INTERPROFESSIONAL COMMUNICATION

AIMA GUIDING PRINCIPLES FOR LETTER WRITING

Australasian Integrative Medicine Association (AIMA)
Interprofessional Communication Working Group (AICWG)

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AIMA

Integrating Mainstream and Complementary Medicine

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present, and future.

Interprofessional communication: AIMA guiding principles for letter writing

Disclaimer

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Contents

Integrative Medicine (IM) terms

The following terms, definitions and meanings are used throughout this document.

Complementary Medicine (CM) refers to:

> A broad set of health systems, modalities, and practices and their accompanying theories and beliefs situated outside the dominant health care system of a society or culture. CM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries between the various CM practices and that of the dominant medical system are not always sharp or fixed. Based on (WHO, 2013, NICM, 2017, AIMA, 2020)

For this document, the term complementary medicine is used synonymously with **complementary therapies, complementary and alternative medicine** and **traditional medicine**. CM includes, but is not limited to the use of **complementary medicine products** that in Australia are defined by the Therapeutic Goods Administration to include "vitamin, mineral, herbal, aromatherapy and homoeopathic products" (TGA, 2017).

Integrative Medicine brings *"conventional and complementary approaches together in a coordinated way"* (NICM, 2017).

The **Australasian Integrative Medicine Association (AIMA)** definition is as follows:

> Integrative Medicine a whole-person, patient-centered medical practice. It combines the best of conventional western medicine with evidence-based complementary medicine and therapies. These practices are combined to provide the highest level of safe, effective healthcare for our patients.
>
> Integrative Medicine reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, health care professionals and disciplines to achieve optimal health and healing.
>
> Integrative Medicine takes into account the physical, psychological and social wellbeing of the person with the aim of using the most appropriate, safe and evidence-based treatments available. (AIMA, 2020)

The term **Healthcare practitioners (HCPs)** is used when referring to all types of practitioners be they medical, nursing, pharmacy, allied health or complementary medicine practitioners.

BACKGROUND

Communication between all healthcare practitioners plays an important role in the provision of safe and appropriate, patient-centered multidisciplinary health care.

Introduction

The following guiding principles and accompanying letter templates respond to calls from healthcare practitioners (HCPs) for the Australasian Integrative Medicine Association (AIMA) to provide leadership and practical help with interprofessional communication. The purpose is to support the delivery of safe, coordinated, multidisciplinary care that is patient-centred and provide guidance on interprofessional communication and collaboration between the different types of HCPs that patients might chose to be involved in their care.

Along with supporting interprofessional communication in general, key objectives of these resources is to assist all HCPs with navigating the relatively new terrain called integrative medicine (IM) and to improve their cultural competency when communicating with the diverse range of healthcare practitioners (HCPs) in Australia.

> Communication between all HCPs plays an important role in the provision of safe and appropriate, patient-centered multidisciplinary health care.

These resources were prepared by the AIMA Interprofessional Communication Working Group (AICWG), a collaborative multidisciplinary team of volunteer healthcare practitioners (HCPs), academics and educators. Throughout 2017 and 2018, the templates were presented to attendees at AIMA's *'New models of care: Doctors and practitioners working together'* workshops and other practitioner workshops and conferences in Australia and New Zealand. Feedback was overwhelmingly positive for the rationale behind creating the templates and has been used to further refine the content and structure of the templates.

This document has three sections, the first covers relevant background information. The second provides practical guidance and tips for professional letter writing. The third presents five letter templates with accompanying examples. The templates are structured around the ISBAR framework – Identify, Situation, Background, Assessment, Recommendations – a proven, best practice tool for efficient interprofessional communication. The framework has broad applications e.g. clinical handovers, emergency care, telephone calls, and letters of correspondence.

Integrative Medicine in the context of the Australian health care system

Integrative medicine is a practice of healthcare that is respectful, patient-centred and focuses on the whole person. IM makes use of all appropriate therapeutic approaches, health care professionals and disciplines to achieve optimal health and healing. IM multidisciplinary healthcare respects and responds to the increasing number of people in Australia who choose to concurrently utilise the services of a wide range of HCPs, including complementary medicine (CM) practitioners.

IM teams have been found to operate in a variety of ways (Wiese et al.).

1. Selective incorporation – medical doctors provide selected CM interventions or directly supervise CM practitioners.
2. Integrative – multidisciplinary teams collaborate to provide coordinated CM services alongside biomedical services.
3. Patient-centred pluralism – the patient chooses the level of integration between practitioners. Potential disagreements between the different paradigms and philosophies of healing are allowed.

Boon et al. argue that to be truly integrative, the IM team must be non-hierarchical, with the patient and practitioners having shared goals and values (Boon et al., 2004).

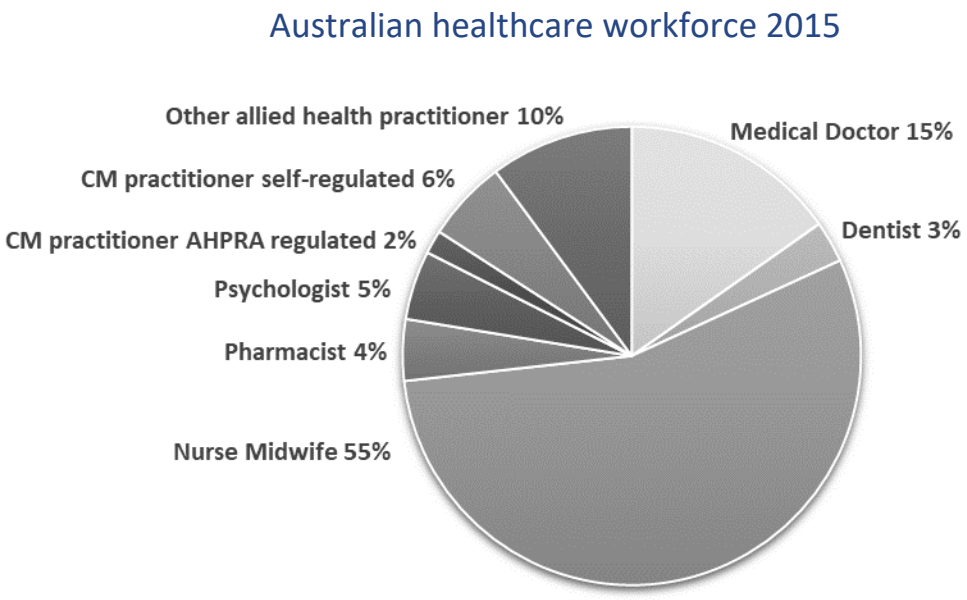
Irrespective of the level and type of integration, effective multidisciplinary IM healthcare relies upon a clear understanding of the roles and responsibilities of team members; cultural competency and respect; agreed mechanisms for resolving conflicts and improving information sharing; and strategies to eliminate inappropriate barriers to providing high quality, patient-centred care.

The extent to which integration occurs in practice will depend on a wide range of factors. In Australia, along with dedicated IM clinics, IM healthcare is also provided through 'virtual', multidisciplinary teams of practitioners working in different locations. The nature of the Australian healthcare system has also been found to influence the dynamics of Australian IM teams (Hunter et al., 2012).

Australian healthcare workforce

Australians consult a wide range of HCPs. Over a twelve-month period, an estimated 29% of Australians will consult an allied health practitioner, 9% a CM practitioner (a rate that is most probably under-estimated given that the ABS data did not include visits to mind-body and massage therapists), 8% a general practitioner (GP) and 3% a medical specialist (ABS, 2013). Six percent will seek formal advice from a pharmacist that may include advice about CM use, including those products available through pharmacies (ABS, 2013, Braun et al., 2011, Ung et al., 2018).

Interprofessional communication between the various HCPs a person may consult is key to coordinating multidisciplinary care. Although communication pathways between GPs and medical specialists are well established, correspondence between medical doctors and other HCPs tends to be more ad-hoc. The risk of insufficient communication is greater fragmentation of the healthcare system, which subsequently increases the responsibility of patients to manage and coordinate their own care (Eastwood, 2002).



Data compiled from AHPRA: the Australian Health Practitioner Regulation Agency 2015 and estimates from the National Infrastructure Audit CM Practitioners 2015 (unofficial)

Australian health care system

The Australian healthcare system is a mixed public-private model. The country has a strong primary care service where general practitioners (GPs) act as the gatekeepers to specialised, secondary care services. A substantial amount of primary care however, is also provided by allied health, pharmacists, nurse practitioners and CM practitioners.

Coordinating patient care across the various public and privately-operated healthcare services in Australia can be challenging and inefficient. Each practitioner or service maintains their own, confidential clinical records are not routinely shared. Interprofessional communication mostly relies upon letters of correspondence, such as referral letters and discharge letters, reports, telephone calls and case conferences. A substantial amount of the health service and the practitioner's time can be spent trying to obtain and collate clinical information from various sources, time that could be spent treating and caring for their patients.

With the exception of nursing and midwifery, HCPs mostly provide their services in the community on a fee-for-service basis. Direct costs to patients are subsidised by either the national insurance scheme (Medicare) or private health insurance. Despite a large public health sector, equity remains an issue in Australia (Schneider et al., 2017). Out-of-pocket costs can be substantial, with limited rebates for CM, nursing, pharmacy and allied health services and large gap-payments for some specialist medical services (Schneider et al., 2017).

The Medicare Benefits Schedule (MBS) lists the services available to all Australian residents that are subsidised by the Department of Human Affairs (MBS-Online, 2018). MBS items cover most services provided by medical practitioners, including imaging and pathology tests, and a limited number of services provided by allied health practitioners and some CM practitioners (chiropractors and osteopaths). Each MBS item has strict criteria for the type of practitioner who can provide the service, the clinical indications, and patient eligibility. If the MBS criteria are not met, then at the discretion of the practitioner, the service may still be provided at the patient's expense.

A written referral from a medical doctor is a prerequisite of Medicare and private health insurance rebates for most services provided by a medical specialist (including imaging and pathology); and the specialists have an established tradition of sending a letter of correspondence (or the results) back to the referring doctor. The only instance where a referral letter from a GP to allied health or CM practitioners is a Medicare requirement is for patients seeking Medicare rebates from the Better Access initiative for mental health services or the Chronic Disease Management program. As part of the contractual arrangement, the HCP must report back in writing to the referring GP at the commencement and conclusion of the episode of care.

Pathology and imaging requests

MBS rebates are available for a wide range of pathology and imaging investigations. These services must be requested by an authorised healthcare practitioner. The rebate can only be claimed if the service is deemed to be 'clinically relevant'. Other restrictions may also apply (see below for examples). If the eligibility criteria are not met, then the Department of Human Services can order the requesting practitioner to repay the Medicare benefit. It is for these reasons that a practitioner may specify on a request form that the test is not eligible for a Medicare rebate or even create their own private accounts with pathology laboratories.

Detailed, up to date information about the criteria for MBS rebates can be found online (MBS-Online, 2018). However, it is often easier to use the summary documents provided by pathology laboratories and radiology services for commonly ordered tests. For example, some pathology tests require specific clinical history to be documented on the request form (e.g. MTHFR gene requires a proven DVT/PE or the presence of this mutation in a first-degree relative; T3 and T4, requires one of 4 clinical indications; and Vitamin D requires one of 11 clinical indications to be listed on the request form). Other tests are restricted by the number of tests or frequency of

testing (e.g. a maximum of 2 tumour marker tests per episode). Testing for vitamins A, E, B1, B2, B3, B6 & C are restricted to 6 monthly, and vitamin B12 to yearly.

