Evaluation of death registers in general practice

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SUMMARY

Background. *General practitioners (GPs) do not routinely receive information about the deaths of those patients whose death certificates they have not completed. We developed and evaluated a system for producing death registers for GPs.*

Aim. *To evaluate GPs' and practice managers' views on, and uses of, the death register.*

Method. *General practitioners in Newcastle (n = 161) and Sunderland Family Health Service Authority (n = 144) areas were sent a questionnaire on their sources and use of information about patients' deaths. Death registers were sent to Newcastle practices; Sunderland practices were the control group. A follow-up questionnaire was sent to Newcastle (n = 173) and Sunderland (n = 140) GPs after two years. Newcastle practice managers (n = 45) were interviewed after their practice had received death registers for one year.*

Results. *Ninety-two per cent of Newcastle responders had seen the death register. Seventy-three per cent saw it regularly. Of those who saw it, 92% found it useful for communication within the primary health care team, bereavement follow-up, and administration and medical audit. One fifth of GPs named the death register as their first source of information about their patients' deaths. Newcastle GPs reported greater levels of change in use of patient death information than the control group. Practice managers circulated, used, and recorded information from the death register.*

Conclusion. *Death registers are valued and have demonstrable benefits with regard to administration, bereavement care, and medical audit.*

Keywords: death; registers; information sources; questionnaire survey.

Introduction

GENERAL practitioners (GPs) do not routinely receive information about the event or cause of the deaths of patients whose death certificates they have not completed. Over 80% of GPs said that they would welcome such information.[1] A system for producing death registers for GPs was developed in Newcastle upon Tyne in collaboration with the District Health Authority and the Family Health Service Authority.[2] The details of each patient's death, including all causes as stated on the death certificate, age, home address, and GP's name were entered onto a computerized database.[3] Practice-specific lists of deaths were sent out every two weeks (Figure 1). This took two hours per

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week and cost about £1000 a year. Newcastle practices (*n* = 46) received the death register and six updates about the project. GPs in Sunderland comprised the control group and did not receive death registers or updates.

This study aimed to evaluate GPs' and practice managers' use of and attitudes to the death registers. Changes in the use of death information by GPs were examined by time and place. The practice managers' survey gave information on circulation of and referral to death register data. Attitudes to the death registers are illustrated by giving examples of GPs' and practice managers' comments.

Method

A questionnaire for self-completion was sent to all GPs in the Newcastle upon Tyne (161) and Sunderland (144) Family Health Services Authority (FHSA) areas (total = 305). GPs were asked how they first learned of the death of a patient, whether they systematically collected information about patients' deaths, and what information was recorded and how it was used. The findings of this survey have been published.[1] Death registers were then sent to Newcastle practices. After two years, Newcastle GPs (*n* = 173) were sent a second questionnaire, which repeated the baseline questions and asked specifically about the uses made of information and the GPs' attitudes to receiving the death registers. The second questionnaire sent to Sunderland practices (*n* = 140) omitted these additional questions. Postal reminders and second questionnaires were sent to non-responders after two weeks. Differences in numbers of recipients were due to changes in the FHSA list membership. For comparisons between places and times data were analysed for respondents who participated in both surveys (*n* = 135). Closed questions were analysed using the EPI-INFO statistical package.[6] Following advice from a statistician on further handling of these data, statistical tests were not applied because the approach of the analysis was descriptive rather than inferential. Responses to open questions were transcribed and coded thematically.

Telephone interviews were conducted with practice managers in Newcastle to ascertain what usually happened to the register, including whether it was circulated, where it was filed, and its administrative uses. Proforma were completed during the interviews and subsequently coded and quantified.

Results

The response rate of GPs was 108/173 (62%) in Newcastle and 78/140 (56%) in Sunderland, and of practice managers, 45/45 (100%).

Newcastle general practitioners' perceptions and uses of the death register

At the end of the project, 99/108 (92%) Newcastle GPs had seen the death register, and 79/108 (73%) saw it regularly. Of those who saw it, 91/99 (92%) found it useful. Eighty-six GPs wrote free-hand comments on its value, including that it gave the cause of death (22) and informed them about deaths not otherwise known (22). Such comments included, 'It is often the only way we get to know cause of death', and, 'helps avoid embarrassment of visit when you don't know of the circumstances'. Eight GPs said it was not useful because they were already aware of the information (2), it was of no practical use (2), they already had a system

Date of death	Surname	First name	Date of birth	Sex	Address	Cause I	Cause II	Coroner's case?	Place of death[a]	GP
27.7.97	Robinson	Betty	20.8.22	F	37 Green St	Broncho-pneumonia	Senile dementia	No	6	Jones
27.7.97	Barker	George	17.3.30	M	8 Coronation Rd	Pulmonary embolus	Fractured femur	No	3	Smith
30.7.97	Clark	Mary	19.10.20	F	10 Parkside Rd	Myocardial infarction		Yes	7	Smith

Figure 1. Example of a death register (all names, and addresses are fictitious). [a]Place of death code: 1 = home address; 2 = Newcastle General Hospital; 3 = Royal Victoria Infirmary; 4 = Freeman Road Hospital; 5 = other hospital; 6 = residential; 7 = street; 8 = dead on arrival at hospital; 9 = hospice; 0 = other.

of being notified of deaths (2), or there were very few deaths in their practice (2). Comments from those who had not seen the register included, 'Would be useful if I knew where it was!'.

