Nurses’ Perspectives on Referral Letters and Discharge
Summaries: Towards Profession-oriented Writing Test Criteria

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Abstract

Effective written communication among overseas-trained health professionals is critical for accurate diagnosis, safe patient care and appropriate delivery of multi-disciplinary interventions. In Australia, the written communication of overseas-trained health professionals, including nurses, is often assessed through use of the Occupational English Test (OET), a specific-purpose language (LSP) test. The written component of the test requires nursing candidates to write a letter, usually one of referral or discharge, to another health professional. A set of case notes – similar in structure and content to hospital discharge summaries – are provided to test takers as a stimulus for writing the letter.

In the field of LSP testing, test designers and researchers are becoming increasingly aware of the need to develop criteria that more accurately reflect work-related performance. Assessment criteria are more likely to be professionally relevant if domain experts, such as individuals who have experience in interacting in the particular setting, are involved in the decision-making process and their perspectives on what is required of test takers are considered. However, the OET writing test assessment criteria were initially developed by language professionals without direct input from health professionals.

The aim of this qualitative, exploratory study was to understand what domain experts value by investigating nurses’ perspectives on the qualities of referral letters and discharge summaries that are critical to effective written communication. These perspectives enabled recommendations to be made to OET test developers about potential modifications to the current writing test criteria, as well as the test task.

Data collection was conducted in two phases. Phase One comprised the extraction and analysis of referral letters and discharge summaries from 200 medical records at two
hospitals. In the second phase, interviews (n=31) and focus-group sessions (n=36) were conducted with nurses to establish the qualities of referral letters and discharge summaries that nurses valued.

Genre analyses, which focused on the key linguistic features, content and structure of 100 referral letters and 100 discharge summaries, were undertaken on the ways these two documents were written. Both documents contained abbreviations, acronyms and symbols. Polite language was a common feature of the referral letters.

Both type of documents tended to follow a prescribed structure with discharge summaries predominantly written in note form and referral letters in prose. Markers of identification (e.g. name, address, designation) for the patient and writer were common in both documents, as was the inclusion of the presenting patient complaint.

Interviews and focus groups showed that nurses considered the communicative competence, awareness of audience and clinical knowledge displayed by the writer, as being crucial for high-quality referral letters and discharge summaries. Another important aspect of effective documentation identified by nurses was balancing comprehensiveness and relevance of information with writing concisely. A model of the qualities of referral letters and discharge summaries was developed based on the interview and focus-group findings.

The results also shed light on nurses’ reading and writing practices in relation to referral letters and discharge summaries. Nurses regularly engaged with both document types and relied on them to enhance their work practices; however, they were more likely to read rather than write referral letters and rarely contributed to writing discharge summaries.

The findings relating to nurses’ reading and writing practices of referral letters and discharge summaries, the qualities they value in these documents and the results of the genre analyses could be adapted for use in healthcare education, professional development in hospitals and other healthcare settings, and to inform healthcare policy about documentation.
The findings also contribute to the emerging field of research, which seeks to include domain specialists’ perspectives about what they consider important in the review and development of assessment criteria for LSP tests.

Recommendations for modifications to the OET include establishing a separate criterion for balancing conciseness with comprehensiveness of information. Candidates undertaking the nursing-specific writing test should be encouraged to write a referral instead of a referral letter, a genre which more closely resembles what nurses actually write in the healthcare setting. To ensure that there is sufficient language for examiners to assess, and to promote positive washback, it is also recommended that a second task commonly undertaken by nurses be included such as a set of progress notes.
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# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
</tr>
<tr>
<td>ANUM</td>
<td>Associate/Assistant Nursing Unit Manager</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>EAL</td>
<td>English as an Additional Language</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EMR</td>
<td>Electronic medical record</td>
</tr>
<tr>
<td>ESP</td>
<td>English for Specific Purposes</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>ISBAR</td>
<td>Identify/Situation/Background/Assessment/Recommendation/Request (verbal handover structure for health professionals)</td>
</tr>
<tr>
<td>L1</td>
<td>First language</td>
</tr>
<tr>
<td>L2</td>
<td>Second language</td>
</tr>
<tr>
<td>LSP</td>
<td>Language for Specific Purposes</td>
</tr>
<tr>
<td>NESB</td>
<td>Non English Speaking Background</td>
</tr>
<tr>
<td>NUM</td>
<td>Nursing Unit Manager</td>
</tr>
<tr>
<td>OET</td>
<td>Occupational English Test</td>
</tr>
<tr>
<td>TLU</td>
<td>Target Language Use</td>
</tr>
</tbody>
</table>
Declaration

This is to certify that:

• the thesis comprises only my original work towards the PhD,

• due acknowledgement has been made in the text to all other material used,

• the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signature:
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Chapter 1: Overview

1.1 Introduction

This thesis investigates the qualities of effective referral letters and discharge summaries valued by nurses, and examines their reading and writing practices in relation to these two documents. It also reports on genre analyses of 100 referral letters and 100 discharge summaries with a focus on structure, content and linguistic features. The current chapter provides an overview of the context of the research in the fields of both healthcare communication and language for specific purposes (LSP) testing. Next, the rationale for the study is given, followed by a statement of the research questions and a summary of chapters.

1.2 Context

1.2.1 Communication in healthcare. Effective communication, including written communication, is regarded as a pivotal aspect of healthcare (Schiavo, 2013). Healthcare professionals are required to share patient information and management strategies both inter-professionally (e.g. nurse to doctor) and intra-professionally (e.g. nurse to nurse) (Coiera, 2006; Cornett & Kuziemsky, 2018).

With variations identified in communication styles of different health professional groups (Foronda, MacWilliams, & McArthur, 2016), and a high level of occupational stress in clinical settings (Gholamzadeh, Sharif, & Rad, 2011; Vivian et al., 2019), there is the potential for ineffective collaboration to occur. Communication breakdowns between health professionals in the clinical setting have a negative impact on both patient outcomes and the provision of health care, and must be minimised (Abu et al., 2018).
One method for improving healthcare standards is to investigate and review current practices with the aim of making changes to enhance the quality of clinical performance (Batalden & Davidoff, 2007). Although this thesis does not provide a formal list of recommendations on how to improve referral letters and discharge summaries, it does investigate the aspects of these documents that nurses consider to be effective. The results could be used as a starting point for reviewing and improving writing standards of referral letters and discharge summaries in various healthcare settings, or as a basis for professional development in hospitals. The findings could also be used as a foundation for designing a module on writing referral letters and discharge summaries for health professional university courses.

A number of investigators have evaluated communication practices in healthcare settings with the majority focusing on spoken communication, whether clinician to patient (e.g. Visser et al., 2019; Zolnierek & DiMatteo, 2009) or clinician to clinician (e.g. Fealy et al., 2019; Finnigan, Marshall, & Flanagan, 2010). Less attention has been paid to written communication in healthcare, although a number of papers which focus on the introduction and impact of electronic medical records have been published (e.g. Danaei, Rodríguez, Cantero, Logan, & Hernán, 2018; Ford, Carroll, Smith, Scott, & Cassell, 2016). Although some studies have evaluated the effectiveness of referral letters from the perspectives of doctors (e.g. Eskeland, Rueegg, Brunborg, Aabakken, & de Lange, 2018) and dental practitioners (e.g. Ricketts et al., 2003), none so far have specifically explored the qualities of referral letters which nurses deem important. Similarly, discharge summaries have predominantly been analysed for effectiveness through a medical practitioner lens (e.g. Smith, 2019). Nurses’ perspectives on medical records as a whole, have been documented to some extent in the literature (e.g. Vossebeld, Puik, Jaspers, & Schuurmans, 2019); however, this thesis is unique in that nurses’ perspectives on the qualities of two specific documents in
the medical record – the referral letter and the discharge summary - are investigated, as well as their reading and writing practices in relation to these two documents.

1.2.2 Language testing for specific purposes. Language for specific purposes (LSP) testing refers to the assessment of language skills associated with a particular profession or field, such as health care and accounting. This type of test differs from general purpose language testing in that the tasks are relevant to a particular discipline. For instance, an LSP test designed for accountants might include the task of writing a financial statement, which is a widespread practice for accountants. In addition, their performance on a particular task relevant to the specific profession is able to be assessed, and allows for inferences to be made about how well they would perform linguistically and communicatively in the accounting setting.

The premise of testing LSP lies in the notion that firstly, language performances differ depending on the particular context and secondly, that the language used for specific purposes is unique and specialised according to the domain (Douglas, 2010). From a test validation perspective, the language performance elicited by the LSP test should reflect the actual communicative tasks used in the particular Target Language Use (TLU) domain (Knoch, 2016), which is the place where the communicative activity occurs in the real world (e.g. an accounting firm in the case of an LSP test for accountants).

Although LSP test tasks tend to be closely aligned with activities which are regularly undertaken in the TLU domain, the process of defining the test construct and establishing how to assess communicative competence through the development of criteria has traditionally been the realm of language specialists (Elder, McNamara, Kim, Pill, & Sato, 2017). One of the main criticisms of LSP tests, and especially the assessment criteria developed for these tests, is that they do not necessarily comprehensively reflect language use.
in the TLU domain, nor do they fully capture aspects of communication that are most valued by those who actually interact in the particular field (O’Hagan, Pill, & Zhang, 2016).

To address this criticism and to enhance test authenticity, LSP assessment experts have begun taking steps to identify what domain experts find meaningful and important in a communicative sense, and to make recommendations about incorporating what they value into the assessment criteria (e.g. Jacoby, 1998; Jacoby & McNamara, 1999; Pill, 2013). This thesis focuses on what nurses as domain experts value, the findings of which could be used as a basis for establishing more profession-oriented assessment criteria for the Occupational English Test (OET), an LSP test for overseas-trained health professionals.

1.3 Aim, Scope and Research Questions

A central aim of this thesis is to gain a detailed understanding of the qualities of referral letters and discharge summaries valued by nurses in order to ascertain the criteria by which they judge these documents, and consequently make recommendations for linguistic and communicative modifications to the OET writing test criteria. An additional aim is to establish the context in which nurses use referral letters and discharge summaries for their work, and to determine the reading and writing techniques they employ when engaging with the documents. A further aim is to develop a comprehensive understanding of the content, structure and linguistic features of both referral letters and discharge summaries in order to make recommendations regarding the OET writing task and accompanying stimulus material.

Nurses were selected as participants because nursing candidates are the largest cohort of OET test takers; therefore, understanding nurses’ perspectives was vital in making recommendations for modifications to the assessment criteria. Nurses comprise the largest group of health professionals in the world (Wong et al., 2015), but their perspectives on written documentation in medical records, including referral letters and discharge summaries, have been under-researched. This thesis takes steps towards remedying this lack of research.
Nurses also have a unique understanding of the healthcare system and of written documentation in medical records. They liaise with a range of health professionals on a regular basis and establish relationships with patients; therefore, understanding their viewpoint is extremely valuable.

Referral letters are the focus of this thesis because writing referral letters is a common OET writing test task. Analysing the genre, understanding what nurses value about referral letters, and how they engage with them was considered important. Discharge summaries were also a focus of the thesis because they closely resemble the stimulus material, or case notes, that the test takers are provided with in the test to help them write their letters. Moreover, test takers may also be tasked with writing a discharge letter for the OET writing sub-test, so it was vital to develop an understanding of how patients are discharged and the ways in which patients’ discharge is expressed in writing, as well as how nurses engage with discharge summaries as a genre.

This thesis forms part of the Australian Research Council (ARC) Linkage project, *Towards improved quality of written patient records: language proficiency standards for non-native speaking health professionals* (LP130100171), which was undertaken by the Language Testing Research Centre located in the School of Languages and Linguistics in the Faculty of Arts at The University of Melbourne. The project was conducted in conjunction with the Medical Education Unit and the Department of Nursing, both at The University of Melbourne. The partner organisation involved in the project was Cambridge Boxhill Language Assessment, owner of the OET and situated in Melbourne.

The ARC Linkage project was conducted in four phases: (1) investigating reading and writing practices of health professionals in relation to documents in the medical record, (2) exploring the qualities of clinical documentation which health professionals value, (3) developing and applying the criteria to OET test takers’ performances in conjunction with
language-trained assessors, and (4) developing new passing standards for the OET writing test. This thesis is situated in the first two phases. The first phase comprised the extraction and analysis of referral letters and discharge summaries from 200 medical records at two hospitals. In the second phase, interviews and focus groups with health professional informants were conducted to establish the qualities of referral letters and discharge summaries that health professionals, including nurses, value. Knowledge gained from these two phases formed the basis for enabling recommendations to be made about the OET writing test task and criteria.

The research conducted for the thesis was carried out solely and independently by the student researcher, and the findings informed the first two phases of the larger study. While recommendations are made about revising the OET writing-test assessment criteria and task based on the findings, the third phase of the wider project aimed to operationalise the criteria and assess the usability of the suggested criteria through feedback from the language-trained assessors. This thesis seeks to investigate the following research questions:

1a) What is the content and structure of referral letters and discharge summaries?
1b) What are the key linguistic features of referral letters and discharge summaries?
2a) What is the context in which referral letters and discharge summaries are read and written?
2b) How do nurses read or write referral letters and discharge summaries?
3) According to nurses’ perspectives, what features of referral letters and discharge summaries are critical to effective written communication?

The research questions are addressed through a combination of interviews and focus-group sessions with nurses, as well as genre analyses of samples of referral letters and discharge summaries sourced from hospital medical records.
1.4 Significance of the Study

Although researchers have previously drawn on genre analysis to analyse clinical documents such as GP medical certificates (e.g. Aarseth, Natvig, Engebretsen, & Lie, 2019), and medical case reports (e.g. Canziani & Mungra, 2018), to date, referral letters and discharge summaries have not received the same treatment. The current study addresses this gap through two detailed genre analyses of referral letters and discharge summaries, thus providing a perspective on how these documents are constructed, the types of information included and the linguistic features specific to the two genres.

This thesis also differs from prior research in that nurses’ views on the qualities of referral letters and discharge summaries were investigated, a novel undertaking considering that nurses’ perspectives on these documents had not previously been presented in the literature. It was important to gain an understanding of nurses’ viewpoints considering that referral letters and discharge summaries are key documents in the medical record as they provide a record of how patients are to be managed at transitions of care. Referral letters and discharge summaries are a crucial aspect of healthcare written communication. In addition, the development of a model depicting the qualities of referral letters and discharge summaries valued by nurses had not been attempted by healthcare communication scholars prior to this thesis.

From an LSP testing standpoint, this thesis is in line with the work that language testing experts are currently undertaking in researching the particular aspects of communication that hold importance for domain experts with the aim of potentially incorporating what they value in the assessment criteria of LSP tests (e.g. Jacoby, 1998; Jacoby & McNamara, 1999; Knoch, 2014; O’Hagan et al., 2016; Pill & McNamara, 2016).

A previous Australian Research Council Linkage Project conducted by a team at The University of Melbourne made headway into identifying the aspects of spoken
communication valued by health professionals from the fields of Medicine, Nursing and Physiotherapy, with the researchers able to make recommendations for modifications to the OET speaking test criteria based on their findings (Elder et al., 2013). The current thesis also investigates aspects of communication valued by health professionals, but the focus is on written communication from the perspective of nurses.

1.5 Summary of Chapters

This thesis is presented in nine chapters. The first and current chapter has introduced and contextualised the thesis topic and outlined the aim, scope and significance of the study.

The two major fields of research relevant to this study – healthcare communication and LSP testing - are considered in Chapter 2, the literature review. Firstly, literature pertaining to written healthcare communication is discussed with a focus on referral letters, discharge summaries and nursing documentation. Following this discussion on documentation, the Occupational English Test is introduced. Notions of test authenticity, communicative competence and indigenous criteria, which are of central significance to this study, are then explored. The final section of the literature review discusses the concept of genre and presents the English for Specific Purposes (ESP) genre analysis approach which was undertaken as part of this thesis.

Chapter 3 elaborates on the methodology used for the research. Firstly, the stages of the research are presented. Next, the participants, instruments and procedures are described, as are the three different data collection techniques utilised for the study, these being: (1) extraction of medical records and genre analyses of referral letters and discharge summaries; (2) semi-structured interviews with nurses in which their perspectives on effective documents and their methods for reading and writing referral letters and discharge summaries were discussed, and (3) focus-group sessions in which nurses talked in detail about the aspects of referral letter and discharge summary samples which they found effective. In addition, the
data coding techniques carried out for each of these three types of data collection are presented. The chapter culminates with a discussion of ethical considerations of the research.

Genre analyses of 100 referral letters and 100 discharge summaries are presented in Chapter 4. The rhetorical moves and steps of referral letters are categorised and discussed in relation to structure, content and linguistic features. The sample of discharge summaries is also analysed for structure, content and linguistic features but with comparisons drawn between the sample and the national guidelines for on-screen presentation of discharge summaries as set out by the Australian Commission on Safety and Quality of Health Care (ACSQHC, 2016). Comparisons were made between the sample of discharge summaries and the national guidelines, because the guidelines are considered to be best practice and it is recommended that all health professionals writing discharge summaries follow these strategies. The genre analyses inform the task and stimulus materials used in the OET.

Chapters 5 and 6 report the results of the semi-structured interviews with nurses and the focus-group sessions respectively. The results inform the criteria by which performance should be judged, i.e. the domain experts’ perspectives on what they value and how they engage with referral letters and discharge summaries. Based on the findings described in these two chapters, a model of the qualities of referral letters and discharge summaries valued by nurses is presented in Chapter 7.

The findings from the previous chapters, and the implications of these findings, are discussed in Chapter 8.

Chapter 9, the concluding chapter, provides recommendations for modifications to the OET writing test task and assessment criteria. The chapter also addresses the limitations of the current study and provides recommendations for future research. A summary of the study is also included.
Chapter 2: Literature Review

2.1 Introduction

This chapter presents a critical appraisal of the literature pertaining to healthcare written communication, Language for Specific Purposes (LSP) testing and genre analysis. As one of the main aims of this thesis is to establish the context in which nurses use referral letters and discharge summaries for their work, and to determine the reading and writing techniques they employ when engaging with the documents, research exploring nursing documentation is discussed in this chapter.

Another major aim of the study is to gain a detailed understanding of the qualities of referral letters and discharge summaries valued by nurses in order to ascertain the criteria by which they judge these documents, and consequently make recommendations for linguistic and communicative modifications to the assessment criteria of the Occupational English Test (OET), an English-language test for overseas-trained health professionals. Considering this aim, research on the effectiveness of referral letters and discharge summaries is examined. The notion of ‘indigenous criteria’, which is the standards used by experts to assess the performances of less experienced individuals in the field, is also considered, as is research pertaining to test authenticity.

As the final aim of this thesis is to develop a comprehensive understanding of the content, structure and linguistic features of both referral letters and discharge summaries in order to make recommendations regarding the OET writing task and accompanying stimulus material, the chapter concludes with an exploration of genre and approaches to genre analysis.
2.2 Literature Search Strategy

The first literature search for this thesis was conducted in 2013, and subsequent literature searches were carried out each year from 2014 to 2019 to update the references and keep abreast of current research. The University of Melbourne library catalogue was used to conduct literature searches based on key words, for example: ‘LSP testing’, ‘indigenous assessment criteria’, ‘communicative competence’, ‘referral letters’, ‘discharge summaries’ and ‘written communication in healthcare’. The library search engine provided direct access to journals such as Language Testing and the International Journal of Nursing Studies. A number of books related to language testing and healthcare communication were borrowed directly from the university library. E-books were also borrowed online through the university catalogue.

To complement the library literature search, Google Scholar was also utilised. Either journal articles were directly accessible through the search engine, or through databases such as ‘Taylor & Francis Online’, ‘Wiley Online Library’, ‘Sage Journals’, and ‘ERIC’.

Most of the information drawn upon for the literature review was sourced from journal articles and books; however, credible websites, such as the Occupational English Test website were also included. Text types such as commentaries and editorials were excluded.

In total, 238 references were cited in the thesis. The references included: 191 published papers, 36 books, six web pages and five unpublished PhD theses.

2.3 Written Communication in Healthcare

Healthcare communication is both spoken and written. Critical information about patients and their treatment is often conveyed through writing (O’Daniel & Rosenstein, 2008). In fact, written communication is the most prevalent form of communication between specialists and health professionals in primary care (Vermeir et al., 2015), and is used extensively in hospitals (Stevens & Pickering, 2010). Healthcare written communication can
be defined as any document, note, chart, summary or letter written by a health professional about a patient, their condition, treatment and care (Creed, 2017).

Maintaining high standards of written communication amongst health professionals is vital for informing individuals about diagnoses and treatment, multi-disciplinary interventions and for patient safety (Gausvik, Lautar, Miller, Pallerla, & Schlaudecker, 2015; Jefferies, Johnson, & Griffiths, 2010; Vermeir et al., 2015). Healthcare documents are not simply summaries of events that have already taken place, they are also dynamic in that they provide a means for collaboratively establishing future treatments and outcomes (Harvey & Koteyko, 2012). Healthcare documents are also modified and updated over time as the needs of patients change. Health professionals, including nurses, are expected to communicate effectively in writing both in an intra-professional sense with their nursing colleagues, and in an inter-professional sense with other health professionals such as doctors, physiotherapists and social workers (Key-Solle et al., 2010).

2.3.1 Nursing documentation. Nursing documentation can be defined as ‘a written or electronic communication tool that generates information about a patient and is typically used to describe the patient’s care and response to treatment’ (Lindo et al., 2016, p. 509). Documents commonly written by nurses include progress notes, reports, charts, nursing care plans, inpatient referrals and discharge notes (Cpiao, 2012; Saranto & Kinnunen, 2009). Written communication is an integral part of nursing practice (Kent & Morrow, 2014), with nurses usually spending approximately 15% to 25% of their time during a shift recording information about the patient care they have provided (Lindo et al., 2016).

Nursing documentation is important because it provides evidence of how nurses care for patients, their perspectives on the patient journey from admission to discharge, the decisions made by both nurses and patients, and the resulting outcomes (Jefferies et al., 2010). Keeping a written nursing record enables nurses, and other health professionals to
access patient information when required (Jefferies, Johnson, Nicholls, & Lad, 2012). It is also valuable evidence of nursing care and treatment from a legal standpoint (Jefferies, Johnson, Nicholls, & Lad, 2012). Additionally, nursing documentation can be used as a basis for nursing development and research, for working out how to allocate resources and for care planning (Wang, Hailey, & Yu, 2011).

2.3.2 Standards of nursing documentation. Considering the importance of nursing documentation, research investigating nurses’ written communication has shown that there are inconsistencies in record keeping (e.g. Wu et al., 2018). This is problematic considering that inadequate nursing documentation contributes to discontinuity of patient care and is a major cause of nursing and medical errors (De Groot, Triemstra, Paans, & Francke, 2019; Instefjord, Aasekjær, Espehaug, & Graverholt, 2014).

A meta-analysis which investigated the components of effective nursing documentation as documented in the literature found that there were several factors which contributed to sub-standard documentation (Jefferies et al., 2010). Firstly, at times, nurses did not document certain aspects of care or concerns they may have held because they did not have the nursing language to accurately express highly complex issues such as psychosocial concerns. Nursing documentation tended to be predominantly focused on routine elements of care such as vital signs (observations), rather than clinical judgements and decision-making processes. Nurses also assumed that readers would be familiar with the treatments and procedures they had undertaken and therefore did not provide sufficient detail in their documentation (Jefferies et al., 2010).

A qualitative study conducted in Indonesia, in which focus-group sessions with 35 head nurses and hospital staff were conducted, had similar findings regarding the causes of sub-standard nursing documentation, these being: inadequate supervision of nurses, lack of
competency in writing documents, and a lack of motivation and confidence when it came to record keeping (Kamil, Rachmah, & Wardani, 2018).

Other contributing factors were the nurses’ busy working schedules, which meant that documentation usually occurred hurriedly at the end of a shift when nurses were less likely to spend sufficient time documenting their nursing activities due to time constraints (Donoghue, Pelletier, & Duffield, 2005). Additionally, errors in nursing documentation often occurred due to a lack of training in record keeping (Krishna & Khyati, 2017) or due to a lack of proper systems in place, such as protocols and checklists, to support effective documentation (Nadzam, 2009). There is also an increased burden on nurses in terms of having to complete documentation of a number of risk screening tools and observation charts (e.g. Cascio & Logomarsino, 2018; Mohammmed Iddrisu, Hutchinson, Sungkar, & Considine, 2018).

2.3.3 Strategies to improve nursing documentation. Several suggestions have been made by researchers as to how to improve nursing documentation. Standardised documentation, which provides explicit guidelines for documenting care of patients, has been recommended as one solution (Blair & Smith, 2012). The careful design of health service orientation sessions has also been identified as an option for nurses commencing work to ensure that they are up to standard with best practices in the particular healthcare setting (Okaisu, Kalikwani, Wanyana, & Coetzee, 2014). In addition, continuing education of nurses in regard to documentation standards is paramount (Okaisu et al., 2014).

In a Swiss study involving an experimental design, investigators examined the outcomes of an education program attended by nurses which was implemented with the aim of improving the quality of nursing documentation (Müller Staub, Needham, Odenbreit, Ann Lavin, & Van Achterberg, 2007). The program was conducted over a few sessions using a case scenario method and focused on developing nurses’ documentation skills regarding diagnoses, interventions and patient outcomes. Analysis of the participants’ documentation
both before and after the education program showed a marked improvement in their record keeping of diagnoses, interventions and patient outcomes following completion of the program. For example, prior to the program, the mean number for record keeping of nursing interventions made by participants was 1.27 (SD = 0.51), while after the program, the mean number was 3.21 (SD = 0.50), p > 0.0001, showing a significant increase in record keeping for carrying out nursing interventions. Furthermore, the nursing interventions were reported to be of a higher quality and better directed towards nursing goals (Müller Staub et al., 2007).

Similarly, a ward-based education program was implemented in an Australian hospital in 2012 with the aim of improving the quality of nurse documentation (Jefferies, Johnson, Nicholls, Langdon, & Lad, 2012). The program involved teaching nurses to accurately document the care that they provided and information about the patient’s condition, in a way that would enable the reader of the documentation “to develop an overall picture of the patient’s condition and care from admission to discharge” (Jefferies, Johnson, Nicholls, Langdon, et al., 2012, p. 395). The study followed a mixed-methods approach in which pre and post program results were analysed quantitatively and focus-group sessions discussing record keeping and the program provided the qualitative component of the study. While the quantitative results showed that there were no statistically significant differences in the quality of documentation after participants had completed the program, the qualitative findings suggested that the participants believed the program was valuable in helping them to develop their record-keeping and writing skills.

These two studies (Jefferies, Johnson, Nicholls, Langdon, et al., 2012; Müller Staub et al., 2007) demonstrate the importance of providing nurses with opportunities to develop their record-keeping skills to ensure that their documentation is up to standard. For education programs to be effective, there needs to be an understanding of what effective nursing documentation comprises.
2.3.4 Qualities of effective nursing documentation. For nursing documentation to be effective, there are several standards or qualities that must be present. In the meta-analysis conducted by Jefferies et al. (2010), the investigators examined the essential components of quality nursing documentation as described in 171 papers. Through an analysis of the research findings, data were categorised into key concepts. Investigators found seven main themes or standards which emerged from their research: 1) nursing documentation must be patient-centred; 2) it should describe the work that nurses do including the provision of education and psychosocial support to the patient; 3) the documentation must reflect the objective clinical judgement of the nurse; 4) documentation needs to be presented in a logical and sequential way; 5) documentation should be undertaken regularly as events take place; 6) variation in care should be recorded, and 7) nursing documentation must meet legal requirements (Jefferies et al., 2010).

Other research indicates that nursing documentation should be “legible, clear, concise, concrete, and complete” (Scruth, 2014, p. 312). It should also include use of only abbreviations and symbols that are authorised in the particular healthcare setting (although this view could be problematic if the patient moves from one healthcare setting to another). The patient must be identified sufficiently and events should be reported chronologically (Obioma, 2017; Ofi & Sowunmi, 2012; Wang et al., 2011). A combination of all these factors contributes to high-quality nursing documentation.

One method of reporting clinical activities and patient care in a sequential order is through use of the ISBAR, which is a standardised communication technique used by Australian health professionals during mainly oral handovers, but could be adapted for written transitions of care (Finnigan et al., 2010). The acronym is: I (Identify), S (Situation), B (Background), A (Assessment) and R (Recommendation) (Mannix, Parry, & Roderick, 2017). When conducting a handover using ISBAR, health professionals, including nurses,
work their way through the mnemonic in order, starting with ‘I’ which involves firstly identifying who they are, their role and then adequately identifying the patient. The ‘situation’ relates to the patient’s current healthcare situation (e.g. reason for admission), and the ‘background’ provides a clinical context including medical and social history. The aim of the ‘assessment’ is for health professionals doing the handover to identify what the problem may be based on a judgement of the patient’s observations. They will then make recommendations (R), highlight possible risks and may mention responsibility of care ("ISBAR, a standard mnemonic to improve clinical communication," 2016; Mannix et al., 2017).

Some institutions use ISOBAR in which the O stands for ‘observations’, the A represents ‘agreed plan’, or the explanation of what needs to occur, and the R denotes ‘read back’ which enables clarification of the information (Manias et al., 2016; Porteous, Stewart-Wynne, Connolly, & Crommelin, 2009). While both ISBAR and ISOBAR techniques are predominantly used for verbal handovers, they may be accompanied by written documents such as forms or checklists. ISBAR and ISOBAR techniques could also be drawn upon as a basis for structuring more extensive and complex medical documents such as referral letters and discharge summaries. In the United Kingdom and the United States, the acronym ‘SBAR’ is more common, with the ‘I’ for ‘identify’ omitted, although patients and treating health professionals are likely to be identified through the description of the situation (S) and background (B) (Labsom, 2019).

2.3.5 Transition documents. The concept of ‘transitional care’ is widely discussed in the healthcare literature (e.g. Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011), and is defined as ‘a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location’ (Coleman, 2003, p. 549). Referral letters and discharge summaries are key
documents which play a role in transitional care in that they are written when patient care is transferred from one health professional or team to another during a period of changeover or transition (i.e. from one stage of the treatment process to another). Therefore, for the purpose of this thesis, the umbrella term for referral letters and discharge summaries is *transition documents*. Although this phrase is not prevalent in the clinical setting, nor in healthcare communication research, it is a succinct term which can be used to describe both referral letters and discharge summaries.

The term ‘handover documents’ was also considered for use in this thesis; however, the word ‘handover’ evokes transitions of care revolving around spoken rather than written communication for health professionals such as an oral bedside handover conducted by nurses. Furthermore, handover notes are written by health professionals as part of the handover process and are a different type of documentation to referral letters and discharge summaries. Consequently, to avoid confusion, *transition documents* was considered the most suitable term.

### 2.3.5.1 Referral letters

One transition document that commonly appears in medical records is the referral letter, which is a form of correspondence between two or more health professionals, concerning a patient. Referral letters are usually either written by primary-care doctors (e.g. general practitioners) to specialists and hospital doctors, or vice versa (Ramanayake et al., 2013).

According to the literature, the main functions of referral letters are to communicate the patient’s diagnosis, to describe the treatment and management of conditions to date (Jiwa & Dadich, 2013; Piterman & Koritsas, 2005), to arm the receiving health professionals with ‘essential information which permits the ideal treatment of the patient’ (Navarro, Miranda, Onofre, & Sposto, 2002, p. 537), and to provide continuity of care (Dickie, Ellwood, & Robertson, 2011). In Australia, the United Kingdom and New Zealand, referral letters are
often required by surgeons and specialists before they can begin treatment, especially in the public health system (White et al., 2014)

Although use of referral letters is widespread, the quality of these letters is sometimes questionable (Scott, Mitchell, & Logan, 2004). It has been found that many recipients are dissatisfied with the standard of referral letters, especially the content and quality of these documents (Berendsen et al., 2009; Tattersall, Butow, Brown, & Thompson, 2002). In fact, a cross-sectional Dutch study, which investigated how referral letters written by general practitioners (GPs) were received by specialists, found that there was much dissatisfaction by the specialists in regard to the GPs’ referral letters (Berendsen et al., 2009). Of the 232 specialists surveyed, only 29.1% of the specialists believed the GPs’ referral letters were ‘qualitatively good’. The researchers did not specifically define ‘qualitatively good’ in their paper but respondents were asked to respond to the statement, ‘generally, the GP's referral letter is qualitatively good’ through use of a five-point scale (from ‘agree’ to ‘completely disagree’). From the GPs’ perspective, 50% of GPs (n=259) were of the opinion that the specialists did not adequately address the issues raised in the referral letters they had written (Berendsen et al., 2009, p. 146). It is evident from the results of the study that there was much dissatisfaction with the standard of referral letters written by GPs, as well as with responses to the referral letters given by specialists.

Australian researchers have also found that referral letters are not always as effective as they should be. One mixed-methods study looked at the comprehensiveness of information contained in referral letters written by GPs and obstetricians in the Foetal Medical Unit at The Canberra Hospital. Pregnant women (n = 103) who had presented for their first consultation at the unit were sent out questionnaires regarding information pertaining to their pregnancy and their health, as well as their medical, obstetric and gynaecological history and their reason for presenting at the hospital. Their responses were
compared with the information written in the referral letter. The results showed that relevant and important medical information, including the reason for the referral and medical history, was missing from 57% of referral letters in the sample (Dickie et al., 2011).

Another Australian study, which involved a prospective case-study design, was conducted by Harwood, Paoloni, and Mitic (2015) and compared the prevalence of medication discrepancies (i.e. lack of accuracy in regards to medications) in two sets of GP referral letters sent to the Emergency Departments of two hospitals. One set of referral letters was written for patients with congestive cardiac failure (heart failure) and another set was written for patients with polypharmacy, comprising those patients using four or more medications. Results showed that there were more medication discrepancies per letter for the patients with heart failure, and that the medication discrepancies were potentially more serious compared to those with polypharmacy. One of the most important findings of the study was that the prevalence of medication errors was extremely high in both sets of referral letters, with 91% of the referral letters for patients with heart failure containing at least one medication discrepancy and 88% of the referral letters for patients with polypharmacy also containing at least one medication discrepancy. The most common type of error was the addition of a medication that a patient did not take. Thus, there is a need to improve the effectiveness of referral letters in Australia, as well as in other countries.

Currently, in Australia, there are already guidelines in place to assist health professionals with writing referral letters. Websites managed by most of the larger hospitals have links to either referral templates or a list of instructions for writing referral letters. The proformas can easily be downloaded, filled out and then emailed, faxed or mailed to the hospitals. Depending on the size of the hospital, there are separate referral templates for different departments or units. The instructions for writing referral letters are usually detailed. For example, St Vincent’s Hospital in Sydney (not one of the sites for the current
research), lists all the information that should be included in the referral including the patient’s full name, address, contact numbers and date of birth, the reason for the referral, medical history, relevant diagnostic results and current medications ("St Vincent's," 2017).

In Australia, the Victorian State Government designed a state-wide referral form in 2013 which GPs can download, fill in and then send to both private and public hospitals and clinics (see Appendix A). The template is available in most GP software packages and can be typed, auto-populated or handwritten (NHV, 2013). Some Victorian hospitals have links to the state-wide referral form on their websites. However, not all GPs use the referral templates provided by the government and hospitals.

### 2.3.5.2 Discharge summaries
A second type of transition document found in hospital medical records is the discharge summary, which is a report written by health professionals when a patient is discharged from hospital or another healthcare facility (Parvin, 2014).

Discharge summaries allow for the transfer of clinical information about the patient from inpatient to outpatient settings and across different hospital admissions (Abdul-Rahman, 2012). They provide GPs and other health professionals with information about the patient’s condition, treatment and progress during the hospital admission and detail the follow-up care that needs to be undertaken once the patient has been discharged (Barr, Chin, & Yeong, 2013). In addition, discharge summaries provide continuity of care as the patient transfers from one healthcare setting to another (e.g. when a patient is discharged from hospital and goes back home so that the GP can take over care) (May-Miller et al., 2015).

As with referral letters, research showed that discharge summaries tended to vary in quality with many considered to be substandard (Sakaguchi & Lenert, 2015). This substandard quality has been found in Australia (e.g. Middleton, Appleberg, Girgis, & Ward, 2004), and in other countries such as Bangladesh (Parvin, 2014), the United Kingdom (May-
Miller et al., 2015), and the United States (Al-Damluji et al., 2015). Some discharge summaries described in the research lacked adequate information (e.g. not including recommendations for how to treat the patient) (Moore, McGinn, & Halm, 2007; O’Leary et al., 2009), whilst others had inaccurate discharge information, such as medication discrepancies (Harlan et al., 2010; Sakaguchi & Lenert, 2015). Poor quality discharge summaries have been found to increase the likelihood of an adverse event occurring, and may lead to rehospitalisation of the patient (Dinescu, Fernandez, Ross, & Karani, 2011; Hesselink et al., 2012).

Variations in information sources to inform the writing of discharge summaries may also affect their quality. A cross-sectional study conducted at a hospital in Norway involved investigation of the documents from the medical records which nurses (n = 510) and physicians (n = 236) drew upon to write discharge summaries (Hellesø & Sogstad, 2014). According to the authors, in Norway both nurses and physicians usually write discharge summaries and they tend to produce these separately (Hellesø & Sogstad, 2014). The results showed that physicians seldom looked at nurses’ admission notes or nursing care plans to write their discharge summaries, although 26.3% of the doctors did report that they drew upon nurses’ notes while writing their discharge summary. They were much more likely to use laboratory results and physicians’ notes to inform their writing. In contrast, nurses most frequently drew on their nursing notes but also used some physicians’ admission notes to write their discharge summaries. Consequently, the two groups of participants were more likely to source information which was in line with their own practices, in parallel to each other. Doctors in particular were less likely to draw on information written by other health professionals such as nurses, which has implications for the effectiveness of discharge summaries as inter-disciplinary perspectives were not considered.
Health professionals and researchers have begun to put measures in place to ensure that discharge summaries are received in a timely fashion and are of adequate quality. For instance, a team of researchers and health professionals at a hospital in Chicago developed and implemented an electronic discharge summary which they reported significantly enhanced outpatient clinicians’ satisfaction with both the quality and timeliness of the discharge summaries (O'Leary et al., 2009).

Another group of researchers were able to make recommendations about the accuracy and timeliness of discharge summaries based on conducting an initial analysis of how discharge summaries were written at The Mount, a psychiatric hospital in the United Kingdom (Shastri, Bangar, Waldman, Esfahani, & Brindle, 2014). They made recommendations for timely dissemination based on their analysis which resulted in clinicians writing and sending off discharge summaries significantly more quickly than they had done prior to the researchers’ recommendations.

Other researchers have attempted to design discharge summaries which are suitable for specific domains in order to ensure that all relevant information is included. For example, by conducting semi-structured interviews and performing qualitative analysis, researchers in Canada were able to create orthopaedic-specific discharge summaries to improve hospital transitions (Soong, Kurabi, Exconde, Tajammal, & Bell, 2016). These studies demonstrate that healthcare professionals and researchers are seeking to improve the quality and timeliness of discharge summaries to ensure adequate patient care and safety.

Another important initiative in improving the quality of discharge summaries in Australia is the development of a document by the Australian Commission on Safety and Quality in Health Care entitled ‘National guidelines for on-screen presentation of discharge summaries’ (ACSQHC, 2016). The report makes detailed recommendations about the structure and content of discharge summaries and recommends against using abbreviations.
This document is discussed in more detail in Section 4.11 of the thesis in response to the sample of discharge summaries.

A second report which was also produced by the Australian Commission on Safety and Quality in Health Care in conjunction with the Sax Institute, comprised a literature review with a focus on improving documentation for complex patients during transitions of care (Manias, Bucknall, Hutchinson, Botti, & Allen, 2017). The report showed evidence of patient safety being compromised due to poor documentation. Recommendations were made about specific features of documentation that should be included at transitions of care for patients with complex needs such as ensuring the inclusion of patient details, medications and details of the clinical encounter (Manias et al., 2017).

2.3.6 Nurses’ contributions to transition documents. There is scant reference in the literature to referral letters written by nurses, other than psychiatric nurses (e.g. Shaw, Smith, Middleton, & Woodward, 2005) and those working in hospices or aged care (Robinson & Street, 2004). This lack of reference suggests that nurses, especially those working in hospitals, may not often be directly involved in writing referral letters or that their contribution to the referral-letter writing process is yet to be documented in healthcare communication research. Although nurses do not usually write referral letters, they do read and engage with the letters as part of their clinical work, a practice which has not yet been specifically addressed in the literature.

Similarly, although nurses’ perceptions on the discharge process as a whole have been explored (e.g. (Atwal, 2002), the writing of discharge summaries by nurses has not yet been documented, apart from the Norwegian study conducted by Hellesø and Sogstad (2014) which is described in Section 2.3.5.2 of this thesis. The current study fills a research gap by investigating how nurses engage with referral letters and discharge summaries in the hospital setting.
2.3.7 Electronic documentation. Electronic medical records (EMRs) are becoming more prevalent, both in hospitals and private practice (e.g. GP and specialist clinics). Advances in EMR technology mean that patient information is likely to be exchanged electronically (Li, Ladner, Miller, & Classen, 2018). Since the late 1990s, a number of studies investigating the use of EMRs in healthcare settings have been conducted (e.g. Lin, Jha, & Adler-Milstein, 2018; McCarthy et al., 2019). Although there are many advantages to using EMRs, there are some possible pitfalls as well.

The use of EMRs is advantageous in that it may lead to improvement in patient care due to a synthesisisation of medical documents (Russo, Sittig, Murphy, & Singh, 2016). Doctors, nurses and allied health professionals (e.g. speech pathologists and occupational therapists) can access and collectively contribute to integrated medical records, leading to a reduction in medical errors caused by a lack of communication between health professionals (Russo et al., 2016), because all treating health professionals have access to relevant documents and notes. Furthermore, EMRs also provide a means of archiving data, which means that health professionals and medical researchers can gain access to extensive databases, thereby being able to treat individual patients more comprehensively and effectively but also being able to conduct research in a way that was previously impracticable (Hauser et al., 2001; Raghupathi & Raghupathi, 2014). Having accessible information on hand means that health professionals can more effectively treat their patients (Wani & Malhotra, 2018).

EMRs also have the benefit of enhanced accuracy and legibility, especially as health professionals do not need to decipher the handwriting of their colleagues (Karaksha, Hattingh, & Hall, 2010). Additionally, the retrieval of the records, especially in emergency situations, is quicker and more straightforward (Pourasghar, Malekafzali, Koch, & Fors, 2008). EMRs can be accessed from multiple locations (for example, at the patient’s bedside...
and in the operating theatre); delays in treating the patient are less likely to occur as a result.

Computer programs such as Electronic Nursing Discharge Messages which allow ‘nursing content to be to be specified and exchanged between electronic patient record systems’ (Goossen, 2009, p. 269) and have the benefit of allowing nurses to share relevant patient information instantaneously, would also go some way to improving the effectiveness and quality of documentation (Goossen, 2009).

Conversely, some researchers argue that use of EMRs may end up prolonging the amount of time that healthcare professionals spend writing, considering that EMRs may generate multiple reports to be completed, leading to a decrease in patient contact time (Mamykina, Vawdrey, & Hripcsak, 2016). There are also concerns about variations in the consistency and the quality of EMRs within and across different healthcare settings (Liaw et al., 2012). Discrepancies in the use of EMRs may be caused by differences in the way clinicians enter information (e.g. use of abbreviations), and their decision-making processes – for example, choosing to include or omit certain information (Liaw et al., 2012).

**2.3.7.1 Electronic transition documents.** Electronic versions of referral letters and discharge summaries can be found in both EMRs and paper-based records. The documents may be electronic in the sense that they are completed online as part of the EMR technology, or, alternatively, they may be typed, sent out by mail or fax and then scanned into the EMR or placed in the paper-based record. The mode for writing transition documents electronically is dependent on the systems in place within a particular clinical setting. For instance, EMRs might not be used at a specific hospital; thus, employees would be expected to type and circulate referral letters rather than use an online program.

The introduction of computers in general practice, as well as EMRs in hospitals, has enabled electronic transition documents to be transferred more rapidly than handwritten documents (Piterman & Koritsas, 2005). However, it has been found that switching to an
electronic system does not necessarily significantly improve the quality of transition documents such as referral letters (Corwin & Bolter, 2014).

In some cases, electronic referral letters have been found to be ‘less concise and clinically relevant than their paper predecessors’ (O’Malley, Grossman, Cohen, Kemper, & Pham, 2010, p. 182). This may be in part because, even in current times, sending electronic referral letters is not as common as one might expect. For example, a recent mixed-methods Australian study which involved a survey of 204 doctors and allied health professionals about their attitudes and behaviours regarding electronic modes of communication found that the fax machine was still the preferred mode for sending referral letters, with 53% of respondents electing to fax (Hughes, Allen, & Bentley, 2018). Posting referral letters was the next most common mode (27% of participants) identified and only 12% opted to send electronic referral letters.

It has been suggested that with the advent of EMRs, discharge summaries, in their current form, should be phased out completely by making clinical information automatically accessible and visible to the relevant health professionals, hence negating the need to write a separate discharge summary (Arya, 2015). Arguably, there would still be a need to synthesise the information for another health professional, so phasing out discharge summaries would not be practical. Alternatively, use of a more structured and standardised format to improve communication between healthcare professionals has also been recommended (ACSQHC, 2016; Piterman & Koritsas, 2005; Tattersall et al., 2002).

2.3.8 Electronic documentation and nursing. As part of their work, nurses are required to record the care they have provided and their patient’s progress, and the use of electronic documentation can contribute to the efficiency and effectiveness of nurses’ written communication (Lavin, Harper, & Barr, 2015). Some studies have shown that having data and notes readily available online, as well as shared use of electronic medical records
(EMRs) by different health professionals tends to lead to better nursing care and enhanced patient safety (Englebright, Aldrich, & Taylor, 2014; Saleem, Flanagan, Wilck, Demetriades, & Doebbeling, 2013).

2.3.9 Summary of written communication in healthcare This section provides a brief summary of what has been explored so far regarding written communication in healthcare. The importance of effective nursing documentation has been discussed in response to the literature. Strategies such as continued education in regards to documentation, have been identified in the literature as a means of enhancing nurses’ written communication skills.

The research shows that writing referral letters and discharge summaries is a common task for doctors, but it is less so for nurses. Referral letters and discharge summaries tend to vary in quality, however putting specific writing guidelines in place may enhance the effectiveness of these documents. Electronic versions of referral letters and discharge summaries are in use, especially since the introduction of electronic medical records.

Researchers are yet to explore how nurses engage with referral letters and discharge summaries as part of their work, and how and if they contribute to writing these documents. The qualities of referral letters and discharge summaries valued by nurses have not been identified by the literature prior to the current thesis. In the following section, literature pertaining to nursing pathways and the Occupational English Test will be examined.

2.4 Nurses and the Occupational English Test

Nurses are the largest health professional group in the world and make a significant impact on their patients’ health (Wong et al., 2015). However, many countries, including Australia, are currently facing a shortage of registered nurses, predominantly due to an ageing population with an increased need for healthcare (Li, Nie, & Li, 2014; Stankiewicz &
O'Connor, 2014). The global nursing shortage is set to continue and may potentially reach ‘a crisis point in the next decade’ (Wang, Whitehead, & Bayes, 2017, p. 1).

In response to the nursing shortage, many high income countries have established policies to actively recruit overseas-trained nurses (Brunero, Smith, & Bates, 2008; Smith, 2008). In Australia, the government relies on overseas-trained health professionals to fill gaps in employment and ensure that an adequate healthcare system is maintained (Short, Hawthorne, Sampford, Marcus, & Ransome, 2012). Working abroad in high income countries such as Australia is seen as an attractive option for many overseas-trained nurses, especially those from low and middle income countries such as India and the Philippines; increasingly, Chinese nurses are also seeking work in Australia (Zhou, Roscigno, & Sun, 2016). After receiving a work visa, overseas-trained nurses must go through a registration process which enables them to work in Australia.

2.4.1 Pathways to nursing registration in Australia. The Australian Health Practitioner Regulation Agency (AHPRA) is the body that manages the registration and accreditation of health professionals including nurses in Australia (AHPRA, 2018). Nurses must be registered by AHPRA to legally practise. For overseas-trained nurses, part of the registration process involves demonstrating English language competence.

There are several possible pathways which can be taken, including showing evidence of completing a minimum of six years of primary and secondary schooling in Australia or another country recognised by AHPRA (e.g. New Zealand), where English is considered the primary language, or completing a qualification in the relevant discipline (i.e. a recognised nursing course) in the medium of English. Overseas-trained nurses generally only have one pathway available to them: the English language test pathway. This pathway involves achieving the required minimum scores on one of the recognised English tests (see Section 2.4.2). Other pathways, irrelevant to overseas-trained nurses who have not studied in a
recognised country include registered nurses and midwives, or enrolled nurses demonstrating evidence of five years of education taught and assessed in English in one of the recognised countries, and special cases in which English language proficiency can be demonstrated as equivalent to the other pathway standards.

2.4.2 English-language tests for overseas-trained nurses. Overseas-trained nurses can show evidence of English-language proficiency for registration by achieving the required score on one of four accepted language tests: (1) the International English Language Testing System (IELTS) (2) the Test Of English as a Foreign Language, Internet Based Test (TOEFL iBT), (3), the Pearson Test of English (PTE Academic) and (4) the Occupational English Test (OET) (AHPRA, 2018). The latter test is explored in more detail in the subsequent section because the current thesis was undertaken, in part, to inform the task and assessment criteria of the OET.

2.4.3 The Occupational English Test. Commissioned by the Australian Government in the 1980s, the Occupational English Test (OET) was designed and developed by Professor Tim McNamara (Elder, 2016; McNamara, 1990). The OET assesses the English-language proficiency of overseas-qualified health professionals seeking to obtain registration in order to be employed at an English-speaking workplace (OET, 2019).

In 2013, Cambridge English Language Assessment, in conjunction with Box Hill Institute took over ownership of the OET and established the Cambridge Box Hill Language Assessment (CBLA) Trust. Currently, the test is administered in approximately 40 different countries at more than 100 locations each month and is recognised by councils and healthcare boards in Australia, the United Kingdom, Ireland, New Zealand, Singapore and Dubai (OET, 2019).

The OET assesses the English-language proficiency of health practitioners from twelve different professions: nursing, dentistry, dietetics, medicine, occupational therapy,
Currently, nursing provides the largest number of candidates (OET, 2019). The OET is composed of listening, reading, speaking and writing sub-tests, with the latter two components being profession specific (McNamara, 1990), meaning that nurses sit speaking and writing tests specifically developed for their field.

During the initial development stage, a needs analysis was carried out to ensure the test was relevant to health professionals (McNamara, 1996; OET, 2019). Many research studies have since been conducted to examine aspects of the validity, reliability and authenticity of the test (e.g. Elder et al., 2012; Manias & McNamara, 2016). According to the OET website, ‘findings and recommendations from key research studies have informed the development of OET test materials and tasks, ensuring the test remains relevant’ (OET, 2019). In September 2018, the OET was updated, with changes to some sub-tests and a more detailed scoring scale with numerical results provided to candidates, as well as the continued use of the A to E alphabetised scoring system (OET, 2019). The assessment criteria pertaining to the OET writing test were recently updated in August, 2019 with the aim being to ensure the test remains relevant to health professionals (OET, 2019).

**2.4.3.1 OET writing test.** The OET writing test requires candidates to compose a letter to another health professional based on a set of clinical case notes. See Appendix B for a sample nursing task found on the OET website, and Appendix C for a sample response. Candidates are usually expected to write a referral letter, although for some professions, a different type of letter task may be required, such as a discharge or transfer letter. Letters that advise or inform a patient, carer or institution may also be set, as well as other variations (OET, 2019).

For the writing sub-test, candidates are required to include treatment information and request that certain issues be addressed by the imagined recipient of the letter. Written input
in the form of case notes are an integral component of the task and candidates must refer to these notes in their letter. Test-takers are expected to complete a letter of approximately 180 to 200 words and must do so within a 45 minute time frame, including 5 minutes’ reading time (OET, 2019).

