Survey of Australian emergency physicians' expectations of general practitioner referrals

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SUMMARY. This paper reports the first study of Australian emergency physicians which concentrates on their relationship with general practitioners. A self-administered questionnaire was mailed to every known fellow and senior trainee of the Australasian College of Emergency Medicine working in Victoria, Australia. Good response rates were achieved (97% from fellows, 78% from trainees). Referral letters from general practitioners were always read by 99% of respondents. Telephone calls from general practitioners were found to be desirable for imparting details of social history or other qualitative information and for determining the appropriateness of the referral. The list of patients' current medication and the details of any emergency treatment administered by the general practitioner were almost universally considered essential inclusions in all urgent referral letters. Other items of information were considered to be influenced by the particular patient presentation. The majority of respondents (87%) felt that a written management plan had some influence on the patient's management in their emergency department. Eighty nine per cent of respondents stated that they always or usually responded to general practitioners' communications.

The outcome for patients attending emergency departments with referral letters warrants study. If a good referral letter is seen to be of value in terms of more accurate diagnosis, quicker patient processing, less investigations and better responses, then general practitioners will be encouraged to write better letters. The results of this study offer a useful definition of inappropriate referral to the emergency department and it may now be possible to investigate any link between poor referral letters and inappropriate referrals.

Keywords: referral letters; GP–hospital communication; emergencies; referral response.

Introduction

IN Australian hospitals emergency departments function as clearing houses for patients presenting acutely via ambulance services and general practitioners' surgeries, as well as those who are self referred. Patients are usually attended and assessed by the emergency department prior to the involvement of the specialist unit.

In the past anecdotal reflections have concentrated on perceived problems in communication between emergency physicians and general practitioners and on the control of patient care.[1] However, Morrison and colleagues reported the outcome of a study investigating local general practitioners' expectations of the Glasgow Royal Infirmary's accident and emergency department.[2] This study took the first systematic step in investigating the barriers between general practice and the emergency department.

Although the general principles of referral letter writing have been addressed, the varied quality of general practitioners' referral letters is well documented,[3–8] as is the similarly wide variation in general practitioners' referral rates.[9–13] Specialty-specific referral criteria have been suggested as a possible solution to both problems.[9] Specialties including ophthalmology and psychiatry have suggested standardized referral letter formats which communicate all relevant referral information efficiently.[14–16] Newton and colleagues recently suggested an empiric approach to the format and content of any referral letter to the outpatient department.[17] They demonstrated a high level of agreement between general practitioners and specialists about many items that should be included in a referral letter. A case may be made however, for urgent referral letters having different general requirements to elective referral letters.

The primary objective of this study was to determine the content of general practitioners' referral letters to emergency departments in Victoria, Australia, required by emergency physicians, and to suggest a standard content format for general practitioners' referral letters to the emergency department. Other work has examined referral letters to the emergency department against various empirical items of inclusion, and judged them to be lacking by such criteria.[3,18] The role of verbal communication in the referral of patients to the emergency department was also examined.

The secondary aim of this survey was to determine the general characteristics of cases referred inappropriately to the emergency department, according to emergency physicians. A study describing general practitioners' referral letters to a regional emergency department in Victoria found an association between the inclusion of a provisional diagnosis or a management plan in the urgent referral letter and the appropriateness of the referral itself.[3] No other work has investigated the suggestion that aspects of the referral letter may reflect appropriate referral behaviour. Previous definitions of inappropriateness of referral have been made for elective outpatient situations. Nunez judged referrals to ear, nose and throat outpatient departments as inappropriate if the patient was new, no disease was found, and no investigation or treatment was ordered.[19] Others simply report as inappropriate those problems that are considered to lie within the scope of general practice.[20]

Method

A self-administered questionnaire was mailed to all 140 fellows and senior trainees of the Australasian College of Emergency Medicine working in Victoria, Australia in August and September 1991. The list of doctors was provided by the college. A senior trainee is a doctor of registrar or senior resident level who has affiliated with the college in order to accredit current work and sit the fellowship examination. Questionnaires that were returned noting that the doctor was overseas or at an unknown address were excluded from the study. A personalized

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covering letter was included with each questionnaire and non-respondents were identified by means of an identifying code number. The questionnaire included closed, open and semi-structured questions. A second mailing, to non-respondents, was carried out two weeks after the first. Reply paid envelopes were sent with each mailing.

Results

A total of 120 questionnaires were sent and 100 replies received (response rate 83%). All 33 fellows were surveyed and replies were received from 32 (97%). The response rate from trainees was lower, with 68 replies from 87 surveyed (78%).

Of the 100 respondents 16% had no general practice experience, 36% had experience of occasional locum work and 48% had some full time experience in general practice. The responses of those with full time experience in general practice were not found to differ significantly from those without such experience (chi square test). Nor was there any significant difference between the responses of fellows and senior trainees, and the subsequent results are presented for emergency physicians in general (chi square test).

