ORIGINAL ARTICLE

Outpatients Attendance in a tertiary care hospital; is the referral justified or not?

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ABSTRACT

Aim: To assess whether referral to OPD of our tertiary care hospital were justified or not?
Study Design: Cross sectional
Place & duration of study: OPD of AIMT Hospital affiliated to Khawaja Muhammad Safdar Medical College Sialkot, Pakistan from October to November 2016.
Methods: 600 consenting adult patients coming to OPD for the first time were included. Patient coming for second or more than twice were excluded. Six OPDs including general surgery, orthopedics, gynecology, internal medicine, psychiatry and neurology were involved in the study. Referrals to OPD were assessed by consultants not below the rank of Assistant Professor. Data was collected for 4 working days from all the six departments on a data sheet and analyzed by SPSS v 21.
Results: Assessment of the referral by the receiving consultant of the respective specialty was in 3 categories. Was the referral justified, unjustified or indecisive? In the surgical OPD the % of justified, unjustified and indecisive was 45.53%, 47.32% and 7.14% respectively. In medicine it was 48.30%, 31.35% and 20.33%. In gynae/obs it was 81.66%, 13.33% and 6.66%. In orthopedic it was 69.60%, 23.52% and 4.90%. In psychiatry it was 56.41%, 38.46% and 5.12%.
Conclusion: Among the surgical and allied specializes highest percentage of unjustified referrals were in general surgery patients (47.32%) while in gynya/obs patients there were least number of unjustified referrals 13.33%. Among the medical and allied patients there was no significant difference in unjustified referrals.
Keywords: Tertiary health care, Patient referral, unjustified referral, Health Services, Referral

INTRODUCTION

Quality of providing healthcare is now a universal issue. In traditional terms doctor and patient relationship was dominated mostly by the doctors. Patients had little or no role in making decision about their care. As the times are changing the health care system is also changing. Attitudes and perception of patients are changing. Health care providers also need to incorporate these changing trends in their practices. Health system is working as independent industry in some countries and caters to the demands and perceptions of the patients which are now seen as clients[1]. Hospitals are also changing their policies. Needs of the patients are assessed and catered according to the new trends. If there is no change in hospitals the health care delivery will be affected. Patients have choices and needs to be addressed. Humane and user friendly hospitals are need of the hour now. Perceptions of the patients are important in better functioning and outcome. Patients want quality in providing care. The older system of authoritarian style doctor is changing. Patients want more participation in their management of health issues[2].

Many patients who are not provided with proper services may become distressed. Patients suffering any medical or surgical illness want early care and better management. Delay in provision of health care to patients may lead to adverse outcomes. The outcomes may be physical or psychological. Physical outcomes which lead to negative outcomes may result in death and disability. Psychological reactions can lead to depression. Depressed patients may develop ruminations which may be brooding or reflection. In another study carried out in our hospital it was observed that patients who were suffering from depression and were admitted in the hospital, nearly half of these patients had ruminations[3].

Studies carried out elsewhere have also pointed out at that fact that patient satisfaction affects outcomes. Health care providers need to be aware of the aspirations of the patients and act in a prompt manner to provide early and better quality of services to the patients to improve indicators of health outcome and patient satisfaction. Provision of health care near to their homes rather than too far off tertiary care hospitals in developing countries may

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lead to undue delay and decreasing in better outcomes. Satisfaction of the patients is also negatively affected. In developed countries where there are better equipped and specialized tertiary health care faculties, there is usually insurance and referrals by GPs which act as gate-keeper in the system leading to undue delay in reaching the patient to concerned tertiary care hospital and receive treatment. This leads to negative health outcomes. Patients need to be involved in their care and their journey to tertiary care should be shortened to achieve better outcomes and satisfaction[4-8].

One such example is Japan. It is a developed country with advanced health system. All the citizens of Japan have health insurance and they can freely access the hospitals. There is no difference in access to different hospitals. There are no GP or other referral by any other gate-keepers. Hospitals whether in public or in private sector are generally perceived as equal by the people[9]. Even nursing homes which cater for the needs of older population do not have much difference[10].

In Pakistan we have health care providers in primary and secondary care, private hospitals, faith healers, traditional healers and alternative medicine. Usually they are first contacted by patients for health care services. Some services they provide and for some services they act as gate-keepers. They refer the patients to tertiary health care hospitals. More over as most of the tertiary health care hospitals are in public sectors, any patient can come directly to hospital to get treatment. Many times patients are referred by other patients who had received treatment in the hospital previously. No study has been done to see the pattern of referral in our hospital. The objective of the current study was to assess whether referral to OPD of our tertiary care hospital were justified or not?

