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Referral letters from General Practitioners to Hospitals in Sri Lanka; Lack information and clarity

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Abstract

Background: Referral of patients to hospitals, specialists and other institutions is an essential part of primary health care. In many instances the referral letter is the sole means of communication between general practitioners (GPs) and specialists/hospital doctors. This study was planned to assess the quality of referral letters sent by general practitioners to out patient departments (OPD) of hospitals.

Methodology: This descriptive cross sectional study was conducted in four hospitals of different levels of care provision in Sri Lanka. Referral letters received by the OPDs during a period of 2 weeks were analyzed. A check list to extract data was developed based on the items of information expected in a referral letter and legibility. Each item was assigned a score. This scoring system was validated using a panel of experts by means of Delphi method. Maximum score possible for a letter was 30.

Results: A total of 461 letters were analyzed. Items of information most often present were; to whom referred (96.7%), symptoms (91.5%), reason for referral (90.2%) and date (88.9%). The least often present items were; family history (0.2%), history of allergy (1.1%) and social history (1.7%). Most of the words were not legible in 42.3% of the letters.

Median score of the sample was 16 (mean=15.69)

Mean score of structured form letters was 18.61 (n=33) and in conventional letters it was 15.53 (n=428). The observed difference was statistically significant ($z=-3.544$, $p<0.01$).

Discussion: Most of the letters did not have the required information and legibility was also poor. Expected benefits of a referral letter to the patient, recipient and the referring doctor will not be achieved due to these short comings. Form letters were comparatively better. Measures should be taken to improve the content and clarity of referral letters.

Key words: Quality, Referral letters, General practice

Background

Referral of patients from primary care institutions to hospitals and specialists is an essential and inevitable aspect in patient management. Primary care doctors refer patients when therapeutic or investigation options are exhausted or when opinion or advice is necessary from specialists(1). Indication for referral could be routine (thyroid goiter), urgent (carcinoma of thyroid) or emergency (hyperthyroid crisis).

In the process of referral, written communication in the form of referral letters are the standard and in many instances the sole means of communication between general practitioners and their hospital colleagues and specialists(2,3,4). A referral letter reflects the diagnostic skills, communication skills, professionalism and courtesy of a doctor(5). It is also important as a medico legal document(5).

Advantages of referral letters are that they save time for clinicians as well as patients; reduce unnecessary repetition of investigations and decrease poly pharmacy(3,6). They help avoid patient dissatisfaction and loss of confidence in general practitioners(3). More importantly referral letters reduce health care costs for the patient and the state(2). Clarity and easy retrieval of information are also essential features of a good referral letter. Therefore a good command of the language and letter writing skills are vital in order to produce a quality referral letter.

Studies worldwide have demonstrated a paucity of relevant information in referral letters and therefore dissatisfaction among specialists(4,6). Time constraints(6) and lack of secretarial support(4) have been presented by primary care doctors as reasons for incomplete and badly written referral letters.

All details that are pertinent for patient management need to be included in the referral letter. This includes details regarding the presenting problem, examination findings, investigation results as well as the management up to the point of referral. Similarly the family doctor who has provided continuity of care to his patients will be privy to such details as past medical and surgical conditions, family history, social history, allergies, co morbidities and the treatment the patient is on.

The Sri Lankan setting is such that a referral letter from a primary care doctor is not a requirement to consult a specialist neither it is necessary for hospitalization. The frequently encountered scenario is that the patient had been instructed verbally to either get admitted to hospital or consult a specialist. Despite the relatively widespread availability of quality health care and good health care indicators, Sri Lanka lacks a referral/back referral system.

It must be stressed that referral letter writing skills have been included in the undergraduate curricula of most medical schools in Sri Lanka and is a frequently examined skill. Also all postgraduate curricula in family medicine recognize the importance of writing an appropriate referral letter. But in practice, there are no guidelines available as to the standard expected and what items of information to include in the referral letter. Thus the variables included in referral letters vary widely without adherence to any particular format making them operator dependent. Also most of the referral letters are written by hand and there hasn't been much emphasis on structured referral letters.