Telephone calls

Telephone calls by general practitioners prior to admission were rated on a three point scale: no value, some value, very valuable. Calls were considered very valuable by 58% of the respondents. The reasons why calls from general practitioners were considered valuable are shown in Table 1 (open-ended question). However, 16% of respondents reported that access to telephone calls and messages was poor in their emergency department, and they thus attached little value to the use of the telephone. Specific problems cited included: the doctor caring for the patient in question not receiving the call; switchboard difficulties; and the patient not being present at the time of the call.

General practitioners' referral letters

General practitioners' referral letters accompanying patients to the emergency department were rated on a five point scale: a distraction, not valuable, of some value, significantly valuable, extremely valuable. Referral letters were felt to be extremely or significantly valuable by 90% of respondents, and they were always read by 99% of respondents. Of the 100 respondents 17% felt that the referring doctor's name and contact telephone number were sufficient identification for a good referral letter, 53% felt that the name, address and telephone number were necessary, and 23% felt that the qualifications of the referring doctor should be included as well as the name, address and telephone number (2% felt that no identification was necessary, 2% that only the doctor's name was necessary and 3% that name, contact telephone number and qualifications were needed). Further identification considered necessary on open questioning was an indication of whether the referring doctor was a locum or working for a deputizing service (8% of respondents).

Respondents were asked to rate certain details contained in referral letters using a five point scale: a distraction, not a necessary inclusion, of interest, significant inclusion in some letters (with space to specify), necessary inclusion in all letters. Almost all the emergency department doctors surveyed rated a list of the patient's current medication and details of the emergency treatment provided by the general practitioner as necessary inclusions in all letters (87% and 95% of respondents, respectively). A social history or psychological profile was felt to be a necessary inclusion in all letters by only 10% of all respondents and a management plan (outcome expectation, specific requests or follow-up plan) was felt to be necessary by 21%. The percentage of respondents rating the following items as necessary in all letters were as follows; chronological sequence of symptoms or events (52%); provisional diagnosis or clear problem definition (62%); full relevant past history (62%); results of investigations performed (63%); vital signs (54%); relevant clinical findings on examination (60%). Eight per cent of respondents listed all the above variables except social history as necessary inclusions in a referral letter — this was the most common combination of responses.

Table 1. Reasons given by respondents for value of telephone calls from general practitioners.

Reason for valuing telephone call	% of respondents (n = 100)[a]
Further information can be sought	*40*
Averts inappropriate referral	*29*
Social history/qualitative patient information can be obtained	*23*
Management problems in complex presentations can be prioritized	*18*
Rapport, courtesy	*16*
Allows department to prepare for patient	*13*
Letters are usually poor	*9*
Emergency advice can be given to GP	*3*
Quality of GP can be assessed	*3*
Other	*13*

n = number of respondents. [a]Respondents could list more than one reason.

Respondents were also asked to list other details of history and examination that were felt to warrant inclusion in a good referral letter. Other details of history considered important included allergies (7% of respondents), previous hospital or specialist involvement in care (8%) and insurance status (7%). Other examination details suggested included known pre-existing findings (7%), results of tests in the practice (including electrocardiogram, peak expiratory flow measurement, urine test sticks, blood glucose) (6%) and internal examination (4%).

Management plans

The respondents rated the influence of the general practitioner's management plan, if included in the referral letter, on their management of the patient in the emergency department on a three point scale: no influence, some influence, strong influence. Eighty seven of 98 respondents stated that the general practitioner's management plan had some influence, where this was defined as incorporation of elements of the general practitioner's plan where or if the emergency physician felt it to be appropriate. Eight respondents stated that the suggested plan was disregarded as a matter of principle (no influence), but three reported that their intention was always initially to comply with the plan (strong influence).

Inappropriate referrals

The respondents' descriptions of the characteristics of a case inappropriately referred to the emergency department (open-ended question) are given in Table 2. It should be noted that 6% of respondents felt that no referral to an emergency department was inappropriate.

Response to general practitioners' communications

Eighty nine of the 100 respondents stated that they always or usually responded verbally or in writing to general practitioners' communications, while three stated that they rarely or never responded. Table 3 outlines the reasons given for responding or not responding to such communication (open-ended questions). Seventy seven respondents stated that pro forma letters were

Table 2. Characteristics of an inappropriate referral to the emergency department.

Characteristic of inappropriate referral	% of respondents (n = 100)[a]
Opinion by outpatient department only required	35
Inadequate communication from GP	30
Problem or procedure within the scope of general practice	29
Social problem	17
Chronic problem/palliative treatment required	17
Investigations only needed	16
GP has not seen the patient	16
Wrong place of referral	14
GP has inadequate knowledge of community services	10
Other	16

n = number of respondents. [a]Respondents could list more than one characteristic.

used in their departments for responding to general practitioners' referrals and 48 reported that copies of their written responses were kept in the patient's hospital record.

