AN INSIGHT INTO THE REFERRAL LETTERS RECEIVED AT PULMONOLOGY UNIT OF A TERTIARY CARE HOSPITAL

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ABSTRACT

Background: Referrals letters are an integral part of multidisciplinary approach to health care. Problems with quality and content of the referral letters have been documented in literature. The objective of this study was to study the content of referral letters received at Pulmonology unit of a tertiary care hospital.

Materials and Methods: This was a prospective study of the referral letters received at Pulmonology unit, Khyber teaching hospital Peshawar, from 1st Feb 2016 till 30th April 2016. Patient's clinical information (brief history and examination), specific reason for referral, and identity of referring doctor (name/designation) were considered minimum requirements of the referral letters. The data was recorded in a structured proforma, analyzed via SPSS-19 and the results were presented as table or figures.

Results: A total of 164 referral letters written on patient's charts were analyzed. Clinical history and examination was documented in 89.02% and 17.07% respectively, while specific reason for referral was mentioned in 42% only. Main reasons for referral included diagnostic problem (4.89%), therapeutic (37%), anesthesia fitness (12%), take over (10%), and interventions including pleural biopsy (5.4%), chest intubations (9.1%) and bronchoscopy (11.6%). Name of the referring doctor was missing in 87% of the letters. Conclusion: There is a need to develop a standardized referral letter with minimum essential information fields as the current referral practice needs improvement

Key Words: Clinical Audit; Multidisciplinary Approach; Referral letters

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INTRODUCTION

Multidisciplinary approach in health care has been well recognized across a wide range of clinical applications, including respiratory diseases. Evidence shows that clinical decisions taken by multidisciplinary teams are more parallel with evidence-based guidelines than decisions made by the individual healthcare professionals.[1] A multidisciplinary approach to health care may also results in reduction in mean duration of stay at hospital, greater patient satisfaction and a decrease in unplanned hospital re-admissions rate.[2]

Referral letters serve an essential mode of contact among different specialties and between general practitioners and specialists to ensure efficient and effective health care to the patients. Concise referral letters with sufficient information help the general practitioner, the specialist and the patient.[3] Three coordination events in the referral process have been proposed by Williams et al[4]: (1) the referring physician communicates the specific reasons for referral and relevant clinical information to the specialist, (2) the specialist completes the referral by sending back clinical findings/answer to the referring physician, and (3) the referring physician, specialist, and patient negotiate and continue the appropriate care.

Breakdowns in several aspects of referral process

have been documented in various studies. Referring clinicians commonly do not communicate relevant patient history and examination to the specialist, and when they do, the reasons for the referral are often missing.[5] Improper coordination may result in repeated or un-necessary investigations, missed or delayed diagnoses and treatments, adverse drug reactions , and increased risk of litigation.[6]

High quality referral letters with sufficient clinical information and specific question result in better reply letters and can also be used as a means of continuous medical education. Optimal communication between general practitioners (GPs) and specialists by referral letters, can be considered one of the indicators of good quality care.[7] Although previous studies have demonstrated problems in the quality of both referral and reply letters,[8] research in this field is scarce particularly at the national level. The purpose of this audit was to assess whether the content of referrals received at our unit meet the desired standards and to generate evidence for change if relevant to improve the current referral practice.

OBJECTIVE

To study the content of referral letters received at Pulmonology Unit from 1st Feb 2016 till 30th April 2016.

Materials and Methods: We conducted a prospective audit of the referral letters received at Pulmonology unit, Khyber teaching hospital Peshawar from 1st Feb 2016 till 30th april 2016. Patient's clinical information (history and examination), specific reason for referral, and identity of the referring doctor were taken as minimum requirement of the referral letter. Any comment in the referral letter related to the clinical history of a particular patient and examination finding was accepted as history taken and sign/s elicited. Specific reasons for referral included diagnostic dilemma, therapeutic problem, anesthesia fitness, take over and interventions including pleural biopsy, chest intubation, and bronchoscopy. Identity of the referring doctor was assessed by checking for the name with or without designation. The data was recorded in a structured proforma, analyzed via SPSS-19 and results were presented as table or figures.

RESULTS

A total of 164 referral letters from various clinical units, written on patient's charts were analyzed. Majority were sent from medicine department (32%), followed by surgery (26%), gynae (14%), orthopedics (3.6%), ENT (3.6%) and ophthalmology (2.4%) as shown in figure 01.

Clinical history and examination findings were documented in 89.02% and 17.07% respectively, while specific reason for referral was mentioned in 42% only as shown in table 01. Main reasons for referral included diagnostic problem (4.89%), therapeutic intervention (37%), anesthesia fitness before surgery (12%), take over patient management care (10%), and interventions including pleural biopsy (5.4%), chest intubations (9.1%) and bronchoscopy (11.6%) as shown in figure 02. Name of the referring doctor was missing in 87% of the letters.

