DOCTOR TO DOCTOR

Writing and talking about patients

Edited by
Sir John Walton and
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Preface

In 1972 the Nuffield Provincial Hospitals Trust published in its series of Rock Carling monographs the volume entitled *Communication in Medicine* by C. M. Fletcher. Subsequently the Trust became increasingly concerned about the practical consequences of failures of communication in the National Health Service and accordingly sought ways to foster the improvement of communication between doctors and patients. To this end it established a Working Party, which I was privileged to chair, and which ultimately produced a document, *Talking with Patients*, published in 1980. This booklet was well received by doctors in many branches of medicine, including those engaged in medical education both in the hospital and in the community. It was also well received by medical students and by other health care professionals.

While communication between doctors on the one hand and patients and their relatives on the other is clearly a fundamental aspect of clinical medicine in all its branches, there is also no doubt that communication between individual doctors often leaves much to be desired. Stories about misunderstandings and mistakes caused by careless clinical requests, notes, and letters are often recounted by doctors when they meet and talk 'shop' and are attributed, with some merriment, to curious idiosyncracies of other doctors from which the gossipers feel themselves to be free. The fact that it is usually the patient rather than the doctor who may be most inconvenienced or even harmed by these mistakes is often overlooked. As the practice of medicine becomes even more technical and complex, effective communication between doctors in its various branches becomes more and more essential for efficient practice. Yet it seems that few doctors give much thought to how this could be brought about. Most of them, while well aware of the errors of this kind which their

colleagues make, are relatively unaware of the carelessness and mistakes to which they are themselves prone. But it is just these mistakes which they could most readily avoid and correct. Problems also arise from time-to-time affecting communication between doctors and other members of the health care team, including nurses, physiotherapists, occupational therapists, social workers, and many others. Even communication between doctors and their receptionists and secretaries is sometimes less than perfect. In order to explore these further problems, the Trust brought together a group of doctors and other health care professionals in 1982, and after a long and fruitful meeting it was decided that an expanded Working Party should attempt to take matters another stage by looking first at the problems which arise in communication between doctors. This second booklet is the outcome of its deliberations. It is hoped that yet another Working Party will in the future explore in similar depth communication between doctors and other health care professionals.

The Working Party considered whether to approach its task in the same way as when preparing *Talking with Patients*, but found a similar approach difficult because of the relative scarcity of research and of published work on this particular subject, a point brought out by Professor Fletcher in his 'Epilogue'. It therefore decided to adopt a different method of presenting the problem, pointed more towards recording the fruits of diverse personal experience. Accordingly, in this booklet we present a series of essays, the first two of which, one by a general practitioner and the second by a consultant psychiatrist, deal with communication between GPs and hospital doctors. In the second section, a consultant physician looks at communication by and between clinicians and consultants in radiology and pathology and analyses the difficulties affecting communication between doctors in clinical medicine who request diagnostic tests and the staff and doctors who provide and interpret them. The third section, written by a former consultant obstetrician in collaboration with a general surgeon, handles the problems which arise in communication between doctors in clinical work on the one hand and those working in administration on the other; it also looks at committee work, at doctors as patients, at doctors who

teach and at the inter-relationships between doctors working in the hospital, in the community, and in other branches of medicine such as occupational medicine. In the fourth section a consultant physician describes and illustrates some personal experiences and views, and in the 'Epilogue' another physician with a life-long interest in the topic of communication fills in a few gaps left by the earlier essays. He also summarizes various conclusions and recommendations arising from the earlier contributions and from accounts of ways by which communication has been improved in industry.

In this diverse group of essays the reader will clearly recognize that some of the views which are expressed are highly personal and indeed personalized. There are several minor conflicts of opinion as well as a good deal of repetition and overlap between the various sections, but a common thread of principle runs through all the contributions. This stresses the need for courtesy and clarity in written communication; the necessity when referring a patient for another opinion, whether by a clinical colleague or by a diagnostic department, of clearly expressing the patient's problems and the questions to which answers are needed; stress is also laid upon the absolute requirement that the response should be as explicit as possible and should endeavour fully to answer the questions posed by the referring doctor. Throughout, too, we can recognize the value of speaking either on the telephone or whenever possible face-to-face, in order to reinforce views expressed on paper; and also the need for legible, concise, and prompt letter writing, not only in the interests of all the professional colleagues involved but more especially in the interests of their patients.

These are all areas in which close study followed by appropriate action is likely to be more effective than exhortation.

As in *Talking with Patients*, the pages of this booklet have been enlivened by illustrations in the inimitable style of Dr John Moll. I believe that the essays which follow pose important questions of interest to all doctors, in whatever branch of medicine they work, and do their best to answer most, if not all, of them.

JOHN WALTON

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The thread of principle to which Sir John Walton draws attention in his Preface forms many strands of the network of good communication which is needed to link the complex relationships so vital in modern medical care. Central to the organization and tradition of British medical care upon which the NHS is based is the dialogue between the GP working in the community and the Consultant practising in hospital. This illustrates the essential continuity of health care. The issues arising in each branch are discussed by Dr Paul Freeling and Professor Neil Kessel.

The reader should realize at the outset—and this applies throughout the booklet—that few of the shortcomings touched upon in each essay are found in many individuals, and never all in any single person. To imply that would be a gross travesty of fact. But if one recognizes any at all in one's own (and of course in one's colleagues'!) mode of practice, a modest first objective of this monograph will have been achieved.

A general practitioner's view

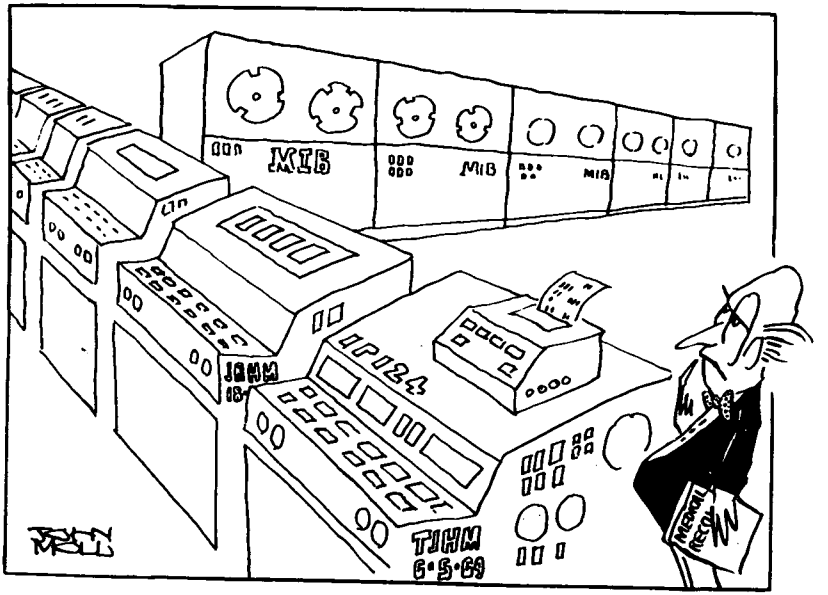
GPs AND WRITTEN COMMUNICATION

As medicine advances its organization becomes more complex; hence any individual in our geographically mobile society is likely to come into contact, in his lifetime, with many different providers of care. This has made continuity of care more difficult but increasingly important, and potential conflict is best resolved by an adequate record system.

In the United Kingdom each individual has a confidential, comprehensive, life-time medical record held by the general practitioner (GP) with whom he or she is registered. It contains information recorded for use within the practice as well as correspondence between the practice, hospitals, and many other agencies in the community. GPs have been encouraged to improve their records and minimum standards of record-keeping are now demanded before appointment as a GP trainer. The physical constraints imposed by a medical record envelope designed more than 50 years ago are often used to excuse poor record-keeping, but there is no excuse for records in which the GP's own notes are illegible or even non-existent and in which hospital reports are not filed chronologically.

CORRESPONDENCE VIA RECORDS

When most GPs worked single-handed written notes about a patient-contact were only a personal aide-memoire. Most doctors did not feel that it was important to write a note for use by another GP, who would only see it if the patient changed practices. Now that so many GPs work in partnership



1. The now imminent introduction of microcomputers to general practice is unlikely to change the need for good manually held records.

or groups their notes are a form of correspondence. Good written notes, ordered hospital reports, a summary record of problems, treatments, allergies, and relevant social information all now seem essential if the patient is to receive good safe GP care. Nevertheless, no single format is yet generally accepted for GP notes. The introduction of micro-computers to general practice may enforce a standard structure for summaries (Fig. 1) but is unlikely to reduce the need for good written notes.

CORRESPONDENCE BETWEEN GPs AND HOSPITALS

Medical care in the UK is dependent upon a system of referral so that good written communication between GPs and specialists is also essential. Specialists have long complained about the quality of letters which they receive from GPs, although most would agree that their legibility and relevance

have improved greatly of late. GPs also have justifiable complaints about letters from specialists and their dissatisfaction will only increase as they strive to improve their own record-keeping. The principal problems may be considered under several headings.

The functions of letters between GPs and specialists

A letter about a patient is a passport which is required by our system of referral. Its short-term function is to convey that information which in earlier times might have been exchanged when the specialist and GP met in joint consultation. Each letter also has a long-term function since it forms part of the patient's permanent records in both hospital and general practice. It is sometimes difficult to write a letter to serve both these short- and long-term functions.

Availability

A letter is of no use if not available. The situation today is unlikely to be as bad as that reported in 1974 (1) when no full report had been received by the GP on 20 per cent of patients four weeks after discharge from an emergency hospital admission, and no report at all arrived within three months upon 14 per cent of patients attending hospital out-patient clinics. Nevertheless, GPs still complain about delays, and failure to send the GP even a preliminary report of treatment and recommendations when a patient leaves hospital cannot be excused.

Investigations

In addition to references to hospital specialists, GPs often request investigations by those hospital departments to which they have access. The line between these two types of hospital use is blurred by variations in the degree of 'open-access' afforded in different hospitals. Also, many GPs will need an opinion upon the significance of a result rather than a simple description. Results of investigations are much less often delayed than are reports of consultations. It would be helpful,

however, when an investigation gives a result seeming to require rapid action, to telephone a message to the GP. It would also seem reasonable to send a telephone message when, because data provided on the request form are inadequate, interpretation is difficult. Unfortunately many request forms seem, from the GP's point of view, to offer too little space for clinical details: the one widely used for requesting blood counts is particularly poor.

Legibility

The need to make a letter available can conflict with that of making it legible. In an emergency admission a GP may have no option but to pen a letter, sometimes under very adverse circumstances. Illegibility is still difficult to excuse but enforced brevity can be compensated for by means of a telephone conversation with the receiving hospital doctor, who should make notes of the conversation for inclusion in the patient's hospital file.

Comprehensibility

The ranges of tests and procedures used in hospitals change rapidly, as do the abbreviations used to record them. To many GPs it seems that hospital staff have a code of abbreviations as impenetrable as any other form of cryptogram: 'TL' for tubal ligation, 'CIN III' to describe the cervix of a uterus, are two recent examples. Another kind of private language is the use of an eponym for a syndrome recently recognized in a particular specialty: one GP, confronted by a patient said to have 'Stickler's Syndrome' was consoled in his ignorance by a letter from a neurological registrar who wrote:

> She told me today of the recent discovery that she suffers from 'Stickler's Syndrome'. I must confess I have never heard of this, but she tells me she has hyper-extensible joints.

Another bar to comprehension is the inclusion of irrelevant or redundant information. When the first few paragraphs of a specialist's letter simply reiterate material from the letter of

referral a GP may lose concentration and overlook an item of importance which is new to him, especially if he is also struggling to interpret a dozen newly received letters about other patients.

Another barrier to comprehension can be removed by the GP himself. He will see more than 30 patients a day: out-patient consultations may take place several weeks after seeing the patient and writing the referral letter. It seems sensible that the GP should keep a copy of his own letter in order to understand the reply he gets.

Relevance

The relevance of any communication can be judged only when its purpose is known. Some letters from hospitals to GPs clearly fail in their purpose, which should be to tell the GP about his patient's continuing need for care, about prognosis, and about what has been said to the patient and his relatives. Their failure often seems to stem, as already mentioned, from attempts by the specialist to use one piece of writing for several purposes. Some GPs, on the other hand, may at times obscure rather than clarify their purpose of making a referral because they are reluctant to write down the real motive. Many different reasons can lead to referral, not all of which are related to the clinical activities of diagnosis and management. All consultations must be terminated in some way and referring a patient is one way of doing this.

WHY GENERAL PRACTITIONERS REFER

One in six of the population attend hospital out-patients at least once a year and each new attendance seems to generate between two and three follow-up visits. It is thus important to analyse the different reasons for which GPs arrange such consultations. To do so requires one to categorize the content of their referral letters. Variations upon the traditional 'for the benefit of your opinion and advice' cannot reflect the whole truth.

The reasons for referral by GPs can be divided into two main categories: patient-centred for clinical reasons, arising

from the doctor's diagnostic and therapeutic responsibilities; and doctor-centred for covert reasons, arising from the complexities of doctor-patient relationships in general practice.

Patient-centred reasons

Patient-centred reasons may be for consultation or for technical help and either sub-division may concern diagnosis, management, or both.

'Consultation for diagnosis' is the reason for referral when the GP simply does not know what is wrong with the patient. If he has a view whether or not anything at all is wrong he should express it, giving his reasons, which will often be related to past experience of the patient as a frequent or infrequent user of his service. The GP may need no advice about management once the diagnosis is made, or may even have views upon which of several alternative managements would be best. These, too, should be expressed.

'Consultation for management' is a reason for referral when the GP is sure of the diagnosis but uncertain about the best management. He may feel fully able to implement it once established, and may indeed be better placed to do this conveniently for the patient. The GP should have indicated in the referral letter his intention to manage the case according to the specialist's advice. Hence the specialist should not hesitate to go into detail. One example might concern a request for guidance as to the best anti-hypertensive agent for a patient whose hypertension is not controlled by a thiazide or who becomes depressed taking methyl-dopa.

'Technical help in diagnosis' is a good reason for referral when the GP knows what must be done to establish a diagnosis but is unable technically to do it himself; examples are endoscopy or the use of radiological contrast methods where direct access is denied. Again, the GP should indicate clearly the purpose of his referral and must say whether or not

he wishes to be responsible for any management which proves necessary. The supervision, for instance, of a patient suffering from a hiatus hernia is well within the competence of most GPs.

'Technical help with treatment' is a category which is sometimes wasteful of out-patient clinic time. In many surgical conditions the GP will have made a firm diagnosis for which the management is clear but lies outside his competence or is impossible within the facilities available to him.

Doctor-centred reasons

Doctor-centred reasons for referral are often kept more covert by the GP, since they result from that continuing relationship between the patient, his family, and the doctor which is a keystone of British general practice. They also often underlie requests for investigations which seem on strictly clinical grounds to lack indications. Doctor-centred reasons can co-exist with patient-centred ones and may be divided into three sub-categories; reinforcement of the GP's opinion; pressure from patient or relatives; and seeking relief.

'Reinforcement of the doctor's opinion' is requested when a GP knows that he has given a correct opinion or advice, but this for some reason seems unacceptable to the patient. Some GPs believe that confirmation by a specialist will reinforce the effect of their own statements. The belief may be ill-founded but cannot be tested unless the reason for referral is made explicit to the patient.