Until recently, five criteria were used to assess the candidate’s writing, these being:

1. **Overall task fulfilment** – including whether the response is of the required length
2. ** Appropriateness of language** – including the use of appropriate vocabulary and tone in the response, and whether it is organised appropriately
3. **Comprehension of stimulus** – including whether the response shows the test taker has understood the situation and provided relevant rather than unnecessary information to the reader
4. **Control of linguistic features (grammar and cohesion)** – how effectively the test taker communicates using the grammatical structures and cohesive devices of English
5. **Control of presentation features (spelling, punctuation and layout)** – how these areas affect the message that the test taker wants to communicate (OET, 2019).

These criteria measured communicative competence (see Section 2.5.1 for a discussion on this concept), including use of grammatical structures and vocabulary, as per the guidelines stipulated by the Australian government when the test was originally created by McNamara (1996).

The updated criteria, which came into effect on August 31st, 2019, take into account other aspects of performance, while still evaluating test takers’ communicative competence. The new criteria are:

1. **Purpose** – whether the purpose of the letter is immediately apparent to the reader and sufficiently expanded in the course of the letter
2. **Content** – whether all the necessary information is included and accurate for the reader

3. **Conciseness and clarity** – whether unnecessary information is omitted so that the letter is an effective summary for the reader

4. **Genre and style** – whether the register, tone and use of abbreviations are appropriate for the reader

5. **Organisation and layout** – whether the letter is organized and well laid out for the reader

6. **Language** – whether the accuracy of the grammar, vocabulary, spelling and punctuation communicates the necessary information to the reader (OET, 2019).

In order to pass the OET writing sub-test, candidates must achieve a minimum of a B grade, which demonstrates a ‘high level of performance; i.e. an ability to use English with fluency and accuracy adequate for professional needs’ (OET, 2019). According to AHPRA’s registration standards, nursing candidates must either achieve B grades in each skill (reading, writing, listening and speaking) in one test sitting or, alternatively, in two different sittings within a period of six months, as long as no grade is lower than C, (which is a lower proficiency level than B).

### 2.5 Language Testing for Specific Purposes

The Occupational English Test is an example of an internationally recognised language for specific purposes (LSP) test. LSP testing came about due to ‘a practical need to assess individuals’ abilities to perform specific tasks in academic and professional settings’ (Grapin, 2018, p. 1). Assessing language for specific purposes involves making inferences about how effectively test takers are able to communicate in a particular domain based on their test performance (Naoua, 2016). For instance, the OET enables assessors to make
judgements about how effectively a candidate may be able to communicate in a clinical environment based on their test performance. In the case of the OET writing test, receiving a B grade, which is considered a pass for nursing registration, indicates that the test taker is expected to have the ability to write an effective referral, discharge or transfer letter in a healthcare setting.

In Douglas’ (2000) seminal work on LSP testing, he identified two components which differentiate LSP testing from general language assessment: 1) the authenticity of test tasks and 2) the interplay between knowledge of domain-specific content and knowledge of language. The current thesis draws on these two main aspects of LSP testing identified by Douglas (2000) by investigating how - and whether - nurses read and write referral letters and discharge summaries as part of their clinical work, and by exploring the features of transition documents valued by nurses.

In a subsequent paper, Douglas (2001) argued that although test content is often established through the analysis of language use in the target domain, the development of assessment criteria generally take place without direct research in the particular setting. Instead, assessment criteria have tended to be based on more theoretical concepts of language knowledge and usage (Douglas, 2001; Jacoby & McNamara, 1999). According to Douglas (2001), it is essential that assessment criteria are not simply derived from theories of language proficiency but that research in the TLU domain occurs and the criteria are established empirically. This thesis contributes to the growing body of empirical research that considers what experts, such as nurses, value in the healthcare domain, especially in relation to written communication.

2.5.1 Communicative competence. Language tests such as the OET are considered communicative because they include tasks which elicit interactive and communicative performances and are often constructed to reflect real-life situations (Fulcher, 2000). OET
candidates are expected to perform on tasks which simulate the types of communication they are likely to experience in a healthcare setting, such as writing a letter of referral, discharge or transfer, which is a common task for most health professionals (Macqueen et al., 2012), although less so for nurses as this thesis will later discuss (see Section 5.2). As the main aim of the OET is to gauge how effectively candidates can demonstrate their ability to communicate, the notion of communicative competence provides a framework for assessing test-takers’ performances and language skills.

Communicative competence is a measure of the learner’s knowledge of language and their ability to use it effectively (Douglas, 2000; Hymes, 1972). It is considered a measure of language proficiency, but one that is connected to the cultural and social context (Costin, 2011; Douglas, 2010; Kormos, 1999). The concept of communicative competence was first proposed by Hymes (1972) in relation to speaking a first language and subsequently developed by a number of researchers looking at second language testing (e.g. Bachman & Savignon, 1990; Canale, 1983; Canale & Swain, 1980). While their models and definitions of communicative competence varied, there were overlaps in the way they defined communicative competence, including taking into account factors such as performance and language competence, and knowledge (McNamara, 1996). For a comprehensive comparison of the numerous models of communicative competence, see McNamara (1996).

The communication competence model advanced by Canale and Swain (1980) proposed that communicative competence comprised dimensions of the test taker’s grammatical, sociolinguistic and strategic competence. Douglas (2000) elaborates further by suggesting that:

Communicative competence involves judgements about what is systematically possible (in other words, what the grammar will allow), psycholinguistically feasible (what the mind will allow), and socioculturally appropriate (what
society will allow), and about the probability of occurrence of a linguistic event
and what is entailed in the actual accomplishment of it’ (p.26).

Bachman (1990), building on Canale and Swain’s model, saw three aspects of
communicative competence as being key: language competence, strategic competence and
psychophysiological mechanisms or skills (McNamara, 1996). Currently, a number of high-
stakes language tests (i.e. tests which have significant implications for stakeholders) such as
the OET are based on various aspects of communicative competence (Bachman & Savignon,
1990; Young & He, 1998). For instance, the assessment categories for the OET are “defined
communicatively” (McNamara, 1996, p. 106), and include elements of grammatical,
sociolinguistic and strategic competence.

Other high-stakes language tests which are available to nurses, including the
International English Language Testing System (IELTS), are also based on the notion of
assessing communicative competence. While general purpose test tasks cover a range of
topics including environmental and societal issues, what distinguishes the OET from other
communicative language tests is that the tasks replicate what occurs in the health professional
domain and contribute to the perceived authenticity of the test. Developing assessment
criteria which take into account what domain experts value, is another important means of
enhancing test authenticity.

2.5.2 Test authenticity. In communicative language testing, tasks that are relevant to
test takers’ experiences outside the test environment are considered more authentic than tasks
which are unrelated to real-life settings (Elder, 2016; Ross & Berwick, 1992). As such,
authenticity is seen as a crucial element of LSP testing because the tasks closely resemble the
practices that occur in the domain (Bachman & Palmer, 1996).
While authenticity in LSP testing has been perceived by some language test experts as an unachievable goal given that the communication may simulate real-life interactions but will never be truly genuine (Elder, 2016; Lewkowicz, 2000), it is now widely accepted that ‘some degree of authenticity is worth striving for’ (Elder, 2016, p. 147). This notion is in line with Widdowson’s (1979) distinction between language use which is ‘genuine’ in that the text was created to meet a communicative purpose in a real-life context, and the ‘authenticity’ of readers or listeners engaging with the text as they may in the real-life setting (Cook, 2000; Widdowson, 1979).

Although not all LSP test tasks directly emulate the communicative activities that test takers routinely undertake once they enter the domain, the tasks can be considered partially authentic if they are drawn from a specific realm and make use of content and form found in the real-life setting. For example, even though nurses may not regularly write referral letters in the form required for the OET writing task, as this thesis shows, they are still familiar with the genre. Additionally, nurses rely on discharge summaries, documents similar to the OET writing test stimulus material, to inform their clinical work. Therefore, the OET writing task for nurses is not inauthentic, in that it is still situated within the health professional domain and nurses do actually engage with the genre.

Authenticity is not only reflected in the test tasks but potentially in the assessment criteria as well (Spence-Brown, 2001). Although the authenticity of assessment criteria was largely ‘ignored’ in language-testing research until the early 21st century, ‘the relationship of the criteria used to judge performances to real-world judgements in particular domains is clearly crucial to validity’ (Spence-Brown, 2001, p. 465). In recent times, what domain experts value, or the criteria they use to assess effective performances in the domain, are beginning to be incorporated into the assessment criteria of LSP tests, thus enhancing test authenticity, and by extension, the validity of the test. Furthermore, in preparing for a
specific-purpose language test, test takers have the opportunity to prepare for and practise
tasks which they may encounter in the healthcare setting, and also to attend to the criteria by
which they will be judged.

2.5.3 Indigenous assessment criteria. One of the concepts central to this thesis is
the notion of ‘indigenous assessment criteria’ which are the standards by which specialists in
a certain field assess naturally-occurring communicative performances (Douglas, 2000;
Jacoby, 1998; Pill, 2013). For instance, experienced nurses implicitly understand what makes
certain nursing practices successful. They make these assessments while undertaking their
everyday work by providing feedback and advice to less experienced nurses such as graduate
and student nurses in the clinical setting. Their suggestions for improvement, as well as their
assessments of how effectively the student or graduate nurse is completing the nursing tasks
in relation to their understanding of effective nursing, are the criteria by which experienced
nurses measure performances of less experienced individuals.

Indigenous criteria were first recognised in Jacoby’s (1998) ethnographic,
conversation analysis study in which she investigated the feedback of a group of physicists (n
= 8) preparing for conference presentations through practice sessions. Her research
demonstrated that the criteria by which the physicists evaluated their colleagues’
performances were based on an understanding of relevant communication practices within
the specific context (Jacoby, 1998). Jacoby (1998) noted that the physicists drew upon their
own “methods of practical reasoning and on a rich inventory of tacitly known assessment
criteria” (p.311). Furthermore, it was found that although both first language (L1) and
English as an additional language (EAL) speakers were involved in the practice
presentations, linguistic features per se were not always of central importance to the
participants. Non-linguistic factors such as ‘timing’ (e.g. keeping to time limits), and ‘visual
coherence’ (e.g. use of visual material to enhance the presentation), also contributed to a
successful performance (Jacoby, 1998; Jacoby & McNamara, 1999, pp. 229-230). Therefore, specific-purpose performance is dependent on the particular context and the task (Jacoby & McNamara, 1999), which means that only domain experts truly have a comprehensive understanding of what comprises a successful performance.

Test designers and applied linguists, who are traditionally involved in the development of assessment criteria for LSP tests, are not likely to have specialist knowledge of the specific practices and use of the target language in the particular domain. At best, they may attempt to gain an insight into the practices of the profession from the outside and incorporate their findings in the development of assessment criteria (Roberts & Sarangi, 2003; Skelton, 2013). At worst, the test scores based on the criteria that they develop may not be aligned with what domain experts value, leading to issues with test validity (Elder et al., 2017). Hence, the inclusion of indigenous assessment criteria in LSP tests is likely to lead to more accurate predictions of how test takers will fare once they enter the domain in which they will primarily be communicating (Elder, 2001).

It is also important to consider how washback is enhanced by the inclusion of indigenous assessment criteria in LSP tests. In the field of language testing, washback is defined as practices undertaken by test takers specifically to prepare for the test, which they otherwise would not do, and the effect this preparation has on their communicative competence be it positive or negative (Alderson & Wall, 1993; Messick, 1996). With the inclusion of indigenous assessment criteria, test preparation arguably becomes a means of enabling test takers to develop the communication skills that they would require in the actual domain. Consequently, the addition of indigenous assessment criteria has advantages for test takers.

In the case of the OET, establishing professionally-relevant criteria in line with what is required in the clinical setting would contribute towards a smoother transition for overseas
trained health professionals entering into healthcare settings (Elder, 2016; Knoch et al., 2015), compared to those who sat tests that were not healthcare specific. In fact, the OET website states that ‘many organisations, including hospitals, universities and colleges, are using OET as proof of a candidate’s ability to communicate effectively in a demanding healthcare environment.’ (OET, 2019, para.4); therefore, when assessing test takers’ communicative competence, the criteria need to reflect what it actually means to communicate effectively in a healthcare setting. Stakeholders, including the test takers, health professional recruiters and healthcare managers, have an expectation that the construct of the test is aligned with what occurs in a clinical setting, and that what is measured or assessed is relevant to the industry.

An Australian research project looked at what health professionals value to inform the OET speaking test criteria (Pill, 2013, 2016; Pill & McNamara, 2016). The research team carried out an exploratory, interpretive study to investigate the interactions between trainee health professionals and patients during consultations, and the feedback provided by experienced health professionals (including nurses, doctors and physiotherapists) to the trainees. The feedback given by the more experienced professionals, in this case educators and supervisors, was considered to demonstrate indigenous criteria, as Pill (2016) notes: ‘the assumption was that, in their comments, educators would give information pertinent to trainees’ acculturation to the expectations and behaviours of the profession, that is, to “what matters” to practitioners’ (p.175).

After undertaking thematic analysis of the interactions and comments made by the senior health professionals, the research team was able to recommend two new criteria for the OET speaking test – ‘clinician engagement’ and ‘management of interaction’ which were professionally relevant. These additional criteria, which were established based on their findings, have been incorporated into the recently-updated OET speaking test criteria.
According to the OET website, from September 2018, the speaking sub-test will assess ‘a wider range of communication skills, more similar to those (health professionals) will encounter at work’ (OET, 2019).

This thesis draws on the notion of indigenous assessment criteria to inform the research methods (i.e. investigating what nurses value about transition documents with the aim of informing the OET writing test criteria). Methodological complications of research on naturally occurring feedback are explored both in the methodology chapter (see Section 3.3.1), and in the discussion (refer to Section 8.3.5).

2.6 Genre

This section explores communities of practice in relation to genre, and draws on the literature regarding genre theory and analysis.

2.6.1 Communities of practice and genre. The current thesis explores two different genres found in the medical record: referral letters and discharge summaries. These transition documents are written in clinical settings by healthcare professionals who are part of a ‘community of practice’.

A ‘community of practice’ (Lave & Wenger, 1991), is defined as a group of people who are involved in a common pursuit and work together to enhance their practices and systems (Eckert, 2006; Lave & Wenger, 1991). Members of a community of practice contribute to a shared practice and develop their own particular processes, power relations and ways of talking and writing (Eckert, 2006). For communities of practice, the forms and the processes evident in their writing reveal a lot about their field and their identity (Flowerdew & Costley, 2016). For instance, investigating how clinical documents are co-written by nurses, doctors and other health professionals gives insight into how collaboration occurs and the roles and responsibilities taken by each profession.
In order to be a ‘fully-fledged member’ of a community of practice, it is necessary to have an understanding of the documentation systems and to be able to write documents relevant to the community (Flowerdew & Costley, 2016, p. 4). Being able to produce and engage with particular types of writing, or genres (e.g. referral letters), means drawing on the ‘rules’, both implicit and explicit, of the genre, as established by the community of practice, which at the same time strengthens and re-establishes the rules as standard practice (Davenport & Hall, 2002; Yates & Orlikowski, 1992).

A genre which is specific to a community of practice serves as both a means of categorising and documenting the practices of the community, but also prescribes the activities its members undertake (Davenport & Hall, 2002). To illustrate, discharge summaries document what health professionals do as part of their role, including the medical tests they give their patients and the way they have treated their patients’ conditions. Discharge summaries also prescribe what health professionals must do whilst patients are in their care, such as researching the patient’s medical history in order to document it.

2.6.2 Genre theory. There has been much debate about what constitutes a genre and several different approaches have been presented and discussed in the literature over the past few decades. There are those that consider genre to be a form of social action which creates meaning (Miller, 1984) in the tradition of New Rhetoric studies. From this perspective, genre is seen as ‘a typified rhetorical response to (uptake of) a recurrent rhetorical situation’ (Miller, 2015, p. 56). In other words, genre is a way of responding and acting in typified ways within recurring situations (Bawarshi & Reiff, 2010). Genre has also been defined as a social process which is both staged and goal-oriented (Bhatia, 2004; Martin, 1985), and as a communicative activity within the community of practice (Swales, 1990) (see Section 2.6.5 for further information about these approaches). The sociocultural contexts (e.g. professional
settings), in which genres emerge have also been explored, with the context seen as a way of understanding what constitutes a genre (e.g. Schnurr, 2012)

Research which investigates and analyses specific genres, such as the current thesis, is useful in the sense that it can document the practices that are represented by the genre and, contribute to the understanding of the genre for the members of the community of practice, as well as for researchers and the wider community. Research investigating specific genres can also inform pedagogical practices based on the findings.

2.6.3 Professional genres and genre analysis. The types of genre, both written and spoken, which are found in workplace settings, are referred to as ‘professional genres’. The two transition documents analysed as part of this thesis can be considered professional written genres. Communities of practice working in professional organisations - whether large or small - have unique hierarchies, cultures, values and linguistic conventions (Gunnarsson, 2009). These factors influence the way that professional genres are constructed and produced.

There are many environmental factors that affect the modes and types of communication in a workplace including the local setting (e.g. the specific ward or hospital), the organisation (e.g. the particular health group), and local, national and international sectors (e.g. regulation boards and agencies) (Gunnarsson, 2009). In this way, professional practices and procedures are not simply embedded at the professional level, but are institutionally entrenched as well (Sarangi & Candlin, 2011; Sarangi & Roberts, 1999). While practices tend to be institutionally entrenched, they are also transferable across institutions to enable effective communication to occur.

Investigating and analysing professional genres has important, real-life implications (Bhatia, 2013; Holmes et al., 2011). In instances where researchers uncover communication breakdowns or problematic processes, suggestions can be made as to how these issues could
be alleviated (Janicki, 2010). In addition, genre analysis can enable the identification of criteria for evaluating the quality of specific documents, as is the case for the current thesis, the results of which may form the basis for assessment and pedagogy.

2.6.4 Health professional genres. Healthcare researchers have acknowledged genre as a useful concept for exploring the nature of healthcare communication (Ford-Sumner, 2006). A number of investigators have explored the structures and purposes of written genres in the health professions, even though the term ‘genre’ may not always be explicitly used (e.g. Frykholm, Nilsson, Groth, & Yngling, 2012; Winman & Rystedt, 2011). Much of the research has been undertaken in response to concerns about breakdowns in communication between health professionals which often result in compromised patient safety (Jefferies, Johnson, & Nicholls, 2012).

While researchers have explored the differences between oral and written approaches to reporting (e.g. Jefferies, Johnson, & Nicholls, 2012), and the incorporation of medical records into everyday communication practices (Newell & David, 2012), no generic research to date has investigated the two genres of referral letters and discharge summaries. Therefore, the current thesis fills a gap in research pertaining to health professional genre analysis.

2.6.5 Approaches to genre analysis. There are three major traditions of genre analysis, which have been modified over time and possess similarities as well as differences in their techniques and perspectives (Askehave & Swales, 2001; Schnurr, 2012). All three approaches are presented in this section to provide an understanding of why the ESP tradition in genre analysis was selected for the analysis of referral letters and discharge summaries.

Firstly, New Rhetoric studies, which originated in North America, focus on ‘the situational contexts in which genres occur’ (Hyon, 1996, p. 696). The actions or social purposes of the genre are seen as central (Hyon, 1996; Miller, 1984). New Rhetoric
researchers often rely on ‘ethnographically-oriented methodologies such as observation or interviews’ to inform their work (Schnurr, 2012, p. 48). The New Rhetoric approach was not considered suitable for the current thesis because rather than following an ethnographic approach, interviews and focus group sessions were conducted. To do justice to the New Rhetoric approach, a deeper understanding of health professional clinical practices through observation would have been necessary, and this would not have been practical nor relevant given the scope of the research. Additionally, the context in which referral letters and discharge summaries were read was one of the focuses of the study, and interviews and focus-groups provided a means of understanding the context in a way that observation would not.

The second tradition, Systemic Functional Linguistics (British/Australian in origin and alternatively known as the Sydney School), draws on Halliday’s work (e.g. Halliday, 1978) in which genres are seen as ‘staged, goal-oriented social processes’ (Martin, 1997, p. 13; Schnurr, 2012). This approach prioritises the purposes or functions of the genre in specific contexts such as academia and professional settings, and research is often pedagogically motivated, with the aim being to inform and empower students who wish to understand and recreate the genre (Hyon, 1996; Schnurr, 2012). Systemic functional linguists tend to focus on the ‘text-internal, linguistic features that are characteristic of a particular genre’, and generally ‘conduct detailed analyses of how the various stages of a genre are realised linguistically’ (Schnurr, 2012, p. 48).

As Systemic Functional Linguistics is a detailed and highly specific theoretical framework for analysing genre, it was not considered practical to employ SFL analysis for the purpose of the current study given that genre analysis was only one component of the research. The primary aim of the study was not to give a generic account of referral letters
and discharge summaries, rather it was to investigate the qualities of these documents valued by nurses.

The third tradition is the English for Specific Purposes (ESP) approach to genre. While both SFL and ESP researchers tend to frame genres in terms of their formal and linguistic properties and are likely to take into account the communicative purposes (Hyon, 1996), the ESP approach was considered a more practical, straightforward and appropriate way of characterising genre for the purpose of this thesis.

The ESP approach to genre was initially based on the teaching and research of scientific writing, or English for Science and Technology, but has since expanded into other areas (e.g. English for Academic Purposes) (Hyon, 2017). While researchers initially focused on aspects of register and genre analysis (e.g. Halliday, MacIntosh, & Strevens, 1970), ground-breaking work by Swales (1981) on article introductions was what ‘propelled genre theory and its application to analysis of ESP texts into the limelight’ (Flowerdew, 2019, p. 2).

The analyses of referral letters and discharge summaries in the current thesis (See Chapter 4) draw on structural moves, an approach made popular by Swales (1981, 1990) whose seminal work saw him investigate the moves and steps that are typical of particular genres. Swales (1990) established the Creating A Research Space (CARS) model by researching the common structural elements or ‘moves’ of research articles from different fields written in English and documenting the moves in detail. Swales found that there were moves and steps that the writers called upon when writing introductory sections which typified the genre. The ESP approach was selected because the main purpose of analysing structural moves is to understand and define the ‘global organisation patterns of genres’ from an ESP perspective (Hyon, 1996, p. 695), which was the aim in analysing the sample of referral letters and discharge summaries for the current thesis. Gaining an understanding of how these transition documents were structured and written, and the particular moves or
patterns that the writers employed, has the capacity to inform the OET writing test task and stimulus material, and provides an understanding of the purpose and structure of clinical transition documents to contribute to the field of healthcare written communication. See Section 3.5.1 in the methods chapter of this thesis for a discussion of how genre analysis in the ESP tradition was undertaken.

2.7 Summary of key limitations of previous research in relation to the current study

This section presents the key limitations of previous studies conducted in the areas of written communication in healthcare and language testing for specific purposes, in relation to the current research.

2.7.1 Written communication in healthcare. Previous studies have demonstrated that there are inconsistencies in healthcare written documentation, and a need for improvement (De Groot et al., 2019). Although a number of research studies have been carried out to investigate how these inconsistencies could best be addressed in clinical settings (see Sections 2.3.3 and 2.3.4), only a few have examined how referral letters and discharge summaries could be improved (e.g. Harwood et al., 2015; Soong et al., 2016). None so far have explored how nurses engage with referral letters and discharge summaries as part of their work, and how and if they contribute to writing these documents, which is a gap in the research addressed by the current study. The qualities of referral letters and discharge summaries valued by nurses were also not identified in the literature prior to this thesis.

2.7.2 Language testing for specific purposes. Two key specific-purpose language testing concepts are explored in the current study: authenticity and indigenous assessment criteria.
Arguably, authenticity is a significant feature of specific-purpose language tests for stakeholders and has been explored in the literature to date. While several studies have demonstrated that tasks which closely align with communicative activities that occur in the particular domain setting, enhance the perceived authenticity of specific-purpose tests (Elder, 2015), there are only a few studies which have considered the importance of aligning the assessment criteria with what domain experts value (e.g. Elder et al., 2013), and these studies focus on spoken communication, rather than written communication. The study conducted for this thesis is one of the first to look at what domain experts, specifically healthcare professionals, value about written communication in order to inform the assessment criteria of a writing test.

Jacoby (1998), and Jacoby and McNamara’s (1999) seminal work demonstrated that domain experts attended to, and valued, particular features when they evaluated the performance of their less experienced colleagues. Since their research was first published, other researchers have investigated what domain experts value with the aim of incorporating these qualities in specific-purpose assessment criteria (e.g. O’Hagan et al., 2016). However, much of the research, as is the case with the current study, was conducted outside the domain setting and is not naturally occurring (e.g. through interviews rather than observations in the domain setting). While this methodological issue is not necessarily considered highly problematic because valuable data can still be collected through artificial data collection activities such as focus groups or interviews (Elder & McNamara, 2015), further studies need to be conducted to ascertain whether what domain experts claim to value in more artificial settings, is actually evident in the feedback they give to less experienced members of their profession in the target domain.

Additionally, there is a dearth of research investigating how successful the use of indigenous assessment criteria is. For example, when language experts assess features valued
by domain experts, do they have the expertise to be able to make judgements about how effectively a test-taker has performed on a particular task? This is currently an under researched area in the field of specific-purpose language assessment.

2.8 Summary

In this chapter, published literature was drawn upon to discuss three key topics: healthcare written communication, LSP testing and genre. This chapter highlights the gaps in research about nurses’ perspectives on referral letters and discharge summaries and the qualities that they value. It is also evident that incorporating domain experts’ (e.g. nurses) perspectives into the assessment criteria of an LSP test is complex, yet valuable. Finally, genre analysis has the potential to provide researchers with an understanding of the linguistic and structural features of genres, including health professional genres. The next chapter describes the study design and methodological approaches undertaken.
Chapter 3: Methods

3.1 Introduction

The purpose of this chapter is to present the design of the study and outline the methodological approach selected to answer the following research questions: 1a) What is the content and structure of referral letters and discharge summaries? 1b) What are the key linguistic features of referral letters and discharge summaries? 2a) What is the context in which referral letters and discharge summaries are read and written? 2b) How do nurses read or write referral letters and discharge summaries? 3) According to nurses’ perspectives, what features of referral letters and discharge summaries are critical to effective written communication?

These research questions address the bigger picture of how nurses engage with referral letters and discharge summaries in the clinical setting, what they value about these documents, and what the authentic documents extracted from the clinical setting actually look like, for the purpose of informing the assessment criteria and task of the OET writing test. The setting, participants, instruments and procedures are described in relation to three stages of data collection. Data coding, methods for analysing data and ethical considerations are also explained in the current chapter.

3.2 Stages of the Research

This chapter describes the data collection methods employed at each point of the study, as well as the data analyses undertaken. Figure 1 summarises the three stages of data collection. Stages 1 and 2 were conducted concurrently, whilst the latter stage took place after completion of the first two stages. Data analysis was carried out subsequently and is addressed in Section 3.5.
3.3 Research Design

Qualitative research involves looking at how and why particular phenomena occur and the ways in which people interpret their own practices (Merriam, 2014). A qualitative, exploratory approach was taken to investigate nurses’ perspectives on referral letters and discharge summaries and their reading and writing practices in relation to these two transition documents. This approach was selected because one of the main aims of the current study was to investigate nurses’ perspectives on referral letters and discharge summaries and to identify the meaning they attach to these documents (Marshall & Rossman, 2014). The semi-structured interviews and the focus-group sessions provided insight into nurses’ perceptions and shed light on hospital workplace practices. Analyses of referral letters and discharge summaries offered a further insight into the way these documents are written.

Genre analysis is a ‘powerful and useful tool’ which can be drawn upon for different applied linguistic purposes (Bhatia, 2013, p. 11), therefore, this approach was considered suitable as a means of generating new knowledge about how referral letters and discharge summaries are structured, and what their key linguistic features are.

Figure 1: Three stages of data collection.

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Semi-structured interviews with nurses (data relevant to all research questions)</td>
<td>• Extraction of referral letters and discharge summaries from medical records (data relevant to research questions 1a &amp; 1b)</td>
<td>• Focus-group sessions with nurses (data relevant to all research questions but mainly research question 3)</td>
</tr>
</tbody>
</table>
To date, applied linguists have tended to take a qualitative approach to investigating domain experts’ perspectives, opinions and values (e.g. Jacoby, 1998; Pill, 2013). One example is a PhD study conducted by Pill (2013), who looked at what doctors value in doctor-patient consultations with the aim of updating the assessment criteria of the OET speaking test through the inclusion of indigenous criteria. Pill implemented a qualitative, exploratory approach, in which he collected oral and written feedback provided by experienced clinicians to trainees. Similarly, the present thesis follows a qualitative, exploratory research design to gain an understanding of how nurses read or write referral letters and discharge summaries, and their perspectives on the qualities of referral letters and discharge summaries through interviews and focus-group sessions.

3.3.1 Accessing indigenous criteria: methodological considerations. As mentioned in the literature review (Section 2.4.3), the term ‘indigenous criteria’ refers to how domain experts assess naturally-occurring communicative performances of less-experienced professionals through provision of feedback in the particular setting (Elder & McNamara, 2015). As noted in Section 2.5.3, the inclusion – or lack thereof – of indigenous criteria in ESP tests has implications for test authenticity (Elder & McNamara, 2015).

As one of the primary aims of this thesis is to investigate nurses’ perspectives on the qualities of referral letters and discharge summaries, the data collected can be considered a starting point for determining what domain experts value in judging written communication, especially as their perspectives in relation to particular communicative activities (reading or writing referral letters and discharge summaries) are investigated. However, the data cannot simply be treated as a sufficient or adequate basis for determining indigenous criteria because the feedback from the participants regarding written documentation did not occur in a natural setting while they were critiquing less experienced nurses (see Section 8.3.5 for a discussion
on research methodologies for establishing indigenous assessment criteria, and Section 9.3.5 for limitations).

3.4 Method

3.4.1 Stage 1: semi-structured interviews. In the first stage of the study, semi-structured interviews were conducted with nurses (n=31) with the aim of eliciting information about the context in which referral letters and discharge summaries were read and/or written by nurses, their perspectives on the content, structure and language used in these documents and their understanding of the features which were crucial to effective written communication.

In the field of applied linguistics, semi-structured interviewing has been increasingly adopted as a fundamental data collection technique (Talmy, 2010). Semi-structured interviews are interviews in which a set of questions are prepared prior to the session; however, unlike structured interviews, the interviewer can vary the questions according to the responses of the participant (Gill, Stewart, Treasure, & Chadwick, 2008). Semi-structured interviews allow the researcher to make use of ‘a written list of questions as a guide, while still having the freedom to digress and probe for more information’ (Mackey & Gass, 2005, p. 173). Semi-structured interviews are generally considered a valuable way to gather data as this interviewing technique permits an understanding of the participants’ perspectives and experiences on specific matters (Gill et al., 2008; Minichiello, Aroni, & Hays, 2008). Interviews also enable participants to discuss issues that they may not be willing to raise in a group setting (Gill et al., 2008).

Talmy (2010) made a distinction between ‘the interview as research instrument’ and ‘the research interview as social practice’ (p.128). The former approach situates interviews ‘as a resource for investigating truths, facts, experience, beliefs, attitudes, and/or feelings of
respondents’ (Talmy, 2010, p. 128), as is the case for the current study. This means that interviews are simply perceived as a methodological tool. In contrast, the latter perspective takes into account the collaboration between interviewee and interviewer and the interview practice itself becomes a ‘topic for investigation’ (Talmy, 2010, p. 128). From this viewpoint, the collaboration between the interviewee and interviewer influences the findings and should be addressed by the researcher (Mann, 2011).

3.4.1.1 Setting. Data collection took place on site at two hospitals in the state of Victoria, Australia: one rural (henceforth referred to as Hospital A) and one metropolitan (Hospital B). The first site was a 280-bed, public hospital with a wide range of services available to patients including an aged care assessment service and a community rehabilitation centre.

The second site was a metropolitan hospital with approximately 400 beds. The hospital offered an extensive array of services, such as cancer and cardiothoracic treatment. It had numerous departments and treatment facilities including a well-established Emergency Department and was a major provider of health services in the region.

The two hospitals were chosen as the sites of the study because they had a variety of wards and services and employed a range of health professionals.

3.4.1.2 Participants. Potential interviewees were sourced through convenience sampling at both hospitals. See Table 1 for an overview of the participants. Nurses were approached via email and in person through professional networks. The contact person at Hospital A had access to the contact details of two Nurse Unit Managers (NUMs) - one from the Intensive Care Unit and the other from the Emergency Department, and suggested emailing them to ask if they and their staff would participate in the research. The NUMs were contacted because they oversaw the nurses in their departments and could make
decisions about scheduling and interview locations. In total, eight participants from Hospital A voluntarily took part in the interviews including one NUM, who was in charge of their unit, two Associate Nurse Unit Managers (ANUMs) who assisted in running the unit, and a Clinical Nurse Specialist who was a senior registered nurse.

A professional contact at Hospital B recommended attending nurse education sessions to source participants. As a result, two information sessions were conducted by the student researcher for the nurses at Hospital B during their education sessions – one in the Emergency Department and the other in a general medical ward. These two wards were identified and selected through professional networks based on advice from the professional contact. During the 10-minute information sessions, the purpose of the research was explained, and participants volunteered their contact details so that they could participate in the study. Twenty-three nurses gave informed consent and participated in the interviews including one ANUM. The main inclusion criterion was that nurses were qualified with a Bachelor’s or Master’s degree and were registered nurses.

Australia is a multicultural country; thus, it was expected that there would be a mixture of both first language (L1) and English as an Additional Language (EAL) speakers taking part in the interviews. Four participants self-identified as being EAL speakers. In any case, participants were not included or excluded based on their first language because it was important to sample a cross-section of nurses working in an Australian clinical setting to gain an understanding of the qualities they value as a group.
Table 1

*Overview of Interview Participants*

<table>
<thead>
<tr>
<th>Participant code</th>
<th>Gender</th>
<th>Role (as described by participant)</th>
<th>Ward</th>
<th>No. of years or months of experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Female</td>
<td>Emergency nurse</td>
<td>Emergency Department</td>
<td>34</td>
</tr>
<tr>
<td>P2</td>
<td>Female</td>
<td>Emergency nurse</td>
<td>Emergency Department</td>
<td>5</td>
</tr>
<tr>
<td>P3</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Emergency Department</td>
<td>4</td>
</tr>
<tr>
<td>P4</td>
<td>Female</td>
<td>Assistant Nursing Unit Manager</td>
<td>Orthopaedics</td>
<td>11</td>
</tr>
<tr>
<td>P5</td>
<td>Female</td>
<td>Registered nurse</td>
<td>General medicine</td>
<td>4</td>
</tr>
<tr>
<td>P6</td>
<td>Female</td>
<td>Registered nurse</td>
<td>General medicine</td>
<td>6</td>
</tr>
<tr>
<td>P7</td>
<td>Female</td>
<td>Nurse and midwife</td>
<td>General medicine</td>
<td>15</td>
</tr>
<tr>
<td>P8</td>
<td>Male</td>
<td>Nurse/clinical specialist</td>
<td>Acute medicine</td>
<td>31</td>
</tr>
<tr>
<td>P9</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Surgical</td>
<td>5</td>
</tr>
<tr>
<td>P10</td>
<td>Female</td>
<td>Nurse</td>
<td>Surgical</td>
<td>7</td>
</tr>
<tr>
<td>P11</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Liver transplant unit</td>
<td>6</td>
</tr>
<tr>
<td>P12</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Surgical</td>
<td>6 months</td>
</tr>
<tr>
<td>P13</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Surgical</td>
<td>7 months</td>
</tr>
<tr>
<td>P14</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Liver transplant unit</td>
<td>5</td>
</tr>
<tr>
<td>P15</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Neurology</td>
<td>6 months</td>
</tr>
<tr>
<td>P16</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Gastroenterology/ Liver transplant unit</td>
<td>15</td>
</tr>
<tr>
<td>P17</td>
<td>Male</td>
<td>Registered nurse</td>
<td>Liver transplant unit</td>
<td>6</td>
</tr>
<tr>
<td>P18</td>
<td>Male</td>
<td>Nursing Unit Manager</td>
<td>Intensive Care Unit</td>
<td>36</td>
</tr>
<tr>
<td>P19</td>
<td>Female</td>
<td>Associate Nurse Unit Manager/ Critical care nurse</td>
<td>Intensive Care Unit</td>
<td>27</td>
</tr>
<tr>
<td>P20</td>
<td>Female</td>
<td>Clinical nurse specialist</td>
<td>Intensive Care Unit</td>
<td>7</td>
</tr>
<tr>
<td>P21</td>
<td>Female</td>
<td>Registered nurse/Educator</td>
<td>Intensive Care Unit</td>
<td>14</td>
</tr>
<tr>
<td>P22</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Intensive Care Unit</td>
<td>5</td>
</tr>
<tr>
<td>P23</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Emergency Department</td>
<td>25</td>
</tr>
<tr>
<td>P24</td>
<td>Female</td>
<td>Registered nurse</td>
<td>Emergency Department</td>
<td>5</td>
</tr>
<tr>
<td>P25</td>
<td>Male</td>
<td>Associate Nurse Unit Manager</td>
<td>Emergency Department</td>
<td>10</td>
</tr>
<tr>
<td>P26</td>
<td>Female</td>
<td>District nurse</td>
<td>District nursing service</td>
<td>17</td>
</tr>
<tr>
<td>P27</td>
<td>Female</td>
<td>Nurse specialising in mental health</td>
<td>Psychiatric</td>
<td>3</td>
</tr>
</tbody>
</table>
3.4.1.3 Instruments. The interview schedule consisted of a list of questions for nurses about their reading and writing practices in the workplace (see Table 2). The schedule was developed to probe for specific information about nurses’ practices and perspectives. The questions, which were written by the student researcher, focused on individual documents found in the medical record, with an emphasis on referral letters and discharge summaries, with the aim of discovering what nurses read and write, their methods for doing so, and the qualities they value.

The schedule was divided into three sections: the general introduction (Section A), questions relating to written documents in medical records (Section B), and concluding questions (Section C). Questions were posed about the main purpose of each document, the structure and layout, particular features (such as being handwritten or typed), the intended recipients and those involved in the writing process. Participants were also asked to describe qualities of referral letters and to identify features that they considered less effective.

The general introduction questions in Section A were designed to find out more about the participant and collect demographic information. Section B of the interview schedule targeted referral letters specifically because they were initially considered to be the primary focus of the research; however, as the interviews progressed the same questions were asked in relation to discharge summaries. The nurses were also asked specific questions about the context in which they read referral letters and discharge summaries. Other questions, not found on the interview schedule, were asked according to the responses of the participants. Section C provided the concluding questions and was an opportunity for participants to
further discuss their views on their experiences with writing and reading documents in the medical records, and their perspectives on the documentation practices of staff members from culturally and linguistically diverse backgrounds.

Table 2

*Interview Questions for Nurses*

<table>
<thead>
<tr>
<th>Interview questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. General intro</strong></td>
</tr>
<tr>
<td>Good morning/good afternoon. Thank you for taking the time to participate in this interview. It should take approximately 30 minutes. We are looking at the kinds of writing tasks health professionals in Australia are currently performing as part of their work. The reason we are doing this is because we are reviewing the writing section of the Occupational English Test which overseas health professionals have to take before they can practise in Australia and we want to make sure that the test remains relevant.</td>
</tr>
<tr>
<td>• First of all, could you please tell me what your profession and specialisation is?</td>
</tr>
<tr>
<td>• How long have you been working in this profession?</td>
</tr>
<tr>
<td>• We are interested in finding out what kinds of things you regularly write, type or dictate for medical records, e.g. admission notes, referral letters, patient notes, discharge summaries etc. What sorts of things do you write in a typical work day?</td>
</tr>
<tr>
<td>• Are there any documents in the medical records which you don’t personally write but that you regularly read as part of your work? (Please include referral letters – see Section B ‘for reading referral letters specifically’).</td>
</tr>
<tr>
<td><strong>B. Written documents in medical records</strong></td>
</tr>
<tr>
<td>I’d like to discuss each of the documents you mentioned in more detail.</td>
</tr>
<tr>
<td>• In your opinion, what is the main purpose for writing [text type, e.g. referral letters]?</td>
</tr>
<tr>
<td>• Who are [the referral letters] written for? (i.e. who is the intended reader/recipient?).</td>
</tr>
<tr>
<td>• Could you briefly describe the structure/layout of the letter?</td>
</tr>
<tr>
<td>• When you are writing a [referral letter], what kind of information do you need to make sure you include?</td>
</tr>
<tr>
<td>• What specific words and/or phrases are important to include?</td>
</tr>
<tr>
<td>• What do you think makes a good [referral letter]?</td>
</tr>
</tbody>
</table>
All interviews were transcribed by the student researcher. It has been suggested that approaches to transcription can be represented by a continuum, with naturalised transcription methods at one end and denaturalised techniques at the other (Davidson, 2009). Naturalised transcription involves a close representation of how language is used and understood in the real world and as much detail about the idiosyncratic characteristics of speech are provided in this type of transcription (Davidson, 2009). This means that features such as pauses and overlapping speech are transcribed. On the other hand, denaturalised transcription techniques highlight the substance of the interviews and rely less on contextual details such as involuntary vocalisation, accents and interruptions (Bailey, 2008; Oliver, Serovich, & Mason, 2005).
For the purposes of this thesis, denaturalisation techniques were utilised for both interview and focus-group transcription because the main purpose of the interviews and focus groups was to explore the nurses’ perspectives on referral letters and discharge summaries, rather than the way they used language to express their views and interacted with the interviewer. The decision to use denaturalisation techniques has implications for the findings in that the interactive nature of the data collection is not evident (Talmy, 2010).

3.4.1.4 Procedure. Data collection commenced once ethics clearance had been received from the hospitals and the university. Section 3.6 provides more information about ethical considerations. The confidentiality of the participants was protected, as stipulated by the hospital and university ethics procedures.

The interviews at Hospital B, the metropolitan hospital, took place over a period of six months from the beginning of May, 2015 to the end of October, 2015 and were conducted at times and locations convenient to the participants. Most interviews occurred in the interviewees’ offices or in a quiet room on their ward. The eight interviews at Hospital A, the rural hospital, were carried out on two separate dates in October, 2015 and similar procedures were followed. One interview with a district nurse who was not affiliated with either hospital was conducted over the phone in October, 2015. The district nurse was recruited through convenience sampling via a group member of the wider project to provide a community nursing perspective. The interviews were approximately 30 minutes in length.

3.4.1.5 Data coding. A codebook was developed which listed the coding categories and included examples and descriptions. It provided a systematic means of documenting the codes and was used by the two coders; one was the student researcher and the other was a healthcare communication PhD student. Appendix E contains a sample of the codebook. The coding system was organised according to main categories (e.g. ‘referral letters’,

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60 Nurses’ Perspectives on Referral Letters and Discharge Summaries: Towards Profession-oriented Writing Test Criteria
‘discharge summaries’ and ‘communication between doctors and nurses’), which were colour coded. At the end of each coloured section relating to discharge summaries and referral letters, letters were placed to represent sub categories. For instance, a section of the transcript dealing with the content of referral letters was firstly highlighted yellow and then a [C] for ‘content’ was added. See Appendix E for a complete list of the main and sub categories. All responses in which referral letters and discharge summaries were mentioned were coded, whilst references to other genres such as drug charts, which are not recognised as a transition document, were omitted from the coding process.

The coding system was firstly trialled by the student researcher, who coded three transcripts using the aforementioned method. In response to this trial, some of the coding categories which overlapped were conflated; for instance, the purpose and the function of documents were initially coded separately but then amalgamated into one category. Additional categories were included and some were removed. For example, the category of ‘discourse features’ was discarded for being too abstract and ‘words and phrases used’ was added instead. Transcripts were coded manually in Microsoft (MS) Word 2013 by highlighting the relevant section of the transcript in the corresponding colour, as shown in Appendix F. In the transcript, ‘I’ signified the interviewer and ‘P’ indicated the participant. All transcripts were double coded manually by an independent researcher who was a healthcare communication PhD student, to ensure that consistency was maintained. A high level of agreement - approximately 95% - was initially reached for all coded interviews with the coding taking place separately. The two coders then came to an agreement about how to code the remaining sections, based on discussion.

Once the coding process was completed in MS Word, the transcripts were uploaded to NVivo 11 so that the data could be better managed. Nodes and child nodes were used to separate the data into different sections within NVivo and corresponded directly to the colour
and letter coding in MS Word. For example, ‘referral letters’ was a main (or parent) node which was colour coded in MS Word. ‘Method of writing’ was a subcategory, or child node, which appeared as a letter code in Word. Sections of the transcripts were copied into the relevant nodes. Quotes coded with multiple letters were copied into various corresponding nodes, as per the original coding system.

**3.4.2 Stage 2: Medical records.** In the second stage of data collection, referral letters and discharge summaries, along with the entire medical record corresponding to the documents, were extracted from hospital files. The referral letters and discharge summaries were collected to provide the stimulus material for the focus-group sessions in Stage 3, and for the genre analyses.

**3.4.2.1 Sample.** In all, 200 de-identified medical records regarding patients who were admitted in 2014, were collected by the student examiner and other researchers from the larger project team. Team members with a health professional background and many years of experience were confident that data saturation would be reached with a sample size of 200 records. The records were sourced from two hospitals with 114 records collected from hospital A and 86 from hospital B.

The inclusion criteria for the medical records were that the patients were admitted during 2014, were in hospital for longer than 24 hours and that only the last admission was included if patients had multiple admissions. Only medical records with discharge summaries and/or referral letters were included. There were no exclusion criteria. A random sampling approach was utilised to retrieve the records.

The records at Hospital B were electronically stored. To narrow down the vast selection of electronic medical records, only the records from the first week of each month were included. Medical records of patients admitted for less than 24 hours were omitted.
Through use of the hospital’s computer system, filters were applied to randomly select patient numbers connected to medical records.

**3.4.2.2 Instruments.** See Table 3 for a list of procedures which were developed by the larger project team for document selection and extraction. A tool for removing personal identifiers was also utilised; the procedures of which can be found in Appendix G. The process included using a black marker to remove identifiers on paper-based documents, and inserting black shapes from Microsoft Paint over identifiers found in the electronic documents.

Table 3

*Procedures for Document Selection and Extraction*

1. Open the patient record.
2. Check that there is at least one discharge summary or referral letter in the record.
3. Check that bullet points are not used throughout the entire document.
4. Check that the patient was admitted between January and December 2014.
5. Skim read the discharge summary/referral letter, examples where communication may be problematic are of interest to the researcher. A range of admission types and letters/discharge summaries from different units are also required.
6. Find out the date when the discharge summary/referral letter was written and find any notes in the patient record that are associated with it (i.e., that provide information used in the summary/letter). These notes may be in the ‘diagnostics’ field. Note that the admission date may be about two weeks before the data of the letter.
7. Check that the content of the discharge summary or letter and corresponding documents does **not** include sensitive information (Ethics approval has not been sought to access sensitive information held in patient records.)
Print one page of each of the following: admission notes, progress notes, outpatient notes, discharge and treatment summaries, referral letter.

3.4.2.3 Extracting the medical records. At Hospital A, 25 medical records, which were photocopies of the original paper versions, were extracted by the health information services officer in full and given to the researcher and project team. Patient, staff and hospital identifiers were then redacted and the records were scanned electronically. Subsequently, 89 medical records were also redacted by the same officer but then electronically scanned before being received by the student researcher. Decisions about which records to extract were made entirely by the health information services officer at the hospital’s request; however, records of patients admitted for less than 24 hours were excluded due to the limited scope of documents and lack of referral letters. Some of the medical records selected by the health information services officer did not include referral letters at all, although all but one of the medical records contained discharge summaries. Some medical records included multiple referral letters or discharge summaries depending on the patient’s experiences.

Extraction of records followed a slightly different procedure at Hospital B because the records were electronic. Before commencing the extraction process, an independent researcher and a quality and safety officer at the hospital decided that records spanning a 12-month period (January to December 2014) would be randomly extracted from varied settings - for example, a range of admission types and from different units - using the hospital software. The student researcher was provided with a list of the patient unit record numbers by a hospital staff member and given access to the hospital software so that referral letters and discharge summaries could be extracted and redacted as necessary.

3.4.2.4 Accessing referral letters and discharge summaries. The referral letters and discharge summaries attached to the first 25 medical records obtained from Hospital A were...
received as hard copies and then scanned digitally by the student researcher. The letters and discharge summaries from the remaining medical records were available electronically in individual files attached to each record.

The referral letters and discharge summaries from Hospital B were extracted by the student researcher through use of the hospital computer system. Once logged into the system, the referral letters and discharge summaries could be found in the correspondence section of the medical record. To extract the documents from the hospital’s software, a screenshot of each letter was made using a snipping tool. The letter was then pasted onto a Microsoft Word document, saved and redacted in Microsoft Paint by the student researcher. All referral letters and discharge summaries were printable.

3.4.2.5 Selection of referral letters and discharge summaries for focus group sessions. The process of selecting referral letters and discharge summaries for the focus groups was coordinated and carried out by the student researcher in conjunction with a group of six expert informants, two of whom had clinical and academic backgrounds (one doctor and one nurse/pharmacist). The other informants were applied linguists, with one specialising in healthcare communication and education. It was decided that only referral letters and discharge summaries from the patient’s last admission of the medical record would be included, to ensure that the letters were current and relevant. The group members were able to draw on their expertise and professional backgrounds through a collaborative process to select referral letters and discharge summaries that they considered most suitable for the focus-group sessions.

The referral letters and discharge summaries were selected from the 200 medical records. As some medical records contained multiple referral letters relating to the patient’s admission, there were 244 letters in total (Hospital A = 69, Hospital B = 175) and 255 discharge summaries (Hospital A = 111, Hospital B = 144). The informants and student
researcher decided that as the focus groups were only forty-five minutes long, seven referral letters and three discharge summaries would be suitable for the sessions; thus, giving participants approximately five minutes to discuss each document.

The selection process was a collaborative effort with the applied linguists pointing out interesting and/or unusual linguistic or organisational features that they had noticed in the referral letters, such as inconsistencies in grammar, vocabulary and structure which contributed to coherence, or lack thereof. The length, tone, legibility and cohesion of the letters were also considered. The health professionals identified letters which varied both in terms of the patient conditions and treatments, and the quality of the content and writing. They were also interested in the legal requirements, medical terminology and the selection of information which was included in the letter.

Although the applied linguists were initially actively involved in the process of selecting the discharge summaries, the medical terminology was difficult to interpret without health professional training and the writing tended to be in note form rather than in prose, which made it difficult to identify linguistic features and discern differences between the extracted summaries. Consequently, two of the expert informants, one with a nursing/pharmacy background, the other with a medical background, narrowed down the selection of the discharge summaries and decided which three to include in the focus-group sessions.

See Table 4 for a breakdown of the seven referral letters and three discharge summaries selected for the focus group sessions. There were two types of referral letters: incoming (letters coming into the hospital from outside, mainly written by General Practitioners), and outgoing referrals (most often written by specialists at the hospital to other clinicians in external healthcare practices, including General Practitioners). One referral letter (RL1) was selected for the first part of the focus group session (see Section 3.4.3.4), in
which one incoming referral letter was used as a stimulus for a whole-group discussion. This referral letter was selected for Part 1 due to its brevity, inaccuracies and missing information.

Table 4

**Breakdown of Referral Letters and Discharge Summaries for Focus Group Sessions**

<table>
<thead>
<tr>
<th>Letter code</th>
<th>Hospital where document was sourced</th>
<th>Type of document</th>
<th>Writer</th>
<th>Intended audience</th>
<th>Selection criteria/notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>RL1</td>
<td>B</td>
<td>Incoming referral</td>
<td>General Practitioner (GP)</td>
<td>Emergency department doctor</td>
<td>Used for Part 1: whole group discussion. Legibility, level of detail, cohesion, length Missing information, inaccuracies</td>
</tr>
<tr>
<td>RL2</td>
<td>B</td>
<td>Incoming referral</td>
<td>GP</td>
<td>Clinicians at hospital</td>
<td>Organisation/layout, lexico-grammatical features, cohesion, tone. Sections auto-populated, some irrelevant information, spelling mistake</td>
</tr>
<tr>
<td>RL3</td>
<td>B</td>
<td>Incoming referral</td>
<td>GP</td>
<td>Clinicians at hospital</td>
<td>Organisation/layout, cohesion, level of detail. Simple case, issues with language, similar purpose to OET, sent to Surgical Outpatients instead of Emergency</td>
</tr>
<tr>
<td>RL4</td>
<td>A</td>
<td>Incoming referral</td>
<td>Clinician at small country hospital</td>
<td>Clinicians at hospital</td>
<td>Level of detail, lexico-grammatical features. Writer from a non-English speaking background? Too much information included?</td>
</tr>
<tr>
<td>RL5</td>
<td>B</td>
<td>Outgoing referral</td>
<td>Hospital clinician</td>
<td>GP</td>
<td>Organisation/layout, cohesion. A narrative, family history included</td>
</tr>
<tr>
<td>RL6</td>
<td>A</td>
<td>Outgoing referral</td>
<td>Hospital clinician</td>
<td>Specialists at another hospital</td>
<td>Formatting: one sentence paragraphs, simple case, good letter from linguistic and clinical perspective</td>
</tr>
</tbody>
</table>
3.4.2.6 Selection of accompanying documents from the medical records. Some sections of the medical records which corresponded with the outgoing referral letters and the discharge summaries, were extracted for participants. The outgoing referral letters and the discharge summaries both had accompanying documents because the patient had been admitted to the hospital and therefore had a medical record containing other medical documents. The incoming referral letters did not have medical records attached because they were the first point of contact with the hospital. The participants did not identify the lack of accompanying documents with the incoming referral letters as problematic, as this was considered standard practice.

