General Practice Observed

General Practitioners and Psychiatrists—Do They Communicate?

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Good communications are essential to the practice of good medicine, and communication between specialist and general practitioner is of paramount important in the management of the outpatient.[1] Nowhere is this more true than in psychiatry, both because of the nature of the specialty and because of the rapidly increasing numbers of psychiatric outpatients—a quarter of a million people attended a psychiatrist for the first time in 1969.[2] The letter is the standard tool of communication between the general practitioner and the specialist, and though several studies have evaluated its worth none have been specifically related to psychiatric outpatient services.

de Alarcon *et al.*[3] looked at the value of specialists' reports in medicine generally and found that 96% were "useful contributions to the management of the patient." de Alarcon and Hodson carried out a complementary survey in 1964 to look at the value of the general practitioner's referral letter. They noted that "as letters of introduction to hospital, all 500 [letters] in our survey served their purpose: in the light of consultant requirements, many did not."[4]

The only study of written communications and the psychiatric patient was that of Birley and Heine,[5] who looked at general-practitioner referrals to an emergency clinic and concluded that referral letters were an ineffective means of communication. This paper reports the results of a study of general practitioners' referral letters to psychiatric outpatient clinics, and also the replies from the psychiatrists, in the light of both their needs.

Method

Questionnaires were sent to all general practitioners and psychiatrists in the Cardiff area to determine attitudes and needs, and then 100 consecutive general practitioner referrals to psychiatric outpatient clinics were studied. The questionnaire sent to the psychiatrists consisted of a series of questions on the general standard of referral letters and a check list of items such as might be found in a general practitioner's outpatient referral letter. The check list was compiled by asking a random sample of psychiatrists which items they considered should not be omitted from a referral letter; there were 12 in all. The questionnaire was sent to all psychiatrists, junior and senior, except those whose work was exclusively in subnormality and child psychiatry. They were asked to answer the general questions and to rate each item on the check-list along a four-point scale of "importance in a referral letter." The response was 88% (33 sent, 29 replies).

A similar questionnaire was sent to general practitioners. The check list in this case was compiled by asking the members of the Welsh National School of Medicine's general practice unit which items they considered indispensable in a psychiatrist's report letter. The questionnaire was sent to all practitioners on the Cardiff Executive Council list, except the medical school unit. The response was 56% (145 sent, 81 replies).

Altogether 100 consecutive general practitioner referrals to adult psychiatric clinics from 1 June 1972 were studied. From each set of case notes the referral letter and the psychiatrist's report were extracted. The general practitioners' letters were assessed in terms of the check-list items rated for importance by the psychiatrists. Each item was rated simply as "present" or "absent." A definitive negative statement such as "no past psychiatric history" was rated as "item present." Legibility, which was one of the items on the check list, was assessed as "typewritten," "easily legible," or "not easily legible." These assessments were carried out by a psychiatric registrar (P.W.).

The psychiatrists' reports were similarly assessed in terms of the items rated for importance by the general practitioners. Again each item was rated as "present" or "absent" and a definitive negative statement rated as "item present." These assessments were carried out by a senior lecturer in general practice (B.B.W.).

Results

WHAT THE PSYCHIATRISTS WANTED

Each item on the check list having been rated along a four-point importance scale, a mean score for each item was easily calculated (purely clerical items such as address of patient etc. though considered important by the psychiatrists were not included in the following calculations).

The five items considered to be most important in a general practitioner's referral letter and hence should not be omitted were, in order of importance: (*a*) an indication of present medication; (*b*) a letter which was typewritten or, if not, easily legible; (*c*) an indication of the patient's past psychiatric history; (*d*) a description of the present symptomatology; and (*e*) an indication of the duration of the present problem. The least important item was considered to be the general practitioner's own diagnosis.

In general psychiatrists seemed reasonably satisfied with the standard of referral letters. Nine felt that there was "often" enough information, and 19 that there was "sometimes" enough. No psychiatrist, however, felt that there was always

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enough information in referral letters, while only one felt that he never received enough information. No psychiatrist said that he always disagreed with general practitioners concerning their assessment of patients, or that he never did. Three "often" disagreed and 26 "sometimes" did.

WHAT THE PSYCHIATRISTS GOT

In 100 referral letters studied the five most commonly occurring items were, in order of frequency: (*a*) typewriting or legibility, (*b*) a description of present symptomatology, (*c*) the general practitioner's diagnosis, (*d*) an indication of present medication, and (*e*) an indication of the duration of the present problem. This correlates reasonably well with what the psychiatrists wanted. In fact, there was a correlation coefficient of + 0·53 between the ranking of items for importance by psychiatrists and their occurrence in the letters studied. This indicates a good degree of correlation.

