Communications between General Practitioners and Consultants

SIR,—The study by Miss Anne Long and Dr. J. B. Atkins on communications between general practitioners and consultants (23 November, p. 456) raised many interesting points. Obviously there is plenty of room for improvement on both sides. Some thoughts come to my mind as a result of my experiences in both fields of endeavour.

The main source of information about patients in general practice records is often provided by letters from consultants or their deputies. A good letter or hospital discharge report is an invaluable record, and with the present pressure on hospital medical staff and shortage of clerical staff understandably these reports cannot always be prepared and dispatched quickly. This applies especially to medical cases, and similar factors explain the inadequacy of many referral letters. Letters from hospitals, however, provide a useful, legible and permanent record. Notice of a patient's discharge from hospital is a different matter. It should be dispatched promptly, with the full report to follow as soon as possible. Urgent advice on immediate treatment should be, and generally is, given by telephone or in a brief note with the discharge notice.

The usefulness of domiciliary consultations is, in my opinion, limited and consists mainly of providing reassurance to patients and their relatives or a means of opening up an avenue for the patient's admission to hospital. Such consultations are time consuming and the circumstances do not often permit a deep discussion of the case. They can, of course, lead to better mutual understanding between the doctors concerned, provided they can spare the time.—I am, etc.,

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SIR,—We were most interested to read the article by Miss Anne Long and Dr. J. B. Atkins (23 November, p. 456), which reported findings similar to ours in a study carried out in relation to a district general hospital in south-east England.¹ Our study was designed to elicit information from general practitioners, consultants, and hospital doctors about the channels of communication, the circumstances surrounding such communications, and their timing in relation to significant events. Methods, speed, and nature of communications were found to be related more to personal decisions than to a defined policy of the hospital or the various specialties.

Most family doctors seemed satisfied with the communications, though there was concern about delays in receiving information about the discharges or deaths of inpatients. Consultants seemed to be less satisfied with their communications to family doctors, and attributed the shortcomings primarily to lack of adequate secretarial assistance.

We agree that shortcomings in the communications system are longstanding, for these two recent studies confirm the continued existence of many of the problems elicited from previous studies. Experiments to eliminate the difficulties commonly found in hospital/general practice communications

should now take the place of examination of the problems.—We are, etc.,

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¹ Bevan, J. M., et al., *Health and Social Services Journal*, 1974, 84, 1040.

SIR,—Miss Anne Long and Dr. J. B. Atkins (23 November, p. 456) stated that in their survey only 35% of consultants and 51% of general practitioners favoured the idea of consultants holding sessions at health centres. But only four doctors had had practical experience of such an arrangement.

We general practitioners working in the Nuffield Health Centre, Witney, find that the large number of consultant clinics held in the building are an invaluable asset. They encourage personal contact between consultants and general practitioners; give an opportunity for immediate discussion on patients referred and for the discussion of other patients already receiving joint care; and also for discussion of problems in general for getting advice on particular patients who may not then require referral. I believe we learn much from these contacts and I hope it improves our selection of patients who require referral.

Another point concerns discharge letters. As a rule, when a patient attends hospital as an outpatient or for admission he carries his general practitioner's letter of referral with him. Why should not the patient bring his own discharge letter home with him? It would then be his responsibility to see that it is delivered to his doctor promptly.—I am, etc.,

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Accidental Hypothermia: Central Rewarming in the Field

SIR,—In many outdoor pursuits rescue teams are faced with people in remote situations suffering from hypothermia or the "exhaustion hypothermia syndrome." On-the-spot treatment has so far been limited to insulation and rapid evacuation.² The calls on rescue teams are almost universally increasing, and there is a growing demand for an effective way of treating hypothermia at the site of the incident. In a critical situation this could be life saving.

Core rewarming is considered ideal in accidental hypothermia, but most methods are impracticable for widespread use. Supplying warmed, humidified air to breathe, however, can make a great difference to the amount of heat available for rewarming the patient,^{3,4} resulting in a rise of core temperature with no initial after-drop. This method has been found effective in hospital⁵⁻⁷ and is potentially portable. The portable equipment used in the case reported below utilizes the interaction of carbon dioxide and soda lime to produce moisture and heat. Oxygen is breathed through the soda lime transferring heat and moisture to the patient.⁸

An inexperienced pot-holer trapped in a narrow rift lay without a wet suit partially in water for about five hours. The terrain was such that he could not be carried out, and it took two hours for him to crawl with considerable help. When he reached the surface he was ketotic, shivering

vigorously, uncoordinated, and ataxic though his cerebation was not grossly impaired. He felt very cold and his mouth temperature was 92°F (33.3°C). He was put in a heated ambulance at the cave entrance, wrapped in blankets, and given airway warming with the portable resuscitator. His condition rapidly improved, the shivering stopped, and after 20 minutes his mouth temperature was 98.4°F (36.8°C). The patient reported subjective benefit from the method.

Use of the mouth temperature could be criticized as not representing a true core reading, but the measurement of rectal temperature was impracticable under the circumstances and might not have been an any more reliable guide.⁸ Mouth temperatures were measured with a low-reading thermometer kept under the tongue with the mouth closed for three minutes. The rate of re-warming, 3.5°C in 20 minutes, compares very favourably with the 3.5°C in 75 minutes achieved by extra corporeal re-warming,⁹ though the heat production of a young, conscious man is inevitably far greater than that of an 84-year-old unconscious woman. In a case in which survival was attributed to an abnormally active metabolic system re-warming over the range 33-37°C took four and a half hours despite recovery of consciousness.¹⁰

Allowing for the prolonged transport time owing to the remote situation and the preparation of a bath, the time required for re-warming this patient through the airway compares favourably with the time required to re-warm by the hot-bath method. The warmed-air method would therefore seem to have potential value for the treatment of cases of accidental hypothermia in remote situations.—We are, etc.,

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- 1 British Mountaineering Council Leaflet, *Mountain Hypothermia*, 1974.
- 2 Frankland, J. C., British Association of Caving Instructors Bulletin No. 7, 1973.
- 3 Lloyd, E. LL., et al., *Scottish Medical Journal*, 1972, 17, 83.
- 4 Shanks, C. A., *British Journal of Anaesthesia*, 1973, 45, 887.
- 5 Ledingham, I. McA., and Mone, J. G., *Lancet*, 1972, 1, 534.
- 6 Lloyd, E. LL., *British Journal of Anaesthesia*, 1973, 45, 41.
- 7 Shanks, C. A., and Marsh, H. M., *British Journal of Anaesthesia*, 1973, 45, 522.
- 8 Burton, A. C., and Edholm, O. G., *Man in a Cold Environment*, chap. 11. London, Arnold, 1955.
- 9 Davies, D. M., Millar, E. J., and Millar, I. A., *Lancet*, 1967, 1, 1036.
- 10 Laufmann, H., *Journal of the American Medical Association*, 1954, 147, 1201.

Safety and Fibreoptic Bronchoscopy

SIR,—It was with considerable pleasure that we read Dr. I. W. B. Grant's letter (23 November, p. 464) pointing out the limitations of the flexible fibreoptic bronchoscope, for these are views which we have held for some years. We believe that the trend towards training operators in the use of the flexible instrument alone is not only short-sighted but may be dangerous in a small proportion of cases: the bronchoscopist should be trained to use both flexible and rigid instruments.

The flexible bronchoscope in its present form is a fine additional telescope allowing more peripheral vision and specimen taking than is possible with conventional instruments. It is invaluable for this purpose but can do nothing else as well as can the best