> One example of a request for reinforcement is illustrated by a letter about a women weighing 115 kilos and experiencing pain from osteo-arthritis of her left hip—relieved somewhat by indomethacin. The GP had told her that real improvement would occur only if she lost a great deal of weight and that no operative treatment would be undertaken until she had done so. The GP could end his letter of referral honestly: 'It would be most helpful to me

> if you would confirm this opinion, although if you have other advice she would be most grateful'.

Sometimes a GP is constrained to seek a second opinion because **'the patient or relatives insist upon it'.** Many such referrals also fall into the category of reinforcement of the GP's opinion but, since the circumstances can vary, these cases are best categorized separately.

The burden borne by a GP in relationships with some patients is such that he may reach the end of his tether and refer the patient to get temporary relief. Letters about patients with somaticized depression, hypochondriasis, cancer-phobia and other behavioural problems may be categorized as **'seeking relief'** but only when the letter shows that the GP is aware of the diagnosis and appropriate management but cannot personally tolerate the relationship.

> This is illustrated by the example of a 52 year-old woman who had complained for two years of a multitude of aches and pains. She had had similar episodes 10 years and seven years previously each of which had been treated by the GP with anti-depressants with some improvement. She had continued for 10 years, however, to complain of a variety of 'terrible' pains. Her GP had re-examined her repeatedly and had had a large number of investigations performed and repeated. When she presented once again, complaining of 'floating feelings in her head', the GP seized the opportunity to refer to a specialist. The letter of referral closed with the sentences 'I would be grateful if you would reassure us that we are not missing something here. Perhaps you could see her a few times before discharging her from your clinic'.

A study was conducted of the letters of referral generated in four general practices in one week using the categories listed above, which proved to have high inter-rater reliability. The total patient population of the practices was 39,500 served by 17 general practitioners and four trainees. There were 2300 patient contacts at the practices and 358 in patients' homes. Letters to out-patient clinics were written for five per cent of the contacts. Twenty-four per cent of letters sought consultation about diagnosis and 22 per cent about management; 11

per cent sought technical help with diagnosis, and 29 per cent technical help with management; four per cent asked for reinforcement, four per cent were responses to pressure, and two per cent sought relief; four per cent were unclassifiable. 800 consecutive out-patient referral letters received at each of two hospitals, one a teaching hospital, one a District General Hospital (DGH), were also studied (2). The letters which originated from GPs showed a similar frequency of types of referral to those in the practice-based study although fewer ostensibly arranged for doctor-centred reasons were received at the DGH.

GOOD PRACTICE

Much can be said about how GPs should write to specialists. Letters should be typed whenever possible and copies filed in the patients' notes. Each letter should be headed with the patient's full names, address, and date of birth. All treatment already prescribed should be listed together with its results as well as the results of investigations or relevant clinical measurements. Any knowledge the GP has of the social or psychological status of the patient should be included. He should state clearly the questions to which he wants answers, any actions he expects the consultant to take, and above all, what the patient has been told to expect. The doctor should also indicate the degree of urgency he attaches to the consultation.

Much can also be said about the ways in which specialists should write to GPs. All letters should be despatched as soon as possible. The specialist's letter should seek to inform the GP instead of being designed for the patient's hospital file. It should be a reply to the letter of referral and should avoid repeating more than the crucial information given in the latter whilst adding anything new which has been discovered, including where needed relevant data such as blood pressure readings. The specialist must try to answer the questions asked, indicating the steps which will or should be taken and, like the GP, should report what the patient has been told. The most offensive and unacceptable document a GP can received is a duplicate copy of a long and detailed so-called summary

dictated for inclusion in the hospital records and arriving three months after the patient has died.

Perhaps the most important injunction to both GPs and specialists is that their letters should be designed to help each other to help the patient. It is the GP who will have the ultimate continuing responsibility for catering to the patient's needs, however long out-patient surveillance may continue.

ATTITUDES AND BELIEFS

All forms of communication are affected by attitudes and beliefs. The training, experience, NHS work, and organization patterns of specialists differ greatly from those of GPs. This must affect the attitudes and beliefs of both and therefore their communication with each other. All GPs have been taught by specialists at some time; relatively few specialists have been taught by GPs. Perhaps this teacher/pupil relationship contaminates what should be a relationship between peers of different backgrounds united by a common purpose of helping and not harming the patient. This 'hangover' effect may explain some of the difficulties in communication which have been described. The extent to which the actions of a specialist should depend upon the GP's letter may be impossible to define precisely but there is no doubt that it is affected by the relationship between the doctors concerned. GPs seem to write better notes in their own records when they know that these will be read by colleagues with whom they have personal contact in partnership. Unfortunately teaching hospitals often lie in inner-city areas where hospital doctors are less likely to know personally their GP colleagues, who may themselves live some distance from where they practise. All students should have their attention drawn to the importance of good written communication and it is essential that young doctors be trained to write good letters (3). Vocational training for general practice affords the opportunity of teaching GPs about all kinds of written communication.

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A hospital consultant's view

INTRODUCTION

The division of medical care in the UK is such that the GP provides continuing supervision, or what may be called longitudinal care, whereas hospital admission gives cross-sectional treatment—intense, at moments of severe illness, but without on-going commitment to the patient. The out-patient clinic comes somewhere between the two. There, a diagnostic consultation provides specialist attention without continuing care. If a patient is asked to re-attend regularly the specialist provides an overview without direct ongoing responsibility. It is the GP who would have to deal with any emergency or visit the patient at home. This mutual involvement of two systems is useful provided that both GP and specialist accept that they are mutually dependent partners and that diagnosis and treatment require that they pool information about the patient and his condition. Hence the importance, and not infrequently the vital importance, of good communication between the two.

THE ELEMENTS OF GOOD COMMUNICATION

Five elements are necessary. The communicator must himself acquire the information that he has to pass on. Second, he must not be too lazy or too busy to convey it. Third, he must keep in mind exactly what he needs to tell and, fourth, he should always consider what the recipient will want to know. Last, the door should always be kept open for further communication.

Dr Freeling, in dealing with the matter largely from the standpoint of the GP, has drawn our attention to deficiencies that sometimes occur in communications with the hospital but has stressed only a few of the improvements that could be made by hospital doctors. I propose to redress the balance and to sharpen some perspectives of the GP-hospital doctor interface.

THE REFERRAL LETTER— INFORMATIVE OR INTRODUCTORY?

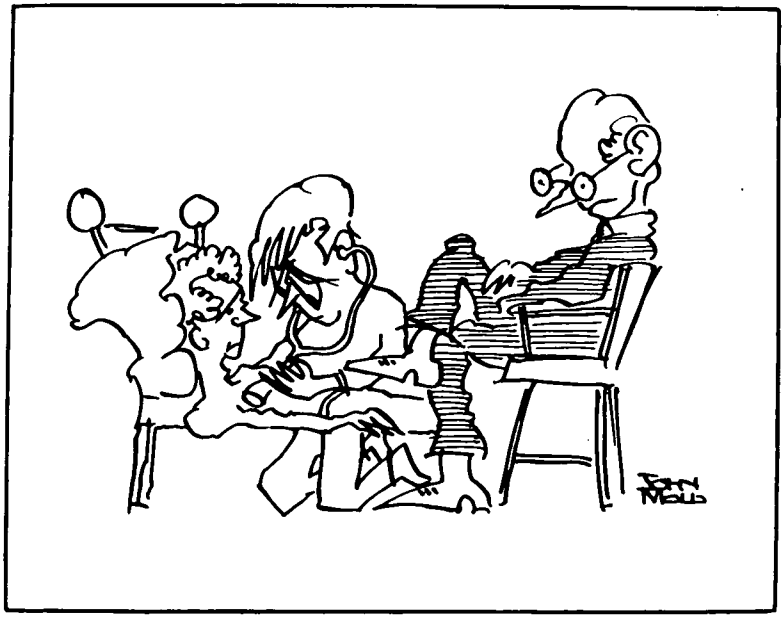
A philosophical point, but one of great practical importance, arises when the hospital doctor sits the patient down—let us say in the out-patient clinic—and reads the letter of referral. Should the consultant absorb the GP's history and suggested diagnosis or should he assiduously attempt not to be biased and instead to approach the patient with a completely open mind, taking a history from scratch, examining him without preconceptions and thus reaching conclusions independent of the GP's view? Or, should he absorb the story given in the letter, and direct his own history taking and diagnostic thinking in order to build on that information and on the GP's suggestions? This latter approach accepts that the process of referral is a collaboration between two partners in the medical care of the patient, while the former treats the consultation as an opportunity to provide an independent opinion. Each method has something in its favour yet they are alternatives. When a specialist adopts the one or the other he is illustrating how he sees the roles of the two types of doctor. For some time now I have asked senior medical students what they have learned to do. Almost invariably they answer that they have been taught to adopt the former approach; they should take the history untrammelled by any previous information about the pain, the weakness, or the anxiety. To me this seems clinically unwise, although I accept that medical students must learn the history-making and examination process for themselves. But for the specialist it is surely better to use all the information that a colleague is able to provide, especially since that information represents the fruits of the longitudinal approach previously mentioned, whereas I, the specialist, can

only question and examine the patient at one moment in the course of his illness.

Sometimes the patient puts such a different emphasis on what he tells me that I must redirect my thinking. That is only right. I am not an automaton. Yet it does not happen very often; and even when it does I may be following a blind alley that the GP has already explored and rejected. The patient may be obsessed with his breathlessness and may press its dominance. The GP may know that the dyspepsia is the new and significant symptom. All consultants, and especially those with teaching responsibilities, should explore this dilemma and consider the use they make of the referral letter. If they are consistent in their determination to disregard its detail and to embark afresh upon the process of history taking and examination, then they deserve no more in a referral letter than 'This is to introduce Mrs. McTavish'.

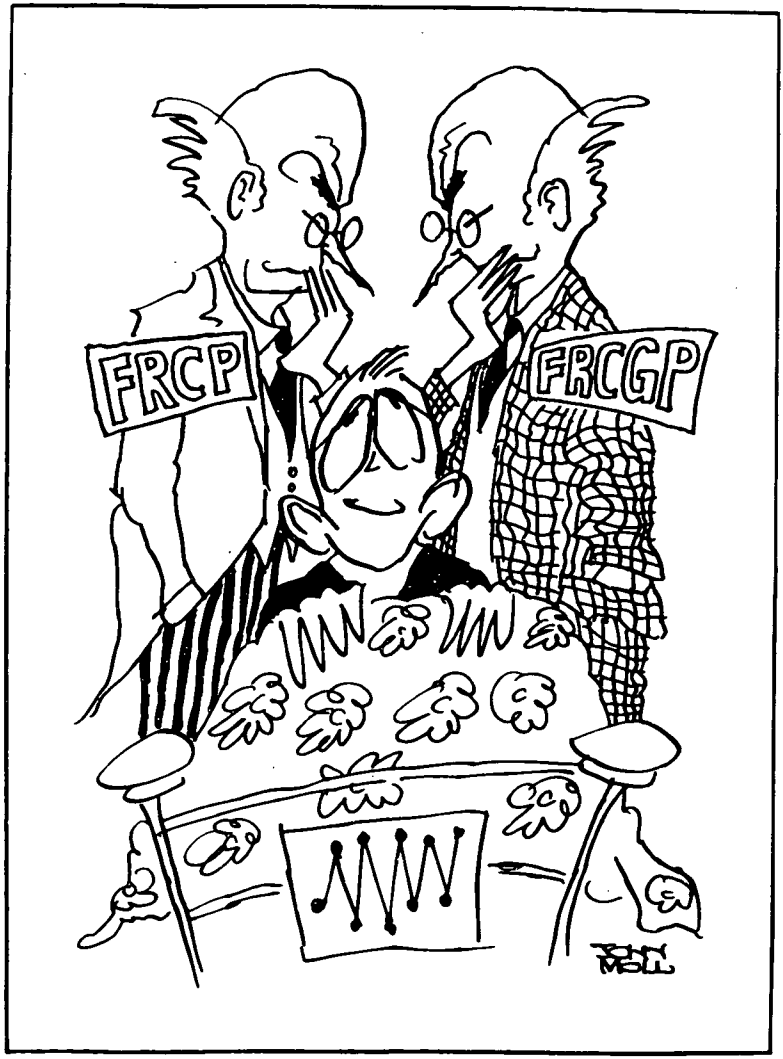
'Please see and treat'. I have often heard of such referral letters though none has ever come my way. Are they fact or fiction? 'Please examine and advise'. 'Dear Dr Smallweed,

2. You examine . . . we advise.



You examine, we advise. Yours sincerely' (Fig. 2). Such exchanges are talked about, particularly by hospital doctors. If they really exist then so does an unfortunate patient whose doctors are engaged in hostilities rather than in alliance. 'Query feet'? 'These are, unquestionably, feet'. The riposte to the short entreaty penned on a prescription form is short, smart, and sweet to deliver. Unfortunately it does not help the poor patient with his sore feet. From the medical exchange he, and they, have been eliminated. I remember a doctor telling me that during her student days she had plenty of instruction in how not to write letters to the hospital—admonition disdainfully delivered as a letter was held well away from him by thumb and scornful forefinger of the consultant—but never a word about how to write in reply to a GP. The same may largely be true today, for, with so much to teach, methods of good communication between doctors can remain forever uncommunicated. Moreover, the instances I have given illustrate an underlying attitude upon the part of the hospital doctor, at best one of rivalry with the GP, at worst one of superiority. It is true that hospital doctors are better than general practitioners, just as it is true that general practitioners are better than hospital doctors (Fig. 3). Each is better at something different. The patient needs the best from both and he does not get it unless they collaborate and communicate warmly, wisely and well. I once published in the *Lancet* an exchange of letters between GP and consultant with the writing between the lines showing:

> Dear Doctor, *(I haven't the time to look up your name and anyway the patient is quite likely to be seen by a registrar).*
>
> Mrs. McTavish, 72 Scrawl Place *(the clerk will get it right)* I would be grateful if you would see this lady *whom I have managed perfectly well for the last five years until her son came to visit and made her ask to see a specialist. Still it will be a relief to load her on to someone else for a bit,* who complains of headache and sleeplessness. There's a lot of complicated history and a good deal of family tension; *however, I'm too busy to write it all down and you see so few patients in an afternoon that you can elicit it for yourself; it's a pity that her husband won't come with her though; he'd have given you quite a different picture.*



3. It is true that hospital doctors are better than general practitioners just as it is true that general practitioners are better than hospital doctors.

I have prescribed sedoflat for her with some improvement *but I know I can't win at that game because you're sure to recommend tranqrelax.* I should be glad of your opinion *and most surprised if it tells me anything new.*

Yours sincerely,

My Dear Dr Snodgrass,

Thank you for referring this most interesting patient whom I saw at out-patients yesterday. *Actually my secretary writes this bit automatically.* The bulk of this letter is no more than a recapitulation of history which you must know better than I do *but if I didn't put it in there would hardly be anything to say and, in any case, it is the only part of the notes that gets typed so I use this letter as a summary. A good many polysyllabic technical words are included as befits a clever hospital doctor.*

I think it worthwhile trying her on tranqrelax which I have generally found to be more useful than sedoflat in this type of case. I did not think it necessary to make another appointment for her *as I have better things to do than take on this kind of intractable problem* and I feel sure that her symptoms will clear up under your care. I have reassured her that there is nothing for her really to worry about but I shall be happy to see her again if you think it necessary. *Since this will indicate failure on your part I think I can count on her not coming back.*

With kind regards,
Yours sincerely,

Those two doctors are, I hope, dead and buried. Side by side.

