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"For review and management": the role of the referral letter in surgical consultations

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ABSTRACT

Background: The referral letter serves a central role in the transfer of patients from referring doctors to specialist care in Australia. **Aim:** We analysed the form and function of referral letters and examined their role in surgical consultations to better understand the information in the letter and what impact that may or may not have on consultation openings. **Methods:** Thirteen referral letters and their associated recorded surgical consultations were analysed with an iterative, multi-methods qualitative approach. Using inductive and deductive linguistic methods, we considered clinical and paraclinical information as well as contextual factors in the letters' alignment with referral guidelines as well as overall relevance to the consultation. **Results:** The analysis showed that surgeons tend to have a "set piece" when opening a consultation that is independent of the content or style of the referral. While referral letters fell short of guidelines, additional patient information was frequently discussed in the consultation. **Discussion:** Patients and surgeons are generally able to work around interactional challenges related to patient information. However, recognising the need to supplement referral information particularly around paraclinical information and contextual factors is important. **Conclusions:** Future changes to referral letter guidelines could reflect these realities.

KEYWORDS

Action research, linguistic analysis, referrals, surgeon-patient

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Introduction

The ideal referral letter is intended to provide specialists with relevant patient information and express a request for temporary care for a particular concern (White et al., 2014). Accurate and informative referral letters create a reliable system of documented communication between medical professionals (Xiang et al., 2013) and assist specialists in prioritising patients (Xiang & Smith, 2012). Referral letters can be hurriedly, even automatically generated and may not reach this ideal. In Australia, a referral from another doctor in the form of a letter is required to receive government subsidised specialist care, known as a Medicare rebate. If there is no referral, a patient can still see a specialist, but the visit is not rebated at the specialist rate.

The aim of this study is to understand how letters impact the consultation itself. We examine the extent to which the contents of the referral letter aligned with the consultation. We also assess, using comparative analysis, if and how expectations of the letter's purpose align between referring and treating doctor. Using an iterative process, we can identify the information relevant to surgeons that is not routinely included in referral letters (paraclinical information) as well as information relevant to patients that is also not routinely included nor specifically advised for (contextual factors). In turn, these findings will support further research and guideline development.

Literature review

Numerous health systems worldwide, including Australia, work on a referral process for surgical services. This process utilises a referral letter to handover care of the patient, with the letter functioning as a token for "passing the baton" of care. More importantly, this act of referral can be a way to manage continuity and improve communication at this potentially risky point of transfer between care providers. As the referral process represents a gap in the care continuum between providers, poor referrals can have serious implications for patient safety (van Walraven et al., 2010), with patients "falling through the cracks" and risks of missed diagnoses and inappropriate or inadequate treatment recommendations.

The referral process in Australia has been functioning the same way for almost 50 years and there are calls for an update, particularly as the current system does not effectively use workforce expertise and is not aligned with contemporary patient needs (Prime et al., 2020). However, the updating of a complex system needs to be grounded in evidence that identifies the strengths and limitations of the current process. We argue for the need to understand alignment between guidelines and practice in referral letters to identify ways in which referral letters might be more relevant to a consultation. Addressing these discrepancies between 'work-as-imagined' and 'work-as-done' in practice (Hollnagel et al., 2015) provides a data-driven understanding and opportunity to enhance referral letters and the safety and quality of patient care. This is not to suggest that guidance is inherently better than practice, but rather to question whether both guidance and practice need reconsideration to ensure that referral letters and the way in which they are used within the consultation are supporting holistic, patient-centred care.

Improving this system requires investigation of all parts of the referral process, including letters. Referral letters serve different functions at different levels of the medical system. At one level, the referral takes a gatekeeping role, limiting a patient's access to the specialist. In the consulting suite, the referral letter provides information to the clerical staff and surgeon prior to the visit which can facilitate triage and registration and, as such, referral letters influence consultations from the very beginning (White et al., 2016).

