

Secondary–primary care communication: impressions of the quality of consultant communication with specific regard to cancer patients

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The objective of this study was to determine the views of Somerset GPs, on the quality of communication from hospitals, with particular reference to the cancer patient. A questionnaire was designed as a result of focus group discussions with 22 GPs. This questionnaire was then sent to all Somerset GPs, of whom 312 participated. The questionnaire was designed to ascertain the perceived quality of communication from hospitals. The results of the study concluded that most GPs believe good communication is more important with cancer patients than with other patients. Written communication was regarded as being very good with the exception of discharge information which should provide more detail on follow-up and treatment plans. However, more detail was desired on potential side effects of treatment and recommended action, as well as on prognosis. It was generally felt that greater use of fax and e-mail would be helpful.

Key words: cancer; communication; primary care

Background

Within the new envisaged framework of ‘a new and dependable NHS’ (Department of Health, 1997), the primary–secondary care interface is seen as integral to delivering high-quality patient care. The importance of this interface in cancer care cannot be overstated. In order for the notion of a ‘primary care-led NHS’ to be realized, communication between the providers of primary and secondary care with regard to cancer patients becomes pivotal to the successful delivery of appropriate care closer to the patient. As such, the primary–secondary care interface represents a crucial pathway to the goal of patient-centred care. Clinical effectiveness results when the needs of all stakeholders in clinical

encounters are met. The key to delivering this type of healthcare is communication and information.

One area where this issue becomes crucial is in the provision of unambiguous advice and information to patients suffering from cancer. Treatment of patients suffering from cancer requires reliable and timely information exchange (Van der Kam *et al.*, 1998). Information is seen as being vital for the support of this patient group. Surveys have indicated that most patients have a desire to know about prognosis, treatment options and potential side effects (Meredith *et al.*, 1996). These surveys are supported by qualitative research. For example, Mathieson and Stam (1995) in interviews with cancer patients asked ‘Do you feel you have received adequate information from health care professionals?’ and reported responses such as: ‘Please don’t ever do that to me again. I don’t mind not knowing something, but I don’t like you knowing something, and me not knowing something’. Patients are expressing their need and desire to be informed.

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The Calman Hine Report reinforces this when it states that 'patients, families and carers should be given clear information and assistance in a form they can understand about treatment options and outcomes available to them at all stages of treatment and diagnosis onwards' (Calman, 1994).

The report acknowledges the Primary Health Care Team (PHCT) as being a central and continuing element for both patient and families. The PHCT is central to the future care of the cancer patient. The success of the PHCT in responding to patients' needs for information, as highlighted above, will rely upon good, prompt and reliable communication between hospitals and GPs. Research has indicated that the quality of information filtered through from the hospital to GPs is often inadequate. More detailed advice about the management of the disease is necessary (Van der Kam *et al.*, 1998). We set out to investigate GPs views as to the type and quality of information being provided to the cancer patient and their GPs by secondary care.

Method

Sedgemoor Primary Care Research Group invited 22 GPs to participate in three focus groups to explore their information needs from their consultant colleagues. The focus groups were facilitated in such a way that each of the key areas in a cancer patient's journey was covered. Each focus group lasted 1 hour. In order to encourage a more natural environment, the group's deliberations were not recorded. The facilitator made appropriate notes, in effect, summarizing the specific points raised by the groups. Facilitation aims were not necessarily to seek consensus. The opportunity to share experiences of communication was a specific focus-group objective. The main discussions focused around specific stages of illness trajectories and how information needs might vary according to the stage. Table 1 indicates the main areas of discussion in each of the focus groups.

The focus groups' discussions generated a range of particulars. It was deemed important to use a qualitative methodology to inform the content of the questionnaire, the view taken by the researchers being that qualitative and quantitative methods build upon each other and offer information that neither one alone can provide (Barbour, 1999).

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Table 1 Focus group discussion topics

Referral to diagnosis
Diagnosis to ongoing treatment
Progress and follow up
Changes in status:
Relapse
Deterioration
Death
Cure

Sequential designs should be seen as tools that improve the validity of measurement instruments such as questionnaires. By engaging the ultimate audience in identifying key themes, variables if you like, which are then operationalized in a questionnaire format, increases the likelihood of GPs feeling the research is relevant to them and their current practice.