THE RESPONSE FROM THE HOSPITAL DOCTOR

One more question. At an out-patient consultation who is doing the consulting? Is it the patient or the GP? To a certain extent this is hair-splitting. The specialist is going to tell the patient what he considers to be wrong, how it should be treated and what the prognosis is. Today he is not likely to say (although this was once considered the ethically proper course): 'Right ho! Off you go and I'll write to your GP. See

him and he'll tell you all about it'. That would be inhumane and the patient would be dissatisfied. He has come to hear what the expert thinks. Yet the more thoroughly the specialist discusses details, especially of treatment, the more he is cutting out the GP, diminishing his role, and undermining his authority by intruding his own. This is especially incorrect if he is asking the GP to carry out the on-going treatment and supervision.

Certainly the specialist should represent to the patient that he may seek further information and advice from his GP, who will, as a result of the partnership, be fully in the picture and will also be the appropriate person to consult further. This is an occasion when the specialist must remember that the GP is better than he is, particularly in the exercise of continuing responsibility.

What the hospital doctor tells the patient should inform, advise, and educate; the patient must understand sufficient about his illness to be able to comprehend its events and why he must be treated in the way proposed. There is, of course, evidence that he may remember very little. What is told to the GP should inform, advise, and instruct; for direction of the treatment is the specialist's task. Therefore the prescription should be exactly stated, the procedures exactly spelled out. Even if this seems supererogatory it is nevertheless necessary; otherwise accidents may happen. Nor should it be resented. In one enquiry about psychiatric consultations it emerged that GPs did not like being advised how often they should see a patient, or for how long. This came as a surprise to the psychiatrists, since these are difficult matters of technique requiring expertise which the psychiatrists had laboured long to acquire.

A letter to the GP should be carried by the patient only if you do not mind his reading it. Since this is often unwise, it is better to use the post.

A good hospital letter should tell the GP what he has asked to be told but must also impart anything else that the specialist considers necessary. The referral letter will indicate the former; but, when the diagnosis has been reached and a treatment plan is formulated, it is often proper to convey more than has been aked for. Thus, if a drug has potentially serious

side-effects then I owe it to the patient to particularize these to the GP. This is especially needed if I have discussed them with the patient. Inadvertently I may touch upon sensitivities here. An 'as you know' phraseology can help, but, even so, the well-informed GP may resent that I should think it necessary to tell him. If so, I apologize, but I have erred only on the side of safety. I hope he forgives me.

It may also be necessary to send a copy of a letter to someone other than the referring doctor. If the consultation request comes, for instance, from a hospital colleague, the reply to him can serve also for the GP. In that circumstance a brief covering letter sent with the copy rarely goes amiss. Conversely, if you are referring the patient to another specialist, a note of what you are asking him may accompany a copy of your letter to the GP.

Dr Freeling has specified the information that the hospital letter should contain. I concur and add two items. The letter should, where relevant, spell out the circumstances in which the patient should be referred again. The second particular is aimed at the most conscientious of GPs. With many patients full recovery cannot be expected; often the specialist, seeing more of serious illnesses, knows this better than the GP can. He ought therefore to indicate the best that can be hoped for, so that the GP, concerned that his patient should improve optimally, does not feel he is failing to provide any worthwhile treatment.

Sometimes a patient may indicate to the specialist that he would like some of the things that have been discussed not to be passed on to the GP. This may occur when the GP has other members of the family as his patients, and can also happen if the patient considers the GP to be a friend or perhaps something of a moralist. I believe that the hospital doctor should, if appropriate, discuss with the patient what he may or may not tell the GP. Ethically, of course, he may disclose anything to the patient's doctor and in consequence, if truth be told, to some of the ancillary staff in the surgery or health centre; the patient may express justifiable apprehensions on that score also. If information must be passed on, then the specialist must tell the patient so and that he intends to override his wishes. However, if the information is not

essential to the GP's appreciation of the clinical situation or to his further treatment of the patient (and that is usually the case) then the hospital doctor should, in his letter, tactfully conceal the patient's indiscretions, habits, difficulties with his relatives, etc. There is no point in exacerbating the difficulty facing a GP who is bent on seeing himself as a family doctor but who has also an absolute duty to preserve each individual patient's right to absolute confidentiality.

Following the hospital consultation the patient should see his GP again, and he must do so if the GP is to prescribe at the specialist's instigation. The GP may already have advised the patient to make a further appointment after seeing the specialist, but the latter should nevertheless tell the patient to do so. This return visit may reasonably be postponed while the results of investigations are awaited. It is important that the letter from the hospital is available to the GP when the patient arrives. The specialist should therefore, in advising the patient, take a realistic view of when the hospital letter can be expected to get to the GP. However, if treatment should begin speedily he can circumvent delay either by telephoning the GP himself, or by asking his secretary to read his letter over the phone to the practice secretary. Such forethought can prevent a frustrating encounter in the surgery from which the annoyed patient emerges convinced of the inefficiency of both his medical attendants.

The specialist must use his discretion whether to delay the sending of letters in order that they may receive his personal signature or whether to allow his secretary to 'pp' them and reduce delay. There can be no hard and fast rules. Different patients, and different matters about them, have different urgencies. According to the content, error may be more serious or less serious. Such a letter as 'I am arranging to admit him in the next day or two' can fairly safely go out unchecked. 'I recommend U 100 insulin 40 units in the morning and 30 in the evening together with chlorpheniramine for his allergy 4 mg tds' ought to be read through carefully. Another variable is the reliability of the secretary. Common sense will provide the answer in the case of out-patient letters but there can be no excuse for delay in letting the GP know of the discharge, or death, of one of his patients. It is most distressing for the GP to

hear for the first time of the death in hospital of one of his patients from a grieving relative. Even if the letter can be sent at once, it is still courteous to telephone the facts to the practice secretary. If when a patient leaves hospital a letter cannot be typed in advance it must be handwritten at the time, and the houseman must be sternly persuaded that any hand skilled enough to put up a drip can learn to write legibly.

Today the letter is the most widely used instrument of communication between hospital and surgery. It is the most convenient and, although it takes more calendar time than would the telephone to put the GP in the picture, it probably takes less consultant time than any other method. Also, leisure pursuits, visits, ward work, and committees, probably in that order, make both sorts of doctor rather mobile creatures (Fig. 4). If it were not so I should urge the telephone as a more useful means of communicating, because it facilitates better exchanges. Nothing gets written down and those laggardly to record, and the litigation fearing, may worry about that; nevertheless when I am able to talk directly to a GP about a patient, I get more from him and I think I can be of more use to him. I can supplement his information with my questions and can answer his questions. He can tell me exactly what he wants to know. I recommend communication by telephone wherever this is feasible. A letter can follow if necessary.

I believe that I send better letters to a GP whom I know; I am then better seized about what help he, in particular, wants in respect of his patient. The converse is also true. Referral letters to a named and known consultant are always more informative than those missives that begin: 'Dear Dr'. The local postgraduate centre greatly facilitates getting to know other doctors. This is one of its more important functions. It brings together colleagues from different branches of medicine to learn to relate to one another. The good communication which they establish there facilitates all their communications.

4. Leisure time, visits, ward work, and committees, probably in that order, make both sorts of doctor rather mobile creatures.

CONCLUSION

Communicating well is not particularly difficult but it requires to be thought about, in general and in each particular instance. If that is so a consultant, as master to his apprentices, should take time to teach it, to help his juniors to acquire the skills and to monitor in jealous defence of his patients' needs and his firm's honour, that everyone is informing well. He may care to quote Quintillian's maxim that 'care should be

taken, not that the reader may understand if he will; but that he must understand, if he will or not.'

Relating well and communicating well are variations on the same theme. Where relations are good, effective communication can be brief. Generally hospital doctors complain that GPs' letters contain too little information, while GPs insist that letters from specialists are too long. I certainly counsel brevity. Therefore the letter to the GP should not serve as a record of the specialist's thought about the patient nor as his summary of the notes. The GP should not be put to the unnecessary and counter-productive trouble of having to read irrelevancies. It is not necessary for the specialist to spell out every particular, every detail of history, examination, or investigation. Nor should the GP receive a blow by blow account of how the diagnosis was reached and what possibilities were considered and eliminated along the way.

Pascal once apologized to his publisher that he had not had time to write a short book. This moral should be seized by doctor with one hand, while he seizes his dictating machine, or his secretary, with the other.

Section 2

Communication within the hospital

The clinical consultant

CLIFFORD HAWKINS

The diagnostic services and the clinical departments

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Communication between specialties within a hospital has become increasingly complex and new technological developments associated with medical practice enlarge the flow of information to be passed. In order to present reasonably succinctly the potential faults in the various links between doctors within a single hospital, this section concentrates on: (1) relationships within and between the various hospital specialities; and (2) viewpoints of those working in the departments which provide diagnostic services for such specialities. Thus Dr Hawkins sketches the network of horizontal and vertical communication within and between the clinical departments themselves as well as that with the medical service departments. Drs Whimster and Eban set this in perspective by outlining what seem to them to be the essential requirements of good communications between clinicians and the diagnostic services, as represented by the departments of radiology and pathology.

The clinical consultant

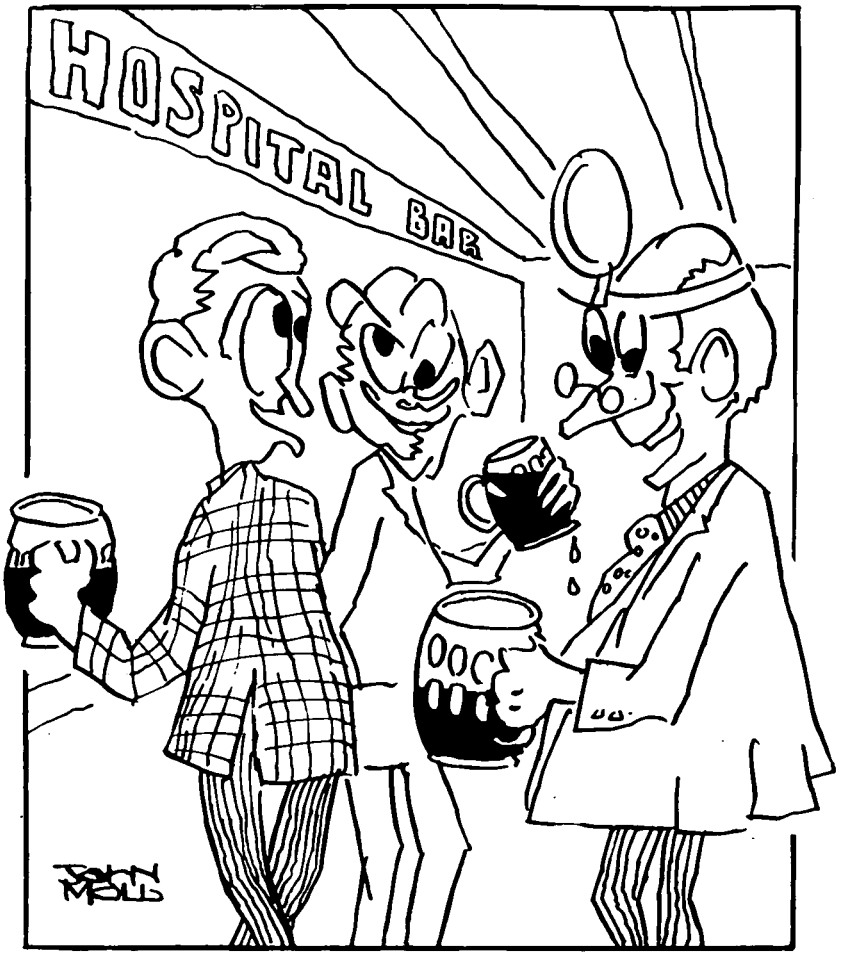
COMMUNICATIONS WITHIN THE HOSPITAL

CLINICAL DEPARTMENTS

Nothing can fully replace personal contact between colleagues in a hospital (Fig. 5). Unfortunately many hospital doctors find that their time is so occupied, on committees or attending medical meetings either in the hospital or elsewhere, that talking with colleagues about a patient has to be omitted. Also, the size of a hospital is important; if it is large, those in different departments may be isolated and never meet colleagues in corridors or during lunch. Hence, much communication even about simple matters may be through scribbled notes or by letters dictated to secretaries.

COMMUNICATION BETWEEN CLINICIANS

Shared care is inevitable in these days of specialization if patients are to get the best care in the most effective manner. Hesitancy in calling in a colleague may be due to fear of being shown to be wrong, especially if he might tactlessly contradict what has already been said to the patient, and to anxiety about being supplanted; these difficulties are usually avoided if clinicians meet together on the ward. Another irritation affects staff who have developed special techniques; for example, a request may be sent 'Please do respiratory function tests' without an invitation to see the patient beforehand, or 'Colonoscopy please'—a time-consuming procedure often unnecessary when the gastro-enterologist is called into consultation. Clinicians do not like to be regarded merely as technicians and an opinion can be of more value than a test.



5. Nothing can replace personal contact between colleagues in a hospital.

Request forms or letters must state clearly the reason for asking for a colleague's help and should define his intended role, viz:

only to advise;
advise and treat;
take over the case (to avoid role confusion);

to see if interested (for those with a special interest in the disease or when doing research).

Time can be wasted from the moment when the request is written to when the patient is seen. Sometimes it takes too long to reach another ward or the consultant may be away and his deputy has no instruction to deal with it. Then the patient may sit for days in bed waiting in suspense for the 'other specialist' to come; or he may arrive when the patient is being X-rayed or has even gone home for the weekend, or the case-notes are not available. This can be prevented if a member of the junior staff checks that everything is ready—patient, notes, X-rays, and so on—at the time when the specialist has agreed to come.

CLINICIANS COMMUNICATING WITH OTHER HOSPITAL DEPARTMENTS

Radiological. Incomplete information is the bane of many radiologists' lives. Detailed data are especially needed in certain cases; for example, particular preparations of barium or particular techniques may have to be used for patients suspected of having ulcerative colitis. Radiologists should also know what the patient has been told; indeed, sometimes they can be encouraged to aid in the cure, for instance by offering a patient with nervous dyspepsia reassurance that nothing abnormal has been found.

Laboratories. Many laboratories use a request form of the 'tick-box' type which is all too easily completed and can lead to over-requesting of commonly used tests. Discussion between ward consultants and heads of laboratories can be invaluable in standardizing ward requesting policy so that the requesting habits of inexperienced staff can be more easily monitored. Laboratory booklets like *How to Use the Laboratory* can also be useful for day-to-day guidance on the wards.

Sometimes a clinician has a special interest in a new and complex test and a registrar, or the consultant himself, sends a request to, perhaps, the clinical chemistry department asking for such a test without realizing that it may take a biochemist

several days to complete the work; discussion prevents the irritation that this causes. Similarly a 'full blood count', without further definition, may be requested in circumstances in which the opinion of the haematologist would be preferable. To avoid such errors junior staff should, for instance, be encouraged to visit the haematology laboratory to look at the blood and marrow films of problem cases and to discuss the next diagnostic step with the haematologist.

Specimens may be sent to the pathology department with little indication as to the part of the body from which they come, although detailed information has become especially important because so many pathology specimens are nowadays taken through endoscopes. A close liaison with the pathologist, through invitations to endoscopy sessions or to lunch-time meetings, greatly aids communication.

