An integrated model of cardiological consultation and primary care medicine

Sir,
Two archetypal medical practitioners have emerged in recent years: the highly sophisticated, procedure-oriented, hospital specialist, and the family practitioner who emphasizes the humanistic aspects of patient care. Since patient care undoubtedly benefits from cooperation between these two types of practitioner, we have developed an integrated model of cardiological consultation within the framework of primary care medicine. The principles of the integrated model are: (1) the consultant examines referred patients in the primary care clinic with the family practitioner; (2) an explanation of the consultation is conveyed to patients by the family practitioner; (3) medication is prescribed by the family practitioner; (4) investigations and invasive treatment are recommended only when agreed by both the consultant and family practitioner; (5) investigations and/or treatment are performed in the consultant’s department and are explained by the consultant.

We report here the effects of this model on patient care and patient satisfaction. The scheme was tested in an academic primary care clinic serving a population of 1800 in a rural area. A cardiology consultation service was established by a senior cardiologist from a tertiary referral centre. He visited the clinic once a month and consulted with six to eight patients in the presence of the primary care family practitioner. After a short, formal introduction the patient described his or her symptoms and further information, when needed, was provided by the family practitioner or nurse. The consultant then asked his own questions and examined the patient. After completion of the clinical evaluation, the family practitioner presented his or her perspective of the patient’s problem and suggested further investigation and therapy, while the consultant expressed his own viewpoint. In all cases, the consultation was explained to the patient by the family practitioner. Necessary investigations and treatment were scheduled in the consultant cardiology department of the tertiary referral centre. Changes in drug treatment were dealt with by the family practitioner. Any disagreement between the consultant and the family practitioner was settled in the absence of the patient.

Fifty one consultations were performed using the integrated model during a period of seven months. Twenty nine effort tests were scheduled (eight of which were thallium stress tests), together with nine echocardiographic and Doppler studies. Coronary angiography was performed on six occasions. Three patients were treated by coronary angioplasty and another four patients underwent aorto-coronary bypass surgery. There were no self referrals to emergency departments during the study period.

Forty one patients completed a questionnaire evaluating the integrated model. Thirty eight patients (93%) graded the model as most satisfactory. The factors most appreciated by the patients were the presence of the family practitioner at the consultation, not having to visit the specialist outpatient clinic which was further from the patients’ home than the primary care clinic, and the fact that when transfer of the patient to the tertiary referral centre was necessary, a familiar cardiologist was present to continue investigations and therapy. Twenty four patients had previously had non-integrated cardiological consultations and of this subgroup, 21 patients (88%) regarded the integrated model as superior.

The integrated model emphasizes the major role of the primary physician both during and after the consultation. The model is cost effective as patients save travelling time and do not have to wait for consultations in busy hospital outpatient departments. The combined discussion between patient, consultant and family practitioner eliminates the need for an often lengthy series of visits, conveying letters of recommendation and suggestions between family doctor and consultant. The proposed model would be applicable in most health systems and the only investment required is a change in attitude.

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Palliative medicine: a change in emphasis?

Sir,
The recent appointment of a physician in palliative medicine to the Dorothy House Foundation hospice in Bath suggests the possibility of a change in attitude regarding the role of a specialist doctor in palliative care.

In 1980 the Department of Health and Social Security published the report of a working group chaired by Professor Wilkes into terminal care. The working group stated that expert advice on pain control and relief of other symptoms should be available from district general hospitals and proposed the establishment of teams to offer advice and support to general practitioners, health visitors and district nurses.

The role of the medical director in many hospices has traditionally been that of director of clinical care, controlling and managing such care during the patient’s association with the service. Such a role ensures rapid and effective change in medical care for the patient, bringing about effective change in drug regimen and quickly controlling symptoms. There is a danger, however, that such active intervention separates patients from those...