Journal of
Professional Communication jpc

What makes a good medical referral?

Adam Boggon*, Nuha Wani, Kiloran Metcalfe

East London NHS Foundation Trust, Bolton NHS Foundation Trust, Royal Manchester Children's Hospital (United Kingdom)

Article Info

Article Type:
Research Article

Article History:
Received: *2021-08-21*
Revised: *2024-01-13*
Accepted: *2024-02-01*

Keywords:
Communication
Healthcare
Quality improvement
Patient safety
Medical education
Medical referrals
SBAR

Abstract

Referrals between medical and surgical specialties are an important communication challenge in healthcare. Poor communication between specialists wastes time and creates confusion, yet there is little published work on how to make a competent referral. This study sought to clarify the qualities of a good referral by means of a qualitative study. A total of 51 specialists from 29 clinical specialties in the UK and US participated. The main themes identified were the need for a standardized structure, appropriate method and relevant content of referral. Barriers to a good referral included insufficient staffing levels, high workload, and complexity of the referral process. A modified question, situation, background, assessment, referral technique (q-SBAR) is one way that such a referral could be structured. Reflecting on this core task of medical practice will benefit clinicians, medical students, and their educators.

©Journal of Professional Communication, all rights reserved.

Doctors routinely refer to and seek advice from colleagues in other specialties. Delivery of multi-disciplinary care for patients with co-morbid conditions and complex care needs is challenging (Royal College of Physicians, 2016). Failures in communication between doctors are a common source of medical error (Kohn et al., 2000). Doctors must be competent in the clear, safe, expedient, and effective communication of information (General Medical Council, 2020). Doctors must refer to specialties appropriately in order to deliver excellent clinical care and make optimal use of limited resources (Royal College of Physicians, 2017).

The importance of safe handovers and communication is well documented (Steadman et al., 2014; Royal College of Physicians, 2015; Till et al., 2014; Pa-

★*Corresponding author (Adam Boggon)*
Email: adam.boggon@nhs.net
©Journal of Professional Communication, ISSN: 1920-6852. All rights reserved. See front matter.

tient Safety Solutions, 2007). The situation, background, assessment, recommendation (SBAR) technique has been shown to improve communication in healthcare settings (Stewart, 2016). SBAR was developed by the U.S. Navy as a means of conveying critical information succinctly, and is now commonly used in healthcare (Narayan, 2013). The SBAR model works like this. The referrer:

- states what is happening (the situation);
- outlines the relevant past medical history and context (the background);
- describes their observations and findings on examination and investigations to date (the assessment); and
- offers their impression of what the patient needs or what the outstanding issues are (the recommendation).

SBAR promotes a standardized form of communication designed to promote the accurate exchange of information between individuals. It has been shown to reduce communication barriers, and its widespread adoption has been proposed as a means by which to reduce patient mortality (Sinamor et al., 2019). Nevertheless, junior doctors frequently describe difficulties in making referrals to other departments. Inexperience, lack of knowledge, time constraints, and adversarial relations between specialties are obstacles to the mastery of this difficult art (Agrawal et al., 2009; Reid et al., 2005).

Research on inter-specialty communication to date has tended to focus on the perspective of the referrer rather than the recipient of the referral (Bulstrode, 1995; Reid et al., 2005). Some research has demonstrated that perceptions of handover quality can differ between the giver and receiver of information (Thakore & Morrison, 2001). It is recognized that where individuals have different agendas and use different handover methods, e.g., nursing versus medical handovers, key information may be lost when a clear structure is not used (Woodhall et al., 2008). We sought to establish the generic qualities of a high-quality specialty referral - as perceived by the specialist receiving the referral - by means of a multicentre qualitative survey of specialist medical and surgical practitioners. From these generic qualities, we propose a standard referral structure and highlight key aspects of a good referral, which we hope will be of use for doctors and their educators in improving their clinical practice.

Methods

This was a qualitative study involving a combination of semi-structured

interviews and email correspondence. These were conducted between April and July 2020 using a predefined topic schedule aiming to explore the core qualities of a good inter-specialty referral. Doctors from a wide range of clinical specialties and levels of clinical seniority (from registrars to consultants) were invited to participate by email. Specialty registrars and consultants were selected as research participants because they are the primary recipients of referrals from hospital doctors and general practitioners and have a clear incentive to improve the quality of this process. Participants were recruited via personalized email and participated by email or in-person interview. A short two-item email questionnaire was employed to improve the response rate since, anecdotally, we have found that long questionnaires can deter respondents.

Purposive sampling was used to select participants from a wide range of specialties. Participants were asked two questions. What information particular to your specialty do you look for in referrals made by other doctors? Do you have any general tips for doctors making specialty referrals?

