Implications for research and practice

We have shown that present assumptions about patients' goals are unlikely to be correct. If unnecessary symptomatic intervention is to be avoided in patients with unexplained symptoms, general practitioners will need to understand better the influences that shape patients' presentations and doctors' responses.

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Views of doctors on clinical correspondence: questionnaire survey and audit of content of letters

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Clinical correspondence between general practitioners and specialists remains fundamental to the process of referral from primary care and transmission of management advice from consultants. However, both older and more recent studies indicate that opportunities for good communication are commonly missed.[1–3] Newton and colleagues explored the views of general practitioners and consultants on the desirable content of letters, and proposed standards against which the content of letters might be audited.[4] After a decade of increasing emphasis on good communication, clear records, and patient involvement, we repeated that study, and also audited letters written by doctors who responded to the questionnaire.

Participants, methods, and results

Questionnaires were sent to 360 general practitioners, 157 in areas served by the Royal Devon and Exeter Hospital and 203 in areas served by the Freeman Hospital, Newcastle, and to the consultants doing outpatient clinics (107 in Exeter and 101 in Newcastle), asking for their views on the desirability (always/usually important or sometimes/never important) of defined items[4] in the referral letter and replies. The response rate was 84% for both general practitioners (304/360) and consultants (174/208); the table shows their views. General practitioners now attached greater importance to documenting three items in their letters than in 1992: medical history, findings on investigation, and whether the referral is new. An increased proportion of consultants concurred with the need for medical history, but fewer consultants viewed what the patient expects from the referral as an important item. Fewer general practitioners and consultants thought that the general practitioner's expectation was an important item. A higher proportion of consultants now thought that including a summary of the case history in the consultant's letter was important.

Letters (including attachments) about two recent outpatient referrals from each consultant were audited, using uniform criteria for each item of content (table). The defined items were recorded more often in Exeter than in Newcastle by both general practitioners (six items) and consultants (three items). For two items, general practitioners in Newcastle recorded items more often.

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Views on, and contents of, general practitioners' and consultants' referral letters. Values are numbers (percentages) of respondents who viewed each item as "always/usually important" and number (percentage) of letters containing the items

