REVIEW

Facilitating patients’ dietary change: A review of dietitians’ correspondence practices with general practitioners

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Abstract

Aim: Dietitian and general practitioner collaboration in the nutrition care of a patient is important to assist patients to achieve their nutrition goals. This paper aims to review the published literature on dietitians’ correspondence practices with recipient general practitioners regarding nutrition interventions recommended to patients.

Methods: A literature search was conducted of publications from 1995 to December 2009. Key words were used to search the electronic databases Medline, CINAHL Plus, ProQuest, PsycINFO and Google Scholar. Twenty papers that addressed this topic were selected by two authors for inclusion in the review.

Results: There is evidence that dietitians often fail to provide general practitioners with formalised correspondence that describes dietitians’ nutrition interventions with patients. Doctors report they lack patient information via dietitians’ correspondence. Information about nutrition care of hospital patients often remains within hospital records. Doctors prefer standardised letter formats with content presented succinctly. The letter should include a nutrition diagnosis, agreed goals, a plan for ongoing dietetic visits and instructions for a general practitioner’s supportive actions.

Conclusion: Dietitians need skill in drafting reports or letters useful for general practitioners by selecting content of value to doctors and using a suitable style. Implementation of shared electronic records in Australia will facilitate information transfer to help realise collaborative patient care. Further investigations of dietitian–general practitioner correspondence are warranted to determine best practice.

Key words: chronic disease management, consultation letter, dietetics, interdisciplinary communication, primary care.

Introduction

The increasing prevalence of chronic disease where health risk is related to lifestyle has led the Australian Government to implement initiatives aimed at improving the coordination of patient care.¹ In this area of public health, Australian general practitioners (GPs) provide the majority of primary health care services. More than 90% of the population see a GP at least once a year and on average individuals visit their doctor 6.5 times per year.² Hence, GPs offer patients an important intervention point and a doctor’s role is increasingly recognised as that of coordinating each patient’s care.²

Medicare statistics show that GPs are increasing the involvement of dietitians in the nutrition care of patients.³ General practitioners may refer a patient for dietetic intervention to dietitians in a range of work settings including community health centres, specialist clinics, cardiac rehabilitation centres or outpatient ambulatory services.⁴ Eligible patients with chronic disease are entitled to subsidised dietetics consultations in private services under Medicare national health insurance, upon GP referral.⁵ Alternatively, a GP’s patient may receive dietetics interventions while receiving institutional care such as at hospitals or in ambulatory services.⁶–⁸

Dietetics standards of practice in Australia recommend communication with others in a multidisciplinary team regarding patient care in helping patients to achieve their nutrition goals.⁷ However, dietitians and GPs frequently work in separate locations, with few opportunities for verbal communication about patient management.⁸ Little is known about what information is provided by dietitians back to the referring GP. The expectation is that a written report is the...
main form of communication. There is evidence that GPs’ needs for patient information about a nutrition consultation are not being met; an issue that is explored below. This does not apply to dietetics alone, however, as studies show a lack of information in patient referrals and in reports throughout the medical community.10

This paper aims to review the literature on correspondence practices of dietitians with recipient GPs. Two questions will be addressed: first, what are the key components of dietetic care that should be reported back to the referring GP and second, is there a preferred correspondence framework or template for reporting patients’ dietetics interventions to GPs?

Method

A systematic search was made for publications in English from 1995 to December 2009. Key words were used to search the databases Medline, CINAHL Plus, ProQuest, PsyCINFO and Google Scholar. Examples of key words used and search strategies from the Medline database are given in Table 1. Citations from the articles’ reference lists were also examined to identify missed papers. The selected studies were analysed using published guidelines.11

A total of 188 articles were identified. Two authors screened the article titles for topic relevance and 32 articles remained. The abstract of each of these articles was reviewed and full text papers were retrieved when topics included the terms nutrition, dietetics or covered the subject of knowledge transfer. The findings were synthesised in accordance with narrative methodology.

Results and discussion

Twenty papers selected for review are shown in Table 2. These include two reviews of literature, 11 experimental or quasi-experimental studies using surveys, four qualitative studies using observation or interview, two reports and one case study. The studies relate to dietitian–doctor correspondence, and doctor–doctor or doctor and other health professional correspondence. Eleven papers reported studies of communications between dietitians and doctors using the letter format (Table 2).4,6,8,12–19 The remainder reported correspondence between doctors, or doctors and other health professionals.20–29 There was no single preference for a correspondence framework found in the papers. All studies were analysed to identify the various components of a patient’s dietetics care that should be included in the correspondence to the referring GP and options for information transfer.

