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Where have all the copy letters gone? A review of current practice in professional-patient correspondence.

Susan Baxter, Caroline Brown, Jayne Clarke, Helena Davies, and Kathleen Farrell

Academic Unit of Child Health, PGME, Stephenson Unit, University of Sheffield
Western Bank, Sheffield, S10 2TH, UK

Corresponding author:

Susan Baxter

Email: s.k.baxter@sheffield.ac.uk

Telephone: 01226 765183

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Abstract

Objective

This article reviews the literature in relation to patients receiving copies of health professional correspondence. It examines progress in adopting the practice three years on from its introduction as policy in the UK, and considers potential benefits and obstacles to implementation.

Methods

A review of the literature on copy correspondence, accessed via Medline, PubMed, CINAHL and also online resources, using the search terms "patient letter", "copy letter", "copy correspondence" and "doctor letter".

Results

Studies describe a range of benefits from copying letters, but implementation remains inconsistent, ranging from 8% to 87% of patients reporting receiving copy correspondence. A number of concerns are identified which may be delaying whole scale adoption of the policy by health professionals.

Conclusion

This paper argues that researchers should move from examining the benefits and concerns around copying letters to patients, and instead focus on exploring the quality of correspondence and the optimum process of implementing the practice. As patients can "opt out" of receiving copy correspondence, current audit of service delivery may be problematic in not taking account of patient choice.

Practice implications

Copying letters to patients may have a number of important benefits and should be routine practice where patients wish to receive correspondence. Future studies examining patient preference regarding the style and content of letters would be helpful, and there is a need for studies in non-medical professions. Mechanisms for recording patient preference need attention, with further consideration of methods for auditing of the practice.

Author Keywords

Copy correspondence, letters, patient-physician relationship, communication, patient education, patient-centred care.

1. Introduction

In 2000 the UK National Health Service (NHS) Plan [1] highlighted the need to give patients the option of having much greater information about the treatment that is being planned for them. Patients already had the right to see their medical records, although in practice much communication between professionals was not available. Patients often did not know why they were being referred to another practitioner, or what was being said about them [1]. As a result of this legislation "letters between clinicians about an individual patient's care will be copied to the patient as of right" (NHS Plan, Paragraph 10.3). Implementation of this was to be achieved by April 2004. This policy formed an important part of a wider UK government agenda to modernise health care, making it more patient-centred and patient-led [2].

Three years past the introduction date however, the evidence is that implementation is patchy. A recent survey [3] measuring progress towards this objective, reported that in 2006 37% of patients in England received copy correspondence, an increase of only 2% on the 2005 survey. The results also demonstrate significant variation between healthcare trusts, ranging from 8% to 87% of adults reporting receiving copies of letters sent between hospital doctors and their family doctor.

2. Method

A review of literature published in the last ten years was undertaken using the databases Medline and PubMed. The search terms used in the databases were firstly “copy correspondence” and “copy letter” which yielded 150 and 176 results respectively. Of these, 28 documents were found to be of particular relevance in relating to patients receiving correspondence. Searching using “doctor letter” and “patient letter” yielded considerably more results (5723 and 31980 respectively) however scrutiny of this work found few additional papers concerning copying letters to patients. Within this body of work there were however relevant studies describing correspondence between hospital doctors and General Practitioners, and a small number discussing the content and format of referral correspondence between medical practitioners, which provided additional background to this review.

As the legislation is intended to encompass copy correspondence between all healthcare practitioners, the CINAHL database for the nursing and allied health professions was also examined using the same search terms. “Copy letter” yielded only one reference (this work was in addition to those identified previously), “copy correspondence” none, and “patient letter” only one reference (which had been previously identified). As other health professionals may write a report rather than a letter, “copy report” was also entered as a search term, but yielded no identified work. The key documents for scrutiny from the peer-reviewed literature thus encompassed twenty-nine papers. There was additional searching of online material carried out via Google and Google Scholar, together with examination of references cited in the work retrieved, which revealed further texts of relevance.

3. Findings

3.1 Why copy correspondence?

The review identified a conclusive evidence base for copying of **health professional** correspondence to patients, with a range of benefits reported.

Authors have described the copying of correspondence as leading to greater patient understanding [4, 5], and greater patient involvement [6]. This enhanced understanding and involvement may be associated with having more information or knowledge [7, 8], and is considered to be "helpful" or "useful" by patients [9, 10, 11]. A benefit of this increased knowledge can be the reduction of inaccuracies in medical record keeping, as patients can highlight any inconsistencies or errors, for example in dosages or recommendations [12,13].

