gastrointestinal and hepatobiliary tracts. *S. haematobium*, which principally infects the renal tract, is similarly highly endemic in the Nile Valley but is also found throughout Africa and Arabia, in Iraq and Iran, and in a small area of India around Bombay. During the initial febrile illness eosinophilia occurs but it is

frequently impossible to make a definitive diagnosis of schistosomiasis at this stage. During the later stages of the disease, however, the characteristic eggs can be seen on microscopy of stool or urine. There is also a fluorescent antibody test. Treatment requires experience of the disease.

General Practice Observed

Communications between General Practitioners and Consultants

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Summary

During 1972-3 a survey was made of the pattern of communication between 80 consultants in four hospitals in south-east England and 100 general practitioners in the catchment areas of these hospitals. This aimed to identify the factors which affect the efficiency of communication between these two groups and to look for ways of improving this.

Face to face contact between consultants and general practitioners was extremely limited. The main communication links were the letters of referral and discharge, but even this form of communication had serious defects. Though most doctors were satisfied with communications in general the evidence suggested ways of improving communication between consultants and general practitioners, such as encouraging domiciliary visits where both doctors are present and consultant sessions in health centres, but that any innovation in this field could only be successful if the attitude of the consultants and general practitioners were in harmony with the new venture.

Introduction

The Harvard Davis Report states that the primary object of all medical care "is to meet the health needs of the individual and the society in which he or she lives; medicine must be integrated with other skills and disciplines and there must be a balance between care within and care outside the hospital,"¹ and the Gillie Report had earlier stated, "It has been estimated that in this country some 90% of all medical episodes are handled from start to finish by the family doctor. . . . The admission of a patient to hospital often represents only a brief, but very expensive episode in the long-term care of an individual by his general practitioner."² Hence close co-operation between hospital and

general practice is a prerequisite of satisfactory medical care, but does this exist? The Porritt Report³ suggests that it does not:

"The various branches of the medical profession are isolated as regards co-ordination, planning, and development of their services. The general practitioner, though accepted as the key figure in the Health Service, is isolated both administratively and clinically from the hospital and the local health authority. What exists is an artificial tripartite division of the present National Health Service organization."

The reorganization of the Health Service is intended to break down these barriers but it is doubtful, because of the lack of factual information, if the profundity of these divisions and the factors underlying them are fully appreciated.

"The British medical system is based on the principle of referral and this is likely to continue."⁴ It is claimed that communication between consultant and general practitioners has become almost solely dependent on the letter of referral and reply, a type of two-way exchange of facts and opinions which implies mutual isolation.^{5,6} Almost every report on the National Health Service since its inception has made some sort of recommendation about the general practitioner playing a bigger part in the hospital service.^{1,2,7} Very few beds, however, are available to general practitioners in consultant-orientated hospitals,⁸ and only a few specialist departments in any particular hospital provide openings for clinical assistants, mainly in casualty work and anaesthetics.⁹⁻¹¹ The evidence indicates that bringing together these two sections of the Health Service will be a formidable task.

Our aims in this study were: (a) to look at communication patterns between the consultants and general practitioners to identify the factors which influence their efficiency; (b) to find out what doctors' attitudes are to present forms of communication between the hospital and general practitioner service; and (c) to look for ways in which communications, and thus mutual relations, might be improved between consultants and general practitioners to the benefit of the communities they serve.

Method

Four acute general hospitals and their catchment areas were selected for the study, on the basis of information provided by the North East Metropolitan Regional Hospital Board (table I).¹² Two hospitals were large by regional standards and two were small. Environmentally, both A hospitals were similar in so far as the populations in their catchment areas were relatively

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TABLE I—Data on Four Hospitals Selected for Study

	Rating on Socioeconomic Index	Average Daily No. of Beds Available	Yearly No. of Attendances at Consultative Clinics
Large hospital A ..	119	994	139,664
Small hospital A ..	120	156	24,161
Large hospital B ..	92	670	69,484
Small hospital B ..	79	201	37,600

isolated whereas those served by the B hospitals came from larger urban complexes.

