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General practitioners' reflections on referring: An asymmetric or non-dialogical process?

OLAV THORSEN^{1,2}, MIRIAM HARTVEIT^{1,3} & ANDERS BAERHEIM¹

¹Department of Public Health and Primary Health Care, University of Bergen, Norway, ²Stavanger University Hospital, Stavanger, Norway, and ³Research Network of Integrated Care in Western Norway, Helse Fonna HF, Haugesund, Norway

Abstract

Objective. Identify and describe general practitioners' (GPs') reflections on and attitudes to the referral process and cooperation with hospital specialists. **Design.** Qualitative study using semi-structured focus-group interviews with GPs analysed using Giorgi's method as modified by Malterud. **Setting.** Interviews conducted over four months from November 2010 to February 2011. **Subjects.** 17 female and 14 male GPs aged 29 to 61 years from 21 different practices, who had practised for 3–35 years. **Main outcome measures.** Description of GPs' views on the referral process. **Results.** GPs wished for improved dialogue with the hospital specialists. The referral process was often considered as asymmetric and sometimes humiliating. GPs saw the benefit of using templates in the referral process, but were sceptical concerning the use of mandatory fixed formats. **Conclusions.** The referral process is essential for good patient care between general practice and specialist services. GPs consider referring as asymmetric and sometimes humiliating. The dichotomy between the wish for mutual dialogue and the convenience of using templates should be kept in mind when assuring quality of the referral process.

Key Words: Family practice, general practice, general practitioner, Norway, qualitative research, referral process

Introduction

In most Western countries, we have two levels of care, the primary health system with general practitioners (GPs) and hospital specialist health care. Communication from GPs to hospital takes place mostly in terms of a referral letter. This describes a wish or need for a further examination or treatment of the patient that the GP cannot give, and is the document that hospital specialists use for the assessment of necessary medical examination and to prioritize patients for treatment in hospital. In Norway, a country with five million inhabitants and four thousand general practitioners, the GPs produce approximately 1.9 million referrals per year to the specialist health care services [1]. In 2011 there were over 280 000 persons on waiting lists for assessment and treatment [2].

Research shows that referral patterns and rates vary greatly [3]. Possible reasons for this may be: characteristics of the patient (age, gender, social, education, occupation), pressure from and expectations of patients, characteristics of the physician (age, gender, years in practice, size of practice, belief in

self-knowledge, willingness to deal with uncertainty), organization of medical practice, the number of consultations and list size, access to specialists and assessment of necessity and relevance for examinations and treatment. National laws and regulations may also have imperative impacts on the referral process, waiting times and clinical pathways for patients [4].

Hospital doctors have complained about the poor quality of referral letters [5], and have claimed that this, among other things, may lead to longer waiting times for investigations and treatments in hospital, with implications for the health and well-being of the patients [6]. Many hospitals have long waiting lists for examinations and treatment. Studies on the referral process have shown that there is a considerable potential for quality improvement in this area [7]. So far no definite correlation has been found between the quality of referrals and the final outcome of treatment in hospital. Training and guidance from hospital specialists are proved to have a positive influence on making general practitioners better equipped to provide medical treatment through increased confidence

- The referral letter represents a wish or need for an examination or treatment that the GP cannot give the patient.
- GPs want improved dialogue with the hospital specialists.
- GPs see referring as asymmetric and sometimes humiliating.
- Referral templates can be useful, but not as mandatory fixed formats.

in their own knowledge [8]. Exercises in procedures and use of clinical guidelines are helpful in the referral decision [9]. The number of inappropriate referrals can be reduced through postgraduate training and the establishment of formal and informal communication channels between GPs and hospital specialists [10–12]. Continuous medical education can have a significant impact on diagnosis, treatment and referral practice. Based on this knowledge, many aspects of the referral process need to be further elucidated, as regards both sending and receiving. In our study we have focused upon the sender. The aim was to identify and describe general practitioners' (GPs') reflections on and attitudes to the referral process and cooperation with the hospital specialists.