Studies have described links between doctor-patient relationships and copying letters, with increased trust [14], better communication [15, 16, 17], and better relationships [18] reported. Copying correspondence has also been highlighted as a factor in perceptions of improved or shared decision-making during a consultation [19, 20], and with increased patient satisfaction [21, 22]. It has been suggested that copying correspondence can be seen as part of a changing culture in healthcare delivery [23], with patient empowerment requiring the sharing of knowledge [24, 25], allowing an individual more control over their own healthcare [18, 26]. This sharing of knowledge can also be perceived as being treated with respect [27].

Receiving a copy letter can relieve patient anxiety [12, 28], and can serve as a useful reminder of discussion that took place during a consultation, as well as the decisions agreed [7, 15, 17]. Patients can find it useful to show to relatives [8, 17], and copy letters may have some value in helping the acceptance of “bad news” [7]. They also can act as confirmation that following the appointment “something is being done” [4, 12].

3.2 Perceived obstacles – why not copy correspondence?

In view of these well-documented benefits, it may seem surprising that copying correspondence to patients is yet to be consistent practice. However, a number of concerns and issues have been raised which may be impacting on **widespread** implementation.

A frequently reported concern of healthcare staff is that patients will be unable to understand medical terminology [7, 8]. There is some evidence to support this, indicating that a minority of letters may need to be altered [29] to make them suitable for patient viewing, and that a letter written especially to a patient may be better comprehended than a copy of a letter between doctors [30]. Linked to these concerns regarding the need to simplify letters for patient understanding, is the argument that changing the content of letters impacts on the quality of available information for other doctors [4].

However, in response to these concerns, the majority of studies have reported that patients accept medical terminology in correspondence without any difficulties [17, 31]. It has also been concluded that there is no difference in patient understanding between standard letters and modified letters [32]. It seems that worries regarding patients not understanding medical terminology tend to be voiced by health professionals, without corresponding concerns from patients [21, 33]. This difference in perception regarding the status of profession-specific terminology may be associated with tensions around shifts in patient-professional power relationships [18]. The advent of the internet as a source of easily accessible information may also have helped to de-mystify medical jargon.

A second, commonly expressed concern, relates to the potential for copy correspondence to cause worry or distress [8, 17]. There are concerns that a letter may be insensitive to patient needs, particularly where there is “bad news” or where serious symptoms or multiple possible diagnoses are described. Studies have described wide variation in reported patient worry/distress. For example one study found no patients reporting that they were worried or distressed on reading a copy letter [35] however, another found 18% of patients reported feelings of distress associated with receiving a letter [29]. These differing findings may be linked to factors specific to a medical specialty, with the above studies reporting contrasting findings from the very different areas of otolaryngology and psychiatry. The literature describes the implementation of copying correspondence to patients across a wide variety of healthcare contexts in addition to psychiatry and otolaryngology, for example dermatology [17], haematology [21], and has been reported in particular in paediatrics [5, 13, 27, 38, and 40], and cancer care [7, 16]. It has been suggested that some situations may need to be handled differently [34], however currently there is a need for practitioners to be given clear guidance on what these instances are and how to handle them.

A further concern raised relates to the potential for copy correspondence to be sent to the wrong address, or that a letter may be opened by someone other than the patient and thus breach confidentiality [23, 36]. There may be particular difficulties ascertaining where copies should be sent in paediatric services, where parental access and rights issues occur [9]. Studies have also highlighted the importance of consent issues [32], with the need for patients to be able to “opt out” as well as “opt in” to the receipt of copy correspondence [4] where they either do not wish to receive a letter, or where there may be concerns regarding confidentiality. Also, the importance of considering the needs of patients with special communication difficulties has been raised, such as how non-English speakers or those with limited literacy should be provided with copy letters [28, 37].

The issues of cost and workload in particular have been highlighted as obstacles to the introduction of copy correspondence. It has been estimated that sending copy letters to patients could cost the National Health Service 15 million pounds per year [35]. Studies have reported that dictating letters suitable to copy to patients takes longer [30], and increases secretarial workload [35]. Estimates of workload increases are not borne out by all studies however, with minimal impact on workload also described [4, 38]. Reports of additional costs vary considerably, ranging from just over 25 pence per letter [17] to one pound fifteen pence [32]. Concerns regarding cost to the National Health Service have been raised not only by staff, but are also identified by patients who question the prioritisation of resources [36].

