General practitioner and hospital letters

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Accepted 8 March 1995

SUMMARY
Communication by letter was assessed between hospital consultants and general practitioners for outpatients and inpatients referred to the Ards Hospital during the month of January 1993. The information was assessed to be poor in several sections of 104 outpatient referral letters, and of 89 inpatient referral letters despite a high use of the standard referral letter form. Consultant physicians’ or senior house officers’ letters to general practitioners achieved higher scores in 72 outpatient letters, and 152 inpatient discharge summaries. The use of headings was approved by 80% of general practitioners and probably accounted for the highest scores for the headed discharge summaries. Further support and education in the use of headed letters is to be encouraged.

INTRODUCTION
Good communication between general practitioners and hospital consultants is vital for efficient and effective care of patients. Usually this will take place by letter, for both outpatients and inpatients. Failure to impart all relevant information may result in delays. At worst patient care will suffer. We present the results of a prospective audit of letter communication for both outpatients and inpatients from the medical unit at Ards Hospital.

METHODS
All referral letters from general practitioners or their deputies for new patients seen at the medical and cardiology outpatient clinics at Ards and Bangor hospital during the month of January 1993 were assessed using a standard form. Most of these assessments were carried out by the consultant concerned. A questionnaire was sent with all consultant and senior house officer letters to general practitioners, who were asked to assess the hospital letter.

Most letters referring inpatients were for emergency admissions. All referral letters for these admissions during the month of January 1993 were assessed using the standard form, again usually by the consultant concerned. All hospital discharge summaries sent out during the same month (but not necessarily referring to the same patients) were accompanied by a questionnaire for assessment by the general practitioner.
Doctors’ letters

The staff of the audit department at Ards hospital ensured completion of forms. A second or third questionnaire was sent to the general practitioner if there was no reply. Data were analysed using the Statistical Package for Social Services (SPSS).

RESULTS
There were 104 general practitioner letters to outpatients assessed during the study. Of these 99 were from the patient’s own general practitioner, with two each from other general practitioners or locums, and one from a general practice trainee. All but two utilised the Eastern Health and Social Services Board standard referral letter. The letter was analysed in five sections: demographic data, presenting complaints and history, past history, drug history and other (mainly social) history. The content in these sections was assessed as good, average or poor. (Table 1). Demographic data was the most complete, scored as good in 68 and average in 34. Past history and drug history were scored as poor in 40 and 38 letters respectively, and 28 had a poor score for other (social) histories. (Information was missing for demographic assessment in one case, and other history in four cases).

| Assessment | Demographic Data | Present History | Past History | Drug History | Other |
|------------|------------------|----------------|--------------|--------------|-------|
| Poor       | 1                | 13             | 40           | 38           | 28    |
| Average    | 34               | 33             | 22           | 10           | 42    |
| Good       | 68               | 58             | 42           | 56           | 30    |

Eighty-two letters were sent from hospital doctors to the general practitioners regarding outpatients within the study period. This was fewer than the number received due to the limits of the study period. Replies to the questionnaire were received from 72 (88%) of the general practitioners. The hospital letter was also analysed in five sections: clarity of diagnosis, clarity of treatment advised, drugs suggested, whether information given to the patient was clear, and whether future plans and review arrangements were clear. These sections were assessed as good, average or poor (some were categorised as unclear or inapplicable). (Table 2). The information was considered good in 59-64 letters in four categories, but the information given to patients was good in only 43 cases and may have been poor in the 13 letters assessed as “none/not applicable” as well as in three other letters.

Eighty-nine inpatient referral letters were considered, which concerned patients referred initially to the accident and emergency department, as well as direct referrals. Of these 61 were from the patient’s own general practitioner, 15 from locum or deputising doctors, 11 from other general practitioners, one from a trainee and one was unknown. The EHSSB standard letter was used in only 63 cases. Assessment was as for the outpatient letters (Table 3). Demographic

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Consultant outpatient letters assessed by the general practitioner (72 letters).

| Assessment       | Diagnosis | Treatment Clear | Drugs | Patient Information | Plans/Review |
|------------------|-----------|-----------------|-------|---------------------|--------------|
| None/ not applicable | 1         | 4               | 6     | 13                  | 3            |
| Poor             | 2         | 2               | 2     | 3                   | 1            |
| Average          | 10        | 7               | 4     | 13                  | 4            |
| Good             | 59        | 59              | 60    | 43                  | 64           |

data, presenting history and drug history were the best documented sections, but were scored good in only 37, 41 and 39 cases respectively. Past history and other (social) history were good in only 21 and 15 cases, and in four no useful information at all was given.

