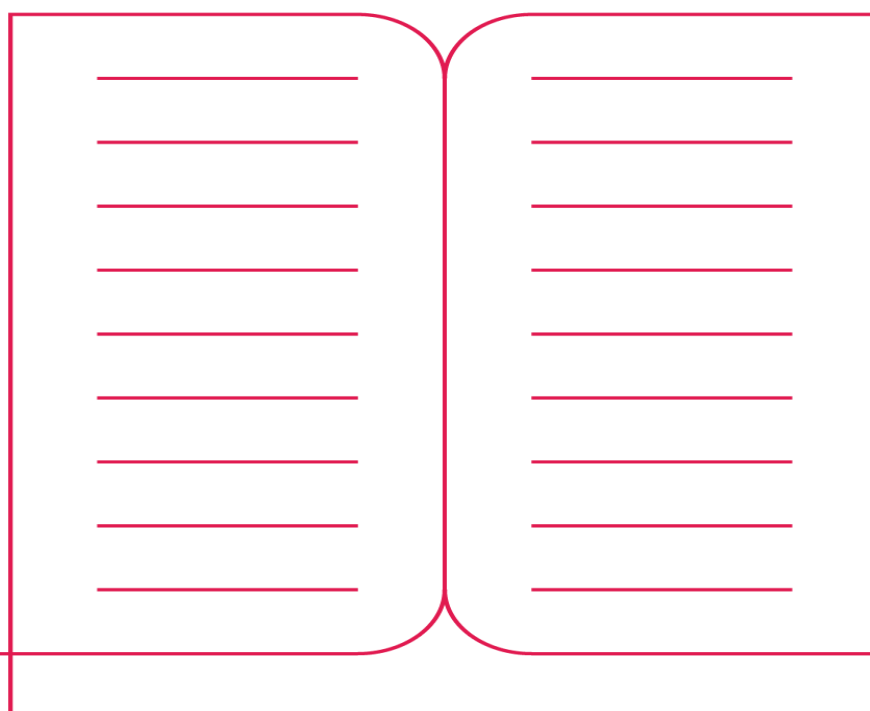


September 2018

Please, write to me

Writing outpatient clinic letters to patients

Guidance





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Foreword

This guidance should help and encourage doctors to write most of their outpatient clinic letters directly to patients and send a copy of the letter to the patient's General Practitioner. The Academy of Medical Royal Colleges endorses this as best practice.

The guidance covers general aspects of letter writing and applies to letters sent on paper and electronically. The focus of this document is on doctors' letters but it is relevant to all clinicians who write clinical letters.

We encourage Medical Schools, Royal Colleges and Specialist Societies to produce their own specific guidance. The guidance can be included in undergraduate¹ and post-graduate teaching materials and used when assessing written communication skills.

We encourage hospital trusts and clinical teams to support this initiative and provide help and training to all who need it.

Professor Carrie MacEwen

Chair, Academy of Medical Royal Colleges



Why doctors should write letters directly to patients

Writing letters directly to patients is in keeping with Good Medical Practice^{2,3}, which states: 'You must give patients the information they want or need to know in a way they can understand', and the NHS Constitution⁴, which states that patients '...have the right to be given information about the test and treatment options available to [them], what they involve and their risks and benefits' and have 'the right of access to [their] own health records and to have any factual inaccuracies corrected'. The NHS Constitution also states that staff should 'involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis, and their individual care and treatment'.

There are more than five million outpatient visits per month in England, making outpatient clinic letters the most-written letters in the NHS. The benefits of writing directly to the patient rather than sending them a copy of a letter written to their GP have long been recognised, notably in Clinical Genetics⁵. In a randomised trial in a haematology clinic, patients and referring clinicians were very positive about letters written directly to patients⁶. Doctors who have adopted the practice say their communication style has become more patient-centred⁷. GPs find the letters easier to understand and spend less time interpreting the contents for the patient.

Most importantly, patients find such letters more informative, supportive and useful. Writing directly to the patient or the parent/guardian should also avoid awkwardness caused by writing about patients in the third person⁸.