There is a range of literature advising on best practice for referral letter writing (Tattersall et al., 2002), including guidance from the Australian Royal Australian College of General Practitioners (RACGP) (The Royal Australian College of General Practitioners, 2019; 2020). These recommendations are built on a combination of expert opinion, bureaucratic requirement and evidence from research analysing perceptions of the quality and content of referral letters (Hartveit et al., 2013). There is little evidence on the role a letter actually plays in the surgical consultation.

While there have been attempts to improve referral letters (François, 2011; Gandhi et al., 2008; Grol et al., 2003), two key problems remain: 1) there is little understanding as to what impact the referral letter has on the subsequent surgeon-patient interaction; and 2) there is little evidence from practice as to the best way to improve referral letters (e.g. through use of form letters, templates, recommended phrasing, etc). This study provides supporting evidence to answer the first of these questions.

Methods

Approach

The approach taken draws on action research, with the inclusion of two of the four surgeon participants as investigators and use of an iterative approach to the study design that included four discreet, cyclical phases involving data collection, analysis, and reflection to identify the priority and approach for the next phase (Koshy et al., 2011). Through this, we piloted methods for evaluating alignment in content between the doctors (referring and treating) and the patient as well as comparing referral letters to existing best-practice guidance.

We conducted an in-depth analysis of a small complementary dataset of audio-recorded consultations and associated referral letters (n=20). Data were transcribed for analysis using a linguistic ethnographic approach (Copland & Creese, 2015), which involves observation of language in use through video and audio recordings as well as written materials. In this, we specifically drew on inductive sociolinguistic interaction analytic traditions (Gumperz, 2008) and deductive content analysis (Hsieh & Shannon, 2005), described further in the analysis section. Combining inductive and deductive analytical processes allowed us to assess alignment between recorded consultations and referral letters, and compare letters to existing frameworks, specifically the RACGP referral letter guidelines (The Royal Australian College of General Practitioners, 2019) and the '4C' Contextual Factors coding scheme (Weiner et al., 2020), which was chosen during the iterative analytic process described below.

Setting and sampling strategy

The dataset consisted of 20 consultations drawn from two existing datasets, with five consultations each from four different surgeons (colorectal, orthopaedic, breast, and plastic). Data were collected as a convenience sample based on willingness to participate. Ethics oversight for this project was provided by Macquarie University Human Research Ethics Committee (#52020297214756).

Data collection

From one data set, we used five consultations with matched referral letters. From another data set, we requested consent from 15 patients to collect referral letters connected with existing recordings of surgeon-patient consultations. Three of those patients did not consent, reducing the number to 17. During the course of the analysis, the number of consultations was reduced to 13, as some had mismatched letters (e.g. we had recorded a second visit within the referral period).

Thirteen consultations and matched letters were included in the final data set, with seven attending initial visits and the remaining six referred for a return visit (Table 1). When a patient is referred to a surgeon, there is minimal difference in the overall structure of the consultation between initial and return visits (cf. White et al., 2013; 2016). These were identified through either the referral letter or through the opening sequence on the consultation, where interactants who were familiar with each other would discuss having previously met. Three recordings included a discussion with the nurse following the consultation.

Table 1: Visit and surgeon type across data set

Video code	Initial or returning patient	Surgeon type
MQ-VL17-13	Initial	Orthopaedic
MQ-VL17-20	Initial	Plastic
MQ-VL17-21	Initial	Plastic
MQ-VL17-22	Initial	Plastic
MQ-VL17-33	Returning	Orthopaedic
MQ-VL17-44	Initial	Orthopaedic
MQ-VL17-48	Returning	Breast
MQ-VL17-49	Returning	Breast
24_IE_11-11-16	Returning	Colorectal
16_SM_11-11-02	Initial	Colorectal
13_MF_11-10-26	Returning	Colorectal
12_LU_11-10-26	Initial	Colorectal
09_CO_11-10-26	Returning	Colorectal