The accompanying documents for the outgoing referral letters and discharge summaries provided contextual information to the participants about the patient’s condition, past medical history and treatment. Appropriate documents were selected by the expert informants with a clinical background; these included progress notes, drug charts and triage forms. They also provided valuable contextual information for the student researcher which enhanced the analysis of the outgoing referral letters and discharge summaries in Chapter 4.
3.4.3 Stage 3: Focus groups. The aim of Stage 3 was to investigate the features of referral letters and discharge summaries which were considered important for effective written communication from the nurses’ perspectives. In this final stage of data collection, six 45-minute focus groups were conducted to provide insights into the qualities of referral letters and discharge summaries valued by nurses, and to elicit the criteria they used to assess effective written communication. Nurses were asked to imagine that they were reading the documents as part of their work in the clinical setting and to discuss their thoughts on the effectiveness of the documents with their colleagues.

Focus groups are group discussions facilitated by a researcher, or research team, which explore a central theme or topic with the aim of documenting and understanding the participants’ perspectives, beliefs and attitudes (Al Ghazali, 2014). They were selected as a data collection technique to encourage a dynamic in which group members built on each other’s responses (Stewart & Shamdasani, 2014). The triangulation technique of using multiple methods of data collection, in this case semi structured interviews and focus groups, to gain an understanding of nurses’ perspectives on referral letters and discharge summaries, arguably allows for a more comprehensive understanding of their viewpoints (Pope, Ziebland, & Mays, 2000).

3.4.3.1 Setting. The six focus groups were carried out at Hospital B. No focus groups were held at Hospital A due to logistical issues such as not being able to fit the sessions into the nurses’ schedules and having difficulties with coordinating facilitators to attend the sessions. In the first ward, two adjacent rooms were booked by the Nursing Unit Manager (NUM) for the conduct of focus groups. A projector was set up at the front of the larger room. The NUM of the second ward provided one room as well. There was also a projector available so that a brief slideshow could be shown to the nurses in the introductory part of the session.
3.4.3.2 Participants. Participants (n=36) were registered nurses who were accessed from two different wards: orthopaedic and neurology. Among them were an Assistant Nurse Unit Manager and a Clinical Nurse Specialist. The two types of wards were sourced through hospital networks and selected due to the availability of the participants. The participants ranged in age from 21 to 50. Only one of the nurses was male. The fact that fewer male than female participants took part in the study can be explained by the gender imbalance in the nursing profession, as the majority of nurses working in the field are female (Halcomb, Patterson, & Davidson, 2006). Their years of nursing experience ranged from 4 months to 16 years, with an average of 6.7 years of experience.

The participants were selected through convenience sampling consistent with the ethical requirements of the research (see Section 3.6). Seven nurses took part in the first two focus groups. Following the first two focus groups, there were six participants in the two subsequent sessions. The penultimate focus group consisted of four participants and there were six nurses present in the final session. See Table 5 for individual participant details.

Table 5

*Overview of Focus Group Participants*

<table>
<thead>
<tr>
<th>Participant code</th>
<th>Designation</th>
<th>Age group</th>
<th>Gender</th>
<th>Years and months of nursing experience</th>
<th>Focus group attended (1-6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse 1</td>
<td>Registered nurse</td>
<td>31 - 40</td>
<td>Female</td>
<td>13</td>
<td>1</td>
</tr>
<tr>
<td>Nurse 2</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Nurse 3</td>
<td>Clinical nurse specialist/ Orthopaedic liaison nurse in specialist clinics</td>
<td>21 - 30</td>
<td>Female</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Nurse 4</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>1.5</td>
<td>1</td>
</tr>
<tr>
<td>Nurse 5</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>3.5</td>
<td>1</td>
</tr>
<tr>
<td>Nurse</td>
<td>Position</td>
<td>Age Range</td>
<td>Gender</td>
<td>Experience</td>
<td>Length of Employment</td>
</tr>
<tr>
<td>-------</td>
<td>---------------------------------</td>
<td>-----------</td>
<td>--------</td>
<td>------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Nurse 6</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>6 months</td>
<td>1</td>
</tr>
<tr>
<td>Nurse 7</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Male</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Nurse 8</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Nurse 9</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>1.5</td>
<td>2</td>
</tr>
<tr>
<td>Nurse 10</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Nurse 11</td>
<td>Registered nurse</td>
<td>31 - 40</td>
<td>Female</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Nurse 12</td>
<td>Registered nurse</td>
<td>21 – 30</td>
<td>Female</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nurse 13</td>
<td>Registered nurse</td>
<td>31 - 40</td>
<td>Female</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Nurse 14</td>
<td>Associate Nurse Unit Manager (ANUM) Orthopaedics</td>
<td>31 - 40</td>
<td>Female</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td>Nurse 15</td>
<td>Registered nurse / Preceptor</td>
<td>31 - 40</td>
<td>Female</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Nurse 16</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>7.5</td>
<td>3</td>
</tr>
<tr>
<td>Nurse 17</td>
<td>Registered nurse /Clinical nurse specialist</td>
<td>31 - 40</td>
<td>Female</td>
<td>13</td>
<td>3</td>
</tr>
<tr>
<td>Nurse 18</td>
<td>Registered Nurse</td>
<td>51 - 60</td>
<td>Female</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Nurse 19</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Nurse 20</td>
<td>Registered nurse</td>
<td>31 - 40</td>
<td>Female</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Nurse 21</td>
<td>Registered nurse</td>
<td>31 - 40</td>
<td>Female</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Nurse 22</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Nurse 23</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>2.5</td>
<td>4</td>
</tr>
<tr>
<td>Nurse 24</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Nurse 25</td>
<td>Registered Nurse</td>
<td>21- 30</td>
<td>Female</td>
<td>4 months</td>
<td>4</td>
</tr>
<tr>
<td>Nurse 26</td>
<td>Student nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>3 years - undergraduate</td>
<td>4</td>
</tr>
<tr>
<td>Nurse 27</td>
<td>Registered nurse</td>
<td>31 - 40</td>
<td>Female</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Nurse 28</td>
<td>Registered nurse</td>
<td>21 - 30</td>
<td>Female</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
To source the participants, NUMs were initially identified through professional contacts of the student researcher, and the student researcher then contacted them by telephone and email. Information was provided about the aim of the study, the number of participants required and the procedures for the focus groups via email. The NUMs scheduled the focus group sessions as part of the nurses’ ongoing education program and encouraged their nursing staff to attend to further their professional development, although they emphasised that participation was voluntary. Participants were informed that their details would be kept confidential, as per the ethical requirements of the study.

3.4.3.3 Instruments. A focus group procedure was drawn up prior to carrying out the sessions (see Appendix I). The procedures provided comprehensive guidelines for those involved in facilitating the focus group sessions. A minimum of three facilitators were present at each focus group session. Six facilitators took part overall, including the student researcher, an applied linguistics student, a research assistant and three academics from The University of Melbourne who volunteered to collect data. All facilitators were given digital recorders to record the participants’ discussions. They were also provided with a log sheet to document the participants’ progress (Appendix J), which included the number and type of
referral letters and discharge summaries they discussed. Participants were required to fill out a short background questionnaire in order to capture demographic data (see Appendix K).

In each focus group session, seven referral letters and three discharge summaries extracted from the two hospitals were supplied to participants. The letters and discharge summaries were the same in each session to maintain consistency (Section 6.2 provides details of the documents). The referral letters were divided into two types: referral letters from the hospital (outgoing referrals addressed to GPs and other health professionals) and referral letters written to the hospital (external or incoming referrals). See Table 6 for an overview of the accompanying documents.

Table 6

<table>
<thead>
<tr>
<th>Document code</th>
<th>Type of document</th>
<th>Medical record included (Y/N)</th>
<th>Accompanying documents from medical record</th>
</tr>
</thead>
<tbody>
<tr>
<td>RL1</td>
<td>Incoming referral (used for Part 1)</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>RL2</td>
<td>Incoming referral</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>RL3</td>
<td>Incoming referral</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>RL4</td>
<td>Incoming referral</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>RL5</td>
<td>Outgoing referral</td>
<td>Y</td>
<td>2 letters from Neurologist/Neuro-Oncologist</td>
</tr>
<tr>
<td>RL6</td>
<td>Outgoing referral</td>
<td>Y</td>
<td>Specialist clinical referral, discharge summary, request for elective procedure, admission plan, progress notes, risk assessment and prevention plan, weight/length/head circumference charts, infant irritability study chart, fluid balance chart, paediatric observation chart, information for patient on discharge</td>
</tr>
<tr>
<td>RL7</td>
<td>Outgoing referral</td>
<td>Y</td>
<td>Discharge summary, progress notes, surgical daily notes, admission risk form, general observation</td>
</tr>
</tbody>
</table>
Prior to the focus group sessions, a pilot study which was part of the larger study was conducted with a group of doctors to trial the procedures. A few changes were made based on the pilot study including having participants seated throughout the session instead of asking them to move around to different stations, and making multiple copies of the referral letters and discharge summaries so that each participant could see their own copy.
Before the focus group sessions with nurses commenced, the six facilitators were briefed on the procedures and trained to use the digital recorders and log sheets effectively by the student researcher.

Figure 2: Focus group session procedures.

Figure 2 shows an overview of the focus group procedures. At the beginning of each focus group session, there was a five-minute presentation conducted by a facilitator, in which the aims and procedures of the focus group were outlined. PowerPoint slides enhanced the introduction by clearly setting out the information visually for participants.

During Part 1, which followed the introduction, participants were shown one referral letter (RL1) and asked to comment on the effectiveness of the letter in terms of communication, the main functions, and the strengths and weaknesses of the letter during a short group discussion (see Figure 3 for the rubric). They were encouraged to make notes which they would use in the ensuing discussion. Any notes written by the participants did not form part of the body of data, instead they were used simply to stimulate discussion.
Most participants did not write notes, and those who did, were not invited to submit them. The decision was made to refrain from collecting and analysing the notes because they were simply a way for the participants to organise their thoughts and orientate themselves to the situation so that they could express themselves verbally.

**Figure 3: Part 1 rubric.**

After Part 1, participants were assigned a work partner. Small, two- or three- person groups within the wider focus group enabled each participant to actively contribute and express their own views about the letters and discharge summaries. Groups were selected based on convenience, by pairing or grouping participants sitting next to each another. It was assumed that since all the nurses regularly worked in the same ward, they would be able to work effectively together during the focus group session; thus, strategically choosing partners was not considered necessary. Across the six focus group sessions, there were sixteen smaller focus groups altogether; three groups in the first four focus group sessions and two groups of participants in the final two sessions.
For Part 2, groups were seated in different corners of the room with a facilitator who was either the student researcher, an applied linguistics student, a research assistant or an academic from The University of Melbourne. The group’s facilitator recorded the participants’ conversation and prompted them when necessary with a list of pre-established questions (see Appendices L to N). One facilitator who was not directly working with a group was responsible for distributing the referral letters, discharge summaries and accompanying documents as required. Once a pair had finished their discussion about a particular referral letter or discharge summary, it would be moved on to a different group; this way, participants would have the opportunity – time permitting – to discuss the majority of documents (see Figure 4 for the rubric). Due to time restraints, the participants in the sixteen smaller groups only commented on an average of 3.5 documents each. The group that discussed the most documents had time to comment on six referral letters and discharge summaries. Another group that discussed the least documents, was only able to focus on two in the allotted time.

![Part 2 – Individual stations](image)

**Figure 4: Part 2 rubric.**
No time limits were given to the participants in discussing the documents because a) it was thought that the data would be richer if participants were able to discuss the referral letters and discharge summaries in as much detail as possible and b) facilitators were instructed to keep the participants on topic so it was expected that the discussions would not continue indefinitely. The decision to allow time flexibility meant that a limited number of documents were discussed; however detailed discussions took place. Participants were not required to provide any written notes. Wrap up at the end of the session was conducted by individual facilitators who asked two concluding questions addressing general perspectives (see Appendix L), and thanked the participants.

3.4.3.5 Data coding. Coding and transcription for the focus groups was carried out in much the same way as the interview coding and transcription (See Section 3.4.1.5). Transcription followed denaturalisation techniques (as described in Section 3.4.1.3). A codebook was developed which listed the coding categories and included examples and descriptions. The student researcher and the same healthcare communication PhD student who had coded the interview data, independently double coded the focus group data. Appendix R contains a sample of the codebook and Appendix S shows a coded transcript sample. The coding system was organised according to two main categories: ‘referral letters’ and ‘discharge summaries’, which were colour coded. At the end of each coloured section relating to discharge summaries and referral letters, letters were placed to represent sub categories. For instance, a section of the transcript dealing with the context in which referral letters were written and/or read were labelled ‘C’, while comments that were related to language use were labelled ‘LF’ for linguistic features. See Appendix R for a complete list of the main and sub categories.
3.5 Data analysis

Genre analyses of 100 referral letters and 100 discharge summaries were undertaken to determine the structural and linguistic features of the two different genres. Thematic analyses of the interview and focus-group data were also carried out to determine how nurses engage with referral letters and discharge summaries, and the qualities of these documents they value.

3.5.1 Genre analysis. As discussed in the literature review in Section 2.6.5, there are a variety of possible approaches to genre analysis. The extracted referral letters and discharge summaries were analysed to gain an understanding of the content, structure and key linguistic features of referral letters and discharge summaries. Analysis of the documents took place after the focus-group sessions, in part so that the student researcher could learn more about referral letters and discharge summaries before beginning the analyses.

The ESP genre analysis method (see Section 2.6.5 for an explanation of this approach) draws on the work of Swales (1990) and Bhatia (2004) in which gaining an awareness of the communicative purpose and the structural and linguistic features of the genre is central. Bawarshi and Reiff (2010) described the methods that applied linguists often employ when undertaking ESP genre analysis:

A typical ESP approach to genre analysis, for example, will begin by identifying a genre within a discourse community and defining the communicative purpose the genre is designed to achieve. From there, the analysis turns to an examination of the genre’s organization—its schematic structure—often characterized by the rhetorical “moves” it undertakes, and then to an examination of the textual and linguistic features (style, tone, voice, grammar, syntax) that realize the rhetorical moves. The trajectory of the analysis thus proceeds from a genre’s schematic structure to its lexico-grammatic features, all
the while attending to the genre’s communicative purpose and the discourse community which defines it. The process is by no means linear or static, but generally speaking, it has tended to move from context to text (Flowerdew 91-92), with context providing knowledge of communicative purpose and discourse community members’ genre identifications.’ (pp.46 – 47).

Drawing on the ESP technique, each rhetorical section of the genre is categorised as a move. Within each move, particular steps that characterise the communicative function are identified (Swales, 1990). The methods described above were employed for the analyses of referral letters and discharge summaries described in Chapter 4 of this thesis. The communicative purposes of both documents were considered. Then the schematic structure of referral letters was documented, including the rhetorical moves and steps, and the structure of discharge summaries was also examined. Finally, the lexico-grammatical features including the writers’ use of abbreviations and verb tenses were analysed.

3.5.2 Thematic analysis. Thematic analysis was used to analyse both the interview and focus-group data. Themes from the interviews were discussed in a separate chapter to the focus-group themes so that all themes could be adequately presented and explored. Thematic analysis is widely practiced in qualitative research (Guest, MacQueen, & Namey, 2011). It is an interpretative process by which the researcher aims to uncover and categorise themes found within the data (Attride-Stirling, 2001; Smith & Firth, 2011). The process involves the researcher becoming familiar with the data collected, transcribing verbal data and then developing codes through systematic searches for latent and/or semantic themes (Braun & Clarke, 2006). The emerging themes, or patterns in the data are analysed by the researcher (Fereday & Muir-Cochrane, 2008). The search for themes differs from coding in that coding predominantly involves selecting and organising the data during the first stage of
analysis, whilst searching for themes is a more in-depth analytical process (Clarke & Braun, 2013).

One of the reasons that researchers use thematic analysis is that it allows for flexibility (Bakar, 2013). Braun and Clarke (2006) stated that “thematic analysis is not wed to any pre-existing theoretical framework, and so it can be used within different theoretical frameworks (although not all) and can be used to do different things within them.” (p.85). As the current investigation relies on interpretation of participants’ perceptions and the identification of themes, thematic analysis was considered the optimal analytical tool for the present thesis.

Inductive analyses, in which evaluation of the data is predominantly exploratory and descriptive, are most common in qualitative research (Guest et al., 2011). Trends, concepts and key words are identified in the course of data analysis, in contrast to more confirmatory approaches, in which analysis is driven by specific hypotheses (Guest et al., 2011). This thesis takes an inductive approach to exploring nurses’ perceptions of referral letters and discharge summaries.

One of the most important aspects of carrying out thematic analyses is to “move beyond counting explicit words or phrases and focus on identifying and describing both implicit and explicit ideas within the data, that is, themes” (Guest et al., 2011, p. 10). In order to do that, Clarke and Braun (2013) recommended adhering to the following guidelines, which were observed for the thesis:

1. **Familiarisation with the data** in which the researcher becomes well acquainted with all aspects of the data.
2. **Coding**, which involves labelling salient features of the data relevant to the research questions. The process is both descriptive and analytical.
3. **Constructing themes** in which the researcher actively scours the data and constructs themes. Clarke and Braun noted that themes are not ‘hidden in the data’ but must be established by the researcher.

4. **Reviewing themes**, a process that includes checking that the themes adequately correspond to the coded extracts as well as the complete data set.

5. **Defining and naming themes** by recording detailed information about each theme and establishing a name for the category.

6. **Writing up**, in which analysis continues as the data extracts are woven into the thesis.

Thematic analysis of the interview data was carried out according to Clarke and Braun’s (2013) list of procedures for data analysis. Firstly, as the student researcher had conducted the interviews and transcribed them, there was already a level of familiarisation with the data. To gain a deeper understanding of the nurses’ perspectives, the transcripts were read numerous times. As mentioned in Section 3.4.1.5, data were then coded.

After coding the data, themes were established through detailed reading of the quotes in each coded category in the codebook, and by making connections within and across categories. For example, *empathy* and *patient-centred care* were themes that emerged in the context of nurses’ perceived effectiveness of referral letters and discharge summaries. Central themes also arose in relation to the participants’ views on their experiences with reading referral letters and discharge summaries, their notions of what constitutes effective written documentation, and their ideas about written communication in hospitals. For an in-depth discussion of interview themes, see Chapter 5.

Thematic analysis of the focus group data followed the same stages as the interview analysis, as set out in Clarke and Braun’s (2013) guidelines. One problem with analysing focus group data is that the sessions often generate a lot of data, which can be overwhelming...
for novice and experienced researchers alike to sift through (Rabiee, 2004). Consequently, it is essential that researchers keep the aims of the study in mind as they develop themes (Rabiee, 2004). Focus group data also differ from interview data in that there are multiple interactions between participants, as well as between the researcher and participants. Participants may agree or disagree with each other’s opinions, which could form part of the thematic analysis (Stalmeijer, Mcnaughton, & Van Mook, 2014). These factors were all taken into consideration while undertaking analysis of the focus-group data for the current thesis. For an in-depth discussion of focus group themes, see Chapter 6.

3.6 Ethical considerations

Ethics approval for the interviews, extraction of medical records and focus group sessions was obtained using the procedures of both hospitals’ ethics committees and the Human Ethics Research Committee at The University of Melbourne. Approval letters can be found in Appendix O. The following forms were also completed: a National Ethics Application Form, a Site Specific Assessment Form and a Victorian-Specific Module which is mandatory in the state of Victoria when conducting research at hospitals. Participants received a Plain Language Statement and a Participant Information and Consent Form, as per the ethics procedures of the hospitals and university (see Appendices P and Q). These documents stipulated that participants could withdraw at any stage of the data collection process and that confidentiality would be maintained.

The ethical considerations and procedures for this study were in line with the National Statement on Ethical Conduct in Human Research (NHMRC, 2018). Regarding storage of the medical records and participant information, hard copies of the medical records were stored in a locked filing cabinet. Electronic copies of medical records and participant lists were stored in an encrypted shared drive. All paper and electronic documents and records
relating to the research will be destroyed after seven years, in line with The University of Melbourne’s ethics guidelines.

To protect the participants’ privacy, all paper and electronic copies of referral letters and discharge summaries had personal identifiers removed either through use of a black marker pen to redact personal details on the paper-based records, or by covering identifiers found in the electronic records with black shapes from Microsoft Paint. Methods to reduce identifiability were utilised such as storing documents with identifiers in different folders to the transcripts, and using participant codes (NHMRC, 2018). In addition, the participants’ workplace was not identified in the thesis.

To protect the confidentiality of the participants, interview and focus-group transcripts were stored in an encrypted shared drive. Only the student researcher and wider project team had access to the drive.

Interview and focus-group participants were given the option to opt out at any stage, and this was specified in the Plain Language Statement. Recruitment and consent strategies adhered to the principles of justice and respect as described in the National Statement on Ethical Conduct in Human Research (NHMRC, 2018), including ensuring that potential risks were minimised for participants, and that there was minimal impact on existing hierarchical relationships. For example, when recruiting participants through the Nurse Unit Manager (NUM), the NUM was asked to put out a general message regarding non-compulsory recruitment to all employees in the team, rather than targeting specific individuals. The nurses were also advised verbally before participating in the interviews and focus-groups that participation was voluntary and they could decide not to be involved at any time. This notion was reiterated in writing in the Plain Language Statement and consent form, which participants received prior to participating in the study.
3.7 Summary

This chapter has defined the three stages of data collection and analysis. The first section highlighted the importance of qualitative research and described the semi structured interviews in light of this approach. The next section described the extraction and use of referral letters and discharge summaries. Following this, the methods for conducting the focus-group sessions were discussed. Finally, thematic and genre analyses were described. In the next chapter, the results of genre analyses of both referral letters and discharge summaries are described.
Chapter 4: Genre Analyses of Referral Letters and Discharge Summaries

4.1 Introduction

This chapter presents the results of the analyses of referral letters and discharge summaries extracted from medical records at two hospitals by drawing on an ESP approach to genre analysis. The chapter provides the results of an analysis of 100 referral letters - 50 from each hospital. The structure and content of the letters are described through an identification of the rhetorical moves and steps. Subsequently, the lexico-grammatical features of the referral letters are described. The chapter also includes an analysis of the structure, content and formal features of 100 discharge summaries – 50 from each hospital.

4.2 Separate Analyses of Transition Documents

Referral letters and discharge summaries were analysed separately because even though the two genres share many similarities (e.g. they are both documents used to hand over care of the patient), there were enough structural and linguistic differences evident to warrant separate analyses. While structural and linguistic variations were evident, nurses valued the same qualities of referral letters as discharge summaries; therefore, the model presented in Chapter 7 conflates the two genres to represent what nurses value.

Another reason to analyse referral letters and discharge letters separately was that the contexts in which the two genres were written varied. From an ESP genre analysis approach, genres written in different contexts are not the same and should be analysed separately. According to the nurse interviewees, the referral letters they usually engaged with were often written by external sources (e.g. general practitioners and specialists) with the aim of informing hospital clinicians of the reason that the patient was being sent to hospital, and of
providing a summary of their care and expected treatment. In contrast, the interviewees stated that discharge summaries were written by hospital clinicians once the patient was discharged, with one of the main functions being to communicate to external health professionals how the patient was treated during their hospital stay.

4.3 The Content of Referral Letters and Discharge Summaries

Genre analyses of referral letters and discharge summaries were undertaken by the student researcher in order to capture the structural, linguistic and lexico-grammatical features of these two transition documents (with the overall aim to inform the OET task and evaluate the effectiveness of the stimulus material), and the interview and focus group findings formed the basis for understanding the qualities of referral letters and discharge summaries valued by nurses from a clinical perspective (with the aim of informing the OET assessment criteria for the writing sub-test). Although the content of referral letters and discharge summaries is described as part of the analyses, judgements about the quality of the clinical information could not be made by the student researcher who has an applied linguistics background and is not a health professional.

4.4 The Schematic Structure of Referral Letters

This section provides reference to the communicative purpose of referral letters and describes the schematic structure of the sample.

4.4.1 The communicative purpose of referral letters. Interview findings, discussed in Chapter 5 of this thesis, shed light on what nurses, the relevant community of practice, identified as being the communicative purposes of referral letters. Section 5.3.6 in Chapter 5 provides a discussion regarding the participants’ perspectives.

4.4.2 Analysis of the schematic structure of referral letters. Drawing on the work of Swales (1990), the typical moves and steps evident in referral letters are described in this
section and also listed in Table 7. These moves and steps were established by taking into account how the different concepts (or schemata) were organised, as well as noting the sentence structures, paragraphing and breaks in information which were evident in the letter. The aim of analysing and explaining the schematic structure of referral letters is to provide a step-by-step description of how these letters were constructed to inform the OET writing test task in terms of provide OET developers with an understanding of how the documents are written in the clinical setting. This information could be useful for researchers, OET test takers, OET assessors, OET preparation teachers, health professional students, academic nursing staff and clinical educators.

It is important to note that although the moves and steps generally followed the structure set out in Table 7, there were instances in which moves were omitted from individual referral letters. For example, some writers of referral letters elected not to explicitly hand over care to the recipient and others chose not to include information pertaining to the patient’s medical history. Table 11 in Section 4.4.4 shows a breakdown of optional and obligatory moves. Optional and obligatory moves are prevalent in Swales’ and his colleagues’ genre analysis work (e.g. Swales & Feak, 1994), and are a feature of other approaches to genre analysis such as the Sydney School (Fakruddin & Hassan, 2015).

Table 7

Moves and Steps in a Referral Letter

<table>
<thead>
<tr>
<th><strong>Move 1: Establishing person, place and time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1 Identifying writer, department and institution</td>
</tr>
<tr>
<td>Step 2 Indicating date on which letter was written</td>
</tr>
<tr>
<td>Step 3 Identifying letter recipient, department and institution</td>
</tr>
<tr>
<td>Step 4 Identifying patient (including name, date of birth, contact details and UR number)</td>
</tr>
</tbody>
</table>

**Move 2: Establishing the situation**
Step 1  Addressing/acknowledging the letter recipient
Step 2  Expressing gratitude and/or providing further identification of patient
Step 3  Identifying reason for referral and/or presenting complaint
Step 4  Describing patient’s presentation

**Move 3: Establishing the patient’s medical background**

Step 1  Describing the history of the presenting complaint
Step 2:  Providing results of examinations and investigations
Step 3  Describing treatment to date
Step 4  Listing past medical conditions
Step 5  Describing family, social and lifestyle history
Step 6  Listing allergies
Step 7  Listing current medications
Step 8  Mentioning attachments (e.g. pathology)

**Move 4: Handing over care**

Step 1  Making recommendations
Step 2  Establishing willingness to continue being involved in the patient’s care and/or willingness to clarify treatment to date
Step 3  Thanking the letter recipient in advance for their care of patient

**Move 5: Signing off**

Step 1  Using a closing phrase
Step 2  Signing the referral letter with name and designation

There was also some variation in positioning of the moves, with **Move 4 (handing over care)** most changeable in terms of position, with some writers preferring to hand over care of the patient between Moves 1 and 2 or between Moves 2 and 3. In some cases, writers chose to identify the patient (Move 1, Step 4) after they had addressed the recipient (Move 2, Step 1). Some steps within the moves were omitted by writers depending on the length and
comprehensiveness of their letter. Individual steps will be discussed in Sections 4.4.3.1 to 4.4.3.5 of this chapter.

Figure 5 shows an authentic referral letter divided into moves. This letter was extracted from one of the medical records at the metropolitan hospital because it was representative of the structure and wording of the sample of referral letters. The black shapes indicate sections of sensitive information which have been redacted. This referral letter was selected as an example because the layout, which included paragraphs and headings, was clear and the different moves were easy to distinguish at a glance. However, there were some variations between letters. Table 8 shows the same wording of the referral letter broken down into moves.
Figure 5: Referral letter moves.
### Table 8

**Referral Letter Moves and Example Phrases**

<table>
<thead>
<tr>
<th>Referral letter moves</th>
<th>Phrase(s) from the representative referral letter (Figure 5)</th>
</tr>
</thead>
</table>
| Move 1: Establishing person, place and time  | Step 1: (Writer, department and institution redacted)  
Step 2: Sunday, 19 January 2014  
Step 3: (Letter recipient, department and institution redacted)  
Step 4: (Patient details redacted)                                                                                                                                                            |
| Move 2: Establishing the situation           | Step 1: Dear doctor  
Step 2: Thank you for seeing (patient name redacted), age 78 yrs  
Step 3: For opinion and management of his high temperature  
Step 4: Since this morning had high temp, respiratory: no cough, ENT: No sore throat. No rhinorrheoa.  
H/O- Bladder Ca (history of bladder cancer), Rt (right) nephrostomy & ileal conduit (urinary drainage) – holding 2 bags now [NB: This section belongs in Move 3, and is in fact repeated in Move 3]  
Examination: General: temp: 39.3 Axillary  
Respiratory: No respiratory distress. Normal air entry on Right, Normal air entry on Left. No creps. No rhonchi. [‘Creps’ and ‘rhonchi’ are lung sounds]. No pleural rub [sounds in chest cavity].  
Step 3 (repeated): Reason for contact: Fever - ? cause with |
| Move 3: Establishing the patient’s medical background | [NB: Not all steps included]  
Step 1: [No history of presenting complaint provided]  
Step 2: [No results of examinations and investigations provided, none conducted]  
Step 3: [No treatment described]  
Step 4: Past History; Inactive; Date: [no dates included]; Condition: Ileal conduit, Nephrostomy – Rt (right sided).  
Step 5: [No references to family, social and lifestyle history]  
Step 6: Allergies: No known allergies  
Step 7: Current medications (blank) |
| Move 4: Handing over care                    | Step 1: [No recommendations made]  
Step 2: I look forward to hearing the outcome of (patient name’s) attendance  
Step 3: Thank you for your care and assistance |
| Move 5: Signing off                          | Step 1: Yours sincerely  
Step 2: Signature included [signature, name & designation redacted] |
4.4.3 Moves and steps. In subsequent sections, the steps within each move are described. Two examples, or excerpts, from the referral letter samples are provided to adequately highlight how the move is structured and the content that is included. The sample of 100 referral letters as a whole is also discussed in relation to each move and its corresponding steps.

4.4.3.1 Move 1: Establishing person, place and time. The first move involved identifying the writer, the date on which the referral letter was written, the letter recipient, and the patient. Figure 6 shows the steps. Two examples of the move are provided in Figures 7 and 8.

<table>
<thead>
<tr>
<th>Move 1: Establishing person, place and time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
</tr>
<tr>
<td>Step 2</td>
</tr>
<tr>
<td>Step 3</td>
</tr>
<tr>
<td>Step 4</td>
</tr>
</tbody>
</table>

*Figure 6: Move 1: Establishing person, place and time.*
1st Example:

![First example of Move 1.]

Figure 7: First example of Move 1.

2nd Example:

![Second example of Move 1.]

Figure 8: Second example of Move 1.

While both referral letter excerpts contained all four steps, the dates (Step 2) were positioned differently. In the first example, the date was included before the patient details, whilst in the second excerpt, the date came after the patient information. Also, in the second
example, the recipient’s details were listed at the end of the move, while in the first excerpt, the recipient’s details were documented before the patient’s details.

In the wider sample of 100 referral letters, 36% of the referral letters showed that the steps were predominantly ordered in the same way as the first example which followed a Step 1/Step 2/Step 3/Step 4 structure. The next most common structure was Step 1/Step 3/Step 4/Step 2 which appeared in 17% of the letters. Table 9 shows a full breakdown of the order of steps in Move 1, seven referral letters did not have dates; therefore, Step 2 was omitted in those cases.

Table 9

*Order of Steps in Move 1*

<table>
<thead>
<tr>
<th>Order of steps</th>
<th>% of referral letters in sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1/Step 2/Step 3/Step 4</td>
<td>36</td>
</tr>
<tr>
<td>Step 1/Step 3/Step 4/Step 2</td>
<td>17</td>
</tr>
<tr>
<td>Step 1/Step 3/Step 2/Step 4</td>
<td>15</td>
</tr>
<tr>
<td>Step 1/Step 4/Step 2/Step 3</td>
<td>15</td>
</tr>
<tr>
<td>Step 1/Step 4/Step 3/Step 2</td>
<td>7</td>
</tr>
<tr>
<td>Step 2/Step 1/Step 3/Step 4</td>
<td>2</td>
</tr>
<tr>
<td>Step 1/Step 2/Step 4/Step 3</td>
<td>1</td>
</tr>
<tr>
<td>Step 1/Step 3/Step 4</td>
<td>7</td>
</tr>
</tbody>
</table>

Step 1 (*identification of the writer*) was provided first in 97% of the letters, while the order of the latter three steps varied. In Step 4, writers tended to preface patient information with ‘Re’ (‘regarding’). In all, 76% of writers used the term, followed by a colon (i.e. ‘Re:’). While the order of steps was variable, they were included in almost all the referral letters.

4.4.3.2 Move 2: Establishing the situation. Move 2 involved acknowledging the letter recipient, expressing gratitude and/or providing further identification of the patient, identifying the reason for the referral and/or presenting complaint and describing the patient’s presentation. The steps are set out in Figure 9, and examples are shown in Figures 10 and 11.
Move 2: Establishing the situation

Step 1  Addressing/acknowledging the letter recipient
Step 2  Expressing gratitude and/or providing further identification of patient
Step 3  Identifying reason for referral and/or presenting complaint
Step 4  Describing patient’s presentation

Figure 9: Move 2: Establishing the situation.

1st example:

Figure 10: First example of Move 2.

2nd example:

Figure 11: Second example of Move 2.
The structure of Move 2 was rigid, with little variation. The two Move 2 excerpts are in numerical order, beginning with Step 1, then Steps 2 and 3 and finally, Step 4. The sample of 100 referral letters showed the same pattern. The writers moved through the four steps sequentially. Even if one step was omitted, the steps were still written in order. For example, if a writer excluded an expression of gratitude and further identification of the patient (Step 2), they would move directly from addressing the letter recipient (Step 1) to identifying the reason for the referral and/or the presenting complaint (Step 3).

In the sample of 100 referral letters, 90% of referral letters included Step 3 which involved identifying the reason for the referral and/or the presenting complaint. Step 1 (addressing/acknowledging the letter recipient) was also common, with 84% of referral letters including the step. Describing the patient’s presentation (Step 4) was the least common step, only appearing in 33% of the referral letters.

4.4.3.3 Move 3: Establishing the patient’s medical background. Figure 12 shows the eight different steps involved in establishing the patient’s medical background including describing the history of the presenting complaint and providing results and examinations. Table 10 provides an abbreviations key, while Figures 13 and 14 show examples of Move 3.

<table>
<thead>
<tr>
<th>Move 3: Establishing the patient’s medical background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
</tr>
<tr>
<td>Step 2</td>
</tr>
<tr>
<td>Step 3</td>
</tr>
<tr>
<td>Step 4</td>
</tr>
<tr>
<td>Step 5</td>
</tr>
<tr>
<td>Step 6</td>
</tr>
<tr>
<td>Step 7</td>
</tr>
</tbody>
</table>
Step 8  Mentioning attachments (e.g. pathology)

Figure 12: Move 3: Establishing the patient’s medical background.

Table 10

Abbreviations in Move 3

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>HOPC</td>
<td>History of presenting complaint</td>
</tr>
<tr>
<td>Ix</td>
<td>Investigations</td>
</tr>
<tr>
<td>Meds</td>
<td>Medications</td>
</tr>
<tr>
<td>PMH</td>
<td>Past medical history</td>
</tr>
<tr>
<td>Rx</td>
<td>Treatments</td>
</tr>
</tbody>
</table>
1st example:

Step 3

No current Rx

Past hemiplegic migraine in 2010
No current numbness but weird sensation left arm
Neck feels sore with slight flexion
Feels weak and lethargic sensitive to light and noise since yesterday

Dizziness 1 month worse last 1 week
Feeling of vertigo when still Feels of balance
No tinnitus or hearing loss

Step 1

has private ins

Examination:
MEASUREMENTS;
BP Sitting 135/85 Regular Pulse 76
has marked nuchal spasm and light sensitivity

Step 2

Past History:

Date	Condition
2010	THALASSAEMIA MINOR
	MIGRAINE
	HEMIPLEGIC MIGRAINE

Step 4

Allergies:
No Known Allergy

Step 5

Current Medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Strength</th>
<th>Dosage/Freq</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHENOXYPHENYL-PHENICILLIN POTASSIUM</td>
<td>300 MG</td>
<td>1 Q.I.D.</td>
</tr>
<tr>
<td>VOLTEAREN TABLETS</td>
<td>35 MG</td>
<td>1 R.D.</td>
</tr>
<tr>
<td>RELPAK TABLETS</td>
<td>40 MG</td>
<td>1</td>
</tr>
</tbody>
</table>

Step 7

Step 8

Pathology Results

NB: Step 5 not included

Figure 13: First example of Move 3.
In the sample of 100 referral letters, the steps listed in Move 3, as opposed to the other moves, were most likely to be omitted. Describing family, social and lifestyle history (Step 2) was excluded most frequently, as was the case in the first Move 3 excerpt. In fact, only 11% of letters contained this step. Listing allergies (Step 3) and providing test results (Step
5) were also omitted from some of the letters, with the steps included in 41% and 87% of the referral letters respectively. The step which most writers included was Step 1, the history of the presenting complaint, which was described in 97% of referral letters.

Past medical conditions (Step 4) and the treatment the patient had received to date (Step 3) were sometimes listed in reverse order. The patient’s medications (Step 7) were predominantly listed towards the end of the move but in a few cases, appeared earlier in the referral letters, after Steps 1, 2, 3, 4 or 5 depending on the writer’s preference.

4.4.3.4 Move 4: Handing over care. Handing over patient care from one health professional to another involves making recommendations, establishing willingness to continue being involved in the patient’s care and/or being willing to clarify treatment carried out so far. The steps are set out in Figure 15. Letter fragments are shown in Figures 16 and 16, to demonstrate how the steps appear in authentic referral letters.

<table>
<thead>
<tr>
<th>Move 4: Handing over care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
</tr>
</tbody>
</table>

*Figure 15: Move 4: Handing over care.*
1st Example:

Additionally, we would like to request that upon discharge (if she is discharged home rather than back to [redacted] her ability to cope at home is taken into account, as on last admission she was discharged without adequate information, social work referral, or mobility aids. If on discharge, she could also be referred to the [redacted] High Risk Foot Service (on [redacted] [redacted] that would be fantastic, so she could be followed up appropriately in the long term.

Please contact the medical registrar under Dr [redacted] (via [redacted] [redacted] should you have any further queries.

Thank you for her ongoing care.

Yours Sincerely,

[Redacted]

Medical Intern for Dr [Redacted] (Consultant)

Figure 16: First example of Move 4.

2nd Example:

Our impression at this stage is that [redacted] may likely have cow’s milk protein allergy causing food aversion. Since his admission, we have started him on Pepti-junior

We would appreciate your input regarding the suitability of elemental fully hydrolysed formula. Thank you for your care of this patient. Please do not hesitate to contact us should you require further information.

Figure 17: Second example of Move 4.

The two examples for Move 4 demonstrate how referral letter writers handed over care. The first step involved making recommendations: ‘we would like to request that…’, ‘she could also be referred to…’ (1st example), and ‘we have started him on Pepti-junior (a subtle recommendation to continue the patient on the medication)’ (2nd example). In the wider sample, 49% of referral letters included recommendations. For the next step, the
writers established their willingness to continue being involved in the patient’s care/and or clarify their treatment to date, e.g. ‘please contact (name and contact number of doctor), should you have any further queries’ (1st example) and ‘please do not hesitate to contact us should you require further information’ (2nd example). Of the 100 referral letters, only 26 letters contained this step.

The writers also thanked the recipients in advance for their care: ‘thank you for your ongoing care’ (1st example) and ‘thank you for your care of this patient’ (2nd example). This step was least popular in the wider sample, with only 14 writers including a phrase to thank the recipients in advance for their care.

Generally, the steps in Move 4 were written sequentially; however, in two referral letters, Steps 2 and 3 were reversed. As Step 3 was only included in 14% of the letters, Move 4 predominantly consisted of the first two steps.

4.4.3.5 Move 5: Signing off. Move 5 comprised two steps: using a closing phrase and signing the referral letter with name and designation, as shown in Figure 18. Examples are provided in Figures 19 and 20.

<table>
<thead>
<tr>
<th>Move 5: Signing off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
</tr>
<tr>
<td>Step 2</td>
</tr>
</tbody>
</table>

Figure 18: Move 5: Signing off.

1st Example:

Figure 19: First example of Move 5.
Figure 20: Second example of Move 5.

Move 5 comprised two steps: using a closing phrase, such as ‘yours sincerely’ and the name and designation of the writer, as shown in the two examples. All closing phrases preceded the name and designation. While 80% of writers elected to use a closing phrase, it was not possible to evaluate the number of writers who signed off as many of the letters were redacted to the point where signatures and designations could not be discerned.

4.4.4 Summary of the schematic structure of referral letters. In all, five moves were identified as being integral to the structure of referral letters. In Move 1, the writers established person, place and time by identifying details about themselves, the letter recipient and the patient, and noting the date on which the letter was written. Step 3 of Move 1 (identifying details about the letter recipient) was most likely to be omitted by the referral-letter writers and Step 1 (identification of the writer) was included in all of the referral letters.

Move 2 comprised four steps including addressing and/or acknowledging the recipient of the letter, expressing gratitude and providing further identification of the patient, identifying the reason for the referral and/or the presenting complaint, and describing the patient’s presentation. Little variation was evident in the order of the steps for Move 2. Step 4 (describing the patient’s presentation) was most likely to be omitted. Step 3 (identifying reason for referral and/or presenting complaint) was present in the majority of referral letters, with 90% of writers electing to include it.
Move 3 encompassed eight steps altogether including the history of the presenting complaint, results of examinations and investigations, information about the patient’s treatment to date, their past medical conditions, their family, social and lifestyle history, their allergies and current medications. References to attachments (e.g. pathology reports) were also included in Move 3. The steps in Move 3 were more likely to be omitted compared to the steps in other moves. Of all the steps, Step 2 (describing family, social and lifestyle history) was most likely to be excluded by the referral-letter writers. The order of the steps in Move 3 did not follow as rigid sequencing as those in other moves.

Move 4 was the process of handing over care which included making recommendations for treatment and care, demonstrating willingness to continue involvement in the patient’s care and thanking the letter recipient in advance for taking over care of the patient. The steps in Move 4 were generally sequential and Step 3 (thanking the letter recipient in advance for their care of patient) was most likely to be omitted, in fact, only 14% of referral letters included the step.

The fifth and final move involved the writer signing off through use of a closing phrase as well as their name and/or designation. The majority of writers (80%) included a closing phrase. Due to the redaction methods of the referral letters, it was not possible to distinguish signatures, names and designations.

Table 1 sets out the moves and steps, and provides brief descriptions of the variations in sequencing of steps (i.e. whether or not the steps usually occurred in order). Table 1 also indicates whether each step was considered optional or obligatory. Without a healthcare background, it would not be possible to make a value judgement about which individual steps would be considered integral to the referral-letter writing process; therefore, steps that appeared in less than 50% of referral letters were listed as ‘optional’ and steps employed in more than 50% of cases were labelled as ‘obligatory’. While a step appearing in
more than 50% of referral letters is considered obligatory for the purpose of the present study, it is recognised that although this a mathematically rational cut point, the decision is still ad hoc. Inclusion or exclusion of particular steps by the writer would be dependent on many factors such as the patient’s individual medical case and how familiar the writer and/or letter recipient were with the patient.

Table 11

*Referral Letter Moves and Steps*

<table>
<thead>
<tr>
<th>Move</th>
<th>Steps</th>
<th>Sequencing</th>
<th>Optional/Obligatory</th>
<th>% of referral letters in sample containing step</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establishing person, place and time</td>
<td>Some variation in sequencing of steps</td>
<td>Obligatory</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>1. Identifying writer, department and institution</td>
<td></td>
<td>Obligatory</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>2. Indicating date on which letter was written</td>
<td></td>
<td>Obligatory</td>
<td>93%</td>
<td></td>
</tr>
<tr>
<td>3. Identifying letter recipient, department and institution</td>
<td></td>
<td>Obligatory</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>4. Identifying patient</td>
<td></td>
<td>Obligatory</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>2. Establishing the situation</td>
<td>Little variation in sequencing of steps</td>
<td>Obligatory</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>1. Addressing/acknowledging letter recipient</td>
<td></td>
<td>Obligatory</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>2. Expressing gratitude and/or providing further identification of patient</td>
<td></td>
<td>Obligatory</td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>3. Identifying reason for referral and/or presenting complaint</td>
<td></td>
<td>Obligatory</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>4. Describing patient’s presentation</td>
<td></td>
<td>Optional</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

106 Nurses’ Perspectives on Referral Letters and Discharge Summaries: Towards Profession-oriented Writing Test Criteria
### Chapter 4: Genre Analyses of Referal Letters and Discharge Summaries

<table>
<thead>
<tr>
<th>medical background</th>
<th>Some variation in sequencing of steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Describing the history of the presenting complaint</td>
<td>Obligatory 97%</td>
</tr>
<tr>
<td>2. Providing results of examinations and investigations</td>
<td>Obligatory 87%</td>
</tr>
<tr>
<td>3. Describing treatment to date</td>
<td>Obligatory 71%</td>
</tr>
<tr>
<td>4. Listing past medical conditions</td>
<td>Obligatory 58%</td>
</tr>
<tr>
<td>5. Describing family, social and lifestyle history</td>
<td>Optional 24%</td>
</tr>
<tr>
<td>6. Listing allergies</td>
<td>Optional 41%</td>
</tr>
<tr>
<td>7. Listing current medications</td>
<td>Obligatory 75%</td>
</tr>
<tr>
<td>8. Mentioning attachments (e.g. pathology)</td>
<td>Optional 12%</td>
</tr>
</tbody>
</table>

#### 4. Handing over care

<table>
<thead>
<tr>
<th>Some variation in sequencing of steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Making recommendations</td>
</tr>
<tr>
<td>2. Establishing willingness to continue being involved in the patient's care and/or willingness to clarify treatment to date</td>
</tr>
<tr>
<td>3. Thanking the letter recipient in advance for their care of the patient</td>
</tr>
</tbody>
</table>

#### 5. Signing off

<table>
<thead>
<tr>
<th>No variation in sequencing of steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Using a closing phrase</td>
</tr>
<tr>
<td>2. Signing the referral letter with name and designation</td>
</tr>
</tbody>
</table>
4.5 Analysis of Lexico-grammatical Features of Referral Letters

This section provides analyses of the lexico-grammatical features prevalent in the individual moves and steps of the sample of referral letters. The aim of this section is to establish what authentic referral letters are comprised of, to inform the OET test task, and assist OET developers in gaining an understanding of the lexico-grammatical features of authentic referral letters. In this section, the lexico-grammatical features of each move and step are analysed individually.

4.5.1 Move 1: Establishing person, place and time. Move 1 consisted of four steps: 1) identifying the writer, department and institution, 2) indicating the date on which the letter was written, 3) identifying the letter recipient, including their department and institution, and 4) identifying the patient, including their name, date of birth, contact details and UR number. Due to the redaction of the letters, and the simplistic language involved in listing the date, names, departments and institutions, it was not useful to examine the lexico-grammatical features of Move 1.

4.5.2 Move 2: Establishing the situation. There were four steps associated with the writer establishing the situation: addressing or acknowledging the recipient of the letter, expressing gratitude and/or providing further identification of the patient, identifying the reason for the referral and/or the presenting complaint and describing the patient’s presentation.

4.5.2.1 Step 1: Addressing/acknowledging the letter recipient. The first step in Move 1 was to address or acknowledge the recipient of the letter through a greeting. Of the sample of 100 referral letters, 84 letters contained an explicit acknowledgement of the recipient. The most common form of address to appear in the letters was: ‘dear doctor (name)’, for example, ‘Dear Doctor Smith’. This was the case for 24 letters, almost a quarter
of the sample. The two other most common ways to address the recipient were ‘dear doctor’, and ‘dear (name)’; for example, ‘Dear Bob’. These two address forms appeared in a further 36 referral letters. Due to the redacting process, it was not possible to establish whether given names or family names were used by the writers.

Other ways of addressing the recipient included: ‘Dear Sir/Madam’, ‘Dear colleague’ and ‘Dear (name of hospital)’. Table 12 lists the preferred expressions for addressing and acknowledging letter recipients, and the frequency at which they appeared in the referral letters. Sixteen of the writers did not include an expression for addressing or acknowledging the recipient of the letter, but simply launched into the content of the referral letter without providing a greeting.
Table 12:

**Addressing or Acknowledging Recipient of Referral Letter**

<table>
<thead>
<tr>
<th>Expression for addressing/acknowledging recipient of letter</th>
<th>Number of letters which included the expression (84 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dear Doctor (name)</td>
<td>24</td>
</tr>
<tr>
<td>Dear Doctor</td>
<td>18</td>
</tr>
<tr>
<td>Dear (name)</td>
<td>18</td>
</tr>
<tr>
<td>No address form included</td>
<td>16</td>
</tr>
<tr>
<td>Dear Sir/Madam</td>
<td>8</td>
</tr>
<tr>
<td>Dear Colleague</td>
<td>3</td>
</tr>
<tr>
<td>Dear (name of hospital)</td>
<td>2</td>
</tr>
<tr>
<td>Attention: (name of doctor)</td>
<td>1</td>
</tr>
<tr>
<td>Dear Doctors</td>
<td>1</td>
</tr>
<tr>
<td>Dear (blank space, not filled in)</td>
<td>1</td>
</tr>
<tr>
<td>Dear Emergency Department</td>
<td>1</td>
</tr>
<tr>
<td>Dear Admitting Team</td>
<td>1</td>
</tr>
<tr>
<td>Dear Admitting Officer</td>
<td>1</td>
</tr>
<tr>
<td>To Whom It May Concern</td>
<td>1</td>
</tr>
<tr>
<td>Dear Cardiology Team</td>
<td>1</td>
</tr>
<tr>
<td>To (name of hospital) Emergency</td>
<td>1</td>
</tr>
<tr>
<td>Dear ED Doctor</td>
<td>1</td>
</tr>
<tr>
<td>Dear Orthopaedic Liaison Nurse</td>
<td>1</td>
</tr>
</tbody>
</table>

**4.5.2.2 Step 2: Expressing gratitude and/or providing further identification of the patient.** The second step involved expressing gratitude and/or providing further identification of the patient. Although the two different functions of the step, 1) expressing gratitude and 2) providing further identification of the patient, do not seem to be conceptually connected, many of the writers elected to combine both elements in a single sentence (e.g. ‘thank you for seeing this 43-year-old woman’). In fact, all of the referral letters which included an expression of gratitude, also provided further identification of the patient in the
same sentence. Consequently, the two different functions are combined as one step for the purpose of the analysis.

Forty-eight letters, almost half the sample, included an expression of gratitude. Writers used thank you for + gerund, e.g. ‘thank you for reviewing this patient’. A further three writers used the same grammatical structure but employed the less formal expression of thanks for + gerund. The final letter contained a slight variation: ‘many thanks for’. The most common gerund to follow ‘thank you/thanks for/many thanks for’ was ‘seeing’, e.g. ‘thank you for seeing this man’. In total, 35 of the referral letters contained the phrase ‘thank you/thanks for seeing’. Other gerunds that commonly followed the phrase ‘thank you for’ were: ‘accepting’ (5 letters) and ‘referring’ (4 letters). See Table 13 for a list of verbs used by referral-letter writers.

