VALUE OF THE SPECIALIST'S REPORT

BY

**R. de ALARCON, M.S.L. (Madrid), M.R.C.S.
L.R.C.P., D.P.M.**

*Consultant Psychiatrist, Institute of Education, University
of London; Associate Chief Assistant, St. Bartholomew's
Hospital, London*

HUGH de GLANVILLE, M.A., M.B., B.Chir.

General Practitioner, London, N.W.

AND

J. MARK HODSON, M.A., M.B., B.Chir.

General Practitioner, London, N.W.

Since the introduction of the N.H.S. Act of July, 1948, the medical profession has become increasingly aware of a lack of efficient co-ordination between the general practitioner and the specialist. The G.P. may complain that the specialist either avoids the specific problems for which his services were asked or leaves him in the dark about diagnosis or treatment planned for the patient. The specialist may reply that the G.P. is not interested in knowing more about his patients, and will quote the "please see and treat" type of letter as typical. He may even disregard the contribution the G.P. has to offer towards diagnosis and treatment, without realizing that eventually the G.P. will have to bear the responsibility for the patient's health. There is a division of responsibility for the patient's welfare between the two, and if the roles of specialist and G.P. are not clearly defined the patient suffers.

The G.P., because of his accessibility to the patient and the obvious facilities he has for long-term observation and continuity of treatment, is responsible for the overall management of the patient, who goes to the specialist on his advice, but will return once the latter has fulfilled his role. He is not a sorting clerk, and should be able to follow his patient through either directly or indirectly. He would like to compare his initial diagnosis and treatment with what has been discovered by the specialist in hospital. For this he requires an adequate report, which should reach him before the initial freshness of the clinical picture has been wiped from his mind by several weeks of full surgeries.

The specialist, on the other hand, by concentrating on one particular field, has had the opportunity to acquire the skill and knowledge to deal with certain diagnostic and therapeutic problems which, coupled with the facilities to which he has access in hospital, enable him to cope with some aspects of diagnosis and treatment which are out of the reach of the G.P.

In human relationships, negative points in a situation are the ones that tend to remain fixed in the mind and lead to resentment and misunderstanding: it was felt that an objective study of the mechanism of the situation would be helpful.

Method of Investigation

This study is an attempt to find: (a) factors which may enhance or detract from the specialist's contribution to the diagnosis and treatment of the patient; and (b) which of these factors could be modified to the benefit of the patient and of the specialist-G.P. team considered as a therapeutic unit.

In order to do this 500 cases which had been referred to specialists were selected at random from the records of a practice which cover a period of five years. Obstetric cases were excluded from the study. In all letters of referral, advice or opinion was requested from the specialist. Four points were considered important in assessing the value of the reports.

1. *Contents of the Reports.*—The reports were classified as useful or vague and useless. A report was regarded as useful if it gave clear, practical indications with regard to diagnosis or treatment. A frank indication from the specialist that he was unable to provide a diagnosis or definite line of management was also considered to be useful. If the report did not meet these basic requirements it was considered vague and useless. It should be pointed out that the diagnosis or treatment which afterwards proved to be wrong was tabulated as "useful," as the purpose of this study was to assess the value of the report itself and not diagnostic or therapeutic acumen. An independent agreement of all three members of the team was required before any report could be called "useless."

2. *What was Told to the Patient.*—The reports were also studied to see whether any mention is made of what was told to the patient about his illness, and it was felt that it is important that there should be a connexion or congruity between what the G.P. and the specialist tell the patient about "what is wrong with him."

3. *Information about Proposed Operation.*—In the case of patients who were subsequently operated upon, we noted whether the G.P. was informed or not that the operation would be performed at an approximate date.

4. *Reports Timely or Late.*—A report from the specialist arriving after the patient has come back to the surgery to inquire about the outcome of his visit to or stay in hospital loses much of its value. The time of arrival of the report was studied from different angles. (a) Out-patients: whether the letter arrived before or after the patient attended surgery or was visited. (b) In-patients: (1) Whether a letter was received after admission and, if so, whether it arrived within the first 48 hours after entering hospital. Emergencies and ordinary admissions were considered separately. (2) Letter on discharge: whether within 48 hours of discharge or after. (3) Letter arriving at surgery before or after patient.

Results

1. Contents of Reports

In only 4% of cases was the letter "vague and useless." This was far below what had been anticipated by members of the team, who, before calculating the results, had each predicted a much higher figure. This shows the effect a relatively small number of unsatisfactory reports can have. It also implies an overall high standard of specialist help being available. However, in the practice studied there are 15 hospitals within a radius of about two miles, allowing for a wide choice of specialist services. It would be interesting to compare a similar survey in a country practice where this choice is restricted.

In most of these unsatisfactory reports, when analysed individually, the following pattern was found to recur: (a) They repeated what the G.P. had already written in his letter of referral, without adding any conclusion or judgment. (b) They answered some point other than the specific problem posed in the letter of referral,

ignoring any statement made in the letter. (c) They quoted inconclusive laboratory and x-ray reports without adding an opinion.