DISCUSSION

Patient care hinges partly on good correspondence between the treating doctors. There has been problem with referral process worldwide. Referral and reply letters are common means by which doctors exchange information pertinent to patient care. Ensuring that letters meet the needs of letter recipients saves time, reduces unnecessary repetition of diagnostic investigations, and helps to avoid patient dissatisfaction and loss of confidence in medical practitioners.[9] Studies of referral letters have consistently reported that specialists are dissatisfied with quality and content of these requests. The concerns most often expressed are the frequent absence of an explanation for referral, medical history, clinical findings, test results and details of prior treatment.[10]

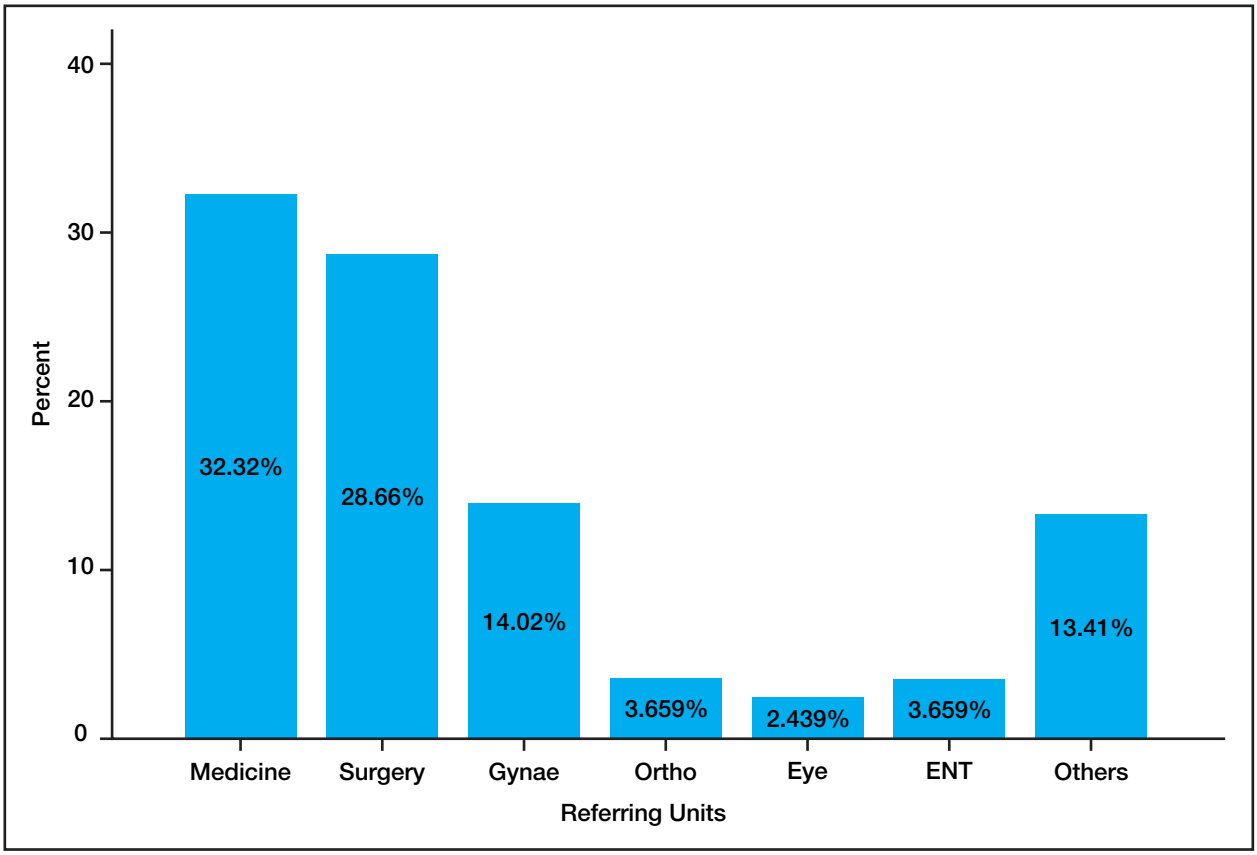
Brief clinical history was the best filled field of our referral letters, which was provided in 89% of the letters. Many other studies have reported different percentages i.e 29%, 31%, 62% and 87% depending upon the local practices.[11-14] In addition, the way how the history was assessed can also change the percentages.

Clinical signs were mentioned only in 17% of the

Table 1: Percentage of the individual parameters considered as the minimum requirement of a referral letter

S.NO	Parameters	Number of cases	Percentage
1	Brief history	146	89.02%
2	Examination findings	28	17.07%
3	Reason for referral	69	42%
4	Name of the referring doctor	22	13%

Figure 1: Percentage of referral requests received from various departments



letters which is far less than 79% reported by newton et al[15]This may hint towards inadequate assessment on the part of referring doctors. A limited audit was made of 103 consecutive new patients seen by one radiation oncologist in Sydney.[16] Of the 80 referral letters available, 95% reported the diagnosis, but only 56% provided a history of the current illness. Less than half the letters described the clinical findings or included information on medical history, social history, current medications or allergies. The author concluded that relevant and important information was not communicated in referral letters.[16]

Reason for referral was documented in 42% of our referral letters, which has been reported as 86%, 95% by Hansen et al, newton et al respectively.[13,14] Moreover, the reason stated included vague and non-clinical terms i.e. bad chest, shortness of breath, not maintaining oxygen.