Communication between a dietitian and a GP generally occurs by written letter rather than a face-to-face meeting.8,12,16 This is likely to be influenced by GPs and dietitians working in separate settings. A survey of dietitians Australia wide showed less than one-third of Australian private practice dietitians were co-located with a GP in 2008.8

The literature shows that reports or consultation letters sent to referers generally fulfil two main functions.20 They signal to the recipient the items of high importance for the medical care of the patient. Therefore, the letter reflects the writer’s assumptions about the information needs of the recipient. However, it may be difficult for novice practitioners to determine the relevance of factors that should be included in correspondence.21 There is a lack of published evidence that correspondence training is applied in dietetics. Keely et al. reported on a training program for Canadian medical undergraduates in writing consultation letters. They argue that written composition reflects a professional’s clinical expertise.23 Thus, it forecasts the overall professional competence of the writer—in this case, of a dietitian.

Second, reports or consultation letters record the distribution of responsibility between a doctor and a dietitian in managing dietetic care of a patient by summarising the intervention and identifying practitioners’ roles. The letter reflects professional courtesy in giving advance notice of ‘who’ will do ‘what’.21 In transferring information, reports also have the intent of securing the cooperation of the recipient GP so that each can assist in managing a patient.20

Various principles apply to dietitians’ feedback to GPs. Written reports are required when they manage Medicare-subsidised patients.5 Dietitians’ intention to comply was confirmed in a 2008 survey of private practice dietitians.5

Table 1. Examples of key words and search strategies from the Medline database

<table>
<thead>
<tr>
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<th>1</th>
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<th>3</th>
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<tbody>
<tr>
<td></td>
<td>Nutrition.mp. or dietetics/ or dietitian.mp and knowledge transfer.mp or Interdisciplinary Communication/limit to (abstracts and ‘review articles’ and humans and ‘core clinical journals (aim)’ and latest update and yr=1995 -Current’)</td>
<td>Interdisciplinary Communication/ or Computer Communication Networks/ or Communication Barriers/ or Communication/ or communication.mp or Communication Methods, Total/ or Manual Communication and nutrition.mp or Dietetics/ or dietitian.mp/ limit to yr=1995 -Current’</td>
<td>Nutrition.mp. or Dietetics/ or dietitian.mp/letter.mp/or electronic.mp or Electronics/ or collaboration.mp or Cooperative Behavior/ limit to yr=1995 -Current’</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Target group/origin</td>
<td>Sample selection/allocation</td>
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<tr>
<td>Biesemeier C, Chima CS. Computerised patient record: are we prepared for our future? J Am Diet Assoc 1997.</td>
<td>Cross-sectional survey</td>
<td>Clinical Dietitians (USA)</td>
<td>Stratified, weighted sample of 500 with 34% response (n = 171)</td>
</tr>
<tr>
<td>Brami J, Doumenc M. Improving general practitioner records in France by a two-round medical audit. J Eval Clin Pract 2002.</td>
<td>Post-test survey</td>
<td>GPs (France)</td>
<td>Convenience sample of 246 GPs</td>
</tr>
<tr>
<td>Cant R. Patterns of delivery of dietetic care in private practice for patients referred under Medicare Chronic Disease Management: results of a national survey. Aust Health Rev 2010.</td>
<td>Cross-sectional survey</td>
<td>Dietitians (Aust)</td>
<td>Self-selected national sample of private practice dietitians (n = 358)</td>
</tr>
<tr>
<td>Cant R, Aroni R. Melbourne dietitians' experience of Medicare policy on allied health services (Strengthening Medicare, Enhanced Primary Care) in the first twelve months. Nutr Diet 2007.</td>
<td>Descriptive study (interviews)</td>
<td>Dietitians (Aust)</td>
<td>Purposive sample of 15 dietitians working in private practice in one state were interviewed</td>
</tr>
<tr>
<td>Emerson M et al. American Dietetic Association standards of practice and standards of professional performance for registered dietitians (generalist, specialty, and advanced) in behavioral health care. J Am Diet Assoc 2006.</td>
<td>Research report</td>
<td>Dietitians (USA)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Post-test: survey of instrument

Doctors (UK)

Sample selection method not given. n = 7 hospital doctors

Quality assessment of 7 × 15 letters to GPs using the Sheffield Assessment Instrument for Letters (SAIL) and feedback to writers

Effective medical report framework for correspondence evaluation; a number of sections not relevant to dietetics' reports


Review (non-systematic)

Dietitians (USA)

N/A

Summary elements essential to documentation using focus charting are suggested for various medical conditions

Brief focused notes are recommended using computer recording rather than the pen


Case study

Dietitians and physicians (Canada)

