Hospital-treated myocardial infarction and the general practitioner

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SUMMARY. Patients who had a myocardial infarction were interviewed with their spouses in hospital and after returning home. Advice about rehabilitation, such as that recently recommended by the Working Party of the Royal College of Physicians, was often not received. General practitioners have great opportunities for organising a graded programme of rehabilitation and may often communicate ideas more easily to their patients than hospital staff. However, some practitioners are reluctant to do this work.

Introduction

There is increasing evidence to show that an active approach to management after myocardial infarction is important in achieving a satisfactory medical and social outcome. An authoritative report (Working Party, 1975) states, " In the early weeks after myocardial infarction the family doctor should have frequent contact with his patient " and recommends careful listening, the countering of denial of symptoms by reports from other members of the family, and enquiry about exercise capacity. " In the absence of excessive dyspnoea or other reaction, a progressive programme of increasing exercise should be designed for each patient ". In a previous paper (Mayou *et al.*, 1976) we have suggested that hospitals are unsuccessful in conveying their beliefs about the need for an active convalescence to patients and their relatives. This further paper examines the accounts of relatives and patients of care in general practice before admission to hospital and in the month after discharge.

Method

As part of a larger and continuing psychosocial study of predictive factors of outcome after myocardial infarction, 45 patients and their spouses were interviewed a few days after admission to hospital and approximately one month after discharge. The interviews were semi-structured and tape-recorded. Medical notes were reviewed and general practitioners were sent a short questionnaire four weeks after discharge.

Consultation

The study confirms the findings of other studies of the commonness of delay in consulting and prodromal symptoms (table 1). The interviews with spouses indicate that previous descriptions all based only on patients' accounts substantially underestimate prodromal symptoms, delay, and the role of others in initiating contact. It is common for patients even with considerable discomfort to be unwilling to seek medical help. While many relatives describe symptoms as more severe than do the patients, others appear to have been unaware of the duration and distress of the pain, sometimes commenting that they had repeatedly asked whether anything was wrong.

TABLE 1

SYMPTOMS AND CONSULTATIONS

	Per cent
Prodromal symptoms:	
Patient's account	*32*
Patient and family's account	*60*
Consultation	*20*
Delay in consulting:	
Less than 1 hour	*45*
1–3 hours	*30*
3–24 hours	*10*
24 hours	*15*
Consultation:	
Initiation:	
Patient's decision alone	*22*
Joint decision	*47*
Decision by another despite patient's reluctance	*21*
Decision by another	*10*
Place:	
Seen by general practitioner at home visit	*75*
Attended surgery	*8*
Satisfaction with general-practitioner care:	
Satisfied	*55*
Some criticism	*8*
Dissatisfaction	*12*
Action: by general practitioners:	
Immediate referral to hospital	*56*
Delay in referral	*27*

Typically patients recall little of the initial consultation, but spouses (present in 72 per cent) were usually informed of possible diagnosis and prognosis and advised to travel to hospital in the ambulance. Patients and their families were generally satisfied with the care they had received from general practitioners, whether this had been an emergency call at home or a surgery visit, and whether they had seen their own doctor or not.

However, for five patients (11 per cent) considerable problems had been experienced over a prolonged and distressing period in persuading general practitioners to visit. Where such difficulty occurs with the patient's own doctor rather than an emergency stand-in, it might be expected to lead to permanent damage to the relationship.

General practitioners consulted in the month before infarction about what turned out to be prodromal symptoms had usually reassured patients, in four cases arranged cardiac investigation, and in two instances recording their own electrocardiograms. The only patient dissatisfied with this initial care suffered his infarction immediately on return from being reassured at the hospital outpatients.

Admission during the acute episode was usually immediate, but when this was delayed there were a variety of reasons such as delay in diagnosis and change in physical state. It seems that in the early stages decisions about treatment are deferred and that in no case did the initial action suggest a definite intention to treat the patient at home. Some confusion arose on occasion through lack of continuity between partners and more especially with emergency rota doctors unaware of the full medical factors. Home, rather than hospital treatment, appears to have been discussed with the patient and his family on only two occasions.

Two patients were visited by their general practitioner while in hospital and appreciated this. One wife reported that the doctor had arranged to see her whilst her husband was in hospital so as to discuss convalescence and that this had been most helpful.

