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Trainees' forum

Meetings between general practitioners and a hospital based trainee psychiatrist: benefits for patient care and doctors' education

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Optimal clinical management of seriously ill patients demands effective collaboration between primary and specialist services. This is especially important when pathology runs a chronic or relapsing course and social circumstances contribute to difficulties, and when the patient moves between community and hospital care. Information may be delayed or lost and misunderstandings occur, with effects detrimental to the patient's health, loss of mutual trust between doctors, and waste of time and money (Cybulska & Rucinski, 1989). We report an attempt to improve GP/specialist communication at the time of admission to hospital, for the benefit of the patient and mutual education of GP and trainee psychiatrist.

The study

South Manchester Psychogeriatric Service in a community orientated service which sees 1,500 patients each year and admits 200 for assessment (Lennon & Jolley [in press]); CH was responsible for 20 admissions over four months and arranged appointments to meet their GPs soon after admission. One telephone call usually sufficed, though three GPs were never available. A semi-structured interview was designed to obtain background information about the patients. Following the meeting, each GP was asked to complete a questionnaire returnable by post, rating on a four-point scale if they had learnt anything useful, if they felt they had contributed to their patient's care, if they would like similar meetings to continue, or if the meeting had been inconvenient.

The consultant psychogeriatrician (DJ) rated his view of the quality of communication usually achieved with each practice: poor, passable or good.

Findings

Out of 17 GPs, 16 returned the questionnaires.

Of the 16 patients for whom there is a complete set of data, eight had been admitted from home after a domiciliary assessment requested by the GP, four following routine out-patient visits, three were transferred from other hospital wards and one was identified as ill and admitted when visiting his wife, a patient on the ward. All patients were elderly (mean 75 years, range 59–84). Their problems included depression (8), confusion (4), dementia (2), personality difficulties (1) and alcohol dependence (1).

Visits required 35–70 minutes away from the ward, 15–50 minutes was spent in conversation with the GP and going through the notes, usually with the GP. Notes of 50% of the patients dated back to pre-NHS days and the date of first entry ranged from 1925 to 1982.

Additional information became available to the hospital in all cases and directly influenced management in at least one-third. Information included alcohol abuse, poor compliance with medication, side effects of ECT, and the health of spouses and carers. Other matters discussed included the nature and treatment of psychiatric disorders and the organisation of our department.

Two GPs were unaware that their patients were in hospital, 15 felt they had learnt something from the meeting, and 15 thought they had contributed to the care of their patient. Twelve said the meeting had been convenient and 14 suggested similar face to face contact between hospital and practice should continue.

The various groups of data were compared using Fisher's Exact Test (two tail). There was no direct relationship between the diagnosis and the amount of information gained by the hospital or the GP. Whether or not the GP had been involved at the time of admission or had been present at a domiciliary visit, there was still further useful information exchanged at the planned meeting. GPs in 'good communicating' practices felt they learned more than those in the other practices ($P=0.04$). GPs in the 'good' practices more often felt the discussion had contributed to the care of their patients

($P=0.01$), but those who thought they had only contributed little to our knowledge of their patients had often given a great deal. The GPs' assessment of their own contribution appears to be more a function of self-esteem; those in 'good' practices rate themselves better.

Comment

The value and desirability of face to face contact between hospital doctors and GPs has been well recognised (Long & Atkins, 1974). Our results indicate that face to face communication between GP and hospital doctor at the time of admission is appreciated by the GP and is fruitful for the hospital team in the care of our psychogeriatric in-patients. A 'phone call would permit discussion and avoid the travelling time of the hospital doctor. However, face to face communication at a booked appointment has advantages. Time has been set aside specifically for the task in hand and notes can be studied by both doctors. Discussion inevitably arises from this which helps to clarify what is really relevant to the patient's care. A name on a letter or voice at the end of a 'phone becomes a colleague with knowledge, skills, views and limitations. It has been suggested that psychiatry trainees would benefit from six months in general practice (Haigh & Wear, 1989). However at present, when few career hospital doctors do this, the insight gained from even brief visits into the field may be very useful.

Communication by letter may allow exchange of facts and opinions, but there is inevitable delay, and they tend to reinforce mutual isolation and discourage dialogue (Cybulska & Rucinski, 1989). In a discussion information can be easily and speedily exchanged, explained and clarified, especially if the importance of mutual education and doctor–doctor support is remembered. Dialogue in these circumstances is likely to be more educative and memorable than written communication. Although doctor–patient communication skills now receive more attention at medical school, there is probably not enough taught about doctor–doctor communication (Fletcher, 1984).

Long & Atkins (1974) showed that communication between GPs and consultants took place during the admission of only 3% of patients although 67% of consultants and 58% of GPs considered that there was a need for it. With psychogeriatric patients it is important to build a picture of their past and GPs' holding notes which may contain over 60 years of history, in addition to their own memories, appear to be a significantly untapped source. Referral letters and 'phone calls only contain a small fraction of the information available. Adequate communication between hospital and GP early in the admission may also help the GP and ward staff care better for the patients' relatives at this stressful time.

This short study has pointed to benefits both for patient care and doctors' education, arising from face to face communication during a patient's admission. There is scope for further research within this framework.

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