Information about patients' deaths: general practitioners' current practice and views on receiving a death register

REBECCA WAGSTAFF

ANITA BERLIN

ROSIE STACY

JOHN SPENCER

RAJ BHOPAL

SUMMARY

Background. *Although general practitioners are involved in the care of most dying patients, they do not routinely receive information about their deceased patients for whom they did not complete the death certificate, and often they rely upon informal communication channels.*

Aim. *This study set out to assess how general practitioners obtained, recorded and used information about deceased patients and to determine their views on receiving a death register.*

Method. *A questionnaire was sent to all 305 general practitioners in the Newcastle upon Tyne and Sunderland Family Health Services Authority areas.*

Results. *A total of 225 questionnaires were returned (response rate 74%). General practitioners usually first learnt about their patients' deaths from hospital discharge summaries (54%) and patients' relatives (46%) and less commonly from newspaper obituary columns (20%) and hospital telephone calls (9%). Two thirds of respondents recorded information about decreased patients, mainly listing personal details and the immediate cause of death. One third or fewer of those recording information listed contributory causes. The information was used mainly for following up bereaved relatives and notifying hospitals and other agencies.*

Conclusion. *Current informal systems for handling information about patients' deaths are inadequate. General practitioners need and would welcome prompt, accurate and comprehensive information about all their deceased patients.*

Keywords: patient death; information sources; information needs; records management.

Introduction

APPROXIMATELY 20 patients on an average general practitioner's list of 2000 people die every year.[1] Although about 70% of these patients die in hospital,[2] the primary health care team have probably been involved in their care during their final illness and are likely to care for their bereaved families afterwards. Yet general practitioners do not routinely receive information about those patients who do not die at home or who are the subject of a coroner's autopsy or inquest. Instead they rely on hospitals to inform them either by telephone or a letter (which may not arrive until some time after the death), or on information from patients' relatives and neighbours, newspaper obituary columns and other sources. This lack of information may prevent prompt care of the bereaved and hinder efficient administration. A wealth of potentially valuable information is also being lost, to the detriment of clinical audit and research.

This survey aimed to evaluate general practitioners' current practice regarding death information and their interests in receiving a regular death register containing details of all their recently deceased patients.[3]

Method

In November 1991 a questionnaire for self completion was sent to all general practitioners in the Newcastle upon Tyne (161) and Sunderland (144) Family Health Services Authority areas (total 305). A duplicate questionnaire was sent to non-respondents two weeks later.

The questionnaire comprised open and closed questions. General practitioners were asked how they first learned of the death of a patient, whether they systematically collected information about patients' deaths, what information was recorded and how it was used. Those general practitioners in Newcastle receiving a 'death list' from Newcastle upon Tyne District Health Authority listing all deaths in Newcastle[3] were asked whether they found it useful and to detail any criticisms. All of the general practitioners were asked whether they would like to receive a regular practice death register of all recent deaths among their patients giving details of name, age, address, date of birth, general practitioner, date and place of death and causes of death as recorded on the death certificate. They were also asked whether such a register would be useful for audit.

The questionnaires were analysed using the *EPI-INFO* statistical package.[4]

Results

Of the 161 Newcastle general practitioners 124 (77.0%) responded to the questionnaire as did 101 of the 144 Sunderland general practitioners (70.1%) (combined response rate 73.8%).

The methods by which the 225 respondents always or often first learned about the deaths of their patients are given in Table 1. Hospital discharge summaries and patients' relatives were the commonest source of early information, but 20% often first learnt of a patient's death via newspaper obituary columns.

A total of 151 general practitioners (67.1%) kept a record of patients' deaths, usually in written registers (33.1%), computerized registers (30.5%) or white/blackboards (26.5%). The information recorded about deceased patients is shown in Table 2. The commonest items to be recorded were the patient's personal details. Nearly two thirds of general practitioners recorded the immediate cause of death and about 30% recorded other contrib-

R Wagstaff, MFPHM, senior registrar in public health medicine, North Cumbria Health Alliance. A Berlin, MRCGP, lecturer, Department of General Practice, St Mary's Hospital Medical School, London. R Stacy, MSc, research associate and J Spencer, FRCGP, senior lecturer, Department of Primary Health Care, University of Newcastle upon Tyne. R Bhopal, MFPHM, professor, Department of Epidemiology and Public Health, University of Newcastle upon Tyne.