None of the letter was written on structured /form letter which can improve the content of the letters.

Several authors have reported the use of form letters to enhance information content and communication in referrals from GPs to hospital and medical specialists.[17,18,19] Form letters are generally shorter but contain more information than non-form letters. Couper and Henbest reported an improvement in the quality of referral letters after the introduction of a form letter, but the quality of reply letters did not improve [19]. Dupont reviewed the information content of 600 referral letters to a dermatology outpatient clinic and proposed that a preferred form letter should be sent to GPs by the hospital department with the kind of information required.[20] The names and designation of the referring doctors were missing in 87% of the letters, probably due to informal approach.

CONCLUSION

Current referral practice is suboptimal and needs to be improved.

RECOMMENDATION

Structured/form letter may be designed for referral process to make sure the desired outcome is achieved.

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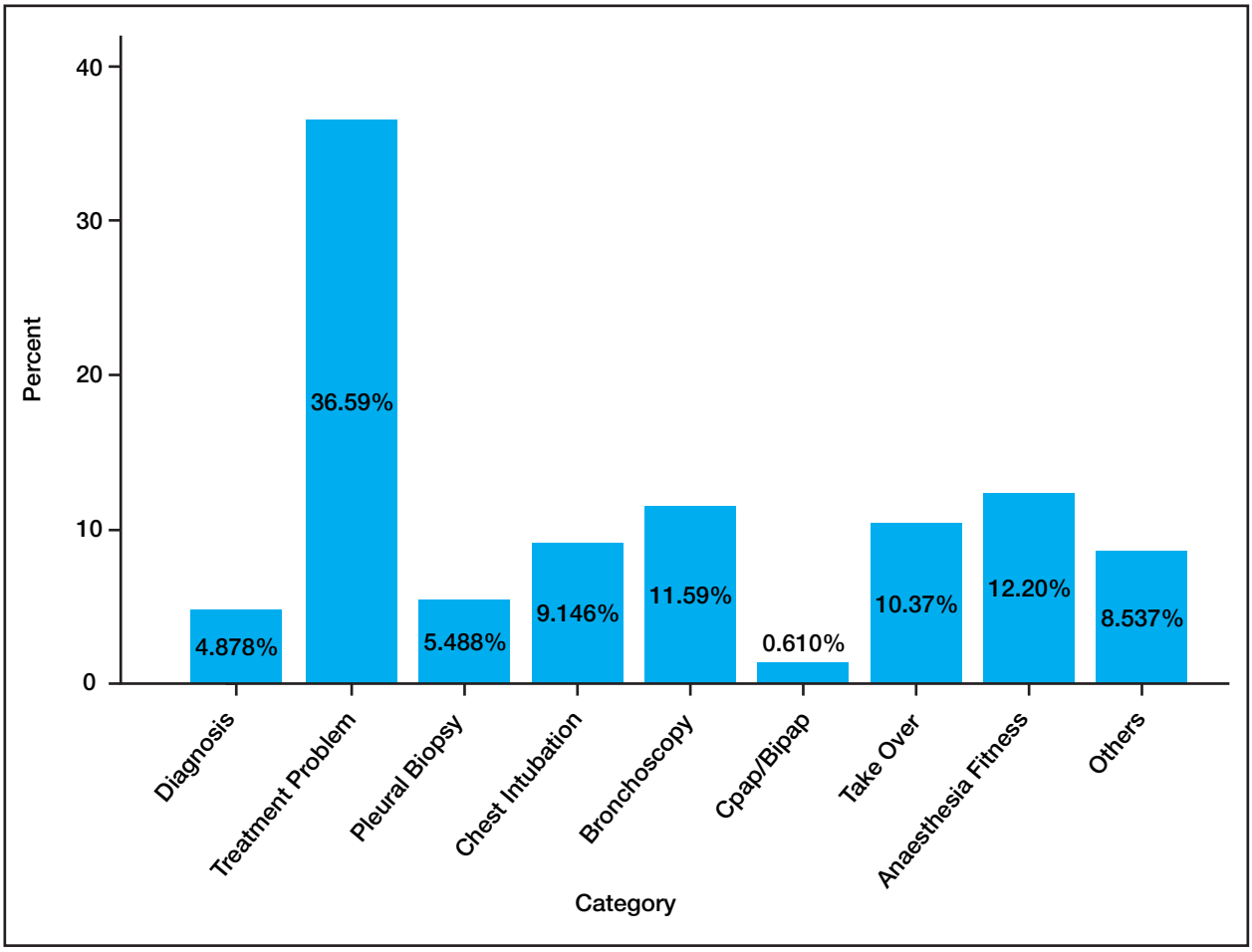
Figure 2: Reasons for referral



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