

# Communication at the interface: do better referral letters produce better consultant replies?

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## SUMMARY

*A study of the quality of 637 referral letters from general practitioners (GPs) and corresponding reply letters from medical specialists showed that both types of letters can be improved, and that specific requests by GPs were addressed explicitly by the specialists in only a limited number of cases. Better referral letters resulted only partly in better reply letters. A letter is considered to be of higher quality when a specialist commences a letter with a reference to the specific request by the GP. In conclusion, opportunities for optimal communication should be better used.*

**Keywords:** referral letters; primary-secondary care interface; communication.

## Introduction

DURING a normal working week, between two and 12 of the patients visiting their primary care physician will be referred to a medical specialist for further diagnosis or management of their health problem.<sup>1</sup> Given the complexity of many of the problems, and the risks of under- or overuse of care, optimal communication between general practitioners (GPs) and specialists by letters, faxes or e-mails can be considered an indicator of good quality care.<sup>2-4</sup> There is wide consensus on the elements of communication that constitute good information sharing.<sup>5,6</sup> Although previous studies have shown problems in the quality of both referral and reply letters,<sup>7-9</sup> research in this field is scarce, particularly with regard to communication between GPs and specialists. For this reason, the extent to which specialists' reply letters are related to the referral letters sent to them, and whether or not better referral letters produced better reply letters, was investigated in this study.

## Method

Over a period of eight months, 42 GPs in an urban area of The Netherlands (the city of Nijmegen) recorded all referrals to departments of general internal medicine, pulmonology, neurology, gynaecology, and orthopaedics in five regional hospitals. The referrals and corresponding reply letters were then traced in the hospitals, made anonymous, and photocopied. The presence or absence of specific information in the referral letters was scored by two trained assessors, and the reply letters by three assessors. The reliability between the assessors'  $\kappa$ -values per information item varied from 0.58 to 1.0. The quality criteria for the referral letters were derived from national guidelines, as well as from the international literature<sup>5</sup> and surveys conducted among specialists.<sup>2,9</sup> The referral letter met the first criterion (provision of clinical information) when four or more of the following clinical items of information were present: the patient's symptoms, findings of previous examinations, whether or not investigations were performed, whether or not treatment had been given, and current medication. It met the second criterion when at least one specific request for the specialist on diagnosis, treatment, and/or a management plan was formulated within the letter. The percentage of the referral letters meeting the above two criteria was then calculated.

The quality criteria for the consultants' reply letters were based on the international literature<sup>3</sup> and surveys conducted among GPs and specialists.<sup>2,3</sup> The reply letters were scored for the presence of clinical information (history taking, findings of physical examination, findings of investigations, diagnosis, treatment, and management plans) and clinical

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**HOW THIS FITS IN***What is already known on this topic*

The quality of both referral letters and reply letters of medical specialists is not optimal and needs to be improved.

*What does this paper add?*

There is a clear lack of real exchange of information between GPs and specialists, and they do not act on each other's information and communication. Better referral letters only partly resulted in better reply letters. Simple measures, such as repetition of the requests of GPs in the reply letters, can improve these letters. Focused training of students in undergraduate and postgraduate training on exchange of information is very important.



considerations (information provided to patients/relatives, and diagnostic and/or therapeutic considerations). If specific requests were presented in the referral letter, the reply letter was checked for an answer. If an answer was given, it was described as 'implicit' when it had to be deduced indirectly from the text by the assessors, and 'explicit' when the consultant directly answered the request made by the GP. Whether a reply letter contained a repetition of the GP's specific request or not was scored as well.

To study the relation between the quality of the referral letters and the content of the reply letters, the percentage of reply letters containing sufficient clinical information, i.e. five or more items mentioned, and one or more clinical considerations, was determined. In addition, the percentage answering to specific requests by the GPs was calculated. The differences in the reply letters between those referral letters meeting, and those not meeting the quality criteria, were then examined. The differences were tested in a  $\chi^2$  analysis, and a value of  $P < 0.05$  was considered significant.