MBS restrictions can also apply to medical imaging. For example, various restrictions apply to the clinical indications for MRI requests that can be ordered by a GP and imaging requests from dentists, allied health and CM practitioners.

My Health Records

The decentralised, haphazard organisation of a patient's various clinical records across the healthcare sector has led to the development of a personally controlled electronic health record: My Health Record (My-Health-Record, 2018). The aim is to collate key information about an individual's past and current medical history. Once a record is created, it can be accessed and amended by the individual (or their representative) and by HCPs and providers who have registered with My Health Record. Registration by practitioners who are regulated by the Australian Health Practitioner Regulation Agency (AHPRA) is automatically approved. Non-AHPRA regulated practitioners are eligible, but approval is not automatic.

Data available in the My Health Record includes health summaries, discharge summaries, e-referrals from GPs to specialists, and prescription data. Increasingly, pathology and imaging results are being automatically uploaded by participating providers. The results can be viewed by the patient seven days after being uploaded; this allows time for the referring practitioner to first review and act upon the results. My Health Record has the potential to reduce the time spent by patients and providers to obtain medical information and the costs of repeating unnecessary tests, whilst improving the accuracy of the information available.

Interprofessional collaboration & patient-centred communication

Effective collaboration and communication are interactive processes characterised by the respectful sharing of accurate, timely information using commonly understood language and terminology. Barriers to interprofessional communication include a lack of cultural competence and hierarchical power differentials (Keller et al., 2013). When patients and caregivers are proactively included in this process it is referred to as ***patient-centred communication*** (Joint-Commission, 2017).

The challenges with interprofessional, patient-centred collaboration and communication were reiterated during an interactive workshop at the 2016 AIMA annual conference. Workshop participants identified the following issues:

- Chronic and complex health issues benefit from coordinated care provided by multidisciplinary teams of medical, allied health and CM practitioners.

- Current communication channels between medical and CM practitioners are underdeveloped, leaving patients feeling caught in the middle and responsible for navigating their own IM care.
- Risks of poorly coordinated IM care include adverse reactions from the concurrent use of CM products and pharmaceuticals that are compounded by persistently low levels of disclosure of CM use to medical doctors.
- Risks of adverse events arising from withdrawal from CM products without adequate consideration of the effects.
- A patient-centred solution to the issue of patients and CM practitioners requesting investigations from medical practitioners is needed to avoid inappropriate requests and contain costs for both patients and health services and is vital to preserve value-based healthcare.
- CM practitioners also see 'medically averse' patients. Cooperative interprofessional communication would assist CM practitioners with supporting their patients to seek appropriate medical care.
- Many HCPs have received limited formal education and training in professional letter writing and interprofessional communication.

Facilitating interprofessional collaboration

Interprofessional collaboration is described as a ***'partnership between a team of health providers and a patient/client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issues'*** (Canadian-Interprofessional-Health-Collaborative, 2010).

Effective interprofessional collaboration

1. HCPs are clear about their own role and scope of practice, along with the roles of the other team members (including patients and their caregivers and families)
2. HCPs cooperate with each other to enable shared problem solving and decision making that is patient-centred
3. HCPs have agreed mechanisms in place for conflict resolution
4. HCPs communicate with each other in a mutually respectful manner that is authentic and builds trust between all parties

(Canadian-Interprofessional-Health-Collaborative, 2010)

Communication failures

Failures in interprofessional collaboration and patient-centred communication threaten patient safety. Communication breakdowns among HCPs, administration, and/or patients and families are a leading cause of sentinel events (Joint-Commission, 2016). Such failures may inappropriately leave patients with the responsibility of accurately communicating complex health information to their HCPs and coordinating their own multidisciplinary care **(Leonard et al., 2004, Pierantozzi, 2013)**. Conversely, effective interprofessional communication and collaboration promotes greater patient satisfaction and professional job satisfaction, as well as safer, more effective and efficient care (McCaffrey et al., 2011).

Added to this, several Australian studies have found that doctor-patient communication about CM is scarce (Shenfield et al., 2002, Xue et al., 2007, Cohen et al., 2005, Zhang et al., 2007). An estimated 63% of Australians who consult a CM practitioner, will have also consulted a medical doctor in the previous 3 months. Despite patients wanting their HCPs to help them make sense of CM information (Smith et al., 2016), at least 60% of Australian adults and 50% of parents do not discuss CM use with their doctor (ABS, 2008, Frawley et al., 2017). Patients often express frustration with having to self-manage the integration of their health care choices and the lack of communication between their practitioners (Lin et al., 2015).

Communication is key to patient safety

(Joint-Commission, 2016)

A leading cause of inadvertent patient harm is communication failure

- between HCPs, including non-clinical staff
- between HCPs and patients (or their caregivers)

Communication failure is caused by

- a poorly constructed message
- missing key information
- inadequate planning or prioritisation
- lack of cultural competence*
- lack of patient-centred communication
- patient relaying information on behalf of another HCP

*Cultural competence impacts practitioner-patient and practitioner-practitioner communication

Well recognised risks from HCPs not discussing CM with their patients include the wide variety of interactions between prescribed medication and CM products that are less likely to be identified (Levy et al., 2017), failure to flag other clinical contraindications to CM, and opportunity costs such as delayed diagnosis or necessary medical management (Wardle and Adams, 2014). Less recognised is the risk to the doctor-patient relationship. A comparative analysis of IM doctors and non-IM GPs in Australia found that the doctor's attitudes and beliefs impact CM disclosure and CM communication (Forth, 2017). Whilst IM doctors described an experience of

building a positive therapeutic alliance with their patients, non-IM GPs often felt therapeutic alienation regarding their patients' use of CM that could result in being sidelined from managing their patients' overall care. Part of the reason for HCPs being side-lined may be explained by a lack of cultural competence.

Interprofessional cultural competence

The term 'culture' refers to the shared knowledge, belief, behaviour, attitudes, values, and practices of a group of people be they racial, religious, social, professional, or organisational. Known communication barriers include a lack of cultural competence and perceived power differentials that are reflected in the use of professional jargon, rather than a commonly shared language (Keller et al., 2013). Regarding the culture of biomedicine, Gaines and Davis-Floyd comment that there is always a tendency for "blindness to a domain of one's own culture, where its power and prestige make it invisible to member participant observers" (Gaines and Davis-Floyd, 2004).

Cultural competence in Integrative Medicine

includes an awareness of, and respect for the diverse range of health care practices, paradigms, and terminologies that patients and practitioners use.

Cultural competence enables HCPs to work effectively with each other and their patients in cross-cultural situations, and for healthcare systems to deliver services that meet the social, cultural, and linguistic needs of patients and HCPs. In the context of interprofessional communication, all HCPs need to be aware of how their own cultural biases can negatively impact communication with patients, their families and other HCPs.

Letters of correspondence

Improved communication between all healthcare practitioners has much to offer. A coordinated approach can help mitigate the potential harm of concurrent use of multiple interventions and unrecognized contraindications. Letters of correspondence between HCPs provide an opportunity to deliver information about the care that a patient is receiving and that the other HCPs involved with the patient's care may have difficulty accessing. They serve as a formal record of correspondence that becomes part of the receiving practitioner's clinical records for their patient. Open communication about the patient, their treatments and clinical response can help increase a HCP's knowledge and understanding of different medical and healing systems and the different terminologies that are used. As such, communication can also be a valuable tool for improving cultural competency.

Letters of correspondence between specialist medical practitioners and the referring GP are commonplace in Australia. Often this is the sole means of communication between practitioners working in different locations. Along with meeting the MBS requirements for rebates from a specialist's services, these letters are used to document and summarise the clinical encounter (history, examination, management, recommendations), and to share this information with other relevant HCPs. Increasingly, pending consent, other relevant healthcare practitioners and also the patient are sent a 'carbon copy' c.c. of the letter. In doing so, everyone involved in the patient's care is kept up to date, any errors or deficiencies in the information can be identified and amended, and knowledge and expertise is shared.

Along with the accurate transfer of clinical information, letters provide a significant opportunity for knowledge transferal between HCPs. For example, it is reported that many non-CM practitioners scarcely access CM research, and often rely on anecdotal information such as patients feedback and experience from their own personal use, rather than evidence-based literature (Cohen, 2005, Corbin Winslow and Shapiro, 2002). If a letter from a CM practitioner includes evidence-based research and treatment information, this is a valuable source of information for the other HCPs who may be less familiar with the field and vice-versa. Letter writing may therefore provide an avenue for HCPs to familiarise, learn and better understand other management options, as well as provide avenues in which HCPs can access evidence-based information about other medical systems that otherwise maybe rarely drawn upon.

It is noteworthy that CM practitioners may attract patients who are "doctor/medically averse". In these instances, the CM practitioner is uniquely placed to build a strong therapeutic alliance to encourage their patients to access all the healthcare they need. A well-crafted referral letter to a medical doctor offers practical support to medically averse patients from an advocate who understands and can communicate their values and preferences. In doing so, patients stand to benefit from a truly integrative model of care.

Rationale for communication tools

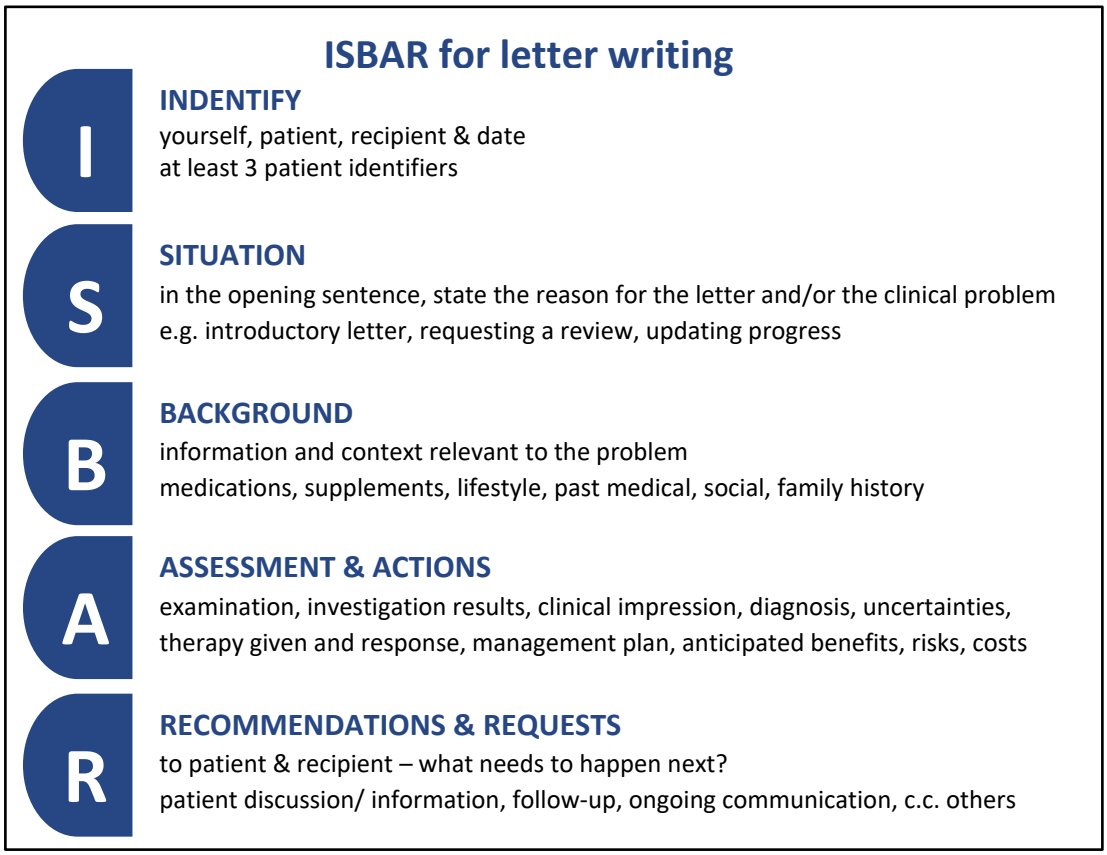
Interprofessional communication is a critical component of effective collaboration, particularly when HCPs are delivering multifaceted interventions for patients with complex care needs. Communication tools are therefore recommended as a method for improving the quality of healthcare (Fereday, 2015). Increasingly, post-graduate training is responding to the need for better interprofessional communication and letter writing, that includes generating letter templates and prompt sheets (Tattersall et al., 2002). Templates and prompts can save time and improve clarity (Ramanayake, 2013).

