Value of the General Practitioner's Letter

A Further Study in Medical Communication

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"Medical communication is a wide-ranging, undisciplined, chaotic and highly unscientific business" (R. K. Bussy, 1960).

The letter is the main instrument for the two-way exchange of facts and opinions between specialists and general practitioners. This type of exchange implies mutual isolation, but emphasizes the importance of the letter. Schuster (1961), in one of the few references to this subject (McMullan and Barr, 1964), suggested that it would be valuable "to investigate the basic requirements of the two sides (hospital and general practice) so as to ensure the exchange of essential information in the most useful form."

The value of specialists' reports to G.P.s was considered in a previous survey of 500 letters (de Alarcon, de Glanville, and Hodson, 1960). Of these, 96% were found to offer a definite contribution to the understanding of the case, and only 4% were "vague and useless." These results showed how the negative feelings aroused by bad letters disturb objectivity.

This time we have shifted our viewpoint and attempted an objective assessment from the hospital of the G.P.'s letter. The "bad" or "please see and treat" type of letter proved—despite common assumptions—rare. On the other hand, the main consultant criticisms—failure to mention treatment the patient has been having, and illegibility—proved justified.

The G.P.'s letter is an instrument of communication. How far it succeeds, where it fails, and how it may be improved is the subject of this study.

So that the assessment could be made in the light of specialists' own opinions, we conducted the survey in two parts. In Part I we asked the specialist what he thought were the commonest faults, and what points should never be omitted. In Part II we searched 500 G.P. letters to see what they provided.

Part I. What the Specialist Wants

A questionary was sent to 70 members of the senior medical staff of several teaching and non-teaching hospitals in the London area. Replies were received from 38 consultants, of whom 18 were general physicians, 13 were surgeons, either general or specialist, 4 were obstetricians and gynaecologists, and 3 were psychiatrists.

Question 1: Are G.P.s' Letters Satisfactory?

To this question 55% answered "Yes" and 45% answered "No."

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Question 2: What are the Commonest Faults in G.P.s' Letters?

Replies to this question are given in Table I in order of frequency of mention.

TABLE I.—*What Are, According to Consultants, the Commonest Faults in G.P.s' Letters*

	No. of Consultants
1. Failure to mention drugs or other treatment the patient is having	14 (37%)
2. Illegibility	10 (26%)
3. Brevity; letter is only a referral note, and no mention is made of history, examination, or treatment	6 (16%)
4. Failure to state problem or specific requirements	2 (6%)
5. Omission of important points in past history	1 (2·5%)
6. Failure to disclose what the patient knows, in case of malignant or other serious disease	1 (2·5%)
7. Failure to organize information in the letter	1 (2·5%)
8. Discourtesy in various forms	1 (2·5%)
Abstained from answering this point	2 (5%)
	38 (100%)

Comment.—What is the function of the G.P.'s letter? If it is simply a note of introduction, or a ticket of entry to the hospital, then clearly the briefest line will suffice. If it purports to be more than this—and most letters do—then consultants' opinions on the defects are worth analysing. All defects, including illegibility and even by implication discourtesy, appear to be faults of omission, and may well be due to lack of time. Unawareness of what the consultant wants is another explanation, and one of the reasons for this survey was to determine his needs.

Question 3: What Items Should Never be Omitted From a G.P.'s Letter?

The items which consultants considered should never be omitted, together with the proportion who mention each item, are given in Table II.

From three to ten items were mentioned by individual consultants; about half (52.6%) mentioned four or five.

TABLE II.—*Items Which Should Never be Omitted*

	No. of Consultants
1. Drugs and treatment patient is having	32 (84%)
2. Details patient is unable, or unlikely, to supply	29 (78%)
3. G.P.'s problem or specific requirement from referral	23 (61%)
4. Other details about drugs, sensitivities, or steroids	23 (61%)
5. Main symptoms, and their chronological development	17 (45%)
6. G.P.'s own diagnosis and opinion	14 (36%)
7. G.P.'s clinical findings, and change of signs over a period	11 (29%)
8. Attitude of patient towards his illness, knowledge of seriousness, type of reassurance required, and what he expects from hospital	11 (29%)
9. Patient's name (Mr., Mrs., Miss)	8 (21%)
10. Previous investigations and hospital attendances	7 (18%)
11. Family history	5 (13%)
12. Address	5 (13%)
13. Age	4 (11%)
14. Personality of patient	3 (8%)
15. Relations with other doctors	3 (8%)
16. Hospital number, if any	3 (8%)
17. Name of G.P. in block letters	3 (8%)
18. Any medico-legal facets	2 (5%)
19. Date	1 (2·5%)

