British Geriatrics Society
Best Practice Guide

Copying Letters to Patients

(Best Practice Guide 2.6 published June 2004, Revised January 2008)

1. Introduction

1.1 Under the NHS Plan, it was proposed that all clinicians, in Primary and Secondary Care, send copies of their clinical letters to the patients. This was subsequently downgraded to good practice advice, mainly because of the appreciation of the administrative cost of such a policy and competing priorities. Implementation of the practice has been very patchy. This article reviews the evidence around the risks and benefits of copying letters to patients, particularly with the older client group in mind, and presents the view of the British Geriatrics Society.

1.2 The BGS sees considerable merit in the policy. Under the Freedom of Information Act all patients have more rights to access their clinical records, although this will probably remain retrospectively until a full electronic health record is established. Indeed a policy of copying letters may be made obsolete by the electronic health record. As implementation still seems some years away, it remains apposite that Trusts review their policy in the meantime.

1.3 The BGS is in favour of openness and transparency in the clinical care of older people. Ageist attitudes can easily lead to the use of half-truths or talking down to patients, with decision-making controlled by health professionals or by collusion with the family. However, it is also important to be mindful of confidentiality issues, and avoiding causing unnecessary distress.

2. What do patients want?

2.2 There is a growing body of small-scale published surveys and audits of older people's attitudes and response to receiving copies of their out-patient letters. They include studies in Old Age Medicine[1], Old Age Psychiatry[2,3], and palliative care[4], with a recent review[5]. There is a clear consensus from these studies which indicate that the overwhelming majority of patients (around 90%) want to receive these letters, understood and appreciated their content (80 - 95%), and have found that the letters enhanced the benefit of the clinical encounter. The principal benefit of the letters was to remind them of what had been said[1], and assist them in their self-management, and therefore probably in their adherence to medication changes. There are low rates of patients being offended or upset by the letters (< 5% [1,2]), or in failing to understand the content. Where patients lack capacity, carers have wanted copies of letters sent directly to them[6].

2.3 There are no published studies regarding copying discharge summaries to older patients. Patients are routinely given a list of their medication, but much less commonly a legible summary of the diagnoses reached during the admission. Some departments might be too embarrassed regarding the limited detail and/or lack of timeliness in sending the clinical summary to copy this to the patient – yet this may illustrate the potential benefits where copying letters became mandatory.

3. What are doctors' concerns?

3.1 Surveys generally emphasise doctors' resistance to copying letters to patients. There is considerable anxiety about the letters being misunderstood, causing unnecessary distress and breaching confidentiality. There is natural resistance to dictating an additional letter tailored to the patient. Published surveys appear to have been conducted by enthusiasts, some of whom are dismayed at the negative attitudes of their colleagues.

4. Quality of communication

4.1 It is the quality of information and communication that concerns our patients and their carers. The public quite rightly increasingly expect more thorough communication regarding their health and management decisions. Paternalistic attitudes that the patient would be unable to understand the inter-professional letter are not born out by the evidence, and a simplified version of the letter has not demonstrated advantages[4]. The additional costs therefore in terms of doctors' time and secretarial time would not justify the use of separate letters as a routine.

5. Principles of good written communication

5.1 An awareness that ordinary members of the public will read the letters sent to the General Practitioner should in itself enhance the quality of the letter and clarity of communication. Departments of Old Age Medicine / Care of the Elderly should provide best practice examples to educate everyone regarding the construction of letters which communicate well to older people. Well constructed letters filed in the casenotes should speak and educate for themselves. Some of the principles include:

- Structure the letter, making it clear why the patient consulted, and the outcome of the consultation. Headings can be useful to achieve this.
- Use plain English (remember KISS – Keep It Short and Simple), with the patient in mind.
- Use no less than 12 font.
- Avoid complex terminology whenever possible – the aim is not to impress!
- Avoid subjective statements such as "This well-preserved octogenarian"
- Generally do not add information that was not covered in the consultation (although test results may be an exception).
- Remember that the content of the letter can and will be used as an aide memoire for the patient to aid adherence to a management plan.

6. Responsibilities for Departments and Trusts

6.1 In view of the evidence showing benefit from copying letters to patients, departments and Trusts must decide if the additional administrative costs are affordable, and where it sits in their priorities. Where the practice is introduced, there must be clear good practice guidelines defining when copied letters should and should not be used. The costs in terms of clerical time, printing and postage must be defined and budgeted. Greater use of electronic communication with GP surgeries may help to offset the incremental cost of introducing posted letters to patients. The policy should be subject to clinical governance through audit cycles to ensure that there is policy adherence, and that patients are deriving the benefit described in the literature.

7. Recommended Procedure

1. The clinician must first decide if it is appropriate to offer a copy of the clinic letter. The legitimate reasons for denying the offer include:
    a. Concern about possible third party access to letters
    b. Third party confidentiality – the letter contains information about a third party who has not had the opportunity to consent to that information being given to the patient.
    c. Confidential information which may be detrimental to the patient – this may be about possible diagnoses not yet confirmed.
2. In one study, consultants judged that 28% of patients could not be offered the clinic letter, although this judgement varied considerably between individuals.
3. Where the copy letter is not being offered, this should be recorded in the out-patient casenote entry, with the reason for withholding.
4. Whenever possible all patients should be asked whether they wish to receive the clinical letter, and the answer recorded in the notes.

5. Third-party consent for disclosure of information to the patient should be sought when needed and the result recorded. This may prevent such information being recorded in the letter or prevent the copying of the letter to the patient.
6. Where the patient is considered to lack mental capacity, and the patient is accompanied by their family, it is appropriate to ask the family member if they would like a copy of the clinic letter, and to which address. It will be a matter of clinical judgement for the clinician as to how appropriate this is, and the result of that judgement and any discussion with the carer should be recorded. Ensuring that people who lack capacity have the opportunity to express their views on this subject is good practice, and should be adopted.
7. When someone who lacks mental capacity attends alone, or without a close family member, it is wiser not to send a copy of the clinic letter on that occasion.
8. When someone attends from a Care Home accompanied by a member of their staff, clinical judgement must be used. Where the patient has mental capacity, they can be sent the copy letter if wished. Where the patient lacks capacity, it is likely that the patient's care, and adherence to the advice being given, will be improved by copying the clinic letter to the matron of the Home.

8. Additional points

- For patients under the care of specialist mental health services in England and Wales they will be given a copy of part of the Care Programme Approach (CPA) documentation. Many services will provide this already.
- It is not necessary for patients to receive multiple letters automatically, particularly where information is repeated.
- Services may choose to develop formatted letters although this may sacrifice important clinical detail. These might be suitable for both GPs and patients.

9. References

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