PRACTICE OBSERVED

Practice Research

Is communication improving between general practitioners and psychiatrists?

IAN M PULLEN, ALEX J YELLOWLEES

Abstract

General practitioners and psychiatrists communicate mainly by letter. To ascertain the most important items of information that should be included in these letters ("key items") questionnaires were sent to 80 general practitioners and 80 psychiatrists. A total of 120 referral letters sent to psychiatric clinics in 1973 and 1983 were studied, together with the psychiatrists' replies, and these were rated for the inclusion of "key items."

General practitioners' letters contain less information about the family but more about psychiatric history than they did a decade ago. Overall, psychiatrists' letters have not changed. Registrars, however, now include noticeably more "key items" than they did 10 years ago, but their letters remain twice the length of those written by consultants.

It is suggested that letter writing skills are vital to good patient management and should be taught to postgraduate trainees in general practice and psychiatry.

Introduction

The need for clear communication in medicine is often emphasised, but of all aspects of medical communication probably least attention is given to that among doctors.[1] Communication between specialist and general practitioner is of paramount importance in managing an outpatient,[2] but, despite the desirability of face to face or telephone contact between consultant and general practitioner, the main mode of communication remains the letter.[1]

One way communication from general practitioners to psychiatrists has been studied by de Alarcon and Hodson and Birley and Heine, and from psychiatrists to general practitioners by Margo.[2-4] The only British study of two way communication between general practitioners and psychiatrists concluded that "the standard of communication in letters needs improvement on both sides."[5] In the decade since that study was published several changes have occurred that might have influenced communication, including compulsory vocational training for general practitioners and more contact between psychiatrists and general practitioners at health centre clinics. But have letters improved?

This paper reports the results of a study of general practitioner referral letters to psychiatric outpatient clinics and the replies from psychiatrists, during two periods separated by 10 years.

Method

Questionnaires were sent to 40 consultant psychiatrists and 40 psychiatric trainees working in the Edinburgh area, asking them to indicate the five most important items that they considered a general practitioner should include in a referral letter. The response was 95% (80 forms sent, 76 returned).

A similar questionnaire was sent to a one in six sample of Edinburgh general practitioners (n = 40) and to 40 general practitioner trainees, asking for the five most important items that they considered a psychiatrist should include in a report on one of their patients. The response was 88% (80 forms sent, 70 returned).

Altogether 120 general practitioner referrals to Edinburgh adult psychiatric clinics were studied: 60 consecutive referrals from 1 January 1973 and 60 from 1 January 1983. The referral letters were assessed in terms of the five "key items" derived from the psychiatrists' questionnaires. Each item was rated as present or absent. A clear negative statement such as "no medication" was rated as "item present." The replies from psychiatrists were similarly assessed

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considered letter to a general practitioner. The positive findings from the history and examination of the mental state, together with important negative findings, should be arranged succinctly to form a concise explanation of the condition and hence the management recommended and the likely outcome. Any questions raised by the general practitioner must be answered. Although communication is improving, only just over half of letters contained a concise explanation—that is, no more than one paragraph.

We have shown that a group of Scottish general practitioners preferred psychiatrists to write a one page letter with two or three subheadings.[7] Examples of an "ideal" letter from a general practitioner and the psychiatrist's reply are given in the appendix.

Conclusions

Patient management depends on effective communication among the doctors concerned. Letter writing and communication skills between doctors need to be taught at a postgraduate level. With the exception of registrars in psychiatry there has been no improvement in the letters studied over the past 10 years.

We thank the general practitioners and psychiatrists who took the time to complete and return the questionnaires and the staff of the medical records department, Royal Edinburgh Hospital, for their help.

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Appendix

Health Centre
Edinburgh
10 August 1984

Dr A Nother
Consultant Psychiatrist

Dear Dr Nother,

re: Lady Macbeth (dob 05.05.61)
36 Any Street, Edinburgh

I would be grateful for your help with this young woman who has developed agoraphobia over the past two months and is not improving despite treatment with diazepam 5 mg tds for the past three weeks. I am uncertain how next to proceed and would be grateful for your advice.

She is a quiet girl whom we seldom see at the health centre except in connection with the pill. There is no history of physical or psychiatric disorder. She married, apparently happily, six months ago and lost her job at the local supermarket about that time. As far as I know, her husband's job is secure. Two months ago she suddenly felt sick, dizzy, and panicky while shopping in a supermarket and for six weeks has been unable to leave the house unaccompanied. Her mother has been visiting daily to help out.