Items That Should Never be Omitted

Treatment.—Of the 38 consultants, 32 (84%) thought treatment the most important item, and stated that the G.P. often omitted any mention of it; 23 (61%) said they needed "further details" about it; and 14 (28%) specifically stated they wanted to know the drugs used previously for the same disease, and response. (This compares with Lord Taylor (1954): ". . . consultants have stressed the great importance of their being told what drugs the patient has been receiving and in what doses . . . without this information the consultant is hard put to it to tell what is due to the disease and what to the treatment.") In addition consultants wanted to know whether the patient had been on steroids at any time, and whether he had any drug sensitivity. Previous treatment with oestrogens was required by gynaecologists, with anti-tuberculosis drugs by thoracic surgeons, and with antidepressant drugs or tranquillizers—with dosage—by psychiatrists.

Details patient will not supply.—Twenty-nine consultants thought this important, and instanced details of family history, previous medical history, and relevant social circumstances.

Reason for referral.—Twenty-three consultants (61%) considered that the G.P. should state clearly why he had referred the patient. Most wanted the G.P. to commit himself to a definite request for diagnosis, opinion, treatment, or even reassurance for the patient. Some thought he should state whether he wanted the hospital to take over or whether he was prepared to continue treatment himself.

Main symptoms and their chronological development.—Seventeen consultants, just less than half, thought this item important. Several clearly did not wish to be burdened with details of history, which they would have to elicit themselves anyway.

Brief clinical findings.—Eleven consultants (29%) required these, and several thought them especially valuable when a change of signs had been observed over a period. Several consultants regretted they could not tell from the letter whether the patient had been examined or not.

Patient's attitude towards and knowledge about his illness, and what he needs or expects.—Eleven consultants required to know this, and also whether a patient who had malignant disease knew about it or not. They also wanted to know whether the G.P. had suggested to the patient what investigations he could expect. Some wanted to know the reason the patient had been given for being referred, others the type of reassurance the G.P. considered appropriate.

Family history.—Five thought this should never be omitted, and obstetricians requested family details of rubella, diabetes, or hypertension.

The other items which consultants thought should never be omitted were not elaborated on, and are given in Table II.

TABLE III.—*Analysis of 500 Letters from G.P.s Referring Patients to Hospital*

Item	No. of Letters							
	Med.	Surg.	Gyn.	E.N.T.	Orthop.	Psych.	Total No.	%
	100	50	50	100	100	100	500	100
With dosage	7	1	1	1	2	26	38	7·6
Without dosage	9	6	3	13	2	17	50	10·0
Only general name of drug (e.g., tranquillizer)	3	1	0	5	2	4	15	3·0
Other treatments	—	—	—	—	10	—	10	2·0
Sensitivity to drugs	—	—	—	—	—	—	—	0·0
Legibility								
Typed	10	6	7	12	13	13	61	12·2
Written: Good	42	15	23	43	48	51	222	44·4
Written: Medium	33	22	15	28	27	24	149	29·8
Written: Bad	15	7	5	17	12	12	68	13·6
Reasons for referral, or "What G.P. wants"	58	49	48	80	93	79	407	81·4
Presenting symptoms	80	43	41	62	88	87	401	80·2
Chronological sequence of symptoms	49	25	28	30	48	41	221	44·2
G.P.'s own assessment, or diagnosis	39	27	24	56	36	21	203	40·6
Clinical findings	32	18	15	16	27	4	112	22·4
Tests	7	5	2	3	9	—	26	5·2
What patient expects from referral	2	4	—	3	6	4	19	3·8
Name of patient	96	50	50	100	100	100	496	99·2
Address of patient	52	36	34	60	57	72	311	62·2
Age of patient	56	34	36	51	52	45	274	54·8
Hospital investigations, and previous operations	7	7	1	5	13	23	56	11·2
Social circumstances	7	1	8	3	9	25	53	10·6
Previous medical history	6	9	11	10	5	17	58	11·6
"Please see and treat"	4	—	—	3	2	1	10	2·0

Part II. What the G.P. Provides

Five hundred referral letters from the records of a London teaching hospital were analysed in the light of consultant requirements. The results are given in Table III.

All these letters had been received in the last two or three years and were obtained from a random sample of case notes. Practically all the referrals were from G.P.s working in the Greater London area, and occasionally there was more than one referral letter from the same doctor. But, except for one case, not more than two referrals from the same G.P. were found in the series. This exception provided, in spite of random selection, eight letters for the series, and it is interesting to note that it also provided the greater part of the "please see and treat" letters.