Reports of the number of patients who wish to receive a copy letter vary, with studies ranging from 75%-93% of patients wishing to receive a letter [21, 39, 40], to less than

50% wanting to receive copy correspondence [26, 35]. It has been emphasised that patients differ in their information requirements [41], with for example younger patients wanting more written information [42]. Different consultations may have different purposes [43], and there is potential for the context of care to have an impact on the information that patients require, for example there may be differences in information requirements between hospital and community services [38].

3.3 Content and process

As in the studies reported above, there has been a tendency for work in the area to focus on reasons why copying correspondence to patients should or should not be implemented. However, two equally important issues to consider are regarding firstly, how the policy should be implemented and secondly, the format and content of the correspondence to be copied. It is possible that differences in patient perceptions of the value of copy letters reported by studies could be influenced by the quality of the correspondence.

The quality of correspondence may be a significant issue in the debate as the literature contains frequent reference to the poor quality of doctor’s letters to other doctors and health professionals [44]. There are reports of omission of key information regarding proposed treatment, expected outcomes or psychosocial information [45], and studies have highlighted improvements to be made such as the use of more structure and brief summaries [46]. It has been suggested that there is a need for doctors to receive training in letter writing [35], and tools have been developed to provide assessment and feedback on letter quality [47]. In the present hospital doctor pyramidal structure of “firms” [48], consultants determine policies adopted by junior colleagues. Action is therefore needed to address current practices if changes are to be made.

In response to the need to consider how the process of copying correspondence should be best implemented, the Department of Health has issued guidelines [49] providing information on when letters should and should not be copied, and also on the need for a clear writing style. The guidance contains a template for out patient clinic letters and GP referral letters, but otherwise offers little information on the content of the correspondence, the process of introducing the system, or guidance for non-medical health professionals.

There is only a small amount of published work available to draw on when considering how best to implement the practice. It has been suggested that letters should be dictated in front of patients [27], with patients reportedly appreciating this sense of openness [50]. In the field of cancer care it has been reported that audiotapes, either instead of or as well as copy correspondence can be helpful in some consultations [51]. Two studies describe the practice of writing separate letters to another health worker and to the patient [18, 40]. This may allow for more personalisation, however doubling up on correspondence clearly has time and resource implications. It could also be argued that separate letters seem not be in the spirit of openness of information that the policy intended.

Other suggestions regarding how to implement the policy refer to the use of glossaries to accompany copy correspondence [30], with use for example of the Plain English medical glossary [52], or for the use of both lay and medical terms with one or the other following in brackets [4], however further work is needed to confirm which format patients prefer. The need for subheadings and structure in correspondence has been proposed, with suggested use of bold typeface for headings and clear language [4], however here again the evidence confirming patient preferences is very limited.

It has been highlighted that there is a need for a range of formats to be available for patients with special communication needs, such as audio recorded versions, brailled copies and translations into other languages [4, 37]. There may be a requirement for support to be provided by patient advocate services or telephone advice help lines [4] where patients are concerned or need assistance understanding terminology. Further work is needed to test these proposed formats however, as for example access to translation services can be limited and costly, and there may be issues regarding achieving alternative formats in a reasonable timeframe.

4. Discussion and conclusion

4.1 Discussion

There is a large body of evidence to support the copying of letters to patients [4-27], and it is an important component of drives to involve patients in their own healthcare and the evolving consumer choice agenda. However, there is as yet limited evidence regarding how best to do it. Therefore, we argue that the focus now needs to shift from whether or not the policy should be implemented, to an examination of the content and process aspects. Further research evidence regarding implementation is required in order to consider how best to overcome the perceived obstacles, if the changed practice that is being sought is to be realised.

The literature review has identified a number of these potential obstacles including health professional concerns that patients will not understand the content of letters, the possibility of causing worry and distress to patients, increased cost, and the potential for breaches of confidentiality [4, 7, 23, and 36]. Further work is therefore needed to explore these obstacles, with for example greater investigation regarding patients preferred format. The potential for causing distress is a frequent issue raised by practitioners [8, 17] and is thus an important area for further study if this perceived obstacle is to be overcome. The DOH guidelines [49] provide some advice regarding the instances when copies should not be sent, however further work to clarify this area is needed to more fully address these concerns if healthcare workers are to change their practice.