Other service departments. Clinicians should, as far as possible, be specific in requesting treatment in, for example, the department of physical medicine and rehabilitation. The request 'physiotherapy please' may lead to unnecessary or futile treatment while wasting the time of the patient and physiotherapist. The indications for prescribing physiotherapy in rheumatic disorders have been published by the Arthritis and Rheumatism Council (1). It is best to meet the physio-therapist on the ward so that the purpose and duration of treatment can be clearly explained. Those who give treatment should know what the patient has been told to prevent them announcing diagnoses of their own, thus confusing the patient and perhaps undermining his confidence in the clinician.

SPECIAL PROBLEMS

Consultants in the diagnostic and therapeutic services such as physio-therapy are often acting as managers in controlling demand while assuring effective services, but knowing that the final assessment rests with clinicians directly responsible for individual patients. A close liaison is then necessary for harmonious relations.

Communication defects can often explain unnecessary

investigations such as repeated chest X-rays or even barium meals because it may not have been realized that these were done before hospital admission.

Investigations carried out during the night or at weekends add greatly to hospital expense, especially when a specialist or technician has to come in to do them. Junior staff often request them indiscriminately, partly for fear of missing something, or to please their chief, or merely from lack of experience (Fig. 6). A regular audit helps to reduce this; for example, the clinical chemistry department can provide a feed-back of all out-of-hours tests done on a particular ward—these can be discussed at a ward meeting.

Investigations are often requested although a normal result is almost certain: they may be ordered in the belief that results are likely to be negative but will reassure the patient. This policy is often effective and facts are available so support it. One study on 176 patients with non-specific chest pain showed that those who had an electrocardiogram and measurement of serum creatine kinase activity did better than those who had no diagnostic tests, in respect of both short-term disability and patient satisfaction (2). Radiologists usually recognize such requests for investigation, but informing them may save an unnecessary search for some hidden organic lesion.

At lectures students can be taught, with the aid of incomplete request forms projected from slides, to fill in these forms efficiently. Sometimes the head of an investigating department may send back incomplete forms but this, if done tactlessly, can cause bad feeling and delay for the patient.

WHAT CLINICIANS EXPECT FROM THEIR COLLEAGUES

Clarity again is needed—and clear writing: delay for the patient is caused when the long-awaited opinion of a colleague is written in the notes but is illegible. Reports of operations written by a junior may merely illustrate interest in technique, for example much detail concerning the type of sutures used may be given with little about the findings at operation or what was done.

6. Junior staff often request these indiscriminately . . . perhaps to please their chief.

Reports between colleagues also have an educational role but then information must be provided diplomatically. The interpretation of some abnormal biochemical results is aided when normal values for that laboratory are included. A further step in teaching could be taken if some possible causes

of an abnormal result, such as a raised serum calcium, were printed as well.

Much confusion is caused if new tests are introduced by research laboratories when their significance and discriminating value are not generally known to clinicians. For example, a positive anti-nuclear factor test (for SLE) is reported and the clinician accepts a diagnosis of systemic lupus erythematosus and begins treatment with corticosteroids, not realizing that the test is non-specific and may be positive in rheumatoid arthritis and other diseases. Education concerning the discriminating value of new tests is essential and this information should be included with the report.

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The diagnostic services and the clinical departments

INTRODUCTION

The clinician (of whatever status) is the prime mover when he decides that an investigation on a patient is required for diagnosis or follow-up. His written request for the investigation to be performed will be received in the service department by someone who may or may not be medically qualified and who may have more or less experience than he himself possesses. The written report sent back to the clinician is the responsibility of a consultant whether or not the consultant has personally written or signed it. So the lines of communication involved can be complicated.

Most investigative procedures are based on anatomy and/or physiology and their pathological alterations in disease. They are intended to reveal abnormalities of structure or function not revealed by routine clinical examination. Departments which perform these procedures tend to be large, such as those of radiology and pathology. They use advanced technology, and are expensive to equip, staff, and run. They are headed by doctors experienced both in clinical matters and in their own investigative disciplines, and employ many highly qualified and experienced paramedical staff. Large numbers of requests are received and processed and the information generated has to be distributed, stored, and kept available for retrieval. A clear organization with strict procedures for receiving and processing requests is essential for dealing with this work-flow. In many hospitals there are also other investigative departments, including those of electro-cardiography, clinical physiology, electro-encephalography, electro-myography, medical physics, biomedical

engineering, and clinical measurement. These operate on similar lines.

The clinician must understand this organization if he is to make efficient use of the appropriate service department when he requires specific information about an individual patient in a particular clinical situation. This information (whether quantitative, descriptive, or in the form of images) reflects and has reference to part (but only a small part) of the normal function or disease processes in the patient.

Major causes of friction and misunderstanding between clinicians and investigative departments include:

(a). Failure to appreciate the complexity and time-scales of the investigative process;

(b). Failure to choose the most appropriate investigation;

(c). The request for the routine extensive but usually thoughtless 'diagnostic trawl'.

Investigations vary enormously in their complexity but even simple routine ones go wrong if, for example, the clinician forgets to enlist the collaboration of the patient by explaining to him the investigation and what it entails. The clinician's request form may also fail to explain to the person in the receiving department what is wanted or why. The report may fail to reach the clinician and may not tell him what he wanted to know.

Aphorisms

1. Stupid requests elicit useless answers, may cause distress, and waste valuable time and money.

2. An investigation is no substitute for careful history-taking and clinical examination.

3. Beware diagnostic overkill.

The patient should not be subjected to every available routine and experimental investigation before treatment is started.

4. Listen to those who actually perform the investigations (technicians, radiographers, and others).

They usually know more than anybody else about the values, limitations, and discomforts of the investigations they perform.

THE DEPARTMENT OF RADIOLOGY

Radiology departments today are more properly called departments of diagnostic imaging. These provide four main types of investigation at present: (1) radiography; (2) ultrasound; (3) gamma (isotope) imaging; and (4) computed tomography. A fifth modality under development at present may become part of the department within a few years; this is nuclear magnetic resonance imaging (NMR). In all these examinations the patient must be present, since it is some part of his body that is being examined, and not, as in pathological studies, a specimen that has been removed from his body. Some radiological examinations are painful, or distasteful, and some involve the painful movement of a sick patient to obtain the required views. Clinicians must always, therefore, weigh the value of the information sought against the discomfort caused to the patient by the examination or the preliminary preparation; and the patient must be warned, if only in general terms, about the nature of the examination, and the reason for it (Fig. 7).

Written communication with the department of diagnostic imaging begins with a properly completed request form, and results in a collection of images together with a report on them, which should be available at the time and place of the next consultation between clinician and patient. This is the ideal; it is seldom realized, however, for many reasons.

The incomplete request form is perhaps the commonest cause of problems. It may lack patient identification details: the name of the referring consultant, clinic, or ward; the existence of previous X-rays or other imaging procedures (where? when? previous reports? further specific recommendations); any indication of radiation protection precautions (the 'ten-day rule') in women of childbearing age. These delay the processing and booking of requests, which have to precede the actual investigation. Failure of the referring clinician to indicate the nature of the clinical problem and the investigation he thinks is needed may cause further delay. The introduction of new techniques into departments of diagnostic imaging may mean that referring clinicians will request the

7. The patient must be warned about the nature of the examination.

latest but not necessarily the most appropriate investigation. Or they may persist in requesting examinations which are no longer appropriate. Thus, 'Renal failure, ? hydronephrosis' or 'Jaundice, ? obstructive' are now best investigated in the first instance by ultrasound and not by intravenous urograms or cholangiograms. '? Secondary skeletal deposits' is better investigated by a gamma isotope scan than by a radiographic skeletal survey. In general, the newer methods are rendering obsolescent some of the more invasive radiographic procedures; thus computed tomography of the brain has resulted in the virtual disappearance of air encephalograms and a marked reduction in cerebral angiograms.

The radiology report, like the histopathology report, is a subjective description and interpretation of a series of images, in relation to inferred pathological states and processes. In this, the knowledge of the clinical problem as seen by the clinician plays a most important part. The radiologist's eye is never innocent, and is always primed, if only by knowledge of the clinic or clinician from which the patient has come. The report, whatever else it does, should answer succinctly the referring clinician's question. Thus, in response to the request for 'Spine, ? deposits', the report 'No evidence of deposits in the spine' is better than 'N.A.D.' (no abnormality detected), because it shows that the particular question raised has been considered by the radiologist.

The clinician should always look at the films or images before reading the report—and then should always read the report. The report may not be accepted by the clinician, but failure to read it may lead to significant delay in or neglect of the patient's treatment, and even to legal action for negligence. Failure by the clinician to inspect the films or images and to question the report may, on occasion, have similar unfortunate consequences.

As always, personal contact resolves most difficulties.

THE DEPARTMENT OF PATHOLOGY

There are now four, and sometimes five, departments of pathology in most hospitals—haemotology (blood tests and blood transfusion), morbid anatomy (postmortems), and

histopathology (examination of biopsies and resected organs), chemical pathology (concentrations of chemical substances, enzymes, and hormones), microbiology (detection and identification of bacteria, viruses, and other micro-organisms), and immunology (detection of antibodies and cell-mediated reactions to disease).

In order that staff in these departments can respond appropriately to requests from clinicians these have to be formulated in an acceptable manner. The incomplete request form is a major source of communication failure and irritation. The failure is often in the patient's details, in particular the age not being given; and sometimes in the description of the specimen. For example, the part of the body from which the skin biopsy was taken may be omitted; and sometimes relevant clinical details are lacking, such as the date of the last menstrual period or previous therapy, as with antibiotics.

In places where research is carried out, consultation is sometimes lacking over the use of specimens by those responsible for reporting to the clinician and those wanting blood or tissues for their studies. This can result, for example, in thyroids or uteruses being chopped up into unrecognizable pieces before the pathologist has seen them.

Another failure of communication sometimes occurs when a second opinion is required on slides. The first opinion is usually provided by a pathologist on the staff of the hospital at which the biopsy or resection is carried out. It must, of course, always be open to the clinician to obtain further opinions from any pathologists of his choice, and indeed pathologists themselves often seek the opinions of colleagues. Nevertheless it is essential that the second pathologist should be given adequate clinical details and details about the specimen, including a macroscopic description and the first pathologist's report if there is one; and it is preferable that the first pathologist should not be antagonized. Difficulties arise if the clinician sends slides to a second pathologist without telling the first pathologist, or if the first pathologist sends the slides without a copy of his own macroscopic description or microscopic report. In these circumstances the second pathologist may cause confusion by appearing, because of lack of

8. The same difficulties arise if the clinician bisects the specimen in an ill-conceived hope of getting a better diagnosis . . . he will certainly alienate both pathologists if they ever find out.

information or use of different terminology, to give a different opinion. On the other hand, if he does conclude, for example, that a lesion previously thought to be malignant is benign, he must be able to make it absolutely clear to the clinician (and preferably also to the first pathologist) that he does so differ. It is then up to the clinician to decide whom to believe and what to do next. Similar difficulties can arise if the clinician bisects the specimen and sends half to one pathologist and half to another (in the hope of getting a firmer diagnosis) without informing both (Fig. 8). He may or may not get conflicting reports, but both pathologists will be embarrassed and offended if they ever find out. Whether this type of communication failure occurs unintentionally or is done intentionally by a clinician who is at loggerheads with a pathologist (or with any other specialist appointed to interpret investigations), it is against the interests of the patient.

A further example of this type of communication failure is seen in the request for a postmortem examination which gives the pathologist no idea what useful information the clinician might hope to elicit from it. Often therefore energy is spent unnecessarily on obtaining information which is of no use to the clinician, and the questions which were really in his mind, but never expressed, remain unanswered.

Communication may also break down in the reverse direction. The pathologist may have misunderstood a request, may not have appreciated the clinical situation, may not have answered the clinician's question; or the report may never reach the clinician. Similar problems occur in the other pathology departments.

Nearly all these failures arise in written communication; and nearly all are easily resolved by verbal contact. Unfortunately the volume of requests in district and teaching hospitals today means that staff are fully occupied in processing those that are adequately presented to them. To place an extra burden on secretarial staff by requiring them to telephone clinicians for missing items of information, even after bilateral discussion, shows a lack of sensitivity to the problems of colleagues in investigative departments.

Thus it seems that the clinician must take steps to train and organize himself and his staff to make his requests effectively.

Staff in the pathology departments must train and organize themselves to interpret the requests and to answer the right questions whether they are well or poorly presented. These steps are infinitely easier when the staff on the clinical side and the staff on the service side know and like, talk to, and are prepared to help each other and in consequence the patients. Lack of communication can make life, and even death, very difficult for everyone.

Section 3

Communication in administration and related spheres

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The next section considers several situations in which good communication contributes towards effectiveness and efficiency. Noting the differences between the written and spoken word it explores the question of style and attitude and touches upon aspects separate from clinical work such as: relationships with Community Physicians: vexed questions relating to Committees, which now in the Western world, both within hospitals and in the community at large occupy so many hours of patient, and sometimes not so patient, attention by doctors; the hierarchical conventions within the profession: some of the relationships shaped by educational requirements of postgraduate and continuing education: the world outside the primary care and hospital environments, in which many doctors function and contribute to total medical care: and the special problems of the medically qualified patient. Finally there must also be reference to that standard mode of communication, the circular, which takes up so much time in construction, as well as in reading and interpretation, but which can be very important because its objective may vary from the clinical to the administrative.

Communication in administration and related spheres

LETTERS IN GENERAL

There are several very odd things about communication by letter. First, we tend to use completely different language from that which we employ in conversation. Second, there is a great difference in style when writing to strangers as compared with writing to friends. Third, there is often a notable difference of tone between letters to people considered as equals and letters to those considered on the one hand as superior or on the other hand as subordinates. Fourth, letters are sometimes used to express abuse or at least are couched in offensive terms which would be much less often used in a face-to-face encounter. Such rude letters are often a form of catharsis to the writer but may not be so recognized by the recipient. The fifth and sixth important points refer in particular to official letters and circulars: they are that such letters may or may not expect a response and the wording may be modified accordingly without any intention of modifying the meaning; circulars present a special problem since the recipients will be drawn from many categories, peer and subordinate, friend and stranger.

THE WRITTEN AND THE SPOKEN WORD

A feature of the written as opposed to the spoken word is that it gets into the record and so may be quoted for years to come. This applies particularly to circulars: undoubtedly the anxiety not to leave room for difference of interpretation is responsible for much cumbersome and unreadable writing and is in fact counter-productive. The Treasury in 1948 invited Sir Ernest

Gowers to write *Plain Words* as a contribution to that department's efforts to improve official English. We know that the book and its successors have been required reading for civil servants and we are assured that they have made a great impact on government circulars and forms. Some would say that there is still ample room for improvement. Certainly communications between doctors on service matters would be improved by a study of *The Complete Plain Words* (1) and by adherence to the guidance therein. Medical Officers in Government Departments and doctors with administrative responsibilities in Health Authorities are not given the same training as are civil servants and, what is more, their role in communication is rather different. Lay civil servants still write most departmental circulars on health matters. The Regional Medical Officer (RMO), the District Medical Officer (DMO) and other Community Physicians, and their equivalents in the various parts of the UK, should not be over-influenced by the wording of such circulars. In their written communications to doctors they should remember that they are writing to colleagues. Their task is often to interpret legislation or regulations and they would do well to follow Gowers' advice that 'clarity, simplicity and friendliness' should be the hallmarks of their letters. This policy has been adopted by the Plain English Campaign whose activities we commend. The campaign is based at 78 WILTSHIRE ROAD, SALFORD, M70 BD, and has offered many simplifications of official notices and forms, not all medical but many of which are related to medicine and to health hazards.