Report on Hamilton Health Service Organization Nutrition Program Model for outpatient care—sample n = 454 to 1298

Audit of pre–post biochemical patient outcome measures

Nine RDs/80 physicians share care (both are co-located) with significant impact on chronic diseases outcomes; patient records are integrated via chart or electronic record to reduce duplication & facilitate communication


Report

Medical students (Canada)

N/A

Report on curriculum for teaching medical consultation letter-writing skills

Consultation letter-writing is a learned skill and should be taught to medical professionals


Post-test surveys

Medical specialists (Canada)

Convenience sample

Peer assessment by independent raters of medical specialists' letters using 34-item tool & feedback

Most participants found peer assessment feasible and useful, preferences of recipient groups appeared to differ

Klein C et al. Physicians prefer goal-oriented note format more than three to one over other outcome-focused documentation. J Am Diet Assoc 1997.14

Cross-sectional survey

Physicians (USA)

Selection not given; n = 19 physicians surveyed by registered dietitian

'Focus charting' of notes was tested against a 'goal-oriented' format for preference by physicians

Dietitians should use the goal-oriented format developed for this study, and preferred by physicians
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Target group/origin</th>
<th>Sample selection/allocation</th>
<th>Methods of data collection/analysis</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kriplani S et al.</td>
<td>Review (systematic)</td>
<td>Physicians (USA)</td>
<td>N/A</td>
<td>Systematic review of randomised controlled trials, controlled trials and non-randomised pre-post designs</td>
<td>Communication deficits in medical discharge reports to primary care physicians at hospital discharge are common and computer-generated/standardised formats may assist</td>
</tr>
<tr>
<td>Kuppersmith N, Wheeler S.</td>
<td>Cross-sectional surveys</td>
<td>Dietitians physicians (USA)</td>
<td>Self-selected registered dietitians (n = 389) &amp; 235 family physicians &amp; 104 examples of correspondence letters</td>
<td>Postal survey analysed using descriptive statistics</td>
<td>Dietitians' perception of 80% frequency of sending letters was not matched by physicians views &amp; this lack of feedback compromised doctors' patient care. Dietitians can improve correspondence with physicians</td>
</tr>
<tr>
<td>Lingard L et al.</td>
<td>Qualitative study</td>
<td>Physicians (Canada)</td>
<td>Selection not given. 116 physicians' letters (medicine, psychiatry, surgery) were collected from 17 physicians</td>
<td>Letters were assessed and 16 physicians and 13 residents interviewed</td>
<td>Functions of referral and consultation letters were evident via tacit understanding but trainees had limited understanding of the factors and did not receive training</td>
</tr>
<tr>
<td>Madigan SM et al.</td>
<td>Qualitative study</td>
<td>GPs (Britain)</td>
<td>Selection not given</td>
<td>Interview 23 GPs and thematic analysis of content</td>
<td>GPs should be involved in decision-making re enteral nutrition and be trained for care of patients discharged from hospital and receive timely patient information/reports</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Participants</td>
<td>Methods</td>
<td>Findings</td>
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<tr>
<td>Nicholas L et al. The role of the general practitioner &amp; the dietitian in patient nutrition management.</td>
<td>Review of literature</td>
<td>GPs dietitians</td>
<td>N/A</td>
<td>Literature review Evidence is lacking about whether GPs in Australia provide nutrition counselling to patients and the efficacy of this intervention</td>
<td></td>
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<tr>
<td>Pomeroy S, Worsley A. Enhancing the dietary management of general practice patients through collaborative care: perspectives of general practitioners and dietitians.</td>
<td>Qualitative and quantitative studies</td>
<td>GPs dietitians (Aust)</td>
<td>Random selection of 30 GPs (interview); 248 GPs and 180 dietitians (surveys)</td>
<td>Audio-recorded interviews &amp; mailed questionnaires; frequency analysis &amp; chi² tests of independence</td>
<td></td>
</tr>
<tr>
<td>Pomeroy S, Worsley A. Contribution of Australian cardiologists, general practitioners and dietitians to adult cardiac patients’ dietary behavioural change.</td>
<td>Quantitative studies</td>
<td>Cardiologists GPs dietitians (Aust)</td>
<td>189 cardiologists, 248 GPs and 180 dietitians (surveys)</td>
<td>Few cardiologists and half the dietitians provided nutrition information in written reports to GPs; thus patients may lack this information</td>
<td></td>
</tr>
<tr>
<td>Wasson J et al. Improving correspondence to general practitioners regarding patients attending the ENT emergency clinic: a regional general practitioner survey and audit.</td>
<td>Quantitative survey</td>
<td>Emergency ENT doctors and GPs (UK)</td>
<td>100 consecutive outpatients’ reports using a computised template were selected for audit by mailed survey of GPs</td>
<td>Post-test survey of 72 (72%) GPs re satisfaction with report</td>
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ENT, ear, nose and throat; GP, general practitioner; RD, registered dieticians.
Table 3 American Dietetic Association standard of practice for registered dietitians in behavioural health care—documentation