This study was planned to assess the quality (information content and legibility) of the referral letters issued by general practitioners to out patients departments of government hospitals in Sri Lanka.

Methodology

This descriptive cross sectional study was conducted in the outpatient departments (OPD) of four hospitals in the western province of Sri Lanka. These hospitals belonged to different levels of care provision, namely the National Hospital of Sri Lanka, a Teaching Hospital, a District General Hospital and a Base Hospital. Referral letters sent by primary care doctors to the OPDs during a period of two weeks were included in the study.

A check list was developed to extract data from referral letters. To ensure face validity, the content items of the check list were generated from extensive review of literature and guidelines(2,3,7,8,9,10,11). Only the items of information essential to ensure high quality patient information transfer were included. Advice was sought from written communication experts also. Legibility of the letters was also included in the check list. Initially each individual item in the check list was assigned a score. The sum of these individual scores represented the overall value of the letter. Next, this scoring method was validated by a multidisciplinary panel of medical experts (comprising family physicians, a general physician, a paediatrician, a general surgeon and a community physician) by means of Delphi method. They were invited to provide comments and suggestions as how important was each item and an individual score. According to the suggestions of the panel scoring method was finalized. The highest possible score for a letter was 30 (Table 1). The significance of the observed differences was determined using Wilcoxon Signed Ranks test.

Results

A total of 464 letters were systematically assessed in the study. Of these 33 (7.2%) were structured form letters and 52 (11.3%) letters were written by doctors with post graduate qualifications in family medicine.

Legibility of letters

All words were legible in 11% of the sample and most words were legible in 47%. Most words were illegible in 42% of the letters

Score

The score for each individual item in each referral letter was totaled to provide the total score for each referral letter and this value ranged from 6/30 to 24/30. The mean score

Item of information	Score
Presenting problem/ History	2
Examination findings	2
Probable diagnosis	2
Investigation for current condition	2
Treatment for current condition	2
Reason for referral	2
Patients name	2
Address of GP	1
Email/Tel No of GP	1
Date	1
To whom Referred	1
Allergy History	1
Patient's age	1
Co- morbidities/PMH	1
Treatment for co-morbidities	1
Social history	1
Family history	1
Name of GP	1
Signature	1
Qualifications of GP	1
Legibility 3- all words legible 2- most words legible 1- most words illegible	3
Total score(maximum)	**30**

Table 1

of the referral letters was 15.97, whilst the median score was 16. The following graph shows the frequency distribution of the referral letters according to the total score.

There was no significant difference (p=0.968) between letters written by doctors with post graduate qualifications in family medicine and those who have the basic degree.

Discussion

The focus of this study was the content and the legibility of referral letters issued by primary care doctors and it did not evaluate the appropriateness or accuracy of the content presented in the referral letters.

This sample was collected from 4 hospitals of different levels which included the National Hospital of Sri Lanka which is the premier tertiary care hospital in the country and another tertiary care hospital (provincial general hospital) and two secondary care hospitals (District general hospital and a base hospital). These four categories of hospitals represent the main referral destinations in the government health care system.