Analysis

The project team met and jointly reviewed all letters and transcripts of consultation openings. SW and LD then used notes from that initial analysis to systematically analyse the full dataset. Preliminary results were then discussed amongst the project team, including the two surgeon participant-investigators (JC and DB), for cross checking and member checking, strengthening

the analysis. These findings were then used to guide the next steps in the analysis. This iterative process extended over four phases:

1. Inductive: Comparing content in the letters to the problem presented in the consultation, and developing data-driven categories for referral letter type and opening question design to determine what, if any, relationship exists between the letter and the opening question, as previous research has demonstrated the importance of the opening of a consultation for both the surgeon-patient relationship (White et al., 2014) and the overall structure of the consultation (White et al., 2016);

2. Deductive: Comparing content of referral letters to information gleaned from two RACGP sources (The Royal Australian College of General Practitioners, 2019; 2020) as GPs write many of the referral letters, to determine whether the guidelines captured actual practice and to highlight gaps between the two;

3. Deductive: Comparing consultations to paraclinical information categories, e.g. information about other health concerns, medications, allergies, etc, in RACGP guidelines to characterise categories that were less well captured in the referral letter; and

4. Deductive: Coding consultations for contextual factors, that is the patient's life context, using an existing coding scheme (Weiner, 2022) that focuses on the sociocultural context of the patient to determine factors routinely raised by patients and surgeons that might have been included in an ideal referral letter.

Results

1. Comparison of content in the letters to the problem presented in the consultation

Letter types

We identified two overlapping categories of problem presentation in the letters: 1. for diagnosis (n=6) or management (n=7); and 2. anatomical location of the problem (n=10) or patient specific (n=3).

Letters for diagnosis or management were categorised based on what the referring doctor sought to achieve by referring their patient to the surgeon. Seeking 'diagnosis' refers to letters (n=6) that contained symptoms and/or history and requested or implied the need for a surgeon's interpretation of the patient's condition to establish a diagnosis. These often included a request for "review" or "opinion" and "management" but included little to no diagnostic information. Referral letters solely for management (n=7) included a suspected or confirmed diagnosis and a request for treatment and continued care for the patient.

Letters specific to an anatomical location or the patient more generally were categorised based on the descriptive granularity of the problem (Table 2). Anatomical location-specific letters (n=10) referred to an anatomical location that required attention from the surgeon. Patient-specific letters (n=3) made holistic references to the patient without referring to specific anatomy.

Table 2: Examples of referral letter content

Code	Letter type	Extract from referral letter
16_SM_11-11-02	For diagnosis	"Thank you for seeing [name] for opinion and management […] She now presents with a single episode of bright blood with a bowel motion. She has never had this before."
MQ-VL17-21	For management	"Thank you for seeing [name] who has right sided facial lesions which do not appear overly malignant however she was hoping for a plastic surgery opinion in regards to best management."
MQ-VL17-44	Anatomical location-specific	"Thank you for seeing [name, age] for excisional biopsy of 2 skin lesions on the right side of his face"
24_IE_11-11-16	Patient-specific	"Thank you for seeing [name]… for your review and management."

Consultation opening types

The clinical component of consultations was initiated by either the surgeon asking for a problem presentation (n=6), using the referral as a prompt with a request for confirmation (n=6) (Robinson & Heritage, 2005), or simply asking the patient how they were (n=1) (Table 3). In seven out of 13 consultations, the surgeon did not explicitly elicit a problem presentation, instead moving directly from the referral recognition sequence (White et al., 2014) to open directive or closed history taking questions (Silverman et al., 2013). Five of the patients in these consultations found other opportunities to present their problems despite not being asked. The question types for the remaining six consultations were categorized based on previous analysis of surgeon-patient consultation openings (White, 2011).

We did not find a connection between the contents of the referral letter or how it was written, and how the surgeon opened the consultation. Instead, we observed individual variation in how each surgeon opened the consultation, a similar style, or "set piece", was modified slightly from patient to patient.