Table 13

<table>
<thead>
<tr>
<th>Gerund following expression of gratitude (thank you for/thanks for/many thanks for...)</th>
<th>Number of letters which included the gerund (48 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seeing</td>
<td>35</td>
</tr>
<tr>
<td>Accepting</td>
<td>5</td>
</tr>
<tr>
<td>Referring</td>
<td>4</td>
</tr>
<tr>
<td>Attending to</td>
<td>1</td>
</tr>
<tr>
<td>Reviewing</td>
<td>1</td>
</tr>
<tr>
<td>Allowing</td>
<td>1</td>
</tr>
<tr>
<td>Sending</td>
<td>1</td>
</tr>
</tbody>
</table>

The 52 referral letters which did not contain an expression of gratitude were either (1) referral forms in which the writers filled out sections with sub headings and did not generally include prose, (2) referral letters that focused on the review that the writer had done (for example, when the patient was being handed back to the recipient and it was the writer who
had done the ‘favour’), or (3) referral letters in which Step 1 was either omitted completely or the writer had chosen to simply provide further identification of the patient.

For the 48 letters which included an expression of gratitude, further identification of the patient directly followed; for example, ‘thank you for seeing (name of patient) age 66 years’. Of the 52 referral letters not containing an expression of gratitude + verb, 31 referral letters still included markers of identification in the body of the letter. In all, 79 referral letters of the total sample size contained further references to patient identification in the body of the letter.

Identification techniques consisted of either the patient’s name or their gender or both. Due to the redacting process, it was not possible to detect how often given names were used in comparison to surnames. The patient’s age also tended to be included but only along with references to the patient’s name or gender. In the majority of cases, writers included all three markers of identification: name, age and gender. Table 14 shows a breakdown of how patients were further identified.

Table 14

Identification of Patients

<table>
<thead>
<tr>
<th>Marker of identification</th>
<th>Example</th>
<th>Number of letters with marker(s) (79 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name, gender and age</td>
<td>Thank you for seeing Mrs (name), an 84 year old lady.</td>
<td>25</td>
</tr>
<tr>
<td>Name only</td>
<td>Thank you for seeing (name).</td>
<td>21</td>
</tr>
<tr>
<td>Name and age</td>
<td>Thank you for reviewing (name), 63 years old.</td>
<td>12</td>
</tr>
<tr>
<td>Name and gender</td>
<td>Thank you for seeing Mrs (name).</td>
<td>11</td>
</tr>
<tr>
<td>Age and gender</td>
<td>Thank you for referring this 50 year old gentleman.</td>
<td>7</td>
</tr>
<tr>
<td>Gender only</td>
<td>Thanks for seeing this man with jaundice.</td>
<td>3</td>
</tr>
</tbody>
</table>


**4.5.2.3 Step 3: Identifying reason for referral and/or presenting complaint.**

Although the expression of gratitude touched on the general reason for the referral (i.e. to see or review the patient), more details were provided in subsequent phrases. The reason for the referral was explicitly stated in 56 referral letters. The most common phrase was ‘for opinion and management’ or slight variations on this expression. Table 15 provides a list of phrases addressing the reason for the referral letter.

Table 15

*Reasons for Referral Letters According to Writers*

<table>
<thead>
<tr>
<th>Reason for referral phrase</th>
<th>Number of letters which included the phrase (56 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For (an) opinion and management</td>
<td>16</td>
</tr>
<tr>
<td>For assessment and management</td>
<td>3</td>
</tr>
<tr>
<td>For an opinion</td>
<td>3</td>
</tr>
<tr>
<td>Other (specific reasons)</td>
<td>34</td>
</tr>
</tbody>
</table>

Whilst the phrase ‘for opinion and management’ was used in a general sense, other phrases tended to more directly address why the patient was being referred. The category ‘other’ in Table 15 refers to the inclusion of specific conditions. There was no particular pattern identified, writers simply noted the patient’s presenting complaint through phrases such as ‘for a tilt table test’, ‘for an ERCP (Endoscopic Retrograde Cholangio-Pancreatography – a diagnostic test)’ and ‘for investigation and surveillance of gastritis’, providing specific information about the required treatment or condition.

Referral forms included sections for diagnoses and current medical issues which addressed the reason for the referral. Referral letters which were written in response to requested patient reviews also included the reason for the letter, e.g. ‘I reviewed (name) today in surgical clinic following his recent endoscopy’.

Of the 100 referral letters in the sample, 90 mentioned a presenting complaint. The relative pronoun *who* was used in 16 of the letters (e.g. ‘Thank you for seeing Mrs (name),...
age 55 years, who has chest pain radiated to left arm associated with tightness in chest’. Phrases such as ‘presents with’ and ‘suffers from’ tended to follow who. For example, ‘thank you for seeing (name), age 42 years, who presents with sudden onset of severe headache’. The word has either directly followed who, as in ‘this patient who has (presenting complaint)’ or was used without who (e.g. ‘I believe she has (presenting complaint)’, which was syntactically different from the phrases including a relative clause.

Writers also had a preference for using conjunctions such as ‘for’ and ‘with’ to identify the presenting complaint. For instance, ‘Mr (name) has been recently under our care at (name of institution) for bilateral DVTs and a mobile thrombus of his proximal ascending aorta’. Table 16 shows a list of words used by referral-letter writers to introduce the presenting complaint. Examples of more varied phrases describing the presenting complaint were: ‘her issues are’ and ‘she suffered’. The referrals structured as forms contained a specific section for the writer to list the presenting complaint.

Table 16

<table>
<thead>
<tr>
<th>Word used to introduce presenting complaint</th>
<th>Number of letters which included the word (90 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No specific word</td>
<td>31</td>
</tr>
<tr>
<td>With</td>
<td>25</td>
</tr>
<tr>
<td>Who</td>
<td>16</td>
</tr>
<tr>
<td>Has</td>
<td>12</td>
</tr>
<tr>
<td>For</td>
<td>6</td>
</tr>
</tbody>
</table>

4.5.2.4 Step 4: Describing patient’s presentation. In all, 33 of the 100 referral letters contained a general statement describing the patient’s presentation. Statements tended to be made in relation to the patient’s overall wellness level, such as ‘she looked very pale and unwell’, ‘Mr (name) was very well at the time of this visit’ and ‘she remains stable at this
time’. Other statements addressed the patient’s pain level, for instance: ‘she is in severe pain’ and ‘the patient feels 10/10 pain’. Vital signs such as heart rate and blood pressure were also mentioned, as were physical features such as ‘he is a very frail, elderly gentleman’ and ‘unexplainable physical bruises on his back’.

4.5.3 Move 3: Establishing the patient’s medical background. Move 3 comprised the largest number of steps, with writers usually moving through eight steps to establish the patient’s medical background: 1) describing the history of the presenting complaint, 2) providing results of examinations and investigations, 3) describing the patient’s treatment to date, 4) listing the patient’s past medical conditions, 5) describing their family, social and lifestyle history, 6) listing the patient’s allergies, 7) listing their current medications, and 8) mentioning attachments to the referral letter.

4.5.3.1 Step 1: Describing the history of the presenting complaint. The history of the presenting complaint (HOPC, which is an abbreviation commonly used by health professionals) describes the reason the patient sought help (i.e. the presenting complaint) and what occurred in the lead up to patient admission. It may also include how the presenting complaint was treated previously if it was a recurring condition and the information was available to the writer.

Three of the 100 referral letters did not mention the HOPC, although in those cases, the reason for the referral was explicitly stated. Of the 97 letters which contained a HOPC, the language varied considerably, and no specific lexical patterns or collocations were evident. When writing in prose, as was predominantly the case, referral-letter writers tended to use either the simple past tense (e.g. ‘she fell back’) or present perfect tense (e.g. ‘he has been feeding very poorly in the past 2 days’).
A noticeable feature of the HOPCs was their comprehensiveness – or lack thereof. Some referral-letter writers wrote three or four paragraphs in order to describe the HOPC in great detail, others wrote a sentence or two. There were many factors that may have potentially affected the comprehensiveness of the HOPCs including: 1) the writer’s understanding of the HOPC at the time of writing the letter; 2) their perception of what information was relevant, and 3) their assumption of whether or not the recipient had access to documentation regarding the HOPC. It was not possible to differentiate which of these factors came into play in the case of each of the referral letters in the sample, partly because it would require health professional expertise to make accurate judgements and also because the writers’ perspectives could not be investigated.

4.5.3.2 Step 2: Providing results of examinations and investigations. Results of examinations and investigations included a general physical examination, Computerised Axial Tomography (CAT) scans, Magnetic Resonance Imaging (MRIs), Electrocardiograms (ECGs), ultrasounds, neurological assessments, vital signs (e.g. temperature, blood pressure and heart rate), blood glucose levels, and chest examinations, to name a few. Eighty-seven referral letters in the sample contained results of examinations and investigations. There were four main ways that the results were presented. Firstly, writers provided a heading and then listed the results. This format was presented in 24 of the referral letters. The most common headings were ‘investigations’, ‘examination’ and ‘examinations’.

Secondly, 14 writers prefaced the results with the phrase, ‘on examination’ followed by a comma. Writers tended to use the present tense (e.g. ‘on examination, her abdomen is nice and soft’) or the simple past (e.g. ‘on examination, she was nauseated with nil findings systematically’) to describe the results. A further five writers used similar phrases such as ‘examinations show’ and ‘examinations revealed’.
Hedging techniques (i.e. use of phrases to express uncertainty through hesitant or vague language) were also evident in the descriptions of the results. Seven of the 14 writers who commenced a description of the results with ‘on examination’ opted to use hedging phrases, with the most common being ‘appear’. For example: ‘on examination, the incision sites appear to be healing well’ and ‘on examination, he appears to have bilateral ischiorectal abscesses’. Use of phrases such as ‘he looks in pain’ and ‘the respiratory examination was essentially normal’ also make use of hedging devices. In the 24 letters in which the results were listed, hedging devices also appeared in the form of punctuation in which a question mark was included next to the result, condition or specified treatment (e.g.: ‘could you please also arrange a CT chest angiogram approx. 2 weeks prior to this appointment for resolution of ascending aortic thrombus’).

A third way of presenting the results was to begin the results section with the name of a specific type of investigative or diagnostic tool or technique such as ‘an ECG (electrocardiogram) showed’, ‘an MRCP (Magnetic Resonance Cholangiopancreatography) was conducted which confirmed’ and ‘her neurological examination reveals’. The verbs ‘show’ and ‘reveal’ most commonly followed the name of the diagnostic tool. Ten of the 100 referral-letter writers utilised this method of describing the results of examinations and investigations.

The fourth method involved simply writing the results in the body of the letter without a heading, e.g. ‘blood pressure was 158/83, temp (temperature) 39.2 degrees C’ and ‘chest was clear, no ankle oedema’. See Table 17 for more information about how the results were reported in the referral letters.
Table 17: Reporting Results in Referral Letters

<table>
<thead>
<tr>
<th>Method for reporting results</th>
<th>Number of letters which included the method (87 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results in body of letter (no heading)</td>
<td>39</td>
</tr>
<tr>
<td>Heading with list of results</td>
<td>24</td>
</tr>
<tr>
<td>Use of phrase ‘on examination’</td>
<td>14</td>
</tr>
<tr>
<td>Slight variation of phrase above (e.g. ‘examinations reveal’)</td>
<td>10</td>
</tr>
</tbody>
</table>

**4.5.3.3 Step 3: Describing treatment to date.** Seventy-one referral-letter writers described the treatment the patient had so far received. The main method of treating patients, as identified by the writers, was the administration of medication. Other types of treatments included operations, draining or dressing wounds and counselling on certain matters (e.g. alcohol consumption).

Although grammatical structures and lexicon varied in relation to describing treatment to date, there were two common phrases used by the writers to refer to the administration of medication. The first phrase was ‘was started on’, for example: ‘she was started on IV tazocin’. The other common phrase was ‘was commenced on’. Examples of usage include: ‘he was commenced on abiraterone’ and ‘she was commenced on a NAC infusion’.

The referral letters which did not discuss forms of treatment were either short, with little information included, or no treatment had taken place at the point at which the letter was written. Writers did not explicitly state the reason for excluding references to prior treatment in the referral letters.

**4.5.3.4 Step 4: Listing past medical conditions.** More than half of the referral letters, 58 in total, had past medical conditions listed. In all 13 referral-letter writers described patients’ past medical conditions using prose. The majority of writers had opted to use a
heading, with the name of the conditions and the year of diagnosis listed below. Table 18 contains headings selected by the referral-letter writers.

Table 18

*Headings for Past Medical Conditions*

<table>
<thead>
<tr>
<th>Heading for listing past medical conditions</th>
<th>Number of letters which included the heading (58 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past history</td>
<td>23</td>
</tr>
<tr>
<td>Past medical history</td>
<td>15</td>
</tr>
<tr>
<td>Relevant history</td>
<td>1</td>
</tr>
<tr>
<td>Patient history</td>
<td>1</td>
</tr>
<tr>
<td>Clinical summary</td>
<td>1</td>
</tr>
<tr>
<td>Past medical problems</td>
<td>1</td>
</tr>
<tr>
<td>Medical history</td>
<td>1</td>
</tr>
</tbody>
</table>

Underneath some of the headings was written ‘nil significant’ or ‘none recorded’, signifying that the writer either believed the conditions to be superfluous to the reader’s needs or they did not have access to information about the patient’s past conditions. In three referral letters, the headings appeared; yet, there was no list beneath.

Although many sections of the referral letters were written in prose, past medical conditions generally were not. Lists may have been utilised for a number of reasons. Firstly, when skimming a letter, the reader’s eye would automatically be drawn to the list; thereby, the reader would not need to trawl through the entire letter to find the past medical conditions. Secondly, writers may have cut and paste the list from the electronic medical records and decided to include the heading for clarity’s sake. Thirdly, the 13 letters in which the conditions were written in prose did not include the year of diagnosis. Writing a list enabled the referral-letter writers to record the year the condition was diagnosed which provided the reader with a more comprehensive picture of the patient’s health.

Past medical conditions were not listed in 42 of the referral letters. This may have been either because the conditions were unknown to the writer or they did not think to
include them possibly due to time constraints during the letter-writing process or because they considered the past medical conditions to be irrelevant.

4.5.3.5 Step 5: Describing family, social and lifestyle history. In all 24 of the referral letters contained references to the patient’s family, social or lifestyle history. Eleven of the letters included a heading with the histories listed below. Table 19 shows an itemisation of the headings. The lists were written in note form and included succinct phrases such as ‘non-smoker’, ‘married, lives with husband’ and ‘very limited English’. Most articles and conjunctions were omitted. Descriptions of the patient’s family, social and lifestyle history were written in prose in the remaining 13 referral letters. The writers wrote in full sentences and tended to use adjectives, for example: ‘she has got a strong family history of asthma’ and ‘this gentleman is a chronic alcohol abuser and smoker’.

Table 19

<table>
<thead>
<tr>
<th>Heading for listing family, social or lifestyle history</th>
<th>Number of letters which included the heading (11 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social history</td>
<td>4</td>
</tr>
<tr>
<td>Lifestyle/family history</td>
<td>2</td>
</tr>
<tr>
<td>Family and social history</td>
<td>2</td>
</tr>
<tr>
<td>Family history</td>
<td>1</td>
</tr>
<tr>
<td>Social situation</td>
<td>1</td>
</tr>
<tr>
<td>Social</td>
<td>1</td>
</tr>
</tbody>
</table>

Seventy-six of the letters did not contain any references to family, social and lifestyle history. As with the letters in which patient’s past medical conditions were not described, it can be hypothesised that perhaps the writers did not have access to relevant records or made the decision to omit what they considered to be unessential information. Alternatively, the writers may have experienced time constraints whilst writing the letter or during the
consultation with the patient, and consequently felt it was easier to exclude information about family, social and lifestyle history. Finally, the writer may also have believed that the recipient of the letter was privy to medical records which outlined the patient’s history.

4.5.3.6 Step 6: Listing allergies. Within the referral letter context, the allergens discussed were most commonly medications. Food and animals were also mentioned. Forty-one referral letters contained references to the patient’s allergies. Two writers chose to describe the patient’s allergies within the text. One referred to a potential allergy to cows’ milk protein whilst the other wrote that the patient ‘was not allergic to any medications’.

Thirty-nine of the referral-letter writers included a heading with the allergens written either beside or underneath the heading. Most commonly, writers used ‘allergies’ as the heading, although there were some variations (see Table 20 for a list of headings). Most writers listed only the names of the allergens (e.g. ‘penicillin’, ‘nuts’ or ‘horses’); however, in some cases, the date on which the allergy was discovered was also noted, as was the patient’s reaction (e.g. a rash or anaphylactic shock).

Table 20

<table>
<thead>
<tr>
<th>Heading for listing allergies</th>
<th>Number of letters which included the heading (39 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>27</td>
</tr>
<tr>
<td>Alerts</td>
<td>4</td>
</tr>
<tr>
<td>Allergies/drug sensitivities</td>
<td>3</td>
</tr>
<tr>
<td>Allergies and medical warnings</td>
<td>2</td>
</tr>
<tr>
<td>Adverse reactions</td>
<td>2</td>
</tr>
<tr>
<td>Allergies/warnings</td>
<td>1</td>
</tr>
</tbody>
</table>

Although 39 of the referral letters made reference to allergies through use of a heading, 20 of the letters did not actually have any allergies listed. The different phrases used
by referral-letter writers to express the absence of allergies can be found in Table 21. ‘No known allergies’ was the most commonly-utilised phrase. In two cases, a heading appeared but nothing was written underneath (referred to as ‘left blank’ in Table 21). A further two writers used abbreviations to describe the patient’s lack of allergies: NKDA (No Known Drug Allergies) and NKA (No Known Allergies).

Table 21

*Phrases for Indicating Lack of Allergies*

<table>
<thead>
<tr>
<th>Phrases used to indicate that the patient did not have allergies</th>
<th>Number of letters which included the phrase (20 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No known allergies</td>
<td>10</td>
</tr>
<tr>
<td>Nil known</td>
<td>5</td>
</tr>
<tr>
<td>Left blank (no phrase)</td>
<td>2</td>
</tr>
<tr>
<td>Nil recorded</td>
<td>1</td>
</tr>
<tr>
<td>NKDA</td>
<td>1</td>
</tr>
<tr>
<td>NKA</td>
<td>1</td>
</tr>
</tbody>
</table>

**4.5.3.7 Step 7: Listing current medications.** Seventy-five letters contained information about current medications. The majority of writers – 41 in total - chose to list medications underneath a relevant heading. Table 22 provides a breakdown of headings selected by the referral-letter writers. Seven letters contained a heading but no information about current medications was listed below this heading. The other 35 referral-letter writers listed current medications within the main body of the letter, using phrases such as ‘her current medications are…’ and ‘currently her medications comprise…’ The full names of medications were noted. A few referral letters included the strength of the medication, the dosage and the frequency of use.

Conversely, when medications were listed under a heading, much more information was provided. This was due to use of sub-headings in some of the letters (which had perhaps
been copied over from a set of progress notes or another document in the medical record, which required writers to include the name of the medication, the strength of the drug (e.g. 100 milligrams), the dosage (e.g. three times a day), the reason for the medication being prescribed and the date when the script was last filled.

Although the medication names were generally written out in full, abbreviations were predominantly used to describe the strength of the medication and the dosage. ‘Mgs’ rather than ‘milligrams’ was common, as was ‘mls’ for ‘millilitres’. Additionally, abbreviations such as ‘bds’ (two times a day) and ‘qid’ (four times a day) were used to express frequency of use.

Table 22

*Headings for Current Medications*

<table>
<thead>
<tr>
<th>Heading for listing current medications</th>
<th>Number of letters which included the heading (41 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current medications</td>
<td>23</td>
</tr>
<tr>
<td>Medications</td>
<td>9</td>
</tr>
<tr>
<td>Current/regular medication</td>
<td>2</td>
</tr>
<tr>
<td>Current medication</td>
<td>2</td>
</tr>
<tr>
<td>Medication</td>
<td>2</td>
</tr>
<tr>
<td>Medications at this visit</td>
<td>2</td>
</tr>
<tr>
<td>Meds</td>
<td>1</td>
</tr>
</tbody>
</table>

**4.5.3.8 Step 8: Mentioning attachments (e.g. pathology).** In all 12 referral-letter writers made mention of attachments. The most common phrases were ‘please find attached’ (e.g. ‘please find attached relevant investigations’) and ‘I have attached’ (e.g. ‘I have attached all investigations and ECGs’). A further eight letters had pathology and test results in the body of the letter, typically towards the end. It is possible that other referral letters in the sample also included attachments which were not sourced during the data extraction process;
therefore, it was unclear how many letters actually had pathology results available to the reader. It was also not possible to determine whether or not writers always made explicit reference to the attachments within the body of the referral letter.

4.5.4 Move 4: Handing over care. Writers followed three steps while handing over care. Firstly, they made recommendations, then they established their willingness to continue being involved in the patient’s care and/or their willingness to clarify treatment to date. Finally, the writers thanked the letter recipient in advance for their care of the patient.

4.5.4.1 Step 1: Making recommendations. In the medical context, making recommendations means providing suggestions for treatment and care once the handover has occurred. Approximately half of the letters, 49 in total, included recommendations. Four writers provided a discharge plan, which was an explicit list of suggestions for how to proceed after the patient had been discharged into the recipient’s care. The writers used either dot points or numbered their suggestions.

The majority of writers, rather than having a specific paragraph for recommendations, made suggestions as the need arose. For example, while writing about the patient’s current medications, recommendations were made about changing strengths and dosages. Formal language was often used to make recommendations. Phrases such as ‘I would thus recommend the following’, ‘while these conditions prevail’ and ‘kindly discuss this result with him’ demonstrate the formality of the prose.

4.5.4.2 Step 2: Establishing willingness to continue being involved in the patient’s care and/or willingness to clarify treatment to date. Fourteen referral letters contained phrases pertaining to willingness to continue involvement in the patient’s care and/or to clarify treatment. The phrases were similar to each other in that they were grammatically complex with use of modals and a combination of independent (stand-alone) clauses and
dependent clauses (e.g. ‘should you require any further information, please do not hesitate to contact us’).

All 14 phrases include the word ‘please’ which indicated politeness and a willingness to be contacted if the need arose. Table 23 contains a list of phrases used by the writers. Formulaic phrases expressing willingness were structured as conditional sentences with inversion, signifying formality. It is not known why other writers chose not to make reference to continued involvement in the patient’s care or their willingness to clarify treatment to date. They may have assumed that the recipient would contact them if necessary and thus an explicit statement was unnecessary.

Table 23

*Phrases to Establish Willingness*

<table>
<thead>
<tr>
<th>Phrases for establishing willingness to continue being involved in the patient’s care and/or willingness to clarify treatment to date</th>
<th>Number of letters which included the heading (14 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should any of the above need clarification, please feel free to contact me</td>
<td>2</td>
</tr>
<tr>
<td>Please feel free to contact me for clarification</td>
<td>2</td>
</tr>
<tr>
<td>If you have any further queries, please do not hesitate to contact us</td>
<td>1</td>
</tr>
<tr>
<td>Please do not hesitate to contact us should you require further information</td>
<td>1</td>
</tr>
<tr>
<td>Should any of the above require clarification, please do not hesitate to contact me</td>
<td>1</td>
</tr>
<tr>
<td>Please contact the medical registrar under Dr (name) should you have any further queries</td>
<td>1</td>
</tr>
<tr>
<td>If you have any further questions, please contact the intensive care unit</td>
<td>1</td>
</tr>
<tr>
<td>Should you require any further information, please do not hesitate to contact us</td>
<td>1</td>
</tr>
<tr>
<td>Should you have any queries regarding this matter, please feel free to contact me</td>
<td>1</td>
</tr>
<tr>
<td>Please do not hesitate to contact me if I can be of any further assistance in the future</td>
<td>1</td>
</tr>
<tr>
<td>Please feel free to refer (name) back to our clinic if there are any further concerns</td>
<td>1</td>
</tr>
</tbody>
</table>
4.5.4.3 Step 3: Thanking the letter recipient in advance for their care of patient.

Twenty-six writers thanked the recipient in advance for their care of the patient. The other writers refrained from doing so, perhaps because they had already thanked the recipient by including an expression of gratitude in Move 2, Step 2 (see Section 4.5.2.2), or they decided not to for other reasons.

The most common phrase employed by the writers was ‘thank you for your ongoing care’, a formulaic expression which was used eight times. ‘Thank you for your care and assistance’ appeared in five of the letters. Other variations included ‘many thanks for your assistance’, ‘thank you for your expert care’ and ‘thank you for your ongoing management’.

Table 24 contains a list of phrases used to thank the recipient for their care.

Table 24

<table>
<thead>
<tr>
<th>Phrases for thanking the letter recipient in advance for their care of the patient</th>
<th>Number of letters which included the heading (26 letters in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank you for your ongoing care</td>
<td>8</td>
</tr>
<tr>
<td>Thank you for your care and assistance</td>
<td>5</td>
</tr>
<tr>
<td>Thank you again</td>
<td>2</td>
</tr>
<tr>
<td>Thanking you</td>
<td>2</td>
</tr>
<tr>
<td>Thank you for your care of this patient.</td>
<td>1</td>
</tr>
<tr>
<td>Thanking you for your time and cooperation</td>
<td>1</td>
</tr>
<tr>
<td>Many thanks for your assistance</td>
<td>1</td>
</tr>
<tr>
<td>Thank you for your expert care</td>
<td>1</td>
</tr>
<tr>
<td>Many thanks for accepting her</td>
<td>1</td>
</tr>
<tr>
<td>Thank you</td>
<td>1</td>
</tr>
<tr>
<td>Thank you for accepting care of this patient</td>
<td>1</td>
</tr>
<tr>
<td>Thank you very much for your prompt attention</td>
<td>1</td>
</tr>
<tr>
<td>Thank you for your ongoing management</td>
<td>1</td>
</tr>
</tbody>
</table>
4.5.5 **Move 5: Signing off.** The final move consisted of writers using a closing phrase and then signing the referral letter with their name and designation.

4.5.5.1 **Step 1: Using a closing phrase.** Eighty referral letters contained a closing phrase. ‘Yours sincerely’ was the most common phrase, appearing in 59 of the referral letters. ‘Kind regards’ and ‘Yours faithfully’ were also utilised by the writers.

4.5.5.2 **Step 2: Signing the referral letter with name and designation.** Due to the hospital staff’s redaction techniques prior to gaining access to the referral letters, it was not possible to determine which writers had included their name, signature, designation or all three elements. However, the information that was still available showed that the majority of writers included their name, often with a signature which was sometimes electronic, and most frequently with reference to their designation. The main designations were interns, registrars, general practitioners and consultants. None of the writers of the sample of the referral letters were nurses.

4.5.6 **Other linguistic features** There were a number of linguistic features commonly employed by referral letter writers including use of abbreviations and acronyms, use of symbols and punctuation, register, and mode of writing.

4.5.6.1 **Use of abbreviations and acronyms.** Medical abbreviations and acronyms were found throughout the letters. Investigative techniques or tools such as ECGs (electrocardiograms), CAT (Computerised Axial Tomography) scans and MRIs (Magnetic Resonance Imaging), tended to be written as abbreviations or acronyms. Similarly, medical conditions, especially those with long or complex names, were often abbreviated. For example, type 2 diabetes mellitus was written as T2DM and gastro-oesophageal reflux disease as GORD. ‘L’ was used to signify the left side of the body and ‘R’ or ‘rt’ referred to
the right. Moreover, names of hospital departments were abbreviated (e.g. rehabilitation units were referred to as ‘rehab’, Emergency Departments were written as ‘ED’ and Intensive Care Units were shortened to ‘ICU’).

In addition, references to other health professionals’ designations were often abbreviated. Paediatricians were referred to as ‘paeds’, orthopaedic registrars as ‘ortho regs’, general practitioners as ‘GPs’ and physiotherapists as ‘physios’. Timeframes also tended to be shortened with four days being recorded as 4/7 with the ‘7’ symbolising a week. ‘2/52’ referred to two weeks (i.e. 2 weeks out of 52 weeks) and 14/24 represented 14 hours out of a 24-hour period. Other time-related abbreviations included ‘qid’ (four times a day) and ‘bd’ (twice a day). Finally, most references to observations (a record of the patient’s vital signs) were abbreviated. The word ‘observations’ itself was written as ‘obs’, heart rate was usually listed as ‘HR’, temperature as ‘temp’ and so on.

4.5.6.2 Use of symbols and punctuation. Not all letters contained symbols, although they were interspersed throughout some of the letters. The question mark was commonly used to signify doubt, uncertainty or lack of knowledge. For instance, one writer was unaware of why a patient was awaiting hip replacement surgery and wrote: ‘I’m not sure of the reason (? loose prosthesis) but (the patient) is in severe pain’. Use of the question mark demonstrated to the reader that the writer was simply hazarding a guess as to the reason the surgery was due to take place. Although question marks traditionally appear at the end of phrases, the referral-letter writers used question marks haphazardly, placing them at the beginning or end of words and in the middle of phrases. Double question marks were also utilised at times, arguably when the writer was extremely uncertain.

Another widely-used symbol was ‘x’, which was used to signify quantities. For example, while describing the patient’s medical history, one writer reported that the patient ‘is diabetic and had x2 stents in 2008’, meaning that the procedure to insert stents was
performed twice on the same patient in 2008. The hash or pound symbol (#) denoted a number, an upward-pointing arrow indicated an increase whilst an arrow pointing downwards represented a decrease such as a decrease in mobility.

**4.5.6.3 Register.** The letters were predominantly written in formal register with a professional, formal tone used by the writers. Words and phrases such as ‘prior to’ (rather than ‘before’), ‘whom’, ‘regarding’ and ‘whereby’ which appeared in the referral letters provide evidence of formal language. The greetings and closing phrases (e.g. ‘yours sincerely’) also demonstrated formality.

Use of the passive voice was a technique used by writers to maintain formality and a professional demeanour. For example, one writer, described how he/she had participated in performing an appendectomy ‘for which no complications were reported’ and stated that ‘the appendix was found to be mildly infected’. Even though the writer was present during the operation, he/she had still used the passive voice.

**4.5.6.4 Mode of writing.** Although the mode of writing did not form part of the analysis, it is worth noting that 85 of the 100 referral letters were typed, whilst only eight letters were handwritten. Another seven letters were partially handwritten but included some typed elements. See below for two excerpts of handwritten referral letters.

![Figure 21: Excerpt 1 of a handwritten referral letter.](image)
The first excerpt reads:

Dear Dr
Thank you for seeing Mr (name redacted)
D.O.B  19/5/1945
With history of feeling unwell, pain, smoking, aching between shoulders, tightness in upper abdomen since Monday.

The second excerpt is as follows:

Dear Dr,
Thanks for seeing (name redacted), he had recent malfunction of his ventriculo-peritoneal shunt. R (right) revision.

4.6 Discussion of Lexico-grammatical Features in Referral Letters

This section provides a discussion of the salient lexico-grammatical features of referral letters.

4.6.1 Identifying person, place and time. All the referral letters contained information which ensured that person, place and time were established. Failure to properly identify the patient may lead to adverse medical events such as operating on the wrong
patient or administering the incorrect medication (Seiden & Barach, 2006); thus, ensuring adequate identification of patients in the referral letters was important from a safety perspective. Consequently, it was essential that the information provided was accurate and complete and that spelling was correct.

The inclusion of additional patient identification in the body of the referral letter highlighted how important it was for health professionals to adequately and correctly identify the patient. Naming the patient was the most common way of providing further identification. Using the patient’s name was also evidence of patient-centred care. The patient was not merely ‘the patient’, but rather a person in their own right with their own identity.

Identification markers such as age and gender provided the referral-letter recipient with potentially valuable health information. Conditions specific to a particular gender (e.g. cervical cancer in women) or age (e.g. onset of Alzheimer’s disease) could be taken into account by the health professional reading the letter.

4.6.2 Addressing/acknowledging the recipient. The majority of referral letters contained a salutation at the beginning of the letter. Making the effort to address or acknowledge the recipient of the referral letter was a common occurrence. Addressing the letter to a particular person (e.g. ‘Dear Doctor (name)’) shows that an effort was made for the letter to reach the correct recipient.

In addition, directly addressing the recipient – or at least acknowledging them if their name is unknown to the writer – is a sign of respect. It demonstrates that the writer considered the recipient capable of meeting the patient’s needs; they have been selected due to their expertise.

4.6.3 Expressing gratitude and identifying the reason for the referral letter

Thanking the letter recipient for taking over care of the patient at the beginning of the letter
was a sign of courtesy and respect. It also showed a sense of formality, evident in the writers’ preferred use of ‘thank you’ rather than ‘thanks’. However, the formulaic expression ‘thank you for + gerund’ not only acted as a marker of politeness and formality, it was also an important segue in highlighting to the reader the main reason for the letter (e.g. *seeing* or *reviewing* the patient).

4.6.4 Expressing doubt and uncertainty. Writers expressed doubt or uncertainty through their use of punctuation and word choice. The question mark symbol (?) was employed when the writer was unsure about a particular treatment, health condition or event which had been recorded by another health professional in the patient’s medical record or had been described by the patient.

Hedging techniques were evident in the referral letters, especially in the section pertaining to providing the results of examinations and investigations (Section 4.5.3.2 provides several examples). Health professionals’ use of hedging devices is commonplace especially when conditions and diseases ‘involve an inherent degree of uncertainty’ (Adolphs, Atkins, & Harvey, 2007, p. 64).

Moreover, writers used modifiers such as ‘somewhat’ to highlight their ambivalence about what they were recording in their referral letter. For example, one referral-letter writer wrote: ‘Mr (name) has a somewhat questionable history of heart disease – 2 presentations to hospital with chest pain & an angiogram in the past but it would be unusual for someone with proven ischaemic heart disease not to be on any medications for it’. The writer’s use of the phrases ‘somewhat questionable’ and ‘it would be unusual’ casts doubt on either the diagnosis or the (lack of) treatment. In other words, was the patient not taking any medication because the diagnosis of ischaemic heart disease was incorrect or was the condition not properly treated?
Use of qualifiers also afforded the writers the opportunity to express ambiguity. For example, one writer suggested that ‘it sounds likely that (the patient) had a gastric bleed’. The writer was unable or unwilling to provide a definite diagnosis at this point in the patient’s care and therefore drew on the adjective ‘likely’ to demonstrate a level of ambiguity.

4.6.5 Politeness. Writers used hedging to show politeness. Rather than issuing orders (e.g. using imperatives) when making recommendations to the recipient of the letter, writers tended to soften their language by using hedging phrases such as ‘we would like to request that on discharge…’, ‘I think it would be worthwhile considering…’ ‘he would benefit from…’ and ‘he will probably need…’. Rather than being prescriptive about future treatment and care, writers used hedging devices to acknowledge that the recipient would ultimately be making decisions about how to proceed with the patient’s care.

In contrast, when there was an urgency to the required care, writers threw niceties aside to stress the seriousness of the situation and the need to act immediately. Writers used language which was terse and straight to the point, for instance: ‘needs urgent imaging to exclude intercranial bleed’, ‘this will need to be commenced as soon as possible’ and ‘appendicitis needs further assessing’. The word ‘need’ which appeared repeatedly in phrases of urgency, highlighted that the writers were not making suggestions but rather, emphasising the importance of the request.

4.6.6 Abbreviations and acronyms. The sample of referral letters showed evidence of wide use of abbreviations and acronyms. Acronyms and abbreviations are an integral part of both spoken and written communication in healthcare, and they are easily transferred from spoken to written language and vice versa. Furthermore, abbreviations and acronyms can be viewed as time-saving devices. Long and cumbersome phrases can be made more concise and noted down more quickly by health professionals. The culture of the ward, hospital and location may also play a role in informing the use of abbreviations and acronyms.
4.6.7 Use of intensifiers. Intensifiers are words used to emphasise statements (Davis, 2007), and they were used frequently by the referral letter writers. For instance, one writer referred to the symptoms a patient displayed as ‘particularly suspicious’ and suggested that an underlying infection may have been the cause. Use of the qualifier ‘particularly’ demonstrated that the writer was almost certain that there was an infection present. Another example is a writer’s description of the patient’s condition as ‘deteriorating significantly’. Use of the adverb ‘significantly’ indicated that there was a marked deterioration and that the reader would need to act accordingly. Similarly, one writer’s use of the phrase, ‘a most impressive ischiorectal abscess’ highlighted the size and/or the seriousness of the abscess.

4.6.8 Use of passive voice. The use of passive voice in the referral letters may signify impersonalisation of the patient, which sometimes occurs in medical discourse (Rundblad, 2007). It may indicate a formal writing style (Xiao & McEnery, 2005) or it could be a demonstration of the writers’ professionalism and objectivity while caring for their patients (Rodríguez-Vergara, 2017). Alternatively, use of passive voice may be drawn upon as a means of situating the patient as the subject of the sentence, especially when routine treatment and care is provided and the identity of the treating health professional is not considered central (Halliday, Matthiessen, & Halliday, 2014; Kailani, 2017). This notion stems from Halliday’s concept of ‘Theme and Rheme’ in which the main topic or ‘theme’ (i.e. the patient in this context) is placed first in the sentence, thus taking priority (Halliday et al., 2014).

4.7 ISBAR and Referral Letter Moves

ISBAR stands for: I (Identify), S (Situation), B (Background), A (Assessment) and R (Recommendation/request). As mentioned in Section 2.3.4, ISBAR is mainly used for verbal handovers; however, it would also be an effective technique for written communication as
well. The moves and steps identified in Section 7.4 show that many writers are already drawing on the ISBAR technique, either consciously or unconsciously, to inform their writing. Table 25 compares the referral letter moves with the ISBAR technique. The descriptions for each letter of ISBAR in the table are based on literature pertaining to ISBAR (Finnigan et al., 2010; Pang, 2017; Thompson et al., 2011).

Table 25: Referral letter moves and ISBAR

<table>
<thead>
<tr>
<th>Referral letter moves</th>
<th>ISBAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Move 1: Establishing person, place and time</strong></td>
<td></td>
</tr>
<tr>
<td>Step 1 Identifying writer, department and institution</td>
<td>Identify – identify self, including ward and team, identify the patient, including name, age, Unit Record (UR) number, identify the person to whom the information is being given</td>
</tr>
<tr>
<td>Step 2 Indicating date on which letter was written</td>
<td></td>
</tr>
<tr>
<td>Step 3 Identifying letter recipient, department and institution</td>
<td></td>
</tr>
<tr>
<td>Step 4 Identifying patient (including name, date of birth, contact details and UR number)</td>
<td></td>
</tr>
<tr>
<td><strong>Move 2: Establishing the situation</strong></td>
<td>Situation – symptoms, the main problem, current concerns, the patient’s stability, observations</td>
</tr>
<tr>
<td>Step 1 Addressing/acknowledging recipient</td>
<td></td>
</tr>
<tr>
<td>Step 2 Expressing gratitude and/or providing further identification of patient</td>
<td></td>
</tr>
<tr>
<td>Step 3 Identifying reason for referral and/or presenting complaint</td>
<td></td>
</tr>
<tr>
<td>Step 4 Describing patient’s presentation</td>
<td></td>
</tr>
<tr>
<td><strong>Move 3: Establishing the patient’s medical background</strong></td>
<td></td>
</tr>
<tr>
<td>Step 1 Describing the history of the presenting complaint</td>
<td>Background – history of presentation (problem), date of admission and diagnosis, relevant past medical history, relevant background information (e.g. social history and medications)</td>
</tr>
<tr>
<td>Step 2 Providing results of examinations and investigations</td>
<td></td>
</tr>
<tr>
<td>Step 3 Describing treatment to date</td>
<td></td>
</tr>
<tr>
<td>Step 4 Listing past medical conditions</td>
<td></td>
</tr>
<tr>
<td>Step 5 Describing family, social and lifestyle history</td>
<td>Assessment – interpretation of the situation and background information to make a diagnosis or educated conclusion, the assessments that have been done so far (e.g. x-rays, blood tests).</td>
</tr>
<tr>
<td>Step 6 Listing allergies</td>
<td></td>
</tr>
<tr>
<td>Step 7 Listing current medications</td>
<td></td>
</tr>
<tr>
<td>Step 8 Mentioning attachments</td>
<td></td>
</tr>
<tr>
<td><strong>Move 4: Handing over care</strong></td>
<td>Recommendations/requests – what needs to be done to assist the patient, treatment or</td>
</tr>
</tbody>
</table>
4.7.1 Similarities between ISBAR and referral letter moves. As Table 25 shows, the ISBAR structure and the referral letter moves and steps which were based on the sample of 100 referral letters, share many similarities. It is clear that many of the referral-letter writers were already loosely adhering to the ISBAR structure.

Both the schematic structure of referral letters and the ISBAR technique begin with an identification of all involved parties, including the recipient (or the interlocuter, in the case of spoken communication), the reader (or speaker) and the patient.

Situation (S) and Move 2 are similar in that the main problem is pinpointed after identification takes place. Move 3 can be equated with the Background (B) and Assessment (A) in the ISBAR structure, as the patient’s background is established and the results of investigations are provided in both cases. Move 4 and R (Recommendations/requests) correlate in that both elements centre around establishing plans for the continued care of the patient.

The similarities between referral letter moves and ISBAR structure have implications for the structuring of referral letters in clinical settings. Section 8.2.2 provides a discussion on this topic.

4.8 Analysis of Discharge Summaries

For the purpose of this thesis, the analysis of discharge summaries was approached differently to the referral letter analysis in that the rhetorical moves and steps were not

---

**Step 2** Establishing willingness to continue being involved in the patient’s care and/or willingness to clarify treatment to date

**Step 3** Thanking the letter recipient in advance for their care of patient

---

**Move 5: Signing off**

**Step 1** Using a closing phrase

**Step 2** Signing the referral letter with name and designation

---

**Step 2** Establishing willingness to continue being involved in the patient’s care and/or willingness to clarify treatment to date

**Step 3** Thanking the letter recipient in advance for their care of patient

---

**4.8 Analysis of Discharge Summaries**

For the purpose of this thesis, the analysis of discharge summaries was approached differently to the referral letter analysis in that the rhetorical moves and steps were not
identified. The discharge summaries in the sample were highly structured, with hospital-prescribed headings and subheadings, and little variation in structure and layout. Therefore, rather than describing the moves and steps evident in discharge summaries, the headings have simply been listed. More emphasis has instead been placed on analysing the lexicogrammatical features. Section 4.11 also provides a discussion of the sample of discharge summaries in relation to the guidelines established by the Australian Commission on Safety and Quality in Health Care (2016).

4.8.1 The communicative purpose of discharge summaries. The interview results in Chapter 5 describe the communicative purposes of discharge summaries from the perspective of nurses. See Section 5.4.6 for further detail.

4.8.2 The structure of discharge summaries. The discharge summaries extracted from medical records at the rural hospital were predominantly inpatient discharge summaries with the exception being one Intensive Care Unit (ICU) discharge summary and one neonatal discharge summary. Table 26 shows the breakdown of the different types of discharge summaries. The inpatient discharge summaries fell into two categories: one with printed headings - a proforma - which the writer filled out by hand. The second type of inpatient discharge summary, also a proforma, was electronic and completed on the computer. All discharge summaries in the sample contained headings and were highly structured. Table 26 shows the headings listed in each of the discharge summaries.

While explanations of acronyms in parentheses were not present in the discharge summaries, Table 26 contains these explanations for ease of comprehension. The headings in the metropolitan inpatient discharge summaries varied, with writers being able to select headings which were relevant to the patient’s particular situation (e.g. if the patient did not have any allergies, the writer did not have to select ‘allergies’ as one of the headings. As a result, the headings listed in Table 26 for both the inpatient and emergency medicine
discharge summaries are not all present in each sample. The only variation evident in the typed rural discharge summaries was that some writers included ‘significant results’ as a heading whilst others chose to omit it. It is unclear if there were variations in the neonatal and ICU discharge summaries as comparisons could not be made due to the limited sample size.

Table 26

*Discharge Summary Headings*

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Type of discharge summary</th>
<th>Sample size</th>
<th>Headings</th>
</tr>
</thead>
</table>
| Rural    | Inpatient (typed responses) | 36          | - Patient details  
- Admission date  
- Discharge date  
- Discharge to  
- Follow up  
- Expected/planned to be re-admitted in the next 28 days?  
- Final diagnosis  
- Current conditions  
- Summary of Attendance  
- Significant results  
- Discharge plan  
- Completed by |
| Rural    | Inpatient (handwritten responses) | 12          | - Admission date  
- Discharge date  
- Principal diagnosis  
- Additional diagnosis  
- Presenting problem  
- On examination  
- Investigations  
- Progress and management  
- Discharge plan  
- Discharge medications  
- Signature/name/date/designation |
| Rural    | ICU                        | 1           | - On arrival in ICU/HDU (high-dependency unit)  
- Plan on admission  
- Problems  
- Notes |
| Rural    | Neonatal                   | 1           | - Date of birth  
- Discharge date  
- Discharge destination |
- Paediatrician
- Admitting Dr
- Admitted
- Account class
- LMO (local medical officer)
- Attending Dr
- Pregnancy (include any risk factors)
- Delivery
- Presentation
- Resuscitation
- Birth weight
- Apgars (newborn health test results)
- Hospital transfer details
- Neonatal period
- Heading test date performed/Result
- Neonatal morbidity
- Birth defect
- Treatment
- Nutrition
- Follow up Arrangements/Investigations
- Medication on discharge
- Name/designation/signature

Metropolitan Inpatient 32

- Admission information
- Hospital
- Admission summary
- Discharge details
- GP details
- Hospital course
- Principal diagnosis
- Clinical synopsis
- Clinical presentation
- Procedures(s)
- Allergies
- Histories
- Discharge information
- Prescribed medications
- Follow-up recommendations
- Author
- Pathology results

NB: the headings did not appear in all 32 discharge summaries; writers were able to select which headings they wished to include

Metropolitan Emergency Medicine 18

- Treating clinician
- Unit
- Admission date
- Discharge date
- Admission source
- Discharge destination
- Other active problems/complications
- Past history/medications/allergies
- Presenting problem/examinations
- Progression notes
- Allergies
In the discharge summaries, patient details were not usually recorded under the headings. This was because the patients’ hospital UR (unit record) stickers, which provided information about the patient, tended to be placed on the first page of the discharge summaries so that readers had access to patient details.

The structure of the different discharge summaries (as evidenced by the headings) were similar in some respects. Firstly, the proformas required admission and discharge details. In addition, the patient’s presentation on arrival, medical problems and diagnoses were necessary, and in some cases, so were the medical history, results of investigations and medications. Discharge plans (i.e. the recommended treatment following discharge), were common and the writers were expected to sign off on the document by included their name, designation and signature.

4.8.2.1 Subheadings and lists. To further structure the discharge summary, many writers used subheadings and lists. Subheadings were frequently used in sections such as ‘summary of attendance’ and ‘medical history’, usually with specific medical conditions used as subheadings. Some writers used subheadings commonly found in progress notes such as ‘HOPC’ (history of presenting complaint) and ‘FHx (family history)’. Writers who chose not to use subheadings tended to draw on paragraphing – or at least left a space between phrases - as a technique for separating information.

Use of lists was another technique used by writers to break up information and assist the reader in easily differentiating items. Examination results, medical conditions,
medications and discharge plans tended to be listed. Lists commenced with bullet points, dashes, numbers and letters, depending on the writer’s preferred formatting style.

4.9 Analysis of Formal Features of Discharge Summaries

4.9.1 Use of abbreviations and acronyms. Abbreviations and acronyms were prevalent in all sections of the discharge summaries except in the section outlining patient details in which names, addresses and so on were written out in full. Some common abbreviations included ‘R/V’ or ‘rev’ for ‘review’; ‘pt’ for ‘patient’; ‘Hx’ for ‘history’ and ‘ADL’ which stood for ‘activities of daily living’. Other ubiquitous abbreviations found in the discharge summaries were ‘rpt’ which stood for ‘repeat’, ‘resp’, short for ‘respiratory’, ‘f/u’ for ‘follow up’ and ‘d/c’ for ‘discharge’.

Some medical conditions were written as abbreviations, such as ‘HT’ (hypertension) and as acronyms, for example, ‘GORD’ (gastro-oesophageal reflux disease). ‘BIBA’ (brought in by ambulance) and ‘LOC’ (loss of consciousness) were also used by the discharge summary writers. Designations were likely to be abbreviated, with general practitioners predominantly referred to as ‘GPs’, local medical officers as ‘LMOs’ and physiotherapists as ‘PTs’. Examinations tended to be abbreviated (e.g. ‘ECG’). Names of medications were often written out in full; however, units of dosages (e.g. use of ‘mgs’ rather than ‘milligrams’) and the frequency of administration tended to be abbreviated.

4.9.2 Use of symbols. Symbols were not as common as acronyms and abbreviations; however, 41 discharge summaries contained symbols. Arrows were utilised most frequently by the writers, either to connect concepts, in which case the arrows were horizontal, or to suggest an increase or decrease with an arrow pointing up or down. Symbols to represent less than (<) or more than (>) were also included, as were question marks when the writer was unsure about a particular medication or condition. Some of the handwritten discharge
summaries contained pictorial representations, or diagrams of particular body parts such as lungs, abdomens or chests with the area in question shaded. At a glance, readers would gain an understanding of where the pain, growth or condition was located. None of the typed discharge summaries included diagrams.

**4.9.3 Use of note form.** Discharge summary writers overwhelmingly elected to write in note form (i.e. short phrases) rather than prose. The succinct phrases enabled writers to include a lot of information on each page, which readers could easily skim or scan.

From a linguistic perspective, definite and indefinite articles were usually omitted from the discharge summaries, as were subjects and verbs. For instance, one doctor, describing a patient’s condition wrote: ‘well on review in morning’.

Passive voice was often used by the writers, with phrases such as ‘daily weight monitored’ and ‘restarted on Warfarin’ being common. A lack of adjectives in the writers’ notes was also apparent. Short and succinct phrases tended to be used to convey information to the reader.

**4.9.4 Use of tenses.** Past tense was used by the writers to describe their medical history and summary of attendance (e.g. ‘the patient was unable to stand’). The patient’s current conditions were predominantly written in the present tense, although the writers tended to list the conditions without including verbs. The discharge plans were mainly written in the imperative mood with requests or suggestions such as ‘no lifting/training for 4 weeks’ and ‘please make a time to discuss this result with your patient’.

**4.10 Discussion of Formal Features of Discharge Summaries**

Writers of discharge summaries tended to use passive voice as a technique in their documents; for example, ‘patient was discharged on 9th October’. Drawing on the example, it is not clear who discharged the patient, who gave permission for the discharge to occur and
whether the patient was actively involved in the process of being discharged. However, use of the passive enabled the writer to situate the patient as the subject, the focus of the discharge summary.

The discharge summaries were distinctly clinical in comparison to the referral letters, in which the prose could be empathetic at times (e.g. through use of the word ‘unfortunately’) and show glimpses of the personality of the writer and the patient. As a genre, discharge summaries were impersonal, but as a result, the language tended to be clearer and more concise than the language found in the referral letters.

**4.11 Discharge Summaries and the National Guidelines**

In this section, the sample of discharge summaries is discussed in relation to the National Guidelines for On-screen Presentation of Discharge Summaries as set out by the Australian Commission on Safety and Quality of Health Care. These guidelines are supported by the Australian Government Department of Health. The aim of comparing the sample of discharge summaries and the national guidelines was to ascertain how closely aligned the discharge summaries were with the recognised standards. Test developers tasked with developing the stimulus material for the OET writing test would benefit from being aware of how discharge summaries are written in the clinical setting, as well how the authentic documents compare to the national guidelines.

**4.11.1 Abbreviations.** The guidelines stipulate that writers should ‘avoid abbreviations in a clinical context because they can be misleading and therefore increase clinical safety risk’ (ACSQHC, 2016, p. 5). In other words, abbreviations should be avoided so that communication breakdowns, which may lead to breaches in patient safety, do not occur.
As mentioned in Section 4.9.1, abbreviations were plentiful in the sample of discharge summaries. Although many of the abbreviations appeared multiple times throughout the discharge summaries, it cannot be assumed that all readers with access to the discharge summaries, especially the patients, understood the abbreviations.

