Emergency Admissions to a General Medical Unit: A Survey of the Accompanying Letters, with Recommendations

P. K. BARNES,* M.B., B.S.; R. W. HOILE,† M.B., B.S.

British Medical Journal, 1969, **4**, 424–425

Summary: Letters of referral accompanied 166 out of 188 emergency admissions to a general medical unit over a four-month period. Of these, 129 contained useful information concerning past medical history, emergency treatment given, drugs taken, and provisional diagnosis. It is suggested that general practitioners should adopt some format based on essential criteria when writing letters of referral, so that important information is not overlooked.

Introduction

There is an impression among some hospital staff that letters of referral from general practitioners could be more useful in emergencies than they often are. This survey was undertaken to assess the truth of this impression and to suggest improvements.

The aims of the survey were (1) to compare and criticize the contents of the letters accompanying patients admitted as acute medical emergencies against predetermined criteria; and (2) to suggest a format for an ideal letter to which family doctors might wish to conform when referring patients to hospital.

Methods

The survey covered a four-month period during which we were the house-physicians to an acute medical unit. The patients were admitted as acute emergencies because of direct requests from the family doctor to the admitting house-physician. Routine admissions and those referred direct from outpatient clinics or arising out of consultant domiciliary visits were excluded from the survey. The information thought most useful to the admitting house-physician was recorded and the letters were judged according to the presence of the following criteria: (1) statement regarding whether or not the patient was receiving drugs and, if so, the relevant dosages; and (2) whether or not emergency treatment had been given, together with details if relevant; (3) details of investigations carried out by the family doctor; (4) details of the patient's past history; (5) statement as to whether the patient was previously known to the general practitioner; and (6) whether or not a diagnosis, no matter how tentative, had been made; and, finally, according to whether the letter was considered to have been useful or useless.

As a rule the first contact between the doctor and the house-physician was by telephone. During this telephone conversation general practitioners often supplied useful information, but, bearing this survey in mind, we made deliberate attempts to avoid leading questions. In all cases the only information accepted for this survey was that contained in the accompanying letter. After admitting the patients, we then scored the contents of the letters against the criteria, and made a final judgement regarding the usefulness or otherwise of the letter as an introduction to the patient.

The inclusion of all the stipulated criteria was not rigidly insisted on, and often, in the final assessment, a letter was considered useful when containing only a few helpful pieces of information or even only one. The letters were judged by us, except for a fortnight during which a locum house-physician assisted in the survey. At all times the assessment was a purely personal one and there was no independent arbiter.

* Formerly House-physician, Amersham General Hospital, Bucks; present address: Department of Anaesthetics, Charing Cross Hospital, London W.C.2.

† Formerly House-physician, Amersham General Hospital, Bucks; present address: Department of Anatomy, Charing Cross Hospital Medical School, London W.C.2.

Results

The letters received were both typewritten and free-hand, on various sizes of paper. This variety in the presentation of information was not taken into account.

The total number of patients included in the survey was 188 (see Table). Of these, 166 were accompanied by letters, of which one was totally illegible. Twenty-one patients were admitted without letters, and of these one (a man with a myocardial infarction) had no letter because the general practitioner's visit had been prevented by a heavy fall of snow. In another instance (a woman with bronchiectasis) the letter was mislaid in the ward. There were also three instances in which the general practitioner requested the letter should be waived.

Contents of Letters

(1) *Drugs.*—In 83 letters no mention of current therapy was made. Of these 83 patients, 47 were not receiving drugs while 36 were.

(2) *Emergency Treatment.*—Fifty of the 166 patients who brought letters had been given some form of emergency treatment before admission. In three of these instances the letters did not mention this treatment, while in a further three important dosages of named drugs were omitted.

(3) *Investigations by General Practitioner.*—Fifteen letters contained details of investigations performed before admission.

(4, 5) *Past History.*—In 66 of the 166 letters there was no mention of the relevant past history. Seventeen patients out of a total of 29 who were unknown to the general practitioner who called to see them bore letters giving details of the past history.

(6) *Diagnosis.*—In 35 letters no attempt had been made to arrive at a diagnosis, but in 131 a provisional diagnosis was offered.

(7) *Overall Usefulness of Referral Letters.*—Thirty-seven of the letters assessed in the survey were considered to be useless—that is, just under one-quarter of the total.

Summary of Results

Total 188		With Letters 166		Without Letters 21	Illegible 1
Known	Not Known	Useful	Useless		
159	29	129	37		

Details Included in Letters

	Mention	No Mention	Mention but No Dose
Drugs	83	83*	
Emergency treatment given	50	3	3
Past history	100	66	
Attempted diagnosis	131	35	

* 36 on drugs and 47 not on drugs.

Discussion

We feel that letters from the patients' family doctors to the admitting staff are valuable documents and should be incorporated into the patients' notes. When the consultant sees the

patient he often refers first to this letter before hearing the history from the junior staff or interviewing the patient. The letter is a useful record of the forms in which acute illnesses can present and should state the reason for requesting admission and include information which may not be readily available to the hospital staff.

Occasionally the house-physician who discusses the admission with the general practitioner over the telephone is not available when the patient arrives at the hospital. As the patient is then seen by a doctor who has not been acquainted with the facts of the case, the accompanying letter is doubly important. Even if the patient is seen by the houseman with whom the case has been discussed the patient's arrival may have been delayed by up to eight hours after the admission had initially been requested. During this time a busy hospital doctor is likely to have forgotten details of drugs, etc., which have been given by telephone but not recorded in written form.

