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LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL MEMORANDA

MIDDLE ARTICLES

BOOK REVIEWS 37

NEWS AND NOTES

CURRENT PRACTICE

CORRESPONDENCE 47

OBITUARY NOTICES 54

SUPPLEMENT

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Correspondence

Letters to the Editor should not exceed 500 words.

Hospital Letters

SIR,—Dr. H. N. Levitt's letter (6 September, p. 594) is timely, and one would readily concede that adequate communication from hospital to general practitioner is vital in the interests of the patient.

Probably most hospital consultants would agree with me that the patients we see and treat are not our patients (in so far as the possessive case can be used at all) but the general practitioner's patients whom we have the privilege of looking after for a limited period. Clearly we must give an account to the practitioner of our handling of the patient and his problem during that limited period. Part of the training of junior medical staff relates to this very point. But it is well known that most doctors do not like clerical work, and junior hospital medical staff are no exception.

House-officers are often recently qualified, have to become adjusted to a new life of responsibility, and may not appreciate the importance of prompt communication with the general practitioner—especially when they are harassed by the innumerable problems which beset the house-officer while he is learning to bear responsibility. The registrar has greater clinical responsibility, works long hours, loses a considerable amount of sleep, and, in what little spare time he has, tends to be preoccupied with preparing himself for higher examinations and in coping with the many personal professional problems which must be solved if he is to succeed in his chosen specialty. Inevitably his clerical duties suffer or tend to be postponed when the stress is greatest.

In addition many hospitals have to employ locum medical officers whose conscientiousness may vary in respect of clerical duties, and some hospitals have had to employ doctors from overseas whose English may be distinctly limited. Moreover, the practice of medicine in all its branches is becoming more complex, the tests regarded as essential are now much more numerous, and the data collected more complicated than ever. The consultant, of course, bears the ultimate responsibility, but even the systematic consultant may have to delegate a considerable amount of clerical work to his juniors. Against this background it would appear understandable, although regrettable, that sometimes letters to practitioners are delayed or even overlooked. And yet hospital consultant and general practitioner agree that these communications may be vital in the interests of the patient.

The remedy? There may not be a single simple remedy. Nevertheless, experience points to the efficient personal medical secretary attached to each sizable "firm" or group of smaller "firms" as the best single means of overcoming the omissions and deficiencies to which Dr. Levitt so rightly draws attention. The good medical secretary co-ordinates the firm's activities and has a personal sense of responsibility to see that nothing essential is overlooked. By her tactful efficiency she fosters an excellent relationship between the general practitioners and the medical staff of the hospital, which is greatly to the benefit of the patient.

But, tragically, some hospital management committees apparently fail to realize this, and would destroy the post of firm's medical secretary, where it exists, in favour of a pool system of audio-typists, supposedly in the interests of economy. Nor do some of the regional hospital boards' work-study teams appear to be any more enlightened. If this kind of policy prevails, Dr. Levitt and his fellow general practitioners are likely to have increased cause for complaint.—I am, etc.,

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SIR,—Dr. H. N. Levitt's letter (6 September, p. 594) comes at a time when this particular problem is causing me considerable concern. I can quote instances of patients discharged from hospital without a discharge note giving even the diagnosis ; often I am not aware they have in fact been discharged, nor is the patient advised to let me know they are out of hospital. Unlabelled tablets are a frequent accompaniment. The complete discharge letter may be days or even weeks in reaching me. Patients of mine have died in hospital and it has been some days later before I have been notified. If I wish for a copy of a postmortem report I have to ask for it.

While not wishing to become involved in acrimonious debate, it should be obvious to administrative staff, hospital staff, family doctor, and patient alike that this constitutes a considerable threat to the patients' well-being and to good relationships between hospital and family doctors. These particular examples, I am afraid, represent only the tip of the iceberg, as in many instances the lines of communication between the hospital service and family doctor have disintegrated where they existed, and have foundered where they should have been established.

With increasing specialization in the hospitals it is easy for a patient to be lost to the family doctor. He can lose track of which hospital department is treating the patient, never mind which hospital doctor. That there is this failure of communication I think is established beyond doubt, and while everyone pays lip service to the concept of the family doctor being a key figure in the continuing care of the patient there exist in most areas wards, units, and departments in which one can only assume that the staff, from the consultants down to the nurses, actually feel that the family doctor is after all not all that important. The resultant situation is one that is dangerous to the