4.11.2 General presentation guidelines. As well as providing recommendations about abbreviations, the guidelines also specified how dates, times, names, addresses, telephone numbers and email addresses should be set out. The guidelines were extremely specific, providing detailed recommendations for discharge-summary writers. For example, when describing how times should be set out, it was recommended that they be presented using a 24-hour clock with the hours, minute and seconds separated by colons.

In the electronic discharge summaries sourced from the rural site, it is likely that nearly all details were auto populated and not entered manually by the writer. With the handwritten discharge summaries, writers used the patient’s UR sticker to provide information. There was also a highly-structured section at the end of the discharge summary for writers to include their own details (e.g. signature, name, designation and date). Consequently, if changes needed to be made to the general presentation of discharge summaries, this would have to be a hospital-wide process rather than individual writers making modifications to their own documenting techniques.

4.11.3 Structure. The National Guidelines include a discharge summary sample (see Appendix T) which demonstrates the optimal way to set out information. The prescribed heading and subheadings enable discharge summary writers to provide a level of detail which they may not have recorded previously. For instance, not only are recommendations for patient care expected, but the person responsible for the recommendation must be noted down by the writer. This means that the reader can follow up on the recommendations with the appropriate person if necessary. In addition, the section relating to recipients requires
detailed information about who the discharge summary will be sent to, meaning that there will be less confusion about who should receive a copy and whether it has been sent to them. The template, including the prescribed headings and subheadings, is structured in such a way as to encourage open communication between healthcare professionals. It also allows for all essential information to be included in a clear and structured manner which means that communication breakdowns are likely to decrease. The use of tables and dot points will also be useful for the readers as they will be able to find important information quickly by skimming and scanning. In addition, the uniformity of the template will allow both writers and readers to become familiar with the document which will also save time and enhance patient safety.

4.11.4 The sample of discharge summaries. In comparison to the National Guidelines, the sample of discharge summaries was generally similar in structure and content. However, the guidelines recommend use of highly-structured discharge summaries which would require more details than the sample of discharge summaries provided (e.g. recording the details of the health professional who made initial recommendations for care). As a result, there was less room for ambiguity with the guidelines, and it would be more difficult for discharge-summary writers to leave sections blank, as was the case for some of the discharge summaries in the sample. The prescribed headings and subheadings required by the National Guidelines mean that essential information is likely to be included. While the National Guidelines advocate avoiding medical abbreviations, the sample of discharge summaries contained many abbreviations and acronyms, which may lead to confusion for readers.

4.11.5 Recommendations. The discharge summaries for the current research were written in 2014, while the national guidelines came into effect in 2016. Therefore, it is possible that the hospital discharge summaries have already been modified according to these...
guidelines. Discharge summary writers should continue to minimise their use of abbreviations and acronyms and adhere to the guidelines specified by the Australian Commission on Safety and Quality of Health Care.

The sample of discharge summaries analysed in the current thesis very closely resemble the OET stimulus material. Therefore, the findings validate the authenticity of the stimulus material for the OET writing test. OET test developers should bear in mind that there are National Guidelines in place for writing discharge summaries. However, whether the test developers decide to take on ‘best practice’ (i.e. writing the stimulus material based on the guidelines) to promote positive washback, or base their material on how discharge summaries are actually written in the clinical setting is a matter for debate. For instance, should acronyms and abbreviations be included in the discharge summaries, as is the case in current clinical practice, or should the abbreviations and acronyms be removed as recommended by the National Guidelines?

4.12 Summary

The structure, and lexico-grammatical and formal features of referral letters and discharge summaries were analysed in this chapter. Drawing on Swales (1990) method of identifying rhetorical moves as part of genre analysis, the steps and moves evident in the sample of referral letters were described in the first section, as were the lexico-grammatical features. The next section focused on the analysis of discharge summaries, particularly in regards to formal features such as the writers’ use of abbreviations, acronyms and symbols. The schematic structure of referral letters in relation to the ISBAR technique was discussed, and the National Guidelines in place for discharge summaries were described in relation to the sample of discharge summaries. In the following chapter, the results of the semi-structured interviews are explored in detail.
Chapter 5: Interviews with Nurses - Results

5.1 Introduction

This chapter presents the results of 31 interviews conducted with nurses. The findings address nurses’ perspectives on the context in which referral letters and discharge summaries are written, and how they read the two transition documents. While the nurses did not write referral letters and discharge summaries as part of their work, their writing practices in relation to a transition document they called a ‘referral’ are discussed in this chapter. The features of referral letters and discharge summaries that nurses deem important for effective written communication are also presented.

The chapter is divided into four sections looking at different aspects of nurses’ perspectives: (1) their views on writing referral letters, (2) their experiences with reading referral letters and discharge summaries, (3) the features of referral letters and discharge summaries which they value, and (4) their perspectives on writers from culturally and linguistically diverse backgrounds. In this chapter, the participant codes are listed as P1 to P31. For more information about individual participants, see Table 1 in Section 3.4.1.2.

5.2 Nurses’ Perspectives on Writing Referral Letters

The nurses stated that they did not write referral letters, (e.g. the generic form required for the OET writing test and those analysed in Chapter 4 of the current thesis), rather these were the domain of doctors. However, the nurses did write referrals to allied health professionals working at their hospitals, such as physiotherapists and speech pathologists, with the majority of participants required to write these documents regularly. They called these documents ‘referrals’ rather than ‘referral letters’. The documents differed from referral letters in that conventional letter writing techniques were not followed, for example, there was no opening phrase such as ‘Dear (name)’ and no closing phrase such as ‘Yours
sincerely’. Referrals were not often written in prose and tended to be less detailed than referral letters. In comparison to referral letters, they were internal rather than external documents which were sent only to colleagues working at the same hospital.

5.2.1 Methods for writing referrals. At the metropolitan hospital, nurses sent referrals electronically via the hospital computer system and did not handwrite them. The only exception was an example given by a psychiatric nurse who handwrote referrals for physiotherapists from time to time, and placed them in their pigeon holes. According to the participants, verbal referrals were not considered best practice and were discouraged. P15 reported that even if a nurse were to walk past an allied health professional and attempt to verbally refer a patient, they would still be required to submit the referral electronically. Psychiatric nurses had more flexibility, with one participant reporting that he would often ring the allied health professional, describe the patient’s condition and ask if it was necessary to request a referral in writing (P29). This way, he could potentially avoid the need to write a referral.

Although the majority of nurses at the rural hospital also wrote and sent their referrals electronically, the option to handwrite them remained. For instance, P25 reported that the Emergency Department was still in a ‘transition phase’ in terms of moving from handwritten to computer-based referrals. Furthermore, P23 stated that, as a part-time worker, she had only just discovered that referrals could be written and sent electronically. At the time of interview, she was yet to send a referral online. Another nurse at the rural hospital stated that she was reluctant to use the online system because she was ‘old-fashioned’ and had made the decision to handwrite her referrals until otherwise instructed (P24). Specific types of referrals such as cardiac rehabilitation referrals and community referrals had to be completed by hand and sent by facsimile.
5.2.2 Structure and content of referrals. The electronic referral systems were nearly identical at both hospitals, although nurses at the rural hospital referred to the computer program as the ‘ISBAR system’ (Section 2.3.4 provides more information about ISBAR). At both hospitals, the referrals were completed using a dropdown system with a separate section for typing notes. Nurses were required to log in under their username and then select particular options from the drop-down lists to complete their referrals, such as identifying the background of the patient and the designation of the recipient (P15).

The program was set up in such a way that referrals were unable to be sent unless all relevant boxes had been selected (P13). It was not necessary to sign off on the referral because once logged in under a username, the name of the referral writer automatically appeared. The handwritten referrals at the rural hospital were usually one-page documents which were ‘split up into different areas’ including ‘history’ and ‘diagnosis’ and were considered easy to complete (P23). According to P23, there was no prescribed structure for the handwritten referrals.

Although it was possible to leave the notes section blank on the electronic referrals, P10 reported that it was important to fill in the section because otherwise the recipients would not know why the referral had been made. According to P10, an optimal way to write the notes was along the lines of: ‘patient from home was walking with four wheelie frame, had fall, can you please review mobility?’ (P10). From her perspective, it was important to keep the notes brief because the recipient of the referral would be able to do their own investigations once they had examined the patient. Additionally, by completing the notes section, the allied health professionals receiving the referrals were able to ‘get the gist’ of the situation and prioritise patients based on the severity of their condition (P14). Writing excessive notes was frowned upon due to time constraints, although it was imperative that the
reason for the referral be adequately outlined (P17). One to four sentences in the notes section was considered optimal (P17, P19).

According to the participants, essential information to include in the referral was:
identification of the person who had requested the examination - including their ward number and the patient’s details (which were auto-populated when using the electronic referral system); whether or not the patient had requested the referral; identification of the area of specialty and/or the specific name of the referral recipient; explanation of the patient’s situation and diagnosis, the patient’s medical history; current medications and allergies; the reason for the referral, and level of urgency. Nurses were able to enter the information in a highly-structured way, by completing specific sections of the template. In the notes section, which allowed for prose, extra information was provided such as more detailed descriptions of the patient’s social situation and their physical or mental state; for example, ‘patient anxious’ or ‘patient malnourished’ (P14).

5.2.3 Use of language in referrals. When writing referrals, nurses used short sentences in the notes section in which articles and pronouns were often omitted, such as ‘patient had fall’ (P10). The interviewees were also inclined to use abbreviations in their writing such as ‘pt’ for ‘patient’ (P17), ‘d/c’ for ‘discharge’ and ‘r/v’ for ‘review’ (P30). In addition, acronyms used by the medical, nursing and allied health staff members were often included in the referrals. (P15). By using short phrases, abbreviations and acronyms, the notes section of the referral was more succinct; thus, the recipient was likely to read the entire document (P14).

The participants were generally aware of the importance of using suitable abbreviations for the recipient of the referral. For instance, P12 commented that she preferred to write complete words and phrases rather than abbreviating her writing if she was unsure about whether the abbreviation was ‘universal’ or not. According to P9, the allied
health professionals receiving the referrals generally had a good understanding of the acronyms used by the nurses. P30 noted that, in her experience, each unit at a hospital made use of different acronyms, so it was important to be aware of ‘whether people understand’.

5.2.4 The communicative purpose of referrals. According to the participants, referrals were necessary so that the patient could be reviewed by a specialist such as a social worker or a physiotherapist, and nurses could receive valuable input about the patient’s condition (P15). They functioned as ‘alerts’ for the allied health professionals to get involved in the patient’s care (P19). The referrals also gave allied health professionals an understanding of ‘what to look for’ when examining and treating the patient (P10). Some participants suggested that referrals allowed the recipient to have ‘a clear picture’ (P12) or ‘overview’ (P18) of the patient’s condition, which was essential for patient safety and effective treatment (P9).

Furthermore, the referrals functioned as handover and discharge planning tools for doctors, nurses and allied health professionals (P11, P24). For instance, allied health professionals were able to make recommendations about whether patients were ready to be discharged from hospital and provide suggestions about their living situation upon discharge. From P14’s perspective, it was important that prior to discharge, patients were ‘assessed by professionals’ to determine how effectively they could cope in a non-hospital environment. P23 noted that when it came to discharge planning in conjunction with allied health professionals, it tended to be ‘all about the holistic care of the patient’ and ensuring patient safety.

Additionally, referrals functioned as record-keeping devices in a legal sense. For instance, referrals to physiotherapists for patients who were elderly and had experienced falls were evidence that the team was taking steps to adequately care for the patient in hospital (P11). P5 noted that referrals were a method of ‘collecting data’. In other words, having
written evidence of the patient’s treatment and care in hospital was necessary in case they were ever called into question.

Referrals were viewed by the nurses as an effective use of time management because the recipients were able to conduct their examination of the patient in a focused, informed and swift manner, armed with the information that they had received in the referral. P15 gave the example of how a referral sent to a dietitian could function as a time-saving device:

Yes, it takes an extra couple of minutes to have a little type, but it helps the person that you’re sending the referral to be prepared for their meeting with the patient when that time comes. There could be a million reasons why a person is at a malnutrition risk and our dietitians would have to go in unprepared and ask those questions, whereas if we tell them, we’re saving them time (P15).

In the hospital environment, where time was considered such a valuable commodity, referrals were regarded as an effective and convenient way of communicating about the patient and passing on important information to colleagues.

5.3 Nurses’ Perspectives on Reading Referral Letters

Apart from the referrals written by nurses, participants generally had access to two types of referral letters in the medical record: those written by doctors working at the hospital and external referral letters entering the hospital from an outside source such as a General Practitioner (GP) clinic. Both types of referral letters were similar in form to the referral-letter task requirements of the OET writing test. In rare instances, nurses working in rural hospitals wrote referral letters when doctors were not available to do so, such as late at night when only a skeleton staff were on duty (P20). Referral letters that were sent to the hospital from an external source were discussed most frequently in the interviews, perhaps because
these letters were more varied and memorable than the referral letters written by the doctors with whom the participants worked.

5.3.1 Readers and recipients of referral letters. Interviewees indicated a difference between the intended recipients of referral letters (i.e. the addressees) and those who read the referral letters as part of their work. P10 noted that referral letters were written ‘just for doctors’. Other participants suggested that referral letters were usually addressed to ‘the treating doctors’ (P16) or the admitting officer, who was the senior doctor in ED (P25, P27).

Nurses working in the psychiatric ward commented that the referral letters were usually addressed to psychiatrists and psychiatric registrars. In P11’s experience, referral letters were not necessarily addressed to a particular person or profession; in fact, the letters were most likely to commence with ‘To Whom it May Concern’.

Although referral letters were often addressed to doctors, either by use of their name and title, or more generally (e.g. ‘dear doctor’), the nurses reported that they did regularly read referral letters. For example, P21 mentioned that referral letters were ‘written by doctors but nurses use them quite a bit as well’ to inform their practices in relation to particular patients. The majority of interviewees concurred with this notion.

5.3.2 Why nurses read referral letters. Nurses had multiple reasons for reading referral letters. They would either search for specific details in the letters, such as the reason that the patient was initially referred (P10), or read them in a more general sense to become aware of the patient’s ‘story’ (P11). Nurses also read referral letters to identify potential errors and amend them; for instance, if the treating doctor had accidentally prescribed medication the patient was allergic to, nurses could identify the error by reading the allergies section of the referral letter. Moreover, often GPs and other health professionals in the community had developed a relationship with the patient; thus, it was generally understood
that referral letters could provide more information than an ED doctor’s brief assessment (P6).

In terms of reading for specific details, nurses were interested in past medical history, allergies and social history (P4, P11, P20). Other sought-after details included confirmation of medications (P13), presenting problem (P27), whether a specific condition precluded a certain type of treatment, and how the patient was injured (P23). For the psychiatric nurses, the patient’s history of psychological trauma was particularly important (P28). For instance, P28 commented that although he was aware that a patient was suffering from post-traumatic stress disorder, he could read the referral letter to pinpoint why the condition occurred. When caring for patients with chronic conditions such as diabetes, nurses found it useful to look at attached test results and reports, such as blood tests, to gain a deeper understanding of the patient’s condition (P11). Additionally, referral letters provided pertinent information about the patient’s condition on arrival. For nurses in the Orthopaedic Unit, if the patient had a spinal fracture, it was essential to understand the patient’s condition so as not to ‘sit them up in bed, in case you’re going to break their neck’ (P4).

Generally, referral letters were read to get ‘a bigger picture’ (P11), and to gain ‘the best understanding’ of the patient (P13). P18, a Nurse Unit Manager, noted that he read referral letters so that he was aware of the patient’s ‘full story’ (P18). In the Intensive Care Unit, for instance, referral letters were particularly important for ‘forming part of a picture’ by providing information about a patient’s medical history and contributing to nurses’ understanding of the patient (P20). In Emergency Departments, when triage nurses were presented with patients who had ‘a weird story’ that did not make much sense (e.g. unexplained bruises), they could consult the referral letters to provide them with a more adequate understanding of the patient’s story (P24). The referral letters assisted the triage
nurses in determining the severity of the patient’s condition and how to proceed with treatment (P25).

Referral letters were also considered useful for identifying errors in the patient’s diagnosis or treatment. For instance, if information was communicated verbally but the nurses believed the information to be incorrect, they could read the referral letters to confirm whether or not an error had been made (P18). P9 provided the example of being able to rectify discrepancies in medication by re-reading the referral letter. For nurses, referral letters provided a means of ensuring that ‘everything’s right’ (P4). P7 noted that it was important to check and clarify medication dosages by reading referral letters.

Referral letters also enabled a comparison of diagnosis and treatment because nurses could refer back to the letters and work out whether their test results and findings were in line with the referring doctor’s. P20 commented that she would check the patient’s history in the referral letter to make sure that the same history was written in the notes; her aim was to confirm that ‘what we’ve got is what they’ve got’. In addition, the information found in referral letters could be used as a benchmark for assessing the patient’s progress. Nurses commented that it was essential to be aware of their patient’s usual state of being and treat them accordingly. Nurses also needed to understand what was expected of them (P3). An example of this was given by P21, who stated that:

If the patient’s not able to move much around, then it’s not likely that we’re going to be able to get them to move or run a marathon, but we might be able to get them back to what they were before.

In this instance, nurses needed to understand what a patient was capable of and what was expected of the treatment, in order to provide adequate care. Furthermore, nurses could check that no major changes had occurred to the patient’s condition during the journey to hospital (P4).
5.3.3 Structure of referral letters. In this section, ‘structure’ refers to both layout and sequencing of referral letters. The structure of referral letters from GPs and other health professionals in the community varied enormously according to most of the participants; however, a few participants suggested that referral letters were mostly similar. P25 stated that some referral letters ‘might be upside down, (with the information in an illogical order), a bit different to each other but they have all the basic information still there’. P1 commented that in her time working as a nurse, structurally she had seen ‘everything and anything’. P17 echoed this notion by stating that ‘different places have different layouts’.

In general, the referral letters read by the nurses followed a ‘letter format’ in that the recipient was addressed at the beginning and the letters were signed off with a signature at the end (P16). There was usually a letterhead as well (P7, P20, P26). Typically, paragraphs were present and the referral letters were approximately one or two pages in length (P16, P27, P30). Letters from specialists who were ‘a bit more educated in their area that they’re dealing with’ tended to be longer, according to P2. The nurses suggested that if GPs were using a computer program to write their referral letters, much of the information would be auto-populated (P2).

Doctors working within the hospital system tended to use the ISBAR system to write their referral letters (P18, P22). See Section 2.3.4 for a description of ISBAR. However, P8 noted that he had not specifically noticed ISBAR being used in letters. In P19’s experience, health professionals in the community followed the ISBAR system ‘to a degree’.

5.3.4 Content of referral letters. Even though there were great variations, nurses were still able to describe the common components of referral letters with ease, almost in a rote fashion. From their perspective, referral letters generally comprised: writer’s contact details, identification of patient, presenting complaint including symptoms, why the patient
was being referred, medical and surgical history, investigations and results (P25). In addition, medications (past and present) were included (P11), as well as social history (P15), response to treatment (P19) and allergies (P2).

5.3.5 Use of language in referral letters. The language used in referral letters was highly formulaic; thus, participants were able to reel off typical phrases found in the letters. Phrases mentioned by participants include: ‘I look forward to hearing the outcome of their attendance’ (P10) and ‘thank you for taking on the care of Mrs so and so’ (P19). Formal language was predominantly used by the writers (P21). Referral letters did not necessarily contain abbreviations, although medical language, such as writing the medical names for particular diseases and conditions, was commonplace.

After the greeting, referral letters usually contained a polite opening phrase which often included the patient’s presenting problem. P29 described how the opening phrase consisted of ‘pleasantries’ and then ‘some sort of description’. An example was provided by P19: ‘thank you for taking on the care of Mrs so and so, she’s come in experiencing weight loss or breathlessness, she has had chest pain the last few days’. Following the opening phrase, other details were provided, such as ‘patient takes these meds, I’ve done abdo (abdominal) x-ray’ (P10). Once information had been provided in the body of the letter, a closing phrase such as ‘I look forward to hearing the outcome of their attendance’ (P10), was added. P4 commented that ‘to be professional, you have to have a closing phrase’. Including a closing phrase meant that formal letter writing conventions were being adhered to. Finally, referral letters were signed and the designation of the writer was usually included as well (P7). The findings of the analysis of referral letters described in Chapter 4 are in line with the nurses’ perspectives regarding use of language, as demonstrated by the moves and steps in Section 4.4.3.
5.3.6 The communicative purpose of referral letters. The interviewees reported that, first and foremost, referral letters were written to inform the treating doctors of the reason the patient was being sent to hospital, to provide a summary of their care and what they expected in terms of the patient’s treatment whilst in hospital (P1, P15, P16). The letters were also considered a means of handing over care from one health professional to another, especially when the referring doctor had exhausted their resources (P10, P17, P21). In addition, they served the purpose of establishing communication between community and hospital-based health professionals, such as the GP and the doctors in the Emergency Department (P3, P11). P7 described referral letters as a form of ‘communication between health professionals, which is fast and efficient’ (P5).

The metaphor of the referral letter functioning as a snapshot or picture of the patient was prevalent in the interviews. For the nurses, one of the main purposes of referral letters was to provide them with ‘a bigger picture’, (i.e. more information) including, amongst other things, the patient’s medical history and allergies (P11). Nurses referred to gaining a ‘clearer picture’ (P19, P24), a ‘better picture’ (P19), an ‘accurate picture’ (P8) and a ‘reasonable sort of picture’.

In addition, referral letters were perceived as record-keeping devices since these letters provided written information about the patient’s background and prior treatment, which nurses and other health professionals could refer back to when necessary. Referral letters also documented evidence of care, which nurses considered important from a legal standpoint.

5.3.7 When nurses read referral letters. All 31 participants interviewed read referral letters as part of their work. According to the participants, referral letters were usually read by nurses when the patient was admitted; however, the letters were also read intermittently throughout the patient’s hospital stay as required. Triage nurses working in
the Emergency Department reported reading referral letters as soon as the patient presented at triage (P1, P25). Similarly, nurses working in the wards tended to read referral letters - which were transferred along with other paperwork – as soon as the patient was admitted to the ward (e.g. P30). P28, a psychiatric nurse, sometimes read referral letters, if he had access to them, even before the patient was admitted to the ward; his aim was to gain an understanding of the patient’s history.

P13, a nurse working on a surgical ward, stated that she endeavoured to read all documents, including referral letters, but because of her busy schedule that was not always possible. P15, a nurse on a general medical ward, rarely got the opportunity to read referral letters on admission because the patient needed immediate care and there were also other patients to tend to. P19, an Associate Nursing Unit Manager (ANUM) in the Intensive Care Unit commented that referral letters were also usually read ‘at the start of each shift if you don’t know the patient’. In P20’s experience, it was important to read referral letters whenever she first ‘came into contact’ with the patient.

5.3.8 Reading methods. Two distinct methods for reading referral letters were identified by the participants. Nurses had a tendency to either read the entire letter from start to finish or to scan the letter, searching for specific information. Some of the participants stated that they generally utilised one particular method; whilst others alternated between the two methods, depending on their purpose for reading the letter and their time constraints. For instance, P21 was inclined to read the letter in a chronological fashion and then, time permitting, scan the letter again, looking for details. There was an equal split between participants who generally chose to read the whole letter and those who tended to scan.

Referral letters were read from top to bottom to ensure optimal patient care, such as to confirm medications and medical history (P11). Nurses in senior positions and those with extra responsibilities, such as district nurses and Assistant Nurse Unit Managers (ANUMs)...
were likely to read the letter in its entirety so that they could follow up and pass on the information to other nurses and health professionals if necessary (P19, P26). Furthermore, reading the entire letter gave participants the ‘best understanding’ of the patient’s situation (P13)

Those nurses who chose to scan for specific information, typically searched for details relating to identification of the patient (P22), test results (P18) and the reason the referral letter was sent (P17). P23 noted that she did not pay much attention to information relating to the writer and their designation; rather, she focused on finding details about the patient. Similarly, P6 did not seek out the writer’s name but was able to tell if a letter had come from a GP. Conversely, P7 commented that when reading referral letters, she checked to make sure that both the document and the writer were ‘legitimate’ (i.e. came from a professional source). P24’s method for reading referral letters was to scan for information in a particular order: first, the diagnosis, then medical history and medications. P28 scanned for key words ‘paragraph by paragraph’.

5.3.9 How nurses use the information found in referral letters. Nurses utilised the information in referral letters to enhance their progress notes and share information with colleagues. Nurse-to-nurse verbal handovers were considered a good opportunity to communicate the information found in referral letters (P10). The content of the referral letters was used by nurses to carry out informed handovers. Similarly, doctors and nurses working on the same ward used the content of referral letters as a starting point for their discussions (P24).

Additionally, nurses often developed care plans and discharge plans based on the information found in referral letters (P15, P23). In triage, the information in the referral letter assisted nurses in making a decision about the severity of a patient’s condition and which ward or department they should be admitted to (P3).
Referral letters could also be used as a source of information for when nurses wrote their own referrals. For instance, if a nurse read about a homeless patient who was in a violent relationship, the nurse could then use this information as the basis for writing a referral to a social worker (P11). Furthermore, suggestions for referrals (i.e. documents written by nurses, see Section 5.2) might be found in the referral letters themselves. P25 commented that if a GP wanted a patient to be referred to a particular allied health professional during their hospital stay, a recommendation for a referral would be included in the referral letter which the nurse would then write.

5.4 Nurses’ Perspectives on Reading Discharge Summaries

As described in Section 2.2.5.2, discharge summaries are written when a patient is discharged from a healthcare facility so that clinical information about the patient, including their condition, treatment and follow up care, can be transferred to a different healthcare setting (e.g. from inpatient to outpatient care or from one hospital to another). Participants reported that discharge summaries were commonly written by doctors and rarely by nurses. Sometimes Emergency Department (ED) nurses were involved in the discharge-summary writing process by contributing to the notes, which were inserted into discharge summaries written by the doctors when the patient was transferred to a different ward or discharged from hospital. Therefore, this section focuses on how nurses read discharge summaries rather than write them.

While the participants commented that they were not expected to write discharge summaries as part of their work, 22 of the 31 participants interviewed were frequent readers of the genre; thus, they were able to share their own perspectives and insights on reading discharge summaries. Nine of the interviewees who worked on the general medical and surgical wards read discharge summaries as part of their work, as did all the Intensive Care Unit (ICU) nurses (n=5) and all but two of the Emergency Department (ED) nurses (n=4).
All the psychiatric nurses besides one regularly read discharge summaries (n=4). The participants tended to read ED discharge summaries, which were sent along with the rest of the paperwork, when the patient was moved to the ward. They also read discharge summaries from previous hospital stays if a patient was readmitted to hospital.

5.4.1 Why nurses read discharge summaries. The nurses reported that they read discharge summaries for multiple reasons. Primarily, discharge summaries assisted nurses in developing an understanding of the patient’s medical background, their condition and their needs. Even though nurses received patient information by verbal clinical handovers, which tended to occur several times during a patient’s hospitalisation, discharge summaries were completed upon the patient’s discharge from hospital and therefore, nurses could access detailed and valuable information about previous hospitalisations and visits to other wards. P11 gave the example of receiving a quick phone call from the nurse in charge, informing her that she was ‘getting Mrs Jones, 84, chest pain’ with no other details provided. In this instance, P11 turned to the ED discharge summary in the patient’s medical record to provide her with further information. Reading the discharge summary gave her an insight into the patient’s condition that she would not have otherwise had. P3 commented that for the patients who are ‘frequent flyers’ (patients regularly presenting to hospital), often they have been ‘tested and tested and tested again, so it’s always nice to know what (the condition) could potentially be’.

Another reason the participants read discharge summaries was to ascertain why a patient had returned to hospital following a previous admission. If patients had been previously admitted, a discharge summary would be attached to their medical record; thus, nurses were able to gain a fuller picture of the patient’s medical history and could also establish if the condition was a recurring one (P13). In P20’s experience, when a patient was readmitted to hospital, she would read the discharge summary first with the hope that
‘everything (she) wanted to know was on that’. Reading the discharge summaries meant that nurses were better able to provide ‘holistic care’ for their patient (P24). P13 commented that her handovers were more informative when she could share information about the patient’s previous hospital visits, as well as their current admission.

Discharge summaries were written about all patients who were admitted to the Emergency Department. As ED discharge summaries were written progressively whilst the patient was being examined and treated in the Emergency Department, ED nurses were able to read discharge summaries to effectively hand over the patient to ward nurses and doctors. For example, P2 stated that:

When handing over a patient, the discharge summary is quite handy because (the patient) might not have been admitted under an inpatient team yet so they’re the only doctors’ notes that you have.

Consequently, reading discharge summaries allowed the ED nurse to complete her handovers to the general ward admitting the patient in a comprehensive and informed way. From P31’s perspective, reading discharge summaries was one of his professional duties. He suggested that as he was part of a team, he and his colleagues should all read discharge summaries so that they could understand their patients’ situations.

5.4.2 Doctors’ methods for writing discharge summaries. Even though nurses do not generally write discharge summaries, they do read them and have a comprehensive understanding of how the documents are written.

According to the participants, in the ED at the metropolitan hospital, all ED discharge summaries were typed on the computer and then sent out electronically to GPs and other external specialists treating the patient (P1). A copy was also kept in the patient’s medical record and was accessible to health professionals working at the hospital. The ED discharge
summaries had automatic prompts with a template for structuring the document (P2). Medications, observations and pathology results were auto-populated (P2). As previously mentioned, notes for the discharge summary were often written consecutively as the patient was treated in ED (P2). The discharge summary was attached to the patient’s medical record on the hospital computer program; therefore, ward staff had easy access to the document (P10). If a patient wanted a copy of their discharge summary, it could be printed off and given to them directly (P10). ED discharge summaries at the rural hospital were usually written by hand using a photocopied template (P23). Participants reported that at times, handwriting contributed to the illegibility of the document.

Doctors on the general wards tended to write their discharge summaries once the patient had been discharged home, to another hospital or to a residential aged care facility; thus, nurses were not inclined to access them unless a patient was readmitted (P13). Discharge summaries written on the wards were completed electronically at both hospitals including in the Intensive Care Unit (P18, P19). P22 described how discharge summaries written by doctors in the surgical unit at the rural hospital were ‘pretty much a tick-box computer program and it just prints out, so (the discharge summaries) are not even personalised’. According to P15, a nurse working in neurology, discharge summaries were an average of three to four pages long. Conversely, in P11’s experience, working in a liver transplant unit, discharge summaries were usually about a page in length. From the nurses’ explanations, it is evident that there were variations in the methods doctors employed to write discharge summaries in different wards and departments.

**5.4.3 Structure of discharge summaries.** At both hospitals, doctors used a template to write discharge summaries, whether electronic or handwritten. At the rural hospital, discharge summaries tended to follow the ISBAR format with a section for notes under each heading (P20). The discharge summaries at the rural hospital also utilised subheadings,
which included: diagnosis, presenting problem, plan and treatment, test results and recommendations (P18, P23).

5.4.4 Content of discharge summaries. At the metropolitan hospital, the components of discharge summaries were: identifying features of the patient (e.g. date of birth), diagnosis, history of presenting complaint, treatments, medical history, allergies, medications, and results of investigations (P4, P9, P10, P19). Patient observations and medication charts were also included in the ED discharge summaries (P15). The discharge summaries written on the psychiatric ward were slightly different, with a description of how the mental health problem started and an outline of risks both for the patient and others included as part of effective discharge summaries as well (P31).

5.4.5 Use of language in discharge summaries. The participants had little to report about the use of language in discharge summaries. Doctors tended to write short, abbreviated sentences. Abbreviations such as ‘qid’ (four times a day) and ‘pt’ for patient were common (P11). At times, participants had trouble understanding the abbreviations written by doctors. P27, a psychiatric nurse, noted that it was essential for doctors writing discharge summaries to use correct medical terminology to describe the patient’s mental state. In her opinion, doctors should not use ‘emotion words’; rather they should use medical terms to describe whether the patient was ‘flat’ or ‘euthymic’. In this particular case, selecting appropriate words and phrases was considered an important aspect of writing discharge summaries.

5.4.6 The communicative purpose of discharge summaries. According to the participants, discharge summaries had multiple purposes. One of the main functions of discharge summaries was to communicate to doctors, including GPs and specialists, and nurses, what had been done to treat the patient during their hospital stay (P10, P11). Furthermore, discharge summaries were considered an effective means of handing over care
of the patient (P18, P24). Understanding the patient’s background and medical conditions was important for nurses in working out how to accurately assess the patient (P19). In a similar vein to referral letters, discharge summaries provided nurses and other health professionals with a snapshot of their medical history and why they had presented at the hospital (P11).

Discharge summaries also functioned as record-keeping devices for patients, GPs and other community health professionals once the patient had been discharged from hospital (P19). Upon receiving a copy of their discharge summary, patients had a tangible record of their treatment, for their own reference and to follow up as necessary (P10, P21). Arguably, patients were more empowered with access to information about their own condition and medical history. The GPs and other health professionals receiving the discharge summaries also had access to the hospital’s suggested plan of care; thus, patients were less likely ‘to get lost in the system’ (P19). Patients could expect a relatively ‘smooth transition from hospital to home’ when discharge summaries were provided to the treating health professionals in the community (P26).

The communicative purpose of discharge summaries was also described in the report which set out Australian guidelines for discharge summaries, published by the Australian Commission on Safety and Quality in Health Care (ACSQHC, 2016). The authors stated that “discharge summaries are critical for providing well-coordinated and effective clinical handover because they are the primary communication mechanism between hospitals and primary healthcare providers” (ACSQHC, 2016, p. 2).

**5.4.7 When nurses read discharge summaries.** ED nurses were inclined to read discharge summaries from previous admissions, as well as notes contributing to the current ED discharge summary, throughout the patient’s stay in the Emergency Department. P24, an ED nurse at the rural hospital, described the stages when she was most likely to read
discharge summaries: ‘from triage, I can read it just to understand, through to, like, looking after them in resusc. (resuscitation) or to in the cubicles’. Ward nurses read both ED discharge summaries and previous discharge summaries attached to the medical record as soon as the patient was admitted to the ward (P17, P30). At times, if they were informed in advance that a patient would be admitted, nurses tried to read the discharge summaries prior to the patient entering the ward (P15). They were able to locate the patient’s discharge summary by searching for the patient’s details in the hospital computer system (P11).

Nurses also tended to read discharge summaries at the beginning of their shift if they were not familiar with the patient (P19). Some participants reported that they read discharge summaries just before the patient was discharged (e.g. P23) in order to ensure that the patient’s care plan was in order, whilst others did not read them unless the patient was readmitted (P13). Hospital management required the ICU Nursing Unit Manager at the rural hospital to read discharge summaries every six months as part of a review process to make sure that documentation was comprehensive enough. He stated that he went ‘through quite a few in that time period’ (P18).

5.4.8 Reading methods and processes. Analogous to referral letters, nurses read discharge summaries two ways: either reading the document in full or searching for key words. Some nurses made use of both methods, depending on the length of the discharge summary and their time constraints (P10). In regards to making a decision about whether to read or scan a discharge summary, P27 stated: ‘if I knew what I was looking for, I’d scan it, but if I was just interested to read it, then yeah, I’d read’. Those who read the entire document commented that their reading style was ‘from top to bottom’ (P9, P19, P24).

The participants reported that they scanned discharge summaries for important information and were likely to ‘pick and choose’ based on what was relevant to the patient’s care (P15). An example given by P13 was scanning a discharge summary for blood-test
results in order to make comparisons between current and past results if abnormalities were
detected (P13). P17 only looked at specific sections, these being: ‘past history, current
medical history and medications’. P22’s method for reading was to glance at the patient
details to confirm that she was in possession of the correct discharge summary and then scan
straight to the ‘core content’ such as current medications and test results.

5.4.9 How nurses use the information found in discharge summaries. The
participants tended to use the information in discharge summaries to assist in the handover
process. For example, P10 used the material found in discharge summaries to write notes to
assist with her verbal handover to her colleagues. Discharge summaries written by doctors
on another ward or from previous admissions were also good sources of information to assist
with care plans (P15, P30). P11 used the information to help structure her care and to get
organised even before the patient was admitted to the surgical ward. She commented that:
‘it’s just little things like, you know, all your machines ready to go, all your lines ready to go
before (the patient) comes up…it gives you just a bit of a heads up’. Discharge summaries
enabled nurses to be prepared and provide optimal care (P9).

If there was any important information in the discharge summaries that had not been
noted by the treating doctors, nurses could advise them of this oversight. For instance, if a
patient was allergic to penicillin but doctors had neglected to notice that information in the
patient’s ED or previous discharge summary, nurses could advise them of the allergy (P19).
Other nurses preferred to speak to the nurse in charge about pertinent information they had
discovered in the discharge summaries (P23).

Some nurses used the information in the discharge summary to provide their patient
with an understanding of their own condition and medical history. P22 stated that discharge
summaries assisted her in ensuring that her patients were ‘fully aware’ of the care they were
receiving. Similarly, P23, an ED nurse, used the content of the discharge summary so that
she could communicate with the patients about where they would be going and what they would be doing after leaving ED. Her aim was to make sure that her patients ‘had a clear picture of what they’ve got to do post discharge’. For the district nurse working in the community, the information found in discharge summaries assisted her in determining how urgently she needed to visit a patient. She could structure her work day based around the information she read in discharge summaries.

5.5 Communication between doctors and nurses

Although the participants were not asked specific questions regarding doctor-nurse communication in the interviews, they mentioned their interactions with doctors in relation to reading and writing documents on several occasions. Their comments tended to focus on two main ideas: (1) nurses’ requests for doctors to assist in making sense of written documents and (2) the differences between doctors’ and nurses’ roles.

5.5.1 Assistance from doctors. According to the participants, nurses were likely to rely on doctors to read documents that they considered illegible or those that included terminology with which they were not familiar. Doctors would also be called on to interpret terminology that nurses had not previously encountered. P11 stated that when she came across obscure ‘jargon’, she was likely to call on doctors to assist her with making sense of it. She commented:

P: But if I don't really understand it, I'll just give up and ask the doctor, yeah.
I: And you'll ask them?
P: Yeah, what do you mean? 'Cause sometimes you read and you think, oh that sounds serious, but they're just like, 'oh no, it's nothing (laughs).

P31 suggested that nurses were likely to approach a second doctor if the doctor who wrote the illegible document was not available to clarify what was written.
5.5.2 Doctors’ and nurses’ roles. The participants emphasised the differences between doctors’ and nurses’ roles when it came to reading documents in the medical record. From P15’s viewpoint, although referral letters were usually addressed to doctors, it was the nurses’ responsibility to read the letters properly in order to ensure that the patient was being adequately cared for. P15 stated:

But nurses, we read everything. We’re kind of like (laughs), um, anything that doctors forget, we have to kind of catch up on and make sure it’s been done. As well as just, um, to know the patient yourself. It’s not the doctor's responsibility to know the patient. We, we don’t just pick up a syringe and say, ‘yep the doctor said give that to this or give that to that person’, we have to understand why they’ve come in and what we’re doing for them whilst they're in our care. So, yep, I would say they’re directed to doctors, but everyone has a use for them.’ (P15).

Nurses were also expected to convey important information that they read in referral letters to doctors. P19 described how the process of nurses alerting the doctors about what was contained in the referral letters as an example of ‘good care’.

The participants described how, at times, nurses also provided support and mentorship to junior doctors. P18 described the importance of newly-registered doctors taking note of the senior nurses’ experience in the Intensive Care Unit:

We’re fairly fortunate in here, you know, the junior doctors who come through are fairly, can be fairly junior and very inexperienced and they actually are reliant on nurses a lot. Professionally they aren’t, but actually culturally they are. And so, the senior crit. (critical) care nurse is a very good, great wealth of experience and anyone who doesn’t listen to them is a fool because they’ve got a wealth of experience behind them, you know, and they’ve been in the crit. care field for a long time.’ (P18).
If nurses were working directly with a medical colleague who was not able to communicate effectively or there was limited time for the doctor to convey important information about the patient, nurses tended to read medical documents such as discharge summaries, instead of speaking directly to the doctor. P2 stated:

So a lot of the time the doctors don’t have time to constantly update you as to what the plan is with the patient, or you have a doctor who doesn’t communicate very well. So often we will try and read their discharge summaries and hopefully see what the doctor’s plan is [laughs]. Which is a shame because it should be communicated personally rather than you trying to find it in the letter

This situation highlighted the essential role that written documents played in bridging the gap between the two professions and alleviating potential communication breakdowns. When nurses felt that they were unable to communicate directly with doctors, they relied on the documents for valuable information about the patient.

5.6 Qualities of Referral Letters and Discharge Summaries Valued by Nurses

This section focuses on the elements of referral letters and discharge summaries valued by nurses. While nurses tended to write referrals to allied health professionals and read referral letters and discharge summaries written by doctors, they valued the same features in all the transition documents. There were several qualities which nurses identified as being important to effective communication.

5.6.1 Conciseness. Firstly, the length of the document was a significant feature. Conciseness was considered essential when it came to writing transition documents due to the demanding nature of the work and the time constraints both the readers and writers
experienced (P10). P14 pointed out that it was possible for recipients to search for further information in other documents, such as nursing notes, if required. In terms of the referral letters sent in by GPs, participants felt that if the writer attached every result in their patient’s file, it was too time consuming for the recipient to ‘wade through’ all the information (P1). From P15’s perspective, ‘the longer (the letters) are, the less likely a person’s going to sit down to read them because being in such a busy, fast-paced environment, you don’t have the chance to’.

Similarly, P10 recommended keeping each section of the discharge summary brief because otherwise the document was less likely to be read properly. P19 noted that discharge summaries were ‘all about actually having a very concise, pertinent thing which isn’t too flowery and it’s just fairly direct and to the point’.

5.6.2 Comprehensive information. Although conciseness was valued by the participants, they believed that transition documents also needed to be comprehensive. P11 gave the example of a referral letter in which the writer had simply written ‘abdo (abdominal) pain, please see my patient’ as being too short and ineffective (P11). Transition documents containing almost no information, were seen as ‘handballing’ the patient, such as trying to hand over care of the patient before they had properly treated them (P16).

In terms of referral letters, P23 recommended including ‘as much history as you can get in there and as much information as you can, covering all the areas of the patient’s care’. P1 provided a list of points that she believed should be included, these being: ‘name, date of birth, the quick reason why they’re here, any past medical history, any past relevant tests and procedures and the attached results and contact numbers, particularly after hours’. Other participants seconded this notion (e.g. P2, P10, P16). P11 and P26 suggested that it was essential to include allergies in the referral letters as well. P25 noted that ‘the more information you can give somebody, the easier their next task is going to be’.
According to the participants, adequately expressing the purpose of a referral (the document that nurses write) was an essential element (P15, P16, P28). Furthermore, the inclusion of patient details (P14) and the level of urgency (P16) were considered valuable features of effective documents. The inclusion of the patient’s medical history and test results was also positive (P17, P20). Writing down a diagnosis, if known, was also considered important, as was considering whether the particular diagnosis warranted a referral. For example, referring a patient to a physiotherapist for a chronic illness such as emphysema was ‘a waste of time because (the physiotherapist) can’t do anything to them’; however, if the patient had an acute illness such as pneumonia, the referral would be considered more appropriate (P11).

Nurses also identified the inclusion of comprehensive information as one of the essential components of effective discharge summaries. Medical history and diagnosis needed to be included (P10, P15), along with current medications (P19). Comprehensiveness of information and brevity or conciseness were also considered key.

5.6.3 Balancing conciseness with comprehensiveness. Striking a balance between conciseness and comprehensiveness was challenging; thus, effective transition documents were those that managed to achieve the equilibrium. From P20’s perspective, it was a difficult process for doctors to balance comprehensiveness with conciseness in referral letters. She suggested including ‘only things that are relevant, not all the bits in between’. In P5’s opinion, when nurses wrote referrals to allied health professionals, a one-page document was ideal, with anything longer not being concise enough. P23’s advice for nurses was to ‘be thorough and be specific’ when writing referrals. Similarly, P24 suggested that effective transition documents should be ‘concise, detailed and to the point’. The participants tended to prioritise comprehensiveness over conciseness.
5.6.4 Structure. The ISBAR system was considered the best way to structure referral letters (P15, P19). P15 stated that ‘it’s just such a perfect process to get the right information across and be able to communicate without having to go back and forth; ISBAR allows us to do it once and do it right’. P19 commented that use of ISBAR was also ‘a safety thing’ in that no essential information would accidentally be omitted from the referral letter.

In addition, the ISBAR system was considered the most suitable way to structure a discharge summary (P19, P20). Sub headings were also looked upon favourably. By methodically splitting up the information, the reader could more swiftly and accurately locate the information that they were searching for (P10).

5.6.5 Clarity. Clarity was flagged as an important quality of effective transition documents. Writing in a clear manner, for example, by only using common medical terminology, was valued by the nurses. P24 commented that the writing found in referral letters should be clear so that ‘anybody could understand it, a nurse, a new nurse could understand, to a doctor understanding, all of that, all the way through’. Letters should be written in such a way so that any health professional is able to read the letter and understand what is being expressed by the writer.

P11 commented that by writing in a clear manner and using ‘good language’ it was easier for the reader to understand what the writer expected in regards to the patient’s treatment and care. P29 suggested that ‘being clear, not sort of just waffling on (i.e. including superfluous information), and telling a whole story about nothing, is the main thing’. P30 advocated being mindful of the words and phrases included in the referrals. She recommended using correct medical terminology. From P31’s perspective, ‘simple English that could be understood’ was most effective.

5.6.6 Awareness of audience. In this context, awareness of audience refers to the reader(s) of the referral letter or discharge summary. Participants noted that there could be
several audience members, or readers of the documents including nurses, doctors, allied health professionals, the patients themselves, their carers and lawyers. Awareness of audience was an overarching theme which was discussed in relation to several different qualities valued by nurses.

The aim of balancing conciseness with comprehensiveness of information was to provide accessible information to the reader. To the nurses, it was about taking into account what the reader needed to know and writing in a way that would convey that information most effectively.

Adhering to a recognised structure for the document, such as use of the ISBAR technique was a useful communication tool, according to the nurses. Again, it was about conveying information about the patient in a way that was accessible to the reader.

Additionally, as discussed in Section 5.6.5, nurses valued clarity in referral letters and discharge summaries so that the reader could understand the information being conveyed to them. Participants also considered politeness a fundamental aspect of effective referral letters. The inclusion of ‘courteous’ words such as ‘please’ and ‘thank you’ went a long way in ‘maintaining good relations’ with colleagues, according to P29. The notion of politeness was not mentioned by the participants in relation to discharge summaries.

5.7 Nurses’ Perspectives on Writers from Culturally and Linguistically Diverse Backgrounds

During the interviews, the participants were asked if they had noticed any issues with the writing of staff members from CALD backgrounds. Additionally, comments were also spontaneously made by participants in relation to the writing of referral letters and discharge summaries by CALD health professionals.

English as a Lingua Franca (ELF) refers to ‘communication in English between speakers with different first languages’ (Seidlhofer, 2005, p. 339). One example of ELF is
the writing of clinical documents by culturally and linguistically diverse (CALD) health professionals, which are then read by either L2 (CALD) speakers or L1 (first language) speakers.

The nurses’ perspectives on CALD writers varied, with some participants reporting that grammatical errors present in CALD health professionals’ speech were also evident in their writing such as incorrect use of pronouns. From P7’s viewpoint, mixing up pronouns was a feature of some CALD health professionals’ writing. When writers used ‘he’ instead of ‘she’, to refer to their patients, P7 felt that it was ‘quite confusing…and you wonder if they are writing about the right person’. In her experience, using incorrect pronouns in writing and in verbal handovers affected the clinical handover process. She stated that when reading notes or listening to CALD health professionals during handover, if pronouns were not clear, ‘it breaks your concentration, you’re trying to work out what’s going on’. P18, a Nurse Unit Manager (NUM) stated that the written communication of some health professionals who speak English as an additional language, ‘needs to be a better standard because there’s (sic) some of them who are very poor in that the word and structure of the sentences doesn’t flow (i.e. meaning is not expressed clearly)’.

The sense of confusion expressed by the participants in regard to pronouns is an example of how CALD health professionals’ English is perceived as being problematic in healthcare settings, especially by L1 speakers. The issue is attributed solely to the way the L2 (CALD) speaker communicates and there is no space for the interactants to negotiate meaning together, as in the case when communicating in ELF (McNamara, 2012; Seidlhofer, 2005, 2013). For example, two health professionals who both speak and write English as an additional language are likely to negotiate meaning and come to a mutual understanding of what they are conveying to each other when they communicate. This should also occur during a communication exchange between an L1 and an L2 health professional.
There were many examples given of how L1 English speakers negotiated understanding in an ELF context. P20 noted that ‘you can still read and understand’ even though those health professionals who spoke English as an additional language, ‘write how they talk, so it’s not an exactly fluent English’. P10 mentioned that when reading a document written by a health professional from a NESB, ‘their English looks a bit strange sometimes but if you know them, you can sort of picture them saying it’. Her familiarity with the writer meant that she was able to understand the document sufficiently. P15 noted that ‘the message still usually comes across’, although it was sometimes necessary to ‘spend a little bit more time trying to read it’.

Similarly, P9 stated that although grammatically incorrect writing took longer to read, it was generally possible to work out the message that the writer was attempting to convey. P3 believed that she could ‘get the gist of what they’re trying to say’, even though grammatical errors were often present. P2 suggested that it was possible to ‘decipher what you need to get out of it’; thus, incorrect grammar did not pose too much of a problem. In addition, P8 suggested that although some documents were not written in ‘very good English’, the writing still communicated ‘most of the time, pretty well, what is going on’. P22 stated that when grammatical errors precluded her from understanding a CALD colleagues’ notes, her way of dealing with the situation was to verbally ask the writer directly: ‘what do you mean?’

According to the interviewees, technology alleviated issues with spelling, grammar and handwriting. P4, an ANUM, pointed out that even though doctors sometimes struggled with spelling and grammar, it was only a problem with handwritten, rather than computer-generated documents. P22 suggested that CALD doctors’ writing was sometimes ‘just scrawl on a piece of paper’, which could be remedied by using the computer to write referral letters. From P25’s viewpoint, doctors from CALD backgrounds tended to ‘write big and to
the side (i.e. the writing appeared along the vertical edge of the page), which, you’ve got to try and turn the page to make any sense of it”; however, according to P25, typing notes and correspondence on a computer program alleviated the problem. P17, from a CALD background himself, noted that ‘it’s just usually all about the handwriting’; thus, he found it advantageous to use electronic, rather than handwritten, forms of communication.

P25 noted that learning medical terminology is equivalent to learning a new language and for CALD health professionals, acquiring English at the same time is extremely difficult. P19 suggested that spelling mistakes were an issue for writers who spoke English as an additional language, especially with writing the names of medications. She noted that having the correct spelling of the drug, using the generic name rather than the trade name, and writing down the dosage, were extremely important and that CALD health professionals ‘have got to be mindful of that’. Ensuring the correct spelling of medication was essential so that medication errors didn’t occur.

Some participants had not experienced any issues at all with the writing of health professionals from CALD backgrounds. Comments ranged from ‘I haven’t noticed anything’ (P13, P30), to ‘you wouldn’t know whether they were from a non-English speaking background or not’ (P16). P21 suggested that she had not considered the language background of the writers at all as it was not something she had noticed. P28 had ‘never really had issues’ with CALD writers, in his experience.

In regards to the writers of referral letters and discharge summaries, P11 stated that ‘when you get up to that stage of your career (i.e. working as a health professional in Australia), you know your English pretty well’. From P11’s perspective, being employed in an English-speaking healthcare setting, in a role which requires one to write referral letters and discharge summaries, meant that the writer possessed a good enough command of English to be able to write effective documents. Likewise, P23 stated that most of the referral
letters and discharge summaries she had read were ‘perfectly legible and succinct’. P29 pointed out that CALD health professionals ‘do have a good command of English’ and that the more experienced they became, ‘the more they’d start to figure out what’s important (and) what’s not important’ when it came to writing documents. According to P31, being from a CALD background would mean ‘it’s going to be pretty hard’ to work as a nurse. He suggested that without a good command of English, people would be reluctant to ‘jump into nursing’ at all.