However, there are few resources from Australian professional associations providing guidance and practical support to their members on the topic of interprofessional IM communication. The Royal Australian College of General Practice (RACGP) position statement provides advice to GPs about how to respond to a patients' request

for investigations not considered clinically appropriate or ineligible for a Medicare rebate. The statement is accompanied by information for patients and a letter template for GPs to write to a CM practitioner if the CM practitioner had recommended these investigations (RACGP, 2016b). Few other professional associations have issued similar guidance for their members and nor provided practical resources that actively promote interprofessional communication. As such, there is the risk that many patients will be left with the task of coordinating their care between different HCPs and communicating complex medical information without the necessary skills or support.

ISBAR communication framework

The ISBAR framework (Identify, Situation, Background, Assessment and Recommendation) has been widely adopted and recommended by Australian health care providers to promote the transfer of essential information about the care of a patient between HCPs (NSW-Health, 2009). The ISBAR framework has been shown to help bridge cultural differences between the way different HCPs think and communicate (Achrekar et al., 2016).



The system originates from SBAR that is the most frequently used mnemonic in health and other high-risk environments such as the military when communicating critical information either verbally or written. The addition of "I" in ISBAR was to ensure the accurate identification of the patient and the practitioners (NSW-Health, 2009). To improve the framework's application to letter writing, AICWG has extended the letter A to included Actions (i.e. *Assessment & Actions*) and the letter R to include Requests (i.e. *Recommendations & Requests*). The practical application of this framework for writing letters of correspondence will be covered in detail in the next section.

Medico-legal considerations for IM communication

There is a paucity of legal authority regarding the practice of IM in Australia. Medico-legal considerations regarding interprofessional communication and referrals are therefore governed by the HCPs' professional codes of conduct, duty of care and any statutory regulations, along with general laws governing criminal behaviour and confidentiality / privacy (Brophy, 2011).

Potential medico-legal and clinical risks of IM practice

1. Failure to ensure a biomedical differential diagnosis has been undertaken
2. Missed or delayed biomedical diagnosis
3. Failure to take a medication history and to check for potential interactions between pharmaceutical and natural health products
4. Complications arising from integrating different interventions
5. Multiple practitioners, interventions and poly-pharmacy
6. Patient confusion and other risks from conflicting advice from different HCPs
7. Failure to conduct appropriate clinical investigations or offer the most effective and safest management options, irrespective of whether the investigation or intervention is classified as biomedical or CM
8. Ordering an investigation without the appropriate clinical training to interpret the results
9. Insufficient clinical training to provide the intervention (biomedical or CM)
10. Failure to obtain informed patient consent, particularly when there are high risks associated with the proposed management or patient refusal of the most effective management option
11. Making a negligent referral to a HCP

In the context of IM healthcare in Australia, as a general rule, the requirement to offer safe, effective biomedical care supersedes other CM or allied health practices. A HCP's duty of care reflects their scope of clinical practice and the risk of harm. Under common law, the standard of reasonable care for a HCP is *'that of the ordinary skilled person exercising and professing to have that special skill'* (Brophy, 2011). In other words, a HCP is judged according to the level of care and skill that is widely accepted by a significant number of their professional peers to be competent and appropriate clinical practice.

IM risk management

Practitioners are obliged to take reasonable steps to avoid foreseeable risks and harm to their patients. This includes clearly communicating to patients any relevant limitations in the practitioner's scope of clinical practice and thus the importance of coordinating multidisciplinary care.

Along with the general risk of any clinical practice, there are specific risks from IM practice and working in an integrative manner with other HCPs in Australia. It is recommended that all HCPs are aware of the potential medico-legal and clinical risks of interdisciplinary IM practice and mitigate these appropriately to ensure the provision of the safest possible care, with the best outcomes for their patients

Referrals to other HCPs

A HCP may be found liable for a negligible referral if they fail to refer their patient to a suitably qualified HCP or if the modality was inappropriate for the patient's condition (Brophy, 2011). The referring HCP is legally obliged to undertake all reasonable steps to minimise risk and avoid any harm to their patient that would be considered to be 'reasonably foreseeable' (Brophy, 2011).

Brophy makes two recommendations for reducing the risk of a negligent referral (Brophy, 2003). First, the HCP should recommend a modality that is informed by the best available evidence about potential benefits and risks and aligns with the patient's preferences and values. This is referred to as evidence-based medicine or evidence-based practice. Second, the practitioner should ensure they recommend the patient to a suitably qualified HCP. This may include obtaining further information from the practitioner.

Regarding the determination of a 'suitably qualified' HCP. If the practitioner has statutory registration through the Australian Health Practitioner Regulation Agency (AHPRA), this is generally considered to be adequate for vetting the practitioner's qualifications, professional code of conduct, continuing professional development activities and insurance. Along with most allied health practitioners, doctors, dentists and nurses, osteopaths, chiropractors and Chinese medicine practitioners are regulated through AHPRA. Other practitioners self-regulate through voluntary membership with a professional body (e.g. dietitians, social workers, naturopaths,

herbalists, nutritionists, massage therapists, lifestyle coaches, yoga / tai chi / qi gong therapists). Membership with a professional association however, is not compulsory. Although professional indemnity insurance is optional by law, most professional associations require their members to be insured and have a current first aid certificate. This standard of professional accreditation is required for consultations to be eligible for a private health insurance rebate.

When vetting a practitioner, consider asking about

1. Training and qualifications
2. Registration with AHPRA and/or accreditation with a professional body
3. Public Liability and/or Professional Indemnity Insurance
4. Continuing professional development activities
5. Current first-aid certificate
6. A description about the proposed intervention
7. Any scientific or traditional evidence about safety and effectiveness
8. Logistical implications for patients (e.g. time, effort, cost)
9. How the success or failure of the intervention is assessed
10. Any contraindications or potential risks
11. If CM products or medicinal foods are prescribed, what are the information sources to check for potential pharmaceutical interactions or medical contraindications
12. Systems in place for identifying 'red flags' and referring patients on for a biomedical review if indicated

Pathology and investigations

Aside from MBS considerations, ordering investigations has implications for best-practice and medico-legal liability. The RACGP's patient information on appropriate diagnostic testing, lists the questions a practitioner should consider before requesting an investigation (RACGP, 2016a). Along with the direct risks and costs of conducting an investigation, other potential risks include incorrect reassurance or delayed diagnosis from a false negative result, further unnecessary investigations or treatment following a false positive result, and delayed diagnosis or treatment from either over or under investigating.

Increasingly, CM practitioners are creating their own commercial account with a pathology laboratory. Request forms and pricing can be tailored. The patient is usually required to pay up front for these investigations. This practice is not without risks, such as a delayed or missed medical diagnosis, as the interpretation of the results

will be limited by the knowledge and scope of practice of the requesting HCP. Further, patients may assume they have been adequately investigated and not seek a second opinion from a suitably qualified medical practitioner. It is therefore good practice for all HCPs involved in a patient's care, and often for the patient, to be sent a copy of the results and to clearly communicate with the patient and other HCPs about how and when the results will be reviewed, and under what circumstances should a second opinion be sought.

Reviewing investigation results

If in doubt, HCPs should always seek a second opinion about the interpretation of results

Acknowledge and communicate any limitations with interpreting results due to clinical training, expertise or scope of practice

Provide clear instructions about how and when results are reviewed

Document instructions given to the patient in their clinical records

Generally, the requesting HCP is responsible for reviewing, interpreting and actioning the results of any test they order. Although results can be shared with other HCPs, the responsibility of following up the results usually resides with the requesting practitioner. Having said this, the RACGP recommends that irrespective of who ordered a test, if there is any doubt about whether the results have been reviewed and appropriately actioned the GP should proactively follow up with the patient or requesting practitioner (RACGP, 2017). Based on the RACGP's recommendations it seems reasonable that irrespective of the initiator of the investigation, all HCPs involved in a patient's care should be proactive in following up the results of investigations with their patient and/or other members of the patient's healthcare team. The requesting HCPs may also request that a copy of the results be sent to other HCPs and/or the patient. Formal communication, such as a letter of correspondence, can be used to clarify which investigations have been ordered, where the results are being sent, and which practitioners are responsible for reviewing and actioning the results, as well as a timeframe.

When to c.c. investigation results

Pending patient consent, request forms should ask that a copy of the results to be sent to the patient's GP and any other relevant HCPs.

Unless there is a reason not to (e.g. the results could be misinterpreted or cause unnecessary distress), patients should be given the option of also being sent a copy of their results

LETTER WRITING

INDENTIFY

SITUATION

BACKGROUND

ASSESSMENT & ACTIONS

RECOMMENDATIONS & REQUESTS

Professional letter writing guidelines

Letter writing is a skill that takes practice. At first it may seem daunting, yet with time and the right guidance (and a few helpful prompts and templates), all HCPs can write a good letter.

Letters are a legal document and it is the responsibility of the practitioner to ensure that all the information, statements and claims in the letter are accurate and that the confidentiality of the patient is maintained.

Confidentiality

Before a practitioner communicates any confidential information with a third party, patient consent is required. This includes all letters of correspondence and results of investigations. Consent may include written signed consent or verbal consent that is ideally documented. Consent is assumed if the patient personally delivers a letter or request form. Faxed letters and electronic referral letters are the most secure forms of communication, followed by postal mail. Email can be used if the server is secure and the patient provides specific consent.

Consent to c.c. patient

Including the patient (or their guardian) in the list of recipients to receive a carbon copy (c.c.) of the letter aligns with the principles of patient-centred care. It can help build a therapeutic alliance by demonstrating greater openness and signalling to the patient that they are an important person in the management team. The process can be empowering, aid the patient's understanding, provide a useful summary of the management plan and thus improve compliance and follow-up (Smith, 2002). The patient can also check for any factual errors and seek clarification. There are instances however, when it is unnecessary or inappropriate to c.c. the patient or their guardian. For example, the patient may not provide consent and decline the offer to be c.c., or the HCP may be concerned that sharing this information may be detrimental to their patient's psychological or social wellbeing.

Content

It is important to efficiently communicate information, in a timely manner, about the diagnosis and/or problems, current medication and treatment, history and examination (including relevant psychosocial history), clinical progress and investigation results, management plan, and expected outcomes. Unfortunately, research consistently finds that many letters are poorly written, contain either too much or too little information, or arrive too late to be clinically useful (Tattersall et al., 2002). The most essential information that GPs want from the referring specialist that is often missing in reply letters, is more information about the proposed management plan, treatment options, prognosis, likely benefits, possible side effects and what the patient had been told (McConnell et al., 1999).