Material and methods

We used focus-group interviews [13] to obtain data regarding views on the referral process from a strategic sample of Norwegian GPs after having received their informed consent. This was achieved after recruiting four separate groups of GPs in 2010 by e-mail to the leaders of certification and re-certification groups for the speciality of general practice in the southern part of Rogaland County in Norway. A total of 31 GPs (17 female and 14 male) aged 29 to 61 years from 21 different practices, who had practised for three to 35 years, volunteered to participate. Two of the groups consisted of experienced GPs from the city of Stavanger (130 000 inhabitants), one group consisted of young GP speciality candidates from the whole region, and one group comprised experienced general practitioners from rural practices. To obtain a range of views, GPs of different experiences, practice types, and locations were sampled until sufficient data were collected for saturation to occur [14]. The first author conducted the interviews during the period from November 2010 to February 2011. He informed participants about the study, and invited them to an open discussion regarding the referral process and different aspects of content and structure of the referral letter. The interviews lasted 1–2 hours, and were audio-recorded

and fully transcribed verbatim. The data were analysed by systematic text condensation using Giorgi's phenomenological method as modified by Malterud [15]:

- (1) getting an overall impression;
- (2) identifying meaning units and coding relevant elements for the referring process;
- (3) abstracting the individual meaning units;
- (4) summarizing and labelling the GPs' views, searching the entire transcripts for accuracy.

At each of the four analytic steps, the three authors first analysed the data individually and then contested each other's analysis and reached a mutual basis for further analysis and final consensus on the results.

Results

Referring is not a simple mechanical process, but a complex interaction influenced by different factors. We found that GPs are using the referral letter for different purposes: a request or requisition for a special diagnostic assessment or medical treatment that the GP cannot perform him/herself for his/her patient, an invitation to have a second opinion on a clinical problem, and a wish for mutual responsibility for the medical handling of a patient.

GPs and responsibility in the health system

The GPs expressed a responsibility towards both the patient and the medical system. It is important when making specifications for referrals to consider the workload related to these. GPs are facing long waiting lists for hospital examinations and treatment, and therefore try to avoid unnecessary referrals. They sometimes felt squeezed between the patients' wants and the professional considerations of a clinical problem. Several GPs mentioned pressure from the patient as a reason to refer. One of the younger GPs said:

If a patient urges me to make a referral, I do so instead of arguing with the patient. (Male, 34 years)

The younger doctors in particular mentioned this as a reason for a referral. They refer to satisfying the patient, and being afraid of losing a good doctor–patient relationship.

You refer to satisfy the patient. Otherwise you may ruin the good doctor–patient relationship. (Female, 33 years)

The doctors who worked at a longer distance from hospital (more than 30 km or 30 minutes' drive)

experienced more often that patients prefer to have an assessment or treatment locally, rather than having to travel to a hospital specialist.

An asymmetric process

Many of the GPs expressed a feeling of an asymmetric process regarding referring. The relationship between hospital specialists and GPs was described as top-down. This appears in several of the interviews. Many felt that new clinical pathways and administrative procedures were forced upon them, and that they had not been included in the decisions concerning the necessary information in the referrals. GPs described the referral process as secretarial work for the hospital doctor. One of the experienced GPs described this as:

There is something hierarchical about it. It seems like some hospital specialists think that the GPs are further down in the system and literally do preliminary work, to make the job easier for them. (Male, 55 years)

The fact that a referral letter can be rejected leaves the feeling that this was done pro-forma and not as genuine dialogue. Having a referral letter back with a following letter indicating low quality or missing information was regarded by many as humiliating. One of the experienced GPs said:

You refer because you don't manage something. If you have the referral refused, you are left empty-handed. It's nice to have a proposal on what to do next. (Female, 52 years old)

There was a fear of sending inappropriate referrals, especially when these were the result of patient demands. There was also frustration concerning information in the referrals not being read, i.e. when hospital specialists ask for information that is already in the referral letter. It is considered a professional imbalance when the referring doctor expresses a need for speedy or urgent help, and the hospital specialist puts the patient on a long waiting list.