P24 was impressed by CALD health professionals’ general writing style and their ability to communicate effectively; she stated that ‘quite often they’re better than half the people’. From her perspective, CALD health professionals have been ‘put through a bit more than what most of (their) counterparts have’; and consequently, in her opinion, CALD health professionals’ writing was ‘probably clearer and more concise’. Moreover, P5 found CALD health professionals - especially those from European backgrounds – to possess more ‘professional’ writing styles, whereas, in her opinion, those for whom English was their first language, tended to write in a ‘quick’ and ‘limited’ way.

Four participants identified themselves as being from CALD backgrounds. They spoke about their experiences with written communication. P14 mentioned that when nurses read documents such as nursing notes, they were not focused on the writer’s background, rather, their source of annoyance stemmed from the notes being too long. Similarly, P21 noted that although at times she used incorrect words, she had not found herself in a situation in which there was a lack of understanding by the reader. She revealed that ‘people understand what I mean, and I have had no one tell me that they have an issue’. P6 believed that ‘as long as you get the key words right’, documents could generally be understood, although, in her opinion, writing referral letters was ‘complicated’ and if the writer was not ‘good with the language’, there was the possibility of causing unnecessary confusion for the
reader. She gave the example of how if a CALD referral-letter writer used past tense instead of present tense, a misunderstanding regarding the patients’ treatment could occur; however, she stated that during her time working as a nurse, she had never experienced this situation herself.

5.8 Summary

The results of interviews with 31 nurses were described and analysed in this chapter. The participants’ perspectives on referral letters and discharge summaries were explored including their writing and reading practices in relation to the transition documents and the features they valued. The nurses’ insights into writers from CALD backgrounds were explained.

The following chapter presents the results of focus groups that were conducted with 36 participants who commented on the effectiveness of referral letters and discharge summaries extracted from medical records. In line with the interviews, the focus-group sessions provide an understanding of the qualities valued by nurses. Additionally, the focus groups captured discussions between nursing colleagues regarding specific referral letters and discharge summaries.
Chapter 6: Focus Group Sessions with Nurses -

Results

6.1 Introduction

This chapter presents the results of six focus groups with nurses conducted at Hospital B, the metropolitan hospital. A total of 36 different participants attended, with an average of six nurses present at each focus group. Nurses were split into groups of two or three and asked to comment on the stimulus material, which included both referral letters and discharge summaries extracted from medical records sourced from the rural and metropolitan hospitals. The results of the nurses’ discussions are described in this chapter.

6.2 Focus-group Stimulus Material

Seven referral letters and three discharge summaries were selected as the stimulus material for the focus-group sessions. See Appendix H for redacted copies of all referral letters and discharge summaries. Ten documents altogether were selected as stimulus material. The decision was made to include more referral letters than discharge summaries because candidates undertaking the OET writing sub-test are expected to write a referral letter, or similar; thus, understanding nurses’ perspectives on the qualities of referral letters was deemed most essential. The content and layout of discharge summaries was comparable to the stimulus material provided to candidates sitting the OET writing test; therefore, gaining an understanding of how these summaries are read and perceived by nurses was also important both in terms of making recommendations about the OET test task, and highlighting task authenticity. The layout of the referral letters was similar to the type of letter which test takers are expected to write for the OET.
Relevant documents from the medical record, including progress notes and pathology results, were attached to discharge summaries and outbound referral letters (letters written at the hospital and sent to health professionals outside the hospital), so that participants were privy to as much information about the patients as possible. Extra documents from the medical record along with the incoming referral letters were not included as the letters were received from other clinical settings outside the hospital (e.g. from a GP clinic) and were the first point of contact regarding the patients’ health care, so besides the referral letter there were no accompanying documents. Expert informants assisted with selecting relevant material from the medical records. A more detailed discussion of the procedures for selecting referral letters, discharge summaries and accompanying documents can be found in Sections 3.4.2.5 and 3.4.2.6. The following two sub-sections provide a summary of the referral letters and discharge summaries which were selected as the stimulus material for the focus groups. See Appendix H for copies of the ten documents.

6.2.1 Referral letters. Of the seven referral letters selected for the focus-group sessions, three were incoming letters (i.e. sent to the hospital by health professionals working outside the hospital in other settings), and four were written by staff members at the hospital and then sent externally to other health services and specialists. Table 27 provides an overview of the referral letters including a brief summary of the patients’ conditions. Referral letters are described in subsequent sections by use of the referral letter codes provided in the first column in Table 27.
### Table 27

**Overview of Referral Letters used as Stimulus Material for Focus Groups**

<table>
<thead>
<tr>
<th>Referral letter code</th>
<th>Hospital from which referral letter was sourced</th>
<th>Incoming (sent to hospital) /Outgoing (sent from hospital)</th>
<th>Writer</th>
<th>Recipient</th>
<th>Patient situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>RL1</td>
<td>Metropolitan</td>
<td>Incoming</td>
<td>General practitioner</td>
<td>Emergency Department (ED) physician</td>
<td>Patient experienced 6 days of severe pain in right buttock and leg</td>
</tr>
<tr>
<td>RL2</td>
<td>Rural</td>
<td>Incoming</td>
<td>General practitioner</td>
<td>ED physician</td>
<td>Elderly woman with severe pain in the neck &amp; ongoing headache</td>
</tr>
<tr>
<td>RL3</td>
<td>Metropolitan</td>
<td>Incoming</td>
<td>General practitioner</td>
<td>ED physician</td>
<td>Patient had chronic pain in feet and recurrent falls. In need of assistance from social work department</td>
</tr>
<tr>
<td>RL4</td>
<td>Metropolitan</td>
<td>Incoming</td>
<td>General practitioner</td>
<td>Surgical outpatient physician</td>
<td>Patient presented with small lump (para-umbilical hernia)</td>
</tr>
<tr>
<td>RL5</td>
<td>Rural</td>
<td>Outgoing</td>
<td>Paediatric doctor</td>
<td>Gastroenterology team at a specialist hospital</td>
<td>Infant with poor feeding and irritability</td>
</tr>
<tr>
<td>RL6</td>
<td>Metropolitan</td>
<td>Outgoing</td>
<td>Doctor from hypertension unit</td>
<td>General practitioner</td>
<td>Elderly woman suffered a fall</td>
</tr>
<tr>
<td>RL7</td>
<td>Rural</td>
<td>Outgoing</td>
<td>Physician from specialist consulting suite</td>
<td>General practitioner</td>
<td>Patient had pain in groin area, recently suffered from acute pancreatitis</td>
</tr>
</tbody>
</table>

#### 6.2.2 Discharge summaries.** Three inpatient discharge summaries were selected for the focus group sessions. Two of the discharge summaries (DS1 and DS2) were extracted...
from medical records at Hospital B, the metropolitan hospital, whilst the third was sourced from Hospital A, the rural hospital (DS3). See Table 28 for an overview of the discharge summaries. For the purpose of this thesis, the discharge summary codes are listed in the first column.

Table 28

*Overview of Discharge Summaries used as Stimulus Material for Focus Groups*

<table>
<thead>
<tr>
<th>Discharge summary code</th>
<th>Hospital from which discharge summary was sourced</th>
<th>Writer</th>
<th>Patient situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>DS1</td>
<td>Metropolitan</td>
<td>Doctor</td>
<td>73-year-old man treated for liver disease but discharged himself early, against medical advice.</td>
</tr>
<tr>
<td>DS2</td>
<td>Metropolitan</td>
<td>Doctor</td>
<td>11-year-old girl diagnosed with epilepsy</td>
</tr>
<tr>
<td>DS3</td>
<td>Rural</td>
<td>Medical intern</td>
<td>68-year-old man, involved in a motor vehicle accident following discharge from hospital after an endoscopy; patient had to be readmitted.</td>
</tr>
</tbody>
</table>

6.3 Nurses’ Perspectives on Referral Letters

This section addresses the findings from the focus-group sessions. Although referral letters and discharge summaries are both transition documents, their functions and content differ slightly; therefore, the two documents are analysed separately.

The participants commented on various aspects of the referral-letter writing process, both in a general sense and in relation to specific documents. In this chapter, the participant codes (Nurse 1 – Nurse 36) are used to signify which participant(s) made particular comments. As participants were working in groups, it was not always possible to differentiate individual participants’ voices; therefore, some comments are attributed to the group as a whole with codes such as ‘Nurses 8 -10’ which indicates that there were three group members involved in the discussion.
6.3.1 Features of referral letters valued by nurses. Through discussions of the stimulus material for the focus group sessions, nurses identified many features of referral letters which they valued. These findings have implications for criteria to be used in evaluating the existing OET writing task for doctors, and potentially other health professionals, as nurses are among the readership of referral letters. Section 8.3.3 provides a discussion of the implications of the findings.

6.3.1.1 Appropriate structure. According to the participants, the structure of the letter was a crucial element which contributed to the effectiveness of the referral letter. ‘Structure’ referred to both the layout of the referral letter including paragraphing, as well as the sequencing of the content provided.

The participants considered paragraphing to be an important component of effective referral letters. Nurses 4 and 5 recommended breaking up ‘blocks of text’ into paragraphs. When asked to identify the strengths of RL5, Nurses 15 and 16 pointed out that the letter was divided into paragraphs that ‘defined each area’. Different topics, such as medical history or current condition, were presented in separate paragraphs. It was also considered important to include ‘some sort of paragraph to introduce the patient’ at the beginning of the referral letter (Nurses 1 – 3). In addition, some nurses advocated the use of bullet points within the letter and separating sections under different headings (e.g. Nurses 19 & 20).

The participants commented that it was also a priority to make sure that all associated information was incorporated into the one paragraph. For example, the writer of RL5 described issues with the patient’s stools in one paragraph and then referred to the pending test results of the stools in a different paragraph and not spread across several paragraphs. In Nurse 13 and Nurse 14’s opinion, the referral letter could have been improved by writing about all aspects of the patient’s stools in one paragraph. Similarly, medications were broken
up into two separate lists in RL7 when they should have been consolidated into one list (Nurses 34 – 36).

The participants were also concerned with the way that information was presented in RL3. A section which was supposed to list the patient’s previous medical history as recommended by the heading, instead detailed current problems (Nurses 4 & 5). Moreover, the patient’s current health condition did not correspond with the medication mentioned in the medication section of the patient’s medical history (Nurses 13 & 14). Nurse 4 and Nurse 5 suggested that this was an issue with the way the writer had used the computer program which documented information about the patients at the general practitioner clinic. The participants commented that the writer had auto-populated the patient information without being discerning about the aspects of care that were important to include. From Nurse 4 and Nurse 5’s perspective, the writer was ‘lazy’; all the relevant information had been included, albeit in a jumbled manner.

One recommended method to improve the structure of a referral letter was the use of ISBAR, a structure for handover (Nurses 25 & 26). The ISBAR acronym is: I (Identify), S (Situation), B (Background), A (Assessment) and R (Recommendation). See Section 2.3.4 for more information about ISBAR. Through use of the ISBAR structure, writers would be able to ensure that the letter had been written ‘more systematically’ (Nurses 11 & 12). Using a standardised referral structure meant that the writer would be more likely to include important information (Nurses 31 - 36).

Headings throughout the referral letter were also valued unless the writer had included a heading with nothing written underneath. Nurses 29 and 30 held the belief that the inclusion of a heading without any proceeding information, as was the case with RL4, was even worse than neglecting to mention an important category. The nurses perceived that the writer was aware that the heading had been included but had chosen not to record anything.
This lack of recording was viewed as a sign of laziness and lack of professionalism. Similarly, Nurses 25 and 26 felt that because the investigation section was blank in RL2, it was as though the writer ‘had done zero, which isn’t always appropriate’. They felt that an effort needed to be made to ensure that if a heading had been included, information pertaining to the heading was also provided.

**6.3.1.2 Politeness and formality.** For the nurses, politeness was considered essential when it came to writing referral letters. In fact, when commenting on the qualities of the referral letters, participants were particularly enthused by evidence of politeness found in the letters. For instance, the phrases ‘please don’t hesitate’ and ‘thank you’ were selected as being important ones in referral letter 5 (RL5). In addition, the phrase, ‘we would appreciate your input regarding…’ was considered a polite way of handing over the patient to the recipient of the letter (Nurses 6 & 7). One participant stated that ‘at the end of the day, you’re doing a referral to another doctor, who’s doing you a favour to help manage their patient’; therefore, politeness was extremely important not just as a way of showing respect for the patient but as a means of successfully requesting assistance (Nurses 11 & 12).

Conversely, phrases such as ‘(the patient) has insisted I write him a referral’ (RL3) were regarded as rude because of the reluctance of the writer to take part in the letter-writing process and the disdain for the patient’s request. Use of the verb ‘insisted’, had negative connotations, according to the nurses, with Nurses 21 and 22 stating that the word was ‘a bit mean’ and ultimately ‘sets (the patient) up for failure’. Participants commented that the rudeness was not directed at the reader, but rather towards the patient. Their perspective was that even though the patient was not likely to read the document, the language was still inappropriate.

Nurses tended to value referral letters which were perceived as being written in a formal way. Formality was often equated with politeness and considered the most
appropriate approach to writing referral letters. RL1, which was considered ineffective in terms of its content and legibility, was, nonetheless, deemed to be a polite letter. Nurses identified the writer’s politeness as being one of the only redeeming qualities of the letter (Nurses 8 - 14). RL5 was praised for its politeness and level of formality (Nurses 31 - 33). It was considered appropriate because it was ‘very formal…you would expect this as a referral letter’ (Nurses 8 - 10).

Colloquial language was frowned upon by the nurses; rather, they felt that the writer should maintain a certain level of formality. Phrases such as ‘(the patient’s) pharmacy will not help him out in the meantime’ in RL3, and ‘so at the moment, I don’t think I can offer much in the way of a diagnosis’ in referral letter 6 (RL6) were considered too conversational (Nurses 8 - 10). RL7 was deemed to be too ‘casually written…it’s like (the writer) is having a conversation’ (Nurses 35 - 36). The participants frowned upon the writer’s use of ‘this guy’ when referring to the patient in RL7, considering it to be too casual. Nurses 21 and 22 suggested that ‘this gentleman’ – a phrase used by the writer in a different section of the letter - was a better option. In addition, the phrase in RL2, ‘she was ther (sic) in last week in ED and since then she is not better’ was considered unprofessional because of the casual nature of the formulation. Participants suggested that the language should be more geared towards ‘doctor-to-doctor’ (formal) language (Nurses 25 & 26).

6.3.1.3 Appropriate use of terminology. When it came to use of medical terms, the participants highlighted the importance of using terminology that the reader could understand. For example, some participants considered RL5 to be well written because the medical terms included were those that could be easily understood by a gastroenterology doctor, the expected recipient of the letter. Likewise, others stated that the writer used ‘proper medical terminology…it’s going to a doctor so that’s fine’. Nurses 25 and 26 pointed out that RL5 used ‘less medical terminology than they should’; however, in their opinion, it
was not necessarily a negative feature of the letter because it could be understood by the patient’s mother (the patient was a baby). RL2 was deemed to be less effective because of the lack of ‘medical language’. (Nurses 1 - 3). One example identified by the nurses was the phrase ‘ten out of ten pain’ in relation to the patient’s level of pain. The participants suggested that this phrase was something that a relative, not a doctor, would be likely to write. They would have preferred for descriptors of pain to be noted, such as ‘throbbing’ or ‘stabbing’ pain.

From the nurses’ discussions, it was evident that the use of medical language also had implications for doctor-patient communication. The phrase ‘I have encouraged (the patient) to continue to stay away from the alcohol’ (RL7), was considered by N11 and N12 to be unprofessional. The condescending tone of the writer was evident to the nurses, who suggested that the writer should have included information about ‘the risks of continuing alcohol consumption’ rather than the simplistic notion of ‘encouraging’ the patient not to drink (Nurses 11 & 12). They suggested that the writer was ‘politically incorrect’ to phrase the sentence in that way. The participants’ concern for the patient, as well as their perception that the writer of the letter had interacted negatively with the patient during the medical encounter, once again highlights the importance that nurses place on using terminology relevant to situation and maintaining respectful, patient-centred care.

6.3.1.4 Conciseness. Referral letters which were concise and straight to the point were considered optimal. RL5 was commented upon favourably in that the writing ‘did not go around the bush, it (was) straight to the point’ (Nurses 8 - 10). Some participants described RL5 as ‘the perfect referral letter’, their reason being that ‘it’s just to the point and that’s it’ (Nurses 31 - 33). Additionally, the writer of RL2 was praised for using a timeline in the past medical history (see the referral letter in Appendix H), which ensured that the letter was ‘not too wordy’ and that the referral letter itself was ‘nice and brief’ (Nurses 17 & 18).
In contrast, it was pointed out that the past history listed in RL2 was ‘not the best’ because it was too long (Nurses 25 & 26). RL3 was perceived as less effective because it was ‘long winded’ and did not get to the point immediately (Nurses 15 & 16).

6.3.1.5 Comprehensive and relevant content. When it came to the content, participants noted that information should be both comprehensive (i.e. providing all relevant information pertaining to the patient), and relevant, with no superfluous information included. RL3 was considered to be an effective referral letter because it was ‘very thorough’ (Nurses 19 & 20). RL7 was perceived as comprehensive, because the writer had ‘given a reason for everything he’s done…and he’s even mentioned what future problems could arise’ (N19 & N20, L9 & 17).

Referral letters which were otherwise considered by the participants to be less effective linguistically (e.g. there were issues with grammar and lexis), were elevated to a ‘more professional’ level when they contained comprehensive details (Nurses 1 - 3). Nurses 4 and 5 pointed out that ‘there’s a big difference between…if (the patient’s) walking or if he’s not walking and stuck in bed, that changes how you treat someone, and these are the kinds of details that need to be included in referral letters’.

Participants commenting on RL3, a letter which was viewed as having grammatical errors and inconsistencies, pointed out that overall, the letter was effective because it provided adequate details. The following quote highlights what the participants particularly valued about the content of RL3:

(The writer) is thanking them initially for actually seeing the person, for the referral, he’s going through the background of the patient, as much as he knows anyway. And then he’s going through (the patient’s) past history, also his social situations. And his current medical, medication as well, which is good, and it’s very clear’ (Nurses 1 to 3).
Consequently, although the use of language in referral letters contributed to or detracted from the effectiveness of the document, the content and structure were more important in determining the nurses’ opinions of the referral letters.

Due to the lack of comprehensiveness of RL5, which described a newborn baby’s feeding difficulties in hospital, participants questioned what had actually occurred and whether the information provided in RL5 was correct. N17 and N18 considered the letter to be ‘disturbing’ because it was unclear what kind of substance (breast milk or formula) the baby was discharged home with and why he had been discharged so soon. They speculated that the nurses treating the patient had probably recommended that the mother switch to using formula due to the baby’s allergies; however, this was not documented in the referral letter and was a big oversight.

The nurses also considered the inclusion of relevant information to be important. The key information varied according to the patient’s condition and needs and the setting (e.g. medical versus surgical wards) (Nurses 6 & 7). RL5 was considered effective because it was ‘certainly very specific as to what’s going on’ (Nurses 17 & 18). Similarly, the inclusion of relevant information in RL6 allowed readers to establish a ‘picture’ of what had occurred with the patient (Nurses 31 - 33). Participants described how the inclusion of relevant information, written in a logical order, allowed them to gain a clear understanding of the ‘series of events’ that the patient had experienced (Nurses 31 - 33).

A number of different suggestions were made about the details that should be included in referral letters. Firstly, participants pointed out that it was important for referral letter writers to include a diagnosis, or if they were not able to provide a definitive diagnosis, then at least a record of what they had so far ruled out. During a discussion about RL6, Nurses 4 and 5 were pleased that the letter ‘goes into good detail and (the writer’s) reviewed, this is the reason why I’ve ruled out this and this and this. And I’m going to treat her for that
and this is the plan’. They considered the inclusion of information about what particular diagnoses could be excluded on the basis of the writer’s investigations just as important as providing a diagnosis. Nurse 4 stated that when receiving such a letter, I’d feel like, okay now I know what’s going on’. Furthermore, expressing an idea of what the condition could potentially be, was important because then the reader could ‘follow that through’ (Nurses 15 & 16).

Secondly, the inclusion of investigation results (e.g. scans) was considered important. RL4, another letter which was initially negatively received by the nurses due to the varied fonts and headings without any details listed underneath, was viewed positively by several participants due to the inclusion of the written analysis of the ultrasound findings which indicated a hernia (Nurses 15 & 16). Rather than the receiving health professionals having to conduct an ultrasound themselves, the results were already available. Participants suggested that this positively enhanced the recipient’s experience because the letter was informative and the reader was able to save time by not repeating investigations (Nurses 17 & 18). While discussing RL3, it was suggested that in order to improve the referral letter, the writer should add a copy of investigation results because the reader needed ‘evidence’ of the patient’s condition and the tests that had already been undertaken (Nurses 1 - 3).

Thirdly, the writer expressing the reason for sending the referral letter, and what was expected of the health professional receiving the letter, was paramount. For instance, Nurses 4 and 5 suggested that to make RL3 more effective, the writer should have included a plan or recommendations for the recipient. RL6 was considered effective in some respects because the writer had ‘clearly stated why (the patient’s) here, what’s happened in the past, what are her signs and symptoms, what (the writer has) investigated and what they’ve done for treatment’ (Nurses 27 & 28). Positioning the plan at the end of the referral letter was considered optimal by the participants (Nurses 11 & 12). Simply writing ‘kindly investigate’,
as was the case in RL1, was not helpful for the reader if what needed to be investigated was not specified (Nurses 21 - 26).

Additionally, referral letter writers were expected to record information relevant to the patient’s social situation, such as documenting if the patient was a heavy smoker and drinker or found it difficult to communicate in English (Nurses 19 & 20).

It was also recommended that medications be listed in the referral letter under a ‘medications’ subheading (Nurses 15 & 16). It was important to include the doses as well (Nurses 31 - 33). Nurses 13 and 14 stated that ‘there may not be any medications but they should at least write that’ so that the reader was aware of whether or not the patient needed medications. If the patient was not currently taking any, writing ‘nil’ in regards to medications was considered a clear way of expressing this situation to the reader (Nurses 1 - 3).

Similarly, in regards to ‘past medical history’, if the patient did not have any history, or at least none relating to the current condition, it was important for the writer to record that information (Nurses 13 & 14). The inclusion of the patient’s medical history was also considered an essential component of an effective referral letter. Nurse 6 commented that as it was likely that those reading the letter had never met the patient, if there was not a section outlining the patients’ medical history, it would be more difficult to treat the patient.

The category of ‘allergies’ was also essential. It was suggested that the referral-letter writer ask the patient directly so that the information contained in the letter was up to date (Nurses 15 & 16). The participants also believed that it would be more beneficial to list the patient’s past history, allergies and medications all on one page so that ‘you don’t leave yourself open to missing information’ (Nurses 11 & 12).

Finally, the suggestion of recording time frames was made, including listing events that were relevant to the patient’s reason for presenting at the hospital in chronological order.
Readers were more likely to understand the patient’s condition and history if writers were specific about when each event had occurred. Nurses 15 and 16 stated that time frames gave the reader ‘more answers’ about the patient and they were more likely to be aware of whether the problem was short or long term.

This section provided a description of what nurses value in terms of the content of referral letters. The moves and steps discussed in the genre analysis chapter demonstrate that the qualities that the nurses commented on were generally present in the sample of referral letters (see Section 4.4.3). For instance, nurses reported that providing a diagnosis was essential, which corresponded with Move 2, Step 3 in which the writer identified the reason for the referral and the presenting complaint. Nurses also valued the inclusion of investigation results which corresponds to Move 3, Step 2 in which the writer provided the results of examinations and investigations.

Additionally, focus-group participants reported that a plan including recommendations for further care and treatment for the letter recipient was important. This quality parallels Move 4, Step 1 which involves the writer making recommendations for the recipient to carry out. However, only 26 of the 100 referral letters contained this step; therefore, rendering it optional. This finding shows that although nurses greatly valued the inclusion of a plan, it was not always incorporated in the letter, and there is room for improvement in the writing of referral letters so that they are more effective.

#### 6.3.1.6 Balancing comprehensiveness of information with conciseness

One of the key themes to emerge from the focus group sessions was the importance of balancing comprehensiveness of information with conciseness. This balance involved providing enough relevant details to get the important information across to the reader, while being succinct in the way that the information was presented. For example, RL7 was perceived as
being ‘really short’, but this was considered a positive feature because all the relevant information was contained in the letter (Nurses 19 & 20).

Although a balance of these two factors was seen as evidence of an effective referral letter, comprehensiveness of information was considered more important than conciseness. When participants were asked about how to include adequate information in a concise manner, they stated that ‘more information is better than not enough sometimes’ (Nurses 19 & 20). For instance, the writer of RL2 had included ‘olive oil’, which had been used to treat a patient’s skin condition in the past, on a list of the patient’s current medications. The patient had presented with a headache and sore neck, and the olive oil was not relevant to this complaint. The inclusion of the olive oil on the medications list was pointed out as being superfluous and unrelated to the reason for the referral letter. While Nurses 17 and 18 noted that the writer had ‘gone overboard’ in listing medications, they did not view the extended medications list as a negative feature of the letter, rather, they were more inclined to feel that it was beneficial to the reader because ‘it’s better than the other way’ (i.e. the writer not noting down enough information).

From Nurse 27 and Nurse 28’s viewpoint, the effectiveness of a referral letter was not measured by the length of the letter, rather ‘it’s the content that you put into it’ that determined its value. The nurses involved in the sixth focus group elaborated on what they expected from a referral letter by stating:

We need detail but succinct; you need enough information that you can use but you need it to be short and sweet at the same time, but it’s a bit of balancing. You don’t want waffle (writing too much superfluous information) because they’re not going to read it all.’
One recommendation the nurses who had attended the sixth focus-group session made was to use dot points to structure the referral letter. That way, the letter would be both concise and comprehensive.

6.3.1.7 Legibility. Legibility (i.e. the referral letter being clear enough for the participants to read), was also regarded as an important quality of an effective referral letter but seemed only to relate to the mode in which the document was written. The letters that were typed, rather than handwritten, were considered ‘more legible’ (Nurses 1 - 3). When asked to describe a positive feature of RL5, participants tended to comment on the legibility of the document. For example, Nurses 15 and 16 initially identified legibility as an important quality of RL5 by stating: ‘it’s typed, it makes it legible and you can read it’. In contrast, handwritten referral letters that the nurses reviewed during the focus groups were seen to be less effective.

6.3.1.8 Clarity. The nurses considered clarity to be an essential component of effective referral letters, although two distinct definitions of clarity were evident from the nurses’ comments. Firstly, *clarity of language*, which meant that readers were able to understand the writer’s choice of terminology, expressions and formulaic phrases. Secondly, *clarity of message* regarding what the writer expected of the reader. For instance, Nurses 19 and 20 commented that RL3 was ‘easy to read’ because, in their opinion, ‘you can get the important stuff out of it’. Similarly, RL2 was considered effective because ‘the message is very clear’ (Nurses 17 & 18).

Referral letters did not necessarily show evidence of both types of clarity. The focus group session involving Nurses 11 and 12 provides an example of a discussion about the two different types of clarity. According to the two participants, although the language in RL7 needed modification, one of the strengths of the letter was that the writer was clear about
what the reader was expected to do for the patient. For instance, the writer had requested that the reader inform the patient of test results by writing: ‘kindly discuss the result with them’. The participants noted that there was clarity about what the recipient of the letter was expected to do even though other phrases throughout the letter were not necessarily as clear.

6.3.1.9 Awareness of audience. According to participants, maintaining an awareness of the reader, including doctors, nurses, patients and their carers, was an important element of referral letter writing. Some of the referral letters generated a discussion about audience. One example is RL2 which had been written at the request of the patient. The nurses reported that the writer seemed reluctant to write the letter because the patient’s regular clinician was away. Nurses 15 and 16 questioned whether or not the writer should have written the letter at all, as the letter was not as comprehensive for the reader as they would have liked. The participants suggested that instead of composing the letter, the writer should have said to the patient: ‘once your doctor’s back, we’ll get you a letter in the next couple of days’. Their suggestion stemmed from the notion that the patient’s insistence that he be seen by the orthopaedic team at the hospital, and the ensuing referral letter, had a direct influence on the reader of the letter as well as the writer.

Taking the reader of the referral letter into consideration was seen as important by other participants as well. For example, Nurses 11 and 12 suggested that although the writer of RL7 had included relevant information, the letter ‘needs to be reworded in a way that it reads well for the audience’. Additionally, Nurses 25 and 26 pointed out that the lack of medical terminology included in RL5 may have enabled the patient’s carer to clearly understand what was written.

6.3.1.10 Duty of care. Although the participants did not use the terms ‘duty of care’ while they were discussing the letters, this topic emerged in their discussions. ‘Duty of care’
refers to the notion that the health professional is expected to do everything in their power to ensure that the patient is being treated as effectively as possible. One of the most pertinent examples of the writer showing a lack of duty of care emerged from conversations that the nurses had about use of question marks, especially in relation to RL3.

On the surface, use of question marks to express doubt or hedging may seem like a linguistic issue, but it is actually representative of a larger issue - the writer was not fulfilling their duty of care. Nurses 8, 9 and 10 noted that the writer had used too many question marks to indicate a lack of knowledge about the patient’s case. N4 and N5 commented that the question marks in RL3 simply showed that the writer could not be bothered looking further into the patient’s condition and therefore was not showing duty of care. Similarly, Nurses 13 and 14 stated, in relation to the same letter, that there were ‘inappropriate’ question marks ‘all over (the patient’s) history’. They commented that the writer should have confirmed the patient’s history at the very least. Nurses 8, 9 and 10 concurred, pointing out that the patient’s history of nocturnal seizures and cerebral palsy should have been adequately investigated, rather than the writer simply putting question marks next to the particular conditions.

6.3.1.11 Professionalism. The nurses identified two main aspects of professionalism. Firstly, they viewed clinical appropriateness (i.e. treating the patient as compassionately and effectively as possible), as a sign of professionalism. Secondly, they also viewed correct use of formal features (e.g. grammar, spelling and abbreviations), as another aspect of professionalism.

In terms of clinical appropriateness, the participants believed that lack of clinical appropriateness was evident in two of the referral letters: RL3 and R4. Firstly, several of the participants were surprised that the writer of RL3 had noted that the patient ‘is currently on the waiting Category 2 at (redacted) hospital for a right foot reconstruction, and then
followed up with the phrase: ‘?not really sure of the full details why’. The participants commented that the writer used a question mark instead of conducting further medical investigations and equated the writer’s lack of follow up with being unprofessional. The perceived complacency of the writer through use of a question mark was considered unprofessional by the nurses and they stated that the referral letter was not well written because ‘it’s like the doctor’s venting in his letter’ (Nurses 15 & 16). The participants’ viewpoint was that rather than maintaining professional neutrality and showing compassion towards the patient, the doctor’s judgemental attitude towards the patient’s situation (as demonstrated through word choice and punctuation), was unprofessional.

However, this referral letter was the most divisive because other participants believed that being asked to write a referral letter for an unfamiliar patient, ‘puts this doctor in a difficult position’ (Nurses 1 - 3). From this perspective, the patient had ‘bamboozled’ the doctor into writing the letter (Nurses 13 & 14). Other participants noted that in spite of the doctor’s reluctance to write the letter, the writer had ‘actually done a really good job’ in handing over care (Nurses 1 - 3). Most participants though, believed that the writer had not adequately attempted to investigate the patient’s condition and had not sufficiently articulated the reason for the referral letter, which was a clinical competence issue. They suggested that the GP had written the referral letter as a way of moving the patient on quickly so that the letter recipient(s) would be responsible for following up and providing care; a technique which was not viewed positively by the participants due to the lack of professionalism (Nurses 4 & 5). Nurses 4 and 5 commented that although the doctor had written the referral letter at the patient’s request, the doctor seemed to lack compassion for the patient:

P: Yeah, and it’s kind of just said: oh I’ve never seen this patient before because his usual doctor is away so it’s just, like you can tell he just doesn’t really, like, the overall kind of impression is that he just doesn’t really care.
P: He’s just done it, he’s been forced almost.

P: Yeah, he’s just like, the patient’s just come in and demanded a referral
so this is what I’ve done, like the bare minimum sort of thing.

Another aspect of professionalism related to the formal features and the presentation of the letter including use of unambiguous words and phrases, correct use of grammar, spelling and use of fonts.

Use of unambiguous language contributed to the effectiveness of a referral letter, according to participants. They noted that ambiguous language was problematic for the reader. For example, the writer of RL4, used the phrase ‘a small lump’ to describe the patient’s condition. Nurses 25 and 26 noted that ‘someone should pull out a ruler and measure’ because the description of the lump was not detailed enough. Ambiguity of language was also noted in RL6. Nurses 27 and 28 stated that they could deduce that the letter had been written by a junior doctor because ‘a senior doctor doesn’t write as vague (sic) as this’. From their perspective, the letter was written in ‘simple doctor terminology’, which did not meet professional standards. The participants suggested that this writing style would change as the doctor became more senior. When asked whether the vagueness stemmed from sentence structure or word choice, the nurses confirmed that the wording was problematic, and that it was essential to select appropriate and specific medical terminology which was suitable for the reader (Nurses 27 & 28).

A further example of vague language is the following phrase found in RL4: ‘a proximal paraumbilical non reduceable (sic) hernia appeared to be present’. Participants were especially concerned by the word ‘appeared’, as they believed that it conveyed ambiguity about whether the hernia was, in fact, present or not. One nurse commented that from a medical perspective, the hernia ‘is either there or it’s not’ (Nurse 6). Another
participant suggested that ‘good assessment (of the patient) is either it is or it isn’t…it’s not that vague, I suppose’ (Nurse 7). The nurses felt that the writer should have investigated properly which would demonstrate their professionalism.

Another example of problematic language evident in the letter which affected the perceived professionalism of the writer was the phrase ‘(the patient’s) urine output has only decreased significantly’ written in RL5. Nurses 15 and 16 suggested that the use of both ‘only’ and ‘significantly’ was confusing and that the words should not have been included in the same sentence. They were concerned that due to the presence of the word ‘only’, the phrase was nonsensical. The lack of a numerical figure for urine output was problematic as well. Furthermore, the participants pointed out that use of vague terms such as ‘a few weeks’ or ‘a few episodes’ were too non-specific when specific numbers should have been used instead. Time lines became ‘blurred’ and consequently, the reader was forced to ‘assume a few things’ about the patient’s history and current condition, rather than being presented with the facts, which was unprofessional (Nurses 15 & 16).

Correct use of grammar was identified by the nurses as being important so that letters could easily be read and understood. When they came across a referral letter with ‘poor grammar’, the errors made it difficult for the nurses to discern the writer’s meaning; thus, they felt the need to ‘keep reading over it to fully understand what’s happened’ (Nurses 11 & 12).

The nurses considered referral letter 3 (RL3) to be particularly poorly written, possibly due to the nurses’ perception that the letter lacked cohesion. Nurses 4 and 5 were taken aback by the writer’s grammar, using the exclamation ‘wowsers!’ (wow!) to express their shock. They commented that the letter was not ‘written as well as it could be’ but did not extrapolate further on reasons for this, although it was still possible for them to understand the essence of what the writer wanted and why the patient had been referred.
Nurses 4 and 5 suggested that the writer should have proofread the letter before sending it. ‘Poor grammar’ also arose as an issue for Nurses 11 and 12, whilst reading RL3. They were concerned that the letter did not ‘flow’ and was difficult to read as a result of the grammatical errors. For example, the writer stated in relation to the patient that ‘he has (rather than ‘had’) a mechanical fall in August 2012’, which caused the nurses some momentary confusion. Arguably, grammatical errors such as the example above should not cause too much confusion to the reader, especially as the date was also given. Nurses may have used the term ‘grammar’ when they were actually referring to other linguistic devices such as cohesiveness and coherence.

Correct spelling was also valued by participants. Spelling errors were perceived by the participants as being problematic. They were considered ‘unprofessional’ and something that could potentially be remedied by proofreading the letter before sending it (Nurses 25 & 26). When speculating about a particular spelling mistake in referral letter 2 (RL2) – ‘ther’ instead of ‘there’ – Nurses 17 and 18 suggested that the mistake could have either been ‘a reflection of the writer’s typing ability’ or the writer’s language background (i.e. speaking English as an Additional Language). Two participants were concerned that a ‘teenager’ had written RL2 due to the spelling and grammatical errors (Nurses 27 & 28); the term ‘teenager’ was used in a derogatory way to suggest that the writer did not have a proper command of English due to their spelling and grammar mistakes.

Although the spelling and grammar in RL2 was considered problematic, some of the participants were inclined to believe that the writer of RL2 had done little more than ‘type the wrong letters on the typewriter’ and had not proof read the letter sufficiently before sending it off (Nurses 17 & 18). Nurses 25 and 26 suggested that the spelling mistakes found in RL2 were likely to be ‘just a simple typo (typing error)’. 
Use of different fonts in typed and/or auto-populated letters was considered problematic by the participants. Referral letter 4 (RL4) was seen as ‘messy’ because the writer had copied and pasted various sections of other documents into the referral letter. (Nurses 6 & 7). Nurses 6 and 7 stated that the ultrasound reports that the writer had chosen to paste into RL4 were written in ‘old text’, which did not integrate well with the regular font used by the writer. Nurse 13 and Nurse 14 noted that the writer of RL4 had copied a whole page from a document by shrinking ‘the actual barriers (the perimeter) of the letter’ and pasting it onto the referral letter. The participants did not consider this to be best practice when it came to writing referral letters.

It is important to note that several of the nurses had strongly prescriptive attitudes towards the sample of referral letters and discharge summaries, choosing to focus on stylistic features such as grammar and spelling, rather than engaging with the documents at a functional level (e.g. considering whether or not the writer had achieved their aim in handing over the patient).

6.3.2 Methods for writing referral letters. As discussed in Section 2.3.5.1 of the literature review, hospital guidelines are put in place to assist referral letter writers with structuring their referral letters. The participants in the first focus group pointed out that there were specific guidelines for referral letter writing, which could be found on the hospital website, with the aim of ensuring that health professionals sending in referral letters were adhering to hospital policies.

6.4 Nurses’ Perspectives on Discharge Summaries

Even though nurses do not regularly write discharge summaries, the participants’ perspectives on and their evaluations of the discharge summaries are included in this thesis because recognising the features which are valued by nurses is expected to contribute to OET
writing test task development and to healthcare education for nurses and for doctors, who generally write discharge summaries, by providing them with details of the features that nurses find essential for optimal patient care.

6.4.1 Features of discharge summaries valued by nurses. Nurses valued several features of discharge summaries which are described in this section.

6.4.1.1 Abbreviations. Even though nurses do use some abbreviations themselves (Blair & Smith, 2012), the participants were unfamiliar with several of the abbreviations that they came across in the discharge summaries. The participants suggested that simple and commonly-used abbreviations were considered acceptable for use in discharge summaries (Nurses 29 & 30). Nurses 29 and 30 recommended that less-common abbreviations be written out in full. In response to DS3, Nurse 11 stated that ‘there’s lots of abbreviations being used, which can be good, but also there’s a few things that I don’t know as well’ (Nurses 11 & 12). When reading the second discharge summary (DS2), Nurses 4 and 5 speculated that the abbreviation ‘FPI’ was ‘some kind of acronym for focal point seizures’ but were not convinced that they had deduced the correct meaning of the abbreviation. Although the participants were not always able to decipher the abbreviations, they were under the impression that GPs, who were the usual recipients of the discharge summaries, would be able to understand them (Nurses 8 - 10). Nurses also routinely read the discharge summaries from the medical record.

6.4.1.2 Formality. The notion of formality was discussed in relation to DS1 and DS2 but was not specifically defined by the participants. Nurses 21 and 22 considered the writing found in DS1 to be effective because it was ‘formal enough’ but did not give an example or elaborate on what they meant by formality. In comparison, DS2 was considered less effective by the participants because ‘it seems very informal’ (Nurses 31 - 33). The example
given was that the writer had used the informal phrase, ‘please can her GP organise this referral’ and the nurses felt that it ‘should have been worded another way’ (Nurses 31 – 33). No suggestions were made about how the writer could have modified the phrase to make it more formal.

6.4.1.3 Structure and content. As in the sections pertaining to the structure and content of referral letters (Sections 6.3.1.1 and 6.3.1.5), structure referred to the layout and ordering of information, while content related to the information contained in the discharge summary. Discharge summaries that were ‘broken down into sections so you can easily see what you need to see’ were perceived most positively and bullet points was considered appropriate for discharge summaries (Nurses 8 - 10). For instance, the dot points in DS2 were seen as being effective because they ‘make it easier to read, it’s better than one big paragraph of information – breaks it up a bit’ (Nurses 31 - 33).

Discharge summaries in which the writing was spaced out well were considered to be most effective. According to Nurses 25 and 26, in the ‘on examination’ section, the writer of DS3 had ‘tried to fit a lot of information in three lines and it’s quite hard to read’. They suggested that perhaps the writer had purposely attempted to restrict the discharge summary to one page; however, in doing so, there was a limit to the information that could be provided for the reader (Nurses 25 & 26). Similarly, Nurses 13 and 14 recommended leaving enough space to include all relevant information about the patient’s care. They also suggested that documents including test results and medication lists should be attached to the discharge summary so that adequate information was provided.

Headings were also perceived positively. It was suggested that DS2 could have been further improved by incorporating headings into the document ‘so that you could just skip to the section that you wanted’ (Nurses 31 - 33). In DS3, the writer had further divided up the ‘examinations’ section of the discharge summary by labelling the examinations from A to D.
This system was viewed positively by participants because the sections were clear and it was easy to distinguish different types of information (Nurses 34 - 36).

Discharge summaries such as DS1 were viewed as being effective in terms of the content because the writer made mention of the problems and alerts, and the patient’s allergies and the blood results were listed in the medical history (Nurses 1 - 3). The inclusion of pathology and radiology results was also considered essential (Nurses 21 & 22), as was a list of medications (Nurses 29 & 30). The participants expected ‘nil’ to be written in each category if there was no information available (Nurses 27 & 28).

The content the writer had provided in DS2 was also viewed positively because the principal diagnosis was included, and the discharge summary contained recommendations and a detailed follow-up plan (Nurses 8 – 10). The participants suggested that although it was useful for the GP to be aware of what had been communicated to the family, the information was primarily included so that ‘the GP can reiterate it again to the family, reinforce it, like a duty of care’ (Nurses 8 – 10). When it came to DS3, the discharge plan was not as clear, which was flagged as being problematic for the reader. Nurses 27 and 28 raised a number of questions, which were not adequately answered by the writer, including: ‘Where (is the patient) going? (i.e. where are they being transferred or discharged to?), Do they need physio(therapy)? Do they need OT (occupational therapy)? Do they need further help at home if they’re going home?’ From the perspective of Nurse 27 and 28, the discharge summary would have been much more effective if the writer had attempted to include a more detailed plan for follow up.

6.4.1.4 Balancing comprehensiveness of information with conciseness. In a similar vein to referral letters, discharge summaries that were ‘detailed’ and ‘thorough’ were most valued by the participants (Nurses 4 and 5). Some participants suggested that discharge summaries such as DS3 gave the reader a ‘clear overview’ of the patient’s situation and were
therefore considered to be effective (Nurses 11 & 12). By including comprehensive information, the writer of the discharge summary 'paints a clear picture' of what the patient had experienced, how they have been treated and the outcome (Nurses 31 - 33). This was because the reader was able to understand ‘exactly what happened, what the injuries were, what was done, the management and the plan’ (Nurses 11 & 12). Similarly, DS2 provided the reader with an understanding of ‘what happened, how long it went for, what happened during and after and expected recovery’ (Nurses 23 & 24).

DS1, which described how a patient absconded from hospital and was later discovered in a Chinese restaurant, raised questions for the participants about the patient’s mental state. They pointed out that the writer had neglected to mention this extremely important information and suggested that it should have been included. Nurses 15 and 16 asked: ‘is he (the patient) really considered in a sound mind that they can’t somehow force him back? Yeah, so you’d like to have that information as well’. In addition, Nurses 21 and 22 suggested that the focus of the discharge summary should have been on the patient’s condition, rather than describing in detail what happened upon the patient’s discharge; therefore, the information provided was not comprehensive enough. Nurse 21 and 22 stated that ‘it would have been better to have fleshed that (the patient’ condition) out more but I can imagine that they would’ve all been stressed after he’s gone down to the Chinese restaurant’.

Discharge summaries that were concise and ‘straight to the point’ were also highly valued by the nurses (Nurses 29 & 30). Nurses 25 and 26 suggested that discharge summaries should be concise because further information was readily available for hospital staff in the medical record (e.g. the progress notes) if necessary. However, comprehensiveness of information was prized over conciseness. In other words, the participants preferred a less succinct discharge summary with superfluous information, as long as it contained all the key details.
6.4.1.5 Awareness of audience. The concept of audience awareness was discussed in relation to DS3. The writing was considered suitable if the discharge summary was solely being sent to the GP; however, if it was for the patient as well, there were too many abbreviations and ‘inappropriate language’ (Nurses 35 & 36). DS1 was considered appropriate for the target reader (the GP), because the information was valuable and could come in useful if the GP wanted to admit the patient to hospital in the future (Nurses 21 & 22).

6.4.2 Methods for writing discharge summaries. According to the participants, residents, including interns (less experienced doctors), were often responsible for writing discharge summaries. Generally, registrars (more experienced doctors) would look over the discharge summaries once they were written (Nurses 27 & 28). The participants stated that on occasion, interns were ‘overwhelmed’ by the amount of work they had to do, which, in turn, could affect the quality of their writing (Nurses 6 & 7). For example, the third discharge summary (DS3) used as stimulus material in the focus group sessions was written by an intern, who, according to the participants, was ‘trying to get out on time; he’s probably got another patient’; therefore, the writer had omitted the plan for follow up which led to some confusion for the reader (Nurses 6 & 7).

Information in discharge summaries was sometimes auto-populated from the patient’s medical record, as was the case with the first discharge summary (DS1), which included a serial number of some sort next to each item in a list of problems and alerts. Participants found the numbers to be ‘confusing’ and did not understand their relevance (Nurses 34 - 36). They speculated that the numbers could be hyperlinks or that they had come directly from a computer program; however, the presence of the numbers was ‘not relevant to whoever this is being sent to’ (Nurses 34 - 36). When asked about why the writer had chosen to include the numbers, the participants stated that the discharge summary had been auto-populated that
way and ‘it was easy’ for the writer; however, they believed that the writer should have ‘spent a little bit more time just deleting the unnecessary things’ (Nurses 34 - 36).

According to participants, once discharge summaries had been written, one copy was sent to the patient’s GP and a duplicate was placed in the patient’s hospital record (Nurses 1 - 3). At their hospital, the computer system was set up so that discharge summaries could automatically be sent to GPs and any other treating health professionals if the writer wished (Nurses 21 & 22). However, it was not always the case that the discharge summaries were actually sent out (Nurses 27 & 28). Additionally, nurses accessed the discharge summaries, which were often scanned electronically from hard copies into the system, but the text could sometimes become slightly blurry and the meaning could become ‘lost in translation a bit’ (Nurses 11 & 12).

6.5 Summary

The results of six focus group sessions, in which 36 nurses discussed and commented on a set of seven referral letters and three discharge summaries, were described in this chapter. The participants’ perspectives on the features of referral letters and discharge summaries that they valued the most were explored, as well as the methods for writing the two transition documents. In Chapter 7, themes from both the interviews and focus group sessions are presented in the form of a model of the qualities of referral letters and discharge summaries valued by nurses.
Chapter 7: A Model of the Qualities of Referral Letters and Discharge Summaries Valued by Nurses

7.1 Introduction

This chapter presents a model of the qualities of referral letters and discharge summaries which are valued by nurses. The model was developed through thematic analyses of both the interview and focus group data, with similar findings in both data sets. This is because the focus was on referral letters and discharge summaries, which are documents that share many similarities, and the participants in both the interviews and focus groups had similar perspectives regarding the qualities they valued. Referral letters and discharge summaries are both transition documents which are used to hand over care of the patient from one health professional to another. Consequently, it was possible to develop a single model for both genres.

7.2 A Model of the Qualities of Referral Letters and Discharge Summaries Valued by Nurses

The model shows the qualities of referral letters and discharge summaries reported by participants as being most essential to effective written communication (see Figure 23). The qualities, or characteristics most valued by the nurses were communicative competence, awareness of audience and clinical knowledge.

While awareness of audience is normally understood to be as aspect of pragmatic competence, (e.g. Bachman, 1990; Canale & Swain, 1980) for the purpose of the thesis, awareness of audience is presented separately in the model depicting the qualities of referral letters and discharge summaries valued by nurses. This is because it was an aspect of performance which was identified by the participants as being of central importance to the
effectiveness of referral letters and discharge summaries. In fact, according to the participants, one of the main purposes of writing referral letters and discharge summaries was to provide the reader with a ‘clear picture’ of the patient’s case, therefore taking into account what the audience needed to know and the best way to provide that information to them was essential.

Section 2.5.1 in the literature review provides a discussion of models of communicative competence. For the model presented in this thesis, communicative competence comprised three characteristics: formal competence (i.e. the form the language takes including grammar and lexis), use of professional language and pragmatic competence. Awareness of audience, the second characteristic, was demonstrated through clear and concise writing, and the inclusion of information relevant to the reader. Pragmatic competence, the final characteristic, encompassed address forms, politeness strategies and demonstration of authority.

The model depicts all three characteristics as being equal in value, with some overlap. For a referral letter or discharge summary to be most effective, all three characteristics must be present. For instance, if a referral letter or discharge summary writer demonstrates evidence of clinical knowledge but does not communicate this knowledge effectively or take into account their reader, the message is likely to get lost. Alternatively, if a writer shows a high level of communicative competence and awareness of their audience, but is unable to provide clinical reasoning and articulate evidence in relation to their clinical knowledge, the reader is not likely to act based on the recommendations of the writer.
Communicative competence

Clinical knowledge

Awareness of audience

Figure 23: A model of the qualities of referral letters and discharge summaries valued by nurses.

7.3 Communicative Competence

As discussed in Section 2.5.1 of the literature review, communicative competence refers to an individual’s knowledge of language and their ability to use it effectively (Douglas, 2000; Hymes, 1972). Hymes’ concept of communicative competence is a response to Chomsky’s generative grammar theory in which people’s ability to follow grammatical principles is considered innate, by emphasising the role of performance in a social and cultural context (Hymes, 1972). In a healthcare written communication context, communicative competence would be measured by how effectively writers are able to convey their message by drawing on contextually-specific and culturally-appropriate lexico-grammatical and other formal features (e.g. use of punctuation) to inform and communicate
with the reader. During the interviews and focus-group sessions, participants identified three main characteristics of communicative competence as being essential to effective referral-letter and discharge-summary writing: formal competence, use of professional language and pragmatic competence, which were non-hierarchical and considered to be of equal importance (see Figure 24).

![Figure 24: The three characteristics of communicative competence.](chart)

**7.3.1 Formal competence.** For the purpose of the current thesis, formal competence refers to how effectively grammatical structures, lexis, spelling and punctuation were used by referral-letter and discharge-summary writers. Participants reported that grammar and lexis, as well as spelling and punctuation, were integral components of effective referral letters and discharge summaries, and that these factors affected the overall clarity of the documents. For instance, incorrect use of verb tenses made it difficult to distinguish when treatment had taken place. Incorrect use of question marks made it a complex task for the participants to decipher what was expected of them in terms of providing further treatment to the patient.
The nurses noted that effective use of grammar, vocabulary, spelling and punctuation also contributed to the perceived professionalism of the writer.

7.3.2 Professional language. The participants valued effective use of professional language in referral letters and discharge summaries. The characteristic of professional language refers to how effectively the writer draws on and uses the professional register of lexis. It comprises the appropriate use of medical terminology, as well as abbreviations and acronyms. Participants reported that when excessive medical jargon was used by writers, the transition documents were not considered effective because they could not be deciphered easily by the reader. Conversely, when medical terminology was not drawn on adequately, the document was also not considered effective. Although appropriate use of medical terminology may be considered an aspect of pragmatic competence, use of professional language was flagged as being of utmost importance to the participants, thus, it is included as a separate characteristic of communicative competence in the model.

As the participants emphasised the importance of not overusing or underusing medical terminology, this suggests that there is point of equilibrium for use of medical terminology in referral letters and discharge summaries. The perceived competence of the writer rests on how effectively they draw on medical terms, abbreviations and acronyms to inform their reader(s) about the patient’s case.