Length of letters

The length of the letter and content provided will reflect the complexity of the problem and whether this is the first letter or a follow-up letter. Information such as past medical and social history may not need to be repeated. Excluding tables or lists, a letter should ideally fit onto one to two A4 pages (Davenport, 2011). There are of course exceptions, however, anything longer is unlikely to be read in detail by a busy practitioner. Conversely, insufficient details can result in patients being incorrectly triaged by a busy clinic or hospital with subsequent delays in management (Hayes, 2015).

Templates and prompts

Most clinical software packages used by Australian doctors contain letter templates. These include autofill options that can save time and improve accuracy (particularly for identifying information). Although helpful, many of these resources require significant modification for the IM setting. For example, prompts typically ask for a diagnosis, yet most CM practitioners are advised that it is beyond their scope of practice to provide a biomedical diagnosis, however, the use of traditional diagnostic terms may only be relevant to colleagues within their own profession.

It is for these reasons that the AICWG have created purpose specific templates that can be used in the IM setting. The aim is to help practitioners organise their thoughts and provide prompts to ensure that essential information is communicated. Practitioners may want to modify the templates and use hybrid combinations of these letter templates to suit the clinical situation. The five letter templates are:

1. General introduction / information letters

This template is designed for instances when the practitioner would like to open communication pathways with another HCP, perhaps to introduce themselves and/or to inform or update the practitioner about a patient they are both seeing, and the services or management being provided.

2. Red flag letters

This template is designed to be short, to the point and for instances when the practitioner needs to formally advise another HCP about a clinical presentation that is beyond the practitioner's scope of practice and may require urgent or semi-urgent assessment.

3. Referral / request letters

This template is designed for instances when a HCP is requesting a non-urgent clinical review or further information about a patient. It includes suggestions for how to make specific requests for information or investigations to help ensure safe, effective and coordinated care. Rather than making specific requests for

investigations, it is recommended that HCPs request an assessment and opinion. The template also aims to help address complaints from GPs that led to the RACGP position statement, letter templates and information for patients about how to respond to patient requests for tests recommended by CM practitioners (RACGP, 2016b).

4. Reply letters

This template encourages HCPs to acknowledge and respond to a referral letter from another practitioner. Although this practice is commonplace for specialist medical practitioners, as yet, it is not routine practice for other HCPs, including GPs.

5. Thank you letters

HCPs are encouraged to provide feedback to another practitioner who has undertaken a clinical review of a patient or forwarded clinical information or the results of an investigation. In doing so, the HCP can demonstrate how this collaboration has informed their management plan and benefited the patient.

ISBAR for letter writing

The five letter templates are structured around the ISBAR framework - Identify, Situation, Background, Assessment/Actions, Recommendations/Requests.

ISBAR is problem-focused and provides a structure for communicating key information about the current problem/s and prompts the practitioner to clearly state the reasons for the letter and any further action that is needed. The ISBAR proforma is a critical clinical information sharing guide for strengthening communication between health care providers.

I

INDENTIFY – yourself, patient, addressee, c.c. others, date

1. Clearly identify where the letter was sent from (e.g. letterhead with logo, name of clinic, address, phone/fax, email/website).
2. Date the letter on the top left or right side.
3. Identify yourself (e.g. your full name, qualifications, relevant practitioner registration/insurance numbers, optional direct phone number or email address) either at the start or end of the letter.
4. Clearly identify to whom the letter is for and their address.
5. Identify your patient (Re: First Name, Last Name, DOB:DD/MM/YYYY, address, phone). Provide at least three identifiers for your patient/client. Centre patient details either above or below the opening greeting - "Dear ……."
6. If you are sending the letter to multiple people, place their details under your sign off, so the person receiving this letter can see who else is being kept in the loop i.e.

   c.c. Practitioners' names, postal addresses

   Patient's name, postal address

S

SITUATION – state the reason and purpose of the letter

in the opening sentence, state the reason for the letter and/or the clinical problem

e.g. introductory letter, requesting a review, updating progress.

B

BACKGROUND – provide context of the current problem/s

Briefly summarise

1. The reasons why the patient came to see you.
2. Clinical history. If appropriate, summarise (if there is a lot of information use points or a table).
1. Current medication/supplements.
2. Known allergies, intolerances, adverse reactions.
3. Past medical history (and dates).
4. Lifestyle, social history, family history.

A

ASSESSMENT & ACTIONS – clinical impression, actions taken, management, rationale

Describe what you have found on examination and relevant results from investigations etc. that are relevant to the current problem/s. Then describe any treatment provided / management plan. Consider commenting on the rationale such as **anticipated benefits, uncertainties, risks and costs**.

Use any of the following points that are appropriate or relevant.

1. Provide rationale for your actions / management e.g. *"based on traditional knowledge", "based on my assessment", "in my experience", "clinical trials have demonstrated", "given patient X's preferences".*
2. Diagnosis (biomedical or traditional) or possible underlying causes.
3. Other management options and why these weren't used or recommended.
4. Briefly describe or list the interventions provided, duration, etc.
5. Details of any response or non-response to date e.g. *"Immediately following treatment, pain started to improve. Four weeks later, fatigue and mood had considerably improved."*
6. If you are unsure about the diagnosis or management, then state this along with any concerns e.g. *"I am worried about the severity of the symptoms; "I am concerned about the lack of improvement/continuing deterioration"; "I am concerned there has been no evaluation by a medical practitioner*"; *"I am unsure about the underlying cause/diagnosis".*

R

RECOMMENDATIONS & REQUESTS – including planned review

1. Document any discussion with the patient about anticipated future benefits from management, possible side effects, safety concerns and costs.
2. State if/when you are next planning to see/review your patient e.g. *"Jane has an appointment to see me in 3 weeks"; "If symptoms get worse, I have asked Jane to contact me"*
3. Any other instructions given or discussed with your patient e.g. *"I have asked patient X to follow-up with you for further investigation" "Although patient X is reluctant to seek a medical opinion, I have reassured him/her that you are an excellent clinician who is open-minded and non-judgmental"; "I have strongly recommended patient X consults you immediately"*
4. Conclude with any further requests or recommendations to the recipient regarding help that you and/or the patient needs e.g. "*Please contact me if you have any concerns or questions"; "Please confirm the accuracy of my medical history, allergies and medication list so I may check for any possible interactions or contraindications"; "Please (urgently) assess and investigate accordingly"; "I would be grateful if you would keep me informed regarding…"*

Common language / terminology

The use of commonly understood terms and concepts when describing problems, symptoms, signs, diagnosis or management will minimise the risk of miscommunication and being misunderstood. For CM practitioners, this may include limiting or avoiding non-medical terms when communicating with HCPs from different fields. While for biomedical practitioners this may include ensuring that any medical terms used are widely understood by lay people. Depending on to whom the letter concerns, terms should be accompanied with a brief explanation.

Guidance for the use of terminology

Does it help communication in any way?

If in doubt leave it out

Practitioners should only use bio-medical terms if they are confident about their meaning. If it is not in the HCP's scope of practice to make a bio-medical diagnosis, then the default is to simply describe the problem, symptoms and signs using plain English. However, any HCP may state that they *suspect* a condition/diagnosis and request a medical review or clinical opinion.

Traditional medical terms i.e. terms not used in conventional medical practice, contentious or emerging concepts will only be meaningful to HCPs with a similar traditional medicine backgrounds. If traditional medical terms are used, provide an explanation to ensure that the receiving HCPs and patient understand its meaning. For example, *"I have discussed with patient X that her traditional Chinese medicine diagnosis is Liver Qi deficiency, which in this case is analogous to stress and anxiety. I have explained that this traditional diagnosis is not related to the liver organ nor its function".* For Chinese medicine, it is recommended that the terminology aligns with those used in the WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region (WHO, 2007). Contentious or emerging terms such as *leaky gut*, *liver detox* and *adrenal fatigue* are best avoided. Instead, use general terms to describe the management plan and its rationale. For example, *"I have recommended the following naturopathic program to support gut health / liver health / energy".* More specific information could be provided if there is scientific evidence to support the claim and potentially improve communication.

Practitioners should be careful with using medical terms such as *allergy*. If in doubt, it is recommended to use non-specific terms such as *side-effect, reaction, sensitivity* or *intolerance*, or simply describe what happened following exposure to the drug, herb, food, etc. Practitioners should take care when describing reactions to food substances such as gluten and wheat. Coeliac disease is an autoimmune disease triggered by gluten exposure in a small percentage of a genetically predisposed population. Non-coeliac gluten sensitivity is a less understood condition that is used to describe clinical presentations associated with the dietary intake of gluten, including GI

symptoms. Until investigated, it would be appropriate for the practitioner to state that the history or clinical presentation "*suggests a possible intolerance to one of the components of common grains including gluten, short-chain carbohydrates (FODMAPS) or wheat proteins"*. Similarly, a diagnosis such as *irritable bowel syndrome (IBS)* should only be used if there has been a thorough medical review. In the interim, perhaps state the symptoms and signs are "*suggestive of IBS"*.

Management rationale

If the proposed management is likely to be poorly understood, potentially contentious, or the risks or costs are high, then along with discussing the patient's preferences, HCPs are encouraged to provide some information about the available evidence in support of their management plan. Examples include evidence-based guidelines for laboratory/radiology testing[1] or clinical practice guidelines[2]; Level I evidence (systematic reviews and meta-analyses), Level 2 evidence (double-blind randomised controlled trials), or lower levels of evidence such as unblinded clinical trials, pilot studies, case studies, or preclinical research. Anecdotal evidence (e.g. "*in my experience)* or traditional evidence (e.g. "*based on traditional knowledge/practice")* might also be given to support the management plan.

Patient preferences, cultural norms and religious beliefs are important and will influence management decisions. Examples include a preference to first try less invasive, less risky, or natural approaches despite scientific evidence to the contrary. Including relevant information in a letter about the patient's background and preferences provides contextual information to support the management plan. It demonstrates that informed consent has been obtained and provides advocacy in support of your patient's decision.

Requesting investigations

Practitioners are strongly advised to avoid sending a list of investigations and to carefully word any requests. It is disrespectful to tell another HCP how to do their job. Requests for investigations should therefore be made in the context of a referral letter e.g. *"I would value your clinical assessment and investigation"*.

Bear in mind, the requesting practitioner must be satisfied that the test is clinically indicated. Any requests for an investigation or results should ideally be accompanied by an explanation for how this information will assist

[1] this is an example of a peer reviewed paper that outlines the diagnosis and indications for investigating gluten related diseases https://www.racgp.org.au/afp/2014/october/coeliac-disease-where-are-we-in-2014/

[2] this is an example of a peer reviewed, evidence based guideline for the use of integrative therapies during and after breast cancer treatment. CA Cancer J Clin. 2017;67:194-232. doi: 10.3322/caac.21397 http://onlinelibrary.wiley.com/doi/10.3322/caac.21397/full

patient management (e.g. *to inform the type and dose of a nutritional supplement, to confirm or exclude a medical condition or contraindication, to monitor clinical response*).