MATERIAL AND METHODS

The study was conducted in the OPD of AIMT Hospital, Sialkot from October to November 2016. It was a cross sectional study. Non-probability convenience sampling technique was used. Ethical guidelines in the Declaration of Helsinki were followed. Inclusion criteria were adult consenting patients attending OPD for the first time of our hospital. Exclusion criteria were patients coming for second, or more than two times in the hospital. Patients coming through accident and trauma centre were excluded. No bias was taken into consideration regarding caste, color or religion of the patient.

A data sheet was prepared. It contained information about the patient. Written informed consent was taken. Purpose and title of the study was explained to patients. If patient was unconscious, it was explained to attendant or relative of the patient and consent taken from the responsible family member or legal attendant of the patient. Demographic and clinical information was collected. Source of referral was asked. Any other relevant information was also collected. Every new patient was examined by a consultant not below the rank of assistant professor of the concerned specialty. Clinical information and the opinion of the consultant regarding referral were recorded. For data collection 4 working days were allotted to each of the six participating departments. The data collectors reached OPD at 8 AM sharp and collected data till 2 PM or afterwards if there were patients to be seen by the consultant. It was made sure that each new patient was seen by the consultant even after junior doctors had examined the patient before. The final opinion of the consultant was always recorded in all patients. Guidelines for consultants were charted to maintain uniformity in opinion making by different departments and consultants. After detailed discussion of the participating consultants definition of terms was formulated. The term JUSTIFIED was defined as the referral which merit admission to ward, surgery requiring senior surgeons or involvement of a team, diagnosis which is rare or required laboratory or radiological equipment, or referral on the basis of failure of treatment at local level hospitals or other facilities. The term UNJUSTIFIED was defined as the referral with minor medical ailments, surgeries which can amicably be done at local level hospitals, referral for want of medicine and referral without any formal referral form and investigations. Indecisive cases meant where at least 2 consultants examined the patient and were not conclusive of the reason for referral. Whatever may be the final opinion of the consultant, no patient was refused treatment or referred back and were provided with the needful treatment in the hospital. Collected data was analyzed by SPSS v 21.

RESULTS

There were a total of 600 patients taken for the current study from the six out patients departments. Mean age of the patients was 33.13 years with standard deviation of 11.67%. Most of the patients were female 62.38% as compared to male patients who were 37.62%. Most of the patients belonged to lower or lower middle income families 78.84%. There were more patients from rural background 70.20% vs 29.80% from semi-urban and urban background. 28.60% were illiterate and mean years of education was 11.23 years with standard deviation of 5.67 years. Of the six OPD departments Surgery received 112 patients which were 18.66% 0f the total sample. The medical OPD received 118 patients which was

19.66% of the total sample in the current study. Gynae and obs department had 120 which were 20% of the total sample in the current study. Orthopedics department received 102 patients which were 17% of the sample. Psychiatry OPD attended 78 patients which were 13% of the sample included in our study. Neurology OPD received 70 patients which were 11.66% of the sample. There were 3 surgical oriented departments and 3 medical and allied departments. Table 1.

Table 1: Distribution of the patients (n=600)

Departments	n	%age
Surgery	112	18.66
Medicine	118	19.66
Gynae/obs	120	20.00
Orthopedics	102	17.00
Psychiatry	78	13.00
Neurology	70	11.66

Table 2. Who referred the patients?

Sources of referral	n	%age
Primary care	143	23.83
Secondary care	118	19.66
Private sector	78	13.00
Faith/traditional healer	48	8.00
By another patient	170	28.33
Others	43	7.16

As regards the source of referral to the tertiary care OPD, 143 patients were from primary care public sector hospital and smaller dispensaries. This amounts to 23.83% of the total referral load. Public sector secondary care referred 118 patients. This amounts to 19.66% of the total referrals. Private sector referred 78 patients in total which amounts to 13% of the sample. Faith and traditional healers are usually frequently visited by the patients. They referred 48 patients in total. This amounts to only 8% of the total sample in our study. Patient to patient or told by relative of a patient is usually very frequent rout opted in our culture. Most number of patients was referred by another patient 170 in total that amounts to 28.83% of the patients. Other sources were healers of alternate medicine and homeopathy. There were 43 patients equal to 7.16% of the patients in our study (Table 2).