Results of Analysis of 500 G.P. Letters

Drugs and treatment given.—In only 113 (22.6%) of letters was some form of treatment mentioned. This is striking because most of the consultants consider that mention of drugs or treatment given should never be omitted. No mention was made of drug sensitivities in any of the 500 letters. It is unlikely that the patients referred to in the remaining 387 (77.4%) of letters had had no treatment, or that there was no single case of drug sensitivity among any of them. None of the *pro-forma* letters in the survey had any heading or space for mention of treatment. Treatment is mentioned in nearly half 47 (47%) of the letters to the psychiatric department. No mention was made of psychotherapy although many G.P.s had evidently been seeing their patients at regular intervals for supportive treatment of this sort.

Legibility.—Letters were classified as typed (61: 12%) or, if handwritten, as good (222: 44.4%), medium (149: 29.8%), or bad (68: 13%). Letters of medium legibility required extra effort to read, had to be read very slowly, and more than once some words required deciphering. Letters of bad legibility were those that had to be seen by two persons to decipher the writing, or in which one or more words remained undeciphered. The doctor's signature was illegible in about half the letters. In most cases where this was likely to create difficulties the doctor had put a tick against his name on the paper-heading.

Reasons for referral.—Reasons for referral were given by 407 (81.4%) G.P.s, even if vaguely. Only three letters specifically stated that the G.P. would like to continue handling the case himself, and just wanted an opinion, investigations, or advice.

G.P.s' own assessment or diagnosis.—A diagnosis was proffered by 203 (40.6%) G.P.s. Those writing to the E.N.T. (56: 56%) or general surgical (27: 54%) departments were most ready to commit themselves to a diagnosis, and those writing to the psychiatric (21: 21%) were most reluctant.

Clinical findings.—Findings on clinical examination were mentioned by 112 (22.4%) G.P.s. The lowest proportion again were those to the psychiatric department, where only 20 (4%) mention psychiatric clinical findings.

Hospital investigations and previous operations.—Only 56 (11.2%) G.P.s mentioned this. This paucity may well be due to the difficulty of extracting from the N.H.S. record details which are to be found only in hospital letters, reports, and

abstracts which have been written on a variety of sizes of paper and have had to be folded several times before they fit the record envelope.

"*Please see and treat.*"—Only 10 (2%) of the total could be considered under the infamous category of "please see and treat." The majority of these came from the same source.

The remaining results of our analysis of these letters are given in Table III.

Discussion

The subject of communication has received attention in the American and British medical press. Much has been published in America about intrahospital communication (Wilkinson, 1961) and the dissemination of information from hospital to outside (Turell, 1960; *Pediatrics,* 1962). Frohman (1960) points out that "physicians communicate with each other by means of medical journals, lectures, papers, books, talks, societies and public meetings"—but makes no mention of the doctor's letter. In this country the White Paper (Ministry of Health, 1963) discussing communication between doctors, nurses, and patients in the hospital service states that "where failure of communication occurs, the repercussions are widespread and give rise to considerable and often disproportionately adverse comment, both private and public." Such communication studies seldom attempt to show how there can be improvement in the two-way exchange of information between specialist and G.P. which is often the basis of a therapeutic doctor–patient relationship. Acheson, Barker, and Butterfield (1962) have pointed out that there is a need for closer association in hospital between G.P.s and specialists. There is a good case for a time being set aside each week for this: but until such facilities are more readily available the letter will remain the key factor in communication.

As letters of introduction to hospital all 500 in our survey served their purpose; in the light of consultant requirements many did not. Since we are concerned with the value of letters as instruments of communication, it is from the consultants' viewpoint that we have examined them.

What consultants regarded as the commonest "faults" could be ascribed to lack of time. This substantiates the plea—reiterated by the late Dr. I. D. Grant (1961) among others—"What the general practitioner requires most of all, if he is to fulfil his proper destiny, is more time."

Meanwhile there is scope for the streamlining of methods and practice organization. For example, in the practice of one of us it was found that on average a handwritten letter took 3½ minutes to write, and a typewritten one 1½ minutes to dictate. At present G.P.s provide secretarial and typing facilities virtually at their own expense. Some, especially if in single-handed practice, are unable to afford such help. But as the White Paper (Ministry of Health, 1963) aptly points out, "communication is not made easier if the facilities for it, notably secretarial services, cannot be provided."

By far the most important item—84% of consultants considered it should never be omitted—is drugs or treatment the patient has been having. Just 22% of G.P.s mention this. From the hospital records it was clear that a much larger number than this had given some treatment, although the patient rarely knew the nature of it. Clearly, if time is limited this, in order of priority, is the one item which should never be omitted, as it is the one which the patient himself is least likely to be able to provide.