Consultation after discharge

After discharge (table 2) there is a considerable variety in the ways in which contact is re-established. Some patients and their families immediately phoned their doctor expecting and looking forward to an early visit. Doctors varied between those who visited immediately they heard from the hospital and those who made no effort to see the patient. At least two doctors were willing to give certificates to relatives without suggesting that they would like to see the patient.

Patients and their families were able to give only vague accounts of the treatment, information, and advice they had received. Work, diets, activity, and smoking are commonly discussed, but considerable differences are clear in the amount of advice, thoroughness of physical examination, and responsibility assumed for supervising medication.

TABLE 2

PATIENT CONTACT WITH GENERAL PRACTITIONER AFTER DISCHARGE

	Per cent
Seen at home—	*65*
initiated by doctor	*30*
initiated by patient	*35*
Seen at surgery	*25*
Not seen	*10*
Patient satisfied	*85*
Relative spoken to general practitioner	*70*
Relative satisfied	*79*

TABLE 3

GENERAL-PRACTITIONER ASSESSMENT AT FOLLOW UP

		Per cent
Physical state:		
	Good	*62*
	Fair	*30*
	Poor	*8*
Mental state:		
	Good	*52*
	Fair	*36*
	Poor	*12*
Outlook:		
	Good	*45*
	Fair	*40*
	Poor	*8*
	Not known	*7*
Other problems likely to affect outcome:		
	Nil	*35*
	Other physical illness	*3*
	Patient's mental state	*16*
	Spouse's mental state	*10*
	Social and family problems	*28*
	Other	*8*
Expect to see patient again:		
	Yes	*72*
	No	*28*

General practitioners were much more likely to speak to both husband and wife and were viewed as much more approachable than hospital staff, one man commenting, " the sooner I saw my doctor the better as I didn't get any advice before leaving the hospital ". For many, consultation provided an opportunity to ask the questions they felt that they had been unable to sort out in hospital. General practitioners were seen as much more aware of home circumstances and there was less criticism of them than of hospitals where advice was seen as vague and contradictory. Family doctors in their assessments after discharge (table 3) often concluded that psychological or social factors were likely to be important in determining outcome and disability.

By medical and patients' accounts it is evident that there is a wide spectrum of approach to management. While at this stage the majority of general practitioners expected to see the patient again, this was usually envisaged in terms of repeat prescriptions, monitoring anticoagulants, or certificates. Only a minority of doctors arrange a number of appointments to supervise convalescence and even fewer think in terms of setting out a supervised graded programme of increasing activity. One doctor hands out a printed leaflet of advice which he has written. Some practices make an effort to provide continuity of follow-up care while in others several doctors were involved.

Communication with hospital

Where general-practitioners' referral letters were available in the notes the majority gave what seemed to us to be reasonable clinical detail in the circumstances, usually a brief history, a record of clinical findings, treatment, and analgesics. Very few letters recorded significant facts of medical or social history that might be relevant to future management, but such detail can hardly be expected in an emergency and where many referrals were not made by the personal doctor.

TABLE 4
HOSPITAL INFORMATION TO GENERAL PRACTITIONER

	Per cent
Discharge letter:	
No copy in notes	*5*
Wrongly addressed	*5*
Diagnosis	*100*
Hospital treatment	*35*
Medication on discharge	*65*
Recommendations	*32*
Advice to patient	*25*
Summary:	
Medication on discharge	*86*
Advice to patient	*18*
No summary written	*8*
Outpatient letters:	
Medication on physical condition	*78*
Work	*55*
Activity	*36*
Social factors	*20*
Mental state	*12*
General practitioner's view of information:	
Satisfied	*73*
Some criticism	*10*
Dissatisfied	*17*

Table 4 summarises content of written hospital communication with doctors. While discharge letters were scantily completed, summaries gave adequate accounts of medical care with, however, little detail of advice on discharge or of future management

plans. There was little information not only as to the advice the patient had received, but about the physician's views on the role of medication and future management. Outpatient notes and letters were brief, often mentioning return to work, but with little other reference to activity or social aspects, or to how long medication should be continued after discharge from the clinic.

Judged by standards set out in the survey by Tulloch *et al.*, (1975) of discharge information in the Oxford area the majority of letters and summaries were inadequate, but most general practitioners were generally satisfied with communication of information. Criticisms were of two types: concern at lack of detail or delays in receiving information in individual cases, and what appears to be a reflection of an attitude to the role of the general practitioner, a desire for much more extensive information about prognosis, advice given to the patient, and future management.

