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Acute tendon injuries in the hand and their management

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Making referrals: a guide for foundation doctors

Introduction

Junior doctors rotate through different specialities as part of their foundation and early speciality training. One responsibility commonly shared by all specialities at all levels is that of making and receiving referrals. According to the General Medical Council's *Good Medical Practice*, a referral is defined as:

> **'transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment that is outside your competence' (General Medical Council, 2009).**

Evolving patient needs may necessitate the handing over of care to a different speciality or hospital which is more suited to deal with the problems at hand. This forms the basis of a hospital referral. For those early in their medical careers, this can be a daunting task. Although there is no substitute for practical experience, this article gives a simple guide to help you through the process of making a referral in a hospital setting.

Types of referrals

Referrals (or consultation requests) vary widely in nature and depend on, among other things, the clinical question itself, the specialty involved and the manner in which the referral is sent. These can be broadly divided into intradepartmental referrals, interdepartmental referrals, interhospital referrals and community practice referrals. The usual methods of referral are written, telephone and face-to-face (direct).

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Referrals within the department

These include senior opinions from within your own team or from a different team within the same specialty. Referrals made between two consultant colleagues may also be included in this section, although they are outside the scope of this article. These referrals will typically be made over the telephone or face-to face.

Depending on whom the referral is being made to, the context of these referrals in practice can vary from a strictly formal exchange to a casual conversation. Nevertheless, it is important that essential information is accurately passed on and that contemporaneous documentation of the referral is made.

Interdepartmental referrals

These are referrals made between two different specialties within a hospital. Examples include referring from accident and emergency to other specialties, requesting an opinion from another department and referring for urgent senior review of acutely ill patients, for example, to the on-call medical or surgical registrar. Sometimes patients may need senior consultation regarding a particularly complex or esoteric condition. Referrals may also be made to specialist staff such as the tissue viability nurse, stoma nurse or pain management nurse among others.

In everyday practice, making a referral for inpatient review is common. This is usually done via a written request being faxed to the consultant's secretary and followed up with either a phone call or face-to-face discussion.

Interhospital referrals

This involves referring a patient from one hospital to another for continuity of care or for further specialist care. Such situations include where the patient has been admitted to a hospital with an acute problem that has been stabilized, and the destination hospital may be closer to where the patient actually lives, therefore being more convenient for the patient and their visitors. An example would be a patient who

sustains a fracture while on a weekend break away from home who was first admitted to the hospital nearest to where the injury occurred but is referred to the hospital nearest to his/her home.

This could also happen if you are working in accident and emergency and have to treat a patient who is on business and already receiving ongoing care from another hospital. In either scenario, you may have to make a referral to another hospital for continued care of the patient. Other common reasons for this type of referral are when tertiary level facilities are not available at the hospital you are working at, for example transplant surgery or cardiothoracic surgery.

Community referrals

These are referrals made from the community, such as those made by GPs or NHS walk-in centres directly to hospital. They will not be considered further in this article.

Getting ready for referral

Who to refer to

It is clearly a waste of time and effort referring to the wrong specialty or to the wrong grade. Make sure you know from the outset to whom the referral needs to be made, and confirm this with your seniors if necessary. It is also worth considering different members of a specialist team when making a referral. For example, is a consultant diabetologist needed for advice on adjusting a patient's insulin dose when there is a diabetes nurse specialist available?

What to find out

1. Basic patient information such as the age, current location, significant medical and/or surgical history, relevant key investigations obtained thus far
2. Reason for current admission
3. The condition that needs expert consultation and the reasons for requesting the consultation
4. What steps have been taken so far, including the rationale for doing so. This also applies in the non-acute setting
5. The urgency of the need for review, as guided by the patient's condition.