Table 3: How surgeons initiate problems

Code	Question type	Extract from consultation
MQVL17-13	In your own words	"What's been the problem as you see it?"
16_SM_11-11-02	In your own words	"I'd like to hear from you what's going on"
MQVL17-33	Follow up	"Are you getting better?"
MQVL17-48	Follow up	"How are you finding it?"
24_IE_11-11-16	Referral based	"So Dr [name] is the oncologist and so th-the oncology doctor has been very happy with you?"
12_LU_11-10-26	Referral based	"So, now, what's [dr first name] sent you along with?"

In patient-initiated openings, patients often started with a story or a symptom that led into a narrative or explanation without specific elicitation by the surgeon (Table 3). These patient-initiated problem presentations occurred in five consultations, with no problem presentation by the patient in a sixth consultation.

Discrepancies in reason for visit

In comparing the content of the letters and the problem presentations, we identified one consultation where there was a possible discrepancy in reason for visit between the patient's view of why they are there and what is in the letter. In the referral letter, the referring doctor

writes “Thank you for seeing [patient name] for her bowel problems”. This is a relatively broad request. In the consultation, the patient initiates the problem presentation almost immediately saying “still having troubles”. The surgeon then responds with “and [doctor other than referring doctor] thinks that we ought to just put another lead in.” This response by the surgeon suggests that he has been made aware of the specific issue by another doctor (as the referring doctor and the doctor the surgeon mentioned have different names) through another means, possibly by phone or a different letter. The mismatch does not prove problematic as both the patient and doctor have sufficient knowledge of the problem for the consultation to progress unhindered.

2. Comparison of referral letters to RACGP guidelines

Following from the above analysis, we compared the letters to RACGP guidelines to identify how aligned the letter content was with what is considered best practice. Across the two source documents from the RACGP (The Royal Australian College of General Practitioners, 2019; 2020), we identified 13 categories considered important for inclusion in a referral letter (Table 4). Of these, the only ones included in all 13 letters were patient identifiers (commonly name, date of birth and address). All letters were legible due to their electronic format. Most included the ‘purpose of the referral’ (n=12) and some ‘relevant history’(n=10) while more than half (n=9) included ‘allergies’ and ‘current medications’. ‘Current medical history’ and ‘examination findings’ were reported in seven letters each. ‘Adverse drug reactions’ and ‘current management information’ were included in two letters. ‘Family history’ and ‘smoking and alcohol’ were not included in any letters.

Table 4: RACGP categories according to the number of letters that included them

RACGP Category	Number of letters that included the category
Three patient identifiers	13
Legibility	13
Healthcare setting to which the referral is directed	12
Purpose of the referral	12
Relevant history	10
Allergies	9
Current medications	9
Current medical history	7
Examination findings	7
Current management	2
Adverse drug reactions	2
Family history	0
Smoking and alcohol	0

3. Comparison of consultations to paraclinical information categories in RACGP guidelines

Member checking with the two participant-investigators led us to delve further into specific aspects related to paraclinical information within the consultations. This captures whether additional information, not in the referral letter, was made relevant within the consultations and who made it relevant, the surgeon or the patient (or a nurse or family member). The

paraclinical information categories listed in Table 5 were derived from the same RACGP sources as the previous analysis. Paraclinical information (PI) was mentioned 60 times across eleven out of 13 consultations. Of these 60 mentions, 34 had not been included in the referral letter. 'Pre-existing conditions' was the most frequently requested piece of PI occurring 25 times and across six consultations.

Surgeons elicited most of the PI (29 mentions across 11 consultations) either based on information in the referral or in other questioning. Patients raised a further 22 PIs (across 8 consultations). A nurse raised another eight PIs (1 consultation), and a patient's support person contributed one PI (1 consultation).