7.3.3 Pragmatic competence. Although definitions of what constitutes pragmatic competence vary, after conducting an extensive literature search taking into account different models and research findings, Laughlin, Wain, and Schmidgall (2015) defined the concept as ‘mastery of strategically relating linguistic and nonlinguistic contextual information in order to generate meaning beyond the grammatical level in oral, written, or a hybrid mode of communication’ (p.19). One aspect of pragmatic competence which the nurses pointed out as being important was the demonstration of respect through writing. From the participants’
perspectives, the use of address forms such as ‘gentleman’ rather than ‘guy’ when referring to a patient and addressing the recipient as ‘dear doctor’, as well as politeness strategies including use of discourse markers such as ‘please don’t hesitate’ and ‘thank you for your ongoing care’, signified respect.

The participants noted that showing respect to both the reader and the patient - through descriptions of and references to the patient - was a key characteristic of effective referral letters and discharge summaries. Showing politeness to the reader through use of appropriate address forms and politeness strategies, meant keeping an adequate ‘social distance’ (Brown & Levinson, 1987), or as one of the interview participants phrased it, ‘maintaining good relations’, which could help facilitate collaboration and cooperation among health professionals. Additionally, demonstrating respect towards the patients was a means of facilitating patient-centred care.

Another aspect of pragmatic competence valued by the nurses was the demonstration of authority through writing. Evidence of authority in a written context is seen as ‘the ability of writers to construct a credible representation of themselves and their work, aligning themselves with the socially shaped identities of their communities’ (Hyland, 2002). Demonstrating authority in the context of referral-letter and discharge-summary writing is essentially the perception of how effectively the writer is able to convey their clinical knowledge and professional expertise through descriptions of the patient’s condition and treatment to date, suggestions for further treatment and instructions to the reader in relation to follow-up care. Referral letters and discharge summaries in which the writer was able to effectively establish authority were viewed positively by the nurses and were seen as being professional.
7.4 Awareness of audience

Awareness of audience was considered a key characteristic of effective referral letters and discharge summaries by the participants. They noted that for a transition document to be effective, the writer not only needed to take into account the intended reader (i.e. the doctor or team to whom the referral letter or discharge summary was being directly sent), but also a variety of other potential readers including nurses, allied health professionals such as occupational therapists and social workers, the patient, carers, auditors and lawyers. It was considered naïve of writers to assume that only the intended reader would have access to the referral letter or discharge summary.

Another quality identified by the nurses who took part in the current study was the importance of balancing comprehensiveness of information with conciseness to ensure that the reader would be able to take in information efficiently and effectively. The most successful referral letters and discharge summaries were those which included all aspects of information vital to the patient’s case but were written in a succinct way. According to the participants, achieving an equilibrium between these features was considered key in providing effective and efficient patient care, and could be achieved by taking into account what the reader, or audience, needed to know and how the information could be conveyed most concisely.

7.5 Clinical Knowledge

The participants identified the conveying of clinical knowledge as an important characteristic of effective referral-letter and discharge-summary writing. They suggested that the inclusion of relevant clinical information was essential, such as presenting significant test results, describing the severity of the patient’s condition if necessary, providing evidence of clinical reasoning including why the writer and health professional team had ruled out a
particular diagnosis, and suggesting a possible care plan based on their clinical understanding of the patient’s situation.

Although the clinical knowledge of the writer is a fundamental aspect of high-quality referral letters and discharge summaries, this particular characteristic of performance is not assessed by the OET. In design and by requirement, the OET is an English-language test and it was not developed with the aim of assessing clinical competence and medical knowledge. While the registration process in Australia requires that clinical knowledge be kept separate from the assessment of language and communicative competence, the findings of the current thesis show that it is not really possible to do so; referral letters and discharge summaries were only considered to be effective by the participants if the writer had an understanding of what was appropriate in a clinical sense. This finding is in line with Douglas’ perspective that ‘specific purpose language ability results from the interaction between specific purpose background knowledge and language ability, by means of strategic competence engaged by specific purpose input in the form of test method characteristics’ (Douglas, 2000, p. 40).

While the fundamental importance of clinical knowledge must be acknowledged in the writing of referral letters and discharge summaries, for the OET, ‘clinical knowledge’ is not able to be incorporated into the assessment criteria of the test at this stage due to government regulations.

7.6 Summary

This chapter presented a model which represents the features of referral letters and discharge summaries that are valued by the nurses who took part in this study comprising communicative competence, awareness of audience and clinical knowledge. In the following chapter, a discussion based on the findings of the current thesis is presented and recommendations are made about the OET writing test task and assessment criteria. In
addition, the concepts of washback, indigenous assessment criteria and cooperation between domain experts and linguists in relation to the findings are discussed.
Chapter 8: Discussion and Recommendations for Practice

8.1 Introduction

This discussion chapter focuses on the key research findings in relation to the relevant literature in the fields of both healthcare communication and language testing. Implications for practice in healthcare education and training, and in LSP test development are discussed. The first section considers nurses’ engagement with referral letters and discharge summaries, and the structuring of referral letters. The second section provides a discussion of the findings with regard to the OET writing task and assessment criteria. Notions of washback and indigenous assessment criteria in LSP testing are also explored. The chapter concludes with a discussion of the importance of collaboration and cooperation between domain experts and applied linguists in the development of LSP tests.

8.2 Healthcare Written Communication

Although the main aim of the current thesis was to gain an understanding of the qualities of referral letters and discharge summaries that nurses value in order to inform the OET assessment criteria and task for the writing sub-test, it is hoped that the findings will also contribute to the body of literature pertaining to healthcare written communication and health professional education and training. In this section, nurses’ engagement with referral letters and discharge summaries, and the structuring of referral letters are discussed.

8.2.1 Nurses’ engagement with referral letters and discharge summaries. As described in Section 2.3.5 of the literature review, doctors’ views on, and their practices in relation to referral letters and discharge summaries have already been investigated to some extent, whereas other health professionals’ perspectives on these documents have not been
extensively considered in the literature to date. As doctors have often been assumed to be the main or sole readers of these transition documents, nurses’ perspectives on and their interactions with referral letters and discharge summaries are yet to be documented adequately in the literature, or taken into consideration by OET test developers in relation to the nursing-specific writing test. This thesis provides the first in-depth investigation on how, when and why nurses engage with referral letters and discharge summaries, and the particular aspects that nurses value and draw upon in these documents to inform their clinical work.

One of the key findings of this study is that nurses do regularly engage with both referral letters and discharge summaries, in the sense that they read them and use the information provided in the documents to directly inform their clinical practice. The nurses who took part in this study considered both referral letters and discharge summaries integral documents to assist them in providing a smooth transition of patient care, in line with doctors’ perspectives discussed in the wider literature espousing the importance of drawing on these documents to provide coordinated transitional care (e.g. Coleman, 2003).

While referral letters and discharge summaries are important documents in that they facilitate smooth coordination of the patient’s care from one health professional (team) to another, the lack of reference in the literature to the interaction of health professionals from different disciplines with these documents, signifies a potential gap in the usefulness of referral letters and discharge summaries in the clinical setting which could be dealt with through healthcare education and training.

The notion of taking into account a range of readers when writing referral letters and discharge summaries could potentially be addressed through healthcare education, either as part of professional development in the clinical setting or within a medical or health professional tertiary-level course.
8.2.2 The structuring of referral letters. While the discharge summaries analysed for this thesis tended to be highly structured, with use of templates and headings, the structure of referral letters varied more. As discussed in Section 2.3.5.1 of the literature review, the research shows that there is some dissatisfaction with the quality of referral letters (e.g. Harwood et al., 2015). Vital details were sometimes excluded leading to medical errors, and the comprehensiveness of information was reported as lacking at times (Dickie et al., 2011; Tobin-Schnittger, O’Doherty, O’Connor, & O’Regan, 2018). Similarly, participants of the current study reported that referral letters were not as comprehensive as they should be, and that this lack of comprehensiveness affected their clinical work and their ability to care for the patient. One example of this lack of comprehensiveness is that some participants reported that they had to spend valuable time searching for information if it was not included in the referral letter, which impacted on the care they were able to provide to their patients.

The results of the genre analysis of referral letters demonstrate that referral-letter writers already follow a general structure when writing the letters, as evidenced by the moves and steps outlined in Section 4.4 of Chapter 4. They also used specific formal features typical of the genre. Although referral-letter writers do tend to follow a structure, albeit with some fluidity, the interview and focus-group participants felt that there was still too much variation in how referral letters were written and structured, and in the details that the writers chose to include or exclude. In light of this finding, it is recommended that guidelines are put in place, in a similar vein to the guidelines already established for discharge summary writing (ACSQHC, 2016), with the aim of ensuring that referral letters are comprehensive, relevant, well-structured and well-written to provide smooth and safe transitions of patient care.

Several interview participants suggested that the ISBAR structure, while predominantly used as an oral handover technique (see Section 2.3.4 for more details about ISBAR), would be a suitable basis for structuring a referral letter. In fact, the comparison of
the generic moves and steps of the referral letter with the standard ISBAR structure laid out in Section 4.7 of this thesis shows that there are many similarities, and that a large proportion of referral letters already loosely followed a similar structure to ISBAR. Therefore, state or nation-wide guidelines explicitly stipulating that referral letters and discharge summaries follow the ISBAR structure, with the inclusion of appropriate medical terminology, would lead to more effective transition documents. Similarly, other research studies (e.g. Manias et al., 2016), have also demonstrated a need to streamline communication techniques, including use of terminology and abbreviations, in health professional contexts.

ISBAR is already a familiar genre to the health professionals (the community of practice), who are likely to write and read this genre as part of their clinical work. This slight shift in the construction of the genre would be beneficial for clinical work in healthcare settings and would alleviate potential communication breakdowns, which is one of the positive outcomes of analysing and reinventing genres to create change in the workplace as described in the literature (Bhatia, 2013; Janicki, 2010).

8.2.3 The quality of referral letters and discharge summaries. Analyses of the samples of referral letters and discharge summaries showed that there was some variation in the quality of documents, and improvements were necessary. The interview and focus group results demonstrated there were several key qualities highly valued by nurses, as depicted in the model presented in Chapter 7. This model could be used as a tool to assist workplace educators in describing and discussing features of effective referral letters and discharge summaries in training sessions with nursing and medical staff to ensure that their writing of transition documents included these key characteristics.

The model could also be used to form the basis of a teaching tool for health professional students. Before entering clinical placement, health professional students could be taught how to include relevant information in referral letters and discharge summaries in a
concise manner, while demonstrating communicative competence and awareness of audience. The findings could also be used as a basis for developing a course module for nursing students on writing referrals to allied health professionals, so that when they enter the clinical setting as a nurse, they are already equipped to write effective referrals rather than having to learn on the job.

Both medical and nursing students could also be taught to take the reader into account in such ways as directly acknowledging the reader and using only widely-known medical terminology and abbreviations. Education sessions could be run collaboratively by both applied linguists and domain experts. The findings of this study have the potential to enhance health professional written communication and, consequently, to ensure that patient safety is prioritised by checking back with the patient that what has been written is accurate, comprehensive and current.

8.3 Specific-purpose Language Testing

The research findings of this thesis contribute to discussions of authenticity in the assessment of language for specific purposes. This section discusses and makes recommendations regarding the OET writing task and assessment criteria. Notions of washback, indigenous assessment criteria, and the cooperation and collaboration of domain experts and applied linguists are also discussed in relation to the thesis findings.

8.3.1 The stimulus material for the OET writing task. The results of this thesis show that nurses regularly read discharge summaries as part of their work. The OET writing task requires candidates to read and draw on information from a set of case notes as the basis for writing their referral letter. According to the health professional informants who assisted with the selection of documents for the focus groups, discharge summaries closely resemble the case notes. In addition, the sample of discharge summaries analysed for the current thesis
also resemble the case notes in terms of their content and structure. In light of this finding, it is recommended that the case notes remain in their current form as the stimulus material for the OET writing sub-test. Potentially they could be renamed ‘discharge summaries’ so that nurses more readily recognise the particular genre, although this is not crucial.

The participants suggested that in the clinical setting, they often skim and scan discharge summaries searching for pertinent details. Their reading is usually done in a short period of time and the nurses may refer back to the document as necessary. For the OET writing sub-test, test-takers are given five minutes reading time before they begin writing and can refer back to the case notes at any time throughout the test. This method is in line with what is occurring in the healthcare setting and thus, is highly authentic.

8.3.2 The OET writing task. As discussed in Section 5.2, the interviewees stated that they wrote referrals, which were short, internal documents sent to allied health professionals; however, they did not write referral letters except in rare circumstances, such as in rural settings when doctors were not available to write them. Although the nurses were not familiar with writing referral letters as required by the OET, they did engage with referral letters regularly in a clinical setting. Therefore, the nurses were familiar with the genre in a clinical context, in comparison to non-domain specific tasks which nurses would be required to write if they undertook a general-purpose language test.

A comparison of the sample of authentic referral letters (e.g. see Appendix H) with the OET writing test response sample (Appendix C), suggests that the two genres share many similarities. Therefore, the OET writing test currently requires nurse test takers to write a referral letter which bears similarity to the longer, more formally structured letters which the participants identified as being written by doctors. The majority of nurses interviewed did not have experience with writing this genre type at all; thus, it can be assumed that a substantial number of the OET nursing candidates would not be required to write referral
letters in this form as part of their clinical duties once they commence work in a healthcare setting.

If the perceived authenticity of LSP tests partly rests on the notion that the tasks should reflect what occurs in the domain (e.g. Bachman & Palmer, 1996; Elder, 2016), it is recommended that candidates undertaking the nursing-specific writing test write a referral instead of a referral letter, a genre which more closely resembles what nurses actually write in a healthcare setting. While writing a referral is an authentic nursing activity, there are some factors that would need to be taken into consideration by test developers. The participants described referrals as being predominantly electronic with frequent use of drop-down menus and minimal prose included. While the OET is currently not administered electronically, it is recommended that future iterations of the test include an option for test-takers wishing to undertake an electronic version of the test. Other English-language tests such as IELTS have recently started offering computer-based tests (Chen, 2019). It is therefore, a fair assumption that the OET will eventually introduce an electronic component and will, therefore, be able to offer test-takers the opportunity to write referrals as part of their writing test.

Although there would be limited opportunities to assess linguistic features such as use of grammatical structures due to the limited prose in referrals, there is still merit in including this highly authentic task, and communicative competence would still be assessable through the responses provided by the test-takers. Additionally, to ensure that there is sufficient language for examiners to assess, it is also recommended that a second task be added. Longer documents that nurses regularly write (e.g. progress notes) may be considered suitable. A second task would also promote positive washback. Arguably, the inclusion of two smaller tasks which nurses regularly write would be more in accordance with nurses’ writing practices in the clinical setting, and would enhance the authenticity of the OET writing test.
Understandably, there is more than just authenticity to take into consideration when developing and running a large-scale high-stakes LSP test. There are practical considerations as well, such as allocating resources and the cost of test development. Whether a change in the test task for the nursing candidates is possible would depend on a number of practical factors. Arguably, as nurses regularly read referral letters in a clinical setting, they do actually have some exposure to the genre; therefore, the current OET task which requires test takers to write a referral letter or similar would still be more familiar to nurses than a non-healthcare genre which would be required for general language tests such as the IELTS.

Through the design of profession-specific writing-test rubrics, the OET developers have already acknowledged that the communicative tasks are specific to the particular profession. Optimally, doctors sitting the OET would continue to write referral letters in accordance with the current OET test task, as the findings of this thesis demonstrate that doctors do regularly write referral letters; therefore, this is an authentic task for them. For the other ten health professions included in the test besides nursing and medicine, (e.g. dentistry, physiotherapy), it is recommended that research be conducted to identify whether or not referral letters are part of the clinical practice of these groups. It may be a time-consuming and costly endeavour for test developers and researchers, but the positive effects of the enhanced authenticity from the perspectives of test takers, their future employers and other stakeholders, could make it a worthwhile undertaking.

An additional finding of this study was that hospitals were moving towards electronic medical records and online communication. In fact, the majority of referral letters and discharge summaries analysed in Chapter 4 were electronic. In addition, participants reported that some of the communication breakdowns in clinical settings could be alleviated through use of electronic documentation (as discussed in Section 5.7). Although there would be
financial and practical implications to running a computerised test, it is recommended that OET developers consider this option.

8.3.3 The OET writing-test assessment criteria. As discussed in the literature review, the authenticity of a specific-purpose test such as the OET is enhanced by the inclusion of profession-oriented assessment criteria in that tests should reflect the qualities that are considered important by domain experts in the real life setting (Elder, 2016; McNamara, 1996). Prior to August 31st, 2019, the OET writing test criteria were as follows: overall task fulfilment, appropriateness of language, comprehension of stimulus, control of linguistics features (grammar and cohesion), and control of presentation features (spelling, punctuation, layout) (OET, 2019).

Although these criteria measure important aspects of communicative competence, they do not specifically take into account the features of referral letters which are valued by health professionals. However, according to the official OET website, the assessment criteria were updated on August 31st, 2019. There are six new criteria: purpose, content, conciseness and clarity, genre and style, organisation and layout, and language (OET, 2019). For the full public version of the new descriptors, see Appendix U. The update is due in part to the recommendations of a related research project investigating the views of health professionals and health information service managers regarding referral letters and discharge summaries (e.g. Knoch et al., 2015).

The OET website states that the criteria have been recently revised to ‘ensure that employers and regulators, like hospitals and health boards, continue to see successful OET candidates as effective communicators with the language skills needed to provide patient safety and high-quality care’ (OET, 2019). This is a positive development in terms of enhancing the authenticity of the test as it shows that domain experts’ perspectives have been taken into account in the development of the new assessment criteria.
The model presented in Section 7.2 of Chapter 7, depicts the qualities of referral letters and discharge summaries that are specifically valued by nurses. The nurses valued the characteristics of communicative competence, awareness of audience and clinical knowledge. Clinical knowledge cannot currently be assessed by the OET, as stipulated by the Australian Government. Consequently, it is the other qualities valued by nurses – communicative competence and awareness of audience – that this study suggests should be addressed through the assessment criteria of the OET writing test. The new criteria take into account factors relating to communicative competence and awareness of audience including appropriateness of tone and register (i.e. pragmatic competence), in relation to the document’s purpose and audience, and they address aspects of language proficiency (e.g. accuracy of grammar and appropriacy of vocabulary), which are in line with what the nurses who took part in this study valued. Table 29 shows a comparison of the thesis findings with the new OET assessment criteria. The thesis findings support and validate the new OET writing-test assessment criteria.

The results of this thesis also show that being able to strike a balance between conciseness and comprehensiveness of information is a key element of effective referral letters. The new OET assessment criteria include both ‘necessary information’ and ‘accuracy of information’ under the criterion of ‘content’, as well as the assessment of how effectively and clearly the patient’s case is summarised and whether or not irrelevant information has been included, under the criterion of ‘conciseness and clarity’. Therefore, the findings of the current study lend support and validation to the inclusion of these new descriptors.

Additionally, although the new OET assessment criteria separately address comprehensiveness of information and conciseness, it would be worthwhile considering the inclusion of an extra criterion that attends to how well the test taker actually balances these features. The participants of this study stated that maintaining an equilibrium was crucial.
and thus, it should be incorporated into the assessment criteria. This may be something OET test developers could consider for future iterations of the assessment criteria. Making amendments to the assessment criteria to take into account what nurses value would also further enhance the authenticity, and by extension, the validity of the test.

Table 29

Comparison of Thesis Findings with New OET Assessment Criteria

<table>
<thead>
<tr>
<th>What nurses value (thesis findings)</th>
<th>OET Assessment Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of audience</td>
<td>Purpose; Genre &amp; Style</td>
</tr>
<tr>
<td>Inclusion of comprehensive and concise information</td>
<td>Content; Conciseness &amp; clarity</td>
</tr>
<tr>
<td>Pragmatic competence (an aspect of communicative competence)</td>
<td>Genre &amp; style</td>
</tr>
<tr>
<td>Professional language (an aspect of communicative competence)</td>
<td>Genre &amp; style; Language</td>
</tr>
<tr>
<td>Formal competence (an aspect of communicative competence)</td>
<td>Language; Organisation &amp; Layout</td>
</tr>
</tbody>
</table>

**8.3.4 Washback.** As discussed in Section 2.5.3, test washback refers to the effect test preparation has on the practices of those preparing to take the test. Any changes made to the task or assessment criteria of large-scale tests will alter test washback. Based on the findings, one of the recommendations of this thesis is that the test task should be changed to mirror a task – or perhaps more than one task - which nurses regularly undertake in a clinical setting (e.g. writing referrals to allied health professionals and writing progress notes). Consequently, through preparing for the test, nurses would have more experience with writing relevant documents before they commenced work in a healthcare environment. However, it is worth noting that even if the task were to remain in its current form, the
washback in preparing for the test would still be positive for nurses in that they would have
the opportunity to engage with referral letters in the lead up to the test, as they would be
required to do in the clinical setting.

The current study supports and validates the new criteria which were rolled out on
August 31st, 2019, and it is expected that washback will be positive in that nurses will be
learning and attending to features that are essential to effective healthcare written
communication. There would also be implications for washback if the OET writing test
criteria were modified as per the recommendations laid out in Section 8.3.3. If a separate
criterion was added which addressed balancing conciseness with comprehensiveness of
information, in the lead up to the test, candidates would be likely to practise maintaining this
equilibrium, which would be intended to inform their practice once they were registered.

8.3.5 Research methodologies for establishing indigenous assessment criteria. As
described in Section 2.5.3 of Chapter 2, for LSP tests such as the OET, the inclusion of
indigenous assessment criteria, (i.e. what domain experts value and how they assess their
juniors in a natural setting) is a way of enhancing test authenticity. Although the data
collected for the thesis are not the basis for determining the criteria indigenous to the clinical
workplace because nurses’ feedback was not captured while going about their everyday
work, the research is still useful in determining the aspects of referral letters and discharge
summaries that nurses value. As described in Section 2.5.3, data collected regarding
participants’ perceptions through data collection techniques such as focus groups, can still
provide researchers with valuable insight into the features of communication valued by
domain experts (Elder & McNamara, 2015). This thesis was also a unique opportunity to
learn about nurses’ reading and writing practices, and the context in which they undertake
these practices, in relation to referral letters and discharge summaries.
8.3.6 Cooperation and collaboration between domain experts and applied linguists. Studies such as the current thesis and other research projects (e.g. McNamara et al., 2016) which aim to understand what domain experts value for the purpose of making recommendations about an LSP test, would not be possible without the cooperation and collaboration of domain experts and applied linguists. Even tasks which may be perceived as simple, such as selecting the stimulus material for the focus-group sessions, ultimately required both domain expert and applied linguist lenses.

Developing LSP tests which are perceived as being authentic requires specialised input from domain experts who are authorities in their field. They bring with them professional knowledge which applied linguists lack. As described in Section 2.6.1, it takes many years to become a fully-fledged member of a community of practice, and members regularly engage with particular genres; therefore, they have an understanding of how specific documents should be written and read, which applied linguists do not.

Applied linguists too, have strengths which can greatly enhance LSP test development and modification. Without being a member of the community of practice, they are able to view practices from a different perspective, to ask questions about what domain experts may not notice or take for granted after being part of the profession for an extended period. Applied linguists can consider communicative and pragmatic competence when designing tasks and developing assessment criteria; they have an understanding of the concept of test construct and how to develop test specifications, which domain experts may not be aware of.

Arguably, when developing or making recommendations about LSP tests such as the OET, it is crucial that domain experts and applied linguists work together. As a team, not only is the authenticity of the test enhanced, but the test construct is more likely to be in line with the expectations of stakeholders.
Collaboration also has implications for work readiness. Drawing on the example of the OET, it is expected that once test takers achieve the required grade on the test and then register in their country of choice, they have already acquired many of the skills necessary to communicate effectively in a clinical setting. When applied linguists and domain experts work together to (indirectly) prepare test takers for work (i.e. through washback), test takers are more likely to acquire the language that they need for the clinical setting. This acquisition is in line with studies that show that input from linguists, working alongside domain experts in university healthcare courses can adequately assist students from culturally and linguistically diverse backgrounds in preparing for clinical placements (e.g. Mikkonen, Elo, Kuivila, Tuomikoski, & Kääriäinen, 2016; San Miguel & Rogan, 2009).

8.4 Summary

This chapter has discussed how the findings contribute to the fields of both healthcare communication and specific-purpose language testing. Recommendations were made about the OET writing test task and assessment criteria, based on the interview and focus group findings about nurses’ reading and writing practices in relation to referral letters and discharge summaries, and the features of the documents which they value. The concepts of washback and indigenous assessment criteria were explored in response to the findings. Finally, the importance of collaboration and cooperation between domain experts and applied linguists was discussed. The next and final chapter describes the implications of the research and sets out the limitations. Suggestions for further research are also provided.
Chapter 9 - Conclusion

9.1 Introduction

This chapter provides a summary of the key findings. The limitations of the study are discussed, and the chapter concludes with recommendations for further research.

9.2 Summary of Key Findings

This thesis set out to investigate the context in which nurses read and wrote referral letters and discharge summaries, if at all. The results showed that nurses read discharge summaries to inform their work, and that discharge summaries were similar to the stimulus material for the OET writing test; therefore, the OET test task is highly authentic.

The nurses were found not to write referral letters, but rather, they sent internal referrals to allied health professionals. The referral letters which resembled the OET test task were written by doctors rather than nurses, however nurses did read referral letters routinely, which has not been addressed in the literature to date.

Nurses were most likely to read referral letters and discharge summaries when the patient was first admitted to their ward but would sometimes read them during the patient’s hospital stay if they needed to know further details about the medical history or condition. All nurses taking part in the study read referral letters to inform their work, and the majority regularly read discharge summaries. The participants used the information contained in the transition documents to assist them with their verbal handovers, as a means of enhancing patient care, and to inform and educate the patient about particular aspects of their condition and care.

The thesis also examined how nurses read referral letters and discharge summaries. They often scanned the documents searching for important information, such as the patient’s current medications, especially when the patient was first admitted, or when relevant.
information was missing from the progress notes. Nurses in management positions tended to read the documents in full.

The structure, content and key linguistic features of referral letters and discharge summaries were also investigated. Discharge summaries were highly structured, with writers tending to use templates and subheadings which were provided by the health service. In contrast, the structure of referral letters varied, with differences in paragraphing noted by the participants. Inclusion of relevant content such as past medical history, medications and allergies was essential in both documents. Referral letters tended to loosely follow the ISBAR structure.

Formal features were varied but many abbreviations and acronyms were found throughout the transition documents. Passive voice and use of note form were prevalent in discharge summaries, while referral letter writers were more likely to write in prose with the inclusion of expressions of empathy. Medical terminology was used frequently by both sets of writers.

Nurses valued similar aspects of referral letters and discharge summaries. They most highly prized communicative competence, awareness of audience and clinical knowledge. Communicative competence comprised the characteristics of formal competence, use of professional language and pragmatic competence. Being able to balance conciseness with comprehensiveness of information was a fundamental aspect of writing effective transition documents.

In terms of the methodology of the study, the focus-group and interview findings showed many similarities. The results of the current thesis have implications for the fields of healthcare communication, healthcare education and LSP assessment.
9.3 Limitations

There were a number of limitations that arose in the current thesis, which are discussed in this section. The limitations include the sampling of participants, the selection of stimulus material, interactions in the focus-group sessions, changes to hospital documentation, and the consideration of appropriate research methodologies for investigating indigenous assessment.

9.3.1 Participants. The current study focused solely on the perspectives of nurses in relation to referral letters and discharge summaries. Although the OET writing test task is profession specific (i.e. nurses are given a task that is deemed to be specific to nursing), there is only one set of criteria to assess the writing of candidates from all 12 professions. This means that a doctor will be assessed by the same criteria as a nurse. As only nurses’ perspectives were taken into consideration in the current thesis, and the assessment criteria are used to rate all the health professions, it is problematic to suggest that the OET assessment criteria should be adjusted solely in light of the findings. However, the findings are in line with the updated OET writing-test assessment criteria, which came into effect on August 31st, 2019 (see Appendix U), which were based on a study of doctors’ views. The findings of this thesis support the case for a single set of criteria, which is more practical than developing separate assessment criteria for each profession.

Another limitation was that the perspectives of nurses from only two public teaching hospitals were included in the study. Nurses working in private hospitals may have generated different perspectives to those in the public sector. In addition, both hospitals provided acute care. Those working in in geriatric rehabilitation hospital environments may have had varying experiences. While not feasible on a practical level for this thesis, different perspectives could also have been obtained with the inclusion of nurses from a variety of
healthcare settings such as those working on different wards (e.g. rehabilitation or paediatric wards), or in private hospitals and clinics.

Additionally, participants were not nurses who originally came from overseas. Overseas-trained nurses may have had different perspectives which would have enhanced the study.

9.3.2 Stimulus material for focus-group sessions and genre analyses. The stimulus material was limited in that only seven referral letters and three discharge summaries were selected for the focus-group sessions. A larger sample of transition documents may have further enhanced the findings of the study. However, the stimulus materials for the focus-group sessions were selected in collaboration with expert informants who had a clinical background, and the documents were selected with deliberation and care. In addition, the nurses had limited time available due to their busy schedules, which constrained the amount of material that could be presented and discussed.

The analysis of the first move in the referral-letter genre analysis (Establishing person, place and time), may have been hindered by not having access to patient and health-professional names in the referral letters due to the redacting process carried out by health-information officers at the hospitals prior to the student researcher receiving the medical records. Consequently, it was not possible to ascertain whether patients, doctors and other health professionals were referred to by their first or family names in the referral letters. If this study were to be replicated, it is recommended that the researcher ask the health-information officer in charge of redacting the information to make a note of whether a first or family name was used.

9.3.3 Nurses’ interactions in focus groups. Another consideration which bears similarities to the Hawthorne effect, in which participants’ behaviour is unconsciously modified as a result of being observed (Adair, 1984), is that the nurses participating in the
focus groups identified different salient features of referral letters and discharge summaries to
those they may have selected had they been undertaking practice in the workplace and
providing feedback to less experienced nurses (i.e. indigenous assessment practices). The
focus groups especially, occurred in a setting in which the participants interacted directly
with their colleagues, and in some cases with their seniors, which may have influenced the
types of features they chose to report on. Nevertheless, there was still much to be gained
from investigating nurses’ perspectives on referral letters and discharge summaries even with
these caveats.

During the focus-group sessions, nurses may have used the term ‘grammar’ when
they were actually referring to other linguistic devices such as cohesiveness and coherence.
During these focus-group sessions, facilitators did not clarify particular terms such as
‘grammar’ while participants were discussing documents, so that the flow of conversation
was not interrupted. However, clarifying ambiguous terms, or terms that the researcher
suspects may have different meanings for domain experts in comparison to applied linguists,
is recommended to alleviate misunderstandings by the researcher when analysing the data.

9.3.4 Changes to documentation in hospitals. Changes to documentation practices
are occurring at hospitals throughout Australia, especially in terms of switching to online
systems and to the use of electronic medical records. With the introduction of the National
Guidelines for On-screen Presentations of Discharge Summaries in Australia, (see Appendix
T for a sample of what is recommended), and a state-wide GP referral form in Victoria (see
Appendix A), it is clear that the healthcare industry is moving towards use of standardised
transition documents for health professionals. Nevertheless, variations are still likely to exist
between documents, and this research goes some way towards understanding how transition
documents can be written effectively.
9.3.5 **Indigenous assessment.** As described in Section 8.3.5, although the findings of the present thesis highlight the qualities of referral letters and discharge summaries valued by nurses, data collection techniques did not capture the indigenous assessment of nurses in a clinical setting (i.e. more experienced domain experts given feedback regarding writing practices to less experienced professionals). For the purpose of this thesis, it was not logistically possible to investigate indigenous assessment, and the results of this study are one step removed from what can be considered indigenous assessment. This methodological issue has been explored in earlier research on spoken clinical communication (e.g. Elder & McNamara, 2015; Pill, 2016). One suggestion to further enhance studies such as the current thesis is to include observation in the clinical setting as one form of data collection, which may lead to a deeper understanding of what domain experts value.

9.4 **Suggestions for Further Research**

There is much scope for further research in both the fields of specific purpose language testing and healthcare communication.

From a healthcare communication perspective, research investigating how and why different audience members (e.g. allied health professionals, patients or carers) engage with referral letters and discharge summaries, would lead to a deeper understanding of how the genres are read and used both in and out of the clinical setting, and their purpose. It would also be an opportunity to establish recommendations about how transition documents could best be written to ensure optimal patient care. Research investigating variations in the way that referral letters and discharge summaries are written at different hospitals could also be conducted.

From a language testing perspective, it is important to bear in mind that this thesis focuses solely on nurses’ perspectives on the qualities of referral letters and discharge summaries; however, the OET actually assesses the writing of eleven other professions. It
would be beneficial – although time consuming and costly - to conduct research on the qualities of referral letters and discharge summaries which other health professionals (e.g. physiotherapists or occupational therapists) value so that their perspectives could also be incorporated in the assessment criteria. This has been achieved to some extent through the wider project from which this thesis stems, in which doctors’ and health information officers’ perspectives on referral letters and discharge summaries were analysed, forming the basis for suggestions for revisions to the OET writing test assessment criteria. Nevertheless, the inclusion of health professionals’ perspectives from all twelve professions in the assessment criteria, and the development of profession-specific criteria, would further enhance the validity of the test, although the feasibility of this from the point of cost would have to be considered.

Conducting a think-aloud protocol with the writers of discharge summaries and referral letters would be useful in understanding why certain features of the documents are important. Potentially, a think aloud protocol could also be conducted with OET test takers to investigate whether or not they attend to the same features. The results of this study could contribute to assisting OET test takers to prepare for the test.

Further studies focusing on indigenous assessment would also provide an understanding of what health professionals value. Data could be collected through shadowing health professionals in the hospital setting and recording verbal and/or written references made in relation to referral letters and discharge summaries. Additionally, genre analyses, such as the ones undertaken for this study, could be conducted with input from domain experts. For example, after establishing the referral letters moves and steps (see Section 4.4.3), participants could have been asked to comment on the individual steps and moves that they considered fundamental to the referral-letter writing process.
Finally, further studies examining the collaboration between applied linguists and domain experts from an LSP assessment perspective are needed. An investigation of how the two cohorts interact, and the benefits (or pitfalls) of the collaborative processes should be explored in more detail. It would also be valuable to examine how applied linguists collaborate with different types of domain experts (health professionals, compared to accountants, for example).

9.5 Summary

The study centred around three data sets: interviews with nurses, focus group sessions with nurses, and genre analyses of referral letters and discharge summaries. The aim of the study was to gain an understanding of what domain experts value by investigating nurses’ perspectives on the qualities of referral letters and discharge summaries critical to effective communication. Based on the findings, recommendations about the OET writing task and assessment criteria were made, and the implications for LSP testing, healthcare communication and healthcare education were explored. This thesis has made a contribution to understanding domain experts’ perspectives with the aim of informing the assessment criteria and task of an LSP test. It also suggests that there is value in exploring domain experts’ perspectives outside the target language domain in more artificial settings, and that collaboration between applied linguists and domain experts is key in enhancing LSP tests.


References


Appendices
Appendix A: GP Referral Form from Networking Health Victoria

Clinical Information

**General practice referral**

*Purpose: to provide a standardised quality referral from general practice to other service providers*

**Warnings:**

**Allergies:**

**Current Medication:**

**Social History:**

**Past Medical History:**

**Investigations/Test Results:**

**Relevant plans (eg General Practice Management Plan, Team Care Arrangement, Mental Health Treatment Plan):**

**Referral Acknowledgment:** to be completed by agency/practitioner in receipt of referral

- To acknowledge a referral you have received, complete this section

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<tr>
<th>From</th>
<th>Name:</th>
<th>Position:</th>
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<tr>
<td></td>
<td>Organisation:</td>
<td>Phone:</td>
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<th>To</th>
<th>Name:</th>
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<tbody>
<tr>
<td></td>
<td>Organisation:</td>
<td>Phone:</td>
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<td></td>
<td>Email:</td>
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**Date referral received:**

**Status of referral:**

- Accepted
- Wait listed
- Rejected (note reason and suggested alternatives)

**Estimated date of assessment:**

**Contact person for further information:**

- As above (From details)
- New contact (Provide in notes)

- I agree to participate in the care of this patient under a Team Care Arrangement
<table>
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<th>Notes:</th>
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http://old.nhv.org.au/resource/40
Appendix B: Sample OET Writing Test Prompt and Stimulus Material

Read the case notes below and complete the writing task which follows.

Notes:
Mr Lionel Ramamurthy, a 63-year-old, is a patient in the medical ward of which you are Charge Nurse.

Hospital: Newtown Public Hospital, 41 Main Street, Newtown

Patient details
Name: Lionel Ramamurthy (Mr)
Marital status: Widowed = spouse dec. 6 mths
Residence: Community Retirement Home, Newtown
Next of kin: Jake, Engineer (37, married, 3 children <10)
Sean, Teacher (30, married, working overseas, 1 infant)

Admission date: 34 February 2014
Discharge date: 11 February 2014
Diagnosis: Pneumonia

Past medical history: Osteoarthritis (mainly fingers) = Voltaren
Eyesight ↓ due to cataracts removed 16 mths ago = needs check-up


Medical background: Admitted with pneumonia = acute shortness of breath (SOB), inspiratory and expiratory wheezing, persistent cough (→ chest & abdominal pain), fever, rigors, sleeplessness, generalised ache.
On admission = mobilising with pick-up frame, assist with ADLs (e.g., showering, dressing, etc.), very weak, ambulating only short distances with increasing shortness of breath on exertion (SOB OE).

TURN OVER
Medical progress:  
- Afebrile.  
- Inflammatory markers back to normal.  
- Slow but independent walk & shower/toilet.  
- Dry cough, some chest & abdom. pain.  
- Weight gain post tr/v by dietitian.

Nursing management:  
- Encourage oral fluids, proper nutrition.  
- Ambulant as per physio tr/v.  
- Encourage chest physio (deep breathing & coughing exercises).  
- Sitting preferred to lying down to ensure postural drainage.

Assessment:  
- Good progress overall

Discharge plan:  
- Paracetamol if necessary for chest/abdom. pain.  
- Keep warm.  
- Good nutrition – ↑ fluids, eggs, fruit, veg (needs help monitoring diet).

**Writing Task:**

Using the information given in the case notes, write a discharge letter to Ms Georgine Ponsford, Resident Community Nurse at the Community Retirement Home, 103 Light Street, Newtown. This letter will accompany Mr Ramamurthy back to the retirement home upon his discharge tomorrow.

In your answer:
- Expand the relevant notes into complete sentences
- Do not use note form
- Use letter format

The body of the letter should be approximately 180-200 words.
Appendix C: Sample OET Writing Test Response

https://www.occupationalenglishtest.org/
Appendix D: Interview Questions

I. Questions for nurses

A. General intro

Good morning/good afternoon. Thank you for taking the time to participate in this interview. It should take approximately 30 minutes. We are looking at the kinds of writing tasks health professionals in Australia are currently performing as part of their work. The reason we are doing this is because we are reviewing the writing section of the Occupational English Test which overseas medical professionals have to take before they can practise in Australia and we want to make sure that the test remains relevant.

• First of all, could you please tell me what your profession and specialisation is?
• How long have you been working in this profession?
• We are interested in finding out what kinds of things you regularly write, type or dictate for medical records, e.g. admission notes, referral letters, patient notes, etc. What sorts of things do you write in a typical work day?
• Are there any documents in the medical records which you don’t personally write but that you regularly read as part of your work? (Please include referral letters – see Section B ‘for reading referral letters specifically’).

B. Written documents in medical records

I’d like to discuss each of the documents you mentioned in more detail.

• In your opinion, what is the main purpose for writing [text type, e.g. referral letters]?
• Who are [the referral letters] written for? (i.e. who is the intended reader/recipient?).  
• Could you briefly describe the structure/layout of the letter?
• When you are writing a [referral letter], what kind of information do you need to make sure you include?
• What specific words and/or phrases are important to include?
• What do you think makes a good [referral letter]?
• Conversely, what would a badly written [referral letter] be like?
• What advice would you give to newly registered health professionals to ensure that they were writing effective [referral letters]?

[The above questions could be asked consecutively for each text type]

For reading referral letters specifically:

• [if the participant hasn’t mentioned referral letters] Do you read referral letters? [if participant responds affirmatively, please ask the questions below]
• When do you read referral letters? (e.g. at what stage of the patient’s admission/stay?)
• What are the main reasons you read referral letters?
• When you read referral letters, what kind of specific information are you looking for?
• Do you have a particular way of reading the letters? (e.g. first identifying the writer, then scanning to work out the treatment plan?)
• When you read a referral letter, how do you use the information in the letter? (e.g. making notes, then informing the doctor etc?) [encourage participant to describe the process from start to finish in detail].

C. Concluding questions

• Are there any issues with the writing of staff members from non-English speaking backgrounds?
• Is there anything else you would like to add about your experience with writing and/or reading written documents in medical records?

Thank you very much. We appreciate you taking the time to participate in this interview.
Appendix E: Codebook for Interview Data

Coding categories

1) Colour coding
   - Referral letters
   - Discharge summaries
   - Other handover documents
   - Documents (non handover)
   - Comments about written communication in general
   - Comments about writers from NESB
   - Communication breakdowns and follow up processes
   - Communication between doctors and nurses
   - Use of technology

2) Letter coding for referral letters, discharge summaries, handover and non-handover documents
   - S = structure
   - F = function(s)
   - M = method of writing
   - C = content (what information is included or should be included)
   - W = writer(s)
   - IR = intended recipient(s)
   - R = reader(s)
   - Q = qualities of effective documents
   - NF = negative features of documents
   - W/P = words and phrases included
   - T = time (when document is read by nurses)
   - St = style/method for reading document
   - Re = reason for reading document
   - U = use of information in document

Coding Category Definitions

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Example</th>
<th>Further information</th>
</tr>
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<tbody>
<tr>
<td>S (structure)</td>
<td>The structure and layout of the letter including paragraphing, order of information, dot points, tick boxes etc</td>
<td>P: Um, which will be Victoria-wide hospital transfer letter which has all the, it’s got lots of little boxes on it and then the, obviously name, address, date of birth, phone numbers up the top, then next of kin. They all have the same common themes, it’s, um, just that the one that we’re trialling now is a little bit more in depth.</td>
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</table>
| F (function/s) | The intended purpose(s) of the document | I: Okay.
P: And it does get filed in the medical record, so.
I: Okay, and, um, is there a section where you can write as well or is it just mostly ticking boxes?
P: Yeah, yep, so there’s a section on ours where it says ‘specific condition information’ or ‘specific treatment requirements’ or things like that and that’s where you can put anything it, that isn’t required on that letter, so, um. (L106 – 115)
I: Yeah, um, in, um, what do you think is the main purpose for writing discharge summaries?
P: Just so the idea, the, sorry, the um, the reason why the patient’s been in hospital is clear for the staff on the receiving end and GP on the receiving end. Most of our patients either go into our rehab facilities that we’re affiliated with or, ah, back to their homes. Um, we do get probably I’d say about 25 to 30 percent of patients that go home directly or, um, or go to other hospitals and that, in that case the discharge summaries are obviously sent on to other doctors, but.
I: Yes.
P: When it’s sent back to a nursing home and the GP only comes in once a week, if that, to see the patient or when required, they need to be able to pick it up and, and have a clear idea of what’s going on, especially with our hip and knee surgeries. (L327 – 336) |
| **M** (method/s) | Means of writing the letter including computer vs. handwritten, writing processes undertaken and procedures involved in writing the letter | P: Mm, nine times out of ten it’s typed. Occasionally I’ll get a hand-written one that’s very legible.  
I: Okay.  (L255 – 256) |
|---|---|---|
| **C** (content) | The information included in the document | P: Um, it generally has name, date of birth, address for the patient, um, it’ll have condition presenting with treatment so far, requirements or what they require us to do or what they want us to do for them.  
I: Yes.  
P: And then, you know, any pathology, um, or imaging attached to it hopefully, in a good one.  (L257-261) |
| **W** (writer/s) | The writer(s) of the document | P: No, so I generally get one from the nursing staff where the patient has been so this is, is an example if they’ve been transferred from another hospital, I’ll get a letter from the nurse that’s either been looking after the patient or the nurse in charge as a handover for myself.  
I: Okay, okay.  
P: Then there’ll also be a le-, a referral letter from the doctor that’s been treating the patient as well.  (L82-86) |
| **IR** (intended recipient/s) | The intended recipients of the document | P: Um, we do get probably I’d say about 25 to 30 percent of patients that go home directly or, um, or go to other hospitals and that, in that case the discharge summaries are obviously sent on to other doctors, but.  (L330-332) |
| **R** (reader/s) | The intended and incidental reader(s) of the document | P: Okay, so they’re for the doctors, but nursing staff accepting the patient would have a read because, you know,
| Q (qualities) | Features that make an effective document (e.g. referral letter) | P: Just be clear, um, don’t waffle, as I said a couple of times. Um, make sure you’re putting in exactly what you’ve done to treat the patient so that the doctor on the other end understands what has already been tried.  
I: Yes.  
P: And what has been done to fix the patient. So that if the, the problem arises again, we’ve got an idea of what or has already been tried and where to go next. (L376-381) |
|---|---|---|
| NF (negative features) | Features that contribute to an ineffective document (e.g. referral letter) | I: Mm, um, are there any other features of badly written referral letters that you can think of?  
P: Just the illegibility, um.  
I: Mm, can you tell me more about that?  
P: So doctors’ handwriting is not great. (L283-286) |
| W/P (words and phrases) | Particular words and phrases to be included in the document | I: And, um, what kind of, um, words or phrases are usually included in that section?  
P: Ah, things like, um, so there is a lot of information on our forms so we even, the only thing that wouldn’t be, that isn’t documented on that form is anything related specifically to an orthopaedic condition because it is a, um, hospital-wide form, it has to be applicable to every department. So in that specific, um, area, I guess you’d be writing ‘neurovascular status’.  
I: Mm. |
<table>
<thead>
<tr>
<th>Time (T)</th>
<th>The stage in the patient’s admission or stay when the document is read</th>
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<tr>
<td></td>
<td>I: Mm, um, and do you usually read referral letters, um, as soon as the patient is admitted or at what stage do you read them?</td>
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<td></td>
<td>P: So for the direct admits, I’m reading them as soon as they’re coming through the door so I can un-, get a bit of understanding about what’s going on, um, if it, you know, if it’s a C spine or something like that it’s very important to understand what’s going on so you can move them appropriately and not sit them up in bed in case you’re going to, you know, break their neck and. (L195-200)</td>
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<thead>
<tr>
<th>Style (St)</th>
<th>How referral letters are read</th>
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<tr>
<td></td>
<td>I: Okay, and do you have a particular way of reading the letters? So will you, um, try and skim through or scan for specific information?</td>
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<td></td>
<td>P: Not particularly no, just as long as it’s got enough, um, on it to identify the patient.</td>
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<td></td>
<td>I: Yes.</td>
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<td>P: I’m, I’m sort of happy with that and, and as long as I’ve got information that matches what the nursing transfer letter says, I’m happy with that.</td>
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<tr>
<td></td>
<td>I: Okay, oh so you compare the two letters then, do you?</td>
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<td></td>
<td>P: Yeah, someti-, someti-, yes, yes.</td>
</tr>
<tr>
<td></td>
<td>I: Mm, and, um, what kind of information do you compare?</td>
</tr>
</tbody>
</table>
| Re (reason for reading document) | Why referral letters are read by nurses | P: Well, I want to make sure I’ve got the right patient to start with (laughs).  
I: Yes, always important. (L217-227) |
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</thead>
<tbody>
<tr>
<td>U (use of information)</td>
<td>How the information contained in the document is used</td>
<td>P: ...we just, we sometimes just want to make sure we’ve got the whole picture correct and, and, um, everything’s right. (L185-186)</td>
</tr>
</tbody>
</table>
|                                 |                                        | P: And what I would do is if I had someone coming in that had an unknown ETA, I’d be reading that letter and then calling the doctor and saying ‘the patient’s arrived, this is what it says in the letter’ and that would give them some sort of sense of how urgent it is to come and see the patient.  
I: Mm.  
P: Whether it’s necessary for them to unscrub and leave theatre or whether it’s, you know, they’re medically stable at the moment, they can stay there. (186-192) |
Participant 23
Interview with registered nurse

I = Interviewer
P = participant

I: Okay, great. Um, and do you write any referrals?  
P: Uh, yes, yep. [W]
I: Okay.
P: We can do those or, but, we’ve also got the option now of doing them online.
I: Okay, so you can…
P: Yeah.
I: …Hand write them or…?
P: Yep.
I: …Do them online?
P: Yeah, yep. [M]
I: Um, and you mentioned that the doctors write discharge summaries.  
P: Yeah, yep. [W]
I: Um, so do the nurses not write the discharge summaries?  
P: Um.
I: Apart from in the notes?  
P: No. [W]
I: Okay.
P: Nup.
I: Um, okay, and, um, as part of your work as well, we’re interested in, um, finding out what you read.  
P: Mm.
I: Um, so, especially with handover documents.  
P: Mm hm.
I: So do you read the discharge summaries that the doctors write as well?  
P: Uh, usually you’ll get a good verbal communication...
I: Okay.
P: …Um, of what they want post discharge.
I: Okay.
P: Um, sometimes we’ll read it if the doctor’s not available.
I: Mm.
P: And then we’ll go through their notes to see what’s happening, what the plan is. [R + M + Re]
I: And do you read other discharge summaries? Say, if the patient’s been discharged from his hospital and then they come back into Emergency?  
P: Yep, definitely.
I: You do?
P: Yeah.
I: Okay.
P: Yeah, we have to do that, yep. [R]
I: Okay, um, and do you read referral letters as well?
P: Uh, definitely, yeah...
I: Okay.
P: ...Yeah, yep.
I: Okay, great.
P: Especially on triage. [R]
I: Okay.
P: Um, and, uh, also with, when we’re looking after the patient just to get a good idea of what’s, what’s their background is and why they’ve come in, yeah. [Re]
I: Okay, great, um, so let’s have a look at, um, the discharge summaries and referral letters in more detail.
P: Mm hm.
I: Um, so, um, in your opinion, let, let’s talk about the referrals that you write first.
P: Mm, yep.
I: Um, so what is the main purpose for writing that?
P: Uh, to, um, ensure that the patient’s supported before discharge. So we might be writing a referral to a, um, a post-acute care team or a district nursing service, uh, it’s more to make sure the patients have, has got follow-up care.
I: Okay.
P: Or we may need to get them seen in the hospital prior to discharge, so we’d, we’d, um, get a referral, write a referral or send that off before...
I: Mm.
P: ...They leave. Um, uh, it’s all about the holistic care of the patient...
I: Okay.
P: ...More than, more than anything, just to make, and to make sure they’re safe...
I: Mm.
P: ...For discharge.
I: Mm.
P: So, yeah, um, so we don’t just sort of fix the problem, we’re looking at the whole picture, really, yeah...
I: Okay, so...
P: ...A lot of the time. [F]
I: ...When, when you write those referrals...
P: Mm, mm.
I: ...What, what would you include?
P: Um, the diagnosis, the history, um, their, um, physical, um, what would you call it? Um, how mobile they are, what medications they’re on, uh, what else? Um, any alerts, allergies, um, um, whether they’re continent, incontinent, diet, yeah, pretty much the whole picture of, of what they’re like...
I: Okay.
P: ...While they’re a, an inpatient. [C + Q]
I: Okay.
P: Yeah.
I: And would the doctors read those as well or...?
P: Um, often the doctors will tell us to do the referral so...
I: Okay.
P: ...Um, yeah, no not, not, if they’ve told us, ‘can you please do a referral to physio?’...
I: Mm.
P: ...They’ll just let us go ahead and do it.
I: Mm.
P: Yeah, we don’t have to, you know, let them look at it or anything...
I: Yes.
P: ...Yeah, yeah. [M]
I: And you mentioned that sometimes they’re handwritten and sometimes they’re...
P: Yeah.
I: ...Typed onto the computer system.
P: Yep, yep.
I: Um, so what’s more common?
P: Uh, I think the ones on the computer are because it’s a new system.
I: Mm.
P: Patient, um, um, data system and I think, I wasn’t aware that there was one on the computer, a referral system, I’ve only just found that out.
I: Mm hm.
P: So prior to that I was handwriting and faxing them.
I: Mm, okay.
P: But...
I: And did you follow the same structure as, um, is on the computer?
P: I haven’t done one on the computer yet.
I: Oh, okay.
P: I only know that it’s there...
I: Yes.
P: ...And I haven’t learnt how to, how to do it. [M + S]
I: Okay, so when you write your referrals by hand, um, are they quite long and detailed?
P: No, no they’re quite, um, they’re split up into the different areas.
I: Yes.
P: Of history, um, history, um, diagnosis, that’s, that’s quick.
I: Mm.
P: That’s not an extensive thing but it’s very, um, succinct, like it’s, yeah, it’s, um, easy to fill in.
I: And do you write in full sentences or dot points...
I: ...Or abbreviations?
P: Uh.
P: Probably, uh, a bit of both. If I, if I’ve got a lot of history, I’ll do dot points...
I: Mm.
P: ...If, if, um, there’s something I really want to, to alert them about, I’ll get as much information in as I can. Yeah, but it sort of depends on how much you want to condense on the form, I think.
I: Yes.
P: Yeah.
I: And is it usually a page, just a page?
P: Yep.
I: Okay.
P: Usually a page. [S + M]
I: Okay, and are there any specific words or phrases, um, that you think are important to include?
P: Um, mm, well, I think, from a health perspective, there’d be their allergies.
I: Mm.
P: Um, and, no, there’s no specific phrases. I think everyone would write it differently, probably.
I: Mm hm.
P: Every nurse would have a different way of documenting it or, or writing it, so I just write it from what information I’ve got.
I: Yes.
P: Just sort of, uh, in a more brief form. [W/P + M]
I: And so there’s no prescribed structure...?
P: No.
I: ...Or way of doing it?
P: No, no, no, no, no, no. [S]
I: Okay.
P: No.
I: Okay, um, and, um, what do you think makes a good referral then?
P: Uh, as much history as you can get in there and, uh, as much information as, as you can, covering the whole, um, uh, what would you say? Well, covering all the areas of the patient’s care, [Q] cause a lot of the time we’ll read referrals and they won’t have things in like their medications or they won’t have in whether they’re mobile or, you know, whether they need walking aids...
I: Mm.
P: ...And that’s really frustrating, [NF + C] so I’m just conscious of the fact that you’ve got to get as much information in there as you can, yeah. [Q]
I: Um, so when you say sometimes there’s information missing...
P: Mm hm.
I: ...In referrals, do you mean the ones that you write or the ones...?
P: No...
I: ...That come in from doctors?
P: ...Ones that come in, yep.
I: Okay.
P: And nursing homes. [NF + W]
I: Oh, and nursing homes?
P: Yeah, oh yeah.
I: Who are those referrals written by?
P: Uh, the nursing staff...
I: Okay.
P: ...Or the PCAs that work in the nursing homes.
I: Okay, what does PCA stand for?
P: Um, patient care assistant. [W]
I: Okay, okay, thanks.
Appendix G: Audit Tool for Extracting Referral Letters and Discharge Summaries

Audit tool

This is the procedure proposed for the extraction of and removal of personal identifiers from documents that come from patient records which are appropriate for use in the study. The procedure is likely to be undertaken by a nominated staff member on behalf of the project team.