Newcastle GPs used the death register for informing other members of the primary health care team about deaths (63%), bereavement follow-up (44%), cancelling outpatients' appointments (41%), medical audit (35%), and promoting discussion of deaths at primary health care team meetings (3%). The death register was named as their first source of information about deaths by 17 GPs (21% of those who saw it regularly).

Comparisons between Sunderland and Newcastle general practitioners

Table 1 shows a comparison of GPs' use of death information between places and times in those who had replied to both surveys. In the control group, several aspects of bereavement follow-up and use of death information increased. Newcastle responses showed greater increases across more areas during the same period.

Practice managers' survey

Death registers were shown to GPs in about two-thirds of the practices receiving them (28/45). In eight of these 28 practices, the data were also entered on a computer or used to update written records. In the other 17 practices the contents of the register were entered onto the computer or death notice board (9), or the register was filed away (8).

Nearly two-thirds of the practice managers (28/45) thought the register was referred to by the GPs, eight thought it was not, and nine did not know. Reasons for referring to the death registers (30 given) included using it to check information about full causes of death (14), deal with correspondence that arrived after

records had been returned to the FHSA (7), answer queries about patients (6), use as a back-up to computer-entered information (2), and to refer to weekly at primary health care team meetings in the discussion of births and deaths (1). Practice managers noted that if the death register itself was not consulted, the information it contained was accessed through a 'death book' updated from the register, or via the computer. Comments included: 'An invaluable resource, it cuts the work in half.' and 'Excellent, we should have had one years ago — complete information all in one place.'

Discussion

Our low-cost system of providing general practices with registers containing information about their recently deceased patients appears to be appreciated by GPs and practice managers. Furthermore, this evaluation indicates that the provision of death registers changes the extent to which death information is routinely used. Before discussing the implications we consider the methods.

The design of this study was pragmatic with a 'before and after' comparison being the primary means of inferring change. The Sunderland GPs, some 15 miles from Newcastle, were considered to provide an appropriate control group to assess the impact of external influences. Response rates, although not as high as one would like, were reasonable for a postal survey of GPs.[5] The restriction of a 'before and after' comparison to responders who completed both questionnaires enabled a more accurate evaluation of change in the use of death information between the study and the control group than a comparison of the whole group of responders. The use of both quantitative and qualitative data, and of two sets of primary health care team members (GPs and practice managers), generated complementary and triangulated findings.[6]

Table 1. Comparison of GPs' use of death information between time periods and places.

Use of death information	Sunderland responders participating in both surveys (n = 61)		Newcastle responders participating in both surveys (n = 74)		Sunderland change over time	Newcastle change over time
	1992 %	1994 %	1992 %	1994 %	%	%
Bereavement follow-up for carers/relatives	44	57	39	65	13	26
Screening for familial conditions	10	20	4	10	10	6
Noting in relatives' records	15	20	27	53	5	26
Contacting carers' GP in another practice	8	8	8	20	0	12
Notification of hospitals	30	44	39	60	14	21
Calculate number/rates of death	18	25	31	22	7	-9
Analysis of death from specific conditions	8	13	19	22	5	3
Analysis of individual cases	7	8	14	26	1	12
Other medical audit	7	8	12	14	1	2
Introduction of practice protocols including guidelines and policies	5	7	7	19	2	12

The data suggest that, in comparison with those in Sunderland, Newcastle GPs were more likely to use death information to improve clinical practice and administration, to provide care for the bereaved, for noting the death in relatives' medical notes, and for the notification of hospitals. Clearly there were positive changes in the control group, notably in bereavement follow-up, screening for familial conditions, and notifications of hospitals. Changes, hopefully involving increases in good practice, would be expected over a two-year period, and it was for this reason that a control group was used. The Sunderland GPs' increase in screening was slightly higher than in Newcastle, as was for calculation of death rates. The latter is attributed to a decrease in this activity by Newcastle GPs, possibly due to a redistribution of their energies to the other activities. The death register was felt to be useful by GPs and appeared to produce changes in practice; for example, a more systematic follow up of bereaved relatives, which has been previously shown to be variable;[7] and the development of guidelines about the care of the dying and recently deceased. In addition, the death register is clearly a useful resource for practice managers and others involved in administration. Systems for the distribution and use of the register within the practices are important. The register's contents need to be seen by GPs at least, and ideally by all members of the primary health care team.

This evaluation has demonstrated the potential benefits of death registers in general practice. Subsequently, Newcastle and North Tyneside Health Authority has taken on the administration of the register and, because of its perceived usefulness and low costs, has extended the service to North Tyneside. We recommend that all health authorities implement a similar service. The flow of information about deaths in the United Kingdom must cease to be one way.[2] It should be used to inform and improve both the quality of clinical service provided by GPs and administration of general practice.

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