Furthermore, there are a range of Medicare restrictions for pathology and radiology requests. This may conflict with the CM practitioners wish for extensive testing to identify subclinical problems or better inform the choice of nutritional supplements. Consider using qualifying statements that acknowledge the HCP's duty of care and any Medicare responsibilities e.g. *"if you consider these investigations are not clinically indicated, then patient X is stated they still wanted these investigations and is willing to pay for any investigations not covered by Medicare".*

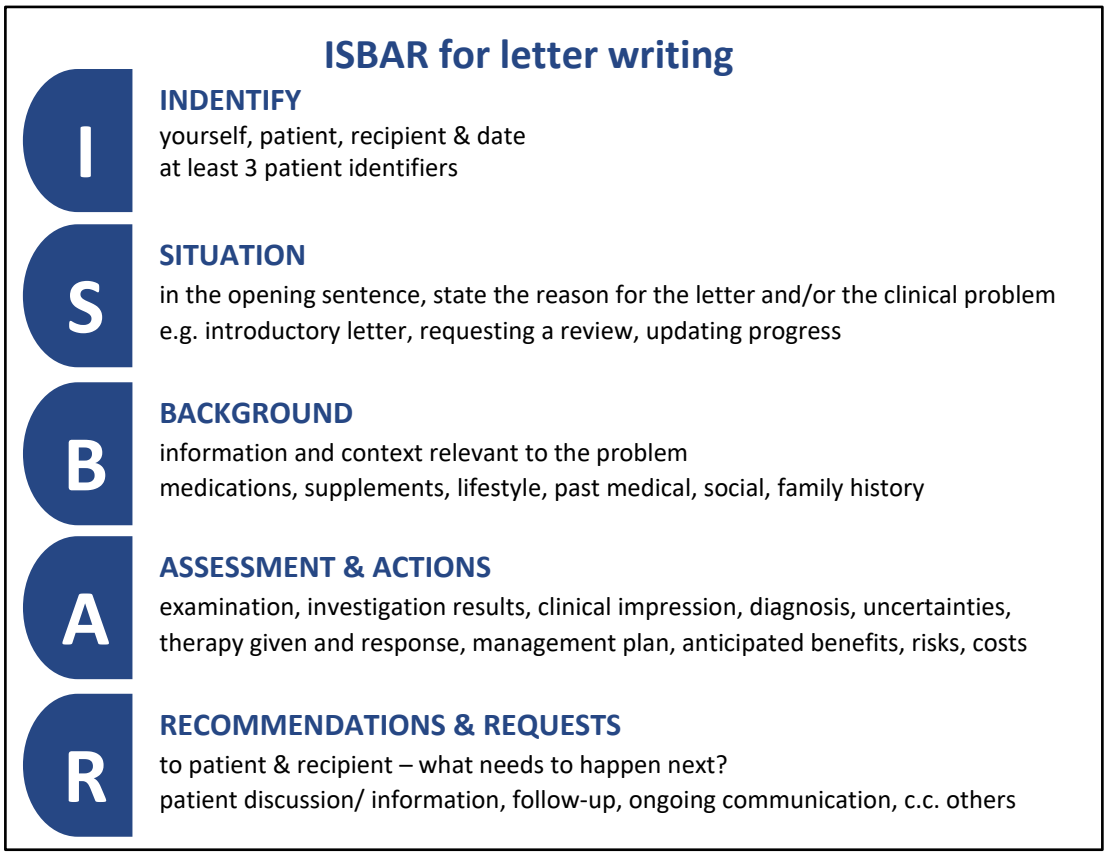
LETTER TEMPLATES

1. Introduction / information
2. Red Flag
3. Referral / request
4. Reply
5. Thank you

1. Introduction / information letter template

This template is designed for instances when the practitioner would like to open communication with another HCP, perhaps to introduce themselves and/or to inform or update the practitioner about a patient they are both seeing, and the services or management being provided. It is best suited for uncomplicated clinical presentation where the practitioner is confident about providing their clinical services and there are no red flags or other reasons to seek a clinical review of the recipient practitioner.

The template can be shortened, modified, and hybrid combinations of these letter templates can be used to suit the clinical situation. The symbols < > are used for information that is likely to be available using autofill functions. The symbols [ ] are used to provide explanatory information.



<LOGO>

<Practitioner Name>
<Type of practitioner/qualification/practitioner number etc>
<Clinic name, Address, Phone number, Email etc>

I

<Title><Healthcare practitioner name>,
<Address>
<Phone
<Date>

Re: <Patient name>
<DOB>
<Address, phone number etc>

Dear <Title><Healthcare practitioner name>,

S

I am writing to introduce myself and keep you informed about <Patient name>. I am a [practitioner type] with a special interest in / and have undertaken extra training in [optional extra information e.g. naturopathic support of fertility / oncology massage / integrative medicine]

<Patient name> first consulted me [date or number of years/months ago] for [reason / complaint].

Presenting complaints: [provide a brief history of the presenting complaint and current problems, relevant observations, investigations etc. List with dates if there are a lot of concurrent problems/complaints]

B

Past medical history: [Use autofill function in clinical software, or manually write a list with dates and/or a narrative summary of the relevant history]

Current medications/supplements: [Use autofill function in clinical software, or manually list. If relevant, include both pharmaceuticals and natural health products, state if you are unsure about name or dose]
Allergies, Intolerances, Adverse Reactions: [ensure the correct use of scientific terms]

Family history: [if relevant]
Social history: [relevant marital status, work, any stresses, family/social support]

Current lifestyle: [diet, physical activity, smoking, alcohol, recreational activities]

Examination: BMI was [number], weight [number Kg], height [number cm] and BP [number mmHg]. Other findings included [observations e.g. dry skin, general pallor, weak nails, frequent crying]

Investigation results: [if relevant]

A

Based on my assessment [optional - state the medical system / principles e.g. *traditional Chinese medicine, naturopathic, chiropractic*], I have provided / recommended / discussed [e.g. differential diagnosis, investigations ordered, treatment, dose, duration, advise or information

A

given]. The aim is to help alleviate / improve / support [symptoms, physiology]. Evidence in support of [if known provide information about any clinical research or proposed mechanism of action from a biomedical perspective e.g. *Treatment x has been shown in clinical trials to be effective, although its mechanism of action is unclear.*] Response to date includes [if relevant describe any outcomes].

I have explained to <Patient name> that the intervention is generally well tolerated and considered to be relatively safe [or other information to the contrary]. Possible side effects include [list and provide some indication of how common these are]. Potential interactions / contraindications are: [list relevant medications or conditions]. I am unaware of any (other) interactions or absolute contraindications.

R

I plan to review <Patient name> in [time frame]. In the meantime, with <Patient name> consent, please contact me if you have any questions, concerns or I have missed any relevant clinical information. I look forward to updating you on <Patient name> progress.

Kind regards,

<Your name>

c.c. <Title> <Healthcare practitioner name> <Address>
<Title> <Healthcare practitioner name> <Address>
<Title> <Patient name> <Address>

EXAMPLE OF INTRODUCTION / INFORMATION TEMPLATE

Chris Christopher
Chinese Medicine Clinic
2 John St, Suburb, 0000
02- 20202002

I

Dr Kim Smith
PO Box 0000
Sydney NSW 2000

01/01/2018

Re: Jane Doe
DOB: 01/01/1981
Address: 1 Smith St
Smithfield NSW 2001

Dear Dr Smith,

S

I am writing to introduce myself and keep you informed about our mutual patient, Jane Doe. I am an AHPRA registered Chinese Medicine practitioner with training in acupuncture and herbal medicine.

Jane first consulted with me one week ago regarding gastrointestinal symptoms, migraines and stress.

B

Jane told me that for many years she has been suffering from a range of gastrointestinal symptoms, mostly bloating and flatulence. Recently, these symptoms have become more frequent and intense. Jane tells me that she is often constipated, and it is not uncommon for her to pass stool only once every two to three days. Jane commented that her stress levels at work have recently increased and she is suffering from more migraine attacks that are now occurring once every two to three weeks and include visual disturbance.

As you know Jane has a history of gastrointestinal issues. I understand that Jane was diagnosed with irritable bowel syndrome many years ago.

Jane advised me that she is not taking any medications or supplements and has no known allergies. Jane is single and originally from Ireland, living in Sydney for past 7 years. She maintains a healthy diet and is very active and exercises daily. Jane consumes on average 8 units of alcohol per week. Relevant family history includes migraines and gluten intolerance.

A

On examination Jane had no tenderness of the abdomen. Based on my Chinese Medicine assessment I administered acupuncture for large intestine health and general gastrointestinal symptom relief, headaches and relaxation. I have explained to Jane that acupuncture is generally a safe and well tolerated, with minimal side effects.

R

I have recommended a trial treatment of six weeks of weekly acupuncture. Depending on Jane's response, I have also suggested that herbal medicine similar to the Chinese herbs used in a clinical trial for irritable bowel syndrome (JAMA. 1998;280(18):1585-1589) may be beneficial and we will discuss this further next time I see Jane. I have discussed the recommended management plan with Jane, including anticipated out-of-pocket costs.

Jane is planning to see you for a general review and I have encouraged her to follow-up with you to ensure there are no medical issue requiring attention.

R

In the meantime, with Jane's consent, please contact me if you have any questions, concerns or I have missed any relevant clinical information. I would appreciate being c.c. any relevant investigations or correspondence.

I look forward to updating you on Jane's progress and continuing to work together to help Jane reduce her symptoms and improve her quality of life and wellbeing.

Warm regards,

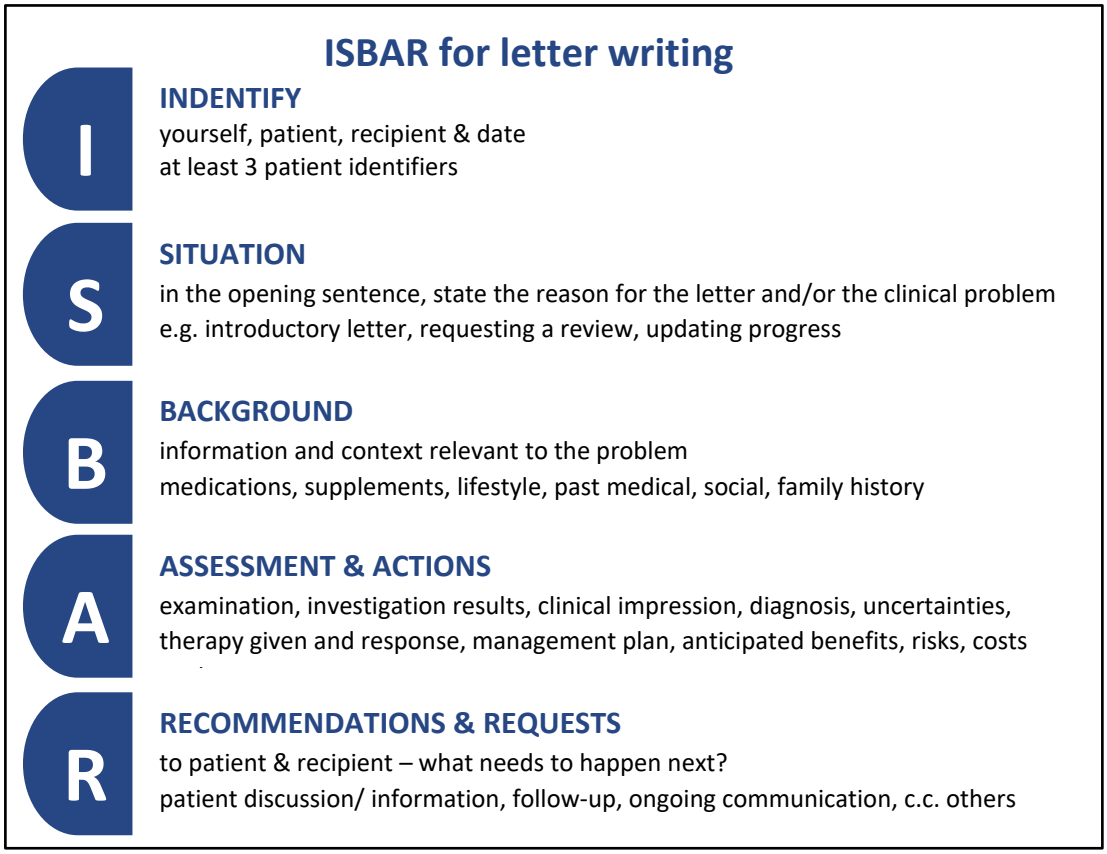
Chris Christopher (BSHc. Acup & Chinese Med, CMRB)
AHPRA Registered Chinese Medicine Practitioner

c.c. Jane Doe, 1 Smith St, Smithfield NSW 2001

2. Red flag letter template

This template is designed to be short, to the point and for instances when the practitioner needs to formally advise another HCP about a clinical presentation that is beyond the practitioner's scope of practice and may require urgent or semi-urgent assessment.