For the research, project team members are particularly interested in documents written by hospital staff (doctors or nurses in particular) with English as an additional language. The aim is to collect a series of documents to demonstrate the full range of writing skills ability. Document selection should therefore avoid having too many texts that might be considered as strong examples.

A. Document selection and extraction (90 records)
9. Open the patient record.
10. Check that there is at least one discharge summary or referral letter in the record.
11. Check that this does not use bullet points to structure the whole text.
12. Skim read the discharge summary/referral letter, remembering that the research team are particularly interested in examples where communication may be problematic.
13. Find out the date when the summary/letter was written and find any notes in the patient record that are associated with it (i.e., that provide information used in the summary/letter). These notes may be in the ‘diagnostics’ field. Note that the admission date may be about two weeks before the data of the letter.
14. Check that the content of the summary/letter and notes does not include sensitive information1. (Ethics approval has not been sought to access sensitive information held in patient records.)
15. Print one page of each of the following: admission notes, progress notes, outpatient notes, discharge and treatment summaries, referral letter.

B. Sub-set of document selection and extraction (10 records)
1. Open the patient record.

---

1 Sensitive information means information or an opinion about an individual’s:
• racial or ethnic origin; or
• political opinions; or
• membership of a political association; or
• religious beliefs or affiliations; or
• philosophical beliefs; or
• membership of a professional or trade association; or
• membership of a trade union; or
• sexual preferences or practices; or
• criminal record
from Victorian Specific Module Guidelines, November 2012
2. Check that there is at least one discharge summary or referral letter in the record.
3. Check that this does not use bullet points to structure the whole text.
4. Skim read the discharge summary/referral letter, remembering that the research team are particularly interested in examples where communication may be problematic.
5. Find out the date when the summary/letter was written and find any notes in the patient record that are associated with it (i.e., that provide information used in the summary/letter). These notes may be in the ‘diagnostics’ field. Note that the admission date may be about two weeks before the data of the letter.
6. Check that the content of the summary/letter and notes does not include sensitive information². (Ethics approval has not been sought to access sensitive information held in patient records.)
7. Print out the entire medical record

Removal of identifying features
8. For paper-based records, use a black texta to obscure any information in the record that would identify the patient or his/her carers. For electronic records, obscure information by inserting black rectangles from Microsoft Paint over identifying information including: the patient’s name and the names and signatures/initials of doctors, nurses, other healthcare providers and family members; house numbers and street names, postcodes; clinic and hospital names; telephone numbers and email addresses.
9. Do not delete titles (e.g., Ms, Dr) or general indicators of the types of information being removed. For example: Ms Olive Smith, Deer Park Clinic, Royal Talbot Rehab, 102 Berkeley Street, Melbourne VIC 3010, (03) 9035 9763, 0404 326543, jpill@unimelb.edu.au
10. Addresses and generic contact details for the institution where the data is being collected (e.g., included on letterhead) need not be deleted, as they are already known by the researchers.

---

² Sensitive information means information or an opinion about an individual’s:
- racial or ethnic origin; or
- political opinions; or
- membership of a political association; or
- religious beliefs or affiliations; or
- philosophical beliefs; or
- membership of a professional or trade association; or
- membership of a trade union; or
- sexual preferences or practices; or
- criminal record
from Victorian Specific Module Guidelines, November 2012
Appendix H: Stimulus Material for Focus Group Sessions: Referral Letters and Discharge Summaries

RL1
Dear Doctor,

RE: [Redacted]
DOB: [Redacted]
Ph: [Redacted]
Mbh: 0 (B): 0
MEDICARE: [Redacted] PRIVATE INSURANCE: None recorded.
VA: [Redacted] TAC: None recorded. WORKCOVER: None recorded.

Thank you for seeing Mrs. [Redacted], an 84-year-old lady has sever pain in neck with ongoing headache. She was there in last week in ED and since then she is not better and feels like 10/10 pain. I think she would need admission and further investigation. Appreciate your assessment and management.

PAST MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935</td>
<td>Tonsillectomy</td>
</tr>
<tr>
<td>1946</td>
<td>Appendicectomy</td>
</tr>
<tr>
<td>1969</td>
<td>Hysterectomy - Abdominal</td>
</tr>
<tr>
<td>1972</td>
<td>Bowel resection</td>
</tr>
<tr>
<td>1972</td>
<td>Motor car accident</td>
</tr>
<tr>
<td>1972</td>
<td>Splenectomy</td>
</tr>
<tr>
<td>1975</td>
<td>Vaginal repair - colpopexy</td>
</tr>
<tr>
<td>1988</td>
<td>Retinal detachment (Bilateral)</td>
</tr>
<tr>
<td>1990</td>
<td>Osteoarthritis</td>
</tr>
</tbody>
</table>
### CURRENT MEDICATIONS

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Strength</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACULAR EYE DROPS Eye Drops</td>
<td>5mg/mL</td>
<td>1 drop b.d. both sides</td>
</tr>
<tr>
<td>ASPIRIN Disp/Tablet</td>
<td>300mg</td>
<td>1 tab daily alt.d.</td>
</tr>
<tr>
<td>AVAPRO Tablet</td>
<td>150mg</td>
<td>1 mane</td>
</tr>
<tr>
<td>CELEBREX Capsule</td>
<td>200mg</td>
<td>1 noce p.r.n.</td>
</tr>
<tr>
<td>CELESTONE CHRONODOSE Sol for Inj</td>
<td>3mg-3.9mg/1mL</td>
<td>1</td>
</tr>
<tr>
<td>DITROPAIN Tablet</td>
<td>5mg</td>
<td>1 b.d.</td>
</tr>
<tr>
<td>EUTROXIXG Tablet</td>
<td>50mcg</td>
<td>1/2 tab alt.d.</td>
</tr>
<tr>
<td>EUTROXISG Tablet</td>
<td>100mcg</td>
<td>1 mane</td>
</tr>
<tr>
<td>EVISTA Tablet</td>
<td>60mg</td>
<td>1 daily</td>
</tr>
<tr>
<td>GANFORT Eye Drops</td>
<td>0.03%/0.5% (0.3mg-5mg/mL)</td>
<td>1 p.r.n.</td>
</tr>
<tr>
<td>LASIX M Tablet</td>
<td>20mg</td>
<td>1 mane</td>
</tr>
<tr>
<td>LIPTIOR Tablet</td>
<td>40mg</td>
<td>1 daily</td>
</tr>
<tr>
<td>NEO-B12 Sol for Inj</td>
<td>1mg/mL</td>
<td>1 each 3 month</td>
</tr>
<tr>
<td>NORMACOL PLUS Granules</td>
<td>620mg-80mg/g</td>
<td>6 tsp daily</td>
</tr>
<tr>
<td>NORMACOL PLUS Granules</td>
<td>620mg-80mg/g</td>
<td>1 tsp daily</td>
</tr>
<tr>
<td>Medicine</td>
<td>Dosage</td>
<td>Frequency</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------</td>
<td>-----------</td>
</tr>
<tr>
<td>OLIVE OIL IN AQUEOUS CREAM CREAM Capsule</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSTEOLIN VITAMIN D Gel</td>
<td>1,000 Units</td>
<td>1 daily</td>
</tr>
<tr>
<td>OXYCONTIN CR Tablet</td>
<td>10mg</td>
<td>1 b.d.</td>
</tr>
<tr>
<td>OXYCONTIN CR Tablet</td>
<td>40mg</td>
<td>1 b.d.</td>
</tr>
<tr>
<td>PANADOL OSTEOR Tablet</td>
<td>665mg</td>
<td>2 t.i.d. p.r.n.</td>
</tr>
<tr>
<td>SERETIDE ACCUHALER 250/50 Powder Inh</td>
<td>250mcg-50mcg/200mg</td>
<td>1 puff b.d. Rinse mouth with water after use.</td>
</tr>
<tr>
<td>TEGRETOL Tablet</td>
<td>10mg</td>
<td>1 every third night prn</td>
</tr>
<tr>
<td>TEMAZE Tablet</td>
<td>5mg/2.5mL</td>
<td>1 p.r.n.</td>
</tr>
<tr>
<td>VENTOLIN NEBULES Neb Solut’n</td>
<td>100mg</td>
<td>1 tab daily</td>
</tr>
</tbody>
</table>

INVESTIGATIONS

Yours sincerely,
26 August 2013
Dear Admitting team,

Thank you for sending...

He has insisted I write him a referral letter. This is the first time I have seen this gentleman. He is a usual...

His issues are chronic in the setting of recent financial stress.

He has a mechanical fall in August 2012 (seen at ....) where he had a hairline avulsion fracture of L tibia which was managed conservatively; he was transferred to inpatient rehab. In December 2012 he underwent an arthroscopy to remove loose bodies. Since his fall, he was initially mobilising with a 4WF then later upgraded to forearm crutches which is currently using now.

He is currently on the waiting list Category 2 at ..... Hospital for a RIGHT foot reconstruction. I am not really sure of the full details why.

He tells me he has had increasing pain in both feet and has had recurrent falls. He feels he needs to be reviewed by the ortho team again to upgrade his category.

Last week, another tenant at his shared accommodation broke into his room and stole all his money and medications. He now cannot afford any of his medications; and his pharmacy will not help him out in the meantime. He will probably need social work input.

Previous history includes:

Current Problems

29/10/2012          Cardiomyopathy - Non-Obstructive Hypertrophic Cardiomyopathy
17/11/2003          Hypertension
09/05/2003          Migraine
19/11/2004          Non-Phed
20/02/2003          Cerebral Disease
12/08/2002          Enuresis
17/10/2000          Right inversion deformity
Nurses’ Perspectives on Referral Letters and Discharge Summaries: Towards Profession-oriented Writing Test Criteria
Appendix H: Stimulus Material for Focus Group Sessions: Referral Letters and Discharge Summaries
19 February 2014

Gastroenterology Team

Bellevue Hospital, Melbourne

Re:

Dear doctor,

Thank you for seeing [BLANK] a 10 weeks old boy who presented to us with poor feeding and irritability associated with feeding, likely due to cow’s milk protein allergy.

[BLANK] was a term baby born via emergency caesarean section. He started breast-feeding however was a poor feeder, requiring NUT feeds overnight. He was discharged home on day 2 of age without further issues. [BLANK’s] mother, tried switching to formula feed and also lactose-free formula however he continues to feed poorly and is irritable. He also had a few episodes of blood-streaked stools in the past few weeks. He was treated on ranitidine but that did not help.

More recently, he has been feeding very poorly in the past 2 days, feeding only every 4-5 hours. His urine output has only decreased significantly. He had 2 episodes of vomiting one night. He was subsequently admitted to our unit for observation and management.

He is otherwise well with no other medical issues or regular medications. He does not have any significant developmental delay. His growth has slowed somewhat, only gaining 90g in the past 2.5 weeks, probably due to growth plateauing after an initial period of rapid growth. His immunisations are all up to date.

On examination, baby [BLANK] examines well. He was well hydrated and systemic examination was unremarkable. Stool and urine specimens were unremarkable. stool reducing substances are still pending.

Our impression at this stage is that [BLANK] may likely have cow’s milk protein allergy causing feed refusal. Since his admission, we have started him on Pepti-Junior.

We would appreciate your input regarding the suitability of elemental fully hydrolysed formula. Thank you for your care of this patient. Please do not hesitate to contact us should you require further information.

Kind regards,
27th March, 2014

Dear [Name],

Re: Mrs [Name]
Date of Birth: [DOB]
U.R.: [U.R.]

<table>
<thead>
<tr>
<th>Conditions / Past history</th>
<th>Medications at this visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain tumour (2002, low grade glicina)</td>
<td>Lamictal (lamotrigine)</td>
</tr>
<tr>
<td>Renal tumour (2004)</td>
<td>Nexium (esomeprazole)</td>
</tr>
<tr>
<td>Focal seizures (10 years)</td>
<td>Allopurinol</td>
</tr>
<tr>
<td>Elevated blood pressure</td>
<td>Vesicuro (sildenafil)</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Perindopril (perindopril)</td>
</tr>
<tr>
<td>Peptic ulcer disease</td>
<td>Vitamin D</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>nocte</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td></td>
</tr>
</tbody>
</table>

Lifestyle/family history
- No alcohol
- Non-smoker

Thank you for referring this 84-year-old woman who has problems with collapse over about the past few years. An event in July 2013 caused admission to the [Hospital]. The story is somewhat vague, but apparently (as documented by [Date]), she was standing by the bed, was a poor colour and fell back. There is perhaps some confusion. I understand there were more events in the early part of 2014.

She has nocturia of 1-2/night and thinks she passes more urine at night than in the day. She does not have heart failure. She has symptoms of sudden postural change, particularly after bending over to tie her shoe laces. She does not have haemorrhoids, hernias or varicose veins and does not have a history of increased joint mobility. She has not had migraines or a fatigue illness.

Her family history is that her daughter died from an astrocytoma and had a history of migraines.

The 24-hour ambulatory monitor showed mildly elevated systolic blood pressure with substantial reversal of diurnal variation and a fairly abrupt fall in blood pressure in the morning. I also measured the clinic blood pressure which was 128/62mm Hg when supine and reached a nadir of 94/52mm Hg during 5 minutes standing.
Summation: I think there is little doubt that these episodes of collapse are due to a problem with controlling her orthostatic blood pressure. The most common cause of orthostatic intolerance is autonomic nervous system dysfunction, but she does not have any evidence to suggest this or a good reason for it. An alternative, which we are increasingly recognising, is that some patients seem to have an abnormal vascular compliance. The only hint that she might have this is the family history of migraines. So at the moment, I don't think I can offer much in the way of a diagnosis.

I will investigate her by repeating ambulatory blood pressure monitor with a Holter device (in about one month from now), but in between times I think we should get moving with treatment. I have begun by adding a GTN patch which she will take at night, and hopefully will suppress nocturnal blood pressure and thereby suppress a nocturnal urine output. This is often associated with a substantial improvement in postural symptoms. I counselled her of the need for extreme care when arising to micturate at night (independent of whether she is taking the patch).

Yours faithfully,

Dr.
Outpatient Letter:

RE:  
DOB: 1957  UR:  
Ph:  

Date: 02/12/2014

Dear Dr. 

I am writing to inform you that I reviewed Mr. today in the medical suite. This gentleman is a chronic alcohol abuser and smoker who recently had acute pancreatitis. His triglyceride then was high at 4.24. He has not had further abdominal pain or steatorrhea since his discharge. However, he complained of pain over his glans penis.

Examination revealed inflammation of the glans penis with some shallow ulcers. I think this guy has balanitis. There could be Herpes infection on top. So I have started him on clotrimazole cream three times a day for two weeks and acylovir 400 mg tds for five days. As for the pancreatitis his abdomen today was soft but he had tenderness in the right iliac fossa and the periumbilical region. I am wondering whether he has pancreatic pseudocyst. I have therefore requested for lipase and amylase with abdominal ultrasound. Kindly discuss the result with him. If the ultrasound confirm the presence of a pseudocyst I think we need to alert the surgeons. However, I have encouraged him to continue to stay away from the alcohol. I have given him fenofibrate 145 mg daily for his triglyceridaemia because this could cause pancreatitis.

Yours Sincerely,

Electronically Signed by 
Dr. 03/12/2014 11:06 A
Dr. 
Consultant Physician

Job No: 
cc: 

284  Nurses’ Perspectives on Referral Letters and Discharge Summaries: Towards Profession-oriented Writing Test Criteria
Discharge Summary

* Final Report *

Document Type: Discharge Summary
Document Date: 07 Apr, 2014 16:00 AEST
Document Status: Auth (Verified)
Document Title/Subject: Discharge Summary
Performed By/Author: [Redacted]
Verified By: [Redacted]
Visit info: [Redacted]

Discharge Summary

Admission Information

URN: [Redacted]
Home address: [Redacted]
Home Phone: [Redacted]

HOSPITAL

ADMISSION SUMMARY
Unit: General Medical 5
Admitted: 28/03/2014 13:20

GP DETAILS
Name: [Redacted]
Address: [Redacted]
Phone: [Redacted]

DISCHARGE DETAILS
Discharge Date: 01/04/2014
Discharge Status: Patient discharged against medical advice.

Hospital Course
PRINCIPAL DIAGNOSIS
Liver decompenation - Principal Dx.

CLINICAL SYNOPSIS
73yo gentleman who p/w Sx suggestive of decompensated CLD was admitted over the weekend, seen by post-take round
seen briefly on Monday 1/4/2014 by home team but absconded later that day
search conducted + police contacted.

Wife's account:
Pt was sighted at a Chinese restaurant in [Redacted] where 2 wives went pickup but pt had taken taxi to daughter's
Discharge Summary

**Final Report**

- Patient's wife picked pt up there but pt not willing to go back to hospital.
- Wife happy to monitor and seek medical attention if needed.

Based on admission notes:
- Six signs suggestive of decompenated CLD. Home team planned ascitic tap post-USC and further tx and management of the decompenation.

**PROBLEMS & ALERTS**

- **All Problems**
  - COPD - Chronic obstructive pulmonary disease / 475423015 / Final
  - GORD - Gastro-oesophageal reflux disease / 353141019 / Final
  - Hyperlipidaemia / 497411018 / Final
  - Hypertension / 641760111 / Final
  - Infecious disease / VTE / Infecious disease / VR / Final
  - See Medtrak for details.
  - Myasthenia gravis / 151829017 / Final
  - Obstructive sleep apnoea syndrome / 200718012 / Final

**ALLERGIES**

- Allergic Reactions (All)
  - Unknown
  - ACE inhibitors - Unknown
  - Contrast media (iodine-based) - Hypotension due to drugs.
  - Reactions to Hyaluronidase due to drugs.

Canceller/Inactive Reactions (All)

- Unknown
  - Contrast dye - Hypotension, Cancelled due to duplication.

**PAST MEDICAL HISTORY**

- Active
  - Hypertension (641760111)
  - Hyperlipidaemia (487411010)
  - Gastro-oesophageal reflux disease (353141019)
  - Obstructive sleep apnoea syndrome (200718012)
  - COPD - Chronic obstructive pulmonary disease (475427019)

- Resolved
  - Mitral valve prolapse (208340111). Resolved.

- Comments:
  - 20/01/2012 AEDT 14:09 AEDT - Porcine valve in 10/2011

**Discharge Information**

**PRESCRIBED MEDICATIONS**
Appendix H: Stimulus Material for Focus Group Sessions: Referral Letters and Discharge Summaries

DS2

Document Type: Discharge Summary
Document Date: 00 Feb, 2014 10:37 AEDT
Document Status: Auth (Verified)

* Final Report *

Discharge Summary:

Admission Information

**ONN**
Home address: 
Home Phone:

DISCHARGE DETAILS
Discharge Date: 05/02/2014.
Destination on Discharge: Patient discharged to home.

Hospital Course
PRINCIPAL DIAGNOSIS
Epilepsy - Principal Dx.

CLINICAL SYNOPSIS
11 year old girl presented for fx and Mx of seizures.
- on 3/2 morning around 4am was woken up and told mum that her right eye was twitching, self-terminated after a few mins. She went back to sleep with all other episodes.
- Then later that morning, was woken up, and mum noted that in the way to school by bus around 8am, mum noted that she started to "stare into space" while sitting on bus, followed by upper part of body turning towards the right side with eyes focused on right side, then eyes twitching, followed by whole body shaking/jerking and very stiff, no tongue bite, no urinary incontinence. This episode lasted about 3-4 mins. With help from bus driver and other people on the bus, mum moved her to the ground, layed on her side, it took about 10 - 15 mins for her to recover and become responsive.
- For the past 2/3 during holiday period. Parents have noticed multiple episodes of "Staring/blanking spells", each episode lasted about several seconds, can happen non to multiple times a day, can recall some of the events.
- Denies myoclonic jerks.
- Was recently anxious about changing to a new school.
- Denies history of febrile convulsion, no family history of seizure/epilepsy, no trauma/injury/brain tumor.
- Has a history of soft murmur incidentally identified in 2008 which was investigated with TTE (normal) and followed by cardiologist review, deemed unremarkable.
- Normal pregnancy, was born two and half weeks pre-term, short period of jaundice, stayed in hospital for 4/7 without other medical issues.
- She has one older sister who's 17 years old, no history of seizure.

Printed by: 
Printed on: 06/02/2014 11:46
Page 1 of 3
(Continued)
Discharge Summary

On admission, neurology exam including cranial nerves, fundoscopy normal, bilateral UL and LL power/tone/sensation/reflex/cor-ordination normal.
- Blood test showed: Hb 134, WCC 5, plt 289, Na 140, K 4.1, Cr 60, LFTx normal, CRP < 0.3.
- 1st EEG on 3/2 showed
- 2nd EEG on 5/2 showed.
- MRI scan showed

Reviewed patient, commenced on Tegretol CR, discharged on Tegretol 100mg

ALLERGIES
Allergic Reactions (All)
Moderate
Cedol- Rash.

Discharge Information

HOME MEDICATION CHANGES
Change Details
Tegretol CR 100mg BD
Home Medication Changes Communicated.
PRESCRIBED MEDICATIONS
Discharge Medications as at 06/02/2014 16
Tegretol CR 100mg BD

FOLLOW UP RECOMMENDATIONS
and her parents have been given information regarding safety issues, including the need for one to one supervision when swimming and avoiding dangerous activities. She can return to school next week if she is well. She has also been advised to keep a seizure diary.

Her parents have been advised to call an ambulance should she ever suffer a convulsion lasting greater than five minutes.

AUTHOR

PLAN TO RE-ADMIT

Completed Action List

Printed by: [Redacted]
Printed on: [Redacted]

NB: Hospital did not include page 3
Appendix I: Focus Group Materials and Instructions for Facilitators

This pack contains:
- Background information – focus group participants x 12
- PICF x 12
- M80 referral letter for Phase 1 x 12
- Commentary notes sheet for Phase 1 x 12
- Facilitator prompts for Phase 2 x 8
- Focus group facilitator log sheet for Phase 2 x 12
- Task prompt, referral letters and medical records:
  - Incoming letters (pink) x 3
  - Outgoing letters + medical records (yellow) x 3
  - Discharge summaries + medical records (white) x 3

Instructions for materials

Set up
1. Ensure that each facilitator has a digital recorder and knows how to use it
2. Check that facilitators understand the focus group procedures
3. Give facilitators one facilitator log sheet for Phase 2 and explain how to fill it out
4. Ensure referral letters and discharge summaries (including attached documents from the medical records) and the task prompt are ready to be given to each group
5. Before the focus-group session starts, give participants one PICF and one background information sheet to complete

Phase 1
6. In Phase 1, distribute one commentary notes sheet and one M80 referral letter to each participant
7. Collect the commentary notes sheet and the M80 referral letter after Phase 1

Phase 2
8. Give each group a randomly selected referral letter or discharge summary; ensure that each group is given new referral letter or discharge summaries as required (once they have finished their discussion of the previous document)
9. Facilitators use the prompts to facilitate discussion about the letters and discharge summaries as necessary
10. Facilitators should also fill out the focus group facilitator log sheet during Phase 2

Wrap up
11. At the end of Phase 2, facilitators ask participants the following concluding questions:
a. Do the handover documents viewed in the focus-group session sufficiently represent those seen in daily practice?
b. Is there anything else the participants would like to add?

12. After Phase 2, collect all materials to give to the main facilitator
Appendix J: Facilitator Log Sheet

<table>
<thead>
<tr>
<th>Record Number:</th>
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<tbody>
<tr>
<td>Type of task: ☐ Incoming letter ☐ Discharge summary ☐ Outgoing or incoming hospital letter</td>
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<tr>
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</tr>
<tr>
<td>Other comments:</td>
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Appendix K: Background Information of Focus Group Participants

First name: 

Profession: 

Specialisation: 

Age (please select):

- □ 21 – 30
- □ 31 – 40
- □ 41 – 50
- □ 51 – 60
- □ 61 and over

Gender: 

Current workplace(s) and role(s): 

Years of experience in profession: 

If applicable, years of experience as educator:
Appendix L: Facilitator Prompts for Focus Groups

Facilitator prompts:

- Has the relevant info been included? (sufficiency)
- Is the info accurately represented? (accuracy)
- Is the ordering appropriate?
- Is the document detailed enough or too detailed?
- Is the writing appropriate for the target reader?

Other questions could be:
- Can you say more about that?
- How would you have formulated that?

Concluding questions at the end of Phase 2
- Do the handover documents viewed in the focus group sufficiently represent those seen in daily practice?
- Is there anything else the participants would like to add?
Appendix M: Participant Prompt – Incoming Letter

Imagine you are receiving/reading this handover document.

- How effective is it?
- Has the writer done what they need to do?
- Please comment on the strengths and weaknesses.
A junior doctor in your team has written a patient handover document and you are checking it before it is sent out.

- How effective is it?
- Are the key details (from the patient record) included?
- Please comment on the strengths and weaknesses.
Appendix O: Letters of Approval - Ethics

Date: 24 September 2014
To: [name redacted]
Project: Towards improved quality of written patient records: language proficiency standards for non-native speaking health professionals
HREC Ref No: [redacted]
Agenda Item No: [redacted]
Approval Period: 24 September 2014 to 24 September 2017

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<th>Version</th>
<th>Date</th>
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<td>1</td>
<td>17 March 2014</td>
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<tr>
<td>Interview Questions</td>
<td>1</td>
<td>17 March 2014</td>
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<tr>
<td>Audit tool for records</td>
<td>2</td>
<td>15 May 2014</td>
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<td>14 May 2014</td>
</tr>
<tr>
<td>SSA Application</td>
<td></td>
<td>26 May 2014</td>
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Further to my letter dated 1 May 2014 concerning the above detailed project, I am writing to acknowledge that your response to the issues raised by the Human Research Ethics Committee (HREC) at their meeting on 24 April 2014 is satisfactory.

This project now has full ethical approval and site authorisation for a period of three years from the date of this letter.

Before the study can commence you must ensure that you have (if applicable):

- Signed Clinical Trial Agreement
- Signed Standard Indemnities
- A copy of the CTN acknowledgment from the TGA. Please note a copy of the acknowledgement is to be forwarded to the site Research Governance Officer (RGO).
- For trials involving radiation it is your responsibility to ensure the research is added to the site Management Licence issued by Department of Human Services – Radiation Safety Section prior to study commencement should it be required (check your Medical Physicist Report). The site RGO must be notified when the research has been added to the licence.
- It is a requirement that a progress report is submitted to the Committee annually, or more frequently as directed. Please note a final report must be submitted for all studies. Should you plan for your study to go beyond the 3-year ethics approval, please request in writing an extension of ethics approval prior to its lapsing. If your study will not commence within 12 months, a request...
must be forwarded to the HREC justifying the delay beyond 12 months. Should such a request not be received, ethics approval will lapse and a resubmission to the HREC will then be necessary.
- After commencement of your study, should the trial be discontinued prematurely you must notify the HREC of this, citing the reason.
- Any changes to the original application will require a submission of a protocol amendment for consideration as this approval only relates to the original application as detailed above.
- Please notify the HREC of any changes to research personnel. All new investigators must be approved prior to performing any study related activities.
- It is now your responsibility to ensure that all people (i.e. all investigators, sponsor and other relevant departments in the hospital) associated with this particular study is made aware of what has been approved.
- In accordance with Sec 3.3.12 of the National Statement on Ethical Conduct in Human Research 2007 (Updated March 2014) – ensure the registration of clinical trials The International Committee of Medical Journal Editors (ICMJE) has adopted a policy that the member journals will only consider publication of clinical trials if the trial has been registered in a World Health Organisation (WHO)-accredited clinical trial registry. Trials can be registered with:
  - The Australian New Zealand Clinical Trials Registry (ANZCTR): http://www.anzctr.org.au
  - The ClinicalTrials.gov registry of the US National Institute of Health maintained by the National Library of Medicine: http://www.clinicaltrials.gov

The Committee wishes to be informed as soon as practicable of any untoward effects experienced by any participant in the trial where those effects in degree or nature were not anticipated by the researchers. The HREC has adopted the NHMRC Australian Health Ethics Committee (AHREC) Position Statement ‘Monitoring and reporting of safety for clinical trials involving therapeutic products’ May 2009

Please ensure you frequently refer to the Research Ethics website for all up to date information about research and ethical requirements.

I can confirm that at the meeting at which the above project was considered, the Committee fulfilled the requirements of the National Health and Medical Research Council in that it contained men and women encompassing different age groups and included people in the following categories:

<table>
<thead>
<tr>
<th>Chairperson</th>
<th>Lay Man</th>
<th>Lay Woman</th>
<th>Lawyer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person fulfilling a Pastoral Care Role</td>
<td>Person with Counselling Experience</td>
<td>Person with Current Research Experience</td>
<td></td>
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</tbody>
</table>

Additional members include:
- Other persons as considered appropriate for the type/s of research usually being considered

I confirm that the Principal Investigator or Co-Investigators were not involved in the approval of this project.
I further confirm that all relevant documentation relating to this study is kept on the premises of Austin Health for more than three years.

Yours sincerely,

Manager, Office for Research
Towards improved quality of written patient records: language proficiency standards for non-native speaking health professionals

Thank you for your letter dated 6th June 2014 which contains your responses to the Ethics & Research Committee's queries regarding your application as were included in my email dated 2nd June 2014.

Having read your responses I am satisfied that the project should proceed. On behalf of the Committee, approval for the project is given from 1 June 2014 with a completion date of 31 December 2016.

Please note that the following standard conditions apply to all projects approved by this hospital:

**Limit of Approval:** approval is limited strictly to the research proposal as submitted on your application.

**Variation to Project:** any subsequent variations or modifications you may wish to make to your project must be notified formally to this committee for further consideration and approval. If the committee considers that the proposed changes are significant you may be required to submit a new application for approval of the revised project.

**Incidents or Adverse Effects:** researchers must report immediately to the committee anything which might affect the ethical acceptance of the protocol including adverse effects on the subjects or unforeseen events that might affect continued ethical acceptability of the project.

**Auditing:** all projects may be subject to audit by members of the committee.

**Final Report:** a final report is to be received by the Committee before 30 June 2017.

Chair, Ethics & Research Committee
Appendix P: Plain Language Statement

Project title: Towards improved quality of written patient records: language proficiency standards for non-native speaking health professionals

INFORMATION ABOUT THIS PROJECT FOR PARTICIPANTS

Responsible researcher: Dr Ute Knoch
School of Languages and Linguistics
University of Melbourne 3010
email: uknoch@unimelb.edu.au
Telephone: (03) 8344 5206

What is the project about?

The aim of the project is to identify more professionally-relevant criteria for the Occupational English Test, an English test for overseas trained health professionals. This project has been approved by the University of Melbourne Faculty of Arts HEAG - Project no: 1544124.1

What will I be asked to do?

You will be invited to take part in a two-hour focus-group session in which you and other participants will be asked to review written handover documents (and associated patient records). You will be asked to comment on the strengths and weaknesses in the handover documents.

With your permission, the group and pair discussions will be recorded. You will be paid $200 as a token of appreciation for your participation in a two-hour focus-group session. We will ask you to sign a research consent form.

How will my confidentiality be protected?

The information you provide is confidential. We intend to protect your anonymity and the confidentiality of your responses to the fullest possible extent, within the limits of the law. Your name will not be used in any publications arising from the research and only the researchers will have access to the recordings from the focus group sessions. We will remove any references to personal information that might allow someone to guess your identity. The recording will be kept securely for 5 years and then destroyed.

What happens if I decide later that I don’t want to be involved?

Participation is voluntary. You can decide not to be involved at any time. In that case, we will not use the information you have given us.

Where can I get further information?
Should you require any further information, or have any concerns, please do not hesitate to contact [details above]. Should you have any concerns about the conduct of the project, you are welcome to contact the Executive Officer, Human Research Ethics, The University of Melbourne, on ph: 03 8344 2073, or fax: 03 9347 6739.
Appendix Q: Consent Form

Project: Towards improved quality of written patient records: language proficiency standards for non-native speaking health professionals

Name of participant:_________________________________________________

Researchers: Dr Ute Knoch, Assoc Professor Robyn Woodward-Kron, Assoc Professor Cathie Elder, Professor Tim McNamara, Prof Elisabeth Manias, Dr Eleanor Flynn, Ms Sharon Yahalom, Ms Annemiek Huisman, Mr Sim Davidson

1. I agree to take part in the project named above, which has been explained to me. A written copy of the information about this project has been given to me to keep.

2. I understand that my participation will involve reviewing written handover documents and the associated patient records and commenting on their strengths and weaknesses during a focus group with other health professionals and that the discussion will be audio-recorded, with my permission.

3. I have been told how the information I provide will be used and I now understand how it will be used.

4. As participation is voluntary, I know I can stop my involvement with this project at any time and I can ask the researcher to destroy the recording at any time.

5. I know this research is being done to identify more professionally-relevant criteria for the writing test of the Occupational English Test (OET). I understand it is not being done for any other reason.

6. I understand that what I say is confidential within the limits of the law. I know that my name and any names I mention will not be used in any writing about the research unless I ask to be identified.

7. I understand that the researcher will keep this form once I have signed it.

8. I understand that the project is for the purpose of research.

9. I agree to my discussion being recorded:

□ yes    □ no    (please tick √)

Signature: ___________________________________    Date: __________
### Appendix R: Codebook for Focus-group Data

#### Coding categories

1. **Colour coding**
   - **Referral letters**
   - **Discharge summaries**

2. **Letter coding**

   - **E** = Effectiveness of document
   - **Q** = Qualities of document
   - **NF** = Negative features of document
   - **In** = Inclusion of key details
   - **L** = Lack of key details
   - **LF** = Linguistic Features/comments about language use
   - **P** = Process(es) for writing document
   - **C** = Context in which document is written and/or read
   - **S** = Suggestions for improving document
   - **R** = Representative of documents in hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Example</th>
<th>Further information</th>
</tr>
</thead>
</table>
| **E** (effectiveness of document) | How well the referral letter/discharge summary accomplishes its purpose and produces the intended result (according to participants). | I: Mm. Do you think this letter achieves its purpose?  
   P: Probably, in a way, because it will still get put through because it’s got a primary diagnosis.  
   P: Investigation, yep.  
   P: And investigation to back it up.  
   I: Mm, so those are kind of the key details that are necessary?  
   P: Yeah.  
   (NW1_M52_N1_N2_N3, L20 – 25) | This category includes references to ineffective documents as well. |
| **Q** (qualities of document) | Features which positively contribute to the effectiveness of the document | P: All typed up nicely though (laughter). It’s nice and neat and easy to read.  
   I: Okay, so you definitely prefer typing?  
   P: Oh yes, absolutely.  
   (NW1_M12_N4_N5, L180 – 182) | |
| **NF** (negative features of document) | Features which detract from the | P: He hasn’t proof read it and just sent it off, like, and hasn’t really, like... | |
| In (inclusion of key information) | **important details from the medical record which are included in the referral letter/discharge summary** | P: It’s got recommendations and what the plan is and the information’s there. (NW2_M12_N8_N9_N10, L27) |
| L (lack of key information) | **important details from the medical record which are omitted from the referral letter/discharge summary but should be included** | P: So I just feel like there might be some details lacking.  
P: Yeah.  
P: Mm.  
P: Like what happened within that three days?  
P: Yeah.  
(NW1_M22_N1_N2_N3, L14 – 19) |
| LF (linguistic features/language use) | **how the writer uses language and writing conventions (e.g. word choice, punctuation)** | (example 1)  
P: It’s a little bit unprofessional to have, like I said, with the query not really sure why, like question mark.  
P: Yeah.  
P: Question marks, like that just shows that you actually couldn’t be bothered to really look into it. [use of question marks] (NW1_M19_N4_N5, L269 – 272)  
(Example 2)  
[discussing the phrase ‘hernia appears to be present’]  
P: Had appeared to be present? Had appeared to be present – hmm.  
P: Like, pres-, present or not? I don’t know.  
P: Yeah (laughs).  
I: So would you say that, um, is not phrased properly and how would you phrase it?  
P: It’s either there or it’s not.  
P: Yeah.  
P: Appears to be present.  
I: Mm. |
| **P** (process(es) for writing document) | Method(s) employed to write the referral letter/discharge summary | P: A lot of these programs, it’s all automatic.  
P: Yeah.  
P: So they would have a list that he would just go, insert this, like, he would...  
P: Mm.  
P: ...Probably just click on the computer and go, insert this information and it would just populate with...  
P: Mm.  
P: ...All the different ways he’s like, all the different things he’s been treated for. Which is a bit lazy but, yeah. (NW1_M19_N4_N5, L98 – 106) |
|---|---|---|
| **C** (context in which document is written and/or read) | Where the document is written and/or read; for example, general practice, in hospital, specific wards, e.g. Emergency Department. Also, specific ways of writing the document in the particular context. | P: Yeah, he’s in hospital, yeah.  
P: I feel it’s from a GP to a specialist.  
P: Why she went in in the first place. Did she have a big fall that caused her to go in? [NW2_M59_N8_N9_N10_L124 – 126] |
| **S** (suggestions for improving document) | Suggestions for how to improve referral letters/discharge summaries | P: But if he was referring to another facility...  
P: Yep.  
P: ...Then I would suggest he add investigations to the referral as well, which is quite important I think. (NW1_M19_N1_N2_N3, L63 – 66) |
| **R** (representative of documents in hospitals) | How similar the referral letter/discharge summary is to those typically read in hospital settings | I: Um, do the handover documents viewed in the focus group today, or here, um, sufficiently represent those seen in daily practice?  
P: Yes.  
P: Yeah. | This category relates to the follow-up questions asked at the end of focus-group sessions.
P: Yep.
I: Why?
P: Um, they’re ju-, they’re standard, most of them are standard, um, h-, how do you mean why, like?
I: No, that’s fine, that’s good.
P: It’s a hard question.
P: It’s true...
P: It’s standard.
P: ...Yeah, familiar, it doesn’t look like strange to us.

(NW2_final questions_N13_N14, L1 – 12)
Appendix S: Example of Coded Focus-group Transcript

I: Ah, this is M52, incoming letter. So you can just start talking when you’re ready.
P: Yep.
I: There’s some on the back too.
P: Oh right on.
[Discussion begins at 00:52].
P: So he’s on nothing pretty much? This is his only issue that he’s had, medical.
P: Well, either that or they haven’t filled it in.
P: They haven’t put it in.
P: Because they haven’t even filled, they haven’t filled in family and social history either, have they?
P: Yeah, true. No past medical history. I don’t know how old he is but if he’s, um, older, he might have a fair bit more co-morbidities.
P: He’s 1988.
P: Oh, 19-, 1988, oh okay, so he’s like your age.
I: So it sounds like lots of information is missing.
P: Mm? [L]
I: Um, what does that mean in terms of, um, for the person that receives this letter?
P: Um, the care’s a bit more difficult. Like you’re going to have to ask, I mean if he, like, for a referral, I don’t know if they’re already admitted or does the referral come first and then we admit them? Is that how it works?
P: Um, well it just means, I suppose that...
P: Well you could always ask them.
P: ...They’ll have to make further efforts to find out the history. [E]
I: Yeah, mm.
P: It’s just quite, um...
P: (Reading) I would appreciate your...
P: ...he mostly likely isn’t on any medications.
P: He’s only younger.
P: But the fact that they haven’t filled out the family and social history...
I: Mm.
P: ...Would sort of question, make you question whether they’ve just forgot to fill in these areas.
I: Mm.
P: Because that part should be filled in, I suppose. [L] Um, other than that, well they’ve got the ultrasound report on there. [In]
P: It’s got a new pain with it? Why is it bothering him? He’s just got a small lump. (Reads) appeared to be present.
P: Yeah, it’s fairly vague (laughs).
P: It’s very vague. [L + NF]
I: So what does...

P: In terms of, it’s, it’s quite clinical in like it’s, um, it’s just sort of stating what’s it, what it is, it’s not, um, really relating it back to the patient and what effects it’s having on them, I suppose.

P: Mm.

P: Like (name of other P) said it’s no, um...

P: Why is he coming?

P: ...Comment of pain, or, um...

I: Mm.

P: So he’s obviously had the hernia and he’s had the operation eight years ago. Now he’s got a small lump, like, that’s the reason he’s come in but is it bothering him? Has he got, like, pain or is it radiating or something like, something like that. So how effective is it? (Name of other P)? (Laughs).

P: What was that?

P: How effective is it?

P: How effective is it? Um.

P: Moderate, moderately. [L + NF]

P: Does ‘received in poor quality’ just means poor quality the way it’s been faxed?

I: Yeah, I think so.

P: Mm.

I: Yeah, I, I don’t, I think it means just the quality of the fax rather than, but yeah.

P: Okay, it’s good that they’ve put in, like they’ve done a little bit of investigation with the, um. [Q]

P: Like there’s no, um, I think there, there’s no blood results or paths or anything here is there?

P: Nope, they’ve only done the ultrasound, they haven’t done any, like, x-rays or yeah, like, bloods, see if any of his bloods are off. Just basic stuff. (Reading) referred for assessment and further management.

P: So in terms...

P: What do you want us to assess? [E]

P: Yeah, in terms of this, they’re, it looks like they’re all, they’re diagnosing.

P: Apparently, (name of other P).

I: So they’re diagnosing, thanks. They’ve diagnosing, um, but is that not enough information for the reader? Or is it done...?

P: (Reading) it says ultrasound, so ultrasound is picked up.

P: I think to rule out other things as well it needs to be a broader history, I’m not, I don’t know...

I: Mm.

P: ...I would think. [L]

P: Seeing you’ve never met this person before, this is all you’re getting from them.

P: Yeah.

P: Not really much to go on. [E]

P: I suppose with the history of, um, an umbilical hernia, there’s a fair chance it could be the, p...

P: Could be something else.

P: ...Could be something else.
I: Mm.
P: Eight years ago.
P: Mm.

I: So are there any strengths to this letter then or is it not very well written?
P: I mean, it’s good that they put the radiology report in. [Q]
I: Mm hm.
P: Um, they haven’t been, well, I mean they’ve said thank you for seeing this person but I don’t, I don’t know, I have no idea about referrals but I probably would want a bit more information...

I: Mm.
P: ...Regarding the patient. [Q + L + NF]
I: How about the structure as well, so different fonts and, um...
P: Yeah.

I: ...Different sections, can you comment on that?
P: It’s a little bit, sort of messy.
P: That’s a bit, like, it’s copy and paste from, like, they’ve copied and pasted from...
P: I don’t know why these ultrasound reports still use this old text (laughter).
P: Yeah, I know. [P + NF]
Appendix T: Sample Discharge Summary in the National Guidelines for Onscreen Presentation of Discharge Summaries
Appendix A: Sample discharge summary

![Discharge Summary Table]

Patient details:
- **Bernice VANK**
  - Date of birth: 21 Jan 1980 (60y)
  - Female
  - 276 Flinders Street, Melbourne, Victoria, 3000, Australia
  - Phone: (03) 9288 3487 (home)
  - ISBN 975141
  - Tel: 1254 9638 9753 2984

Hospital details:
- Roxboro Hospital, Eastern Health District
  - Melbourne, Victoria, 3000, Australia
  - Phone: (03) 9699 5466 (workplace), (03) 9895 5461 (fax)

Ceased medicines:
- **digoxin** - tablet - oral
- **potassium chloride** slow K - tablet - oral

Reasons for ceasing:
- Bradycardia
- Hyperkalaemia

Alerts:
- Nil known

Recommendations:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Person responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP and medication review</td>
<td>Dr Andrew SMTH</td>
</tr>
<tr>
<td>Wound review of laparoscopy sites and removal of 1 suture each site</td>
<td>Dr Andrew SMTH</td>
</tr>
<tr>
<td>Review bloods taken on 7 Mar 2016</td>
<td>Dr Andrew SMTH</td>
</tr>
<tr>
<td>Follow up fasting glucose of 6.9 with outpatient OGTT</td>
<td>Dr Andrew SMTH</td>
</tr>
<tr>
<td>Please organise ECG 1 day prior to appointment with Prof Jones at 2 weeks post-discharge</td>
<td>Dr Andrew SMTH</td>
</tr>
<tr>
<td>Discuss with patient re lifestyle management and care planning - obesity, hypertension, Atrial Fibrillation, Congested Cardiac Failure Body Mass Index 30, waist 88cm</td>
<td>Dr Andrew SMTH</td>
</tr>
<tr>
<td>Follow up pending results of bloods</td>
<td>Dr Andrew SMTH</td>
</tr>
</tbody>
</table>

Follow-up appointments:

<table>
<thead>
<tr>
<th>Description</th>
<th>When</th>
<th>Booking status</th>
<th>Name</th>
<th>Location</th>
<th>Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow up with cardiologist regarding Atrial Fibrillation (AF) and Congested Cardiac Failure (CCF)</td>
<td>2 weeks post discharge</td>
<td>booked</td>
<td>Prof. D JONES</td>
<td>Roxboro Hospital, Eastern Health District, private room</td>
<td>(03) 9699 5466</td>
</tr>
<tr>
<td>Surgical outpatient department - post-appendectomy review</td>
<td>4 weeks post discharge</td>
<td>booked</td>
<td>Mr. Tao YOUNG</td>
<td>Roxboro Hospital, Eastern Health District</td>
<td>(03) 9699 5466</td>
</tr>
</tbody>
</table>

Information provided to the patient:
- Advised no vigorous exercise or lifting more than 10 kg for 4 weeks, increase exercise slowly and no driving for 6 weeks
- To complete courses of augmentin duo forte and flagyl
- Information provided regarding wound management - keep sites dry and observe for signs of infection until reviewed by GP
- Follow up with GP Dr Andrew SMITH on 16 Mar 2016
- Follow up with cardiologist Prof D JONES in 2 weeks
- Follow up with surgeon Mr Tao YOUNG in 4 weeks
Appendix T: Sample Discharge Summary in the National Guidelines for Onscreen Presentation of Discharge Summaries

Appendix U: Public Descriptors of New (post 31/08/2019) OET Assessment Criteria for the Writing Sub-test
<table>
<thead>
<tr>
<th><strong>Criterion</strong></th>
<th><strong>Description</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Helps the reader get a quick and precise sense of what is asked of them. Due to time constraints, health professionals want to understand the purpose behind a written handover document (e.g. referral letter) very quickly and efficiently. This criterion therefore examines how clearly the writing communicates the purpose of the document to the reader. The purpose for writing should be introduced early in the document and then clearly expanded or elaborated (often near the end of the document). The purpose should be easily and immediately identifiable to the reader, so there is no need to search for it. For example, a writer might at the beginning of the letter write “I’m writing to you today to refer patient X who is now being discharged from hospital into your care.” Later in the letter, specific instructions for the healthcare professional on continuing care should be listed.</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>Considers necessary information (audience awareness: what does the reader need to know?) Consider accuracy of information The content criterion examines a number of aspects of the content: All key information is included. Information is accurately represented. Audience awareness is key here. The writing needs to be appropriate to the reader (and their knowledge of the case) and what they need to know to continue care.</td>
</tr>
<tr>
<td><strong>Conciseness &amp; Clarity</strong></td>
<td>Considers irrelevant information (audience awareness: what doesn’t the reader need to know?) Considers how effectively the case is summarised (audience awareness: no time is wasted) Health professionals value concise and clear communication. This criterion, therefore, also considers: whether unnecessary information from the notes is included and how distracting this may be to the reader, i.e. Does this affect clarity? Is there any information that could be left out? how well the information (the case) is summarised and how clearly this summary is presented to the reader.</td>
</tr>
<tr>
<td><strong>Genre &amp; Style</strong></td>
<td>Considers the appropriateness of features such as register and tone to the document’s purpose and audience. Referral letters and similar written handover documents need to show awareness of genre by being written in a clinical/factual manner (e.g., not including personal feelings and judgements) and awareness of the target reader through using professional register and tone. The use of abbreviations should not be overridden thereby assuming common prior knowledge. If written to a medical colleague in a similar discipline, then judicious use of abbreviations and technical terms would be entirely appropriate, but if the medical colleague was in a totally different discipline, or a letter was from a specialist to a GP, more explanation and less shorthand would be desirable. If the target readership includes the patient, the information must be worded appropriately, e.g., minimising medical jargon.</td>
</tr>
<tr>
<td><strong>Organisation &amp; Layout</strong></td>
<td>Considers organisational features of the document. Health professionals value documents that are clearly structured so it is easy for them to efficiently retrieve relevant information. This criterion examines how well the document is organised and laid out. It examines whether the paragraphing is appropriate, whether sub-sections within the document are logically organised and whether key information is clearly highlighted to the reader so that it is not easily missed. The criterion also considers whether the layout of the document is appropriate.</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td>Considers aspects of language proficiency such as vocabulary, grammar, spelling, punctuation. Health professionals are concerned with linguistic features only to the extent that they facilitate or obstruct retrieval of information. This criterion examines whether the language is accurate, used appropriately and whether it interferes with reading comprehension or speed.</td>
</tr>
</tbody>
</table>
Appendix V: Conference Presentations, Publications and Awards

**Conference presentations**


**Publications (as part of the wider project)**


**Awards**

**Student travel award** (2016), Language Testing Research Colloquium, Palermo, Italy.

**Australian Postgraduate Award Scholarship** (2013 – 2016), The University of Melbourne.

**Nursing Departmental prize for the best presentation** (2014), Melbourne School of Health Sciences Research Higher Degree Colloquium, The University of Melbourne.
Author/s:
Yahalom, Sharon

Title:
Nurses’ perspectives on referral letters and discharge summaries: Towards profession-oriented writing test criteria

Date:
2019

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