Assessment of the referral by the receiving consultant of the respective specialty was in 3 categories. Was the referral justified, unjustified or consultant or the team in tertiary care set up was not able to make decision about the suitability of referral and were indecisive. In the surgical OPD the % of justified, unjustified and indecisive was 45.53%, 47.32% and 7.14% respectively. In medical OPD it was 48.30%, 31.35% and 20.33% respectively. In gynae/obs OPD it was 81.66%, 13.33% and 6.66%. In orthopedic OPD it was 69.60%, 23.52% and 4.90%. In psychiatry OPD it was 56.41%, 38.46% and 5.12%. In neurology OPD it was 57.14%, 37.14% and 5.71% respectively (Table 3).

Table 3. Assessment of the referral by the receiving consultant

Specialty (n)	Justified	Unjustified	Indecisive
Surgery (112)	51 (45.53%)	53 (47.32 %)	8 (7.14%)
Medicine (118)	57 (48.30%)	37 (31.35%)	24 (20.33%)
Gynae/obs (120)	98 (81.66%)	16 (13.33%)	8(6.66 %)
Orthopedic (102)	71 (69.60%)	24 (23.52%)	5 (4.90%)
Psychiatry (78)	44 (56.41%)	30 (38.46%)	4(5.12%)
Neurology (70)	40 (57.14%)	26 (37.14%)	4(5.71%)

DISCUSSION

The results of our study show that among the surgical and allied specializes highest percentage of unjustified referrals were in general surgery 47.32% patients while in gynae/obs patients there were least number of unjustified referrals 13.33%. Among the medical and allied patients the unjustified referrals were almost equal in internal medicine, psychiatry and neurology 31 to 38%. Highest number of patients were referred by another patient telling the patient, followed by primary and then secondary care. The tertiary care was being used as walk in just as primary source of care by many patients. Our results corroborate with results from Japan where lack of training in PHC, not taking into account the needs of patients and combination of good support by government in form of low or negligible fee result in high rates of such referrals[11].

Satisfaction of patients also plays an important role in the use of services by other patients[12]. Another patient telling the patient was highest in our study. On the other hand unjustified referrals may lead to stress on hospitals and doctors and may lead to depression in them.[13] In South Africa it was observed that many patients come directly to hospital emergency department and many of them were inappropriate referrals or came by themselves[14]. In other regions of the world it has also been observed that patients who do not need emergency treatment come for emergency treatment leading to burden on the services[15]. One other situation is when patients are discharged from the hospital too early or prematurely. It may be because of cost saving. Many of these patients come back to the same hospital or

in another hospital for re-admission. These patients may be more difficult to treat then. Instead of saving the cost there is increase in cost of management by the hospital. In planning discharge of any patient it must be ensured that all factors are taken into account[16]. In a country like Pakistan it is imperative that doctors take responsible actions while managing the patient and see the long term benefits as most of the costs are incurred by the government and this may lead to additional burden on the health budget of our nation.

The doctors must make sure that when a patient is ready for discharge, is the mandatory requirements for proper disposal of the case has been made? Doctors should decide the most beneficial and suitable discharge plan. They should take account of the medical condition, functional status, supports available to the patient so there is less chance of re-admission. A good rehabilitation plan may also reduce re-admission and relapse of the patients[17]. When all these things are taken into account almost 75% patients return home safely[18]. Regardless of the diagnosis it is important of HCP to make better decisions keeping in mind the surgical, medical and psychological state of the patient. If patient is to be referred, appropriate decision should made by the referring doctor for better care of the patient[19]. Planning of the discharge of each patient should be individualized[20] and should be made mandatory is hospitals[21]. In summary planning discharge or referral is an important issue that must be taken with care by all the HCP so to provide better care for patients[22]. The strength of our study is that it had easy methodology and without any financial support. The limitation of the study was the perspective of the patients who were referred unjustified was not assessed.

CONCLUSION

Among the surgical and allied specializes highest percentage of unjustified referrals were in general surgery patients (47.32%) while in gynae/obs patients there were least number of unjustified referrals 13.33%. Among the medical and allied patients the unjustified referrals were almost equal in Internal medicine, Psychiatry and Neurology 31.35 to 38.46%.

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