The authors believe that referral should not commence unless you have the above information to hand. Your seniors will be happy to help you find this information, but you will also need to be able to use case notes and GP records to find what you need to know. This is especially relevant if you have never met the patient before. In addition, the more you have proactively done for the unwell patient before asking for more senior help, the better your request for help will be received. For example, with an acutely ill breathless patient, performing basic management and baseline investigations such as chest X-ray, basic bloods investigations including an arterial blood gas and electrocardiogram will make referral to the medical registrar much easier. Always use the 'airway, breathing, circulation' (ABC) approach when carrying out the initial management of an acutely unwell patient.

What to write or say

For written referrals there will usually be a pre-formatted form to fill out by hand. Make sure you include all the information that is asked for on the form, as well as the patient information and location. Give a succinct and accurate summary of the patient's current condition, relevant investigation results and significant events. Make it clear whether you are requesting a non-urgent ward review, take-over of a patient's care or something more urgent.

Examples

Some sample referrals are shown in *Figures 1* and *2*. These highlight some key points to pick up on.

Clearly identify yourself with your name, position, department and location. As appropriate, provide demographic details of the patient such as date of birth, hospital identifier and current location. Clearly and concisely state what you expect from the other person. Do you want a formal review or simply verbal advice?

Although it is acceptable to be unsure as to what exactly is required in terms of management (that is, after all, why you are making the referral) it is certainly important that you know the basic information detailed previously. If the referral you are making is urgent, then it is important to stress this along with the reasons why. Be assertive and confident, but not rude. If you are being fobbed off then let your own seniors know straight away, especially if the need for review is urgent. Always be prepared to say what you think is happening. Even if you end up being wrong it shows you are at least trying to use your own clinical judgment and taking an interest.

When making interhospital referrals it is essential to follow up any telephone conversation with a clear written summary that can go along with the patient and his/her notes. It is important to keep nursing staff and other relevant multidisciplinary team members abreast of any developments following review, as their decisions can be affected by your actions. If your shift is about to finish before an important review takes place, make sure the patient and need for review are handed over.

Figure 1. Example of a non-urgent written referral.

Dear Consultant Dermatologist

Mr Smith was admitted a week ago with worsening breathlessness. He is known to have chronic respiratory problems and has been on inhalers and steroids long-term. He is currently being treated with a combination of nebulizers and chest physiotherapy.

Over the last few days he has developed widespread, itchy erythematous macules of varying size over his chest. His inflammatory markers are normal, and he has not had any recent medication changes. He has no previous history of skin complaints or allergies. He remains haemodynamically stable.

Your expert opinion on the cause of this rash and further management would be most appreciated.

Figure 2. Example of an urgent telephone referral.

Hello surgical registrar on-call, this is Dr Smith, medical F1 on-call.

I am calling to ask you to review my patient urgently. His name is Mr Bloggs on ward 3, and he is 73 years old. He was admitted 3 days ago with a urinary tract infection and has been making a good recovery with antibiotics. He has a background of well-controlled hypertension.

Earlier this morning he developed sudden generalized abdominal pain following his breakfast. He has since become very unwell. He is tachycardic with a heart rate of 130 beats/minute and hypotensive with a blood pressure of 80/60 mmHg. His respiration rate is 20 breaths per minute and his oxygen saturations are 98% on air. He is apyrexial. His abdomen is markedly distended and generally tender, with absent bowel sounds. I have commenced intravenous fluids and he is being catheterized. I have sent urgent blood tests to the lab and requested a portable chest X-ray.

I am worried that he has peritonitis and may require urgent surgery, which is why I am asking for your review.

Documenting the referral

Once the referral has been made, it is vital that the details are documented to aid communication with other members of the multidisciplinary team. Documenting the outcome of a telephone conversation for advice is also important. Doing so will help substantially should reference be made to the notes for whatever reason at a later date (for example, medicolegally).

Documentation should include the date and time you spoke with or wrote to the other team, who it was you spoke to along with his/her position and contact details. You should then summarize the discussion and what it is you told them, because this is the information on which their decision is then based. The entry should then mention their input followed by an agreed action plan (even if it is to continue with the current management). Anything you have actioned from the plan should also be mentioned, such as arranging investigations or informing senior colleagues.