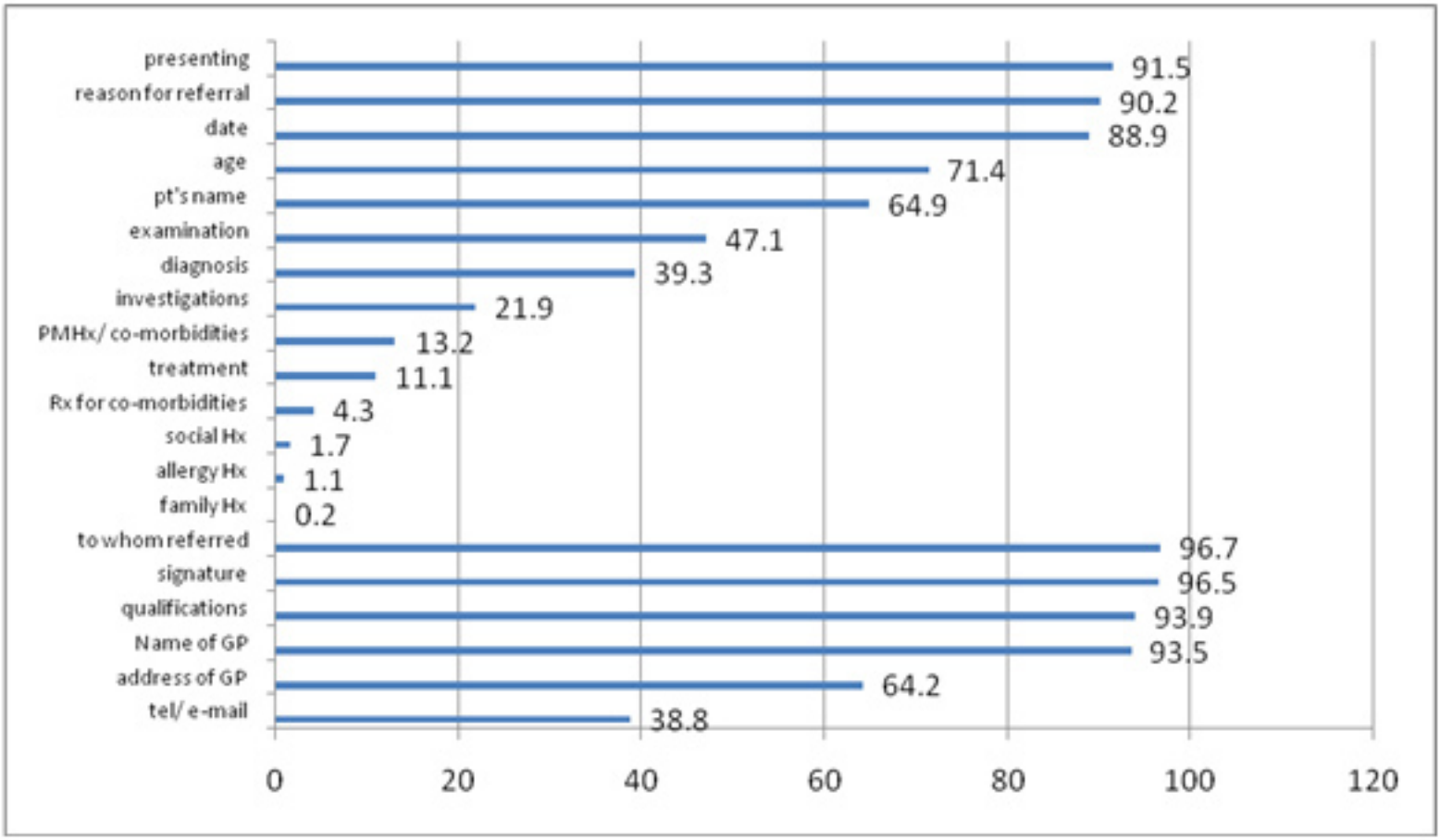
The small number (7.2%) of referral letters as structured (form) letters show that such formats are not widely used by general practitioners. In Sri Lanka post graduate qualification in family medicine is not a requirement to commence a general practice and the majority of the primary care doctors do not have such a qualification. This explains the fact that only 11.3% of the letters were written by doctors with a post graduate qualification in Family Medicine.

Primary care doctor's name, signature and qualifications were present in more than 90% of the letters while the address and telephone number/email were available in 64.2% and 38.2% letters respectively. A similar study conducted in South Africa revealed that demographic data of the doctor were present in more than 90% letters(11) The relatively high representation of the GPs demographic data compared to the data pertaining to the patients can be ascribed to the fact that most of referral letters were on printed letterheads and the fact that the rubber stamps bear the demographic details of the GP.

The name of the patient featured only in 64.9% and this is a cause for concern because on a referral letter, there should be the link between the patient's identity and the ensuing details. It helps to avoid medical errors and ensure patient safety(12).

