



JULIAN MASON AND DAPHNE RICE

## Does a business-like letter written for a general practitioner meet the standards for patients?

### AIMS AND METHOD

To gauge the acceptability of copying a business-like clinic letter for general practitioners, written by a doctor working in the Newbury Community Mental Health Team for Older Adults. Between August 2004 and March 2006 every letter written by each doctor was stored electronically. The letters contained a clear statement of the diagnosis, the active problems and a bullet-point care plan. Any concerns or reactions to the letters were documented as they were received. Between September and October 2006, 50 service user or

carer recipients of the letters were sent a questionnaire, checking whether the letter met standards of clarity, helpfulness and content.

### RESULTS

Over 20 months 427 service users and carers received a total of 731 letters. One carer asked for the letter not to be sent in future; four carers asked for details of the letter to be modified; in only one was the content of the letter to the general practitioner modified before it was sent to the service user. The questionnaire about the suitability of the clinic letter had a 90% reply rate and all respondents said the letters were clear,

understandable and that their content was of no surprise to them.

### CLINICAL IMPLICATIONS

This report of a successful use of a frank business-like letter copied to service users or carers should be understood in the context of the following factors: the doctor who wrote them was familiar with and confident about the clinical work and comfortable with the style of the letter; he had a good rapport with a generally well-educated population and positive support from his colleagues. With these factors in place, the direct style of the letter was well received by patients and carers.

It is good practice for patients to receive their clinical correspondence (Boaden & Harris, 2005) and despite objections (Huline-Dickens, 2004; Sturge, 2004) it is gradually becoming routine practice in mental healthcare (Department of Health, 2003; Lask, 2004) and is welcomed by patients (Lloyd, 2004; Okolo, 2004; Marzanski *et al*, 2005; Uher & Timehin, 2006). However, it still generates anxiety among psychiatrists for a variety of reasons (Thair *et al*, 2005; Combe *et al*, 2006). For one thing, there is a question of what style to adopt with the letters and whether or not they should differ from the ones sent to the general practitioner (Nandhra *et al*, 2004). Also, are there situations where information should be withheld from patients? For example, should upsetting diagnoses such as dementia be concealed from service users (Wald *et al*, 2003)? These questions are open to debate and this brief report describes one doctor's experience of copying over 700 letters that used a frank, direct style to service users of a community mental health team for older adults.

There are certain requirements that all such letters need to meet (Royal College of Psychiatrists, 2004): information should be accurate and understandable; the letter should not be unnecessarily distressing to the recipient, nor should it contain surprising information of which they were previously unaware; the service user or an appropriate carer should give consent to the receipt of the letter.

In Berkshire Health Care Trust there is organisational momentum behind information sharing including the copying of letters to service users. The success of copying letters relies on an open and clear clinical engagement, so that the letter is no more than a reminder of everything

that has been discussed during clinical contact. The workload of the author would be reduced by drafting only one letter, suitable both for the general practitioner and service user (Spiessl *et al*, 2006).

In our study, we had three main goals. We wanted to keep prospective information about all letters sent to general practitioners and check how many of them were copied to patients. We also wanted to record any difficulties encountered as a result of copying the letters to service users or their carers and check the acceptability of the letters to their recipients.

### Method

Between August 2004 and March 2006, 747 letters concerning 443 service users were sent to general practitioners by the Newbury Community Mental Health Team (CMHT) for older adults. It was intended that all service users or, where more appropriate, carers, received a copy of the letter. Before any letters were sent out their style was agreed upon: business-like; aiming to give clear and accurate information; patient copy was to be the same as the general practitioner's copy; standard structure (Box 1).

If the letter was to be copied to anyone else, such as social services, then permission from the service user was also sought. If the plan for further action made reference to nursing colleagues or other professionals, the importance of everyone involved in the case receiving the letter was emphasised. Finally, verbal consent for receipt of the letter by service user or carer was taken.

The decision to send the letter to either the service user or the carer was based on discussion with the doctor and common sense. There were four common



original papers

scenarios. First, competence was assumed for all patients and, unless there was evidence to the contrary, the doctor suggested that they should receive a copy of their clinical letter. Second, in those cases where there was established significant cognitive impairment that would prevent the user understanding and benefiting from the letter, they were asked if they were happy for the correspondence to be sent to an appropriate carer. Third, in individuals with advanced cognitive decline who lacked capacity to consent to the letter being presented to someone else, it was offered to a carer without consulting the user. Finally, there was a small minority of clients who did not fit into the first three categories, and in these cases the destination of the letter was discussed with the client and their carers.

