

REFERRAL LETTERS AND REPLIES

Can we do better?

Consultants in referral hospitals regularly complain about the poor quality, or absence, of referral letters. This has been the subject of numerous journal articles. Equally, however, peripheral practitioners complain about the poor standard of responses received from these hospitals and the frequent lack of any reply letter. Consulting doctors often do not read referral letters, do not understand the problems of the patient outside the teaching hospital and do not keep the referring doctors up to date¹.

Using Medline searches, a review of the literature on this subject was conducted. The aim of this paper is to present a summary of the findings from the literature surveyed.

Referral letters

Communication between primary care practitioners and specialists has been extensively investigated, though largely in terms of referral letters, rather than replies. Furthermore, referral letters have been studied almost exclusively from the point of view of those receiving the letters.

Authors stress the importance of good referral letters, but there is much disagreement over the quality of letters and what their content should be. This makes the establishment of norms difficult, but aggregating the literature one can list at least some core features which should be present in every referral letter: relevant history (subjective findings); clinical examination (objective findings); relevant past events; any past or present management or medications; and provisional diagnosis¹⁸. In addition, referral letters should pose questions to the specialist for which answers are being sought²³ or give a reason for referral¹.

Only two South African studies could be found in which rating of referrals was done. In a six-month study on referrals to the Red Cross War Memorial Children's Hospital, Lachman and Stander⁵ assessed letters according to the presence, absence or completeness of five attributes similar to the ones mentioned. A total of 1143 letters was analysed. Only 5% of letters had all five attributes and 59% had fewer than three present⁵.

Meiring and Van den Berg⁶ looked at 219 referral letters to the emergency unit at the HF Verwoerd Hospital. They found that 9% of letters had no provisional diagnosis and 74% had no history whatsoever⁶.

Possible reasons cited for the varying quality of referral letters are the workload of referring doctors, the lack of understanding of the need for comprehensive details about the patient and the lack of contact between the hospital and the referring doctor⁵. De Alarcon and Hodson⁷ suggest that there is a reluctance to commit oneself arising out of the practice of deriding general practitioners' letters commonly found at teaching hospitals. The usual anonymity and variability of the receiving practitioner gives little incentive to the general practitioner to maintain a good standard of correspondence⁸.

It is difficult to pinpoint the cause of the problem of poor quality, because it is something of a chicken-and-egg situation. Disillusioned general practitioners ask fewer questions because they have not received answers in the past⁹. On the other hand, perhaps a long exposure to poor referral letters has taught some hospital doctors to save their time by ignoring them¹.

Any solutions?

A number of authors recommend the introduction of a pro forma in order to improve the quality of referral letters^{6,8,15}. These structured letters are advocated to ensure conciseness and the inclusion of the relevant information^{8,14}.

The strong statements in favour of such pro forma letters are made without evidence from research. No study could be found

comparing such letters to non-structured ones. One study asserted that stylised letters of referral have been shown to be more likely to be useful in conveying the basic information necessary in a referral letter¹⁰, but no data were presented to support this. The author's own research (see below) showed that a pro forma letter does indeed improve the quality of referral letters¹⁵.

No medical schools teach the art of letter writing, so the presence of a form, to remind the referring doctor of what the contents of a good referral should be, is valuable.

Training and experience may be thought to be a solution to the problem of variable quality of referrals. Lachman and Stander¹⁶ argue that the solution to the problem of poor referrals lies in the role the receiving hospitals should play in supporting, supervising and guiding referring doctors. Again, however, there appears to be no evidence for this.

Reply letters

The literature concerning reply letters is much more scanty than that on referrals and is, it seems, largely based on conjecture. Although disenchantment with the level of attention paid to general practitioners' letters and poor discharge communication is common⁸, most studies do not attempt to look at reply rates or quality of replies.

It has been noted that specialists' replies can be irritating, discourteous and belittling¹. Medical staff writing replies often fail to realise that in writing to general practitioners, they are usually writing to doctors who know more about the patient than they do and often who are more experienced than they are⁹. This is borne out by one study in which half of the hospital consultations were found to be performed by junior registrars¹⁷.

The root of the problem of poor replies probably lies in the attitude of many receiving hospital staff who think in terms of a specialist service rather than a consultative one. They provide all the serious medical diagnosis and care patients are going to get; that is, they see their job not as assisting in providing care but as providing it exclusively⁹.

A few opinion articles have appeared in the literature indicating what should be included in a reply letter. All were written by teaching hospital-based doctors^{3,9,18,19}. Only one study was found in which the opinions of general practitioners were surveyed to find out what they want from a reply letter²⁰.

It is suggested that the minimum ingredients of reply letters are: a primary diagnosis or assessment (with relevant events since or revisions of diagnosis if applicable); a review of the position at this visit (description of findings, including investigations if relevant, and any treatment given); and a plan for the future, that is, opinion, prognosis and management plan^{3,18,19}.

