹ Disease prevalence may vary with altitude and climate and be profoundly influenced by the local customs and way of life. This was so noticeable in one district that it was virtually possible to predict the patient's home area from his symptoms.² Attendances may vary from month to month according to the season and are often dictated far more by social, geographic, and agricultural factors than purely medical ones. The district medical officer must find and record these idiosyncrasies and interpret the regional statistics against this background, for without this interpretation a misleading picture may be drawn. For example, in one tribe the incidence of tapeworm in men was about four times that in the women. Many years elapsed before we found that the people believed that possession of a tapeworm increased the chances of pregnancy. The picture was spurious for the actual incidence was the same, but the women did not come for treatment.