The general practitioner's diagnosis, considered the least important item by the psychiatrists, was present in 71 of the referral letters. One wonders how much this is due to the presence of a space marked "presumptive diagnosis" on the standard referral form rather than to a true expression of opinion on behalf of the practitioner.

Individual letters were then analysed in terms of the five items considered most important by the psychiatrists. Letters addressed to an individual psychiatrist by name were likely to contain more "key items" than those addressed to "The Psychiatrist" ($\chi^2 = 5{\cdot}16$, D.F. = 1, $P < 0{\cdot}05$; see table). This finding was hinted at by de Alarcon and Hodson,[1] but an analysis of the occurrence of each individual item showed that this difference was entirely due to individually addressed letters being typewritten or legible more often —24 letters addressed to named psychiatrists were typed, compared with three of those not so addressed ($\chi^2 = 16{\cdot}3$, D.F. = 1, $P < 0{\cdot}001$). Of those written only two addressed to a named consultant were not easily legible, but 15 of those not so addressed were ($\chi^2 = 9{\cdot}9$, D.F. = 1, $P < 0{\cdot}01$).

The patient's social history was more likely to be commented on by the general practitioner if the letter was addressed to a named psychiatrist, and this implies that the general practitioner is trying to provide useful information; in this case it is misguided, as social history was ranked 11th out of 12 for importance by the psychiatrists.

Presence of Psychiatrists' "Key Items" in 100 General Practitioners' Letters

No. of Key Items Present	Letters addressed to a Named Psychiatrist (n = 50)	Letters addressed to "The Psychiatrist" (n = 50)	Total (n = 100)
5	12 (24%)	7 (14%)	19
4	12 (24%)	10 (20%)	22
3	12 (24%)	11 (22%)	23
2	10 (20%)	11 (22%)	21
1	4 (8%)	10 (20%)	14
0	0	1 (2%)	1

$\chi^2 = 5{\cdot}16$; $P < 0{\cdot}05$.

WHAT THE GENERAL PRACTITIONERS WANTED

For each item on the check list a mean "importance score" was calculated as for the psychiatrists' questionnaire. The five items considered most important were, in order of importance: (*a*) psychiatrist's diagnosis; (*b*) an indication of suicide risk, where appropriate; (*c*) prognosis; (*d*) the arrangements for follow-up, if any; and (*e*) the treatment advised. It is perhaps surprising that treatment was not rated more highly. The information that the general practitioners considered the least important was a detailed family and personal history, the general feeling being that they would know more about this aspect of the patient than the psychiatrist could learn from one interview.

The rating of items did not depend on the practitioners' interest in psychiatry. Practitioners were categorized as "interested" or "less interested," depending on their replies to questions about orientation, postgraduate experience, etc. There was no significant difference between the rating of items by the two groups.

Of the general practitioners who completed the questionnaire 64 (79%) felt that outpatient reports should have an educative function, and of these 40 felt that psychiatric reports fulfilled this function. These views were not dependent on interest in psychiatry. Additional comments from practitioners ranged widely from remarks such as "reports, in general, are excellent" to views such as "they leave a lot to be desired." The most frequent comment, however, was a complaint that the waiting list was too long (see below).

WHAT THE GENERAL PRACTITIONERS GOT

In eight of the 100 outpatient consultations studied there was no letter. In the 92 replies the five most commonly occurring items were, in order of frequency (*a*) a description of present symptomatology, (*b*) the treatment advised; (*c*) arrangements for follow-up (or a definitive statement that the patient was not to be seen again), (*d*) a description of the patient's personal history, and (*e*) the psychiatrist's diagnosis.

There was a distinct lack of correlation between the occurrence of items in letters and their "importance ratings" by practitioners. Spearman's rank order correlation coefficient was −0·21. Some of the reasons for this are considered below.

Suicide risk, which was rated as the second most important item by the general practitioners, was present in only one letter—there were 67 in which such an indication would have been appropriate. If a patient is suicidal he would probably be admitted to hospital and it is extremely difficult to state categorically that a patient is not at risk from suicide. One wonders, in fact, how often a patient is referred to a psychiatrist as a precaution, the general practitioner then having "covered himself." If this occurs frequently it would account for the high rating of this item by general practitioners.

Personal history, which was rated 10th out of 12 items by the general practitioners, was the fourth most common item supplied by the psychiatrists. As the letter is often a valuable part of the outpatient record, however (it not always being possible to wade through pages of manuscript in a busy clinic), the inclusion of such material is usually necessary.

