

Short report

Where is the relevant history and examination recorded? A review of documents in general practice

Moyez Jiwa MA MD FRACGP MRCGP

Professor of Primary Care, Curtin University of Technology, Perth, Australia

Michael Gordon MBBS BMedSci

General Practitioner, Gleadless Medical Centre, Sheffield, UK

Paul Skinner FRCS

Colorectal Surgeon, Northern General Hospital, Sheffield, UK

Bridgitte Colwell

Project Manager, Institute of General Practice and Primary Care (SchARR), University of Sheffield, UK

Jennifer Freeman PhD

Lecturer in Medical Statistics, University of Sheffield, UK

ABSTRACT

This study aimed to compare specific clinical parameters as recorded in a matched set of general practice medical records and referral letters relating to patients with lower bowel symptoms referred to a colorectal surgeon in the UK. Data from 48 matched documents suggest that there is more relevant

information recorded in referral letters than in the general practice records. There was an absence of important details recorded in either document.

Keywords: clinic, colorectal, general practice, medical records, referral letter

How this fits in with quality in primary care

What do we know?

General practitioners are gatekeepers to specialist services. The referral letter is a key part of the process of seeking a specialist opinion.

What does this paper add?

Referral letters contain more relevant details about patients than are noted in the routine patient record at the time of referral.

Introduction

General practitioners' (GPs') referrals to specialists usually involve the composition of a letter; very occasionally, in urgent referrals the process may include a telephone discussion with the specialist. In some localities referrals may require the completion of a proforma or tick box referral document and, rarely,

practitioners are able to refer electronically by entering details onto a website or email document. However, in most cases, and traditionally, practitioners will be expected to compose some sort of referral note. There is no standard recognised format for such referral letters, although guidelines were introduced by the UK

Department of Health in April 2000 to help GPs decide which patients to refer for speedy diagnosis.¹ Such cases, presenting with specific signs and symptoms are prioritised and offered an urgent appointment with a hospital specialist.² Nonetheless, it has been demonstrated that referral notes from primary care often relay scant details, and so it has been assumed that the pertinent details are recorded elsewhere. It remains unclear whether it is the medical records or the referral letter that contains the most information on clinical care.³

Methods

The mean number of signs and symptoms recorded in referral letters from a previous study was 5.8, standard deviation (SD) 3.6. Assuming an SD for the mean difference between groups of 5.3, therefore, we needed to compare 50 paired documents to detect a 1.6 difference in recorded information between documents at 80% power, $\alpha = 0.05$.⁴ Allowing for a 60% response rate we needed to approach 80 patients to allow a comparison of the information documented in the letters and GP medical records.

Consecutive patients referred to a colorectal clinic in England were approached until we achieved the necessary sample size. Referrals to this clinic were not required to be written in any specific format or proforma. Patient and GP consent was sought for access to the records and to the referral note.

The clinical features recorded in the letters, and the practitioner's entry in the paper or computer records at the time of referral were scored for features previously identified as relevant by consensus among GPs and specialists.⁵ The scoring involved an independent researcher, familiar with the relevant medical terminology.

Results

Eighty-two patients were approached for access to the relevant documents. Fifty patients consented, and of these, 48 matched sets of documents were available from 41 practices; no practitioner refused permission to access the records. The mean age of the patients was 55 years (SD 16), 22 male, 26 female. The mean general practice list size was 6826, with all but one practitioner working in group practice. Sixty-eight percent of GPs

were male, and on average had been registered in general practice for 23 years, SD 10 years. On this basis, the GPs were broadly representative of colleagues in England.⁶ Differences in the percentage of individual signs and symptoms recorded in the letters and records are shown in Table 1. In this series, a cardinal feature of bowel disease, a change in bowel habit, was recorded significantly more often in the letters.

