I work as a GP in inner Sydney and I love my job.

When I was an Intern and RMO, some days I loved my job: the problem solving, the satisfaction from getting the cannula in first go, the adrenaline of helping in an arrest, the camaraderie.

Many days I tolerated it. The paperwork, the lack of autonomy, the "small fish in the big pond", the terrifyingly unwell patient at 3am when you can't find a registrar to help - You know the drill.

Other than night shifts, probably what I disliked the most was the discharge process. Although there was strange satisfaction in ticking off my little boxes on my patient list ("OT review- tick!", "D/C meds- tick!"), writing those summaries was unglamorous at best. Would anyone bother to read it?

Recently there was an excellent podcast on here about discharge planning. What a super resource for a new intern! Except... it missed one vital piece of information and it got me thinking. For all the mentions of “team” and who could help you with your discharge planning and general management of a hospital inpatient, only a fleeting reference was made at the very end to the patient's GP. I decided I needed to speak up but wasn't sure how to go about it.

What general practitioners think

With this in mind, I decided to consult a few colleagues - 1700 of them, in fact. They're spread across Australia from inner-city CBDs to tiny remote communities (one of them even works in Antarctica!). Many of them single-handedly run their local General Practice as well as the local hospital. Many work part-time in GP and part-time in some other area of medicine including academia, obstetrics, surgery, anaesthesia and psychiatry. They're a highly-skilled, engaged, motivated and inspiring bunch - who also have an interest in FOAMed, just like you (our group is called GPs Down Under).

To get to this point they've worked as Interns and residents like you. Many spent years as hospital Registrars before entering community-based work. They then underwent training in General Practice, sat exams to become Fellows (and those exams are tough - don't let anyone fool you otherwise) and now see roughly 3-4 patients per hour during which time a history, examination, and management plan has to be formulated. GPs work hard and we often work in isolation. We get to know our patients. We are respected by our communities.
So how can JMOs work better with their GP colleagues?

In Part 1 I’ll talk about teamwork, specifically about professionalism and ways to better include the patient’s GP during the admission and discharge process. In Part 2 I’ll aim to address some specifics around writing a discharge summary and some other tips and tricks.

The GP is on your team!

Hospitals love teams and there’s good reason for it; many hands make light work (well, in theory, maybe not as a JMO!) and many different skill sets hopefully help get patients better and back into the community. Your team of doctors may have a consultant, fellow, registrar, and resident and/or intern on it. The allied health team of physiotherapists, occupational therapists, psychologists, dieticians, pharmacists, social workers and speech therapists will also be on hand. There are the abundant and skilled nursing staff, the administration staff, the cleaners, cooks and patient transport workers.

All these people (and more) come together to help care for a patient during their time in hospital. But as we all know, hospital stays are generally short in relation to length of illness (especially with chronic diseases) and at the end of the day the main people managing the long term health of your patients are the patients themselves and their General Practitioners.

How can the patient’s GP help you with their admission?

- Firstly, check with the patient who their GP is - their file may not be up to date!
- Consider calling the GP if you need an up to date medication list, social history and specialist correspondence. Remember that some patients can’t remember what operations they’ve had or the type of specialists they’ve seen and that key information may make a big difference to how you manage them in ED/on the wards
- If there are issues around consent, capacity, end of life care, etc. consider calling the GP to ascertain whether there are any legal frameworks in place to help guide decision making
- The GP may also be able to highlight potential issues for ward management e.g. alcohol and drug dependency, and certain mental health concerns

Obviously you can’t (and won’t need to) call every patient’s GP for every admission. But remember that we can often save you heaps of time via a quick phone call and a faxed summary - and your boss will love the extra information you’ve ascertained, especially the geriatricians!

How can the patient’s GP help you with their discharge?

Obviously not all patients will need their GP directly contacted at discharge (thank goodness, you say!). But here are a few groups of patients who can really benefit from their hospital doctors connecting with their community doctor via phone:
• anyone who has been started on a new medication which needs close monitoring, e.g. Warfarin
  • There was a recent coronial inquest into the death of an elderly lady who was sent home on newly prescribed warfarin for AF. A discharge letter was typed and posted to her GP but no phone call made. The patient was told to see her GP in a few days for INR monitoring but did not follow through (did she understand the request? Did she hear the request? Was she capable of listening to instructions at the time of discharge?). She had a fall at home 2 weeks later, sustained a subdural haemorrhage and died with an INR of 12. Her discharge summary arrived at the GP’s office 3 days after her death.

• the patient who has received a very significant new diagnosis, eg end-stage metastatic cancer
• the patient who has had a stillbirth or early neonatal death
• the patient who is being admitted to a nursing home for permanent placement
  • not all GPs provide nursing home visits so a new GP may need to be organised at short notice

• in a situation where you’re not sure if the patient fully understands their diagnosis and new management and you want someone to check in with them; their regular trusted GP can be a real asset in this setting
  • sometimes patients get a bit frazzled in hospital
  • they may not comprehend what you’ve been telling them
  • some patients need a bit of hand-holding

Simple tips for calling a patient’s GP

1. Check you have the correct GP on file!

2. When you call, introduce yourself as “Doctor X” from “Hospital Z” and advise which patient you are calling about.

3. Indicate to the reception staff whether you need to speak urgently to the GP (or a colleague).

4. If it’s not urgent, indicate whether you:
   a. want a phone call back and when you are available,
   b. are happy to just have some information faxed over (be specific about what you’re after).

5. Be succinct when you call bearing in mind that if you are put through directly we will often be in the middle of a consultation.

Finally, we know that as Interns and Residents you are busy. We know that large demands are placed on you. GPs don’t want to make your life harder. We want to help you be more efficient and accurate in your information collection. Most importantly we want to be included in the management of our patients when they come to you for help
because we know that a team-based approach is best for everyone. Pick up the phone - we promise not to bite!

ABC News: Warfarin patient's death could have been prevented, inquest told (7 April 2015)

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