Patients' comments about letters written to them

The benefits of writing letters directly to patients are clear, judging by their comments. The letters strengthen the doctor-patient relationship and help the patient cope with their condition.

"Appreciate the letter addressed to me – the patient".

"I can now understand the treatment I am having for my illness and I'm happy to know that I'm making some progress along the way."

The letters serve as a handy reminder of important information as many patients struggle to remember things they were told during a consultation.

"When you come home from outpatients, you have forgotten what the doctor has told you."

"I for one will have forgotten half of what you have told me by the time I get home".

The patient may also want to share the letter with their relatives and carers and discuss its contents. The letters provide useful continuity between clinicians and anyone else involved with the patient's condition.

"Good to keep the letter, if you are under different consultants you can just show them the letter instead of explaining every time."

"Keeps me informed and can update people at work with my progress when they ask."

"Patients can use them as records of visits which show what medications they are on, investigations/tests discussed."

The patient can let clinicians know about any errors and alert them to changes made by other clinicians.

"Wrong post code. 2 medications to be added to list".

"My GP has changed the Pravastatin to Simvastatin".

The letter can include test results and confirms that the doctor has seen them.

"As blood was taken it would be very useful to know the results. If my appointments are at 2 monthly intervals my knowledge of my current state is always 2 months out of date as I do not see results until my next appointment."



The purpose of the outpatient letter

The outpatient letter should do three main things.

- Record relevant facts about the patient's health and wellbeing
- Present information in a way that improves understanding
- Communicate a management plan to the patient and GP.

These three things are best achieved by a well-structured, informative, easy to read and engaging letter.

Structure and content

The letter must meet the standards for outpatient letters set by the Professional Record Standards Body. These can be found on the PRSB website⁹.

The letter should enhance the relationship between doctor and patient, and should draw on and further explain information shared during a consultation. It is rarely the best way to break upsetting news.

The letter should also help communication between clinician, patient and GP. It is helpful to include an email address and phone number to allow the patient and GP to ask follow-up questions and discuss further options. At the end of the letter you can add a PS directly to the GP or other relevant individuals.

It is helpful to include links to reputable on-line sources of information and, where available, encourage patients to access their own electronic records and test results, such as at PatientView.org.

Clarity and readability

If you write the letter in the same way you talk to the patient it may be wordy and hard to read. You can measure the letter's readability using a tool such as the Flesch reading ease score. If the score is low, the software can suggest simple ways to make the text easier to read. Here are three.

- Remove redundant words such as 'actually' and 'really'.
- Use shorter sentences.
- Stick to one topic per paragraph.



In the Problem/Diagnoses list, you may use some medical jargon. However, use plain English when possible, for example, 'kidney' instead of 'renal'. In the body of the letter you can explain jargon, such as with 'You have an irregular pulse. This is called atrial fibrillation'. This is easier to read than using brackets, such as with 'You have an irregular pulse [atrial fibrillation]' ¹⁰.

Avoid writing medical phrases such as 'Your presenting complaint was...' and instead use a plain English alternative, such as 'You went to your GP because...'. Similarly, 'On examination, there was swelling of your ankles' is more simply stated as 'Your ankles were swollen'.

Make sure you explain any acronyms as these are often incomprehensible to non-specialists as well as to patients, e.g. CRT-D = Cardiac Resynchronisation Therapy - Defibrillator.

In the medication list, use English instead of Latin, for example 'twice daily' instead of 'bd'. Highlight any changes you have made in bold print, as with '**furosemide increased to 80 mg** twice a day'.

You can include the clinical indication for the medication, for example 'amlodipine 5mg once daily to lower blood pressure; aim less than 140 mmHg systolic'. You can find a directory of terms to use at www.clinicalindications.co.uk.

If you include the results of tests, explain their significance. Don't include unexpected and potentially upsetting results; in such cases, you might want to telephone the patient instead. Try using images instead of words, such as charts, graphs or diagrams, to describe the natural history of disease, risk, prognosis and treatment¹¹. This can help people with learning disabilities¹⁰.

For children and young people, include information that is appropriate for their age and development¹².

