Why not inform the hospital?

Sir,
As general practitioners we rightly complain when hospitals do not inform us about what they are doing to our patients. Just as serious, however, is the failure to inform us of the sudden or unexpected death of one of our patients in hospital. Most of us have had the unhappy experience of asking a patient about the progress of their relative whom we admitted to hospital and received the reply 'didn't they tell you that he died last week?' This is rude to the relatives and embarrassing to the general practitioner, and also a lost opportunity for early bereavement counselling.

In our six-partner practice of 11 000 patients we have just surveyed the records of the 90 patients who died last year: 18 had died at home, and 14 in nursing homes or old peoples homes under our care. Hence we had personally written the death certificates of 30 of these patients. Forty-one patients had died in our local hospital and seven in other acute, psychiatric or geriatric hospitals. On a few occasions we had been telephoned by the staff, and in many we had received a discharge note soon after death, but in a proportion we had had no communication from the hospital. On some occasions news of death had come from enquiries by the coroner's officer, conversations with distressed relatives, or reports in the local paper. We only discovered that some of our patients had died when the Family Practitioner Committee (FPC) recalled their notes, using form FP22A. For five of our patients we have been unable to obtain any more information except that the FPC has been informed of their decease, and that we have not seen them for many months.

But if we, as general practitioners, do not always know when our patients die, are our local hospitals any better informed? Some may be expecting patients to attend clinics and may issue fresh appointments when they default. Some patients may be called for admission or an ambulance may be sent to fetch the patient. Imagine the embarrassment, and even anger, of the bereaved relatives, let alone the waste of hospital resources. Many departments are concerned about the progress of patients whom they have treated, and are pleased to hear about their failures as well as their successes. Especially in the assessment of new forms of treatment, it is vital that the hospital department know the ultimate outcome.

One consequence of our practice survey was the realization that many of our patients who had died at home or in old peoples residences were also known to local hospitals, and that, with rare exceptions, we had never informed the hospital when patients had died. If both of us are sharing in the care of a patient, we should both be sharing all important information about that patient. In order to make certain that we inform local hospitals, our practice manager composed a standard letter which is now sent to the appropriate hospital soon after any death outside hospital. The letter gives the patient's name, address, date of birth and hospital registration number and informs them of the date of death. It includes a section to allow the hospital to pass these details to specific clinics, ambulance, waiting list, and records department. Because doctors are prone to forget such administrative details, the responsibility for despatching the letter has been delegated to the practice secretary responsible for returning the deceased patients' notes. The system seems to be appreciated by hospital consultants as well as the staff in admission, appointments and ambulance departments.

We hope we are now routinely informing hospitals of patients' deaths, and can now consider other ways of improving our communications with the hospital. In referring patients to hospital clinics we try to include a list of current therapy even though it may alter before they are seen. Our health visitors have surveyed most of our patients aged over 75 years and a copy of their report on social and supporting services is included with geriatric referrals. One of our most useful acquisitions is a plain paper copier and, among other functions, this enables us to send copies of pathological and X-ray reports with referral letters, as well as copies of relevant letters from other hospitals.

We cannot complain about lack of communication from the hospital until we are prepared to inform them as quickly and fully as we expect them to inform us.

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Confusion for diabetics in the use of U100 syringes

Sir,
Many diabetic patients prefer disposable plastic insulin syringes to the prescribable glass and metal ones. During a survey of diabetics in our practice, problems came to light which were attributable to variation in the markings on disposable U100 syringes.

Case 1. A 42-year-old partially sighted housewife had been diabetic for 30 years. She has idiopathic cirrhosis, nephrotic syndrome and retinopathy. In 1984 she required repeated hospital admissions for stabilization of her diabetes, which was always accomplished without difficulty on the ward. Once at home, recurrent hypoglycaemic episodes would be encountered. The problem was solved when nursing staff observed her drawing up insulin by counting marks down the left hand side of the scale, assuming one mark to one unit and ignoring the numbers on the right. At home she had been using a 100 unit model calibrated with five marks for every 10 units, a fact not previously known to the patient, her general practitioner or her hospital consultant.

Case 2. A 67-year-old retired jeweller presented to his general practitioner because of nocturnal hypoglycaemic attacks — the first he had regularly experienced in 27 years of insulin dependent diabetes. He had been stable on a mixture of two insulins. When interviewed, it was apparent that too much insulin had been administered for a number of reasons. One was his habit of drawing the first and larger insulin dose using the numbered scale in the usual way, but completing the mix measuring the dose by counting marks. He assumed one unit to one mark, although his were 100 unit syringes calibrated to two units per mark.

The standardization of insulin strengths is welcomed by all concerned. There are dangers, however, owing to lack of standardization of markings on the disposable plastic syringes which many find so convenient. Despite all our attempts to educate patients, many patients — 40% in our survey — persist in thinking of their insulin in marks rather than units.

The fact that many syringes are calibrated to two units of insulin per mark may not be appreciated by patient and adviser alike. Recent comment on the safety of plastic disposable syringes[1] has concentrated on the problems of infection and calls for them to be available on prescription. Packaging for the types of syringes may be strikingly similar and patient, family, nurse and general practitioner should ensure the same type is provided each time.

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Reference

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