

What information do general practitioners want about accident and emergency patients?

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Abstract

Objectives—To establish what information general practitioners (GPs) want about their patients who attend accident and emergency (A&E) departments and the GPs' preferences for the type of communication and method of delivery.

Methods—Analysis of questionnaire sent to all 350 GPs in the catchment area of one A&E department.

Results—219 completed questionnaires (63%) were returned. GPs requested information about most new attendances at A&E, but only 50% of GPs wanted details of every new A&E patient. Most GPs preferred a small computer generated letter or sticky label which included details of investigation results, diagnosis, treatment, and follow up arrangements. 47% of GPs requested delivery of letters by the pathology specimen service, but 25% preferred hand delivery by the patient or a relative. Individual GPs often had widely different preferences, especially about the type of communication and method of delivery. Most GPs would value a monthly list of all their patients who have attended A&E.

Conclusions—GPs need prompt and appropriate information about their patients who attend A&E. A computerised records system should be arranged so that relevant information can be produced easily and quickly in a format suitable for filing in GP records. Good communications with GPs would improve the continuity of care for A&E patients.

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Key terms: accident and emergency patients; general practitioners; computer generated letters; delivery of information

Accident and emergency (A&E) departments are often very busy and it is essential to minimise delays in the treatment and care of patients. Writing large numbers of letters or recording detailed information takes a substantial amount of time and so may increase delays. However, prompt communication between the A&E department and general practitioners (GPs) is often important, especially to ensure continuity of care for patients who have attended A&E.

Information for GPs about A&E patients may be provided in different ways, including hand written or typed letters, copies of all or part of the A&E notes, computer generated

letters,¹ or sticky labels² giving basic information.

Letters may be sent by post or with a pathology collection service, or given to patients to pass on to their GPs.^{3,4} Information may be sent rapidly by fax or electronic mail but there are problems in maintaining confidentiality.⁵

Some GPs have A4 size notes or fully computerised records but many still use "Lloyd George" envelopes and record cards measuring 7 × 4.5 inches (178 × 114 mm), which limit the size and type of communications which can be filed easily.

We were planning to replace the A&E department computer system and wished to take this opportunity to improve communications with GPs. We therefore asked local GPs what information they wanted about A&E attenders and how they would like it to be sent.

Methods

We sent a questionnaire to all the 350 GPs practising in or near Leeds in the catchment area of this A&E department, which has about 88 000 new patients and 11 000 return visits per year.

We included several questions to determine which patients the GP wanted to know about, distinguishing between new attendances and follow up visits, patients discharged from A&E who needed no further treatment, patients needing follow up by the GP, and patients admitted to hospital or referred on to a hospital clinic. We asked if the GP wanted information about all new patients and every follow up visit to A&E.

We wished to know what information was required in addition to the patient's name, address, date of birth, and date of attendance. The GP was asked if it was essential, useful, or unnecessary to be told about a patient's presenting complaint, the investigations performed, the results of investigations, the diagnosis made in A&E, the treatment given, follow up arrangements, specialty of admission, and the issue of a sick note. We asked what other information might be needed.

Each GP was requested to list in order of preference the possible types of communication (hand written letter, photocopy of all of notes, copy of first page, computer generated letter, sticky labels, or "other, please explain"), their preferred size of paper (A4, A5, or "other, please explain"), and the method of delivery ("via patient or relative", first class post, second class post, pathology shuttle service, fax, electronic mail, or "other, please explain"). Further details and comments on some of

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Table 1 GPs' opinions about the patients on whom information should be sent

	Does the GP need to know?	
	Yes, n (%)	No, n (%)
<i>New patients</i>		
Patients discharged from A&E who need no further treatment	151 (69)	64 (29)
Patients asked to see GP for review or treatment	200 (91)	14 (6)
Patients due to return for review in A&E	144 (66)	65 (30)
Patients referred on to a clinic (eg, fracture clinic)	171 (78)	40 (18)
Patients admitted to hospital from A&E	155 (71)	56 (26)
All new patients attending A&E	109 (50)	110 (50)
<i>Follow up visits</i>		
Patients discharged from A&E who need no further treatment	110 (50)	100 (46)
Patients due to return again to A&E	74 (34)	122 (56)
Every follow up visit to A&E	31 (14)	181 (83)

these options were given in a covering letter sent with the questionnaire. We asked if a list of all the GP's patients who attended A&E in a specified period would be useful and how often such a list should be produced. The questionnaire included space for any comments about communications between the A&E department and GPs. The GPs were asked to give their names and surgery addresses on the questionnaires, unless they wished to remain anonymous.

The returned questionnaires were analysed on a computer using "PinPoint 2" software (Longman Logotron).