Lack of time is not the only reason for faults of omission. Another reason is the custom of handing the letter to the patient, who is likely to read it before it reaches the consultant. The G.P., knowing this, is often reticent about domestic and personal details which may be of great importance, and reluctant to commit himself to a "diagnosis" followed by "what is said to the patient." It is better to write direct to the consultant, giving details, and request him to send the patient an appointment. This request has never been refused in our experience. Although some hospitals provide forms to be posted direct in this way, their number and diversity make them impracticable unless one restricts the choice of hospital and specialist.

Another reason for vagueness, or failure to commit oneself to a diagnosis or to formulate a specific problem, is the sport, familiar to most of us from our teaching hospitals, of deriding G.P.s' letters. Criticism of the G.P. in front of the patient is so damaging that many G.P.s prefer vagueness to committing themselves to a finding or opinion which, if unshared, may be mauled by a never-met consultant or his unknown deputy. In our survey, two consultants pointed out that when letters were addressed to them personally they were entirely satisfactory, but when they were addressed to "the physician" or "the surgeon" this was not the case.

The poor integration of psychiatry and medicine which still exists in so many hospitals means that many people with physical illnesses where anxiety or depression looms large are often badly handled, and this deters some G.P.s from comment on emotional factors. Many such problems could be resolved by personal consultation.

Letters of little value are those thinly disguised requests for pathological or *x*-ray investigations sent to consultants when facilities for open access to these departments are not available to the G.P. When this access is lacking, a G.P. often refers a case "for opinion" when what he wants are special investigations, the results of which he is trained to interpret. This situation could be improved if all hospitals provided these facilities. In spite of this occasional spurious use, the main purpose of a letter is consultation: too often the letter appears to be a reluctant substitute for personal consultation.

Conclusions and Suggestions

1. Treatment should always be mentioned in a G.P.'s letter, even if there is no time to mention anything else.

2. Relevant information the patient is unable or unlikely to supply should be stated. This should include the G.P.'s provisional diagnosis and opinion, development of symptoms and change of signs over a period, drug sensitivities or steroid treatment, social background, attitude of the patient to or knowledge about the illness, and what he expects from hospital.

3. Reason for referral, or the specific problem, should be stated.

4. Typewritten letters are legible: but G.P.s have to provide dictaphone, typing, and secretarial facilities at their own expense. In handwritten letters legibility is obviously of prime importance.

5. Letters, where practicable, should be posted separately and not handed to the patient for him to read on the way to hospital, especially where No. 2 above applies.

6. Details of previous hospital attendance should be given.

The following points arising from the discussion would facilitate effective communication:

7. Hospitals should write letters and reports on paper which fits (folded once or not) the 9 by 4⅞ in. N.H.S. record envelope. This would facilitate extraction of details in No. 6 above.

8. Open access to hospital pathological and *x*-ray departments should be the rule and not the exception.

9. Hospitals should set aside a time, once or twice a week, when G.P.s could meet consultants—and consult.

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Medical Staffing Structure in Hospitals

We print below a statement issued by the Ministry of Health in connexion with the recent announcement (B.M.J., 8 August, p. 394) of the Government's intended action as a result of the reviews of hospital medical staffing. (Leading article at p. 398.)

General

1. The Joint Working Party on Medical Staffing Structure in the Hospital Service, which was appointed by the Minister of Health and the Secretary of State for Scotland, under the Chairmanship of Professor Sir Robert Platt, "to study in the light of experience since 1948 and of all other considerations the principles on which the medical staffing structure in the hospital service should be organized," reported in 1961.

2. The Working Party's main recommendations were as follows:

(1) The medical staffing structure of the hospital service should be based upon consultants, who should take full personal responsibility for patients other than those under the care of their own general practitioners.

(2) Consultants should have the support of assistants of varying grades, including (*a*) doctors in training as a preparation for their professional career; (*b*) doctors who wished to make the hospital service their permanent career (a new grade of unlimited tenure with the generic title "Medical Assistant" was proposed by the Working Party); (*c*) general practitioners and others who were suitably qualified to take part in hospital work.

(3) Consultant services should be more extensively organized on the "firm" system and part-time appointments for a small amount of service should, where practicable, be absorbed into duties of existing staff or grouped together.

(4) Training arrangements for senior registrars should be improved.

(5) The senior hospital medical officer and junior hospital medical officer grades should not continue to be part of the permanent structure. A senior hospital medical officer receiving the special allowance (under HM(59)81, dated 1 September 1959), when occupying a post approved as a consultant post after the review, should be entitled to have his personal grading reviewed. Both grades should be closed to new entrants after the medical assistant grade has been introduced.