If the patient has visual impairment, ask if large print would help; at least 16 point is recommended.

Style and grammar

How you write is a personal matter and we don't want to be too overbearing about grammar or style. However, the following general guidance may help.

Consider how formally or directly you want to present information⁵. At the start of the letter, a familiar style may be best. You might say something like 'It was a pleasure to meet you and your husband for the first time'. At other times a more distant or formal style might be better appreciated, as with 'This letter summarises the information we discussed regarding your heart condition.' It depends on what you are discussing and your relationship with the patient.

You can soften the impact of potentially sensitive information by using a more distant or noncommittal style, as with "...during the examination, the tremor and stiffness in your right arm suggest that you have Parkinson's disease".



You may be more direct when you recommend treatments, as with 'Please increase the dose of water tablets [furosemide] to two daily (80mg) if the swelling of your legs does not improve'.

Consider how you use active and passive voices. In scientific writing the passive voice is often used but the active voice is easier to read in letters. The active voice is more direct and intimate than the passive voice. Consider the difference between 'You decided to have the heart bypass operation' and 'The decision was made to go ahead with the heart bypass operation'.

Use the second (You) and first persons (I, We), as with 'Because of your low peak flow rate, I have referred you to a chest specialist'. This sounds better than 'The peak flow rate is low. A referral to a chest specialist is indicated'.

Avoid stigmatising words and comments that may offend some people [8]. For example, 'You have diabetes' is more palatable than 'You are a diabetic'. Some medical terms can be easily misinterpreted. For example, 'chronic' is often taken to mean 'really bad' rather than 'long-standing'.

Be careful not to impose your point of view when describing a patient's emotions or thinking. Saying, 'One of the reasons you decided not to have another baby was the risk of Down's syndrome' is less potentially upsetting than 'You decided not to have another baby because of the risk of Down's syndrome'.

Consent and confidentiality

Ask for the patient's verbal permission to write them a letter, for example "I plan to write a letter to you about today's consultation and send a copy of the letter to your GP. Is that alright?" The patient may not want to see sensitive information about themselves in a letter sent to their home.

Children under the age of 16 years can give their own permission to be treated if they are believed to fully understand and appreciate what is involved in the treatment. Young people aged 16 or 17 are considered, like adults, to have the capacity to decide their own medical treatment unless there is significant evidence to suggest otherwise¹³. For children and young people who are judged to lack capacity or where you are unsure, usually write to the parents or guardians. You may wish to also write a separate, simpler letter to the child.

For adults who lack capacity, usually write to the GP and copy the letter to relatives or carers as appropriate.

Do not send the letter electronically to the patient without their permission and make sure they are aware of the security and confidentiality issues.

Translation into other languages

In Wales there is a legal obligation to provide information in both English and Welsh. Additional training and resources are needed for the translation of letters into other languages.





Frequently Asked Questions

Q: What is the rationale for the change?

A: Communicating effectively with patients is central to being a good doctor. Writing an outpatient clinic letter directly to the patient, rather than sending them a copy of a letter sent to their GP, can greatly improve communication with a patient. Patients who receive such letters much prefer them, are very appreciative, and would like more doctors to write them in this way.

Q: What does this mean practically for hospital doctors?

A: Doctors will have to learn a new skill of writing letters that are easier for patients to understand and accurately retain all their important content. We have produced some guidance to help doctors learn this skill.

Q: Will this mean more work for hospital doctors?

A: Initially, hospital doctors may take a little longer to write these letters as the process may be unfamiliar. Doctors who have made this change find they quickly speed up with practice until there is no difference. Many also find that the way they explain things to the patient during the consultation improves as this is linked to the writing of the letter after the consultation.

Q: What does this mean for GPs?

A: GPs will receive a copy of the letter written to the patient. They should find this easier to understand and should have fewer patients asking them to explain what the hospital doctor has written.

Q: Will this increase costs?

A: No. The standard current practice is for the patient to receive a copy of the GP letter. There is no increase in the number of letters being sent.

Q: What does this mean for patients?