Hospital discharge summaries for 178 admissions were sent out to general practitioners during the study period. These included patients admitted without any referral letter, who were mainly self-referrals to the accident and emergency department. Some late discharge summaries were also sent. Thus the number is considerably larger than the 89 patients admitted with a referral letter. Replies were received from the general practitioner in 152 cases (85%) (Table 4.) Information was assessed as good for clarity of diagnosis in 140 cases, for clarity of treatment in 135 cases, for drug treatment in 132 cases and for review or other plans in 126 cases. The information given to patients was the least well documented section, assessed as good in only 85 of cases with 37 having nothing recorded.

General practitioner inpatient referral letters assessed by the hospital physician (89 letters).

| Assessment | Demographic Data | Present History | Past History | Drug History | Other |
|------------|------------------|-----------------|--------------|--------------|-------|
| None       | 4                | 4               | 4            | 4            | 4     |
| Poor       | 10               | 11              | 32           | 29           | 25    |
| Average    | 38               | 33              | 32           | 17           | 45    |
| Good       | 37               | 41              | 21           | 39           | 15    |

The discharge summaries had been structured under headings (previous discharge summaries, route of admission, presentation, investigations, treatment, complications, prognosis/discussion, drugs and plans/review), with a slightly different set of headings for cardiac discharges (ECG and cardiac enzyme sections added). These headings were assessed as useful in 122 (80%)

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replies from the general practitioners, and only eight felt they were not helpful, although 22 gave no reply to this question. Only 13 general practitioners preferred an unstructured free paragraph style, 121 (79%) preferring the headed summaries.

**Table 4**

*Consultant inpatient discharge summaries assessed by the general practitioner (152 letters).*

| Assessment     | Diagnosis | Treatment Clear | Drugs | Patient Information | Plans/ Review |
|----------------|-----------|-----------------|-------|---------------------|---------------|
| None not applicable | 5         | 6               | 10    | 37                  | 15            |
| Poor           | 3         | 2               | 1     | 4                   | 1             |
| Average        | 4         | 9               | 9     | 26                  | 10            |
| Good           | 140       | 135             | 132   | 85                  | 126           |

**DISCUSSION**

Good communication of information allows for good patient care. In the case of outpatients, information from the general practitioners was poor in several sections, especially past history, drug history and social history. This was in spite of very high use of the standard letter form provided by the Health Board which has headings designed to reduce important omissions. For medical patients in particular full information is necessary to allow an accurate diagnosis and treatment plan. Outpatient letters from consultant clinics achieved good scores from the general practitioners in most sections, except in respect of information given to patients.

Most inpatient admissions were emergencies. This was reflected in poorer information in some sections of the referral letters, especially past history, drug history and social history. A poor drug history may lead to patients not continuing necessary or vital drugs, or to adverse drug interactions. These poor scores were noted despite high use of the standard letter form. Hospital discharge summaries were assessed by the general practitioners as good in most sections, except in the documentation of information given to patients. Hospital summaries in which headings were used fully were found to give the most complete information. Most outpatient letters from hospital doctors had a list of main diseases at the beginning of the letter which was acknowledged to be helpful.

Newton, Eccles and Hutchinson have shown that general practitioners and hospital consultants reached a high degree of consensus about the contents of referral letters.¹ Where items were thought to be always or usually required, a heading would help to ensure their inclusion. Lloyd and Barnett ² suggested the use of problem lists in outpatient letters, and this idea has been extended to the use of structured letters.³ We recommend further study in the use of structured letters for communication between hospital and general practice. The results of this study have been distributed to the general practitioners involved but no improvements have been noted in the quality of subsequent referral letters. The

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use of a few headings, such as those defined in this study, may encourage better data communication. Word processing, or typed referral letters allowing free text under suitable set headings should be encouraged.

ACKNOWLEDGEMENT
We acknowledge the help of the audit department, UNDAH Trust, and of the general practitioners who returned questionnaires for the study.

REFERENCES
1. Newton J, Eccles M, Hutchinson A. Communication between general practitioners and consultants: what should their letters contain? Br Med J 1992; 304: 821-4.
2. Lloyd B W, Barnett P. Use of problem lists in letters between hospital doctors and general practitioners. Br Med J 1993; 306: 247.
3. Rawal J, Barnett P, Lloyd B W. Use of structured letters to improve communication between hospital doctors and general practitioners. Br Med J 1993 307: 1044.