The date and time of a referral letter is a useful indicator of the time duration from the referring to the receiving doctor, enabling proper evaluation of the patient's clinical condition and its progression. In this study date was present in 88.9% of the letters. Failure to reflect the date on which the referral was written could make it difficult for the receiving doctor to obtain an insight into the patient's condition at the time the referral letter was written.

The presenting problem featured in more than 90% of the letters, but findings of the clinical examination which forms a vital part of a consultation was present only in 47.1%. A referral letter without physical examination deprives the recipient of the patient's clinical picture at the time of the referral. Investigation for the current condition was mentioned only in 21.9% the letters. Non inclusion of investigation details could lead to unnecessary repetition of the same investigations, delay in diagnosis and treatment. The diagnosis was not mentioned in more than 60% of the letters. Paucity of information on the diagnosis could be an indication of the undifferentiated nature of the



Graph 1: Presence of Information in referral letters

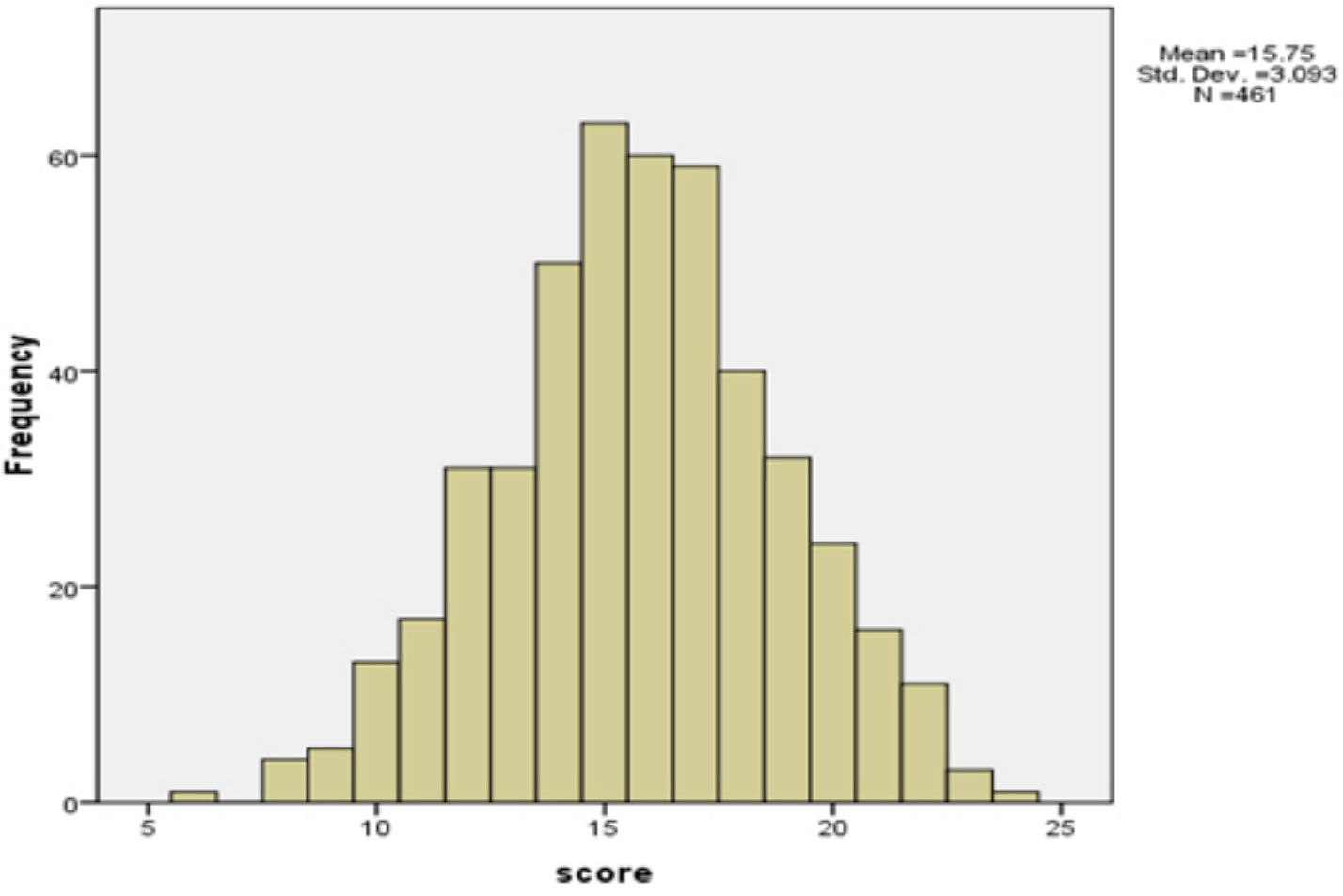
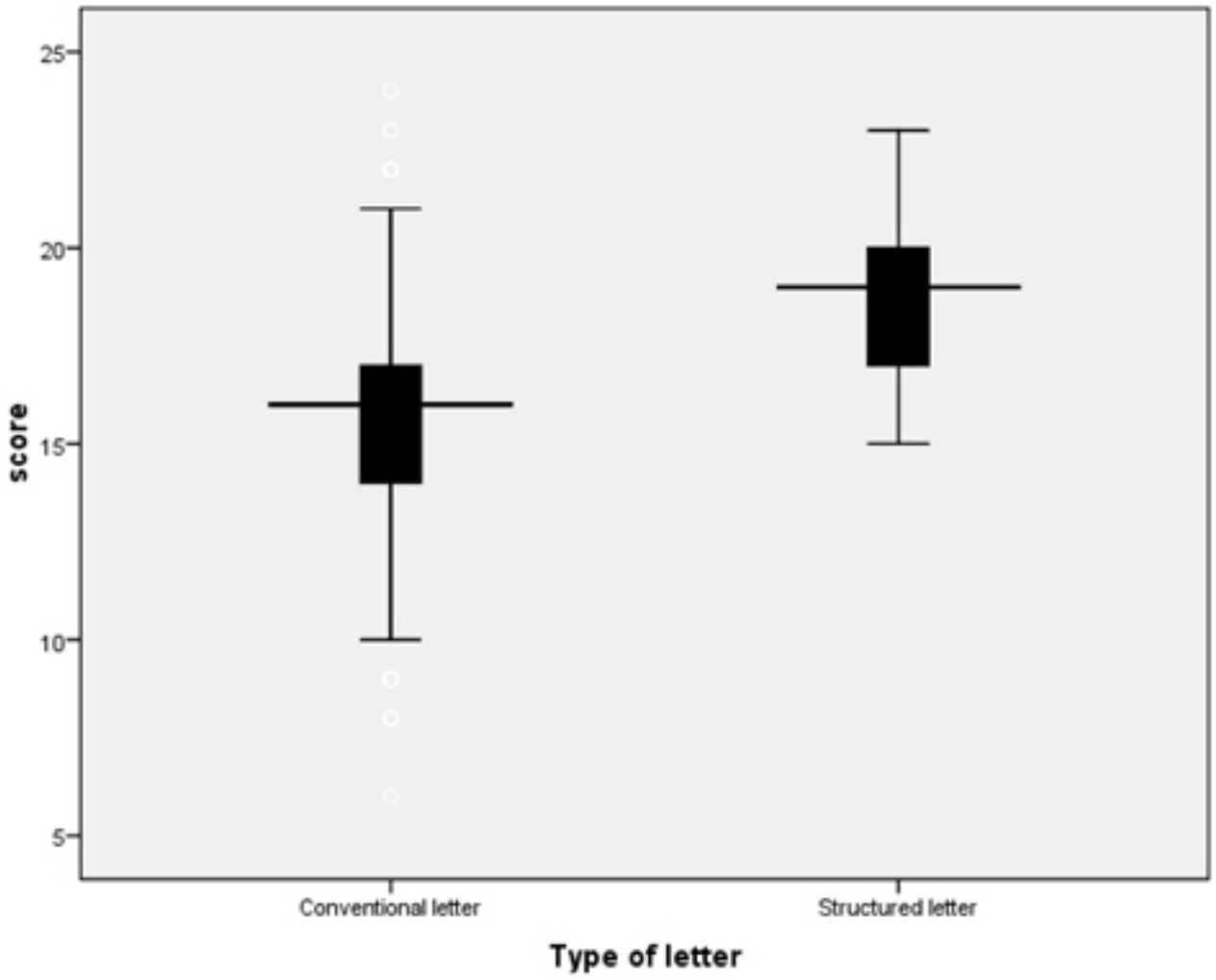