Table 5: Paraclinical information, showing the number of times each paraclinical information category was raised in the consultations and by whom

Paraclinical information	Number of times the surgeon raised it	Number of times the nurse raised it	Number of times the patient raised it	Number of times relation of patient raised it	Total
Allergies	1	2	0	0	3
Adverse drug reactions	0	0	0	0	0
Current medications	12	3	4	0	19
Family history	1	1	0	0	2
Smoking and alcohol	1	1	0	0	2
Pre-existing condition	10	1	13	1	25
Social history	2	0	3	0	5
Other	2	0	2	0	4
Total	29	8	22	1	60

4. Coding of consultations for contextual factors

Using the Content Coding for Contextualization of Care (also known as the 4Cs Contextual Factors coding scheme) (Weiner et al., 2020), we found that across the 13 consultations, 11 included contextual factors. In total, 49 factors were raised, mostly by patients (n=29), then by surgeons (n=17), and by patients' support person or a nurse (n=3) (Table 6).

Table 6: Contextual factors coded throughout the consultations

Contextual factor	How many times the surgeon raised information	How many times the nurse raised information	How many times the patient raised information	How many times a relation of the patient raised information	Total
Access to care	1	0	2	1	4
Attitude towards health care provider and system	1	0	5	0	6
Attitude towards illness	1	0	2	1	4
Competing responsibility	0	0	1	0	1
Emotional state	1	0	3	0	4
Environment	3	0	4	0	7

Financial situation	3	1	0	0	4
Health behaviour	2	0	1	0	3
Resources	3	0	0	0	3
Skills, abilities and knowledge	2	0	6	0	8
Social support	0	0	4	0	4
Total	17	1	29	2	49

The most frequently cited contextual factor was 'skills, abilities and knowledge' which refers to a patient's intellectual understanding and physical ability to manage their health care, commonly occurring as patients were discussing their thoughts about their problem. For example, in a consultation with an orthopaedic surgeon the patient says, "I swim to get my cardio up" (MQ-VL17-13), demonstrating an understanding of the health impacts of exercise as well as the potential relationship between that exercise and their presenting problem. In another consultation, the patient says "I-I hate hospitals. I hate to come see doctors anymore" (24_IE_11-11-16), providing insight into their attitude to the health care system.

Discussion

Referral letters are a key communication activity in the Australian health system and through qualitative mixed methods, we sought to describe the role of these letters in surgeon consultations. We found that the letter's framing most often took the form of a request for assistance in diagnosis or management, and that it could be targeted either to a specified problem location or expressed more holistically. Half of the content recommended by the RACGP was included in the referral letters studied. While paraclinical and contextual factors were not routinely included in referral letters, they were raised in consultations, with surgeons raising paraclinical information slightly more often than patients and patients raising more contextual factors without prompting from the surgeon. These findings call into question the current purpose of letters in the referral process, particularly given that practice does not match guidance. This suggests that there is a mismatch between the intended purpose, as demonstrated through guidelines, and actual practice, seen through how letters are written and used within consultations (Hollnagel et al., 2015).

Drawing on a variety of qualitative communication analytic methods allowed for the creation of a robust examination of the data. Doing so within an action research frame with the inclusion of participant-researchers meant that the study was responsive to findings throughout the research process as well as considerate of the practical implications and clinical relevance of both the research questions and the analysis.

The openings of the consultations were not impacted by the content or structure of the referral letters. The "set pieces" (Dahm & Berger, 2016) used by the surgeons to open their consultations allow them to establish their own direction and rhythm for a consultation. However, these have the potential to create interactional difficulties for the patients, particularly if they do not create a space for patients to present their concerns (Heritage & Robinson, 2006a); this was evident in more than half (7 of 13) of the consultations. This apparent side step of the initial problem presentation (White et al., 2013) was resisted by five patients, who created their own opportunities to present their problems early in the

consultation. This suggests that creating a space for problem presentation may be a more patient-centred approach to initiating a consultation. This could allow for a more linear flow rather than the patient needing to build their problem presentation into a different ongoing activity, such as history taking.