	General practitioners' views of importance			Consultants' views of importance			Audit of letters (2002)		
Item of content	2002	1992	Odds ratio (95% CI) for difference	2002	1992	Odds ratio (95% CI) for difference	Exeter	Newcastle	Odds ratio (95% CI) for difference
General practitioners' referral letters									
Initial sentence stating reason for referral	263 (93)	104 (90)	1.52 (0.72 to 3.21)	155 (96)	146 (92)	2.30 (0.85 to 6.21)	132 (99)	138 (80)	33.48 (4.52 to 247.89)*
Outline of history	278 (97)	115 (100)	0	160 (98)	149 (94)	3.58 (0.97 to 13.26)	133 (99)	155 (90)	14.59 (1.92 to 111.08)*
Important medical history	283 (98)	104 (90)	5.44 (1.99 to 14.87)*	159 (95)	138 (87)	3.02 (1.30 to 7.05)*	85 (63)	117 (68)	0.80 (0.50 to 1.28)
Findings on examination	267 (92)	99 (86)	1.88 (0.95 to 3.70)	123 (74)	126 (79)	0.75 (0.45 to 1.26)	78 (58)	66 (38)	2.28 (1.44 to 3.61)*
Findings on investigation	259 (90)	91 (79)	2.36 (1.30 to 4.25)*	131 (80)	116 (73)	1.47 (0.88 to 2.47)	65 (49)	47 (27)	2.58 (1.60 to 4.16)*
Current medication	271 (95)	110 (96)	0.88 (0.31 to 2.50)	141 (87)	146 (92)	0.60 (0.29 to 1.24)	69 (52)	111 (65)	0.58 (0.37 to 0.93)*
Psychosocial matters	126 (46)	49 (43)	1.13 (0.73 to 1.75)	96 (59)	83 (52)	1.33 (0.86 to 2.06)	32 (24)	50 (29)	0.77 (0.46 to 1.30)
Allergies	187 (65)	85 (74)	0.65 (0.40 to 1.06)	92 (58)	97 (61)	0.88 (0.56 to 1.37)	17 (13)	21 (12)	1.09 (0.55 to 2.17)
Whether/how patient was involved in referral decision	104 (36)	33 (29)	1.38 (0.86 to 2.21)	51 (32)	59 (37)	0.80 (0.50 to 1.27)	22 (16)	39 (22)	0.67 (0.38 to 1.20)
What patient or relative has been told	105 (40)	39 (34)	1.30 (0.82 to 2.05)	80 (49)	86 (54)	0.82 (0.53 to 1.27)	10 (8)	13 (7)	1.16 (0.49 to 2.73)
What patient or relative expects from referral	106 (38)	49 (43)	0.81 (0.52 to 1.27)	60 (38)	87 (55)	0.50 (0.32 to 0.78)*	16 (12)	36 (21)	0.51 (0.27 to 0.97)*
What general practitioner expects from referral	216 (76)	101 (88)	0.44 (0.24 to 0.82)*	98 (60)	127 (80)	0.38 (0.23 to 0.63)*	131 (98)	154 (89)	5.39 (1.56 to 18.61)*
Whether new referral or re-referred	245 (87)	87 (76)	2.05 (1.18 to 3.57)*	129 (79)	121 (76)	1.19 (0.70 to 2.01)	128 (96)	81 (46)	30.02 (11.71 to 76.97)*
Consultants' letters									
Summary of history	219 (73)	79 (69)	1.20 (0.75 to 1.92)	149 (89)	126 (79)	2.17 (1.16 to 4.04)*	132 (99)	172 (100)	0
Findings on examination	269 (90)	102 (89)	1.14 (0.57 to 2.28)	146 (87)	146 (92)	0.59 (0.29 to 1.22)	123 (92)	145 (84)	2.16 (1.03 to 4.52)*
Findings on investigation	287 (95)	105 (91)	1.82 (0.79 to 4.18)	150 (89)	135 (85)	1.40 (0.74 to 2.68)	118 (88)	75 (44)	9.34 (5.11 to 17.08)*
Appraisal of the problem, including diagnosis where applicable	291 (98)	113 (98)	0.86 (0.17 to 4.32)	164 (99)	157 (99)	1.04 (0.15 to 7.51)	132 (99)	156 (91)	12.69 (1.65 to 97.37)*
Management plan	284 (96)	114 (99)	0.21 (0.03 to 1.62)	163 (97)	154 (97)	1.06 (0.30 to 3.73)	134 (100)	172 (100)	0
What patient or relative has been told	258 (86)	105 (91)	0.59 (0.28 to 1.21)	142 (84)	137 (86)	0.84 (0.46 to 1.55)	61 (46)	91 (53)	0.75 (0.48 to 1.19)
Time to follow up appointment	262 (89)	105 (91)	0.78 (0.37 to 1.64)	139 (86)	135 (85)	1.07 (0.58 to 2.00)	129 (96)	165 (96)	1.09 (0.34 to 3.53)
Who saw the patient	251 (88)	98 (85)	1.28 (0.68 to 2.40)	147 (91)	145 (91)	0.95 (0.44 to 2.03)	134 (100)	172 (100)	0

*P>0.05.

Comment

In the past decade the views of doctors regarding the desirable content of letters written by consultants have changed little, but the desirable content of general practitioners' letters has changed somewhat. The audit showed that, despite the views they had expressed, general practitioners frequently did not include "important" items in their referral letters. Nearly all general practitioners considered documentation of medical history and findings both on examination and investigation as important, but these items were documented in only 27-68% of their letters. Consultants' letters more often contained the items they viewed as desirable, but only about half included what the patient had been told.

The study identified differences in the content of letters between Exeter and Newcastle, for both general practitioners and consultants. This indicates that there may be regional variation around the country in the thoroughness of communication which doctors expect.

As well as conveying information from one doctor to another, letters also form a valuable source of reference, evidence of the process of informed consent, and a medicolegal record. Some items may have important safety implications. Letters can also help to inform patients, and it will soon be normal practice in the NHS to send copies of letters to patients.[5] For the guidance of healthcare practitioners and the wellbeing of patients, a more rational and consistent approach to defining the desirable content of letters is required.

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