> The craftsman is proud and careful of his tools; the surgeon does not operate with an old razor blade; the sportsman fusses happily and long over the choice of rod, gun, club, or racquet, but the man who is working in words is singularly neglectful of his instruments (Ivor Brown, (2)).

Let us return to the differences between the written and the spoken word to see the lessons to be learned.

STYLE OF LANGUAGE

Too many of us change our whole style when we come to put pen to paper or to dictate. We are self-conscious and pompous. Instead of saying 'Thank you for your letter' we say 'Receipt of your letter is acknowledged with thanks'. Of course, letters can become too conversational and casual. Much oral conversation is dependent on non-verbal cues denied to the written word, but doctor to doctor communication should in general be as conversational as is consistent with clarity.

Dictating a letter to a secretary or into a dictaphone sometimes leads to verbosity. During some industrial disputes of the past doctors were obliged to write their own letters to referring colleagues at the end of the consultation, thus enabling the patient to deliver the letter in person. This led to clear, brief, and almost instant communication, provided the handwriting was legible.

STYLE ACCORDING TO RECIPIENT

If the recipient is a stranger the style is almost bound to be more formal and stilted than if he is well known to the writer. And the letter will often have to be longer because the writer may not know how well acquainted the recipient is about some matters.

This has special relevance in an organizational setting, where the best solution is to keep the circles of communication small. Thus one can involve a Community Physician closely in many defined clinical or unit activities when he knows the clinicians well and, just as important, the clinicians know him. Correspondence should be an extension of conversation and not something quite different. Of course, an RMO cannot know all the individual consultants in his region. Sometimes it may add authority or establish useful contacts if he communicates directly with them but in most cases it would be better if he communicated with them through a DMO, who does. To draw a parallel from personal affairs you pay more attention to a letter from someone you know than to a circular signed by someone you don't. It is personal contact that defeats

bureaucracy and avoids misunderstandings. The written word should supplement the spoken word and not replace it.

Under this same head comes the third strange thing about letters—differences of style depending on the status of the recipient. To a certain extent such a difference is natural. You don't write to your old Chief as you do to your godson. But difference in status should not be allowed to become a barrier to good communication.

A doctor is more likely to view favourably a letter on a medical subject written (and signed!) by another doctor than by a layman. By the same token a consultant is more likely to view with favour a letter written by a known consultant colleague and a GP by a known GP colleague. Some government circulars on medical subjects would be better received by the profession if they came from a professional committee than from a lay civil servant in the Department of Health.

LETTING OFF STEAM

Most of us find it easier to write a rude letter than to be rude to someone in person. Most of us, also, have received such a letter. The lessons are that they are written more for the benefit of the sender than for any potential harm to the recipient. Therefore, if you feel like sending a rude letter, write it but tear it up instead of sending it. Some secretaries faithfully type out the rude letter dictated to them, but do so on red paper and then hide it for a few days. Time is a great healer. If you receive one of these letters, do not react in the way to which you may feel entitled. Distinguish between communications written for the benefit of patients and catharsis for the relief of the writer.

From time to time one receives a letter which irritates because it is inadequate and slovenly. Gowers's advice again is worth quoting:

> Adapt the atmosphere of your letter to suit that of his. If he is troubled be sympathetic. If he is rude, be specially courteous. If he is muddle-headed, be specifically lucid. If he is pig-headed be patient. If he is helpful, be

> appreciative. If he convicts you of a mistake, acknowledge it freely and even with gratitude. But never let a flavour of patronizing creep in. (1)

THE COMMUNITY PHYSICIAN

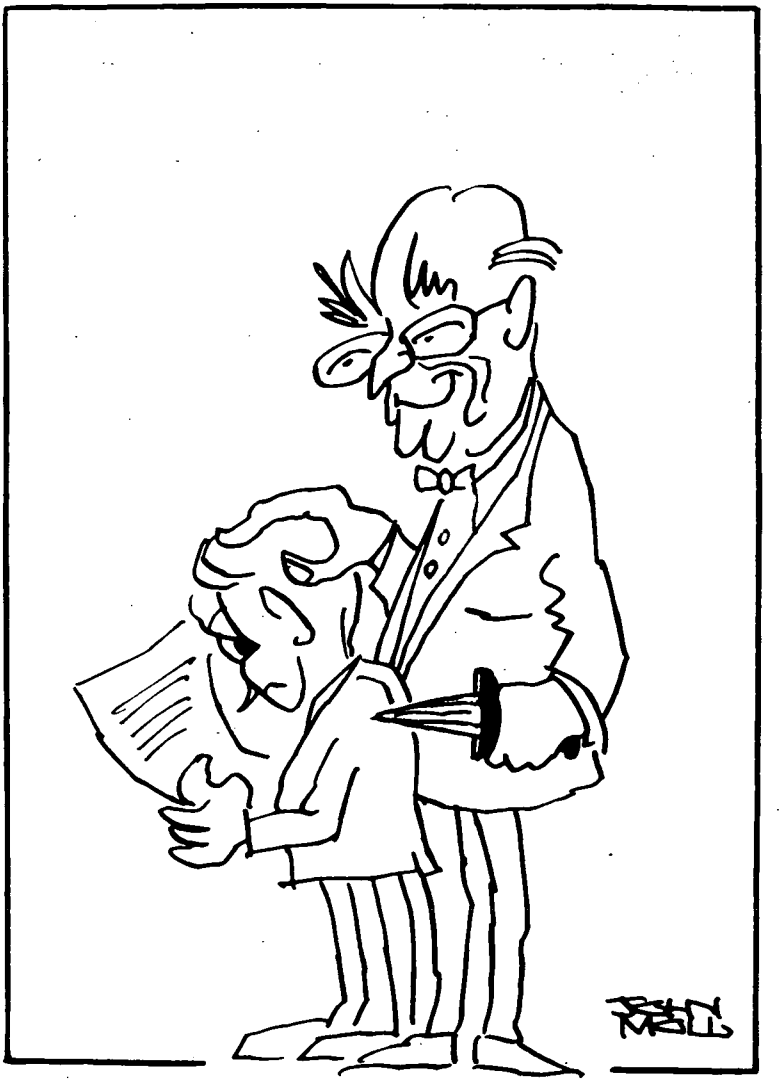
The community physician occupies a relatively new position in the structure of the Health Service, and hence his role is not yet clearly defined or recognized. This may make his style when writing to a senior consultant appear subservient or else he may subconsciously over-correct and sound authoritarian. This problem is compounded by the fact that the community physician may sometimes be writing as a clinical colleague on an epidemiological or quality assurance matter and sometimes as an administrator on a service matter. He deals with populations rather than with individuals. He will continue to be in a difficult position until his role has been more widely recognized and more clearly defined. The more that communication between clinician and community physician is by direct personal contact and person-to-person conversation between colleagues, the better. Unfortunately much of such communication has to be, or tends to be, by letter. The answer again lies in getting to know individuals personally and then in writing naturally. Problems will be reduced by discouraging junior or unknown community physicians from writing to senior consultants on delicate subjects. In the meantime community physicians piqued by the apparent disparagement they receive from senior consultants must not take it out on the junior doctors—if for no other reason that it will be these very juniors who in time, if properly handled, will come to rely on community physicians as indispensable colleagues. So, in summary, better letters are written between those of equal status; or at least in situations where both writer and recipient fully accept the essential role of the other in the interests of patient care.

COMMITTEE WORK

Committee work has come to be an important component of the doctor's work and the way in which individual doctors

participate can make an important contribution to their relationship with colleagues and to the efficiency of their service to patients. Committee work ranges from weekly discharge meetings within units, through Advisory Appointments Committees, to attendance at Health Authority meetings and meetings with the public. Many of these do not come into the category of doctor to doctor communication and therefore will not be considered here, but all are important in relation to the image which the profession gives to the public and therefore in the contribution which the medical profession can make to society. Committee work and public relations activities must be taken seriously and not denigrated. A certain formality is good for the conduct of committee meetings. Addressing the Chair as Mr Chairman, or with equivalent respect, is clearly desirable, but it is immaterial whether other members of the Committee use first names or surnames. Mixing the styles, however, is unacceptable. If the Chairman calls some members 'Bill', or 'Hamish', he cannot call others 'Dr Smith', 'Mr Jones', or 'Miss MacGregor'. Firmness from the Chair does not preclude courtesy. The Chairman also has a responsibility to keep to the time-table, to prevent individuals 'hogging' the meeting, and to draw out the shy or younger members who may have important contributions to make but are hesitant to intervene unless invited to speak.

Appointments Committees may for individual members be a relaxation from routine work, but all must remember how important an occasion they are for the applicants. Each Chairman will have his individual style but he must put the candidates at ease and endeavour to see that each has an equal opportunity of presenting his assets. Members of the Committee are entitled—and indeed required—to probe the qualities and deficiencies of individual candidates, but should remember that these are not occasions for showing off to their peers, or for being sarcastic at the expense of the candidate. Writing references for candidates is a very important part of the appointments procedure. Too often references are a repetition of the *Curriculum Vitae* which Committee members will already have before them. Often they are too long. The golden rule is to think what you would want to know about



9. There is nothing worse than a teacher who is all smiles to his pupil but puts the knife in behind his back.

the candidate if you were in the team in which he is applying for a place, and to say no more but no less than what you yourself would wish to know about his professional and personal qualities—good and less good.

RELATIONSHIP BETWEEN THE TEACHER AND THE TAUGHT IN MEDICINE

Mutual respect, honesty and good humour are hallmarks of a good relationship between the teacher and the taught in medicine. The former should not be content with the respect accorded to him because of his position but should reckon to earn it. The pupil, be he student, house officer or registrar, needs encouragement, tuition and insight. There is nothing worse than a teacher who is all smiles to his pupil but puts the knife in behind his back (Fig. 9). If the consultant doesn't agree with his registrar's management it is of course better to say so (but never in front of the patient). Such frankness is not only desirable for its own sake, but it also allows the registrar to put his side of the case. Frequently, additional information may put such a different complexion on matters that the consultant may change his mind completely. Honesty with junior staff does not necessitate trampling on them; it is all too easy to destroy the delicate flower of understanding in the name of freer communication.

What should be the form of address? Nowadays, students and junior staff prefer to be called by their first names and this is clearly acceptable provided the teacher feels comfortable with such a style. Calling the boss 'Sir' is certainly going out of fashion and this is perhaps desirable (Fig. 10). The ideal is to find the style that suits both parties.

COMMUNICATION WITH DOCTORS OUTSIDE THE NHS

Some doctors serving in the NHS have little occasion to write about patients or other matters to non NHS colleagues. Since such letters are less common they are apt to be forgotten, and just because they are to colleagues in a different service, promptness, courtesy, and clarity are all the more important.

10. Now-a-days, students and junior staff prefer to be called by their first names . . . some find it more comfortable to call the Professor 'Prof'. The ideal is to find the style that suits both parties.

There are also two clinical points that are of great importance—confidentiality and consent. Doctors engaged in occupational medicine have their own employing authority and there may be times when the interests of the employer and those of

the individual are in conflict. The following quotation from the booklet of guidance on ethics for occupational physicians is relevant: 'In normal circumstances with the individual's agreement, his own doctor should be informed of relevant facts which may be in the possession of the occupational physician which have a bearing on the interaction between his work and health. When the occupational physician is seeking further clinical details from a general practitioner or hospital medical staff he should normally do so with the individual's agreement . . .' (3).

In the same way School Medical Officers may have information which in the interest of the child may be valuable to the family doctor or vice-versa. There is no ethical objection to such information being passed on and the parents' permission is not normally required.

In all such forms of external communication extra attention must be paid to confidentiality. We know the arrangements within our own practice or hospital in relation to confidentiality of letters but we do not know what they may be at the receiving end. Therefore, trouble should be taken to ensure person-to-person communication and clear confidential marking.

COMMUNICATION WITH DOCTORS WHO ARE PATIENTS

Theoretically, dealing with doctors who are patients should be no different from dealing with other patients; in practice, however, this may not be the case for they may be given special treatment which cuts the corners. By avoiding orthodox channels they may escape having a proper history taken and a proper examination carried out; for instance a physician with rectal bleeding may accost a surgeon in the corridor of the hospital and request some ointment to clear it up! It is said that a patient can only take in one piece of information per interview unless the patient is a doctor in which case he can only take in half. This exaggeration serves to remind us that it is unwise to assume that the patient is fully conversant with his condition. Special attention should be paid to confidentiality. Doctors are usually very careful

11. Circulars . . . (death by Xerox).

about this unless the patient is a doctor when some laxity can creep in and allow discussion of the diagnosis and results of the investigation too freely within the hospital community. There is much to be said for allowing the patient to view his own X-rays, investigation results, and medical records should he so wish. The truth is bearable, uncertainty may not be, especially if the patient is a doctor.

CIRCULARS

Because they are for such a mixed readership these are particularly difficult to write. The same rules of clarity, simplicity, and friendliness should apply. The reader of a circular should be made to feel that it is addressed to him and has relevance for him personally.

There is a flood of official circulars. Photocopying has made it too easy to send them all to doctors of all sorts—'Death by Xerox' (Fig. 11). Important circulars need to be communicated personally. Yet is must be accepted that pruning circulation lists and distilling the contents of circulars to make

them relevant to different recipients takes time but often proves worthwhile.

Circulars on service matters often contain comment on several quite different matters. Even if each is clearly headed this is not good practice. Separate letters should be sent about separate subjects. The recipient may wish to file them differently or to pass one on a particular subject to a member of staff concerned with that subject only.

The distribution list for each circular must be clearly stated—nothing is as annoying as to take the trouble to pass one on only to find that a copy has already been received. If different circulars with the same information are sent to different groups, as has been suggested, a note such as 'similar letters sent to all consultants in the District' should be added.

And finally we commend Gowers's rules of vocabulary which were given in the following order:

Prefer the familiar word to the far-fetched;
„ „ concrete word to the abstract;
„ „ single word to the circumlocution;
„ „ short word to the long;
„ „ Saxon word to the Romance.

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Section 4

A consultant physician's experience of communication between doctors, and his suggestions for its improvement

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It is not suggested in this collection that in the complex world of medical care good communication between doctors who, in different phases of care have direct responsibility for an individual patient, is easy to achieve. Nevertheless, it is an important requirement on a number of planes and, as was noted in the Preface by Sir John Walton, the patient is the loser in bad or even inadequate communications. Dr Hawkins in this brief essay sets out an approach based on a lifetime's experience to improve matters especially in communications between the hospital and general practice.

A consultant physician's experience of communication between doctors, and his suggestions for its improvement

Communications between doctors in hospital and those in general practice often receive little attention, despite their importance to patients. Both groups of doctors natter about inadequate communication. Experience as a locum tenens for a GP afflicted me with a life-long interest in this subject. Being young and naive, I was surprised and even dismayed when patients were discharged back to my care from a world famous teaching hospital nearby without any communication whatsoever—however long I waited. Since then, many years spent both in teaching and in non-teaching hospitals have taught me how difficult the matter is in actual practice. So the following account simply relates some personal experiences and views.

LETTERS FROM GENERAL PRACTITIONERS

A good policy is for letters about patients to be read by the consultant or deputy as soon as possible after they arrive. Each can be marked according to the urgency. Then the appointment clerk can allot appointments accordingly. A possible case of malignancy is fitted in soon whereas other appointments would be further ahead. The system of reserving places for urgent problems, such as those about which the GP telephones, can be sabotaged, if unfairly used.