A one-in-four sample of general practitioners in the hospital catchment areas was taken. All those consultants who received referral letters from general practitioners were included in the study. Out of 84 consultants and 103 general practitioners 80 and 100 respectively were interviewed with the aid of a structured questionnaire. Secondly, owing to the willingness of 62% of consultants and 68% of general practitioners to record information about discharge and referral letters 856 referral letters and 866 discharge letters were analysed.

The first part of the questionnaire contained questions designed to elicit background information about respondents. The second part explored their attitudes to practices in the N.H.S. which necessitate intercommunication between consultants and general practitioners. The first section provided quantitative data only, but since most questions in the second section were followed by an invitation to doctors to expand on their initial responses this section yielded quantitative and qualitative data. The qualitative data lent themselves to content analysis, the results of which are set out in detail in the report on this study¹³ but are only briefly summarized here.

Results

PERSONAL CONTACT

Face-to-face contact between consultants and general practitioners was limited. Most consultants had either not met general practitioners in the previous four weeks or had had one or two meetings by arrangement. Similarly, most general practitioners had had little contact with consultants (table II). A few consultants had had a considerable amount of contact with general practitioners because of clinical meetings and lectures, but the formal educational area did not provide the most frequent meeting place. They most frequently met at a domiciliary visit (table III).

TABLE II—Percentage of Consultants and General Practitioners who had met Formally in Four-week Period according to Number of Meetings

No. of Meetings	Consultants	General Practitioners
None	41.25	52
1 or 2	26.25	32
3 or 4	13.75	10
5 or 6	11.25	4
7 or 8	0	1
9 or 10	0	1
>10	7.5	0

TABLE III—Number of Times Formal Meeting Places were Mentioned by Doctors in Four Areas

Meeting Places	Consultants				General Practitioners			
	L/A	L/B	S/A	S/B	L/A	L/B	S/A	S/B
Hospital ..	3	3	1	2	1	1	6	3
Clinic ..	1	0	1	0	0	0	1	1
Surgery ..	3	2	1	0	1	0	1	0
Domiciliary visit ..	10	5	6	6	12	10	2	5
Private visit ..	2	0	0	0	1	0	0	2
Patient's house ..	5	0	1	1	1	0	1	0
Lecture ..	1	0	0	0	0	1	0	0
G.P. courses ..	1	0	0	0	1	0	0	1
Clinical meetings ..	4	1	0	2	2	1	1	0
Postgraduate courses ..	0	1	0	0	1	0	0	0
Other ..	4	5	0	1	1	4	1	1

L = Large hospital (or catchment area). S = Small hospital (or catchment area). A = Population area A. B = Population area B.

Both consultants and general practitioners were completely divided in their opinions when asked if they had adequate opportunities to meet at a professional level: 38 consultants and 65 general practitioners thought opportunities were adequate and 42 consultants and 35 general practitioners thought they were not. The consultants were obviously the least content on this point, and many, when asked why they felt the way they did, emphasized that general practitioners did not take advantage of the opportunities already there. General practitioners complained of awkward times, that lectures and meetings were not geared to their needs, and that at these functions consultants' attitudes to the general practitioner left much to be desired. One general practitioner said, "There are weekend courses, but consultants talk down to you, and there are often discussions on obscure surgical techniques not relevant to general practice."

Informal Contact.—Altogether 80% of doctors considered it desirable to meet informally. Most general practitioners, however, said they had not met or had only met a consultant informally on one or two occasions in the previous four weeks. The consultants said much the same (table IV). Certainly, more doctors seemed to meet informally and to meet more often than met formally (tables II and IV). They said they met mainly around the hospital. Their descriptions of their meetings—"met in the street," "saw in the corridor"—did not seem in keeping, however, with the reasons they gave concerning the benefits of informal contact: "You need to know each other as people and not just as doctors. It smooths the lines of communication." "The more people you meet the better. A lot of useful information can be passed over a drink."