<table>
<thead>
<tr>
<th>Initial consultation—Standard 3.16 Nutrition intervention</th>
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<tbody>
<tr>
<td>Documents and communicates:</td>
</tr>
<tr>
<td>• Date and time</td>
</tr>
<tr>
<td>• Specific treatment goals and expected outcomes</td>
</tr>
<tr>
<td>• Recommended interventions</td>
</tr>
<tr>
<td>• Any adjustments of plan and justification</td>
</tr>
<tr>
<td>• Client receptivity</td>
</tr>
<tr>
<td>• Referrals made and resources used</td>
</tr>
<tr>
<td>• Any other information relevant to providing care and monitoring progress over time</td>
</tr>
<tr>
<td>• Plans for follow up and frequency of care</td>
</tr>
<tr>
<td>• Rationale for discharge (if appropriate)</td>
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</table>

Source: Emerson et al.18

Alternatively, hospital policy differs as most information is held in hospital-based records. There is no clear requirement to provide GPs with individual patient reports regarding the nutrition diagnosis or care plan for inpatients or outpatients (Southern Health, Melbourne, unpublished data, 2008). On a patient’s discharge from a hospital ward a single discharge report is compiled by doctor and/or nurses. It may or may not include allied health information such as whether a dietitian has seen a patient. Feedbacks from dietitians working in outpatient clinics have also shown that provision of reports to GPs is not a universal practice as it is for dietitians working in community health centres and to a lesser degree in private dietetic businesses.16

These reporting practices of dietitians are not clear. For example, a study of 500 clinical dietitians in the USA recorded that less than half would give patient transfer information in their documentation written in hospitals.19 The frequency of correspondence letters may also be influenced by the number of dietetic visits that a patient requires to modify their diet. There is a perception that communication letters would be provided after a series of visits rather than after each visit. Thus a lack of nutrition intervention information about a patient may be a key medical concern to GPs27 or even complicate a GP’s task of coordinating a patient’s nutrition care.30

Key components: Interdisciplinary patient management documentation is recognised as part of a dietitian’s professional performance with Australian national standards for dietitians’ prescribing this broadly. It requires documentation of ‘the process of dietetics interventions’ (p. 13).9 A more detailed correspondence standard is used by North American dietitians in behavioural health care. It outlines more comprehensive reporting, including documentation of a patient’s nutrition goals (Table 3).18

In Australia, a lack of evidence of any dietetic training of dietitians in consultation letter-writing skills suggests that this skill is learned informally in the workplace. It seems that practising dietitians lack guidelines for writing these communications. If this is so, the importance of these skills has been underestimated.

Physicians prefer short communications that include goals and plans that are easily identified in a structured report.19,21,22,26,29 A study of British hospital and GP correspondence found that GPs prefer to receive correspondence in a standardised report template. This is concise, easily readable and makes key points readily discernable.22 Structured letters that incorporate headings allow the reader to quickly scan the letter. Furthermore, as letters may be read by practice nurses, other professionals or patients themselves,28 the language used should be suitable for a wider audience. Some key composition points that may facilitate a doctor’s letter reading16,22,26,28,29 are summarised in Table 4.

A study of Australian GPs identified preferences for composition of dietetic reports. They should be individualised to the patient, use standardised nutrition language, be concise in structure and report on steps in the nutrition care process (assessment, diagnosis, intervention, monitoring and evaluation).21 This study suggested key components of dietitians’ correspondence that GPs consider valuable are:

• A nutrition diagnosis
• Nutritional and behavioural goals agreed by the patient
• Any unresolved/incomplete issues
• A plan for ongoing dietetic visits (or not)

Thus, any components of the nutrition care process not yet completed, or those that require further attention need to be highlighted to gain the GP’s attention.

No actual template for dietetics communication via written correspondence was located. To answer the research question ‘Is there a standard or framework for optimal correspondence practice in reporting to GPs?’ we refer to the detail of communication systems used to convey the correspondence to GPs.

