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**Psychiatric Bulletin** (2004), **28**, 40–42

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# Medical records:

## Doctors' and patients' experiences of copying letters to patients

**AIMS AND METHOD**

We conducted a pilot study to determine patients' views on receiving a copy of the assessment letter sent to their general practitioner and to determine how psychiatrists' letter writing practice would be altered in the knowledge that patients would receive copies of such letters. Seventy-six consecutive new out-patients received copies of the initial assessment letter sent to general practitioners. Patients were asked to complete a short questionnaire on how the practice affected them. For each letter, psychiatrists were asked to provide details of anything of importance that had been omitted from the letter that in their normal practice they would have included.

**RESULTS**

There was a broad range of responses on how patients felt about the letters. Only two patients found the letters unhelpful, and 83% expressed a positive desire to continue receiving letters, even though initially 18% found the letter distressing. For 56 out of 76 patients, psychiatrists stated that they composed and sent out the letter to the GP in accordance with their usual practice and copied the letter to the patient in an unaltered form. For 17 patients, the psychiatrist stated that some information he/she would usually have included in the GP letter was omitted in the copy the patient received. In a further 3 cases, the psychiatrist sent no letter to the patient.

**CLINICAL IMPLICATIONS**

Patients found it helpful to receive copies of their assessment letters. Psychiatrists might require training and reassurance about this policy before implementation.

As of April 2004, patients will receive copies of all correspondence between clinicians working in the National Health Service as a matter of course (Working Group on Copying Letters to Patients, 2002). Despite previous research demonstrating the popularity of this practice with patients (Asch *et al*, 1991; Rutherford & Gabriel, 1991; Thomas, 1998), copying letters to patients is not yet commonly undertaken. In 2002 a working group recommended to the Department of Health that certain areas, including mental health care, instituting such a practice could be informed by pilot studies.

We conducted a pilot study to determine patients' views on receiving a copy of the psychiatric assessment letter sent to their general practitioner. We also aimed to determine how psychiatrists' letter-writing practice would be altered in the knowledge that patients would receive copies of such letters. To the best of our knowledge, this is the first study that explores both patients' and doctors' perspectives on this issue.

## Method

Between January 2002 and July 2002, 7 consecutive new out-patients who attended two general adult psychiatry out-patient clinics (one rural, one inner-city) were included in the study, as were all eight psychiatrists who worked in these clinics over this period.

After their initial assessment, patients were sent a copy of their psychiatrist's letter to the general practitioner (GP). Patients were asked to complete a short questionnaire relating to their evaluation of the letter. Questionnaire design was derived from consultation with patient groups and previous research (Asch *et al*, 1991). A single reminder was sent to non-respondents.

In this study, we attempted to emulate the conditions that are likely to be faced by doctors across the country in April 2004, when this policy is to be incorporated into routine practice across the NHS. Psychiatrists were not given any specific guidance as to what information was appropriate to be seen by the patient, and each psychiatrist relied on his or her own clinical judgement as to how to conform with the requirements of the pilot study. They were asked to provide details of anything of importance that had been omitted from the letter that they would usually have included. They were asked to identify, using the questionnaire provided, what had been omitted, the reason, and how the omitted information would be communicated to GPs (Table 1).



https://doi.org/10.1192/pb.28.2.40 Published online by Cambridge University Press

**Table 1. Responses of psychiatrists (*n*=8)**

| | | | | | | |
|---|---|---|---|---|---|---|
| Did you omit anything of importance from the letter? | Yes 17 (22%) | | No 56 (74%) | | None sent 3 (4%) | |
| What did you omit? | History/examination 13/1 | | Diagnosis 3 | | Prognosis 6 | |
| Why did you omit the information? | Fear of distressing the patient 14 | | To protect a third party 2 | | Other 4 (e.g. concern of someone other than the patient reading the information) | |
| Did you/will you contact the GP to discuss/pass on the information omitted from the letter? | Yes 16 | | | | No 1 (GP already aware of information) | |
| How will you contact the GP? | Telephone 0 | In person 5 | E-mail 0 | Fax 0 | Letter 11 | Other 0 |

GP, general practitioner.

Values are numbers (percentages) of responses.

## Results

Seventy-six patients were enrolled in the study. For three patients, psychiatrists decided that it would be inappropriate to send any letter at all. A total of 55% of patients (40/73) responded to the questionnaires (see Table 2). The majority of responses to the practice were favourable; in 83% (33/40) of cases, patients expressed a wish to continue receiving copies of clinician correspondence. Most patients said that the letters were helpful despite, in seven cases, initially finding the contents of the letter upsetting.