She is an only child. Her father died of a myocardial infarction many years ago, and her mother has recently been investigated for hiatus hernia. No one else in the family has a psychiatric history.

Many thanks for seeing her.

Yours sincerely,
T Practitioner

Royal Hospital
Edinburgh EH10 5HF
Telephone: 010 447-6031
17 August 1984

Dr T Practitioner
Health Centre
Edinburgh

Dear Dr Practitioner,

re: Lady Macbeth (dob 05.05.61)
36 Any Street, Edinburgh

This patient attended my health centre clinic today accompanied by her mother who treated her like a very young child. Even following her marriage she continued to see her mother daily, and, until her mother's recent illness, they always shopped together. The incident you described occurred while her mother was in hospital and she was shopping alone.

Diagnosis: I confirm your diagnosis of agoraphobia. The sudden death of her father when she was 13 led to a mutually dependent relationship with her mother which even her marriage has not changed. This has caused arguments with her husband who feels rejected. Despite this, since losing her job she has spent even more time with her mother. Her mother's recent chest pains reminded her of her father's death and made her frightened that her mother might die. She only became aware of the physical symptoms of this anxiety while shopping. She linked these symptoms with shopping, which led to a progressive avoidance of at first shops and then of leaving the house.

Recommendations: Lady Macbeth's agoraphobia should respond to a behavioural approach (systematic desensitisation). At the same time, she needs encouragement to separate from her mother and to share her anxieties and gain support from her husband. I have arranged to see her regularly over the next two months to set graded goals for her to start leaving the house and eventually resume shopping and will involve her husband with this. The diazepam may now be stopped. I am sure that she will benefit from the opportunity to discuss with you both the difficulty of making these changes in her life and the progress she is making.

Conditions of this type tend to improve spontaneously, but the symptoms are likely to return in the face of future stresses. I shall be pleased to discuss her with you in more detail at our regular meetings.

Yours sincerely,
A Nother
Consultant Psychiatrist

in terms of the five key items derived from the general practitioners' questionnaires.

Results

PSYCHIATRISTS' REQUIREMENTS

The key items that psychiatrists identified as being of greatest importance for the general practitioner to include in a referral letter were: (*i*) the medication prescribed so far; (*ii*) family history, especially any information that the patient might not disclose at the first interview; (*iii*) the main symptoms or problems; (*iv*) the reason for referral; and (*v*) psychiatric history.

To be effective letters must be legible. Over two thirds of the letters studied were typewritten and, of those that were handwritten, only nine were difficult to read. Table I gives the number of key items contained in the referral letters. Williams and Wallace found that letters addressed to a named consultant were likely to contain more key items than letters addressed to The Clinic.[5] In this study 27 letters of the 1973 sample and 23 of the 1983 sample were addressed to a named psychiatrist (table II). Overall, the referral letters contained an average of 3·4 key items per letter in 1973 and 3·6 in 1983.

TABLE I—*Presence of key items required by psychiatrists in 120 referral letters from general practitioners*

Key item	No (%) of letters with key item present: 1973 (n = 60)	1983 (n = 60)
Medication	42 (70)	37 (62)
Family history	35 (58)	22 (37)*
Main symptoms problems	58 (97)	60 (100)
Reason for referral	49 (82)	53 (88)
Psychiatric history	27 (45)	43 (72)**

*$\chi^2 = 5{\cdot}65$, df = 1, p < 0·05.
**$\chi^2 = 8{\cdot}77$, df = 1, p < 0·01.

TABLE II—*Presence of key items in letters addressed to psychiatrists*

No of key items present	No (%) of letters addressed to a named psychiatrist (n = 50)	No (%) of letters addressed to "The psychiatrist" (n = 70)
5	18 (36)	6 (9)
4	16 (32)	24 (34)
3	11 (22)	24 (34)
2	5 (10)	11 (16)
1	0	4 (6)
0	0	1 (1)

Analysis of variance, 120 letters: f = 14·49, df = 1 118, p < 0·01.
1973 letters (n = 60): f = 5·16, df = 1 58, p < 0·05.
1983 letters (n = 60): f = 9·32, df = 1 58, p < 0·01.