A: Patients should find it easier to understand what the hospital doctor has written and hence be better able to take in the information and advice. They will have a written record of their outpatient consultation that they can show to others.

Q: Do I have to produce two letters, one to the patient and one to the GP?

A: Not usually. The intention is to send the GP a copy of the letter written to the patient. Rarely, an extra letter specifically written to the GP may be needed.



Q: Are there situations where the patient may not want a letter sent to their home address?

A: Yes, there may be sensitive information that the patient does not want to see in a letter sent to their home. The patient should be asked for their verbal permission to write to them and may request special arrangements for it.

Q: Can the letter be emailed rather than posted?

A: This depends upon the IT systems available in your hospital. You should not send the letter electronically to the patient without their consent, and make sure they are aware of the security and confidentiality issues.

Q: How do I use the Flesch Reading Ease score in my computer?

A: In Microsoft Word, click on the File menu > Options > Proofing tab.

Under the “When correcting spelling and grammar in Word” heading, you’ll see a box that says “Show readability statistics.” Check this box, then exit out of Options and go back to your document. Now, when you run a standard spelling and grammar check you will see the readability scores. Other tools are available on-line.

Q: Is this guidance consistent with the NHS contractual requirement to use the Professional Record Standards Body (PRSB) Outpatient Letter Standard?

A: Yes. The PRSB states on their website: ‘Best practice for most outpatient letters is writing directly to patients’.

The headings in the PRSB Outpatient Letter Standard should be used in the letter written to the patient. In the future it is expected that secondary and primary care IT systems will be linked, so the content of the letter will automatically populate the GP system. This may replace the letter to the GP.

Q: Do doctors have to do this?

A: This is guidance and therefore not mandatory. However, Good Medical Practice states that: ‘You must give patients the information they want or need to know in a way they can understand’. Writing outpatient letters directly to patients helps to meet this requirement.



Example letter to a GP

Dr G Practitioner
The Medical Centre
Tamworth
B79 1XX

6th August 2018

Dear Dr Practitioner

Re: Joseph Bloggs, DOB 12/09/1955, NHS Number 123 234 4567, PID N123456
1 The Street, Tamworth, Staffordshire, B79 1ZZ

Cardiology clinic - Dr Specialist. 1st August 2018

Diagnoses: Cardiac MRI scan shows left ventricular hypertrophy, bi-atrial dilatation and signs possibly of amyloidosis – awaiting further investigation
Diabetes
Hypertension

Medications: Omeprazole 20 mgs od
Insulin
Metformin 1 gram bd
Atenolol 100 mgs od
Irbesartan plus hydrochlorothiazide 300 mgs/ 12.5 mgs od
Doxazosin 8 mgs od
Simvastatin 40 mgs once nightly
Clopidogrel 75 mgs once daily

Allergies: Penicillin – rash

It was a pleasure to see this very pleasant 60-year-old gentleman in the Cardiology Outpatient Clinic today on behalf of Dr S. He had recently presented to the Rapid Access Chest Pain Clinic with increasing shortness of breath on exertion and atypical chest pains. Following this he had an echo scan and MRI scan which is suggestive of cardiac amyloidosis.

On discussion with him about his symptoms, he continues to get shortness of breath on exertion particularly noticeable when climbing hills or stairs but this is not associated with any particular chest tightness.

He also gives a history of intermittent palpitations occurring once every couple of days but denies any dizzy spells or blackouts. He previously had some leg swelling although this has now improved with a recent course of diuretics. He was also suffering with symptoms suggestive of orthopnoea and PND which have improved recently.

Currently he is able to undertake all of his normal activities of daily living at a slightly slower pace than normal.



In his family history, his sister died recently at the age of 47. The cause of her death is unknown and she is currently awaiting a post-mortem examination. There are no other unexplained deaths in the family.

On examination today his weight was 87 kgs. Right arm seated BP was 124/76, resting pulse approximately 72 bpm and regular. Clinically his chest was clear and resonant, JVP was not elevated but there was some pedal oedema to his mid-shins. His heart sounds were normal.