TABLE IV—Percentage of General Practitioners and Consultants who had met Informally or by Chance in Four-week Period according to Number of Meetings

No. of Informal Meetings	Consultants	General Practitioners
None	25.0	41
1 or 2	28.8	22
3 or 4	12.5	14
5 or 6	5.0	7
7 or 8	3.7	0
9 or 10	2.5	1
>10	22.5	15

Contact during Patient's Stay in Hospital.—General practitioners were asked if they contacted the consultant while their patient was in hospital by letter, telephone, or personally. Some form of contact was made in 2% of 734 cases. Similarly, they were asked if the consultant contacted them during their patient's hospital treatment. Contact took place in 3% of cases. These results are in striking contrast to the response of doctors to the question, "Do you feel there is any need for communication between consultant and general practitioner while the patient is in hospital?" Altogether 67% of consultants and 58% of general practitioners considered there was such a need, but they emphasized that contact was not essential but sometimes desirable. General practitioners favoured communication in the interests of the relatives. Consultants, in contrast, did not mention the family needs. Both consultants and general practitioners did feel that closer contact would lead to better relations between them and would benefit their patients.

LETTERS OF REFERRAL AND DISCHARGE

The main method of communication between consultants and general practitioners is the letter of referral and discharge. Out of 856 referrals to consultants in outpatient clinics the telephone was used in 4% of cases and the letter in 96%. The general practitioner heard about the discharge of his patient (24% of discharged patients were from outpatient care and 76% from inpatient care) from the consultant himself in only a minority of cases. In 85% of cases the general practitioner was completely dependent on the routine discharge letter and the discharge

summary for information from the hospital about the patient's discharge.

Discharge

In small hospital B the initial letter of discharge reached the general practitioner more than four weeks late in 21% of cases, and over 40% failed to arrive within a week of discharge. In most cases, however, letters from all four hospitals did arrive within two weeks (table V).

TABLE V—Interval between Patient's Discharge and Arrival of Discharge Letter in Four Hospital Catchment Areas. Results are Percentage of Letters

Time of Arrival of Letter after Discharge (Weeks)	Large Hospital A Area	Small Hospital A Area	Large Hospital B Area	Small Hospital B Area
Not applicable	11	12	2	0
0-1	41	40	56	30
1-2	16	22	23	30
2-3	9	13	6	13
3-4	9	5	5	6
>4	14	6	8	21
No letter	0	2	0	0

Just over 80% of all general practitioners said they had problems with the discharge letter, but fewer consultants were aware of such problems and this difference of opinion was significant. Most general practitioners did not think the problem was too bad but their complaint was that the letters arrive late. "I tend to get letters much too late," and "I have patients discharged following a serious illness several days before receiving notification that they have been discharged and discharged to quite unsuitable home conditions," were two typical remarks. The 36% of consultants who were aware of these delays claimed that shortage of secretarial help and the shortcomings of their junior medical staff were equally responsible for the late arrival of letters. Most general practitioners and consultants consider that the general practitioner should, ideally, hear about the patient's discharge "at discharge."

Referral

Doctors were asked if they had any problems with the referral letter. A total of 77% of consultants in the two B hospitals serving populations with low socioeconomic ratings said they had problems with the referral letter compared with 50% of consultants in large hospital A which served a population with a high socioeconomic index. (table VI).

TABLE VI—Response of Doctors to Question Whether they had Problems with Referral Letters. Results are Percentages

	Consultants		General Practitioners	
	Yes	No	Yes	No
Large Hospital A Area	50	50	28	72
Large Hospital B Area	77	23	50	50
Small Hospital B Area	77	23	14	86
Small Hospital A Area	59	41	27	73

Far more consultants from the "B" hospitals said the referral letters they received were bad or very bad than did those from the "A" hospitals. The main complaint made by all consultants was the lack of information about the patient which the letter contained: "Information is usually skimpy and there is no information on previous drug treatment," and "There is little information given, apart from a nominal diagnosis and request for treatment."