The *Framework Method*, a systematic and flexible approach to analysing qualitative data, was used in data analysis using deductive and inductive approaches (Gale et al., 2013). Following data familiarization, an initial meeting between all three researchers developed themes deductively for the initial framework. Two researchers subsequently coded all data using this initial framework. Additional themes were identified via the inductive approach during the process of initial coding. A matrix was created to organize common themes with representative quotations using Microsoft Excel.

Results

A total of 69 specialists across 29 clinical specialties were contacted by personalized email. The study was conducted primarily among clinicians at Raigmore Hospital (Scotland) with input from colleagues at the Cicely Saunders Institute (England), Guy's and St Thomas' Hospital (England), London School of Hygiene & Tropical Medicine (England), Macmillan Cancer Support (England), Mayo Clinic (U.S.), Royal Marsden Hospital (England), and the University of Aberdeen (Scotland).

The response rate was 73.9% (51 respondents). Twenty-nine consultants, 20 registrars and two nurse specialists from 29 specialties responded. We received over 10,000 words of free-text response from colleagues in acute medicine, breast surgery, cardiology, colorectal, critical care, dermatology, endocrinology, gastroenterology, general practice, general surgery, genitourinary,

geriatrics, hematology, infectious diseases, maxillofacial, microbiology, neurology, neurosurgery, oncology, ophthalmology, orthopedics, otolaryngology, pediatrics, palliative care, psychiatry, radiology, renal, respiratory, urology and vascular surgery.

Responses contained general advice for making referrals and specialty-specific information. Material particular to a given specialty or condition is not presented here. General advice was categorized under three main themes: structure, method and content. Barriers included complex referral processes, staff shortages, high workload and poor understanding of the specialty being referred to by the referring clinician.

Referral Structure

The need for a structured approach was referred to by 98% (n=50) of respondents. This data is summarized in Table 1.

Table 1
Thematic analysis: Summary table for referral structure coding

Code	*Sub-code*	*Mentions*	*Example*
Reason for referral (28)	Need for a specific question	17	"Have a clear question." "Why are you making a referral?" "What do you want from the referral?"
	Expectations of referral	11	"Be clear in your reason of referral - whether it is for advice or review."
	General structure advice	50	"Present it in a logical order." "Summary of the reason for referral and a history of the complaint."
	Be concise	11	"Clear and precise." "Pick out the juicy bits." "Tabloid headlines rather than Guardian discussion piece."
	Patient details	10	"Name, location, date of admission." "Tell us how to locate the patient."

Code	Sub-code	Mentions	Example
Standardized structure (99) - *con't*	SBAR	10	"SBAR format gives structure." "I would strongly recommend SBAR."
	The importance of an opener	10	"Concise opening sentence or headline." "Put the punchline first."
	Basic introductions	6	"Introduce yourself name and grade from ward X on behalf of consultant Dr. Y."
	SBAR alternatives	2	"ABCDE" (Airway, Breathing, Circulation, Disability, Exposure)

Respondents requested that it be clear from the outset what they are being asked to do as a consequence of the referral. Are they being asked to provide an opinion, review in clinic, or attend to the patient immediately? This core information should be packaged into a headline at the beginning of the referral e.g., "Please may you review this patient with recurrent pyrexia and a pleural effusion whom we suspect may have an empyema.".

The need for a clear clinical question was mentioned explicitly 17 times. Opening with a question provides the specialist with a framework upon which to structure the information they subsequently receive. One physician described the function of the opening question as a hat stand to which details of the history, examination and investigations can be hooked or discarded as appropriate.

The referral should then be presented in a logical order. It should be clear both who and where the patient is and who is making the referral. Using a structured communication technique was encouraged, with SBAR (Situation, Background, Assessment Recommendation) being the most frequently cited (10 times). Concision was highly prized. One psychiatrist summarized this concern, "people tend to think we want long referrals, but I would rather have a few relevant sentences than lots of extraneous detail." Or as one consultant urologist put it, "remember the person you are bleeping has potentially got the brain of a butterfly, may be distracted by whatever they are doing at the time – so it's worth thinking tabloid headline rather than Guardian discussion piece."

Referral Method

This was defined as how the referral is made, those involved, and referral etiquette. This data is summarized in Table 2.