A need for moral support is one common cause why a GP sends someone to a consultant. This may be a patient with a chronic incurable illness or an intractable 'hypochondriac' from whom the doctor needs a brief respite which reassurance

from a hospital may provide. As Paul Freeling has pointed out, other reasons are:

1. A diagnosis is needed;
2. Suggestions for treatment in a known case such as one of rheumatoid arthritis are sought;
3. An investigation that is not accessible to the GP is requested;
4. The patient asks to see a specialist.

Usually the reason for the consulation is clear from the letter and it is helpful if this is always so. Many GPs write excellent letters, which are often typed. Badly written letters can be a problem and become impersonal if the signature, however distinguished, cannot be deciphered. Some letters, especially those with additional information concerning results of blood tests or such-like, are brought by patients who may open them. This probably seldom matters but could have caused upset in the following case related by one doctor. His neurotic patient had developed an ovarian cyst. He wrote to the surgeon 'Kindly see this patient and operate if you agree; please keep the patient and return the cyst to me'. The patient opened the letter.... Some GPs dictate a letter in front of the patient and there are advantages in this, apart from the fact that the letter need not be sealed. Emergency cases particularly need letters giving every possible fact. An example of bad communication occurred when a man was sent to a casualty department in diabetic coma: pinned to his pyjama jacket was a visiting card of the doctor and scribbled on it was 'This is to introduce Mr . . .' and nothing else.

LETTERS FROM CONSULTANTS AT OUT-PATIENT CLINICS TO GENERAL PRACTITIONERS

Dictating a letter immediately after seeing a patient is ideal, though seldom possible in a busy out-patient clinic; so letters are usually done at the end of a session, their purpose being:

1. To give an immediate tentative diagnosis with reasons for reaching it;
2. To say what investigations have been ordered;
3. To mention any possible interim treatment;
4. To record what the patient has been told;

5. To educate without being patronizing—concerning current thinking on a topic, new techniques and new drugs.

There is rarely time in a busy clinic to write letters oneself, though a legible hand-written one provides so personal a touch. If an urgent letter is required, it is called an 'instant letter', put on a pocket tape recorder and taken at once to the secretary. The patient waits, or, if ambulant, goes for a cup of tea at the canteen, and later collects the letter to take to his doctor; otherwise it is posted first class or the GP is telephoned. Difficulty arises at the start of a bank holiday or if the consultant pays only occasional visits to the hospital. Letters can then be posted to his home for signature but often are better sent off (first class) 'dictated but not signed' and copies are sent to him (second class postage). Time is saved if hand-outs giving one's views about treating various conditions are included with the letter. This saves time when a specialist is seeing similar cases at every clinic. Also the GP can get on with the various therapeutic suggestions and will only refer the patient back if any problem arises.

The follow-up letter reporting results of investigations is very important and an efficient secretary is essential for chasing up reports and putting the notes before the consultant or registrar—especially if a diagnosis of cancer or other serious disease has been made. The GP, however, will know from the first letter what investigations have been ordered and can if necessary telephone the department directly. Sometimes just one letter is enough—obviously this is sufficient if no tests are ordered and also if the result is expected shortly; yet postponement carries a risk that the notes may be mislaid and the GP remains ignorant of what is going on. Copies may have to be sent to the factory doctor or to others concerned in the case.

Many attend out-patient clinics unnecessarily as follow-up cases (1) so that role confusion may arise, and futile letters can easily be written by junior staff. For example, the GP may have treated a duodenal ulcer patient for ten years and the junior doctor merely recommends a different tablet without considering operation. It is best to decide the policy of follow-up or not at the start and to write it in the case notes.

LETTERS FROM HOSPITAL STAFF TO GENERAL PRACTITIONERS CONCERNING PATIENTS IN HOSPITAL

Interim reports. Keeping GPs in touch, especially during a prolonged stay of a patient in hospital, can easily be done by interim reports. These only need to be a few lines but are useful if an unexpected change has occurred: this may concern the diagnosis, a sudden catastrophe, or an operation. (We used to telephone the GP but this personal contact has become increasingly difficult to achieve.)

Discharge letters. A brief discharge letter is written or preferably typed by the house officer a day or two before the patient is due to leave. Two copies of the original are made: one is put in the patient's notes so that the consultant can check it when bidding the patient farewell; the second copy is given to the patient in an envelope to be handed to the GP, thus providing immediate communication. The original is posted to the GP.

If the house officer writes the letter he must have good carbon paper for copying and a ballpen. It is helpful to involve the secretary by dictating some letters to her, ensuring that she then feels one of the team and realizes the need for urgency. I have always preferred a letter to using the standard form of discharge note but opinions vary about this.

The Registrar's Summary. A good summary is essential for the records of the hospital and is a help to most GPs. It should be typed on a sheet of paper of a size to fit the GP's filing envelope (5×7 in; 13×18 cm) and must not occupy more than two sides. But, however brilliant and conscientious the registrar, the problem is how to get these done and done in time. The following methods have been successful:

1. Talk to the registrar immediately on appointment about their importance, mentioning that he will be assessed partly on his efficiency in doing summaries;
2. Emphasize how much easier it is to do a summary immediately on discharge when details are fresh in the memory, rather than a month later;

3. Appoint an efficient but diplomatic secretary who will put pressure on the registrar to dictate summaries and not let a pile of case-notes accumulate in her office, to be done weeks or months after discharge.

I have long used a problem sheet on the front of the notes. This is helpful even if Problem Oriented Medical Records (2) are not used. It makes it easier to concoct a report and the summary itself is done in the form of a problem list.

The GP must be guided about:

1. Drugs prescribed in the hospital and for how long they should be continued;
2. Whether or not an OP appointment is being made; and
3. What the patient has been told.

Copies may have to be sent, for example, to the doctor in charge of the anti-coagulant clinic or given to the patient if he is going abroad. One is also kept by the secretary in a filing cabinet on the ward. This is invaluable if a patient is re-admitted, especially at a weekend or at night.

TRANSFER OF PATIENT TO ANOTHER HOSPITAL

This can provide cause for irritation especially when nothing is sent with the patient. The house officer should write a letter together, if possible, with a registrar's summary and the sister of the ward should write a note about nursing. Often the case-notes, X-rays, and reports should be sent with the patient, to be returned later.

The medical secretary

The medical secretary plays a key role. She is also a link between the hospital and the outside world and should be made to feel part of the medical team; hospital typing pools are impersonal and dehumanizing. Dictating occasional letters directly to the secretary rather than on tape provides personal contact and enables her to keep in practice with her shorthand. It is helpful to get feedback from the secretary as this maintains smooth running of the firm.

Tape recorders can be a menace since they encourage verbosity especially by those who enjoy the cadence of their

own voices. Junior staff should be taught about using them and *Dictating with Tears: a Guide from Philips* (3) or *Be a Dictator* (4) are helpful. So much of a secretary's time can be wasted if for example the letter has to be started afresh because the speaker, at some stage after dictating a section, has then changed his mind but neglected to go back and erase.

AUDITING COMMUNICATIONS FROM HOSPITAL

Quite simple measures allow an occasional audit to be done on the efficiency of communication. Methods are as follows:

A random check can be carried out to assess the time which elapses before the summary is posted. The secretary types on the summary the date of discharge and also the date when it is sent off. A bar chart is then prepared and discussed with the registrar. Figs 12a and b show audits done on the work of two different registrars. This also brings to light any long delays, which may be due to an investigation or pathological report not having been received—or to the notes having been lost.

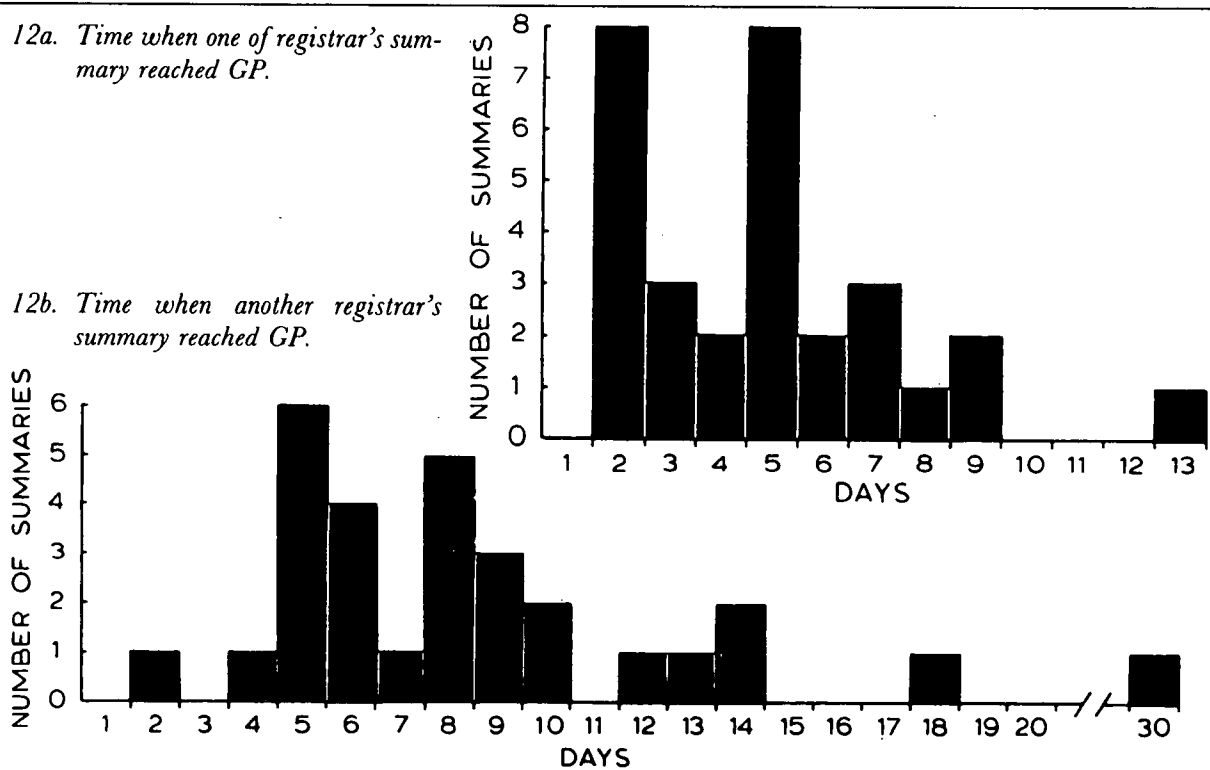
Postal delay. In 1980, the DHSS sent out an instruction—unknown to many hospital staff—that only second-class stamps should be used unless there was a note that the letter or summary was urgent. Hence second-class stamps were used routinely and communications would reach the GP after a few days instead of the next day. An audit was done by enclosing with the letter a franked card upon which the GP recorded the date when it was received, and then posted it back.

I have always asked secretaries to let me have copies of all letters and summaries written by all members of the team. Their value is as follows:

(a) Scanning them is a method of keeping in touch with what is happening to all patients. Also I edit them when necessary and talk them over with junior staff. Some write precise letters in clear English but others may need tuition; case-histories are regurgitated unnecessarily, the letters are too long, no definite conclusion is given, and

12a. Time when one of registrar's summary reached GP.

12b. Time when another registrar's summary reached GP.



the writing is too verbose. For example 'on physical examination, I found an apparently healthy looking adult. She was normotensive and measurement of her blood pressure showed this to be 120/80 and the pulse was 70 per minute, regular . . .'

(b) Because the copies have been kept in various box files under different headings, e.g. rare cases, undiagnosed ones, and diseases of particular interest, they have been accessible to provide data for clinical research. One paper described 163 cases collected ten to twenty years previously and then followed up: this was virtually a prospective study.

CONCLUSION

The approach which I have described may seem authoritarian, especially in relation to junior staff, but the subject is important and should be taught both to under-and post-graduates. As a consultant, I always regarded myself as chairman of a team and not a figure at the apex of a pyramid as was once the case. To achieve—and it is not always impossible—a set of case-notes with good letters and medical reports is most rewarding. Then, a medical student can often gain more from reading from the start (the GP's letter) through the case-notes of a chronic case to the finish (hospital summary) than from reading from a textbook.

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Section 5

Epilogue

CHARLES FLETCHER

CHARLES FLETCHER
CBE, MD, FRCP, FFCM

Finally in this Epilogue Professor Charles Fletcher, who at the invitation of the Trustees was the author of the monograph 'Communication in Medicine' published in 1972 in the Rock Carling series, seeks to complement the previous essays and to fill in some of the gaps, which the reader will no doubt have already identified, with the overall objective of drawing attention to some of the more common failures which contribute to inefficiency and ineffectiveness of practice.

Epilogue

INTRODUCTION

The foregoing essays in this booklet are concerned with failures of communication between doctors in the NHS which seem to be frequent and which are annoying, often inconvenient, and sometimes actually or potentially dangerous to patients. They describe various types of failure, but do not address themselves to their causes, nor, largely because almost no data are available, do they deal with questions such as how and why the frequency of failures may vary within or between different types of hospitals or general practices, or whether and for what reasons these failures may be increasing or diminishing in frequency and effects.

In order to complement the essays, which are designed to promote better communication between doctors, I was invited to make a concluding contribution to fill in the gaps as best I could and to make proposals for action by whch the main purpose might be advanced.

I shall first summarize the main types of communication between doctors and the requirements for success in each of them. I shall then go on to discuss the causes of failure and will finally attempt to propose some types of action that might eventually reduce at least some of the more common failures.

NECESSARY COMPONENTS OF GOOD COMMUNICATIONS OF VARIOUS TYPES BETWEEN DOCTORS

Many of these have been referred to in the preceding essays but it is convenient to summarize, and in some respects to

amplify them, here. A system of checklists is used for this purpose for two reasons. Individual doctors may find them useful to compare with their own actions and they could also be useful in planning studies of present practices and of means by which they might be bettered.

GP referral to out-patient clinic of hospital specialist
(CHECKLIST 1)

Referral letters must include:

Reason(s) for referral:
—for diagnosis
—for management
—to reinforce GPs opinion
—because of pressure from patient or family
—for temporary relief from a difficult patient.

Essentials of clinical history (with precise dates, for patients often forget them).

Details of treatments already given (doses and dates of prescriptions are required) and what effects they have had (good and bad). It is helpful to both GP and consultant to mention any non-prescribed drugs which the patient is taking regularly.

Psycho-social aspects of the present problem (including a statement that none are relevant if this is the case).

Letters must be legible, preferably typed, and the GP must ensure that all letters reach the specialists before the patient attends the clinic. Sending the letter with the patient may inhibit frankness about sensitive matters, but may be necessary in cases referred urgently.

GP to hospital investigating department
See Checklist 6 (p. 82). If the space for clinical details is insufficient these should be typed on a separate sheet and stapled to the request form. The patient must also be told the opening hours of the relevant department.

GPs to other GPs

Here, so far as the patient is concerned, the main issue is that the case-notes should be so kept that a colleague or deputy whom the patient has to consult for any reason can easily check any recent medical history and prescriptions. Brief summaries of any hospital reports (consultations or investigations) should be put into the notes when they are received so that a colleague need not shuffle through a pile of long letters and reports to find the crucial information. Legible handwriting or typing is essential.

