Referral letters from general practitioners

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SUMMARY. If continuity of care is to be preserved, then the process by which a patient is referred to hospital is important. We have analysed a series of letters of referral from general practitioners with special reference to the diagnoses made and the inclusion of a relevant history.

Introduction

The existence of an interface between medical care provided by the general practitioner and further investigation and care in the hospital may be an unfortunate feature of the organisation of health services.

Factors of management before referral, those consequent on attending outpatient departments or on admission, and factors affecting the move can all contribute to a break in continuity of care. It is, therefore, important to try to understand these factors and where possible correct deficiencies.

A study by Fraser, Patterson and Peacock (1974) looked at several aspects of the problem. From the general practitioner's point of view, long delays in obtaining outpatient appointments for their patients were a source of concern. Furthermore, on a patient's discharge from hospital, communication, in the form of hospital summaries, was often delayed and sometimes absent. One of their conclusions was that a similar audit from the hospital would be helpful. We tried to examine in one particular hospital group some aspects of communication between general practitioner and hospital about the admission of patients.

Method

Initially a small pilot study of case notes was carried out to establish a protocol for the survey. After this, in July 1974, during a period of ten days, case notes of patients on wards in King's College and St Giles' hospitals were examined and a record was made of the proportion containing letters of referral for the present admission. All except obstetric wards were included in the survey, and on each ward we examined all case notes not in use elsewhere. The availability of case notes was therefore the only selective factor.

The specialties involved in the survey were:

(1) Surgical (including general, thoracic, urological, orthopaedic and gynaecological),

(2) Medical,

(3) Miscellaneous (including ENT, ophthalmic, neurological, and psychiatric).

Analysis

Within each letter we thought it important to consider the following:

(a) Was it a ' letter of instruction ' requesting specific treatment, or a ' letter of request ' asking either for further tests not available to the general practitioner, or for advice on management?

(b) Was a diagnosis included?

(c) Did the general practitioner's diagnosis agree with the hospital's final diagnosis?

(d) Was a relevant history included?

We were interested in any details of medical, surgical, or psychosocial background considered to have bearing on the patient's management, especially drug therapy. Sometimes information of this kind was omitted from the letter, but supplied by the patient. We considered this to be information readily available to the general practitioner.

Finally, we assessed legibility:

(i) Typewritten,

(ii) Legible—hand-written and easily comprehensible,

(iii) Barely legible—hand-written, but requiring considerable time even for partial comprehension.

Borderline cases between (ii) and (iii) were designated legible so that the poorest grade distinguished the letters in which the sense was lost or in which important information was unobtainable.

Results

A total of 434 case notes were examined. Of these 208 (48 per cent) contained general practitioner's letters relevant to the admission.

Frequency of inclusion

The frequency of inclusion of a letter in the various specialties is recorded in table 1.

TABLE 1
PRESENCE OF A LETTER

		Total	*Number with a letter*	
General surgery		155	93	*60%*
Orthopaedics		87	24	
Gynaecology		25	13	
	Total surgery	267	130	
	Total medicine	112	50	*44·5%*
ENT		24	13	
Ophthalmology		18	8	
Neurology		11	5	
Psychiatry		2	2	
	Total miscellaneous	55	28	
TOTAL		434	208	*48%*

There is a significant difference in the frequency of inclusion of letters between general surgical and general medical cases ($P<0·01$), which may reflect the higher incidence of emergency admissions in the latter.

Instruction/request

Of the 208 letters, 96 were classed instructions and 112 requests. We considered their distribution in the three groupings—surgical, medical, and miscellaneous—as it seemed likely that the incidence of letters of instruction might be higher in surgical cases, where the general practitioner may be making use of the hospital for treatment more often than for advice. We found no significant difference (table 2).

TABLE 2
CLASSIFICATION OF INFORMATION

	Surgical		*Medical*		*Miscellaneous*	
	Number	*% of total*	*Number*	*% of total*	*Number*	*% of total*
Instruction	63	*48·5*	20	*40*	13	*46·5*
Request	67	*51·5*	30	*60*	15	*53·5*
TOTAL	130		50		28	

Diagnosis

A single diagnosis was suggested in 139 letters and several possible diagnoses in seven letters.

In 104 cases the general practitioner's suggested diagnosis agreed with that of the hospital,

and there was a significantly higher agreement (concordance rate) in surgical than in medical cases ($P<0{\cdot}01$; table 3).

TABLE 3
GENERAL PRACTITIONER AND HOSPITAL AGREEMENT

	Number containing					
	Total	*A single diagnosis* Number	%	*A differential diagnosis*	*An agreed diagnosis*	*Diagnosis undecided*	*Concordance rate*
Surgical	130	90	*69*	4	71	6	*84·5*
Medical	50	31	*62*	1	19	3	*68*
Miscellaneous	28	18	*65*	2	15	1	*88*
TOTAL	208	139	*67*	7	105	10	*81·5*

The diagnostic agreement between hospital and general practitioner is particularly important in letters of instruction, where the general practitioner is requesting specific treatment on the basis of his diagnosis.

Table 4 shows a 90 per cent agreement.

