Notifying general practitioners about deaths in hospital: an audit

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SUMMARY: Information from hospital doctors about the death of a patient in hospital is important to general practitioners. Six general practices in the Dundee district recorded the date and place of death for all 272 practice patients dying over a 14-month period. In the 193 cases (71%) for which the hospital was responsible for informing the practice of the death the method by which the practice first learned of the death and the time interval between death and the writing of the official hospital letter was also recorded. An immediate telephone call, the established method of informing practices of deaths occurring in hospital took place in only 58% of cases and the letter from hospital was sent within one week in only 49% of cases. These proportions were unaltered by the issue of a unit medical circular to hospital staff informing them of the problem and requesting more prompt notification.

The ability of general practitioners to help bereaved relatives is compromised by the present inadequacies in communication between hospitals and general practice. The unit medical circular — the standard method of resolving interprofessional problems — would appear to be ineffective.

Method

Six general practices in the Dundee district agreed to collect prospectively information on all deaths occurring over the 14-month period June 1985 to July 1986. Senior receptionists recorded the date and place of death. Where the hospital was responsible for informing the practice of the death the date the practice first learned of the death and how, and the date hospital letters were written was also recorded. The six practices have a combined list size of approximately 22,000 and all operate a system of out-of-hours cover which ensures that telephone messages are recorded and passed on promptly. The hospitals which serve the practice populations are all within the city of Dundee and subject to the same health board administrative structure. No industrial action affected telephones, postal services or secretarial work during the study period.

Recording forms were collected from each practice at monthly intervals. After five months a preliminary analysis of data revealed that the local guidelines concerning notification of deaths by hospitals were not being followed closely. The problem was brought to the attention of the appropriate community medicine specialist, the unit medical officer. Following the established protocol, a 'unit medical circular' was distributed to all hospital consultants. The circular highlighted the problem under study, reaffirmed the recommended guidelines on notification of deaths, that is an immediate telephone call followed by a prompt letter, and asked all consultants to inform their junior staff of the problem. The six practices involved in the study were not identified but the existence of a monitoring project was mentioned in the circular.

After a further four months it was apparent that local guidelines were still not being strictly followed. The matter was raised with a more senior member of the health board administrative staff. Despite a willingness to help, pressure of work prevented a second and more detailed feedback intervention.

The practices continued to record data as planned to allow for an assessment of both immediate and delayed effects of the first circular.

At the end of the study period the recording forms were collected and analysed. Cross-checking of records with the help of the primary care division of the health board was performed to prevent any death being overlooked, and to ensure that dates supplied by the general practitioners and their reception staff corresponded with written information in hospital letters.

Results

Over the 14 months there were 272 deaths in the study practices. This represents a crude annual death rate of 10.5 per 1000 population. In 193 of these deaths (71%) a local hospital doctor was responsible for notifying the practice of the event (Table 1). The relative proportions of deaths where the hospital was responsible for notification ('hospital deaths') and those where it was not were as expected. Only two deaths occurred while patients were outwith the Dundee area, and only one in a private clinic outwith the jurisdiction of the local health board administration.

An immediate telephone call followed 112 (58%) of the 193 hospital deaths. The proportion of deaths notified by telephone each month is shown in Figure 1. There was no demonstrable change in this proportion immediately after or long after the issue of the unit medical circular.
Table 1. Responsibility for notifying general practitioner of death for the 272 study patients.

<table>
<thead>
<tr>
<th></th>
<th>Number (%) of patients</th>
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<tbody>
<tr>
<td><strong>Hospital doctor responsible</strong></td>
<td></td>
</tr>
<tr>
<td>Local hospital inpatient</td>
<td>170</td>
</tr>
<tr>
<td>Dead on arrival in hospital, not seen by GP first</td>
<td>12</td>
</tr>
<tr>
<td>Local terminal care hospice</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>193 (71)</td>
</tr>
<tr>
<td><strong>Hospital doctor not responsible</strong></td>
<td></td>
</tr>
<tr>
<td>Patients' own home</td>
<td>75</td>
</tr>
<tr>
<td>Private clinic</td>
<td>1</td>
</tr>
<tr>
<td>Hospital outwith area</td>
<td>2</td>
</tr>
<tr>
<td>Dead on arrival, seen by GP first</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>79 (29)</td>
</tr>
</tbody>
</table>

The time taken for the hospital to inform the practice in writing was also calculated. The optimal interval is one week or less, calculated from the date of death to the date the letter is written, and this target was achieved for 49% of deaths before, and 48% of deaths after the circular was issued. A delay of greater than three weeks, or the absence of a letter altogether, accounted for 12% of deaths. The unit medical circular had no demonstrable effect on the time interval between a death occurring and the official letter being sent.

Of the 81 hospital deaths (42%) where an immediate telephone call was not received the practices first learned of the death from patients' relatives or neighbours in 25 cases, from the official hospital letter in 23 cases, and from the local newspaper in 20 cases. Seven deaths were discovered by chance and in four cases of sudden death the police were the first to inform the practices. In the remaining two cases the method was unknown.

**Discussion**

This study demonstrates that the recommended procedure for notifying practices of the death of a patient in hospital are not adequately adhered to. A telephone call was received in only 58% of cases and a prompt letter in only 48%. Every time a lapse of communication occurs there can be unnecessary distress for the patient's relatives, and considerable embarrassment for general practitioners and their practice colleagues. It is regrettable that newspapers and even the police should need to play a role in doctor to doctor communication.

It is disappointing that the unit medical circular had no measurable effect, either in the short or long term. There should be a willingness among hospital doctors to help improve communication between hospitals and general practice, particularly when made aware of the problem, and of the existence of a monitoring project. More forceful methods of bringing the problem to the attention of hospital doctors — telephone calls, staff meetings or individual letters requiring a receipt — were not employed in this study as it was presumed that the existing administrative structure for dealing with interprofessional problems would be effective. Ironically, hospitals cannot monitor notification figures when their doctors' own delays prevent quick feedback of accurate information from general practitioners.

It would appear that junior doctors are failing to inform general practitioners of the death of patients in hospital. Although hospital consultants are responsible for supervising junior doctors, teachers of general practice do not appear to have convinced the present cohort of young doctors of the importance of effective interprofessional communication. Much work remains to be done in this important field.7,8

Perhaps the telephone number of the patient's general practitioner should become a standard item of information on hospital case records. A checklist of items to be completed on a patient's death — issue of a death certificate, informing relatives and informing the general practice — might prove useful to junior hospital doctors.

Hospital consultants and those involved in the teaching of general practice need to impress upon students and doctors alike that good interprofessional communication is not a courtesy, it is a necessity.

**References**


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