Action by hospital specialists when GP's letter is received

One good system has been described by Dr Hawkins (p. 61). The important thing is to ensure that the consultant to whom the letter is addressed, (or to whom the patient is allocated by the out-patient clerk if the letter is not addressed to any individual specialist), or the consultant's deputy, should go through all letters of referral as soon as they are received to give priority to urgent cases. Then, at each clinic, patients should be specifically allocated to the various members of the team. It is impolite to the referring GP to leave this allocation to a clerk or to the nurses attending the clinic. One or two vacant appointments must be kept at each clinic for urgent cases referred by telephone immediately before or during the clinic.

Interim post-clinic letter

(CHECKLIST 2)

The letter should be dictated as suggested by Dr Hawkins (p. 62) or written legibly on a self-copying form as in Fig. 13, giving:

Diagnosis (presumptive or alternatives when investigations are needed).

Immediate simple drug therapy (state if already given to patient or to be given by GP).

Investigations arranged.

What the patient has been told.

Date (if any) of next appointment or of admission to hospital.

NAME AND ADDRESS OF HOSPITAL

Tel: ..... Date .....

Dear Dr. .....

Patient's Name .....

Address .....

.....

I saw this patient of yours in the Outpatient Clinic today.

1. My clinical impression is :

* 2. I have prescribed the following drugs , sufficient for .....weeks/months:

* 3. I suggest you should prescribe the following drugs:

* 4. I will/will not be seeing this patient again.

I will send a full report later.

Yours sincerely ,

(print name and qualification)

* Delete as appropriate

Dr. .....

Address .....

.....

13. Letter form for first out-patient attendance.

Interim letters usually contain no more information than the patient has been told and can be taken by the patient to the GP. If posted, to ensure confidentiality, they should be posted not later than the day after the clinic. A final letter written after first attendance should be as in Checklist 3.

Final letter

(CHECKLIST 3)

The final letter either after the first attendance or after the investigations are complete should comprise the following, but omitting superfluous items such as repeating the contents of the letter from the GP:

Important points in history not mentioned in GP's letter.

Any diagnostic physical signs.

Results of investigations relevant to diagnosis, giving normal values in the case of numerical results.

Diagnosis.

Recommended treatment

(a). *Surgical.* Mention operation proposed and expected date of admission.

(b). *Other in-patient treatments.* (e.g. haematological, radiotherapeutic, complex pharmaceutical, etc.). Indicate the nature of treatment and expected date of admission.

(c). *Out-patient pharmaceutical.* For each drug give dose, frequency, duration of administration, any important or likely side effects, and whether the GP or hospital clinic will provide the treatment.

(d). Other. (e.g. physiotherapy). State how this is to be arranged, by whom and for how long.

Brief explanation of the reasons for any new type of investigation or treatment.

Desirable changes in the patient's work, exercise, habits, diet, or residence.

What surveillance or monitoring of the treatment is required and who is to do this.

In what circumstances the patient should be referred back to the clinic.

What the patient has been told about diagnosis, prognosis, and treatment.

There are many reasons for delay, or even failure, in writing to GPs about out-patients, depending on the types of clinics, numbers of doctors who see patients at them and any need for repeated attendance. A good way of reducing these delays and failures is by the type of audit described by Dr Hawkins (p. 66).

Letters after follow-up out-patient clinics

The GP should be informed of any new findings or treatment and whether further follow-up is planned (see Fig. 14).

Accident and Emergency clinics to GP

Whenever a patient attends such a department with anything other than a trivial complaint a report should be sent to the patient's GP in the same way as after any out-patient consultation. Suitable forms should be available (Figs. 12 or 13). If any investigation asked for by a casualty officer shows an incidental abnormality which needs urgent attention the investigating department must ensure that the report has been read and acted on by an appropriate specialist.

GP to hospital for emergency admission

This has to be arranged by telephone. Hospitals must ensure that the telephone exchange can always contact the medical and surgical receiving officers quickly so that the GP may be put through quickly. A deputy must be arranged by any receiving officer to act on his behalf when he is temporarily unavailable for any reason, and the telephone exchange informed accordingly.

NAME AND ADDRESS
OF HOSPITAL

Tel: ..... Date .....

Consultant .....

Dear Dr

Patient's Name ..... Case No. .....

Address .....

.....

.....

I saw this patient of yours in The Out-patient Clinic today.

1 Diagnosis

2 Present treatment

3 Investigations ordered

4 Treatment (underline any change)

5 Date and reason for next follow-up attendance

Yours sincerely

(name and qualification in BLOCK CAPITALS)

Dr .....

Address .....

.....

.....

14. Letter form for follow-up out-patient attendance.

Emergency Admission Note
(CHECKLIST 4)

The GP must send a note with the patient giving:

A short history of the illness.

Provisonal diagnosis.

A list of drugs the patient is currently taking.

Details of any relevant psychiatric or social problems.

Urgent requests by hospital doctors to GPs

These usually concern patients arriving at the hospital disorientated or unconscious when knowledge of current drug treatment or of the previous history are important for diagnosis. For this reason GPs (or deputies) should be available at all times to receive such telephone calls. Single-handed GPs should have a telephone answering machine and should ensure that they listen to it regularly to see if there are any urgent messages.

Report to GP by the investigating department

See Checklist 7, page 82.

Reports to GPs on hospital in-patients

The important points are:

1. Interim reports (p. 64). The desirability of sending such a report should be considered for each patient at the time of each ward round. Junior medical staff should be instructed to post these reports immediately or to give the information by telephone.

2. Discharge reports. See page 64 for recommendation on reports written by registrars. An alternative is a discharge note (Checklist 5 below) which should be completed by the house officer for every patient on discharge. It should be given to the patient or a close relative to hand to the GP when the patient next consults him. This double procedure of an immediate brief note followed by a full

letter should avoid any GP being uninformed when visited by a patient who has recently been discharged from hospital.

Discharge Notes and Letters (Figs 15 and 16)
(CHECKLIST 5)

These discharge communications should include:

Patient's name, address and hospital case number.

Dates of admission and discharge.

Final diagnoses.

Results of any crucial investigations carried out (no long lists of normal findings are needed).

Treatment in hospital (surgical and/or medical).

Follow-up hospital treatment arranged (e.g. physiotherapy/radiotherapy).

Treatment to be arranged by GP.

(a). drugs; (b) other; (c) after-care, e.g. occupation, exercise, diet, habits;

(d) any further out-patient attendances needed and why.

Since patients who are ready for discharge may sometimes be kept in hospital unnecessarily until the specialist has seen them on his ward round, arrangements should be made for junior clinical staff to obtain prompt agreement from their chief, if necessary by telephone, to discharge any such patients.

If the patient is *transferred to another hospital* the GP should be informed as in the case of a discharge to home. Junior clinical staff must also ensure that a statement of the reason for the transfer and a case summary with results of all relevant investigations, including X-rays, accompany the patient.

If a patient dies in hospital the GP must be informed immediately by telephone and told about the circumstances and probable cause of death. If he cannot be reached his

NAME AND ADDRESS OF HOSPITAL

Tel:
Ext:

Consultant ..... Case Number.....
Name of Patient.....
Address.....
Your patient was admitted to hospital on.....
and is to be discharged from hospital on.....
Diagnosis:.....
.....
Treatment in Hospital.....
.....
.....
Recommendations: .....
.....
.....
Patient has been told:.....
.....
.....
Relatives have been told:.....
.....
.....
Date..... Signed.....
(Name and qualification in BLOCK CAPITALS)

A summary of the patient's notes will follow

15. Short discharge form for GP.

secretary must be given this information and told to pass it on as soon as possible. A normal discharge form (Figs 15 or 16) must also be prepared and sent.

If an autopsy is arranged this should be stated in the letter to the GP and a short summary of the findings and conclusions should be sent to the GP not more than two or three days after the autopsy.

HMR 2A (90-615)
(GP Copy)

Please do not enter details in this margin

DISCHARGE NOTIFICATION

FROM

NAME AND ADDRESS

OF HOSPITAL

TEL No EXT
(For this matter only)

Case number.....

Patient's Name.....

Address.....

.....

.....

Dear Doctor
Your patient admitted under the care of.....
will be discharged/transferred ◆ on.....to.....

Diagnosis:

Treatment given:

Fold →

Treatment recommended:

Drug sensitivity:

NOTE
If any of this information requires to be known urgently by the GP it should be communicated by telephone — the discharge form should be completed to follow subsequently.

Community services arranged following discharge:
◆Home Nurse
◆Health Visitor
◆Social Worker
◆Other (please specify)

Medicine has / has not ◆ been supplied (for..... weeks/days ◆)

Information given to the patient:

◆An appointment has / has not ◆ been made for attendance as an outpatient on.....

◆Arrangements have / have not ◆ been made for attendance as a day patient on..... days a week, starting.....

◆The patient should be fit to return to work on .....

◆The patient's fitness for work will be reviewed in out-patients/day hospital

◆The patient has been advised to see you within.....days/weeks ◆

} A certificate has been issued accordingly

Fold →

◆A summary of the notes will follow

Yours sincerely

(Continue overleaf if necessary)

Date: ..... Name and qualification in BLOCK CAPITALS.....

◆ *Delete as required*

GPs Name.....

Address .....

.....

.....

By detaching the perforated margin and this portion the summary can be filed in the record envelope (EC 5 and 6) with one fold

98-1555 9/76 GBR LTD

16. More complete discharge form for GP.

Request by hospital specialist to investigating department
(CHECKLIST 6)

The request form is normally filled in by junior staff who must make sure that:

The information sought is essential for diagnosis and/or treatment.

The investigation requested is the most appropriate way of obtaining this information.

The value of the information to be obtained by the test is commensurate with the work which it will entail. If there is uncertainty about this a senior member of investigating department should be asked to advise.

EVERY detail asked for on the request form has been filled in.

All the clinical information which could help the investigator to interpret his findings are given—particularly results of any previous, similar examinations carried out elsewhere.

The question(s) which it is hoped the investigation may answer is (are) stated (if routine check, say so).

Whether any special preparation of the patient is needed before the test is done, and, if so, that it is carried out.

The patient knows why the test is being done, what it will entail, and when it has been done what it has shown. This is particularly important with investigations which may be painful (e.g. sternal aspiration), uncomfortable (e.g. barium enema) or alarming (e.g. complicated radiological procedures such as cardiac catheterization).

Report by the investigator
(CHECKLIST 7)

This report should:

Reach the referring doctor within 48 hours of completion.

Describe the qualitative findings and, for numerical data, give normal values (and SD or appropriate parameters) for the particular patient.

Ensure where possible that the clinician's questions are answered.

Suggest further investigations which might clarify the clinical problem.

In addition it would be helpful if the investigator makes sure that a report of any serious abnormality has been read and acted on by an appropriate physician or surgeon (e.g. Tb in a routine chest X-ray, or a renal stone in a barium follow-through).

Clinical specialist to a clinical colleague in hospital

A request for consultation must be legible or typed and must specify the reason for the request:

—to advise on diagnosis and/or treatment

—for colleague's special interest

—to be taken over.

Junior staff must ensure:

Prompt delivery of request to the specified colleague, or to a suitable deputy if the invited colleague is unable to see patient promptly.

That the patient and all necessary data (including X-rays and case notes) are available when the visiting specialist comes to see the patient.

That the patient knows what is going on, why the consultation is required and afterwards what the outcome was.

Reply by specialist after in-patient consultation

This should be given not more than three days after receipt of the request. If this is not possible for the nominated specialist he should delegate a junior colleague to see the patient and prepare a report for his chief. This must:

Provide answers to the reasons for request.

Be written legibly in case notes or typed in a form suitable for inclusion in the notes.

Communications between hospital doctors on administrative matters

These frequently concern such things as improved facilities for new kinds of investigation or treatment which may require extensions, structural alterations or additions to the hospital, upon which the interests of different medical, clinical or investigative departments may conflict in some degree.

The worst way of settling any such conflicts is by writing terse and possibly offensive letters. The best method is that of informal discussion by those involved with the chairman of the medical committee so that misunderstandings can be removed before the committee meets. Both (or all) parties should then be ready to accept the committee's decision.

Junior medical staff should be enabled to express their views on administrative changes which may affect them. One way of ensuring this is to have the agenda of each divisional or medical committee circulated or posted on a notice board at least a week before the meeting. Junior medical staff can then see it and any of them who wish to present their views on any item should discuss these with the chairman before the meeting so that he can, if necessary, arrange for junior staff representatives to be present.

Communications between senior and junior medical staff

This should seldom present any problem and has been referred to on p. 54. It is inappropriate for doctors to differ openly with each other on clinical matters in front of patients on a ward round. It is much better to discuss the management of each patient in an anteroom before or after the ward round to iron out any differences in polite but uninhibited discussion so as to ensure that no conflict emerges during the ward round itself. The ward-sister, and when appropriate other members of the health care team, should also attend these meetings.

'Sick' doctors

When doctors become aware that a colleague is in danger of becoming unfit to practice because of illness—such as, for example, mental incapacity or drug habituation—it is essential for the protection of patients that such doctors

should be able to communicate their anxieties promptly to senior colleagues who could, if necessary ensure that the disabled doctor is relieved of his clinical responsibilities. Formal and effective but compassionate mechanisms have now been established for handling these sensitive problems. If a hospital doctor is in any doubt about these mechanisms he should consult in confidence his district or regional medical officer who can advise him. In general practice it is appropriate to speak to the chairman of the Local Medical Committee. Less formal welfare and advisory procedures for the 'sick doctor' are now being established by the Royal Colleges and various specialist associations.

Communication between hospital doctors and their successors

This is the objective of keeping comprehensive case notes, of which the two most important aspects are the case-summary and orderly filing of reports on investigations. If the latter is done well there is no need to fill out summaries with results of negative investigations.

Each summary should be as brief as possible, giving only the diagnosis, the essential diagnostic features of the history, physical examination and investigations, and contain a brief account of any surgical or medical treatment carried out in hospital or recommended to the GP on discharge. A statement of what the family or patient were told about the illness and its management should also be included unless a copy of the discharge note to the GP is filed next to the case summary. Many clinicians now advise the use of Problem Orientated Medical Records to facilitate the writing of concise case summaries and discharge letters to the GP (see p. 65).

CAUSES OF POOR COMMUNICATION BETWEEN DOCTORS

In the absence of published quantitative data it is impossible to make any valid estimate of the relative importance of the different causes of communication failure. Research into this problem is needed: some of the more important causes will now be discussed.

Specialization and jargon

These may affect communication between GPs and hospital doctors because of their differing types of work and special interests. Many general practitioners, particularly the younger ones, dissatisfied by the highly technical methods of diagnosis and therapy on which hospital medicine is increasingly based, have developed a special interest in, and concern with, the psycho-social aspects which predominate in many of the illnesses with which they have to deal. Some wrongly presume that hospital specialists are uninterested in these matters and therefore may leave them out of their letters of reference, or may (as it appears to the specialist) over-emphasize them.

Specialization is probably more often a barrier to communication in the reverse direction, from hospital to GP, as Freeling points out (p. 11). Specialists may mistakenly assume that the GP is conversant with the technical jargon which they use in their daily work and the abbreviations that go with it. Much of this may be meaningless to general practitioners and, indeed, to many of their colleagues in other specialties who will usually be grateful for letters designed to be understood by a junior clinical medical student.