If a service user wanted to have the letter sent to other people than their carers, it was explained that they were free to do so, but that they were responsible for the confidentiality of its contents and the cost of copying and posting additional letters.

A great effort was made to inform colleagues that the service user/carers was also receiving the clinical correspondence. When areas of contention surfaced during the interview, such as the effect of alcohol misuse or the diagnosis of dementia, the doctor discussed this as fully as possible with the user/carers and explained that the recipient may disagree with this particular point in the letter. The letter always concluded with a clear statement inviting the reader to contact the CMHT to discuss its content (Treloar & Adamis, 2005).

For 50 consecutive letters sent out during September and October 2005 a questionnaire (Box 2) was enclosed to obtain the recipient's views of the letter.

## Results

### Those who refused the letter

Of the 747 people who were offered a letter, 14 service users refused to receive it; in each of these cases the user saw the doctor on only one occasion. Eight service users/carers initially refused the letter but on meeting the doctor for a second time they accepted it and received

#### Box 1. Letter structure

- Statement of when and why the service user came to the service and who accompanied them
- Diagnosis (using ICD-10; in case of uncertainty the diagnosis would be classified as tentative or provisional)
- Active problems
- Current level of functioning and support
- Current medication
- Letters concerning initial assessments would include relevant background such as past psychiatric history, family history, past medical history and personal history
- A brief summary of the overall situation
- A bullet-point plan, stating who was responsible for each part
- Recipients

Subotsky, 2005

copies of previously refused letters. Two service users were unable to consent and had no suitable carer or relative to give a letter to. Twenty-one service users were initially 'missed' – all eventually received a copy of their letters.

### Those who accepted the letter

In total, over the 20 months of the duration of the study, 731 letters about 427 service users were sent out; 199 were sent to service users and 532 to carers. Of those sent to carers, 474 were sent to family members and 58 to friends of the service user. The diagnosis given to service users and clearly stated in the letter, as well as the list of the recipients, is set out in the online Tables DS1 and DS2.

## Questionnaire

In September and October 2006, 50 questionnaires were sent out to service users/carers; 45 were returned

#### Box 2. Questionnaire on the quality of the letter

##### QUALITY OF CLINICAL LETTER YOU HAVE RECEIVED

Thank you for taking time to fill in this questionnaire about the letter you have received. To help us maintain and improve the standard of the letters sent to service users or their carers could you please circle a response to each question.

1. Did the letter contain inaccurate information? Yes No  
If yes, please write here what the mistakes were.

2. Was the letter clear? Yes No  
Please write here any terms that you could not understand.

3. Did the specialist tell you that you would receive the letter? Yes No

4. Did you find the letter useful?  
Very useful Quite Useful Of little use Of no use

5. Was there anything in the letter that you had not discussed with the doctor in the clinic? Yes No  
If yes, please write here what it was.

6. Did the letter miss out any information? Yes No  
Please write here anything that you would have liked to be in the letter.

7. If you wanted to discuss the letter do you know how to contact an appropriate person? Yes No

8. Was the letter upsetting instead of helpful? Yes No  
Any other comments you would wish to make:

original  
papers

without prompting or sending the questionnaire again. This very high response rate was probably due to appreciation of the letter and its novelty – the recipients were both pleased and surprised to receive it and they responded in kind. One letter contained inaccurate biographical details, but on the whole the letters were accurate. All respondents said the letter was clear. They knew from the specialist they consulted that they would receive it; no information was missed (Box 1, question 6); recipients knew who to contact if they were concerned about it; and there was no unexpected or upsetting material in the letter. For 32 respondents the letter was 'very useful' and for 13 it was 'quite useful'. Other comments were general thanks for the letter, statements that it reassured recipients that they had been listened to and, paradoxically, that its value was undermined by having known its contents before receiving it. Though the questionnaire was anonymous, responders may have felt constrained from adding additional information for fear of being readily identifiable. This may have prevented a full and honest response to the letters and this should be taken into consideration when interpreting the findings.

## Corrections

There were four letters where the recipients asked for changes to be made. In response to two letters, carers challenged the account of cognitive decline believing that the letter exaggerated the symptoms. In neither case were the diagnoses challenged and there was no breakdown in the therapeutic relationship, with clinical contact carrying on as normal. In reply, the doctor wrote a new letter highlighting the concern raised and at subsequent visits time was spent agreeing the severity of the symptoms of cognitive impairment that were to be recorded in the case notes and the letter.