We examined the possibility that communication between general practitioners and consultants might be influenced

by the work load of general practitioners, but work load, as measured by the number of registered patients for each principal was similar in each of the four areas. A probable explanation for the greater satisfaction with referral letters in area A emerged from the significant differences in general practice organization between areas A and B. Many practices in areas A contained more than two men and received a group practice allowance. These practices also had more supporting staff, such as secretaries and attached nursing staff. The actual content of referral letter did not vary greatly, but 48.5% of the letters in areas B were not written for a particular consultant whereas in areas A this only occurred in 10% of cases. This indicates that in areas A general practitioners knew their consultants at least by their surname.

The kind of information the consultants required from the general practitioners when they referred patients and the kind of information given by general practitioners is shown in table VII. The history and treatment were not given in the referral letter in most cases whereas most consultants considered that they should have been emphasized.

TABLE VII—Topics in Referral Letter which Consultants wanted Emphasized and Those Emphasized by General Practitioners in Four Areas

Topics	% of Consultants who wanted Topics Emphasized	% of General Practitioners who Emphasized Topics			
		Large Hospital A Area	Small Hospital A Area	Large Hospital B Area	Small Hospital B Area
Diagnosis ..	61	62	74	49	65
Symptoms ..	63	75	82	79	90
Treatment ..	74	30	46	27	36
History ..	64	30	47	22	19

Not surprisingly, general practitioners as the originators of those referral letters had few problems with them but used the question to voice discontent at delays in obtaining appointments for their patients.

GENERAL PRACTITIONER CARE FOR PATIENTS IN HOSPITAL

Altogether 69% of general practitioners and 50% of consultants favoured the suggestion that general practitioners should be able to admit and care for patients themselves in hospital. Those doctors who agreed with the provision of hospital beds were asked their opinion on the need for consultant cover for such beds, and a surprising 38% of consultants and 23% of general practitioners considered it unnecessary. Comments volunteered by doctors made it clear that the consultant's role should be an advisory one and not with a status above that of the general practitioner.

Doctors when asked why they felt as they did about the availability of hospital beds emphasized the sort of cases the general practitioner should be responsible for: patients with social problems in need of nursing but not specialized care, normal obstetric cases, and minor cases of surgery. One general practitioner put it this way, "I think a lot of cases we are perfectly capable of coping with. They do not need specialist care but do need hospital facilities and nursing care—particularly medical cases and normal obstetric cases."

The comments also showed that simply putting a few of the acute general hospital beds at the disposal of the general practitioner was not appropriate to meet the demands of the situation. Such facilities give rise to problems of organization for both the hospital and the general practitioner and where already provided are little used. Consultants and general practitioners emphasized the need for the provision of hospitals designed to meet the need of a general practitioner service. One general practitioner said "if we had the co-operation of the hospital it would be a good idea but we are too divorced from hospital. It's a big mistake doing away with old 'cottage' hospitals—that is the ideal situation."

AREAS OF JOINT ACTION

By far the most important meeting place between general practitioners and consultants was in the patient's home at a domiciliary visit (see table III). Nearly all doctors included in this survey approved of this facility and many felt that not enough use was made of it. Obviously this is a valuable area of communication between doctors, and it seems a pity that so often the family doctor cannot be present when the consultation takes place.¹⁴

It would seem a natural corollary to doctors' enthusiasm for domiciliary visits that they would welcome the idea of consultants holding sessions at health centres, but this was favoured by only 35% of consultants and 51% of general practitioners. Four doctors had had practical experience of such an arrangement and of these one, a consultant, explained that it invariably resulted in the patient having to attend his hospital clinic too, owing to the absence of necessary equipment and diagnostic facilities at the health centre. Many others mentioned this practical difficulty as a major obstacle to the scheme, and others stressed the need to limit consultant clinics to those health centres serving large communities so that the consultant's time would not be wasted by small attendances. Nevertheless, some doctors saw advantages to the patient in this facility.