Information gap: Although the intention of dietitians to provide patient care information to referrers may be high, communications often fail to reach GP recipients. GPs report a lack of access to dietitians’ reports. A study of 248 Victorian GPs reported perceptions of only half of their referrals to dietitians resulting in return correspondence.16 This concurs with results of a parallel survey of Australian dietitians. Forty-nine per cent thought they ‘always’ provided a report, and 25% ‘often’ did so.29 In the USA, a study of 389 registered dietitians reported that 84% ‘always’ or ‘often’ sent a nutrition treatment plan to the referring family physician. However, only half the physicians agreed they ‘always’ or ‘often’ received the feedback letters.13

Doctors value dietitians’ consultation correspondence. A study of dietitian–physician communication in the USA reported that family physicians (n = 235) who experienced a lack of feedback thought this would affect their patient care.13 Interviews with 30 Australian GPs found that dietitians’ assessment, diagnosis, education and behavioural change skills were almost always regarded as highly important by the GPs.16 In this study, the GPs considered these dietetic skills to be ‘the cornerstone of patients’ ability to self-manage dietary behaviours’ (p. 6). Additionally, GP–dietitian shared primary care in Canada that included integrated patient records reported an increase in facilitation of dietitian–doctor communication. There was significant
improvement in chronic disease patients’ outcomes. However, other studies show that the information needs of doctors as letter recipients are often not met because of insufficient detail on key aspects of medical care. It is necessary for GPs to access dietitians’ correspondences with care plan information to enable joint professional collaboration in the nutrition management of their patients. These issues suggest that the frequency as well as the content of dietitians’ reports requires re-examination. When dietetic reports are prepared, the question becomes: how can their value be improved?

Improvements in communication systems are needed to enable efficient and timely reporting across multiple health practitioners. GPs require timely reports they can read on the day of the patient’s next medical consultation. Unrecognised delays, filing processes or other errors may contribute to the reported inefficiencies.

Australian government policy has confirmed that shared electronic medical records are the best solution for optimum communications. Electronic clinical packages have been increasingly implemented in primary health care among GPs and specialists and allied health professionals. A number of computer software programs can facilitate instant and secure transfer of patient data (such as letters) via encrypted email between clinical settings. Access can be limited to data in relevant fields so that not all information is shared. Patients’ identification data are automatically inserted into a report template, limiting time-consuming activities such as some data entry. Reports are automatically filed into a patient’s record. However, it is important that dietetics correspondence is easily accessible to GPs in the ‘Results’ section of a patient’s record. Electronic medical records have been flagged as the way of the future for healthcare reporting and should be endorsed by dietitians and other like providers. This will assist the governments’ policy of integrating service provision and providing multidisciplinary care.

Some limitations apply to this review. Little recent primary research of dietetics’ correspondence with GPs has been published. Rapid advances in electronic communication mean that currency of research is critical. The quality of research designs used in the studies was low therefore limiting the generalisability of the results. Furthermore, both dietitians’ and GPs’ communications may operate differently in various health-care settings. However, the strength of this review is that it can raise the issue of how best to conduct correspondence between GPs and other members of a multidisciplinary ‘team’ across disciplines. These are key communications that are required in order to conduct effective patient treatments.

In conclusion, the efficiency of communications via correspondence between dietitians and doctors in primary care has implications for dietitians’ professional competence. Characteristics of desirable written correspondence from dietitian to GP were identified and these confirm the importance of suitable style and content. Improvements in correspondence can occur both by ensuring that dietitians are equipped to select written content of value to doctors, and by increasing the use of shared electronic medical records which utilise structured templates. Without such improvements, GPs may continue to face barriers to clinical decision-making about nutrition management of patients with diet-related risk factors. Further investigations of dietitian–GP correspondence are warranted to determine best practice.

Table 4 Desirable composition characteristics for consultation letters to doctors

<table>
<thead>
<tr>
<th>Element</th>
<th>Composition</th>
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<tbody>
<tr>
<td>Structure</td>
<td>Use a template with subheadings.</td>
</tr>
<tr>
<td>Brevity</td>
<td>Use point form or numbered tables rather than conversation style.</td>
</tr>
<tr>
<td>Clarity</td>
<td>Limit words with more than 3 syllables.</td>
</tr>
<tr>
<td>Composition</td>
<td>Brief sentences—no more than 2 lines of type—edit out unnecessary words.</td>
</tr>
<tr>
<td>Paragraph</td>
<td>Limit each to 4–5 sentences.</td>
</tr>
<tr>
<td>Formatting</td>
<td>Standard size font (11 or 12) and vary the font for headings; allow adequate white space on the page.</td>
</tr>
</tbody>
</table>

References


30 Pomeroy SEM, Cant RP. General practitioners’ decision to refer patients to dietitians: insight into the clinical reasoning process. Aust J Prim Care 2010; 16: 1437–53.