TABLE 4
DIAGNOSTIC AGREEMENT

	Number containing					
	Total	*A single diagnosis* Number	%	*A differential diagnosis*	*An agreed diagnosis*	*Diagnosis undecided*	*Concordance rate*
Instruction	96	96	*100*	0	87	0	*90·5*
Request	112	43	*38*	7	18	10	*54·5*
TOTAL	208	139	*67*	7	105	10	*81·5*

The difference in concordance rate between instructions and requests is statistically significant ($P<0{\cdot}001$).

Relevant history

In 131 cases it was found that a history was available to the general practitioner and relevant to the management; this relevant history was included in 90 letters.

Letters which *do* include a diagnosis are also more likely to contain a relevant history $P=0{\cdot}02$; table 5).

TABLE 5
HISTORY INCLUDED

	Relevant history			
	Total	*Available*	*Included*	*% inclusion when available*
Letters with a diagnosis	139	86	66	*77·5*
Letters without a diagnosis	62	42	20	*47·5*
Letters with a differential diagnosis	7			

Legibility

Of all letters examined, 23 were typewritten, 118 legible and 67 barely legible. The letters in each of these categories were compared to see if any relationship existed between legibility and the other parameters (tables 6 and 7).

TABLE 6
DIAGNOSES RECORDED

	Number containing					
	Total	*A single diagnosis*	*A differential diagnosis*	*An agreed diagnosis*	*Diagnosis undecided*	*Concordance rate*
Typewritten	23	18 *78%*	0	15	0	83·5
Legible	118	80 *68%*	5	58	7	79·5
Barely legible	67	41 *61%*	2	32	3	84
TOTAL	208	139 *67%*	7	105	10	81·5

TABLE 7
INCLUSION OF RELEVANT HISTORY

	Relevant history			
	Total	*Available*	*Included*	%
Typewritten	23	19	15	*79*
Legible	118	69	52	*75·5*
Barely legible	67	43	23	*53·5*
TOTAL	208	131	90	*68·5*

There is no statistical difference in the rate of inclusion of a diagnosis, and in the concordance rate between categories. However, barely legible letters *are* less likely to contain a relevant history ($P<0·01$).

Case notes without letters

Since over half of the case notes examined on the wards did not contain letters of referral from a general practitioner, we were concerned to know how these patients had entered hospital, and, in particular, how many had by-passed their general practitioner and entered the hospital via casualty (table 8).

TABLE 8
ADMISSIONS BY-PASSING THE GENERAL PRACTITIONER

Casualty admissions without a letter	87
*Long-term outpatients	40
Referral from:	
Other departments	28
Fracture clinic	11
Other hospitals	49
No record of mode of admission	11
TOTAL	226

*Long-term outpatients were those with a letter visiting outpatients before admission within the same department.

Admissions from casualty were 92, and a photocopy of a referral letter was found in only five cases. This low proportion may have been due to administrative error in the hospital, and to eliminate this possibility we examined the same number of casualty admissions randomly chosen over the same period in July. Of these 92 cases, 41 were emergency admissions (table 9). However, the remaining cases were all complaints, with at least a 24-hour history, and of these only nine were accompanied by letters of referral.

TABLE 9
EMERGENCY ADMISSIONS

Emergency admissions	
Overdoses	18
Road traffic accidents	9
Other accidents	12
Myocardial infarctions	2
TOTAL	41

Discussion

Do letters have the potential, and, in the hospital system, the freedom, to contribute to the maintenance of continuity of care? This study has set out to examine the general practitioner's letter of referral with regard to information content, opinion expressed, and presentation.

The initial management of a patient on admission is based on information available to the hospital, and this is of three main types:

(1) That elicited from the patient and relatives,

(2) The history of the presenting complaint as described by the general practitioner,

(3) Relevant past history included in the letter.

Where information concerning the presenting complaint or the past medical history is not available from the patient or relatives, the hospital is totally dependent on the letter as a data base. It is therefore disturbing to find so many case notes without any referral letter, and over a half without a general practitioner's letter. The lack of general practitioners' letters accompanying casualty admissions indicates that patients have approached their local hospital rather than to their general practitioner.

Even when a patient is accompanied by a letter, the standard of information contained is variable: although some form of immediate history is consistently available, a third of the letters did not supply what we have defined as relevant history. Not only does this directly affect the data base, but it also undermines confidence in the letter of referral.

Since initial management of the patient in hospital follows well defined lines in *all* cases, it is reasonable to question the importance the hospital attaches to a suggested diagnosis. If a patient is accompanied by an instructive letter, as in half the cases, it might be expected that the management would differ from that of the patient whose problems remain unsolved by his general practitioner.

Experience in the hospital study shows that this is rarely the case, and great care is taken to reassess the condition, despite an agreement rate of 90 per cent between general practitioner and hospital. This inflexibility may be a protection against the variations in standard, or it may be regarded as a safety mechanism so that treatment is not started by one doctor on the basis of a diagnosis made by another.

Finally, it must be pointed out that the barely-legible letter has little impact. The impression it conveys, the frustration of those attempting to understand it, and also the consistent finding that these are most likely to omit a relevant piece of medical history; contribute to the conclusion that such letters function as little more than a social device.

This survey raises serious questions about the individual patient's experience of continuity of care at King's College Hospital. This hospital and its catchment area are by no means typical, and we hope that the letter of referral, both in its content and use, will be examined elsewhere.

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REFERENCE

Fraser, R. C., Patterson, H. R. & Peacock, E. (1974). *Journal of the Royal College of General Practitioners*, **24**, 304–319.