Patients commented that seeing their problems understood and described objectively helped them to gain perspective. One patient informed us that her address had been wrong, but luckily the letter was forwarded to her unopened. Another patient had resumed smoking but did not want her husband to know. In one case a doctor omitted information about sexual abuse for fear of the letter being seen by persons other than the patient. Of note, only one patient complained that the letter was difficult to understand, citing overuse of jargon.

In a quarter of cases, alteration to usual letter writing practice was needed (see Table 1). In 74% (56/76) of cases, the letter was sent to the patient in an unaltered form. Clinicians made omissions in 17 cases. Of these, 16 were provided by just two of the eight doctors. Reasons cited for omission were: fear of distressing the patient (14 instances); concern over persons other than the patient having access to information (four instances); and protection of information from third parties (two instances). All GPs were informed of the omitted information.

At the end of the study, participating psychiatrists and administrative staff were asked for their views regarding any additional workload associated with the practice. Six of the eight psychiatrists said that there was no difference to workload, but two who altered letters that patients received said that this corresponded to a small increase in workload. Secretaries described a small increase in workload from having to photocopy, send, and in a quarter of cases edit, the letter before it was sent to the patient.

## Discussion

Sending patients a copy of the letter to the GP after a psychiatric consultation is popular with patients and can be incorporated into current procedures relatively easily for most doctors. However, in almost a quarter of cases information was omitted. Sixteen out of 17 of those edited letters were from two of the eight psychiatrists. This implies that for a minority of psychiatrists, implementing the policy requires moderate changes to their usual practice. However, it is possible that our results underestimate how much the adoption of this policy will

**Table 2. Responses of patients (*n*=40)**

| | Very | Quite | Neutral | Not very | Not at all |
|---|---|---|---|---|---|
| How accurate was the letter? | 16 (40) | 19 (48) | 5 (13) | 0 | 0 |
| How easy to understand was the letter? | 30 (75) | 9 (23) | 0 | 1 (3) | 0 |
| How upsetting was it to receive the letter? | 2 (5) | 5 (13) | 10 (25) | 8 (20) | 15 (38) |
| How helpful was it to receive the letter? | 18 (45) | 13 (33) | 7 (18) | 2 (5) | 0 |
| Would you like to continue to receive further copies of letters in future? | 33 yes (83%) | | 4 not sure (10%) | | 3 no (8%) |

Values are numbers (percentages) of responses.



https://doi.org/10.1192/pb.28.2.40 Published online by Cambridge University Press

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affect psychiatrists' usual letter-writing practice. It may be that merely by taking part in the study meant that psychiatrists unknowingly altered their letter writing style; such effects would not have been identified in our measures.

Previously, it has been considered that health information is often too sensitive to be included in a letter that will be read by the patient; perhaps especially in areas such as mental health care. A previous study of copying letters to renal clinic attendees cited psychiatric disorder as an exclusion criterion for receiving copies of correspondence (Rutherford & Gabriel, 1991). In our study, even if the letter was initially distressing, the vast majority of patients still found it helpful and expressed a desire to continue receiving copies of correspondence between health care professionals. In this respect, our results from patients confirm the findings of previous studies that have addressed these issues. As more clinicians become aware that the practice is popular with patients, some may feel less inclined to edit letters before patients are permitted to view the contents.

It was of concern to find that at least one letter was sent to the wrong address. This has important implications for confidentiality. This issue was highlighted by the fact that on four occasions, psychiatrists omitted information for fear that someone other than the patient may read the letter. When the policy is adopted nationally, it is possible that such incidents may occur. The possibility of incorrectly delivering letters with sensitive clinical information serves to re-emphasise the importance of ensuring that accurate contact details are available for all patients. The report of the working group on this issue to the Department of Health (2002) addresses this question and states that it is the patients' responsibility to ensure that the service has the patient's correct address. However, the potential for serious harm to occur if sensitive information were to fall into the wrong hands may encourage clinicicians to check that details are correct, and asking the patient's address may have to become routine with each contact.

Although patients have the right to request their medical notes, the report of the working group suggests three areas where it might be inappropriate, unlawful or undesirable to copy letters to patients. These are if the letter includes information about or given by a third party, if there is potential harm to the patient, or if the letter contains significant results or information that have not been discussed with the patient. The report does not mention potential distress as a reason for omission. If the policy is to be implemented nationally in its intended form, it seems that some guidance for clinicians on how it should be implemented is required.

## Declaration of interest

None.

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https://doi.org/10.1192/pb.28.2.40 Published online by Cambridge University Press