Illegibility and illiteracy

Illegible writing is an avoidable barrier to communication but is not very common. In 1964 about 13 per cent of GP's letters were rated as illegible (1) but the prevalence is probably lower now since any GP can now employ a secretary to type his letters if he cannot do this himself. But some doctors, having had little practice in writing lucid English during their training, may write in such a confused way that their true meaning is hidden from everyone, sometimes including themselves. This can be a barrier to comprehension between doctors both inside and outside hospitals. There is no evidence about its prevalence.

Attitudes

1. Lack of mutual esteem. In previous decades the ambition of many medical students was to get on to the staff of a

teaching hospital as a consultant. Doctors who failed to achieve this ambition were often held in low esteem by those who had succeeded (2). Indeed, it was reported that 'after the NHS was set up, hospital doctors, released from their dependence on private referrals, could more openly express their contempt for the level of work which characterized the general practitioners' responsibilities, (3). One practitioner told me that the reason he and many of his colleagues hesitated to mention their treatment in their letters of referral was that consultants often told their patients and students how inadequate and incorrect this had been. We know nothing about the present prevalence of this type of discourtesy but it should now be diminishing as GPs are becoming increasingly recognized as specialists in their own chosen field of medicine. Indeed, GPs themselves are now becoming 'more critical of a science of medicine that looks as if it can only operate by excluding the difficult, the imponderable, and the unquantifiable'. But the interface between general practice and hospital medicine is now beginning to be one of co-ordination rather than division, so that mutual communication should be more easy to achieve (4).

2. Isolation. Within hospitals the former jealous isolation of consultants in competition with each other for private patients is probably lessening now that no specialist can be expected to have full knowledge of every aspect of medicine, but the treasured independence of clinicians proud to be in charge of their own firms may still appear to make some of them unwilling to concede any need for advice from other specialists which might benefit their patients.

3. Conservatism. Although many doctors are unaware of it, much of their work is stressful. 'Consultants, for all their enarmored composure are often anxious men at heart because they must be constantly taking important decisions on incomplete information' (5). The same criticism may equally be levelled at GPs. They may tend to bolster their confidence by developing an inflexible attitude towards their daily work. Suggestions that a change of attitude and practice might make them more effective and easier to work with may

consequently be resisted. This is not in itself a cause of poor communication but may inhibit changes which could improve it.

4. Lack of understanding of the work of other departments. Clinicians do not always appreciate the difficulties which their requests to investigating colleagues may engender. Part-time consultants may seldom meet their laboratory or radiological colleagues to discuss these difficulties and juniors may be hesitant to approach them. Conversely investigative departments may not always realize how unhelpful are some aspects of their reports to their clinical colleagues.

5. Lack of interest in administration. The smooth running of the complex organization of a modern hospital depends on some degree of medical involvement if it is to work for the common good for all the staff (6). Hospital doctors who take no part in the work of medical and divisional committees will miss important occasions for communication with their colleagues which could lessen any conflict between the needs of the various members of the medical staff. More important is an unspoken but common disrespect by doctors in the NHS for their administrative colleagues. This is understandably reciprocated by the administrators who frequently find doctors difficult to deal with.

Shortage of time and increasing complexity of medicine

As medicine advances its practice becomes ever more complicated and time-consuming: doctors become preoccupied by their daily routine and by the struggle to keep up-to-date, and may thus be distracted from the sort of activities which may be necessary to maintain and ensure easy communication with their colleagues. Consultants often delegate these activities to juniors without careful supervision. These juniors may be working such long hours on urgent clinical work that they fail to keep good case records and fail to provide GPs with the information about their patients which is essential for continuing care after discharge from hospital.

Inadequate secretarial help

The preceding essays have emphasized (p. 65) the essential role of good clinical secretaries, especially in communication from hospital doctors to GPs. It is now becoming more and more difficult for hospitals, striving to cut their costs, to provide competent secretaries for all their clinicians. Often substitute agency secretaries have to be called and are quite inexperienced in the sort of help that hospital doctors need from them.

Lack of training

Medical students are probably not taught enough about the need for and techniques of communicating with other doctors nor about the difficulties they will encounter after they qualify and how these may be overcome. Since these matters are rarely raised in their examinations they must rate them as unimportant and give them little thought. When they meet difficulties after qualification indifference may lead them to ignore their failures and even if they are aware of them they have nothing but their untutored common sense with which to overcome them.

ACTION NEEDED TO IMPROVE COMMUNICATION BETWEEN DOCTORS

All of the contributors to this booklet agree that failures in communication between doctors are frequent and harmful enough to merit a careful examination of what could be done to lessen them. The kind of action required can usefully be considered under three main headings: the formulation of necessary studies, their execution, and the education and training of doctors.

Studies of prevalence and severity

It is difficult to suggest methods of solving any problem without having information about its prevalence and severity. Such knowledge could well identify the relative importance of the causes of poor communication which have been outlined

somewhat empirically above. Precise figures would not be required, but better knowledge is needed about the frequency of various types of communication failure, about those which are the most damaging to clinical efficiency, and what appear to be their main causes. Such knowledge might well indicate the sorts of action which might most readily correct the most damaging kinds of failure. It would be helpful to have pilot studies carried out in order to develop appropriate techniques of data collection and analysis. It would probably be best if such surveys were first done in places where preliminary equiries indicated that the problems under study were of contrasting importance so as to allow conclusions to be derived about the effects of differing methods of practice. The following types of survey might be practicable:

1. GP referrals to hospital specialists and investigating departments. Examples of GP referral letters from several practices of different types could be selected at random and their contents scored according to Checklist 1 (p. 72). Samples of request forms for various investigations completed by the same practitioners could also be studied and scored for completeness. Reports on these investigations could then be rated for adequacy according to Checklist 7 (p. 82).

2. Hospital doctors to GPs (out-patients) Replies received in response to the sample of GP letters analysed as above could then be used for analysis and scoring of the replies to them from various standpoints:

(a) frequency and types of faults in:
  (i) interim letter (by Checklist 2, p. 73)
  (ii) final letter (by Checklist 3, p. 75)

(b) delays in receipt of replies—and the frequency of no reply

(c) GP satisfaction with replies (on a 0–4 scale)

(d) frequency of other problems (e.g. conflicts in management when patients are kept under hospital and GP care simultaneously).

It would be useful to conduct surveys of this type in areas where GPs on preliminary enquiry were found to be quite satisfied, moderately satisfied, and dissatisfied with the service

they receive from consultants and hospital departments respectively.

3. Communication between accident and emergency departments and GPs. This would have to be studied from a sample of patients' notes to check whether or not reports had been sent to GPs. Where no letter had been sent a reason would then be sought, where it had been sent the letters could be assessed as above.

4. Urgent admissions. A sample of patients admitted urgently to hospital directly or through accident and emergency departments of hospitals in the neighbourhood of the study practices could be used to investigate first, from the GP standpoint, the difficulties they had had in arranging these admissions and, for hospital doctors, the adequacy of information provided by GPs according to Checklist 4 (p. 78). Any difficulties they had found in getting this information from them and reasons for these difficulties would be recorded.

5. Communications to GPs about hospital in-patients. It would be convenient if this problem could be studied in the same areas of investigation but it might be preferable to base these enquiries upon a small sample of hospitals of different types (teaching, district, general, special). These could be chosen on the basis of preliminary enquiries among a sample of GPs about their general satisfaction with reports they received about in-patients. Two hospitals providing a good service, two with a fair service, and two thought to be offering a poor service might be chosen. A random sample of discharges over, say, one month in winter and one in summer could be taken and the interval between discharge and despatch to the GP of preliminary and final reports for each patient would be recorded. For each of these reports the contents would then be assessed and scored according to Checklist 5 (p. 79). A random sample of patients who had died in these hospitals would then be analysed and reports upon them assessed in the same way. For each patient included in these samples the GP would be asked to rate his satisfaction

with the information he had received on a 0–4 scale. Reasons would be sought for low satisfaction scores.

6. Communication between hospital doctors and investigating departments. The contrasting hospitals used for the previous study might also be used to study the adequacy of completion of request forms. Each of the main investigating departments could examine a random sample of, say, 100 requests over a period of about a week. The requests could be classified as complete or incomplete (including illegible) and the incomplete ones could be classified according to the type of information missing, according to Checklist 6 (p. 82). Those regarded as 'inconsiderate' (in relation to the time involved and the complexity of the investigation) or 'inappropriate' (to the stated purpose of the investigation) and routine requests of doubtful value would be identified. The frequency and types of failures would be recorded and would subsequently be used as a base-line from which to show the benefits of any preventive measures.

The same sample could then be used to study the adequacy of reports of investigations. Delays between despatch of requests and completion of the investigations would be recorded and the reports then rated according to how far they answered the clinician's questions. If they did not the question as to whether any useful suggestions had been made for further investigations would be examined.

The clinicians in these hospitals could be asked whether they had any special criticisms of the work of their investigating departments and *vice versa*. The departments could also be asked whether they had taken any steps to limit inappropriate or excessive requests, and if so whether these measures had had any effect. Any arrangements that had been made for joint meetings between clinicians and investigators would be noted and could be related to the frequency of complaints about each other.

7. Communications between clinicians. It might be difficult to carry out any retrospective study of the efficiency of referrals by one clinician to another, since consultation requests are not always retained in case notes. One way of

getting information about this would be to ask a sample of ward-sisters to keep a prospective record of all consultation requests over a period of a few months, and, for each request, to record date of despatch, the interval before the consultant saw the patient, and any subsequent interval before the report was received. Reasons would be sought for intervals of either kind in excess of 48 hours.

8. Communications between senior and junior medical staffs. These would also be difficult to quantify. A subjective study might prove useful. This could be done by retrospective enquiry from both senior and junior doctors about any difficulties they could recall in the previous 6–12 months. At the same time questions could be asked about opportunities provided for discussing clinical disagreements other than on ward rounds. Both senior and junior staff could also be asked if they knew of the appropriate first point of confidential contact for dealing with a 'sick doctor' problem in their hospital.

It could be valuable to assess the *quality of case records* in these hospitals (on a 0–4 scale) with respect to the ease with which a doctor of the same specialty, but not on the staff of the particular hospital, was able to obtain a clear picture from a sample of case notes of the essential information he would need if the patient had been admitted under his care with a different but related clinical picture.

Carrying out prevalence and severity studies

A team of investigators working over one or more years would be needed to carry out only some of the studies outlined above, even in limited areas. Pilot enquiries to establish acceptable techniques in one or two contrasting districts would be a necessary first step. A more comprehensive study would almost certainly be needed to discover what kind of variations in efficiency of communication exist between different groups of general practitioners and different hospitals. An extensive study would also be needed to determine, by comparing more efficient with less efficient practices and hospitals, some indications of the techniques which would be

most likely to improve communications in the less efficient areas.

Studies which could be started immediately

It is not necessary to wait for comprehensive research projects such as those outlined above before action is taken by enterprising doctors in their own localities. It would be of great advantage if possible avenues of improving communication could be explored and the results reported in the medical literature. This sort of research often seems less attractive to doctors than many academic studies which are regarded as 'scientific'. But carefully planned action research can be just as scientific and is often more immediately useful to the practice of medicine.

Any form of audit of current forms of communication within hospitals, within general practices or between the two (as described by Dr Hawkins on pp. 66 and 67) is likely to prove beneficial, particularly if an assessment is made of simple indices of poor communication such as delays in despatch of letters, and of failures to achieve their ideal content before and after application of audit. Controlled comparisons would be even better, as, for instance, between the content of letters to GPs and delays in their despatch recorded for two separate firms within one hospital, one regularly using audit, and one not. Also all members of a clinical firm who write letters to GPs and their clinical secretaries might be provided with Checklists 2 and 3, of the desirable content of letters to general practitioners, and their value might be assessed by comparing the content of letters sent before and after this action. Many other experiments could be done, all of which would be examples of what Revans (1971) has described as action learning: 'doing better tomorrow by asking how well the job is being done today'—it becomes 'action research' if indices of efficiency before and after the change are applied. A simple study of causes for delays in various forms of communication often reveals things that should be easy to remedy. In one hospital a shortage of dictating machines was a serious cause of delay in preparing discharge letters to GPs, and was easily put right. In another

an educational programme of house staff reduced unnecessary routine laboratory requests (8).

Meetings between doctors

An extension of the practice of many clinical firms of having regular consultations with their colleagues in the radiological department about all the films of their patients could be helpful. This enlarges the clinicians' understanding of new technical procedures and the clinical horizon of radiologists. It also reduces the need for constant transfer of films to and from the department and the wards. Similar meetings when appropriate could be arranged with other investigators. Meetings between specialists and GPs are now more frequent than they used to be because of the postgraduate centres which have been established. It might be advantageous to arrange regular discussion of communication problems at these centres.

The role of hospital administrators

The many problems of communication of doctors with lay administrators and with nurses and other professionals in the health service have deliberately been set on one side at this stage of our deliberations, but all forms of communication within the health service must be the concern of efficient administration. Although the audit system devised by Dr Hawkins to maintain efficient communication with GPs (pp. 66 and 67) is one which depended on his own initiative, this kind of system should be a basic part of any general hospital system of audit of clinical outcome. If such a general audit were introduced many doctors would be pleased to be relieved of this responsibility. The forms of audit which are necessary to monitor other types of communication failure between doctors could, with special effort, be carried out by them, but few are likely to have the time and energy to carry them out. Administrators might say that this is equally true of them. Perhaps we may have to wait until computerized hospital information systems are introduced which one day should be able to take over these activities (9); but preliminary studies of

the kind I have described could provide useful guidance for the design of such systems.

Education and training of doctors

Several of the causes of poor communication between doctors which have been examined could be lessened if medical students, and even more particularly young doctors, were taught more about how poor communication with colleagues arises and about what they could do to lessen it. The value of using clear, simple English, could be emphasized by directing the attention of students to simple accounts of complex matters in the medical literature. When they are given essays to write, this aspect could be emphasized. Medical teachers should be encouraged by Deans of Medical Schools to take particular note of the comments on communication included in the GMC *Recommendations on Basic Medical Education* (1980) (10).

Most important, as far as young doctors are concerned, would be for their chiefs to monitor the letters they write and to show them how ill-written letters can be modified to advantage. To involve them at this stage in 'action research' could also widen their horizons. It is an unfortunate but inescapable fact that the content of examinations largely determines the matters to which students and trainee doctors devote most attention. In advanced medical examinations candidates should be required to write a letter, based on a given case history, to a specialist for GPs and to a GP for specialists. If this were done they would pay more attention to their competence in this sort of communication, which they will need throughout their careers. The Royal Colleges could also encourage attention to this problem by including in their postgraduate courses some lectures and discussions about means for reducing failures of communication between doctors.

CONCLUSION

Reports such as this one seldom lead by themselves to effective action which could remedy the shortcomings that we have described. Even reports of Royal Commissions are renowned

for their ineffectiveness. Individual doctors who read it (probably rather few since not many recognize the problem) may certainly be encouraged to make changes in their own communications which will benefit both their patients and their colleagues and may also give them greater satisfaction in their daily work. But more than this will be needed if widespread improvements are to be achieved by the sort of action research that I have outlined, and for this financial backing will have to be found.

The first step might be the appointments of one, or perhaps two, research officers with experience in communication skills and in action research in administration. Together they could explore the problems considered in this booklet and initiate pilot studies on which wider research leading to general changes in communication practice could be based.

One thing is certain: if no such action is taken by those who are concerned with increasing the efficiency of the practice of medicine and surgery in this country, many doctors will continue to suffer unnecessary frustration and annoyance and their patients will continue to be less effectively cared for than would be the case if communications between doctors were improved.

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