Discussion

The response rate achieved in this study, especially among fellows of the Australasian College of Emergency Medicine, is adequately representative. The response rate is probably a reflection of the interest of emergency physicians in their relationship with general practitioners, rather than a function of the questionnaire design or approach.

The study sought to determine the general impressions of emergency physicians but they may have been influenced by their most recent or most contentious communication with a general practitioner. Differences in the local expertise of general practitioners and their level of association with the hospital were not ascertained, nor was the impact of general practitioners' referral letters on other emergency department staff.

It is clear from the results of this study that a standard general practitioner's referral letter to the emergency department should include the list of current medications and the details of emergency treatment administered by the general practitioner. The referral letter should also contain the name, address, qualifications and contact telephone number of the general practitioner. While the inclusion of other details of the history and examination are of great importance, this study shows that their inclusion is dependent on the particular presentation.

Many authors report that general practitioners' letters are of poor or extremely variable quality.[4–8] A recent study in Victoria of general practitioners' referral letters to an emergency department revealed that examination findings, social history, management plans and investigation results are infrequently included.[3] This survey shows that the omission of social details and management plans from urgent referral letters agrees with the requirements of emergency physicians. It was interesting to note that experience in general practice among emergency physicians did not alter the responses in this survey.

Table 3. Reasons given for responding or not responding to general practitioners' communication.

	% of respondents (n = 98)[a]
Reasons for response	
Continuity of care/follow up	42
Courtesy, rapport	25
To justify management in emergency department	8
Reasons for non-response	
No letter if admitted	20
Time restricted	10
Difficult to contact GP after hours	5
Not required if simple problem	4
Other	14

n = number of respondents. [a]Respondents could list more than one reason.

The emergency physicians in this study found telephone calls with general practitioners valuable in communicating details of social history and other qualitative information. This may explain the emergency department doctors' lack of emphasis on written social or psychological details. However, it is apparent that in telephoning the emergency department the general practitioner may have the appropriateness of the referral questioned and this may result in fewer telephone calls from general practitioners, once again resulting in a lack of objective social information. The organizational difficulties that general practitioners experience in communicating with hospitals by telephone described in Morrison and colleagues' study have been echoed by emergency physicians in this survey.[2] If telephone communication (and communication by facsimile) is to be encouraged, thought needs to be given to streamlining the process.

Emergency physicians dislike referral letters which simply state 'please see and treat'.[1,4] However in this survey, emergency physicians did not give a strong commitment to implementing the general practitioner's suggested management plan, if it was offered. Yet European studies report that the majority of the patients referred to hospital by general practitioners were subsequently admitted, and an Australian study found that urgent referral letters containing a management plan were significantly associated with appropriate referrals.[2,3,21,22] In many instances senior general practitioners are offering management plans to doctors many years their junior. To minimize such guidance would be to deny emergency department staff an important source of clinical advice.

The traditional view that no referral to the emergency department is inappropriate[23] was not common in this survey. The pressures on modern hospitals for access are great, but the use of the emergency department as a de facto outpatient department is a practice that cannot be condoned. Similarly, the referral of patients who have not been seen by the general practitioner, or for the sole purpose of performing investigations, are practices that deserve correction. The referral of patients with problems within the scope of general practice is a more subjective criticism. Many self-referred cases to the emergency department could be managed by a good general practitioner.[22,23] However, the recognized variability of general practitioners' specialist referral threshold must also extend to emergency medicine. The willingness and capacity of general practitioners to perform minor procedures depends on expertise, practice organization and remuneration.[22,23]

The outcome for patients attending emergency departments with referral letters from general practitioners needs further examination. Are patients rewarded for initially seeking and receiving their own general practitioner's clinical assessment? While the benefit is obvious if the problem is completely managed by the general practitioner, it is arguable whether patients benefit if they require subsequent referral to the emergency department. Patients presenting to the emergency department after attending their general practitioner might expect to be attended to more quickly than self-referred patients with similar problems, or to avoid processes and investigations already carried out by the general practitioner. A New Zealand study suggests that there is no reduction in the time spent in the emergency department for patients whose general practitioner sent a satisfactory letter or telephoned the department.[21] Thus, the passport

or triage function of the referral letter may not be valid. One reported outcome of referral letters to outpatient departments is that good letters are more likely to generate a written response.[4] General practitioners feel strongly that they should receive written communication from emergency departments, especially where patients are discharged.[2] Disappointingly, a recent study of referrals to an orthopaedic outpatient department found that the inclusion of a statement of urgency in the general practitioners' referral letters made no difference to the allocation of the patient's appointment time.[24] General practitioners will be further encouraged to take the time to communicate effectively with their specialist colleagues if it can be demonstrated that the result is an improvement in patient care and service efficiency, as well as simply fulfilling professional courtesies.

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