The template can be shortened, modified, and hybrid combinations of these letter templates can be used to suit the clinical situation. The symbols < > are used for information that is likely to be available using autofill functions. The symbols [ ] are used to provide explanatory information.



I

<LOGO>

<Practitioner Name>
<Type of practitioner/qualification/practitioner number etc>
<Clinic name, Address, Phone number, Email etc>

<Title><Healthcare practitioner name>,
<Address>
<Phone>
<Fax>

<Date>

Re: <Patient name>
<DOB>
<Address, phone number etc>

Dear <Title><Healthcare practitioner name>,

S

Thank you for seeing <Patient name> for an (urgent) assessment of [problem/symptom/sign e.g. *acute inflammation in his/her left lower leg, OR acute onset of severe lower back pain with urinary incontinence, OR rapid weight loss, OR a breast lump*]

B

<Patient name> saw me on [date] for a [modality] consultation.

Presenting complaints: [provide a brief history of the presenting complaint and current problems, relevant observations, investigations etc. List with dates if there are a lot of concurrent problems/complaints].

A

I have discussed my concerns about [possible differential diagnosis or the importance of a medical review] with <Patient name> and have recommended he/she see you immediately.

Pending your review and recommendations, I plan to see <Patient name> in [duration - days, weeks, months].

R

I would be grateful if, with <Patient name> consent, you would inform me of your assessment and management. If appropriate, please cc <Patient name> and me on any relevant communication and results of investigations.

Kind Regards,

<Your name>

c.c. <Title> <Healthcare practitioner name> <Address>
<Title> <Healthcare practitioner name> <Address>
<Title> <Patient name> <Address>

EXAMPLE OF THE RED FLAG TEMPLATE

Jenny Therapist
Oncology Massage Clinic
2 John St, Suburb, 0000
02- 20202002

I

Dr James Smith
PO Box 0000
Sydney NSW 2000

01/01/2018

Re: John Doe
DOB: 01/01/1950
Address: 1 Smith St
Smithfield NSW 2001

Dear Dr Smith**,**

s

Thank you for seeing John Doe for an urgent assessment of inflamed, red, swelling in the lower left limb.

B

John saw me today for an oncology massage consultation.

John has had ongoing back issues and has regular massage to help with his symptoms. He is five years post treatment for prostate cancer. Today I noted redness, swelling, inflammation and heat in his left lower leg.

A

I have discussed my concerns about a possible infection or blood clot with John and have recommended he see you immediately.

R

Pending your review and recommendations, I plan to see John in two weeks' time.

I would be grateful if, pending John's consent, I am kept informed of your assessment and management. If appropriate, please cc John and me on any relevant communication and results of investigations.

Kind Regards,

Jenny Therapist

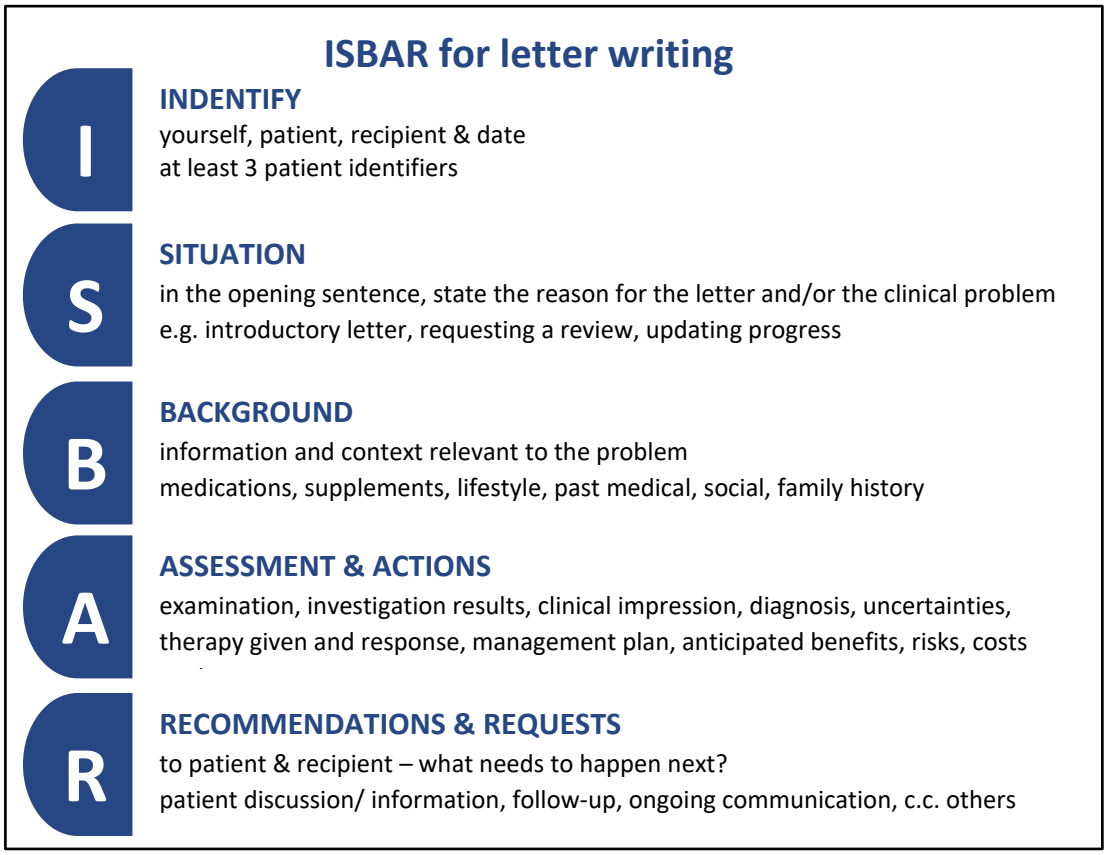
(Letter faxed to 02-30303030 at 11.15am)

3. Referral / request letter template

This template provides guidance for HCPs making specific requests. It is written as a referral letter and includes suggestions for how to make specific requests for information or investigations to help ensure safe, effective and coordinated care. Rather than making specific requests for investigations, it is recommended that HCPs couch such requests in the form of a referral letter for an assessment and opinion.

The template also aims to help address complaints from GPs that led to the RACGP position statement, letter templates and information for patients about how to respond to patient requests for tests recommended by CM practitioners (RACGP, 2016b). Further background information about requesting investigations is discussed in the letter writing guidelines.

The template can be modified, and hybrid combinations of these letter templates can be used to suit the clinical situation. The symbols < > are used for information that is likely to be available using autofill functions. The symbols [ ] are used to provide explanatory information.



I

<LOGO>

<Practitioner Name>
<Type of practitioner/qualification/practitioner number etc>
<Clinic name, Address, Phone number, Email etc>

<Title><Healthcare practitioner name>,
<Address>
<Phone>
<Fax>

<Date>

Re: <Patient name>
<DOB>
<Address, phone number etc>

Dear <Title><Healthcare practitioner name>,

S

Thank you for reviewing <Patient name> for assessment and investigation/management of [problem / symptom / concern].

I am a [practitioner type] with a special interest in / and have undertaken extra training in [optional extra information e.g. naturopathic support of fertility / oncology massage / integrative medicine].

B

<Patient name> first consulted me [date or number of years/months ago] for [reason].

Presenting complaints or problems: [provide a brief history of the presenting complaint and current problems, relevant observations, investigations etc. List with dates if there are a lot of concurrent problems/complaints]

Past medical history: [Use autofill function in clinical software, or manually write a list with dates and/or a narrative summary of the relevant history]

Current medications/supplements: [Use autofill function in clinical software, or manually list. If relevant, include both pharmaceuticals and natural health products, state if you are unsure about name or dose]
Allergies, Intolerances, Adverse Reactions: [ensure the correct use of scientific terms]

Family history: [if relevant]
Social history: [relevant marital status, work, any stresses, family/social support]

Current lifestyle: [diet, physical activity, smoking, alcohol, recreational activities]

A

Examination: BMI was [number], weight [number Kg], height [number cm] and BP [number mmHg]. Other findings included [observations e.g. dry skin, general pallor, weak nails, frequent crying]

A

Investigation results: [if relevant]
Based on my assessment [optional - state the medical system / principles e.g. *traditional Chinese medicine, naturopathic, chiropractic*], I have provided / recommended / discussed [e.g. differential diagnosis, investigations ordered, treatment, dose, duration, advise or information given – see General Informative letter for optional extra details to include]. I am unaware of any (other) interactions or absolute contraindications.

R

I have recommended that <Patient name> consults you for consideration of further investigations for [symptom/problem e.g. fatigue] such as [conditions to test for e.g. anaemia, hypothyroidism, B12 deficiency].
OR
<Patient name> and I would appreciate your opinion regarding the need for further investigations. I discussed with <Patient name> that the following tests might be indicated pending your clinical assessment: [list tests and rationale e.g. Thyroid function tests (hair loss, inability to lose weight, poor concentration, fatigue), FBC, iron studies and B12 (pallor, fatigue, low animal product intake)]. <Patient name> is happy to pay for any testing not covered by Medicare.

I would be grateful if with <Patient name> consent, you could cc <Patient name> and me on any relevant communication and results of investigations. I plan to review <Patient name> in [time frame] and look forward to updating you on <Patient name> progress. In the meantime, please contact me if you have any questions or would like further information.

Kind Regards,

<Your name>

c.c. <Title> <Healthcare practitioner name> <Address>
<Title> <Healthcare practitioner name> <Address>
<Title> <Patient name> <Address>

EXAMPLE OF REFERRAL / REQUEST LETTER TEMPLATE

Jane Therapist
Natural Health Clinic
2 John St, Suburb, 0000
02- 20202002

I

Dr John Smith
PO Box 0000
Sydney NSW 2000

01/10/2018

Re: Alina Adams
DOB: 01/01/1996
Address: 1 Smith St
Smithfield NSW 2001

Dear Dr Smith**,**

S

Thank you for reviewing Alina Adams for assessment and investigation of fatigue and weight gain associated with infertility. Alina advised me that you are her regular GP and has provided consent for me to contact you.

I have a degree in naturopathy and a special interest in fertility and perinatal health. I work closely with local obstetricians and GPs to assist couples who are trying to conceive by providing natural therapies and lifestyle advice.

B

Presenting problem: I met Alina and her partner Peter for the first time today. They have been trying to conceive for over 8 months and currently have no children. Alina is also struggling with losing weight and is constantly tired. Other relevant history includes an irregular menstrual cycle (every 5 to 8 weeks), dry skin and hair, and a flat mood (Alina states she is not depressed). When I asked Alina if she had consulted you or had been investigated, she said that she first wanted to see a naturopath and explore natural options.