Submitted: 5 July 1993; accepted: 27 October 1993.

© *British Journal of General Practice,* 1994, **44,** 315-316.

Table 1. Sources of information that were always or often the first notification of a patient's death for general practitioners.

Source of information	% of GPs responding always or often (n = 225)
Hospital discharge summaries	*54.2*
Patients' relatives	*46.2*
Other members of primary health care team	*26.7*
Newspaper obituary columns	*20.0*
Hospital telephone calls	*8.9*
Patients' friends/neighbours	*7.1*
Coroner	*4.0*

n = total number of respondents.

Table 2. Information recorded by those general practitioners that kept a register of patients' deaths.

Patient information	% of respondents (n = 151)
Name	*89.4*
Date of death	*87.4*
Address	*80.1*
Date of birth	*65.6*
Cause of death as stated on death certificate (if known)[a]	
Cause Ia	*64.9*
Cause Ib	*33.1*
Cause Ic	*27.8*
Cause II	*29.1*
Place of death	*46.4*
Whether autopsy conducted	*31.8*
Risk factors (eg cigarette smoking)	*13.2*
Occupation	*4.6*
Next of kin	*3.3*
Other[b]	*7.3*

n = total number of respondents who kept a record of patients' deaths. [a]Ia is immediate cause of death, Ib and Ic are antecedent causes and II is any other condition contributing to death but not a major factor in the chain of events leading to death. [b]Mainly administrative issues such as whether other agencies had been informed of death, whether a bereavement visit had been made or whether the patient's name had been removed from the list.

utory causes. Few recorded details of risk factors such as cigarette smoking, or occupation.

The most common uses of information about patients' deaths were for follow up of bereaved relatives (57.6% of 151 respondents) and notification of hospitals and other agencies (50.3%). Information was also used to calculate death rates (35.1%), for medical audit or research (16.6%) and for screening for familial conditions (10.6%). Changes in practice as a result of using information about death were reported by 12 of the 151 respondents (7.9%). Changes included the introduction of practice guidelines on the management of bereaved relatives.

Of the 124 Newcastle respondents 24 (19.4%) were receiving a 'death list' from Newcastle upon Tyne District Health Authority. Only six of the recipients of this list found it useful. General practitioners' criticisms were that it was difficult to identify their own patients because general practitioner's names were omitted (eight respondents), that the cause of death was only stated for patients under 19 years of age (three), and that it arrived after the death was already know about (three).

Of all 225 respondents 186 (82.7%) said they would welcome a death register which listed only patients registered with their practice, and gave regular comprehensive details of the deaths; 162 respondents (72.0%) said that such a register would be useful for audit.

Discussion

General practitioners may not learn of the death of one of their patients until several weeks after the event.[2] However, they need prompt, accurate and comprehensive information concerning these deaths to follow up the bereaved, for administrative purposes, and for clinical audit and research.[3] This survey showed that 54% of general practitioners cited hospital discharge summaries as an important source of information, yet this process can be slow.[2] In contrast, telephone calls from hospitals, which can provide immediate information, were an uncommon source of first notification. General practitioners in the north east of England appear to be relying extensively on informal notification which cannot provide accurate information on the certified causes of death.

Only two thirds of general practitioners recorded information about their patients' deaths. Most included only minimal patient details and the information recorded reflects the uses to which it was usually put: following up bereaved relatives and notifying hospitals and other agencies. The full potential of information about patients' deaths may not be being realized. Only 17% of the general practitioners recording information used it for audit or research: one explanation for this may be that they are not in possession of the necessary information.

Although death registers are not a substitute for the rapid notification of general practitioners by hospitals when their patients die, they are a valuable source of information and their usefulness is currently being assessed. Purchasing authorities and fundholding general practitioners should specify methods for notifying deaths to general practitioners and time limits in their contracts with hospitals.

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Acknowledgements

We thank those general practitioners who completed questionnaires; Louise Robinson for her helpful comments on earlier drafts of the manuscript; Newcastle upon Tyne District Health Authority and Newcastle upon Tyne Family Health Services Authority for their help with this project; and Sharon Denley for her secretarial expertise. This project is funded by a grant from the Department of Health.

Address for correspondence

Dr R Wagstaff, North Cumbria Health Authority, Lakeland Business Park, Lamplugh Road, Cockermouth CA13 OQT.

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