Table 2
Thematic analysis: Summary of data for referral method coding

Code	*Sub-code*	*Mentions*	*Examples*
The people involved (29)	Who to refer to	11	"If the patient is known to a specific consultant, try and refer to them directly." "Know who the most appropriate person to refer to is."
	Senior involvement	9	"Does the consultant looking after the patient know?" "Could this issue be solved by going higher up in your own team?"
	Does the patient know	5	"Patients should be aware of their diagnosis/suspected diagnosis at time of referral."
	Who should make referral	4	"It helps if someone who has actually seen the patient makes the referral."
Referral etiquette (33)	General advice	25	"Most conflict is down to poor communication." "Honesty and clarity - be up front and state the problem." "Don't be arrogant ("we need your expertise" not "this is what you have to do")"
	Ask if unsure	8	"It is fine to call and ask the [receiving specialist] what information they need for a referral." "If you are unsure about something during the referral, just ask."
Have the relevant information at hand		14	"Look for old letters." "Always have the notes and the observation chart to hand."
A sense of urgency		6	"Emergency: Tell us we are needed now and where to go." "Be clear what time frame this review needs to happen in"

Any referral involves at least three people: the referrer, the specialist, and the patient. The person making the referral should, where practicable, have examined the patient themselves. Some respondents (n=9) felt it was important to ensure senior members of the referring team were aware of the referral since issues may frequently be resolved internally by the clinical team directly responsible for the patient. Others – notably those in palliative care, general practice, and psychiatry – specified that the patient should be aware and consent to the referral being made on their behalf.

Good manners count. Professional colleagues should be respectful to one another, and any referral should be viewed as a request rather than a demand e.g., we need your expertise, not this is what you have to do. Sufficient preparedness is an important part of referral etiquette: the referring doctor should have all the relevant information to hand while making the referral and communicate how urgently the specialist's input is needed. Unsurprisingly, a sense of acuity was important to intensivists and acute physicians, but the matter was also raised by palliative care e.g., is the person likely to die within hours and is extremely distressed or is the patient stable and could be seen tomorrow?

Referral Content

Common general themes pertaining to referral content are summarized in Table 3.

Table 3
Thematic analysis: Summary of data for referral content coding

Code	*Mentions*	*Examples*
Investigations	18	"Relevant bloods/imaging."
Previous medical history	14	"Some relevant previous medical history."
Presentation	11	"Pay attention to documentation of a good history, physical findings."
Medications and allergies	9	"What drugs are they on?"
Examinations	7	"Make sure you have examined the patient yourself."
Differential diagnosis	7	"Try to have a working diagnosis when you call if possible."

Code	*Mentions*	*Examples*
Imaging	7	"The appropriate imaging should be requested to confirm or exclude the clinical differential diagnosis, or to monitor a known condition, and should be optimized to this purpose."
Functional Status	6	"It's very important to also highlight the performance status."
Social history	6	"Some useful and pertinent social history, e.g., carer for child with special needs, frail with daughter but not son as power of attorney"
Reason for referral	4	"Why I am referring, e.g., diagnostic uncertainty, access to investigation or treatment?"
Management thus far	4	"What treatments have been offered so far and to what effect."
Patient knowledge/wishes	4	"What the patient knows or expects (particularly important if sinister pathology suspected)."
Escalation status	3	"Is the patient appropriate for escalation?"
Observations	3	"Current physiological parameters, e.g., BP, Sp02, HR, GCS, Bloods, ABG or ECG."
Known consultant	2	"If the patient is known to a specific consultant, try and refer to them directly."

The generic content of the good referral was fairly predictable – it should encompass the presenting complaint, past medical history, current medications, escalation status, and relevant investigations. The social history and functional status of the patient were emphasized by many clinicians since this information helps to form an assessment of the suitability of future interventions, e.g., is it appropriate, based on co-morbidities and premorbid functional status, to admit this patient to intensive care?

Discussion

Effective referrals supply receiving specialists with the information they require to provide an informed opinion. This study shows the importance of posing a clear question concisely, accurately, respectfully and in a well-organized and timely fashion.

The most frequently mentioned structure was the SBAR technique. The use of SBAR in medical and nursing handovers has repeatedly been shown to improve communication (Stewart, 2016). It is no great leap to assume it would be useful in making referrals. Given the repeated mentions of the need for a

clear opening statement, however, we propose a modified SBAR where the specific clinical question precedes the standard structure, or Question, Situation, Background, Assessment, Recommendation (q-SBAR).

Applying a sensible referral structure will not solve everything. Previous work has highlighted knowledge gaps and lack of clinical confidence among those making referrals as barriers to effective communication (Agrawal et al., 2009; Reid et al., 2005). Our study corroborated this finding. The SBAR technique cannot replace foundational knowledge but research into nursing handovers has demonstrated that structured communication can improve confidence, particularly when a more junior individual is requesting help from a senior colleague (De Meester et al., 2013; Stewart, 2016).

Our study focused solely on the receiving specialists' perspective and did not specifically ask about perceived barriers to making good referrals. This perspective limits the full exploration of communication in the referral process as it does not consider the position of the doctor making a referral, though this has been examined elsewhere (Agrawal et al., 2009; Reid et al., 2005).

While we have proposed the q-SBAR technique, it has yet to be formally tested. It has been shown previously that SBAR can be readily taught with measurable improvements in handover performance (Marshall et al., 2009; Sinamora et al., 2019); we anticipate a similar result may be achieved by its systematic use in referrals.