(6) Hospital boards should, with consultant advice, institute a review of medical staffing in their hospitals in the light of the recommendations of the Working Party, and report to Ministers.

(7) Ministers should seek advice on the proposals made by hospital boards from professional committees consisting of members appointed by them and by the Joint Consultants Committee.

3. In December 1961 the Minister of Health and the Secretary of State for Scotland announced that the Government and the medical profession had accepted all the main principles of these recommendations, which they commended to hospital authorities. The Joint Consultants Committtee reserved its position on the precise type of any new intermediate grade which might be required and on its extent, title, and salary.

Minister's Conclusions

4. In accordance with the recommendations of the Working Party, hospital boards in England and Wales were asked to report to the Ministry their proposals for medical staffing in hospitals for the next five years. Their reports have been examined in consultation with the Joint Consultants Committee. The Minister has announced to Parliament his general conclusions from this review and they are set out in more detail here.

5. The medical staffs of hospitals other than general-practitioner hospitals can be divided into three broad groups, according to the levels of responsibility: (*a*) Consultants and S.H.M.O.s with allowances who have final responsibility for all patients, except those in general-practitioner beds. (*b*) House officers (pre- and post-registration) and senior house officers who have the immediate day-to-day care of patients and are normally in their first or second years after qualification. (*c*) The intermediate grades, consisting at present of S.H.M.O.s without allowances, senior casualty officers, senior registrars, registrars, and J.H.M.O.s, together with some of those general practitioners at present with contracts under paragraph 10(b) of the Terms and Conditions of Service. The Working Party recommended the abolition of the S.H.M.O. and J.H.M.O. grades and the introduction of a new grade to assist consultants.

6. The proposals of boards for these three groups defined as above are (in terms of the equivalent of whole-time doctors[1]):

	Nos. in Post at the Time of the Reviews	Proposed Nos.
(*a*) Consultant ..	6,864 (including S.H.M.O.s with allowances)	8,670
(*b*) House officers and S.H.O.s	5,366	6,513
(*c*) Intermediate grades ..	6,487	8,727

Thus the total number of hospital medical staff in post at the time of the medical staffing reviews was the equivalent of 18,717 whole-time doctors and the total demand by boards for staff to be available at the end of five years was 23,910, an increase of 28%.

Consultants

7. An analysis showing the number of posts in each region[2] at the time of the reviews and the number of posts proposed by boards is made in Appendix I and an analysis of the figures by specialties is made in Appendix II. Appendix I shows that there was great disparity in percentage increases between regions, and Appendix II that the increases proposed for some specialties were proportionately much greater than for others. A number of boards asked for a level of staffing much above or much below the general range. This applies both to total figures and to individual specialties.

8. The shortage of doctors qualified or expected to qualify for consultant responsibilities and the variations in boards' assessments of needs made it necessary to find a yardstick against which a practicable programme of expansion for boards could be measured. A realistic measure was that which represented the middle figure, or median, of the proposals received. The criterion was the number of consultants by specialties per 100,000 population. The median was determined for each specialty separately by arranging the boards' proposals (per 100,000 population) in order of size and selecting the middle figure.

9. In the case of each board the existing consultant staff (including S.H.M.O.s with allowances) and their proposed increases for five years in each specialty were then compared with the median for that specialty and the proposals were adjusted as follows. (*a*) where the existing staff already exceeded the median, the existing staff figures were used; (*b*) where the board's demand was below the median, the demand figure was used; (*c*) where the demand was above the median but existing staff were below it, the median figure was used.

10. The effect is shown in Column 5 of Appendix II, and boards will be informed of the adjustment made to their proposals on the basis described above and asked to plan the development of their consultant services accordingly.

11. The adjustment gave a figure of 1,095 additional consultants (Column 6 of Appendix II). In addition about 1,400 may be needed to replace consultants who die or retire during the five years. So the number to be appointed each year would need to be, on average, about 500.

12. The principal, but not the only, source of supply for the consultant grade is the senior registrar grade. It is clear that there will have to be expansion of the senior registrar training plan, which has already been expanded in recent years, and which in its present form is likely to produce in the five-year period about 1,600 trained senior registrars on the basis of 4 years' training at

[1] Throughout this paper numbers of medical staff are taken to be the equivalent of whole-time staff.

[2] The figures for provincial regions are those of the R.H.B. and B.G. combined. For the Metropolitan regions teaching hospital figures have been allocated to the Regional Boards according to the residential area of the patients treated in the teaching hospitals.