Some doctors see the extension of part-time clinical posts in hospitals as bridging the gap between general practitioners and consultants. In this survey 13% of general practitioners held such posts and 70% of them thought there should be more posts available. A similar proportion of consultants favoured extension of this system.

GENERAL ADEQUACY OF COMMUNICATIONS

Doctors were asked whether they considered communications in general between consultants and general practitioners to be satisfactory, and 80% of general practitioners and 50% of consultants thought them either fairly or very satisfactory.

Is it really necessary for consultants and general practitioners to communicate to perform their particular task in relation to the patient? The attitudes of doctors themselves to communication would lead us to conclude that their relations with each other are not important. Two points arising from the follow up of patients' discharge from hospital illustrate the dangers of such an opinion.

The job of following up patients after they had been in hospital was felt by 50% of consultants and 62% of general practitioners to be the joint responsibility of both consultant and general practitioner, but 28% of consultants and 4% of general practitioners considered the consultant was directly responsible and 30% of general practitioners thought it was the primary concern of the patient's general practitioner. The overall picture conveyed by these figures is that patients on leaving hospital will usually be cared for by both their consultant and their general practitioner, which could arouse apprehension concerning the patient's welfare. Firstly, if two doctors are concerned in caring for a patient close co-operation between them is necessary so that they complement and do not counteract each others work and to ensure that the patient does not suffer. Are communications between them adequate for such co-operation? Secondly, is the patient receiving any follow-up in cases where the consultant considers the general practitioner is responsible for the discharged patient and vice versa? In such cases the prompt arrival of the discharge letter and the adequacy of this letter is obviously of paramount importance. Over 40% of discharge letters failed to reach general practitioners within one week of the patient's discharge and 33% of letters arrived at a date which was considered unsatisfactory by general practitioners.

No significant differences were found between the large and small hospitals on any factor, and the small hospitals did not have the better communications that might have been expected. The variations occurred in the differences of opinion between general practitioners and consultants.

Discussion

The evidence presented indicates that personal contact between general practitioners and consultants is extremely limited. Though there was general support for contact on an informal or "social" basis most general practitioners did not want increased opportunities to meet at a professional level as they considered these adequate.

In practice there seemed to be general acceptance of the idea that communication must be by letter, other forms of contact being regarded as vaguely desirable or of doubtful practicability.

If it is accepted that improvement in communication between general practitioners and the hospitals is desirable then it is necessary to consider how to strengthen this slender link. The correction of the defects in correspondence—that letters of referral often lack essential details of information and that discharge letters are often delayed—should not prove too difficult, given appreciation by both parties of the difficulties caused by the present defects. But these very shortcomings in correspondence must have their origin precisely in the general failure of mutual understanding between the parties, indicating the need to build up other possible areas of contact and communication. One such area could be the advisory role of consultants in hospitals staffed by general practitioners, a role they would be unlikely to assume naturally in relation to cases admitted to general practitioner beds in acute general hospital. Another area, already fairly extensively developed and widely appreciated, is the domiciliary visit, the value of which to consultant and general practitioner alike, as well as to the patient and his relatives, is undoubtedly enhanced in most cases by their mutual participation in the visit.

Natural extensions of this form of co-operation would be consultant sessions in health centres, and advantage should clearly be taken of the opportunity thus afforded for consultants to improve their understanding of the role and problems of general practitioners.

Though there is much support among both general practitioners and consultants for more openings for general practitioners as clinical assistants in hospitals it seems desirable that these should be seen mainly as opportunities for general practitioners to acquire additional prowess in fields of medicine they encounter in their daily practice and only additionally as means of contact with hospital staff and their ways of working.

The problems outlined are of long standing, and our evidence suggests that there is as yet little impetus in medical circles to overcome deficiencies in communication. Anything that can be done to improve upon the present situation must be of benefit to patients and doctors alike, but success will depend on securing the goodwill of those doctors involved in any development.

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