One carer and one service user asked to correct biographical details. For one it related to the professional grade that the patient's father had reached during his working life and for the second it was the length of time that the service user had lived in their current accommodation. In both cases apologies were expressed and corrected correspondence was sent out to the general practitioner and the user.

## Modification of content

Only one letter had the content modified in comparison to the one sent to the general practitioner. At the request of a family carer, third-party information was removed from a letter that a service user received.

## Reaction to the letter

The reaction to the letters was generally positive and only one carer, of a person with Alzheimer's disease, asked that the letter not be sent in future, as it upset the service user. The only terms that needed clarification in

the letter were the acronyms: MMSE (Mini Mental State Examination); BADLS (Bristol Activities of Daily Living Scale) and DemTect (a screening tool for cognitive impairment; Kalbe *et al*, 2004), but these were explained to recipients by the professionals who administered these instruments before sending out the letter.

## Author's impression

The clear sustained response to the letters was that of appreciation. Service users and their carers, when motivated, readily understood correspondence that was primarily written for general practitioners. Ensuring all aspects of the care plan progressed as planned was easier because, once armed with the correspondence, the service user/carer would contact the CMHT to ask why they had not received a radiology appointment or a visit from social services. Though this was embarrassing if it turned out that the request for the service had not been sent off, it was infinitely better than appearing at the next clinical appointment without the intended report.

The letters also reduced splitting within families and between team members (Cape *et al*, 2005). The clear statements of the diagnosis, problems and care plan prevented users/carers having false expectations. Though the diagnosis can often be upsetting, the recipients appreciated that a clear statement of the diagnosis from a doctor gained them access to support services.

## Discussion

Sending clinical correspondence to service users should be promoted as good practice for all clinical and social contexts. This report shows that the service users of the Newbury CMHT for older adults appreciated clear and direct information about their diagnosis, problems and care plan. The style of the letter used is acceptable to service users and carers, and can be used for both general practitioner and user. However, owing to its limitations, this study is insufficient to answer many of the questions surrounding copying letters to patients (Sawhey *et al*, 2007). In this report, all those who received the letters spoke English as their first language; the level of education among the population was generally high and almost all had reasonable expectations of what mental health and social services could provide. It was relatively easy to develop rapport and a respectful open two-way therapeutic relationship with service users and their carers, which fitted with the style of the letter. The doctor had known the team he was working with for over 2 years and thus it was easy to ensure their cooperation during the study.

To improve the practice of copying clinical correspondence to all service users, reports from the full array of clinical and social contexts are required. Different subspecialties and different social groups, such as non-English speakers, ethnic minorities and those with limited educational attainment, potentially present different challenges not met in the population who received the



original papers

letters in this report. Novel and successful approaches to dealing with copying clinical correspondence to patients should be reported so that clinical teams can adopt proven, suitable strategies. This should include methods of training and supervising inexperienced clinicians in what is expected of letters sent to service users and their carers.

### Declaration of interest

None.

### References

BOADEN, R. & HARRIS, C. (2005) Copying letters to patients – will it happen? *Family Practice*, **22**, 141–143.

CAPE, J., HARVEY, K., JOHNSON, S., et al (2005) Patients' views of letters their psychiatrists and psychologists send to referrers. *Journal of Mental Health*, **14**, 369–382.

COMBE, G., SHORT, C. & STEPHENS, H. (2006) Copying letters to families: attitudes and experiences of child and adolescent psychiatrists. *Psychiatric Bulletin*, **30**, 413–415.

DEPARTMENT OF HEALTH (2003) *Copying Letters to Patients. Good Practice Guidelines*. Department of Health.

HULINE-DICKENS, S. (2004) Evaluation of copying letters to patients. *Psychiatric Bulletin*, **28**, 304–305.

KALBE, E., KESSLER, T., CALABRESE, P., et al (2004) DemTect: a new sensitive cognitive screening test to support the diagnosis of mild cognitive impairment and early dementia. *International Journal of Geriatric Psychiatry*, **19**, 136–143.

LASK, B. (2004) Copying letters to patients. *Psychiatric Bulletin*, **28**, 426.

LLOYD, G. (2004) Medical records: copying letters to patients. *Psychiatric Bulletin*, **28**, 57–59.