If you have verbally given the outcome of the referral to a senior colleague such as your registrar or consultant this should also be documented in the notes for the benefit of team members and the law.

Documenting a written referral follows the same principles, although the information tends to be more delayed chronologically, so it is possible that you will make the initial referring details in one entry and then the plan will be entered at a later stage following review. It is prudent to always state your contact details or those of the colleague you will be handing over to when documenting a written referral.

When a referral has been accepted, or even a transfer of care agreed, you must remember that the patient remains the responsibility of the parent team until that specialist has actually seen the patient and documented in the case notes that the care has been taken over. If a patient requires medical attention before being seen by the specialist team then you must make sure this is attended to.

Difficult situations for referral

Unfortunately, it is not unknown for a parent team to try to 'turf' a patient onto another team, usually at the request of more senior members of the team. An example would be a patient who does not require an emergency operation but who has other non-acute medical co-morbidities, so the consultant asks you to transfer the patient to a medical team, or a complex medical patient who has sustained a non-acute fracture. This can be a difficult situation to deal with as a junior doctor, but you must be able to discuss things maturely and frankly.

Involving other senior members of the team, such as your registrar or the ward sister, can also provide a temperate and sensible approach to the problem. You may find yourself acting as negotiator between the teams, which can be a thankless task. Ultimately, however, if you keep yourself focussed on what is best for the patient then it helps to put things into perspective. The important thing is to not feel alone when dealing with such a problem, and to involve your colleagues as much as possible.

Final points

As you gain experience and seniority you will find greater responsibility being given to you, which increases your workload significantly. Consultants and other senior staff are extremely busy people and would struggle a lot more if faced with a junior doctor referring them a complicated patient with scant basic information and coherence.

How you make the referral will have a huge impact on how your patient is received and managed by the team being referred to. The authors recommend a confident, polite and helpful attitude. Take the time to think about what you are going to say before you pick up the telephone. Always greet the other person in a courteous manner and check that it is OK to proceed with discussing the referral. Make sure you have read the section of this article regarding essential information to have in advance. Finally, thank them at the end of the conversation. When making a written referral, mention as many relevant details as you can as succinctly as possible and always put your name and contact details in the referral so that they can get back in touch with you easily. Make sure you follow up any outstanding referrals and check that they have been received.

Despite your best efforts, there may be occasions when you are unsuccessful in obtaining a review. This can sometimes be the result of deliberate obstruction by the person to whom you are referring. It is vital that this kind of behaviour is reported immediately to your own seniors as well as to the other team as it goes against the professional standard of behaviour expected by the General Medical Council, as well as going against the best interests of the patient. Remain polite and calm, and if necessary explain that you will document the refusal to review your patient. In many cases this will be enough to prompt a more appropriate response.

In other situations, find out exactly why the specialist is not happy to review the patient. It could be that other tests need to be done to help formulate a plan or management decision. As you become more experienced, you will learn the typical things which will be asked for in a given situation, and you will be in a position to have these requests already carried out or arranged.

Conclusions

It is understandable that many foundation doctors find the process of making a telephone referral stressful. Even written referrals can be associated with a degree of trepidation for the unfamiliar. Although there is certainly no substitute for experience, this article has hopefully made the processes of referral clearer to you, and your patients will benefit from timely and appropriate expertise. **BJHM**

Conflict of interest: none.

General Medical Council (2009) Good Medical Practice: Delegation and referral. www.gmc-uk.org/guidance/good_medical_practice/working_with_colleagues_delegation_and_referral.asp (accessed 8 December 2010)

KEY POINTS

- Referrals are important actions that doctors will perform throughout their careers. It is essential that doctors are comfortable with the different situations, both acute and non-acute, in which they need to be made as well as how to make them efficiently.
- Carrying out five basic tasks before making the referral – getting basic patient information, the reason for current admission, the condition that needs expert consultation, what steps have been taken so far and the urgency of the need for review – will make the whole process a lot smoother.
- Involve seniors early on if there are problems with getting the patient seen – do not leave this until the ward round the next day!