We appreciate that, especially in country practices, a telephone may not be available at or near the patient's house and that the general practitioner must often travel several miles or return to his house or surgery before contacting the hospital. This is often a reason for a letter not being sent, as the doctor would have to return again to the patient's house in order to leave a letter. Nevertheless, we feel that a covering letter could either be given to the patient at the time of the visit or be forwarded to the hospital at the earliest opportunity. (Letters forwarded and received after admission were, however, not assessed in this survey.)

In the case of 3 of the 21 patients who arrived without letters it was agreed to waive a letter, but only at the general practitioner's suggestion and when the request was so phrased that refusal was impossible. In one of these three instances a woman in a diabetic precoma was found to be taking potentially toxic drugs ; digoxin, bethanidine, diuretics, and potassium supplements were discovered in her handbag in unlabelled bottles. No mention of these drugs or their dosage was available, and this could easily have been to the detriment of the patient concerned.

In this survey only one letter was totally illegible, but many were borderline. In this one case it was apparent that four drugs were mentioned, but their nature could only be guessed at. As the patient was in semicoma from respiratory failure a history could not be obtained. One of these drugs was later identified as digoxin, and if digitalizing doses of digoxin had been given toxic effects would soon have occurred.

" Perhaps the most striking thing about the whole range of general practitioners' letters is the type of information which tends not be included " (McMullan and Barr, 1964). We found this to be particularly true in the field of therapeutics. Of the patients whose letters did not mention drugs 43% were, in fact, receiving medication. Many of these substances whose mention was omitted could have caused disasters, as the following (far from exhaustive) list shows.

Types of Drugs Received by Patients About Which Information Was Not Given

Vasodilators	Antibiotics
Digoxin	Steroids
Procainamide	Drugs used in psychiatry
Propranolol	Drugs of addiction
Hypotensives	Thyroid supplements and anti-thyroid drugs
Diuretics	
Insulin and oral hypoglycaemics	

General practitioners may not realize that the patients cannot be relied on either to take their drugs with them on admission to hospital or to know their names and accurate dosage. Valuable time may also be lost in an emergency while attempting to identify unlabelled drugs.

In contrast to this the general practitioners were concerned to mention the emergency treatment they gave, though six letters failed to give satisfactory details. In this respect it was useful to know the dosage and timing when morphine or similar drugs were given.

The details of investigations undertaken in general practice were most impressive and relevant when mentioned. These ranged from simple tasks, such as testing diabetic urine, to obtaining chest *x*-ray pictures and sending in old electrocardiograms and biochemical results. We assume that the remaining 173 cases were not investigated before admission, but it is appreciated that in the case of many medical emergencies detailed investigations cannot be made in the practitioner's surgery.

We found some knowledge of the patient's past history helpful. Often the simple statement, " This previously fit patient . . ." was omitted. Nevertheless, this was a section in which useful information was given and, interestingly, more than half of the doctors who were called to other practitioners' patients managed to elicit and record details of their past history. One common error was to assume that recent hospital notes and the latest details of treatment, etc., would be readily available in the case of those patients who had been admitted on previous occasions. Regrettably, this is not always so, and such an assumption should not obviate the necessity for including details of the past history in a letter. Many general practitioners sent in copies of old medical summaries. This seemed to be a particularly helpful practice, but we could understand their reluctance to do this if the notes were not promptly and safely returned to them.

The acutely ill patient is usually received at hospital by a preregistration doctor. It is therefore useful to have a provisional diagnosis to work on, and this makes the doctor familiar with many medical conditions which were not seen during training. Also, on occasions a close look at the patient enabled us to refute the diagnosis and to think again. Thirty-five of the patients were accompanied by letters which bore no mention of or even an oblique hint of the diagnosis. We found on looking through the letters that most of the diagnoses made by general practitioners were accurate, and from this we learnt a lesson. Perhaps general practitioners do not realize that in this respect they have a part to play in postgraduate teaching.

There were few letters which satisfied *all* our criteria, but most were of excellent quality and informative. This gives an indication of the high standard maintained by the family doctors working in the area served by the hospital. We finally classified 37 letters as useless because they contained none of our criteria. " If the reason for referral is clearly stated the need to give details of history and even of positive physical findings is less " (McMullan and Barr, 1964). Thus, despite the fact that on occasions they were long and detailed, these letters were either irrelevant or omitted important facts. It might be fair for our criteria to be criticized for omitting physical findings, but perhaps even more so for omitting to take family and social history into account. Nevertheless, we feel that this is probably of less importance in most emergency admissions than in outpatient referrals.

No one would deny the need for better communication between the general practitioner and the hospital. This discussion has been intended not to criticize but to justify our suggestions. We would like to recommend that general practitioners requesting admission of acutely ill patients should attempt to follow some format when writing their letters, in the hope that in this way omissions may be avoided. Thus sending in a letter bearing the patient's name, age, and address ; present and past therapy ; details of emergency treatment ; some comment on previous health ; and any relevant investigations, together with a clinical diagnosis (and possibly details of social and family background), should provide an adequate introduction for the admitting hospital staff.

Our thanks are due to Dr. J. D. Kidd, Dr. W. Stokes, and Dr. W. B. Thomson for allowing us to conduct this survey.

We also thank Dr. W. B. Thomson, clinical tutor, for his constructive criticisms.

REFERENCE

McMullan, J. J., and Barr, A. (1964). *Journal of the College of General Practitioners*, 7, 66.