Thus, the genesis of the questionnaire categories were derived from the themes expressed by members of the focus groups. These themes were extracted from the notes taken by the facilitator in each of the focus groups and became categories included in the questionnaire, each category containing five questions relating to issues highlighted by one or all of the focus groups. The resultant questionnaire used a Likert scale to record agreement or otherwise with certain statements. In order to ensure that the questionnaire represented the issues felt to be relevant by the focus groups, some members of each group were asked to comment on the final questionnaire. No changes were deemed necessary. The questionnaire was despatched to 312 Somerset GPs, of which 255 completed questionnaires were returned after one reminder letter. Table 2 illustrates the categories included and illustrative statements from each.

The importance of communication between the secondary–primary interface with regard to cancer patients is seen from the view of the patient as well as the GP. This is an encouraging sign that the process of patient involvement in decision-making outlined by Calman Hine is being adopted and supported by specialists and the PCHT.

Results

After one reminder a response rate of 82% was achieved. Practice demographics are reported in Table 3.

Table 2 Questionnaire categories with an illustrative statement

Category	Statement
General views on communication between hospitals and GPs regarding cancer patients	Good communication between hospitals and GPs is generally more important with cancer patients than with other patients
Communication relating to discharge information	Discharge information provides clear information on follow-up plans
Communication with doctors	Normally when patients have been discharged from hospital, or seen in outpatient clinics, the GP is made aware of the treatment options and relative merits
Communication with patients	Normally, when patients have been discharged from hospital or seen at outpatient clinics, they are, whenever appropriate, aware of the treatment options
Communication between hospitals and GPs	Needs improving by greater use of faxes

Table 3 Personal and practice demographics of the respondents

No. of partners	0	1	2	3	4	5	6	>6
%	3	8	14	16	14	44	0	0
Male/Female	73%/27%							
Shared/Personal list	49%/51%							
Full/Part time	72%/28%							

Of the respondents, 74% strongly agreed or agreed with the statement that good communication was more important with cancer patients than with other patients. The view of the Somerset GPs in this survey was that written communication between the hospital and GPs was generally very good. The exception was discharge information where the majority (59%) strongly agreed or agreed that more information could be provided, particularly with regard to follow-up and treatment plans. This information is displayed in Table 4.

Over half the respondents (61%) reported that they wished to know more about the potential side

effects of any treatment regime and the necessary action to take if these side effects manifested themselves. The focus group material recognized the specialist–generalist divide and thought it important that specialist knowledge should be passed to GPs in order that future patient demands could be met. This was further endorsed by questionnaire responses that highlighted the need for more information to be available to patients about the likely prognosis. These issues can be seen in the category responses to the statements detailed in Table 2.

Table 5 shows that the majority of GPs in the survey strongly agree and agree that they are made aware of diagnosis and histology. However, the responses to information about prognosis and treatment options are equivocal whereas information about side effects and actions are not seen as being made available to them. Very positive responses about communication with patients were recorded. Tables 4 and 5 illustrate the views expressed by GPs concerning information provided to patients once they were discharged about various aspects of their patients care.

The majority of GPs agreed with statements that suggested patients had been discharged from hospital aware of diagnosis and treatment options. The responses for awareness of risk and outcomes and knowledge of support available to them are less clear. Forty-three per cent indicated that they felt patients had been involved in decisions about their treatment.

When questioned about communication between hospitals and GPs the majority (82% and 70%, respectively) strongly agreed/agreed that GP's requests for urgent appointments and specialist advice were being met. However, a need was reported for making use of other methods of communication: 52% strongly agreeing/agreeing with the need for greater use of telephones and 52% with regard to faxes. However, the largest proportion of responses was ambivalent when it came to the use of e-mail (39%). These findings are illustrated in Table 5.

Discussion

These results have highlighted the good level of communication between hospitals and GPs in Somerset. However, discharge information was felt

Table 4 General views on communication regarding cancer patients

	Strongly agree	Agree	Neither agree/disagree	Disagree	Strongly disagree
Good communication between hospital and GPs is generally more important with cancer patients than with other patients	34	50	9	4	2
Verbal communication between hospital and GPs is generally very good	3	29	22	38	5
Written communication between hospitals and GPs is generally very good	2	37	37	22	1
Discharge summaries are generally very good	2	26	37	32	2
Outpatient letters are generally very good	5	72	20	2	1