2. What was Told to the Patient

In only 6% of cases was there any indication of what was said to the patient about his illness. It is unlikely that in the 94% of cases no information at all was given to the patient during the consultation, so we must assume that in many cases the specialist did not think it worth telling the G.P. what he had said. The G.P. may have to give some explanation about the illness, symptoms, or management to the patient. If he has no information about whether the specialist has spoken or not to the patient about this, or about the way he may have approached the subject, a contradictory impression can be created, producing unnecessary doubts and anxieties. One large London teaching hospital uses a printed discharge form which includes a heading, "Information given to patient."

3. Information Given about Proposed Operation

Fifty-one cases were operated on in connexion with conditions for which they had been referred, and in only 20 (39%) of these was the G.P. told that operation was proposed. In only one case was he actually informed just beforehand that the patient was about to undergo an operation.

4. Reports Timely or Late

OUT-PATIENTS

Out of a total of 364 out-patient referrals, 28 (8%) of the reports arrived after the patient had been back to the surgery and had had to be told by the G.P. that he was waiting for the specialist's report. Most of the reports arrived in the second week after the patient's appointment, but as in many cases the patient did not return to the surgery until several months after for some other complaint, the proportion of the patients arriving before the report is relatively small, though large enough for the delay to be felt. These patients often express surprise when told the hospital report has not arrived.

IN-PATIENTS

(A) Letter Arriving Within 48 Hours of Admission.—

(1) *Emergency Admissions*.—Out of a total of 71 emergency admissions, in only 8 (11%) was a report received within the first 48 hours. This finding is regarded as important, because only through receiving a prompt report can the G.P. feel the continuity of personal care, check his provisional diagnosis while the case is still fresh in his memory, and reassure the relatives that come to the surgery or stop him on his rounds, requesting information. The habit of writing such a letter might also prove a stimulus to the hospital staff. (2) *Ordinary Admissions*.—Out of 65 ordinary admissions, in 11 (17%) the report arrived within 48 hours. These cases are not so important as emergencies, but a printed form would be helpful, especially if the patient had been referred some time previously.

(B) *Letter While Patient is in Hospital*.—Out of a total of 136 hospitalizations, in only 32 (23.5%) was a letter received while the patient was in hospital: in the remaining 104 admissions the G.P. had no notification of admission whatsoever.

(C) *Letter on Discharge*.—Out of 136 in-patients, in only 41 (30%) was a letter received within 48 hours of discharge.

(D) *Discharged Patient Arrived Before Hospital Letter*.—Out of 136 in-patients, 19 (14%) reached the G.P. before any communication had been received from the hospital (see Table).

Summaries.—90% of summaries arrived one or two months later.

Pathological Reports.—When pathological reports or tests were received from hospitals which offer those facilities to G.P.s 100% of the replies arrived on time.

Distribution of Cases in Which Advice was Received from Teaching and Non-teaching Hospitals Within 48 Hours of Admission or Discharge

	Teaching	Non-teaching	Total
Admission ..	12 (14%)	7 (14%)	19 (14%)
Discharge ..	32 (37%)	9 (18%)	41 (30%)

Conclusions and Suggestions

It was found in this practice that a high standard of specialist help is available. Several deficiencies have become obvious, and there seems to be scope for improvement.

The main factors which detract from the value of the specialist's report in the efficient functioning of the specialist-G.P. therapeutic unit are extrinsic to the report itself: they depend entirely on the arrival of the report at a time when the G.P. needs it or is in a receptive state to make the most of it.

Timely and adequate communication must be maintained between the two members of the unit, but any improvements to be acceptable should be applicable without increasing the paper-work of either specialist or G.P. or their ancillary help.

Within the framework of the present system the following suggestions would increase the value of the report and therefore the therapeutic efficiency of the specialist-G.P. unit.

1. A definite answer regarding diagnosis, treatment, or management. If, owing to the nature of the case, the specialist is not in a position to give it, there should be frank recognition of the fact.

2. If the patient has been told something about his illness or treatment, the nature of this explanation should be disclosed.

3. A timely report is necessary, especially in cases where the nature of the illness or the anxious character of the patient indicates to the specialist that an early return to the G.P. can be predicted.

4. A short report should reach the G.P. within 48 hours of an emergency admission.

We concluded that the value of the specialist's report largely depended upon effective communication being established between him and the G.P.

Bournemouth probably has more registered nursing-homes than any other area in Great Britain, and, says the *Annual Report of the Medical Officer of Health 1959* for the County Borough of Bournemouth, it is extraordinarily difficult to maintain a universally high standard, particularly as the powers of the local authority's inspecting officers are limited to the building, its equipment, and its staff; far too often the standard of these homes has deteriorated. It is difficult to cancel a registration once it has been given, and it is felt that the law should require annual registration, and that more precise standards of staffing should be laid down by the Ministry of Health.