The four doctors who were strongly dissatisfied clearly expected to take on an active and fully responsible role after discharge, and felt that they had inadequate information on which to base their clinical management. In one instance the general practitioner wanted copies of all hospital electrocardiograms.

Discussion

While the accounts of patients and their relatives and brief questionnaires to their doctors can only give a partial view of the general practitioner–patient relationship, they do give us a good understanding of what families believe, if not of what actually happens. The degree of satisfaction with general-practitioner care is encouraging though not unexpected in an area in which lists are relatively small and the quality of medical care is generally accepted to be high. Equally pleasing is the satisfaction of general practitioners with the information and communication from the hospital.

There is a marked contrast to the report by McEwan (1974) in Dundee where half the patients with myocardial infarction do not see the general practitioner at all after discharge from hospital.

Even though most of those concerned with care in general practice after infarction appear satisfied, it is arguable that this in part reflects relatively low expectations by patients, relatives, and their family doctors. Patients do not expect their general practitioners to supervise any graded programme and are usually satisfied with brief contacts. Most general practitioners (unlike Tulloch *et al.*, 1975) do not expect detailed hospital information and vary considerably in their views as to the amount of care which is appropriate. As a result, it was clear that a majority of the patients did not share the current medical view (Working Party, 1975) for the need for an active convalescence and return to normal activities. There can be little doubt that communication of advice and information in hospital is not successful (Mayou *et al.*, 1976) and it also appeared that many general practitioners see little need to take the initiative in giving optimistic advice or arranging any continuing care.

There are some other important reasons which may account for the failure to convey to patients the need for an active convalescence: doctors themselves have various views, patients vary in their receptiveness, and the actual process of communication of information is complex. A survey of general-practitioner attitudes to management of heart attacks (Hampton *et al.*, 1975) shows wide variation in views on the rate and nature of convalescence. Our study also appears to illustrate fundamental differences in practice, from passive waiting for patients to consult and routinely repeating prescriptions to much more active programme, for regularly checking progress, giving advice, and reviewing medication.

It is noteworthy that continuation of outpatient care by hospital doctors appears to bear no relation to the extent of the general practitioner's resumption of clinical

responsibility. While the general practitioner is only one of a number of people involved in therapy, if one accepts the importance of more active management after heart attacks, then he should perhaps be the key person in co-ordinating and supervising rehabilitation after infarction. He is, after all, the person who knows most of the family circumstances and has the opportunity for continuing contact. It is probable that he will be more effective than hospital services in establishing a graded rehabilitation and avoiding the dissatisfaction and difficulties which commonly arise from conflicting and inadequate or inappropriate advice.

An active role with regular consultations and advice to patients and to their relatives about increasing activity, dieting, smoking, and so on, could reduce social morbidity both during convalescence and in the long term. One would predict also a more effective use of medical treatments with increased compliance and also reduction in long-term prescription of diuretics, trinitrate, and other medication which may not be required. It would certainly simplify use of anticoagulants.

General practitioners would find such a role much easier if they received more precise information from hospitals about treatment, especially about the advice given to patients about activity, diets, and work.

We must conclude that even within an area with high standards of medical care in which patients and the family doctors are on the whole satisfied, cardiac rehabilitation is rather unlike the ideals put forward by a distinguished committee (Working Party, 1975). It would be unfair to apportion criticism to hospitals, general practitioners, or to patients, but it does show that we have as yet made rather little progress in finding methods to convey our widely accepted principles of care.

Acknowledgements

We are grateful to the British Heart Foundation for their financial support.

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MEDICAL ETHICS AND TORTURE

There is growing evidence of widespread use of torture among political prisoners throughout the world. Medical personnel frequently become involved, sometimes directly, sometimes peripherally, as in the examination or treatment of such prisoners. Physicians themselves may become victims of torture when the state attempts to subvert the doctor-patient relationship for political purposes. Furthermore, recent studies demonstrate long-lasting medical and psychological effects of torture. For these reasons, physicians have a special opportunity and ethical obligation to resist and oppose torture as well as to support physicians whose lives or professional careers are jeopardised by their refusal to participate in torture. Codes of medical ethics need strengthening to provide clear guidance for the physician who becomes aware of or actively involved in these brutal practices.

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