

TITLE

Correspondence from specialist surgical outpatient clinics to general practitioners

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This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: [10.1111/ans.14510](https://doi.org/10.1111/ans.14510)

Written correspondence from medical specialists to general practitioners (GP) serves not only as a communication and educational tool, but is also important documentation for clinical, medico-legal and research usage.[1] In the Australian healthcare system, where specialty care is provided on a referred basis, this potentially assumes even greater importance. However, there is only limited data on how consistently and based on what underlying factors outpatient clinic visits result in GP correspondence.[2] To assess this, we undertook an ethics approved audit of a weekly uro-oncology clinic over a six-month period.

Patients attending this clinic are seen by doctors at various levels of seniority (surgeons, registrars and residents), who usually enter clinical information into an electronic medical record (EMR) accessible only by hospital staff. A letter to the GP based on this information may also be dictated and subsequently transcribed, with a copy appearing in the EMR. If a letter is not dictated, the GP has to rely on the patient and/or family members for information regarding the clinic visit.

Data collected in this study by retrospective chart review included patient age and sex, treatment stage and progression of disease at the time of review, and time to next appointment. Clinic doctors were individually assessed for rates of GP correspondence in de-identified fashion but coded by seniority –

the number of patients seen by each doctor in clinic was also recorded as a covariate. Other factors that could potentially impact letter dictation such as inclusion in the multi-disciplinary meeting (MDM), which follows the outpatient clinic, as well as discharge from clinic, were included. Comparisons between doctors and treatment stages were undertaken using the chi-squared test, while associations of covariates with the dictation of a GP letter were analysed using logistic regression, with statistical significance set at $p < 0.05$.

At 25 clinics over the study period, 1012 outpatient visits were recorded, with 662 (65.4%) resulting in a GP letter being dictated. Patients were more likely to have GP correspondence if the clinic review documented progression of disease (70%) or results from specific investigations (92%), but less likely at the pre-treatment (51%) or first post-treatment (57%) review, $p < 0.0001$ (Table S1). Significant variations were also noted in the proportion of patients for whom each doctor dictated a letter, ranging from 13.5% to 100% ($p < 0.0001$), although there was no significant association noted with seniority level. Inclusion in the MDM, number of patients seen at clinic and time to next appointment (Odds ratio [95% Confidence interval]: 0.39 [0.23 – 0.66], 0.92 [0.87 – 0.97] and 1.09 [1.03 – 1.15] respectively), were univariately found to have a significant impact on GP correspondence, but age, gender or disease type were not. On multivariate analysis, treatment stage was no longer found

to be a significant predictor, patient numbers was borderline, but all other associations remained significant (Table S2).

This study documents that, although a majority of clinic visits result in written correspondence to the patients' GP, a concerning proportion do not. There were predictable determinants of letter dictation such as clinic workload and clinical scenario. In particular, clinical complexity warranting MDM inclusion, as well as the potential uncertainty of management plan in these cases appears to preclude a letter being dictated from the clinic visit in many instances. It is hoped that as per best practice recommendations, the MDM discussion is appropriately documented and communicated to the GP, but this was not evaluated in this study. There also appears to be significant individual variation between doctors, but with no apparent relationship to seniority level.

It would be of interest to obtain further data from other settings and specialties for a more comprehensive assessment, but it is probable that our findings are fairly representative.[2] The lack of GP correspondence can pose significant barriers to effective patient care, since the GP is usually central to most patients' healthcare – especially in cancer management. Increasingly, GPs are involved not only in co-ordinating care, but also implementing many aspects of management, particularly cancer follow-up.[3] Adequate communication is key to facilitating such “shared care” – even if a GP letter

from every specialist clinic visit may be neither achievable nor necessary. It should also be recognised that it is not sufficient to just ensure a letter is sent – the quality of its contents also matters,[4] although we were not able to assess that in this study.

Nonetheless, efforts are needed to optimise correspondence to GPs. Realities of clinical workloads and complexity may be difficult to alter, especially given potential resource limitations. Individual variation among doctors is potentially amenable to attitude change through educational efforts and/or institutional guidelines or protocols in some instances. Additionally, the increasing implementation of structured electronic medical records often incidentally provides the capacity to automatically generate form letters incorporating standardised fields from the medical record. In our experience, this is already frequently used for inpatient discharge summaries, but could also generate GP correspondence from the clinic notes, potentially overcoming many of the barriers identified in our audit.[5] This may have the added benefits of necessitating greater standardisation of clinical documentation (e.g. by use of drop-down menu options where appropriate), reducing resource requirements for the transcription and transmission of letters, and facilitating subsequent clinical audit and research.

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LIST OF SUPPORTING INFORMATION

Table S1: Characteristics of clinic visits and rates of GP letter dictation

Table S2: Association of co-variates with GP letter dictation