Jacobs and Pringle¹⁷ looked at how often these essential items were present. In a study of 288 letters, they found that 82% included a primary diagnosis or assessment of the findings, 53% included a description of any interventions or investigations and 89% discussed a management plan for the future. In the author's own research, all three items were present in 73% of reply letters, but 15% of replies had only one of them.

With regard to the function of replies, there does seem to be consensus on the fact that an important function of the reply letter from the specialist or teaching hospital should be education. In any consultation the specialist or registrar may be in a position to offer advice which could help to avoid such a referral in the future, provide information on new advances and explain any obscure diagnoses or complications¹. However this is probably the most neglected route of general practitioner education¹.

Is a pro forma letter also a solution to the problem of inadequate replies? Only one advocate could be found for the introduction of a pro forma letter to improve the quality of replies¹⁹!

The link between referrals and replies

Is there a link between referrals and replies? Two studies were

found which sought to explore this scientifically. In the only South African study, Lachman and Stander⁵ examined the quality of referral letters and the influence of this on the writing of replies. Letters with four or more attributes (out of five) were replied to 1.6 times more often than letters with fewer than four attributes. The reply rate was 43% for the former group and 27% for the latter. They conclude that detailed referral letters improved the response of hospital doctors, but admit that this response is still low⁵.

Jacobs and Pringle¹⁷ found that the quality of referral letters and replies was not related. The content of both referrals and replies was felt to be unsatisfactory, but interestingly they found that the content of replies was significantly better amongst those written by junior doctors compared with those written by consultants¹⁷.

In order to explore any link, in 1991 a study was made of all replies received to referral letters written by general practitioners working in the Manguzi Hospital Outpatients' Department, who refer to hospitals in Empangeni and Durban. During the period of the study, a printed pro forma letter was introduced, which included space for replies.

A total of 254 referral letters was analysed; 112 before the introduction of a pro forma letter and 142 after. There was a reply rate of 48% before and 40% after the introduction of the pro forma letter.

The quality of a letter was scored on how many of the essential ingredients described in the literature were present. Mean scores for referral letters before and after the format change were compared and showed a significant improvement in the quality of the referral letters. However, the introduction of the pro forma letter had no significant effect on the quality of reply letters, nor on the reply rate. Furthermore no correlation was found between the quality of referral letters and replies.

Improvement in the quality of replies is thus unlikely to be brought about by improving the quality of referral letters. Whether the converse is true or not, that is, whether improving the quality of replies could bring about improvements in the quality of referrals, would be more difficult to assess.

It is somewhat surprising that the reply rate did not improve after the introduction of a pro forma despite the presence of the reply section in the pro forma and a request for a reply. This indicates that the initiative may need to come from within the receiving hospital for the introduction of pro forma reply letters, or other measures. Also, it implies that any attempts to improve the quality of replies initiated by the referring doctors are unlikely to succeed.

Where a personal relationship existed between Manguzi Hospital doctors and consultants running referral clinics at Ngwelezane Hospital, the reply rate was much higher than the rate from any other clinic or hospital. Perhaps the way to improve the rate of replies would be to increase the amount of personal contact consultants have with the periphery by ensuring regular specialist visits to rural hospitals.

A reply is often the only form of continuing medical education that a rural or peripherally located medical practitioner may receive. One would expect teaching hospitals to make full use of the opportunity. Instead only four out of 111 replies included any specific update comments or continuing medical education.

Academics often bemoan the standard of care in the periphery; by replying more frequently and in more detail they may be able to improve the standard of care and to decrease the number of referrals in the future¹.

Recommendations

1. Pro forma letters should be implemented as a way to improve the quality of referral letters. These should be drawn up in a consultative process between the centre and the periphery, which would further help to improve communication. Whether or not the use of these letters would improve patient care needs further research.
2. Secondary and tertiary hospital authorities should take steps to improve the reply rate of hospital doctors, rather than focusing attention on the problem of referral letters. Perhaps improving the reply rate may increase the number of referral letters received by teaching hospitals - that is a study which needs to

be done! One step that might be taken would be to introduce a reply letter form. Other strategies include the provision of dictaphones and adequate secretarial services so that typed reply letters can be produced at minimal cost in terms of doctors' time.

3. Another factor in improving the reply rate seems to be personal contact. Encouraging visits by consultants to rural hospitals, or vice versa, may have a significant effect on the reply rate in their clinics, apart from other positive benefits such visits may bring.
4. Education is thought to be one of most important roles of the reply letter. Strategies obviously need to be developed to ensure that the reply letter becomes a more worthwhile means of education than it is at present. This would probably mean that receiving doctors would need training to enable them to do this. Letter writing should be an integral part both of medical students' training and of postgraduate training. It would also require the teaching hospitals to make the vital attitudinal change of seeing themselves as centres not only of service but also of support and education for the periphery, as envisaged at Alma Ata²¹.

It is in the interests of our patients, of ourselves as general practitioners and specialists, and of the health service as a whole to improve the quality and degree of communication between referring and receiving hospitals and doctors. ●

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