

How to do a good hospital discharge

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Consider a discharge of a patient from hospital (be it a ward or emergency department admission); what is the goal? You are trying to achieve a smooth transfer of care from the hospital team to the general practitioner. Thus, this article has an alternative title:

"How not to annoy the general practitioner with hospital discharges"

As a hospital JMO (the "turf~~er~~"), discharging a patient back into the community is often a relief. For the general practitioner who is on the receiving end (the "turf~~ee~~"), there can often be many things that are frustrating and annoying. Having worked on both sides of the system, this article is about how to discharge patients without annoying the general practitioner (too much), and thereby, improving continuity of care.

(1) Discharge summaries

I hated doing discharge summaries as an intern and resident ... especially of a general medical patient who had been for weeks, unwell with no firm diagnosis, has had dozens of investigations and in the end, improved for no particular reason. However, they are nevertheless a vital link for continuity of care and they should be done before the patient has a chance to see their general practitioner. Optimally, the patient should be given the letter on discharge so that they can hand deliver the letter to the GP (the accuracy of the stated local medical officer in hospital records is often poor and patients more often than not may change their minds).

Just as patients are sometimes rather clueless to their medical history in the emergency department, they are equally unclear about what happened to them in hospital after an admission. In general practice, I have had patients present after discharge unsure why they went to hospital, what the diagnosis was, what happened, who they were admitted under or what medications they are on now (except that it has "changed"). Remember that in private practice, a GP is not paid for the time spent chasing results and calling for clarifications.

Even a perfunctory discharge letter is better than none at all, though of course, please aim for excellence!

(2) Discharge medications

The reality of most hospital admissions is that the patient's regular medications are changed. A discharge letter (or at least, a discharge medication list) is of enormous help as the general practitioner often needs to educate the patient on their new medications, check for side-effects, and write a new prescription.

TIPS:

- Give a discharge letter or printed discharge medication list to the patient;
- supply enough medications (or a script) so that the patient can see their regular GP (rather than being forced to a medical centre);
- please try to give the generic names of medications;
- try to avoid unnecessary authority drugs as they are **annoying** for the GP (e.g., choosing metoprolol over carvedilol);
- avoid discharge medications that do not fulfill PBS indications (see below);
- avoid discharging patients on regular benzodiazepines and opiates.

PBS indications:

For example, a patient intolerant of a non-selective NSAID (non-steroidal anti-inflammatory) may well benefit from a COX-2 inhibitor like celecoxib. However, the PBS indications for celecoxib is specifically for symptomatic treatment of osteoarthritis or rheumatoid arthritis only. Specifically, the PBS does not fund its use for soft tissue and muscular pain.

Worse is the use of atypical antipsychotics (e.g., olanzapine, risperidone, quetiapine) for delirium or agitation. Although these are useful agents for these conditions, the specific PBS indications are only for schizophrenia and the maintenance of bipolar affective (I) disorder. Furthermore, these are medications that require an authority, i.e., the general practitioner has to call Medicare Australia. Discharging a patient from hospital on these medications not for a PBS approved indication means that you either expect the patient to pay privately (for which they should be informed of such) or expecting the general practitioner to lie to Medicare Australia (which is unreasonable and unethical).

(3) Discharge investigations and follow up with specialists

If a patient on discharge requires an urgent (but elective) investigation (e.g., gastroscopy and colonoscopy), it is usually much easier for this to be arranged while they are an inpatient, compared to the GP from his rooms. Again, remember that the GP does not get paid organising outpatient investigations. This is particularly annoying when a test or intervention is in demand and the GP has to ring around to try to find someone available to perform it, especially if the patient cannot afford it to be done privately.

(4) Social supports

Hopefully, with good discharge planning, the patient is well supported by community teams or family when they arrive home. When this does not occur, it is usually the general practitioner who has to pick up the slack as a matter of necessity. Again, the nature of private practice usually means that there are barriers to arranging services like home nursing.

Please try to ensure patients are not being discharged into a void.

(5) Call the general practitioner

For patients who are complex and in danger of being a disaster once unleashed to the community, give the local medical officer a buzz! I would very much like to know ahead of time and the two minutes of the history of the recent illness over the phone is probably worth more than a thin discharge summary.

You may learn a few things as well (e.g., perhaps the GP has never heard of the patient before, or that they are on holidays), thus giving you time to modify your discharge plan.