Discussion

These findings were unexpected and if confirmed may have significant implications for audit, research and service evaluation. Research on referred populations suggests that GPs occasionally neglect to elicit important elements of history and examination.⁷ Research that includes survey of medical records has been used to identify elements of history and examination that could identify patients with early cancer.⁸ The recommendations rely on comprehensive and reliable note taking. However, in these data, as was reported decades ago, less than half the patients are recorded as having a rectal or abdominal examination.⁷ It remains unclear whether the practitioner elicits signs and symptoms before passing the patient to a specialist. It may be that the practitioner performs the examination and fails to record the findings, or that the findings are relayed directly to the specialist by telephone at least in some cases. Our methodology did not allow us to investigate this possibility. Alternatively it may be that this assessment is neither made nor considered necessary. Whatever the explanation we report findings that merit further study and urge caution about recommendations based on signs and symptoms documented in medical documents. Finally, contemporaneous notes are necessary in medicolegal defence, and the data suggest the need for more attention to such details in general practice. We accept that letters are an integral part of the medical record, however, we report that many clinical features, particularly examination findings, are not recorded in either document.

ACKNOWLEDGEMENTS

We would like to thank the general practitioners and patients who kindly allowed access to their records.

Table 1 Clinical features recorded in notes and letters

	Notes <i>n</i> = 48 (%)	Letters <i>n</i> = 48 (%)	Difference between groups	<i>P</i> value for the comparison between groups ^a
Change in bowel habit	25.0	45.8	20.8	0.01
Weight loss	20.8	39.6	18.8	0.01
Duration of symptoms	34.5	52.1	16.7	0.06
Lower bowel pathology recorded in previous investigation	6.3	16.7	10.4	0.06
Tenesmus	2.1	10.4	8.3	0.13
Abdominal mass or abdominal examination	27.1	37.5	10.4	0.18
GP's opinion about the cause of the symptoms	14.6	20.8	6.3	0.51
Abdominal pain	25	20.8	4.2	0.73
Rectal mass or rectal examination	43.8	47.9	4.2	0.79
Rectal bleeding	83.3	83.3	0	1
Family history of colorectal cancer (CRC)	16.7	18.8	2.1	1
Mucus per rectum	10.4	12.5	2.1	1
Iron deficiency anaemia (or full blood count)	0	8.3	8.3	–
History of inflammatory bowel disease	0	2.1	2.1	–

^a McNemar's test

REFERENCES

- Department of Health. *Referral Guidelines for Suspected Cancer*. London: Department of Health, 2000.
- Department of Health. *The NHS Cancer Plan: a plan for investment, a plan for reform*. London: HMSO, 2000.
- Bowling A and Redfern J. The process of outpatient referral and care: the experiences and views of patients, their general practitioners, and specialists. *British Journal of General Practice* 2000;50:116–20.
- Jiwa M. *Designing and Offering GPs Feedback about the Quality of their Referrals to Colorectal Surgeons: a three-stage study*. MD Thesis, University of Sheffield, 2003.
- Jiwa M, Mathers N and Walters S. The quality of referrals in colorectal surgery: towards consensus. *Current Medical Research and Opinion* 2002;18:1–5.
- The Royal College of General Practitioners. Information Sheets. www.rcgp.org.uk/information/publications/information/infosheettitles_index.asp (accessed 11 August 2006).
- Springall RG and Todd IP. General practitioner referral of patients with lower gastrointestinal symptoms. *Journal of the Royal Society of Medicine* 1988;81:87–8.
- Hamilton W, Round A, Sharp D and Peters TJ. Clinical features of colorectal cancer before diagnosis: a population-based case-control study. *British Journal of Cancer* 2005;93:399–405.

FUNDING BODY

Funded by the Sheffield Health and Social Research Consortium.

ETHICS COMMITTEE

Reviewed by the North Sheffield Research Ethics Committee (NS 2004 2 1861).

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Moyez Jiwa, Professor of Primary Care, WA Centre for Cancer and Palliative Care, Health Research Campus, Box U1987, Perth, WA 6845, Australia. Tel: +61 8 9266 1768; fax: +61 8 9266 1770; email: m.jiwa@curtin.edu.au

Received 18 September 2006

Accepted 20 October 2006