- Trying to conceive for 8 months with no other children
- Alina struggling to lose weight
- Marked fatigue
- Oligomenorrhea: menses every 5-8 weeks
- Dry skin, hair, flat mood

Past medical history / medications / allergies: Alina states she was a healthy child and adolescent. Menarche was uneventful at the age of 13 years. She commenced oral contraceptives for period pain when she was 16 and stopped 12 months ago. Currently Alina is not taking any medication and has self-prescribed Flaxseed Oil and pregnancy multi-formula. She used to take Vitamin D3 following a doctor advising that her levels were low. I am unaware of any allergies; however, Alina suspects she may be gluten intolerant and states that if she eats a lot of wheat flour, she experiences a range of gastrointestinal symptoms, including bloating and loose stools.

Social / lifestyle / family history: Alina describes herself as generally happy despite her fatigue and has a supportive social network. Alina and her partner have been lacto-vegetarian for four years, she has a sweet tooth, walks for at least 30 minutes most days, attends a yoga class three times a week, is a non-smoker, drinks alcohol occasionally and teaches at the local primary school. Her mother had problems with fertility and eventually conceived in her late 20's, she now has type 2 diabetes and hypothyroidism.

A

Examination: Weight 69kg, BMI 27, Abdominal obesity, BP 115/75, Pallor

Based on my assessment, I have discussed the possibility of nutritional deficiencies and hormonal imbalances that could be causing Alina's infertility, fatigue and weight gain. I have provisionally recommended some basic dietary changes such as lowering sugar and carbohydrate intake and increasing vegetarian sources of protein, B12 and iron.

R

Before providing further naturopathic advice, including herbs or supplements, I have strongly recommended Alina consults you for a standard prenatal medical screen and a thorough medical assessment of her presenting problems. I mentioned to Alina that there is a possibility of hypothyroid disease, polycystic ovarian syndrome, or nutritional deficiencies including iron, B12, zinc and iodine, and that she should discuss this further with you. There is also the possibility of coeliac disease or gluten enteropathy and I would appreciate your opinion regarding whether further investigation is indicated.

Whilst I have a private account with a pathology laboratory and could order many of these investigations outside of Medicare, given Alina's clinical presentation I am reluctant to proceed without your medical assessment. Below is a list of laboratory tests that would help to inform my naturopathic advice, some of which you may consider are medically indicated.

Following your review and recommendations, I plan to see Alina in three weeks' time.

I would be grateful if, pending Alina's consent, I am kept informed of your assessment and management. If appropriate, please cc Alina and me on any relevant communication and results of investigations.

Kind Regards,

Jane Therapist
BHSc (Naturopathy)

c.c. Alina Adams, 1 Smith St, Smithfield NSW 2001

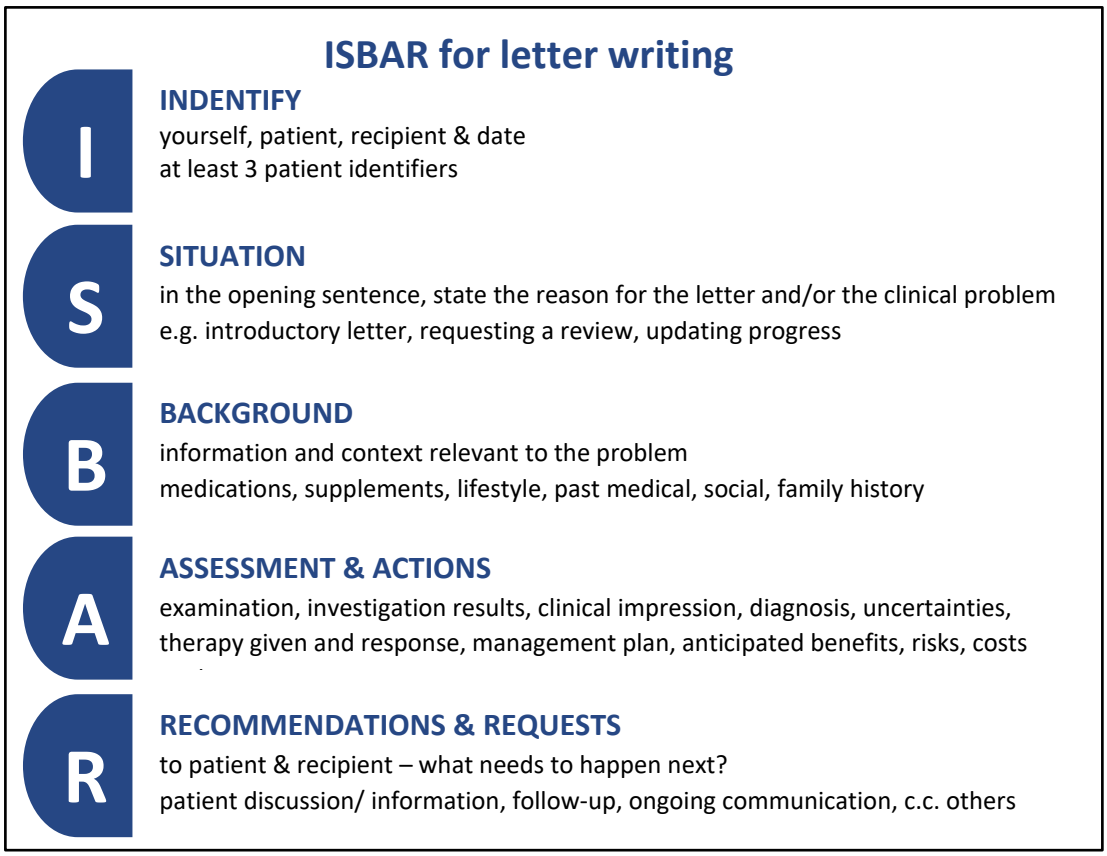
LIST OF INVESTIGATIONS THAT WOULD HELP INFORM MY NATUROPATHIC CARE

- Standard prenatal screening
- FBC – pallor suggesting possible anaemia
- Iron Studies, B12 and Red Cell Folate – assess prenatal status of essential fertility nutrients
- Fasting Glucose and Insulin – screen for insulin resistance related to PCOS
- TSH, T4, T3, Thyroid antibodies – can be indicated in PCOS
- Urinary Iodine – fasting WHO classified Australia as mildly iodine deficient nation – essential for fertility
- DHEAs and Morning Cortisol - Androgen levels for PCOS and to assess stress/ sleep
- Free Androgen Index and Testosterone free and total
- Oestradiol, LH, FSH, Prolactin – day 2 collection or anytime if cycle irregular
- Progesterone – day 21 of cycle or one week after ovulation with long cycles
- SHBG – can be elevated post OCP inhibiting menstruation
- Plasma Zinc – low dietary intake
- Serum Copper – studies show Zn:Cu imbalance is linked OCP use, high oestrogen, PCOS. If indicated, I will supplement with zinc and lower dietary copper intake to help support FSH and progesterone production.
- Vitamin D3 – previously low and low-moderate sun exposure
- Coeliac antibodies and gene testing

4. Reply to a referral letter template

This template encourages HCPs to acknowledge and respond to a referral letter from another practitioner. Although this practice is commonplace for specialist medical practitioners, as yet, it is not routine practice for other HCPs.

The template can be modified, and hybrid combinations of these letter templates can be used to suit the clinical situation. The symbols < > are used for information that is likely to be available using autofill functions. The symbols [ ] are used to provide explanatory information.



<LOGO>

<Practitioner Name>
<Type of practitioner/qualification/practitioner number etc>
<Clinic name, Address, Phone number, Email etc>

I

<Title><Healthcare practitioner name>,
<Address>
<Phone>
<Fax>

<Date>

Re: <Patient name>
<DOB>
<Address, phone number etc>

Dear <Title><Healthcare practitioner name>,

S

Thank you for asking me to review <Patient name> for assessment of [problem / symptom / concern].

Presenting complaints or problems: [provide a brief history of the presenting complaint and current problems, relevant observations, investigations etc. List with dates if there are a lot of concurrent problems/complaints]

B

Past medical history: [Use autofill function in clinical software, or manually write a list with dates and/or a narrative summary of the relevant history]

Current medications/Supplements: [Use autofill function in clinical software, or manually list. If relevant, include both pharmaceuticals and natural health products, state if you are unsure about name or dose]
Allergies, Intolerances, Adverse Reactions: [ensure the correct use of scientific terms]

Family history: [if relevant]
Social history: [relevant marital status, work, any stresses, family/social support]

Current lifestyle: [diet, physical activity, smoking, alcohol, recreational activities]

A

Examination: BMI was [number], weight [number Kg], height [number cm] and BP [number mmHg]. Other findings included [observations e.g. dry skin, general pallor, weak nails, frequent crying]

Investigation results: [if relevant]

Based on my assessment [optional - state the medical system / principles e.g. *traditional Chinese medicine, naturopathic, chiropractic*], I have provided / recommended / discussed [e.g. differential diagnosis, investigations ordered, treatment, dose, duration, advise or information given – see General Informative letter for optional extra details to include]. I am unaware of any (other) interactions or absolute contraindications.

R

I have discussed my recommended management plan with <Patient name> [any instructions given about ongoing care, HCPs roles, referral to HCPs, follow-up of investigation results or clinical review, costs etc].

I plan to review <Patient name> in [time frame] and look forward to updating you on <Patient name> progress.

If possible and with <Patient name> consent, please cc <Patient name> and me on any relevant [communication, investigation results, clinical progress]. In the meantime, please contact me if you have any questions or would like further information.

Kind Regards,

<Your name>

c.c. <Title> <Healthcare practitioner name> <Address>
<Title> <Healthcare practitioner name> <Address>
<Title> <Patient name> <Address>

EXAMPLE OF REPLY TO REFERRAL TEMPLATE

Jack Chiropractor
Chiropractic Care Clinic
2 John St, Suburb, 0000
02- 20202002

I

Dr Kim Lee
PO Box 0000
Sydney NSW 2000

01/01/2018

Re: David Carroll
DOB: 01/01/1950
Address: 1 Smith St
Smithfield NSW 2001

Dear Dr Lee**,**

S

Thank you for asking me to provide four sessions of Chiropractic care for David Carroll as part of the Enhanced Primary Care (EPC) program.

David saw me for the first time today, his primary concern was low back pain and secondary concern was thoracic pain with sensitivity to touch.

B

Mr Carroll tells me that he has been suffering from intermittent lumbar and thoracic pain since 2011. He reported being involved in a motor vehicle accident on 8th June 2011, during which he was knocked down by a car. He reported that he sustained injuries to his lower body and pelvic region and was admitted to hospital overnight. David is unsure whether any fractures were sustained. Although he was able to return to work shortly after the accident, Mr Carroll reports ongoing, intermittent low back pain and occasional thoracic discomfort that over time has become increasing worse in duration and severity. He denies any symptoms suggestive of radiculopathy such as referred pain, weakness or numbness in his lower limbs.

There are no obvious triggers such as lifting, or prolonged sitting or standing. When the pain is more severe, David uses Ibuprofen. Occasionally he still needs to take the day off work due to back pain.

Other past medical history includes hypertension requiring medication since 2015 and an increased cardiovascular risk due to rising cholesterol and difficulty losing weight. David reports that he is finding it harder to exercise regularly due to the increasing frequency and severity of back pain. David tells me that you are concerned that his ibuprofen may exacerbate his hypertension and cardiovascular risk.

Medications & Supplements
Ramipril 5mg daily
Fish Oil 2 capsules daily (various products and doses purchased from supermarket)
Ibuprofen 200mg 1-2 tablets q.i.d. if needed.