Over half the paraclinical information raised in the consultation was not mentioned in the referral letters. While providing a complete history of the patient is not necessary within a referral letter, we argue that providing some additional information and ensuring it is accurate is important, particularly that which might be not directly relevant for diagnosis but has serious implications for treatment. A letter without this information has repercussions for patient care. It imposes a risk, as sharing pertinent information relies on patient understanding of what information is relevant if not specifically asked for by the surgeon. The use of the Australian national electronic medical record platform, “My Health Record”, for example, could assist in providing the data for any omitted paraclinical information. However, it is still dependent on patients and providers opting in and proactively using it, which requires improved usability (Walsh et al., 2017; Walsh et al., 2019), as well as the specialist readily accessing this data for each patient for each consultation. The GP referral should still include their own prioritization of paraclinical information as they often know their patients better than the specialists.

The assumptions made regarding the existing knowledge of each party may lead to the inadvertent concealment of paraclinical information, which may affect their health outcomes due to an inappropriate diagnosis or treatment plan. Structurally supporting GPs to write more comprehensive referral letters through increased consultation lengths and/or more responsive software would allow for the inclusion of up-to-date paraclinical information in the letter. This highlights the multidisciplinary strength of the referral process, where the GP input provides necessary information and opinion to the referred doctor.

Including contextual factors in referral letters would also be of use, however potentially more difficult as these life circumstances may change or may be too personal to include in such a format. As such, it is the role of the surgeon to create opportunities for the patient to share all aspects of their story (Levinson et al., 2013) and to enquire after paraclinical information and contextual factors that may be relevant to the diagnosis and treatment of the patient. Our results suggest that relying on referral letters to identify important paraclinical information and contextual factors may result in an incomplete view of the patient.

While the sample size allowed us to closely analyse the data, it is not representative of larger trends. The finding of surgeon “set pieces” demonstrates the need for future research to include greater numbers of surgeons to identify routine practices beyond individual style. It highlights the variability in practice in referral letter writing and in opening of surgical consultations and raises questions of how the letter and referral process might be reconsidered. The strength of including surgeon participant-investigators in this action research approach is countered by the limitation of no consumer representatives or referring doctors in the research team.

Conclusions

A surgeon that relies solely on a referral letter may miss discrepancies in the referring doctor's and patient's understanding of a problem, may miss changes that have occurred since the letter was written, and may be unaware of important information regarding other aspects of the patient's health (paraclinical information) and life (contextual factors). It is essential to ensure that patients have the 'space' to present their experience and views, and the opening of a consultation is the primary opportunity for this patient agency (Collins et al., 2007).

While discrepancies in the reason for the visit occurred only once in the data presented here, we note the inherent risk in providing a referral with no information as to why the patient is attending. Even if the patient is familiar to the surgeon, the patient and surgeon may be unaware as to why the patient has been referred on this occasion, and so a referral letter limited to "for review and management" may become problematic. Beyond the reason for the visit, we argue that surgeons are less likely to need a diagnosis from the GP, as a diagnostic label could create bias and misdiagnosis (Dahm et al., 2021). Instead, surgeons may benefit more from information that facilitates a more holistic approach. Strategies for referral letter writing, such as writing the letter in front of or with the patient (O'Grady et al., 2014), may help with accuracy and breadth of information included, however such an approach would require sufficient time within the consultation.

Surgeons and patients are adept at "working around" interactional challenges. Patients will create space to present their problems, and surgeons will ask for information that might be expected but is not included in the referral letter. That said, there appears to be a disconnect between the content of referral letters and patient, family practitioner and specialist expectations of what would be best in these letters, with a need for further research to develop an understanding of what occurs in practice in the referral process.

Revisiting the purpose of the letter through additional research that includes examination of practice as well as incorporation of patient and clinician perspectives is needed to update the process of referral in Australia. Such research could focus on the different practices and preferences of specialty groups to assist general practitioners in formulating letters that will facilitate care of their patients as well as exploration of the patient experience. This broader evidence base would then allow more robust guideline development that would include not only expert opinion but also evidence from detailed analyses of practice and experience.

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Competing interests

Two of the authors were also participants in the study. This provided valuable insight into the research and was mitigated through the rigorous application of the methods described including multiple author input into the analysis.

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