Therefore, in summary, this gentleman has investigations which are suspicious for amyloidosis and I have explained and discussed about the diagnosis with him today. The plan will be to arrange for blood tests in the form of serum immunoglobulins and electrophoresis as well as urinary free light chains looking for signs of amyloid.

I will also arrange for an outpatient 24-hour heart monitor given the history of palpitations to make sure there is no significant underlying conduction disease.

The next step will be to take a biopsy to prove whether this is amyloid. In the first instance, we will try for a rectal biopsy and I will therefore discuss his case with one of our Colorectal Surgeons to see if he can arrange this, hopefully within the next four weeks. If we are unable to obtain a rectal biopsy, then the next step would be a cardiac biopsy.

I have explained to him today there is no curative treatment if the diagnosis of amyloid is confirmed but we would potentially be able to refer him on to a Specialist Centre in London for this. I would be grateful if you could please arrange for him to re-start his furosemide 40 mgs od given that there are still some signs of fluid.

I will write to you further once I have the above investigations. Please contact me via 0121 333 4444 if you have questions in the meantime.

Yours sincerely

Dr ST4 – Doctor – Cardiology
GMC 1234567

cc. Mr Joseph Bloggs
1 The Street
Tamworth
Staffordshire
B79 1ZZ



Example letter to a patient

Mr Joseph Bloggs
1 The Street
Tamworth
Staffordshire
B79 1ZZ

6th August 2018

Dear Mr Bloggs

Re: Joseph Bloggs, DOB 12/09/1955, NHS Number 123 234 4567, PID N123456
1 The Street, Tamworth, Staffordshire, B79 1ZZ

Cardiology clinic - Dr Specialist. 1st August 2018

Diagnoses: Cardiac MRI scan shows left ventricular hypertrophy, bi-atrial dilatation and signs possibly of amyloidosis – awaiting further investigation
Diabetes
Hypertension – Clinic right arm seated BP 124/76, pulse 72 bpm SR
Weight 87 kg

Medications: Omeprazole 20 mgs once daily
Insulin
Metformin 1 gram twice daily
Atenolol 100 mgs once daily
Irbesartan plus hydrochlorothiazide 300/12.5 mgs once daily
Doxazosin 8 mgs once daily
Simvastatin 40 mgs once nightly
Clopidogrel 75 mgs once daily
Re-start furosemide 40mg once daily to reduce fluid on legs

Allergies: Penicillin – rash

It was a pleasure to meet you in the Cardiology Outpatient Clinic today, on behalf of Dr S.

You recently came to the Rapid Access Chest Pain Clinic because of increasing breathlessness on exercise and chest pains. When climbing hills or stairs you get short of breath but have no tightness in the chest. You have palpitations once every couple of days but no dizzy spells or blackouts. The swelling of your legs and breathlessness when lying down at night have improved with water tablets and you can do all your normal activities but at a slower pace.

I was very sorry to hear that your sister recently died at the age of 47. You are waiting for the results of a post-mortem examination.

There were no signs of fluid on the lungs or heart strain but your legs were still swollen to the mid-shins. I recommend you re-start the water tablets to clear this (furosemide 40 mgs once daily). A copy of this letter will go to your GP who can discuss your medication with you.



An echo scan and MRI scan suggested you may have abnormal protein deposits in your heart muscle, a condition called amyloidosis. I have arranged blood and urine tests for this protein (serum immunoglobulins and electrophoresis, urinary free light chains) and an outpatient 24-hour heart rhythm monitor.

The next step is to take a biopsy from your back passage to look for the amyloid protein. I will arrange for this to be done by one of our surgeons, I hope within the next four weeks. If this does not give us a diagnosis, we may need to do a heart muscle biopsy.

As we discussed, if the diagnosis of amyloidosis is confirmed the treatment options may be limited. We may refer you to a specialist centre in London to get the most up-to-date advice.

I will write to you again when I have the results of the blood and urine tests. Please contact me via 0121 333 4444 if you have questions in the meantime.

Yours sincerely

Dr ST4 – Doctor – Cardiology

GMC 1234567

cc. Dr G Practitioner
The Medical Centre
Tamworth
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