The use of templates and prompts

GPs are often uncertain about what is needed or expected in the referral letter. They confirmed that the problem concerning referrals can be addressed in clearer and more accurate ways. Templates, prompts and help guides for referrals are widely considered to be helpful. These can make the referral process easier, and are useful as checklists. Most of the GPs preferred templates presented as pop-up

menus or help lists, not as mandatory forms for referrals. They can be useful reminders, to avoid the loss of important information in the referral. Such templates must be made in a mutual setting by representatives from the two groups, hospital specialists and GPs. A few GPs used non-standardized, free-form referral letters. All the GPs expressed the importance of a complete referral, along with the necessary information that allows for a good assessment by the receiver. An experienced GP expressed it like this:

If the specialists can give us the answers to specific questions, it makes the process faster, and makes it easier to manage the investigations or treatment that the patient should have. (Male, 55 years)

Desire for a good dialogue

A referral is described by many GPs as an invitation to participate in shared care in terms of a patient or a medical problem. GPs often need advice and someone to be involved in the patient's care. The term dialogue is used by many, or descriptions such as a request for a common assessment, feedback, or viewpoint. Many referrals are a request for a second opinion or advice on further investigation or treatment in a difficult case.

They can refuse a referral, but there is also a responsibility to guide me further. (Male, 49 years)

Many GPs expressed a wish for easier dialogue with the hospital specialist, electronically or by a phone call. Especially in urgent situations, the need for quick advice is highly valued. Being able to get a quick here-and-now answer or advice was said to avoid many referral letters and to reduce the number of admissions to hospital. One GP described the good referral process as mutual. There was a common agreement that when the hospital specialists need more information about a patient who is being referred, this can best be done through a phone call or an e-mail.

The GPs expressed a willingness to change, according to guidelines, as long as such guidelines are the result of consensus between the hospital specialists and the general practitioners. GPs wanted to know precisely what information is needed in the referral letter. Having specific advice for further investigation or treatment is considered a useful learning process. The hospital doctor calling the referring GP to ask for more information about a patient is perceived as desirable. It can clear up misunderstandings, and give the

patient higher priority. Electronic messaging is expected to replace many such calls. Inaccessibility by phone may be a mutual obstacle for professional dialogue. An experienced GP said:

If I don't get a specialist on the phone, that's why I choose to refer, although this could have been solved on the phone. (Female 53 years)

Discussion

The referral process is complex and multidimensional, with medical, interpersonal, logistical, and legal, as well as indeterminate aspects. In our study the GPs expressed positive attitudes to the professional relationship with hospital specialists, by willingness to change. The referral process is often considered as asymmetric and sometimes humiliating. GPs see the benefit of using templates in the referral process, but are sceptical about the use of mandatory fixed formats. The extended use of electronic communication may facilitate the referral process by making communication faster, but we do not know whether or how this affects the quality of the process. This should be further investigated.

The referral letter, as an entrance ticket to hospital services, gives the GP a gatekeeper role, as described in many studies [16,17]. This role, similar to the role as the patient's defence attorney, sometimes puts the GP in a compromised position that can explain some of the reasons for the variations in referral rates between GPs. In a health system with restricted resources and long waiting times for specialist services, the responsibility and commitment to the community health system is strong, and may sometimes collide with the patients' and his/her own wishes to have a superior viewpoint or assessment for a medical problem.