Table 5 Range of answers to: Normally, when patients have been discharged from hospital, or seen in outpatient clinics, GPs are made aware of

	Strongly agree	Agree	Neither agree/disagree	Disagree	Strongly disagree
Diagnosis	0	72	4	4	0
Histology	6	57	10	10	2
Prognosis	0	22	39	39	5
Options	2	28	32	32	5
Side-effects	0	12	53	53	9
Actions	5	5	56	56	18

Table 6 What do GPs feel patients know on discharge? Percentage responses to each statement

	Strongly agree	Agree	Neither agree/disagree	Disagree	Strongly disagree
Aware of the diagnosis	4	68	21	6	0
Aware of the treatment option	2	48	37	13	0
Aware of the risks and outcomes	1	22	46	28	1
Have been involved in treatment decisions	3	43	38	14	1
Aware of the range of support services available	2	24	43	29	1

to contain too little detail with GPs wishing to know more about potential side effects of treatment and action that might need to be taken, as well as prognosis. Exchanging this type of information not only allows doctors to add to their knowledge but also assists in the development of management plans for a likely illness trajectory (Somerset *et al.*, 1999). The generalist and the specialist possess unique fields of experience and as such have much

to teach each other. The focus groups recognized the limitations of their knowledge and this was endorsed by the questionnaire data which sought to have access to specialist expertise for the benefit of their patients.

Table 6 deals with what GPs feel their patients know on discharge. According to Mathieson (1999), patients have to come to grips with dramatic psychosocial events for which they may be

Table 7 Communication between hospital and GPs. Percentage responses to each statement

	Strongly agree	Agree	Neither agree/disagree	Disagree	Strongly disagree
GP requests for urgent clinic appointments usually met	13	69	11	6	0
Easy access to specialist advice occurs when needed urgently	16	54	18	11	0
Needs improving by greater use of telephone	10	45	32	13	0
Needs improving by greater use of fax	10	42	33	13	1
Needs improving by greater use of e-mail	9	23	39	24	5

unprepared and also experience physical discomfort. They are at the centre of an unfolding illness trajectory that shapes their experience. Central to that experience is the tripartite relationship between patient, GP and specialist. As Sawyer (2000) suggests, cancer patients embark on a journey with an uncertain destination, laden with stress and anxiety. Information is the key to empowering patients to participate fully in their treatment. This survey has highlighted communication issues within that tripartite relationship, that if addressed would improve the already high standard of verbal and written communication concerning patients diagnosed with cancer.

Table 7 deals with communication between hospitals and GPs. Improvements in the use of telephone and facsimile were highlighted. As the majority of respondents felt that verbal communication was generally not very good, this flags an area that could easily be remedied. The antipathy towards e-mail as a means of communication, the researchers feel, reflects a snapshot in time. The technology has moved on apace and judging by the current use of e-mail may now be seen in a more positive light. Westerman *et al.* (1992) states that communication can always be improved and a good way to start is by measuring its deficiencies.

Correspondence forms a vitally important part of patients' records and as such has the potential to inform all stakeholders who interact with the patient at different points on their 'cancer journey'. For the sake of making their journey as easy for them as possible, issues such as the interface between specialist and generalist must always seek out ways to build complementary approaches. The advent of The National Plan and the future direct access that patients will have to correspondence between primary and secondary physicians adds

added support for the need to make sure information is appropriate, relevant and meets the needs of all stakeholders.

A limitation of this study is that only the views of GPs were sought. Specialists have views about communications originating from the general practitioner. Specialists have voiced concern about inadequate information and unnecessary referral (Westerman *et al.*, 1992). Innovations such as 'Boneline' in Doncaster where GPs had access to specialists at advertised times was not well used. Those that did avail themselves of the service found it valuable (Roland and Bewley, 1992). Opportunities to improve dialogue between these two professional groups may be being missed. The next phase in this sequence of studies will need to identify any improvements that can be made in referral communication and updating specialists with information that surfaces in the primary care setting, yet has relevance to colleagues involved in the care of cancer patients. Talking to and collecting the views of specialist is a necessary part of completing the picture.

Communication in any organization is often difficult. The unique settings of health care, the division of speciality and the diversity of patients and their ailments could contribute to a communication quagmire. Fortunately for Somerset patients the general level of communication between the professions involved in their care is very good. The desire of GPs to know more is a reflection of the commitment to providing the best possible service for patients with cancer.

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