Figure 1

Structured letters vs conventional letters



P<0.01 Based on Wilcoxon signed rank test
Figure 2

patients encountered in a primary care setting. But if the GP can include probable diagnosis/ses it would have been useful for the recipient since it guides him/her as to the idea of the referring doctor.

There is a paucity of information regarding treatment received for the current condition (11.1%), treatment for co morbidities (4.3%) and allergies (0.7%) which could compromise patient care. Patients may not know details of management given to them prior to the referral. Lack of records in this regard could lead to a patient receiving an over-dosage as a result of receiving the same medication at the receiving healthcare institution. It is important to document the treatment modalities that have already been tried, but failed in the patient who is being referred. This will prevent repetition of useless medication/procedures incurring cost and losing time.

Family history and social history were reported in referral letters very rarely. Reluctance to spend time on writing these details and underestimation of the importance of this information are possible reasons for these omissions.

This study found that the reason for referral was reflected in 90.2% of the letters. Stating the specific reason for referral creates an impression in the receiving doctor as to what should be done for the patient.

The finding that only 11% of the letters were fully legible and 42% mostly illegible, is of grave concern. This is a much higher rate than that described in studies conducted in the western world(11,12). However much detail the referral letter contains, the secondary level carers will not be able to retrieve any of that information if the referral letter is illegible and will get frustrated. Winslow et al stated that illegible hand writing is an important cause of waste and hazard in medical care(12).

The sum of scores ranged from 6 -24 out of 30 and the mean score was 16. A significant proportion of the letters scored less than 15 which shows the inadequacy of the information provided by the primary care doctors. It is worthwhile to explore the reasons for not providing adequate information and poor legibility.

It is understood that all the items of information included in the check list cannot be expected in all the referral letters. But even the items of information which should be present (date, name and age of the patient, presenting problem, reason for referral and details pertaining to the referring doctor) were absent in many letters. Information most often present was pertaining to the referring doctor.

Structured form letters were of better quality. Literature shows that structured letters are better compared to conventional letters in several aspects(14-18). A structured letter forces and reminds the writer to attend to all identified and listed items which improves the quality of contents. It helps retrieval of information and saves time of both the writer and the reader. According to Jenkins and colleagues(16) they are shorter but contain more information than non structured letters. Couper and Henbest reported an improvement in the quality of referral letters after the introduction of a form referral letter(19). Therefore general practitioners should be encouraged to use structured form letters for patient referral.

It is a concern that letters written by doctors with post graduate training in family medicine were not significantly better than those without a postgraduate qualification. It is worthwhile to look at the curricula of these training programmes and revise those to strengthen letter writing skills.

Transferring adequate patient information accurately on the referral letter is essential for provision of high quality of care. Improving the contents and legibility of referral letters offers the opportunity to improve continuity of care, conservation of resources and prevent delays in diagnosis and treatment. It is also an opportunity to prevent communication and coordination problems between the referring GPs and the hospital doctors and specialists.

Conclusions

1. This study shows the deficits in communication and information transfer between primary care doctors and hospitals.
2. It demonstrated that referral letters lacked information and clarity
3. Structured form letters were of better quality
4. There was no difference in letters written by doctors with and without a post graduate training in family medicine.

Recommendations

1. Reasons for not providing adequate information should be explored.
2. Post graduate training programmes should be designed to enhance the capability of referral letter writing skills.
3. More emphasis should be given for both undergraduate and post graduate training programmes on information transfer.
4. Doctors should be encouraged to use structured referral letters and computer generated letters.

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