The referral letter is the basis for the specialist's assessment of the patient's rights or needs to have an examination or treatment in hospital and for the prioritizing of the patients. It can also be a wish for a second opinion on a diagnosis or advice for treatment from a specialist in the actual field. We found that GPs expressed positive attitudes to the professional relationship with hospital specialists. They described the referring as a learning process. This interactive process should be balanced and mutual. The respect for each other's work situation is mandatory for balanced communication. In the Canadian RESPECT study [18], Manca concludes that this can be improved by creating better relationships between GPs and hospital specialists by supporting each other's roles, by enhancing the profile of family medicine in universities and teaching hospitals, and by changing negative attitudes by promoting the expertise and role of family

medicine to others. In our material, the GPs focused on more use of electronic mail to facilitate an easier means of communication than the more old-fashioned sending of letters.

Several studies have unveiled a lack of respect for GPs by specialist colleagues [19–22] as a challenge for family medicine. The referral can be rejected because it is poorly formulated or justified, ultimately because the specialist refuses to follow the request from the referring GP. This can easily lead to a relationship described as asymmetric or top-down. The "underdog" position described in our study is also described by Manca [18], who found that GPs felt overwhelmed by the workload when specialists imposed upon them new procedures without any negotiations. The difference in assessment of time-liness and urgency is another area where GPs feel overrun [19]. Better communication and personal relationships between GPs and hospital specialists facilitating a more comprehensive culture can improve this imbalance [22].

GPs see help menus, prompts, and templates as practical tools in the referring process. In other studies the extended use of templates and prompts related to specific medical problems and diagnoses is recommended to improve doctors' letters and to reduce waits and delays [23,24]. Many GPs are, however sceptical about mandatory templates. The freedom to use one's own words is assessed highly. The making and implementation of new recommendations, guidelines, or templates for referring should be made in cooperation between senders and receivers of referrals [21]. This is important professional and educational work to secure the quality of the referral process and clinical pathways for patients, and it should reflect both the mutual responsibility for the patient and the most effective level of care.

The GP is often in a squeezed position between the patient with a demand for a referral to a hospital specialist, and the unease felt when sending an inappropriate or unnecessary referral letter. Younger doctors especially expressed this, being afraid of losing a good relationship with the patient or perhaps not detecting a difficult disease or diagnosis. The special work situation in general practice, often being alone with clinical problems and with little experience, makes it more convenient to refer a patient to a specialist in a hospital. Rural doctors expressed less pressure on referring, a fact shown by other studies. A Canadian study showed a more than sevenfold difference in being referred to hospital for similar case scenarios between rural and city doctors [25]. This is explained as being for both cultural and practical reasons. The shorter distance to hospital, the more demands or wishes for a specialist assessment from the patients.

Other researchers have used patients' expectations and views upon being referred as an interesting and useful dimension in the public's opinion on referring [26,27]. In this study only GPs' views and attitudes were explored. It can be argued that if we had included hospital specialists we might have got a more balanced picture of the process. This should be further investigated. Interviewing both experienced and younger GPs working in a city or in rural districts makes our results more valid. The use of open questions has revealed important concepts that may be further investigated. Other interesting subjects might be ignored in studies based on focus-group interviews. The first author has been working within this field for many years, and is known to many of the interviewed colleagues. In qualitative studies the role of the interviewer may have an impact on the focus-group interviews that has to be considered. In addition, the first author's preconceptions may have coloured the analysis and interpretation of results. The second and third authors, living in other parts of the country and not knowing the interviewed persons, have by their reading of the transcriptions and making their own reflective analysis reduced the risks for fallacies and tautologies.

Conclusions

The referral process is essential for good patient care between general practice and specialist services. GPs consider referring as asymmetric and sometimes humiliating. The dichotomy between the wish for mutual dialogue and the convenience of using templates should be kept in mind when assuring the quality of the referral process.

Ethics

According to the Regional Committee for Medical and Health Research Ethics, Western Norway, the Act does not apply to this project (2011/1120/REK vest).

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Conflicts of interests

The authors declare no conflict of interests. The authors alone are responsible for the content and writing of the paper.

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