

where there are no resident neurologists, general physicians care for these.¹ In one third, the diagnosis remains uncertain or is inaccurate.² With the new acute medicine curriculum, there is limited scope for trainees to rotate outside the prescribed core specialties, and this is a potential training flaw.

The previous acute medicine specialist registrar rotation in Wales had a six-month 'elective period' for trainees to pursue other medical interests. One former acute medicine trainee (LA) spent two months of his 'elective' on attachment in a tertiary hospital neurology unit. The attachment included weekly participation at four outpatient clinics (neurovascular, epilepsy, rapid access and general neurology); neurophysiology and neuroradiology sessions, inpatient ward work and seeing urgent referrals from primary and secondary care. The case mix encountered is described in Table 1.

This experience has been invaluable in this former trainee's current role as a consultant acute physician, part of which is in

the ambulatory care unit of a small district general hospital where, in eight months, 40% of the 730 patients seen were referred with a neurological problem. Of these, acute onset headaches were the biggest group (30%) and transient ischaemic attacks and first seizures accounted for 20% each. Of those presenting with acute onset headaches, the most common diagnosis (in one third of headache cases) was migraine.

Incorporating neurology into acute medicine training programmes is extremely useful. It helps the non-neurologist handle the immediate issues more confidently, and to refer appropriately. The increasing use of thrombolysis for acute stroke will only increase the demand for front-line clinicians who are confident in the diagnosis of acute neurological deficits.

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LES ALA

*Consultant acute physician, Cwm Taf LHB,
South Wales*

TOM HUGHES

*Consultant neurologist,
University Hospital of Wales, Cardiff*

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The preference of general practitioners for structured outpatient clinic letters

Background

Clinic letters are the primary method of communication between the hospital specialist and GP. Letters convey advice on management and are also an important part of the clinical record providing a summary of the consultation. Despite this, very little is known about the style of letters written by most hospital specialists (including dermatologists) and the preferences of GPs.

Some hospital specialists advocate the use of structured clinic letters, which include a list of diagnoses and problems with investigations, treatments and follow-up under subheadings. A growing body of evidence shows that GPs prefer to receive structured clinic letters from hospital specialists including paediatricians^{1–3} and orthopaedic surgeons.⁴

The aim of this study was to find out whether GPs prefer to receive structured or unstructured clinic letters from dermatologists.

Method

An electronic two-question questionnaire was sent to all general practice managers in

Table 1. Cases encountered during attachment in tertiary hospital neurology unit.

Conditions seen in outpatient department clinics	Conditions seen on neurology ward
<ul style="list-style-type: none"> • Acute disseminated encephalomyelitis • Benign intracranial hypertension • Benign positional paroxysmal vertigo • Traumatic brain injury 	<ul style="list-style-type: none"> • Anterior spinal artery infarct • Acid Maltase deficiency • Benign intracranial hypertension • Chronic inflammatory demyelinating polyneuropathy
<ul style="list-style-type: none"> • Cerebellar paraneoplastic syndrome • Cerebrovascular disease • Epilepsy and other causes of seizures • Guillain-Barre syndrome • Hereditary spastic paraparesis • Headache (variety of diagnoses) 	<ul style="list-style-type: none"> • Cranial nerve (isolated) palsies • Carotid artery dissection • Epilepsy and pseudoseizures • Guillain-Barre syndrome • Headache (variety of diagnoses) • Idiopathic sensory axonal neuropathy
<ul style="list-style-type: none"> • Mononeuritis multiplex (Churg Strauss syndrome) • Multiple sclerosis • Migraine • Motor neurone disease • Neurosarcoidosis 	<ul style="list-style-type: none"> • Leukoencephalopathy • 'Locked in' syndrome • Multiple sclerosis • Normal pressure hydrocephalus • NMDA-antibody-mediated encephalopathy
<ul style="list-style-type: none"> • Neurofibromatosis type 1 • Occipital neuralgia 	<ul style="list-style-type: none"> • Neuroendocrine tumour • Progressive multifocal leukoencephalopathy • Paraproteinaemic neuropathy • Spinal dural arteriovenous fistula • Stroke (post thrombolysis) • Transverse myelitis
<ul style="list-style-type: none"> • Peripheral neuropathy • Parkinson's disease • Syncope • Venous sinus thrombosis 	

Table 1. Response to the question ‘How long would you typically spend reading a clinic letter that had been sent to your surgery from secondary care services?’

Less than 30 seconds – n (%)	45 (29)
Between 30 seconds and one minute – n (%)	77 (49)
Between one minute and two minutes – n (%)	28 (18)
More than two minutes – n (%)	7 (4)
I am not required to read clinic letters	0

Oxfordshire asking them to distribute it to GPs at their practice. One month was allowed for completion during which reminder emails were sent.

Respondents were shown two letters, one structured and the other unstructured (Fig 1), and asked which they would prefer to receive if the fictional dermatological patient described was registered at their practice. The letters had an equivalent word count (approximately 120 words) and differed only in the format and language used to describe the investigations, treatments and follow-up. We also asked how long a GP would typically spend reading a clinic letter offering a choice of five responses (Table 1).

Results

One hundred and fifty-seven GPs completed the survey including 123 partners, 26 salaried GPs and eight trainees (ST1 and above), amounting to one third of the approximately 450 GPs registered with the primary care trust at the time of the study. One hundred and forty-nine of the 157 GPs

(96%) preferred the structured letter. One hundred and twenty-two GPs reported that they spend less than one minute reading a clinic letter (78%, Table 1).

Discussion

This survey demonstrates that GPs in Oxfordshire have a clear preference for structured dermatology clinic letters. This finding confirms the results of surveys in other specialties.¹⁻⁴ This study also highlights how little time GPs typically spend reading letters.

The findings are limited by the sample size which represents only one third of the eligible population so response bias may have exaggerated the preference for the structured letter. We cannot validate the GPs' estimate of the time they spend reading clinic letters; however, the result is consistent with our experiences of general practice.

We did not examine the reasons why GPs prefer the structured letter but the limited time that a GP has to read a letter may explain the preference for this format. It is

likely that headings and lists make a letter easier and quicker to read. With the current trend towards management of evermore complex diseases in the community, concise and clear communication between the physician and GP is vital. We propose that our dermatological patient would be representative of many of the patients managed by physicians across a range of specialties and the preferences of GPs in Oxfordshire would be representative of GPs across the NHS.

Trainees in our department are encouraged to use the structured format in clinic letters with subheadings for diagnosis, investigations, management and follow-up. Nevertheless, an internal audit demonstrated that only one half of the doctors in our department write structured letters. With such strong support for the structured clinic letter, dermatologists and other hospital specialists need to re-examine the format of their letters.

TOM PARKS

Academic FY1, Oxford University Clinical Academic Graduate School, Oxford

EMILY KINGHAM

GP registrar, School of General Practice, Oxford Deanery Postgraduate Medical and Dental Education, Oxford

DIANA MCEWEN

GP registrar, School of General Practice, Oxford Deanery Postgraduate Medical and Dental Education, Oxford

SUE COOPER

Consultant dermatologist, Department of Dermatology, Churchill Hospital, Oxford

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Fig 1. Examples of structured and unstructured letters.