Results

We received 219 completed questionnaires (a response rate of 63%), many of which contained additional constructive comments and suggestions. Only 39 replies were anonymous. In a few replies some questions were left unanswered or choices were given equal priority, so not all answers add up to 219 (100%). There were often wide differences of opinion between different practices, and occasionally between partners working in the same practice.

Table 1 records which patients the GPs wanted to know about. Most GPs (91%) wanted information about patients who were told to see them for review or further treatment, such as removal of sutures. However, only 50 % of GPs requested information about every new attendance at A&E, and only 14 % wanted to know about every follow up visit.

Table 2 shows the clinical information required by GPs after an A&E attendance. Although there were individual preferences, the majority of GPs required similar items of information, namely the diagnosis (described as "essential" or "useful" in 98% of replies),

treatment (98%), results of investigations (95%), and details of follow up arrangements (93%) or specialty of admission (90%).

Individual GPs had widely different preferences for the type of communication and the method of delivery. The overall preference was for either a computer generated letter (33%) or self adhesive label (33%), rather than hand written letters or copies of all or part of the A&E notes. The preferred size of paper was A5 (50%) rather than A4 (25%), but some specified "Lloyd George card size" or "as small as possible". Forty seven per cent of GPs favoured delivery by the pathology shuttle service but 25 % preferred hand delivery by the patient or a relative. A minority of GPs requested first class post (9%), second class post (7%), fax (7%), or electronic mail (3%). Some GPs commented that different types of communication were appropriate in different cases, depending on the urgency of the message and the reliability of the patient or relatives in delivering letters. Four GPs asked to be telephoned more often about urgent or difficult problems.

Eighty four per cent of GPs thought that a list of all their patients who had attended A&E would definitely or possibly be useful. Most of these GPs (64 %) requested a monthly list, but 23% preferred a weekly list.

Discussion

Previous studies have shown that hospital doctors do not always communicate with GPs as effectively as they might.^{6,7} This survey shows that our local GPs would like information about most new A&E patients. However, only a few GPs wanted to know about every follow up visit to A&E. The overall consensus was for a short, legible (preferably computer generated) letter or sticky label containing details of the diagnosis, treatment, results of investigations, and follow up or admission arrangements. Similar findings of the type of information needed were reported in a previous study⁸ which specifically referred to patients with abdominal or chest pain.

Computer generated letters are often printed on A4 paper, but many GPs clearly prefer the smaller A5 paper, or alternatively brief information on sticky labels which can be attached to Lloyd George cards or larger records.² Our new computer system will be able to print letters to GPs on A5 paper.

In this survey the pathology shuttle service was generally the preferred mode of delivery of letters, but this service is not available to some of our more distant practices. Delivery by the patient is sometimes considered unreliable, but Sandler and Mitchell⁴ found that 55% of discharge summaries were delivered within one day and 81% within four days, more than by postal delivery. However Sherry *et al*⁹ reported that by two weeks only 60% of patients attending A&E had delivered letters to their GPs. One advantage of hand delivery is that the letter is available immediately to the first doctor or nurse to see the patient and so continuity of care can be provided.⁴

Table 2 What information does a GP need?

	GPs' opinions about items of information		
	Essential n (%)	Useful n (%)	Unnecessary n (%)
Patient's presenting complaint	95 (43)	84 (38)	31 (14)
Investigations done	93 (42)	97 (44)	19 (9)
Results of investigations	124 (57)	83 (38)	6 (6)
Diagnosis made in A&E	171 (78)	44 (20)	0 (0)
Treatment given in A&E	160 (73)	55 (25)	1 (1)
Follow up arrangements	130 (59)	78 (36)	7 (3)
Specialty to which patient has been admitted	100 (46)	97 (44)	15 (7)
Issue of sick note	31 (14)	105 (48)	74 (34)

When a patient is referred back from A&E to the primary care team clear information is needed to avoid delays, confusion, and errors. The electronic transfer of information between A&E departments and GPs will become increasingly important but is not feasible here at present. There are concerns about the confidentiality of information on computer networks.⁵

Most of our GPs would value a regular printout of their patients who have attended A&E. Some GPs commented that this would help them to identify and advise appropriately patients who attended A&E with non-emergency conditions. Regular lists of A&E attenders would be useful to GPs for audit purposes.²

A&E departments and GPs see large numbers of patients and need to communicate in an effective and efficient manner. A computerised A&E record system should make it easy to produce the information which a GP needs but this must still be delivered reliably and promptly. Ideally the system would record the individual preferences of each of the local GPs for the method of delivery of routine information. We hope that this will soon be possible with our new computer system.

Prompt communication of accurate information would improve the working relationships between an A&E department and the local primary care teams and allow better continuity of care for A&E patients.

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