I am unaware of any allergies nor any relevant family history.

Mr Carroll is married with two teenage daughters. He works in retail and is on his feet most of the day. David does not have a regular exercise routine. He is using his 5th EPC consultation to see a dietitian, Ms Dianne Black for help with lowering his cholesterol and losing weight.

A

On examination, David was overweight at 85kg (BMI 26.2). Today he was pain free and there were no signs of radiculopathy.

Surface electromyography (EMG) and thermography indicated an altered pattern of increased muscle activity in the lumbar and upper thoracic spine. Erect postural X-rays showed loss of disc height at L5/S1 and degeneration of the lower back and a postural scoliosis of the thoracic spine with accompanying degeneration between T6 and T10.

Based on this assessment, Mr Carroll's presentation is consistent with chronic postural compensations of the spine and related pelvic region, subsequent to a chronic ligament laxity following a sprain/strain injury. The above described injury in 2011 is a likely underlying contributor.

Today, I commenced a program of corrective chiropractic whole body postural adjustments that will be delivered weekly for 16 weeks. The chiropractic adjustments notably do not involve any twisting or torsion of the spinal segments and will be accompanied by a self-help tailored exercise program to be rigorously maintained by Mr Carroll.

R

I have discussed the recommended management plan with Mr Carroll, including anticipated out-of-pocket costs. Since he does not have private health insurance and earns a modest income, I will bulk-bill him for the first four sessions under the EPC. I have advised David that if he actively participates in this program and is diligent with keeping his appointments and self-management exercises, then he can anticipate significant long-term improvement in his symptoms. We will monitor his progress using a self-scoring visual analogue pain scale and postural assessments.

I plan to review Mr Carroll in one week. I look forward to updating you on his progress at the completion of the four EPC consultations and at the completion of the 16-week program.

I would be grateful if, with Mr Carroll's consent, you could keep me informed of any relevant clinical changes. If appropriate, please cc David and I on any relevant communication and results of investigations.

Kind Regards,

Jack Chiropractor
BchiroSc. MChiro

c.c. David Carroll, 1 Smith St, Smithfield NSW 2001

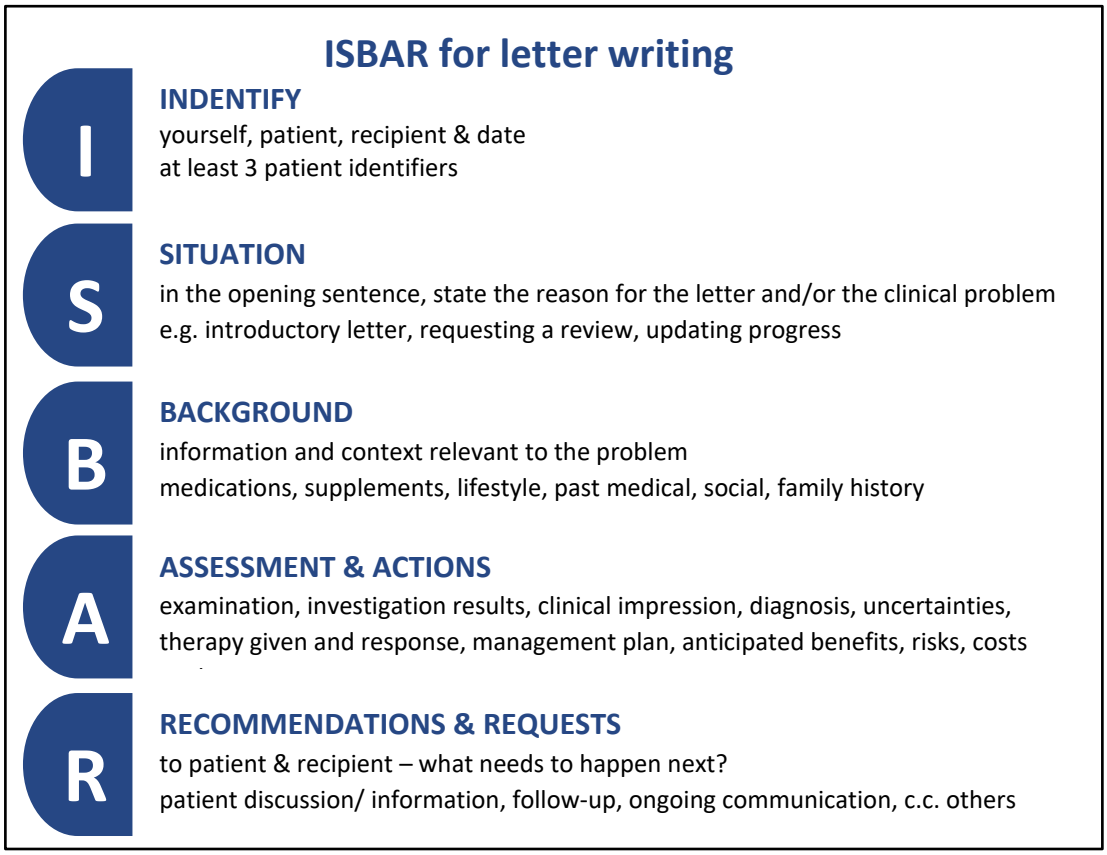
Ms Dianne Black, Food for Life, 20 Main Ave, Smithfield NSW 2001

5. Thank you letter template

This template encourages HCPs to thank another practitioner who has undertaken a clinical review of a patient or forwarded requested clinical information or investigation results and provide feedback that demonstrates how this collaboration has informed their management plan and benefited the patient.

The template aims to help address complaints from GPs that lead to the RACGP position statement, letter templates and information for patients about how to respond to patient requests for tests recommended by CM practitioners (RACGP, 2016b). Further background information about requesting investigations is discussed in the letter writing guidelines.

The template can be modified, and hybrid combinations of these letter templates can be used to suit the clinical situation. The symbols < > are used for information that is likely to be available using autofill functions. The symbols [ ] are used to provide explanatory information.



<LOGO>

<Practitioner Name>
<Type of practitioner/qualification/practitioner number etc>
<Clinic name, Address, Phone number, Email etc>

<Title><Healthcare practitioner name>,
<Address>
<Phone>
<Fax>

<Date>

Re: <Patient name>
<DOB>
<Address, phone number etc>

Dear <Title><Healthcare practitioner name>,

I

Thank you for taking the time to [review / assess / forward information or results regarding] <Patient name>. This information has been very helpful in guiding my management plan.

S

Presenting complaints or problems: [update any changes e.g. improvement or deterioration, new complaints or problems.]

Past medical history: [Use autofill function in clinical software, or manually update any changes]

Current medications/supplements: [Use autofill function in clinical software, or manually update any changes. If relevant, include both pharmaceuticals and natural health products, state if you are unsure about name or dose]
Allergies, Intolerances, Adverse Reactions: [ensure the correct use of scientific terms]

B

Family history: [if relevant]
Social history: [relevant marital status, work, any stresses, family/social support]

Current lifestyle: [diet, physical activity, smoking, alcohol, recreational activities]

Examination: BMI was [number], weight [number Kg], height [number cm] and BP [number mmHg]. Other findings included [observations e.g. dry skin, general pallor, weak nails, frequent crying]

A

Investigation results: [if relevant]

Based on my assessment and the information I have received from you, I have provided / recommended / discussed [e.g. differential diagnosis, investigations, treatment, dose, duration, advise or information given – see General Informative letter for optional extra details to include]. I am unaware of any (other) interactions or absolute contraindications.

R

I have discussed my recommended management plan with <Patient name> [any instructions given about ongoing care, HCPs roles, referral to HCPs, follow-up of investigation results or clinical review etc].

R

I plan to review <Patient name> in [time frame] and look forward to updating you on <Patient name> progress.

If possible and with <Patient name> consent, please cc <Patient name> and me on any relevant [communication, investigation results, clinical progress]. In the meantime, please contact me if you have any questions or would like further information.

Kind Regards,

<Your name>

c.c. <Title> <Healthcare practitioner name> <Address>
<Title> <Healthcare practitioner name> <Address>
<Title> <Patient name> <Address>

EXAMPLE OF THANK YOU LETTER TEMPLATE

Jane Therapist
Natural Health Clinic
2 John St, Suburb, 0000
02- 20202002

I

Dr John Smith
PO Box 0000
Sydney NSW 2000

22/10/2018

Re: Alina Adams
DOB: 01/01/1996
Address: 1 Smith St
Smithfield NSW 2001

Dear Dr Smith**,**

S

Thank you for reviewing Alina Adams for management of fatigue and weight gain associated with infertility, and for kindly forwarding me a copy of her pathology results and pelvic ultrasound report.

Alina came to see me today and told me that you had reassured her that she does not have anaemia nor PCOS; however, you were concerned about her nutritional status (low iron, borderline low zinc and iodine) and you were going to continue monitoring her thyroid function and nutritional status.

Presenting problem: Alina's symptoms have not changed, she has not lost any weight, is tired both physically and mentally, and is yet to conceive.

B

Medications / Supplements:
Pregnancy multivitamin formula (contains 150mcg of Iodine, 60mg elemental iron, 11mg zinc, 200 IU Vit D3)
Iron polymaltose 100mg daily
Iodine drops 300mcg daily (will reduce dose in 3 months if not pregnant)
Zinc glycinate 50mg, plus Vitamin B6 10mg
Vitamin D3 1000IU daily
L-Tyrosine 1000mg daily
Compounded liquid herbal formula 5ml 3 x day (*WIthania somnifera, Vitex agnus castus, Paeonia lactiflora, Hypericum perforatum)*

Social / lifestyle / family history: see previous letter.

A

Based on the information you have sent me and my naturopathic assessment, I have commenced extra nutritional supplements and compounded a liquid herbal formula that aims to reduce stress, improve energy production and shorten menstrual cycle length to encourage regular ovulation. The herbs have a long tradition of use for these indications and some scientific evidence. We spent some time reviewing Alina's diet and continued to focus on strategies to reduce sugar and carbohydrate intake and increase lacto-vegetarian sources of protein, B12 and iron.

I am wondering if perhaps part of the fertility issue is related to Alina's long cycles and missing her fertile window. Along with the herbal formula, I have discussed with Alina strategies to help her better pinpoint her fertile window, provided her with LH urine strips and discussed sex timing for conception. We are also working on establishing regular routines for eating and sleeping, along with introducing some basic mindfulness exercises for stress management.

R

Alina and I have discussed my recommendations. I have given Alina information about known safety and side effects of the herbs and supplements, including perinatal safety. I have encouraged Alina to also talk to you about any concerns or questions she might have.

Alina showed me your next pathology request form that includes assessment of thyroid antibodies and gluten intolerance. Based on these results, a lower gluten intake may be indicated, and I can assist Alina with these dietary changes if need be.

Prior to our next consultation in 5 weeks, if Alina is still suffering from fatigue and infertility then along with your investigations I have recommended pathology testing (non-Medicare) of DHEA, morning cortisol, serum copper and repeat plasma zinc. I will compare the copper zinc ratio and if indicated, I will supplement further with zinc and provide advice about how to reduce dietary copper intake with the aim of supporting FSH and progesterone production. You should receive a copy of these results.

Alina has requested that we all work together as she is feeling overwhelmed with managing her health and fertility care. I would be grateful if you could keep me informed of your assessment and management. If appropriate, please cc Alina and me on any relevant communication and results of investigations.

Kind Regards

Jane Therapist
BHSc (Naturopathy)

c.c. Alina Adams, 1 Smith St, Smithfield NSW 2001

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