Conclusion

This study shows the qualities of a good medical referral from the perspective of the receiving specialist. Common themes were the need for a clear opening question, a logical structure, and the inclusion of pertinent details. It was emphasized that referrals should be made in a concise and timely manner by someone adequately familiar with the patient's case. We propose a modified q-SBAR technique for referrers, which considers the need for receiving specialists to understand the precise question they are being asked to provide an opinion on at the outset. Ultimately this study draws a similar conclusion to the early Wittgenstein, "clear things should be said clearly, and what we cannot talk about, we must pass over in silence" (1974, p. 3).

References

Agrawal, V., Ghosh, A.K., Barnes, M.A., & McCullough, P.A. (2009). Perception of indications for nephrology referral among internal medicine residents: A national online survey. *Clinical Journal of the American Society of Nephrology, 4*(2), 323-328. https://doi.org/10.2215/CJN.03510708

Steadman, J., Steadman, S., & Alderson. S,. (2014). Handing over patients on call. *BMJ*, 349. https://doi.org/10.1136/sbmj.g5582

Bulstrode, C. (1995). Continuity of care - sacred cow or vital necessity? *BMJ, 310*(6987), 1144-1145. https://doi.org/10.1136/bmj.310.6987.1144a

De Meester, K., Verspuy, M., Monsieurs, K.G., & Van Bogaert, P. (2013). SBAR improves nurse-physician communication and reduces unexpected death: a pre and post intervention study. *Resuscitation 84*(9), 1192-1196. https://doi.org/10.1016/j.resuscitation.2013.03.016

Gale, N.K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology,13*(1), 117-117. https://doi.org/10.1186/1471-2288-13-117

General Medical Council. (2018). *Outcomes for Graduates*. https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/outcomes-for-graduates/outcomes-for-graduates

Kohn, L.T., Corrigan, J.M., & Donaldson, M.S. (2000). *To err is human: Building a safer health system*. National Academies Press. http://ebookcentral.proquest.com/lib/mcmu/detail.action?docID=3375380

Marshall, S., Harrison, J., & Flanagan, B. (2009). The teaching of a structured tool improves the clarity and content of interprofessional clinical communication. *Quality & Safety in Health Care 18*(2), 137-140. https://doi.org/10.1136/qshc.2007.025247

Narayan, M.C. (2013). Using SBAR communications in efforts to prevent patient re-hospitalizations. *Home Healthcare Nurse 31*(9), 504-515. https://doi.org/10.1097/NHH.0b013e3182a87711

Patient Safety Solutions. (May 2007). *Communication during patient hand-overs: Patient safety concerns.* World Health Organization. https://cdn.who.int/media/docs/default-source/patient-safety/patient-safety-solutions/ps-solution3-communication-during-patient-handovers.pdf

Reid, C., Moorthy, C., & Forshaw, K. (2005). Referral patterns: An audit into referral practice among doctors in emergency medicine. *Emergency Medicine Journal, 22*(5), 355-358. https://doi.org/10.1136/emj.2003.008409

Royal College of Physicians. (2015, September 3). *Acute care toolkit 1: Handover*. https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-1-handover

Royal College of Physicians. (2016, September 21). *Underfunded, underdoctored, overstretched*. https://www.rcplondon.ac.uk/guidelines-policy/underfunded-underdoctored-overstretched-nhs-2016

Royal College of Physicians. (2017, June 6). *Referring wisely.* https://www.rcplondon.ac.uk/projects/outputs/referring-wisely

Simamor, R.H. & Fathi, A. (2019). The influence of training handover-based SBAR communication for improving patients safety. *Indian Journal of Public Health research & Development, 10*(9), 1280-1285.

Stewart, K.R. (2016). *SBAR, communication, and patient safety: An integrated literature review*. [Honors thesis]. University of Tennessee at Chattanooga. https://scholar.utc.edu/cgi/viewcontent.cgi?article=1070&context=honors-theses

Thakore, S., & Morrison, W. (2001). A survey of the perceived quality of patient handover by ambulance staff in the resuscitation room. *Emergency Medicine Journal, 18*(4), 293-296. https://doi.org/10.1136/emj.18.4.293

Till, A., Sall, H., & Wilkinson, J. (2014). Safe handover: Safe Patients - the electronic handover system. *BMJ Open Quality, 2*(2). https://doi.org/10.1136/bmjquality.u202926.w1359

Wittgenstein, L. (1974). *Tractatus logico-philosophicus* (Pears, D.F. & McGuinness, B.F). Routledge & Keegan Paul. (Original work published 1921)

Woodhall, L.J., Vertacnik, L., & McLaughlin, M. (2008). Implementation of the SBAR communication technique in a tertiary center. *Journal of Emergency Nursing, 34*(4), 314-317. https://doi.org/10.1016/j.jen.2007.07.007