Letters from Psychiatrists to General Practitioners

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The need for clear communication in medicine is often stressed, but of all aspects of medical communication probably the least attention is given to that between doctors themselves. The structure of the NHS and the mode of referral from general practitioners (GPs) to specialists mean that the quality of communication between GP and specialist has a strong influence on the way patients are managed and the standard of the care provided. Although it might seem preferable that contact between doctors should be on a face to face basis, this is often not possible. By far the most common mode of communication between GP and specialist is the letter.

The most important letter for setting the tone of the partnership involving hospital and GP is that sent by the specialist to the GP after the first assessment visit. This initial letter is the one which reaches the GP at his most receptive, with the particular problem which led to referral fresh in his mind. At times GPs refer patients as much for their own needs as for those of the patient. If the response to his referral leaves the GP feeling his needs are being neither met nor understood, this can undermine the patient's further care and the GP's attitude towards him (Brook, 1978).

For some medical or surgical conditions a structured, even pro forma letter may be an adequate and relatively economic form of communication (Leading Article, *Lancet*, 1973). However, such letters are less suitable in psychiatry, where the greater complexity of problems and their multi-faceted nature create a need for greater length and less structure.

Psychiatrists, however, have to ask themselves at what point greater length and lack of structure in letters might actually impede the communication process; and as time (medical and secretarial) is costly, to what extent long letters are appreciated by GPs and thereby justified. In addition, consideration needs to be given to the aims of the letters. Hospital letters have two main aims. The first, as suggested above, concerns the total care of the patient; the second has to do with the educative value of the letter (Cummins *et al*, 1980). This paper reports an attempt to audit letters by a survey of general practitioners in order to ascertain whether detailed letters were appreciated and whether the aims of the communication were being met.

The survey

This survey began as an informal attempt to assess the value of letters from a teaching hospital psychiatric team to GPs. Particular stress was placed on the response to the letter sent by the psychiatrist to the GP after the initial out-patient assessment. The study does not offer a comparison of GPs' responses to two or more different formats of letter, but GPs were asked to comment freely and were able to make comparisons with letters received from other teams or specialties.

Method

General practitioners who had made referrals to the out-patient clinics run by a particular psychiatric team during a four-month period were surveyed by questionnaire between two and four months after the end of the period. Many had referred patients on other occasions or on more than one occasion during the survey period, and their comments were not restricted to letters sent during the survey period. Questionnaires were deliberately kept brief and were accompanied by a stamped envelope to encourage co-operation. There was a personally addressed covering letter introducing the questionnaire, but this could be removed and the questionnaire returned anonymously.

The letters on initial visits were generally between one and two typed A4 pages in length. These letters usually followed a fairly homogeneous pattern. Although in theory they may have been written by any of four doctors, in practice responsibility for letters was frequently linked with supervision of medical students, and over half these letters were, in their final form, the responsibility of one doctor. The introduction to the questionnaire suggested that these reports could be divided into three sections: that dealing with reasons for referral and presenting problems; that dealing with family, past and social history; a final section dealing with mental state assessment at interview, conclusions as to diagnosis and formulation of the problem, and decisions as to further management. Questions were then asked about these three sections, followed by other questions related to the letters. These are detailed under 'results' below.

A brief enquiry was also made into the letters on follow-up visits (see below).

Results

Fifty-four general practitioners were sent questionnaires, of which 44 (81.5 per cent) were returned. Fifteen were returned anonymously. There was no significant difference in terms of critical responses between those which were returned anonymously and those which were not. Not all respondents answered all the questions, but the percentages given below are percentages of the total number of respondents, i.e., 44.

Initial letters

(1) The GPs were asked whether they found each of the three subdivisions mentioned above too long and detailed, too brief, or satisfactory in length and detail. Thirty-eight (86

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per cent) found the initial section (reasons for referral and presenting problems) satisfactory, while 5 (11 per cent) thought it too long; none found it too brief. Corresponding figures for the middle section (family, past and social history) were 31 (70 per cent) satisfied, 7 (16 per cent) too long and detailed, and 2 (5 per cent) too brief; and for the final section (mental state, diagnosis and formulation, and management), 33 (75 per cent) satisfied, 1 (2 per cent) too long and detailed, and 6 (14 per cent) too brief.

(2) Asked whether they found the letters too technical in the use of psychiatric terminology, none found the letters faulty in this respect, 2 (5 per cent) felt the letters were not technical enough, and 38 (86 per cent) were satisfied.

(3) Practitioners were asked whether they would like more explanatory material, e.g., how certain diagnoses were reached or why particular drugs were chosen. Thirty-one (70 per cent) expressed a positive wish for more explanatory material.

(4) To investigate the frequently heard claim that long letters go unread, GPs were asked whether they read the entire letter in detail or only concentrated on parts of it. Forty-one (93 per cent) said they did read the entire letter in detail; two tended to read opening paragraph and conclusions and skim the middle, and one admitted to reading 'mainly the conclusions'.

(5) The above is an index of whether the GPs found the letters useful; in addition they were asked whether, having read the letter, they 'generally have a clear idea of how the patient's problems have been formulated and what the plans are for future management'. Thirty-seven (84 per cent) answered in the affirmative.

(6) The GPs were asked whether they felt 'that the difficulties that lead to referral have usually been sufficiently appreciated'. Thirty-six (82 per cent) answered 'yes'.

(7) GPs were asked whether they felt that telephone discussion of new patients would be a helpful and feasible addition to communication by letter. Twenty-six (59 per cent) answered in the affirmative, but when asked whether this was generally necessary only 2 (5 per cent) thought this to be the case.