MARZANSKI, M., PADMAPRIYA, M. & COUPE, T. (2005) Copying letters to patients: a study of patients' views. *Psychiatric Bulletin*, **29**, 56–58.

NANDHRA, H., MURRAY, G., HYMAS, N., et al (2004) Medical records: doctors' and patients' experiences of copying letters to patients. *Psychiatric Bulletin*, **28**, 40–42.

OKOLO, D. (2004) Copying letters to patients. *Psychiatric Bulletin*, **28**, 343.

ROYAL COLLEGE OF PSYCHIATRISTS (2004) *Copying Clinical Letters to Patients. Guidelines for Old Age Psychiatrists*. Royal College of Psychiatrists Faculty for the Psychiatry of Old Age.

SAWHEY, I., TAJER, A. & MORGAN, J. (2007) Copying clinical letters to patients – views of people with learning disabilities and their carers. *British Journal of Developmental Disabilities*, **53**, 17–23.

SPIESSL, H., ROTHBAUER, J. & CORDING, C. (2006) Discharge letters addressed to patients – confidence enhancement and psychoeducation (Entlassungsbriefe an Patienten – Vertrauensbildende Maßnahme und Psychoedukation). *Psychiatrische Praxis*, **33**, 296–298.

STURGE, C. (2004) Sharing information/disclosure. *Psychiatric Bulletin*, **28**, 304.

SUBOTSKY, F. (2005) Copying letters to patients: issues for child and adolescent mental health services. *Psychiatric Bulletin*, **29**, 201–203.

THAIR, T., BISSON, J. & WILCOX, J. (2005) Copying clinic letters to psychiatric patients. *Psychiatric Bulletin*, **29**, 327–329.

TRELOAR, A. & ADAMIS, D. (2005) Sharing letters with patients and their carers: problems and outcomes in elderly and dementia care. *Psychiatric Bulletin*, **29**, 330–333.

UHER, R. & TIMEHIN, C. (2006) Managing patient's information in a community mental health team. *Psychiatric Bulletin*, **30**, 172–174.

WALD, C., FAHY, M., WALKER, Z., et al (2003) What to tell dementia caregivers – the rule of threes. *International Journal of Geriatric Psychiatry*, **18**, 313–317.

\*Julian Mason Specialist Registrar on Oxford Deanery Rotation in Psychiatry, West Oxfordshire Community Mental Health Team for Older Adults, Welch Way, Witney, Oxfordshire OX28 6JQ, email: jdtmason@msn.com, Daphne Rice Consultant in Old Age Psychiatry, Newbury Community Mental Health Team for Older Adults, Beechcroft, Berkshire

Psychiatric Bulletin (2008), **32**, 262–265. doi: 10.1192/pb.bp.107.019174

ANNA SPARSHATT, EROMONA WHISKEY AND DAVID TAYLOR

## Valproate as prophylaxis for clozapine-induced seizures: survey of practice

### AIMS AND METHOD

To evaluate the prescribing of valproate in clozapine-treated individuals who may be at risk of seizure. We collected point-prevalent clinical characteristics and demographics of all in-patients prescribed clozapine in an acute mental health trust. Data

were collected from case notes, electronic records and drug charts, and analysed against a set audit standard.

### RESULTS

Data were collected for 81 in-patients. Of all deemed to be at risk of seizure (n=37) only 24% were

prescribed valproate at a therapeutic plasma level.

### CLINICAL IMPLICATIONS

The majority of patients prescribed clozapine at risk of seizures were not adequately protected from this risk. Clear guidelines are required.

Clozapine is an atypical antipsychotic agent with an established and valuable role in treatment-refractory schizophrenia (National Institute for Health and Clinical Excellence, 2002). In this patient group, clozapine has been shown to be consistently effective (Taylor & Duncan-McConnell, 2000) and is more effective than switching to another atypical antipsychotic when other atypical agents have failed (McEvoy et al, 2006). However, it has a serious adverse effect profile and

attrition from treatment is high (Ciapparelli et al, 2003). Outcome has been shown to be poor for individuals who discontinue clozapine for any reason and it has been observed that preventable death is a common occurrence in those stabilised on clozapine, including death associated with seizure (Atkinson et al, 2007).

Much has been written on clozapine's propensity for lowering the seizure threshold (Devinsky & Pacia, 1994; Pacia & Devinsky, 1994; Sajatovic & Meltzer, 1996;