**Results**

A total of 637 referral letters and the associated reply letters were traced and assessed during the period of this study. Of the reply letters, 30% were written by consultants and 30% by house officers, and in the remainder this was unknown. Of the referral letters, 35% met the first quality criterion regarding the provision of clinical information, 59% met the

second quality criterion regarding formulation of a specific request, and only 20% of the referral letters met both criteria. In the reply letters, the provision of clinical information varied from 62% (information on treatment) to 93% (history taken). The most frequently mentioned item in the reply letters (92%) was information on the management plan; for example, further investigations, referral back to the GP, admission to hospital. Less frequently mentioned were: information provided to patients/relatives (29%), and considerations regarding diagnosis or treatment (16% and 20%, respectively). About 80% of the reply letters did not contain any consideration of diagnosis or treatment. About 75% of the reply letters started with a repetition of the reason for referral and 61% repeated the symptoms. Much less frequently, the specific requests put forth by the GPs were repeated (13%). When the GP presented a specific request, an explicit answer was provided in only 11% to 14% of the reply letters, depending on the issue in question (Table 1). No answer was provided whatsoever for 20% to 42% of the specific requests. However, when the reply letter started with a repetition of the specific request from the GP, 38% of the referral letters containing a specific request received an explicit answer, and when no repetition of the specific request from the GP was provided, 9% of the requests were answered explicitly ( $P < 0.001$ ). When the referral letters met the quality criteria for the presence of clinical information, the reply letters also contained both sufficient clinical information and sufficient clinical considerations (Table 2). When the referral letters contained at least one specific request for the medical specialist, the reply letters contained less clinical information.

**Discussion**

The findings of this study confirm the results of other research, which shows that the quality of both referral and reply letters can be improved. A particularly striking and new finding concerns the apparent lack of a real exchange of information. Referral letters were shown to provide only a partial opportunity for the specialists to supply a focused reaction. Reply letters often contained only standard clinical details and little or no consideration of important diagnostic information, therapeutic considerations, or information given to patients/relatives. The specific requests provided by GPs rarely received an explicit answer. Although some correlations between the quality of the referral letters and the reply

Table 1. Types of answers in reply letters to specific requests by GPs in referral letters (total = 637).

	Answer in reply letter		
	Explicit (%)	Implicit (%)	No answer (%)
All requests ( $n = 421$ )	13	62	25
Specific request by GP in referral letter <sup>a</sup>			
Regarding diagnosis ( $n = 252$ )	14	66	20
Regarding treatment ( $n = 104$ )	11	60	29
Regarding management plan ( $n = 65$ )	12	46	42
Repetition of request in reply letter <sup>a</sup>			
Yes ( $n = 60$ )	38	55	7
No ( $n = 361$ )	9	63	28

<sup>a</sup>Difference significant,  $P < 0.001$ .

Table 2. Numbers of reply letters containing sufficient clinical information and considerations, by content of referral letter.

	Sufficient clinical information (%)	Sufficient clinical considerations (%)
Content of referral letter <sup>a</sup>		
Sufficient clinical information	87 <sup>a</sup>	50 <sup>a</sup>
Insufficient clinical information	76	38
Content of referral letter <sup>a</sup>		
At least one specific request	76 <sup>a</sup>	42
No specific request	86	42
Total (n = 637)	80	42

<sup>a</sup>Difference significant,  $P < 0.05$ .

letters were found, the relations were generally weak. Better referral letters only partly resulted in better reply letters.

The two types of letters appear to reflect very different and largely unrelated worlds, which is of some concern. When the specialist starts the reply letter with a repetition of the specific request or requests put forth by the GP, an explicit answer is formulated about four times more often than when the reply letter lacks such a repetition. It may be that most specialists do not consult the referral letter itself when dictating a letter to the GP in question. Teaching specialists to start each letter with a clear repetition of the reason for referral and the GPs specific request (when provided) may greatly facilitate the exchange of information. In such a manner, a real interaction between colleagues can be initiated. To conclude, while the quality of the care at the interface between the GP and the specialist is increasingly being attended to,<sup>4</sup> opportunities for optimal communication and information sharing should be better used.

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