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' general practice records is 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 shortage and pressure on medical cases, and similar incompetence related communications, seem to have been a problem in general practice for a considerable time. The inadequacy of many referral letters, and their lack of relevancy to the problems of the patient, is a problem that needs prompt and quick resolution.

We general practitioners working in the Nuffield Health Centre, Woking, 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 hospitalisation 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 he not be provided with his own discharge letter home with him? It would then be his responsibility to see that it is delivered to his doctor promptly.

—J. M. BEVAN

K. SHERIDAN DAWES

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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 held consultations holding sessions at health centres. But only four doctors had had practical experience of such an arrangement.

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—N. V. BIRRELL

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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 "extremes of hypothermia." Onsite "spot treatment" has 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 employed are impractical for widespread use. Supposing warmed, humidified air to breathe, however, can make a great difference to the amount of heat available for rewarming the patient,4 resulting in a rise of core temperature with no initial after-drop. This method has been found effective in hospital5 and is potentially portable. The portable equipment used in the case reported below utilizes the interaction of heat, air, and soda lime to produce moisture and heat. Oxygen is breathed through the soda lime transferring heat and moisture to the patient.6

An inexperienced pot-hole trapped in a narrow rift with water in the narrow rift for about five hours. The terrain was such that he could not be carried out, and it was necessary for him to crawl with considerable help. When he reached the surface he was ketotic, shivering vigorously, uncoordinated, and ataxic though his cerebration was not grossly impaired. He felt very cold and his mouth temperatures were 92°F (33.3°C). He was put in a heated ambulance at the cave entrance, wrapped in blankets, and given airway ventilation with the portable equipment. His condition rapidly improved, the shivering stopped, and after 20 minutes his temperature was 98-4°F (36-8°C). The patient reported subjective benefit from the method.

Use of the mouth temperature could be criticised 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. Mouth temperatures were measured at a low reading of 92°F. He was kept under the tongue with the mouth closed for three minutes. The rate of rewarming, 3·6°C in 20 minutes, compares very favourably with the 3·5°C in 7·5 minutes achieved by extra corporeal rewarming,4 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 rewarming over the range 33-37°C took four and a half hours despite recovery of consciousness.8

Rewarming for the prolonged transport time owing to the remote situation and the preparation to a bath, the time required for rewarming this patient through the airways compares favourably with the 90 minutes required to rewarm 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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Margaret B. Noble

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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 to the personal decisions made 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 this to a lack of cooperation on the part of the family doctors, which was possibly attributable to lack of adequate secretarial assistance.

We agree that shortcomings in the communications system are longstanding, for these two recent studies confirm the conclusion that the concern of many doctors is already well known 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.,

—J. M. BEVAN

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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 fiberoptic bronchoscope, for this is the same instrument 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 shortsighted but may be dangerous in a small unit such as ours, the bronchoscope must be trained to use both flexible and rigid instruments.

The flexible bronchoscope in its present form is a fine addition to the diagnostic armamentarium, allowing for a more peripheral vision and speculation than is possible with conventional instruments. It is invaluable for this purpose but can do nothing else as well as the best...