Each psychiatrist's letter was then analysed for the key items other than suicide risk—(namely, diagnosis, prognosis, follow-up, and treatment). Altogether 46 (50%) of the letters contained either three or four of these items, while only three letters contained none. These results are similar to those for general practitioners' letters.

The average delay between receipt of a referral letter at the hospital and the patient being seen was, for those marked "urgent," 11·7 days. For those not so marked it was 15·9 days, the overall mean being 14·0 days. This finding is at variance with views expressed by general practitioners. However, an increase in the number of psychiatrists practising in Cardiff and an improvement in outpatient facilities has led to a recent improvement—that is, a decrease—in waiting lists; certainly a year or so ago adverse criticism of delay in patients being seen would probably have been justified.

It was not possible easily to determine the delay between the consultation and the general practitioner's receipt of the report, but the delay between the consultation and the dictation of a letter could easily be noted. This, of course, is under the control of the specialist, whereas postal and secretarial

delays are not. In fact, for the 92 letters studied the average delay between consultation and dictation was 4·7 days; 40 general practitioners felt that a delay up to 14 days was acceptable.

Conclusions

The standard of communication in letters needs improvement on both sides, but the general practitioners' referral letters came nearer to meeting the needs of the psychiatrists than the psychiatrists' letters did to meeting the general practitioners' requirements. What recommendations can be made? A special "psychiatric referral form" is unlikely to be an advantage, as in practice there is already a profusion of forms to be coped with, and to add yet another would not be appreciated.

General practitioners should take note of psychiatrists' requirements and try, so far as possible, to fulfil them in their referral letters. Bearing in mind the remarks made above about suicide risk it would also be helpful if a general practitioner could state specifically with what aspects of the patient's problem he required help.

As regards the psychiatrists' letters the dual function of case summary and specialist opinion is not satisfactorily fulfilled in one letter. A detailed summary for retention in the notes, with an additional but shorter letter to the practitioner, seems to be the ideal answer. Since this is unlikely to take place (because of lack of time, clerical staff, etc.) it is the duty of psychiatrists, and indeed of all hospital doctors, to make themselves aware of general practitioners' requirements in respect of letters and to attempt to fulfil them, particularly in respect of their educative function.

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References

[1] McMullan, J. J., and Barr, A., *Journal of the College of General Practitioners*, 1964, 7, 66.
[2] Department of Health and Social Security, *Digest of Health Statistics for England and Wales*. London, H.M.S.O., 1969.
[3] de Alarcon, R., de Glanville, H., and Hodson, J. M., *British Medical Journal*, 1960, 2, 1663.
[4] de Alarcon, R., and Hodson, J. M., *British Medical Journal*, 1964, 2, 435.
[5] Birley, J. L. T., and Heine, B. E., (1966). Cited by Kaeser, A. C., and Cooper, B., 1971, *Psychological Medicine*, 1, 312.

Clinical Topics

Outbreak of Meningococcal Disease in Devon

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Summary

In a recent outbreak of 31 cases of meningococcal disease in Devon there were six deaths. Several patients had an unusual rash as the presenting feature and there was an unusually high incidence of complications, affecting the central nervous system, joints, and the heart among other sites.

Introduction

During the past 25 years the incidence of meningococcal meningitis in England and Wales has been decreasing steadily. Recent figures suggest that there has been a recrudescence of meningococcal infection.[1] There were minor outbreaks in Bolton during 1970 and 1971 and in Monmouth in December 1972. We report an outbreak of meningococcal infection in Devon between October 1972 and May 1973 which reached its peak in the early months of 1973. The main purpose of this paper is to highlight the high complication rate which may reflect a changing pattern of meningococcal disease in Britain.

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Patients and Methods

There were 31 patients, 18 of whom had proved meningitis. In 24 the diagnosis was confirmed by isolation of meningococci from the blood, cerebrospinal fluid, or joints. In seven patients the diagnosis was made from the characteristic haemorrhagic rash and the clinical course of the illness. The symptoms had lasted from a few hours to several days, the history was 24 hours or less in all the fatal cases. Two of the deaths occurred suddenly at home and the remainder shortly after admission to hospital. The disease was most common in the first year of life and 21 of our patients were under 10 years (table I). There were 17 male and 14 female patients.

TABLE I—*Age Range, Incidence, and Mortality in 31 Patients*

Age in Years	0–	1–	5–	10–	20–	30–	50 and Over
No. of Cases	7	9	5	5	3	0	2
No. of Deaths	2	0	0	3	0	0	1