TABLE III—*The length of psychiatrists' letters*

Grade	Average length (cm): 1973 (n = 60)	1983 (n = 60)
Consultants	16·4 (n = 14)	16·0 (n = 22)
Senior registrars	23·6 (n = 8)	20·2 (n = 6)
Senior house officers and registrars	30·4 (n = 38)	29·5 (n = 32)

Analysis of variance:
1973 consultants v registrars df = 1 50, f = 14·27, p < 0·01.
1983 consultants v registrars df = 1 52, f = 23·21, p < 0·01.

GENERAL PRACTITIONERS' REQUIREMENTS

The key items that general practitioners identified as being of greatest importance for the psychiatrist to include in a report on an outpatient were: (*i*) diagnosis; (*ii*) treatment recommended; (*iii*) follow up arrangements; (*iv*) prognosis; and (*v*) a concise explanation of the condition.

The length of psychiatrists' letters ranged from one paragraph to four sides of A4 paper. The uniform size of hospital paper permitted comparison of letter length. For both years studied consultants' letters were significantly shorter than registrars' letters (table III).

Table IV gives the number of key items contained in the psychiatrists' letters. The psychiatrists' average score for 1983 was 3·6 key items per letter compared with 3·2 in 1973. Within this overall picture the registrars (senior house officer plus registrar grades) improved their scores from 2·9 items per letter 10 years ago to 3·3 in 1983 ($p < 0{\cdot}05$). In 1973 their scores were significantly lower than those of the consultants ($p < 0{\cdot}01$) but not significantly different in 1983.

TABLE IV—*Presence of key items required by general practitioners in 120 letters from psychiatrists*

	No (%) of letters with key items present: 1973 (n = 60)	1983 (n = 60)
Diagnosis	48 (80)	53 (88)
Treatment	47 (78)	55 (92)
Follow up	59 (98)	57 (95)
Prognosis	13 (22)	16 (27)
Concise explanation	23 (38)	36 (60)*

*$\chi^2 = 5{\cdot}63$, df = 1, p = 0·05.

Discussion

The scope of this study was limited to the general practitioner's referral letter to a routine psychiatric clinic and the psychiatrist's first letter in reply. In the case of many patients further correspondence would follow.

In their referral letters three quarters of the general practitioners who mentioned medication specified the dose prescribed, but fewer than half mentioned the duration of treatment. In the case of antidepressant drugs this information is particularly important. The decline in the inclusion of material about the family may represent a decline in the knowledge of families or may merely reflect a change of attitude on the part of the general practitioners. This change was balanced by more information about previous psychiatric contact, so that, overall, general practitioners provide as much information in each letter as they did a decade ago.

When replying to the general practitioner the failure of psychiatrists to mention prognosis is perhaps excusable as the letters were written after a single interview. Even when no further interviews were planned, however, prognosis was seldom mentioned. Where medication was suggested, nearly all letters clearly indicated who should prescribe it, but in only a fifth of cases was duration of treatment mentioned.

The style of psychiatrists' letters has changed over the decade, with a greater use of subheadings (10% in 1973 to 35% in 1983), but the length of letters has not changed. Registrars' letters are still twice the length of letters written by consultants, although the number of key items present is now the same. Psychiatric trainees are taught to take extensive case histories, which tend to be regurgitated in toto in many letters. It seems that consultants have taught themselves to present material efficiently but do not necessarily teach this skill to their trainees. Last year for the first time the Edinburgh postgraduate training course in psychiatry included a teaching session on letter writing and communication with general practitioners, and sensible advice on letter writing is given in a recent postgraduate textbook.[6]

Williams and Wallace commented that "as regards the psychiatrists' letters the function of case summary and specialist opinion is not satisfactorily fulfilled in one letter," but they were unable to suggest a workable solution to this problem.[5] The argument that the letter acts also as a case summary is not a valid excuse for long, rambling letters but is merely a smokescreen to hide a poorly conceptualised case. The hospital record requires no more information than is contained in a well

Drug users in contact with general practice

J R ROBERTSON

Abstract

A group of heroin users who are in contact with a general practice in north west Edinburgh are described. The study group was younger and included more women than previous studies. These people used a large variety of drugs and mainly purchased them locally. Frequent and often prolonged abstinent periods occurred with no prescribed opiate treatment. The group had experienced a high rate of drug related medical disorders. All these points raise the possibility that opiate users who are known to general practitioners may be a distinctly different population from those who attend drug dependency clinics. The frequency of remission and the prevalence of polydrug use have profound implications for planning and evaluating an effective medical response.