(8) Thirty-eight (86 per cent) were happy prescribing drugs recommended by the specialist, rather than making their own decisions regarding prescriptions.

Follow-up letters

GPs were asked about letters on follow-up visits. Thirty-one (70 per cent) were satisfied with these; 6 (14 per cent) thought they were too detailed and long; 4 (9 per cent) felt they were not long or detailed enough.

GPs were asked for their own comments about both kinds of letter, and these were often useful and revealing. Comments ranged from requests not to reiterate details the GP already knew as evidenced by his referral letter, to expressions of satisfaction with the letters and their thoroughness. Two themes which emerged were, firstly, requests for greater promptness in sending all letters and greater regularity in the sending of letters after routine outpatient visits; and secondly, a reiteration of the request for a greater degree of explanatory material of both a theoretical and practical nature.

Discussion

This study cannot pretend to have been scientific in its approach, but the great degree of consensus manifested in the replies enables certain conclusions to be based on its findings. The model of initial letter investigated here is one characterized by the fullness of the account given of the patient and his background, based on the initial interview with him and often including information from an accompanying relative. Despite apprehensions one may have that these letters err on the side of length and detail, GPs appear generally very satisfied with these letters, read them carefully, and are happy to accept the plans suggested for management.

There does, however, seem to be room for modification. The middle section, dealing with social details often well known to the GP, is best kept as brief as possible, while the concluding section could with benefit be expanded. This latter section is important in that it should answer questions raised by the GP and should give clear information as to how the patient is being managed, what responsibility the GP has in this, and if relevant, what the patient has been told and how he has reacted. This is the section with the greatest potential for explanation and education.

There seems to be slightly less overall satisfaction with follow-up letters. From the comments received, it would appear that the ideal follow-up letter is sent after every follow-up visit and combines up to date details of significant recent events and management changes, with the greatest possible brevity and succinctness.

A number of other points deserve fuller discussion. As has been mentioned, many GPs complain of delays in receiving letters, and sometimes of not receiving them at all. This echoes a concern expressed in many previous studies (Cummins *et al*, 1980; de Alarcon *et al*, 1960; Fraser *et al*, 1974; Isbister, 1980; Long and Atkins, 1974). Such failures in communication put at risk the efficient functioning of the GP–specialist partnership, on which much of hospital medical practice is based. If the GP has not received the letter before he sees the patient or his family again, embarrassment and confusion may arise with respect to what the management actually entails and who is responsible for its supervision. Feelings of anger further undermine the practitioner's attitude, not only to the hospital, but also possibly to the care of his patient. In addition, the patient will lose confidence in the therapeutic partnership if he feels it is not co-ordinated. Little over half the practitioners in this study felt telephone communication to be a helpful and practical adjunct to communication by letter, and of these almost all felt that telephone communication was not a general need,

but to be reserved only for situations of urgency. The letter alone represents an adequate mode of communication—but only if it is timely.

Another point that needs to be stressed is the educative value of the letter, particularly the initial letter. In response to the questionnaire, 70 per cent of GPs expressed a positive wish for more explanatory material and this was reiterated often in comments added by individual GPs. It is interesting that the final section of the letter (i.e. that most likely to contain explanatory material) was the only one which more GPs thought too short than too long. The initial letter being the one which reaches the GP at his most receptive and with the problem which lead to referral fresh in his mind, is the one in which educational material is most likely to have impact and to be appreciated. Isbister (1980), in a study of letters responding to referrals to a surgical clinic, found a strong demand from GPs for letters to be of educational value and concluded that whatever the pressure on resources, it was inappropriate to shorten letters if this would mean a loss of their educative function.

Particularly in psychiatry, the use of pro forma letters is not indicated. This is no reason for letters not to be at least semi-structured. Both the GP and the psychiatrist looking up old notes need to know where to look for information recorded in the initial letter, rather than having to wade through pages of rambling, unstructured prose. Many doctors feel restricted by the use of sub-headings and only one GP in this study suggested their use. They would seem to be unnecessary as long as the letters are logically organized.

Despite the generally satisfied tone of the responses, it must be noted that there were a number of GPs who were dissatisfied with aspects of their communication with the hospital. This points to a need for psychiatrists to arrange contacts with the GPs with whom they deal, preferably on a face to face basis (even if only infrequently), so that such difficulties can be discussed.

In conclusion, the GPs surveyed in this study appear satisfied with the type of 'initial' letter discussed in this paper, i.e. one which is semi-structured and fairly long and detailed. Although brevity where possible is always a virtue, there is a need for specialists to be aware of the educative value of their letters and to include explanatory material of a theoretical and practical nature. Good letters facilitate a constructive therapeutic relationship between GP and hospital and justify their cost and the time spent on them.

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Trainees' Forum

Contributions are welcome from trainees on any aspects of their training

Objectives in Psychiatric Teaching

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There has been a recent upsurge of 'educationalism' in the field of psychiatry which, as a trainee, I would like to comment upon. The Cambridge conference on education and training (*Bulletin*, June 1982, **6**, 105; 107) briefly considered the option of educational objectives as a way of planning, monitoring and assessing a training scheme. Others have called on the College to issue a syllabus for the MRCPsych Examination (*Bulletin*, November 1981, **5**, 215), and Dr R. Symonds of the Southern Division has presented a syllabus for in-service training which is adapted from a Canadian model. All these suggestions suffer from drawbacks, but some are more appropriate to the needs of trainees than others. Each is trying to tackle the same problem: to fill in the educational gaps which all trainees have, some more than others, and which frequently go undetected until the exam. Such elementary skills as mental state examination and interview skills are often poorly taught.