Issues regarding cost are important to resolve as no additional funding has been allocated to service providers to support this initiative, and any decisions regarding the distribution of limited resource require careful consideration. We suggest that an important factor in the debate regarding cost may be the evidence that copy correspondence is not desired by all patients in all instances [21, 26, 35, 39, and 40]. Currently the standard of provision audited by the Commission for Healthcare Audit and Inspection team is the number of patients reporting receiving correspondence [3]. This implies that in a quality service patients must receive a copy letter. The available evidence suggests however that there are occasions when patients may feel that they have been involved and given sufficient information during a consultation without needing a letter [26, 35], or do not wish to receive one for other reasons [4].

It may therefore be appropriate to review the way in which the standard of service provision is currently audited, with perhaps a more appropriate measure being the number of patients who are asked if they would like the option of receiving copy letters. Sending copy correspondence only in instances where patients have expressed a wish to receive it may reduce resource spent on postage and stationary. Time resource may remain a concern however as it is likely that extra time spent by clinicians in discussion of the option will be required. A "two option" system of opting in or out from copy correspondence also requires effective systems of recording and responding to patient choice.

An alternative system of auditing services by monitoring whether copy letters have been offered also may not address the change in patient role that is central to the drive for patient-led healthcare. Authors [53, 54 and 55] have highlighted the considerable challenges to be faced in increasing patient participation, describing a continuum of involvement that is dependant on the level of patient power. Copying correspondence may be an important factor in changing power differentials as the provision of information has been recognised as a central requirement in patient involvement [56], requiring some surrendering of professional power to narrow the "information gap" [53].

The literature suggests that there may be reasons on both sides why greater patient information and involvement does not happen. It has been reported that clinicians are poor at assessing patients' wishes for being involved in decision-making, and may therefore not offer the opportunity for a patients' involvement [57]. Alternatively, patients may not seek greater participation if they are unaware of the benefits of being involved, or prefer not to be involved, thus declining information if it is offered [58].

A further factor that may impact on initiatives such as this, which seek to increase patient involvement in their care, is highlighted in the literature on professional-patient interactions. Communication between patients and professionals is increasingly recognised as a complex process with interpersonal relationships and communicative behaviours during consultations influencing information exchange [59] and shared decision-making [60]. The take up of the option to become more involved such as by receiving copy letters may therefore be significantly influenced by the interaction between patient and professional, and the way that copy correspondence is offered. This work suggests that a system that merely audits whether or not a copy letter was offered may therefore not encourage change in either clinician interaction or patient role.

The literature accessed during this review almost exclusively concerned doctors copying correspondence to patients. One study [61] in contrast considered information provision amongst members of a multidisciplinary team, with the introduction of nurses sending correspondence in addition to the doctors' letter. Disappointingly, the letters from the nurse were sent to a General Practitioner only, with no mention of copying the patient in to the correspondence. This work however highlights that with the increasing adoption of multidisciplinary team working in healthcare it seems a timely opportunity to examine the communication of information from professionals to patients. As highlighted earlier, the legislation [1] on copying correspondence is intended to apply to all health practitioners, however currently there is a paucity of work reporting studies in professions other than medicine.

5.2 Conclusion

This review suggests that rather than blanket implementation, there is a need for due consideration of the copying of correspondence, taking into account the wishes of the patient and the guidelines provided by the Department of Health. As an area of healthcare provision where there is a good evidence base for benefit outcomes, practitioners have a clear justification for implementing the practice. The cost of providing copy correspondence where the patient wishes to receive it seems an important part of healthcare modernisation, and the drive for patient-led care [1].

The literature emphasises the importance of giving patients the right to “opt out” [4], which presents a challenge for auditing of the policy. The current process requires clarifying; as to date there is uncertainty as to whether the lack of copy letters is due to practitioners not offering them (either by choice or omission) or patients choosing not to receive them. The suggestion has been made that a better measure may be whether copy correspondence has been offered. However, it has been discussed that this alternative method of auditing may not address the change in patient role being sought.

In light of only 37% of patients reporting receiving correspondence [3], and large disparities between services, there needs to be further investigation to determine why copy letters have not been sent. There is a need for more work to examine patient preferences regarding the format and content of correspondence, and also to provide further evidence to support or refute the perceived obstacles reported.

5.3 Practice implications

Practitioners should be aware of the benefits of sending copy correspondence to patients, and adopt the policy as normal practice whilst recognising that not all patients wish to have a copy letter. In addition there is a need for more guidance on those occasions when a letter is not appropriate, and on the components of a good letter. Also, there needs to be attention paid to effective mechanisms for recording and auditing if copy correspondence has been offered. As the majority of work to date has concerned letters from doctors to patients, studies to investigate practice in other professions are needed.

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