Introduction

Detailed characteristics of illicit drug users today are almost entirely confined to those who attend drug dependency clinics. Edwards commented that the role of the general practitioner was unexplored and unrecorded.[1] Thorley observed the lack of information on what happens during dependency and noted that most studies record "snapshots" of groups of opiate dependents at one point in time, or else at the end of a period of time.[2] Without information about what happens to problem drug users during their disease, which most physicians recognise to be a relapsing disorder, claims for successful treatment are difficult to assess.

Official United Kingdom statistics related to notified "addicts" show a rising average age and an increasing percentage of female drug users.[3] Chapple *et al*, in a study of 108 problem drug users in 1972, reported a mean age of 26 and a male:female ratio of 73:27.[4] Polydrug use has been recognised by Plant[5] and in the recent report by the Advisory Council on the Misuse of Drugs.[6] The results of Stimson and Oppenhemer's classic study of 128 drug users attending drug dependency clinics in London during 1969 showed that at the outset of the study the average age was 25 and they had been using heroin for an average of five years.[7] The age at the onset of use ranged from 14 to 48 (average 19·5), and all these users were receiving heroin on prescription at the time of the first interview (82% were also receiving methadone). Of the study group, 93 were men and 35 women (73%:27%). The authors noted that abstinence was attempted but chronic relapses and frequent admissions to hospital with drug related disorders occurred.

This paper is about a group of patients in a large Scottish group practice seen at the doctor's surgery.

Method

In a large Scottish group general practice located in north west Edinburgh, with predominantly council estates of poor quality housing, there were among the 18 000 patients 162 people who at some time had taken intravenous heroin. The Lothian Regional Drug Treatment Centre had some years previously abandoned prescribing maintenance doses of opiates and pursued a policy of minimal intervention, admitting problem drug users to hospital during crises or exceptional circumstances only.

Detailed information was gathered relating to 46 of the 162 drug users by questionnaire and review of case records. This was carried out by one partner, and the study group was selected only by the fact that they attended this doctor's surgery from June 1982 to December 1983. In addition, some restricted information was gathered about the remaining 116 individuals from case records.

Results

The average age of the 162 heroin users was 27 and the male:female ratio 112:50 (69%:30%). Among the 46 users the average age was 22·5 and the average age at onset of use of heroin was 18·9; 77% had started using heroin before the age of 20. The male to female ratio was 28:18 (61%:39%). Sixty nine per cent were initiated into opiate use by an unspecified friend, 16% were introduced to heroin in the company of a school friend, and 11% by a spouse or sibling. All had purchased drugs in the vicinity of the practice, and only a fifth went as far as the other side of the city. Six per cent had bought drugs outside Edinburgh. The daily cost of illicit drugs ranged from £5 to £150 (average £27).

TABLE I—*Illicit drugs used by respondents (n = 46)*

Drugs ever used	No
Heroin	46
Cannabis	38
Dihydrocodeine (DF118)	36
Diazepam (Valium)	31
Dipipanone (Diconal)	30
Barbiturates	22
Cocaine	22
Amphetamines	12
Physeptone (methadone)	9
Morphine	8
LSD (lysergide)	6
Pethidine	2
Opium	1
Gee's linctus	1

TABLE II—*Duration of abstinence from opiate use reported by study group (n = 46)*

Duration of abstinence	No
1-7 days	9
8-14 days	5
15-30 days	6
1-6 months	11
6 months	14
Total	45

The study group was mainly from social classes IV and V (Registrar General's classification), unemployed, and all native to Edinburgh. All were regular (daily) users of heroin by intravenous injection and most admitted to two or more injections daily intermittently, depending on supply. All had ample evidence of multiple intravenous injection sites to substantiate their histories.

About half reported having illnesses that were directly related to drug use: 38% had had jaundice and 5% bacterial endocarditis, and the remainder had had abscesses or phlebitis of varying severity. Sixty two per cent admitted sharing needles with other drug users. Many other drugs were used (table I). The longest period of abstinence for problem drug users ranged from several hours to over six months before relapse (table II).

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