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Impact of providing patients with copies of their medical correspondence: a randomised controlled study

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*The impact of providing patients with copies of their medical correspondence: a randomised controlled study.*

## **TEXT**

### **INTRODUCTION**

It is standard practice in Australia to send consultation letters and procedure reports to a patient's general practitioner (GP) following a specialist consultation or procedure. Actively involving patients is paramount in the evolving culture of healthcare, yet most patients do not routinely receive copies of their medical correspondence. There is great emphasis on improving doctor-patient communication beyond the face-to-face interaction alone, and increasingly patients expect more information regarding their health and healthcare encounter. Written communication is an important way to enhance patient autonomy, understanding of their medical condition, and provide holistic management.

The provision of medical correspondence to patients has been suggested to improve shared decision making and promote empowerment of patients (1). Consequently, the United Kingdom (UK) National Health Service (NHS) proposed a policy in 2000 outlining that "letters between clinicians about an individual patient's care will be copied to the patient as of right" (NHS Plan, Paragraph 10.3) (2,3). This policy highlighted the need to provide patients with the option of receiving their medical correspondence. While patients already have the right to view their medical records, many are unaware of this and there is often a considerable administrative and cost burden in doing so.

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A number of studies have demonstrated advantages arising from copying correspondence to patients, including improved doctor-patient relationships (4), increased patient satisfaction (5, 6), reduced patient anxiety (7,8) and greater patient comprehension of their medical condition (9,10). Furthermore, recipients of medical correspondence have cited increased trust (11), better relationships, shared decision making and communication (4,10-13) amongst the perceived benefits. Furthermore, receiving a letter can serve as a useful reminder of the discussion that took place during a consultation, as well as the decisions and actions agreed (14-16). Patients can discuss the content of the letter with relatives and carers and these letters may have some value in helping the acceptance of "bad news" (8,14,17). This correspondence also acts as confirmation that following the appointment "something is being done" (7,10). The advantages of copying correspondence to patients have been reported in a number of specialties including ENT, dermatology and colorectal surgery (6,13).

Within gastroenterology, current practice regarding the provision of endoscopy reports to patients is clinician dependent. A non-randomised study conducted by Spodik et al demonstrated that the provision of an endoscopy report at discharge reduced post-procedure anxiety, improved recall of findings and recommendations, and may increase compliance (18). The benefits of a simple, safe and inexpensive intervention such as the provision of endoscopy reports to patients therefore warrants further examination.

Despite the demonstrated benefits of providing patients with a copy of medical correspondence in outpatient settings overseas, there have been no published studies investigating the effects of sending medical correspondence to an Australian patient

population. Moreover, in only one study was the provision of correspondence to patients randomised (19). Our study builds on this existing research, aiming to provide insight into the attitudes and perceived benefits of receiving medical correspondence in an Australian patient population. Specifically, to determine whether providing patients with a copy of their medical correspondence and endoscopy report, would lead to a measurable increase in subjective understanding, increased satisfaction and decreased anxiety with respect to their medical care.

## **METHODS**

This was a prospective, randomised, single centre study conducted at The Royal Melbourne Hospital in Victoria, Australia. Participants were recruited from October 2013 until February 2015, and followed up until October 2015. Ethics approval was granted from the Melbourne Health Human Research Ethics Committee.

### ***Participant selection and randomization***

Participants were recruited from a single general gastroenterology evening clinic, which primarily receives new referrals from GPs. Patients were identified as appropriate for the study by the six gastroenterology consultants at the clinic. All adult patients who attended the clinic and were undergoing a category 1 (urgent) endoscopic procedure were eligible for the study. Participants were required to be able to read and write in English.

All patients consented to completing and receiving follow up questionnaires, with the freedom of opting out at any stage. It was felt that requiring written consent in a

prospective manner might bias questionnaire answers and diminish the significance of study findings. This is not a significant departure from routine practice at the hospital in which the study was based where providing correspondence is clinician-dependent and all patients have access to correspondence and endoscopy reports upon request through Freedom of Information Act (1982). At the completion of the study, participants were sent a 'Patient Information Sheet' advising them of their randomisation to receiving correspondence and presented with the option of withdrawing from the study.

Participants who agreed to participate in the study were randomised to standard care ('no correspondence') or intervention ('correspondence') groups using a coin toss. Participants and their respective gastroenterology consultant were blinded to the randomisation group. Questionnaires were administered by researchers independent of the gastroenterology clinic.

### ***Protocol***

All participants underwent routine care: an initial consultation; endoscopic procedure; and post-endoscopy consultation. Surveys were conducted at three time points: immediately following the initial consultation; at the post-endoscopy consultation; and finally one month after the post-endoscopy consultation as a postal questionnaire (Figure 1, Appendices I-III).

The 'no correspondence' or control group received no correspondence by mail, the current standard of practice. The 'correspondence' or intervention group received copies of the letters to referring doctors from their initial and post-endoscopy consultations, as well as their endoscopy report. Correspondence letters and reports

were sent to the participant's home address as confirmed during the initial consultation. All endoscopy reports and clinic correspondence were screened prior to postage. Participants found to have malignant diagnoses requiring urgent notification and follow up were to be excluded from the study, however, no such diagnoses were identified.

### ***Research tools***

The hospital anxiety and depression scale (HADS) and a questionnaire were administered at each survey point. The HADS is a self-assessment scale developed by Zigmond and Snaith to detect states of depression, anxiety and emotional distress in patients being treated for a medical condition (20). It is not a diagnostic tool and questions are designed to be answered in relation to the previous week. The HADS was utilised due to its simple nature, taking only two to five minutes to complete, and was intended as a comparison at different stages of the patient journey.

Alongside the HADS, separate questionnaires were administered at each survey point. These consisted of visual analogue scales (VAS) for patients to rate anxiety and subjective understanding levels on a continuum of 0-10. They also included a series of simple yes/no questions. (Appendix I-III).

### ***Statistical Analysis / Data storage***

GraphPad Prism version 6.00 for Mac, GraphPad Software, La Jolla California USA, was used to generate statistical analyses. The Mann-Whitney test was used for non-parametric data comparing the two unpaired groups. A p value of <0.05 was used to determine statistical significance.

All data were stored in a re-identifiable manner as patient identifiers were needed to

match endoscopy results, clinic letters and follow up clinic details to ensure that all correspondence was posted to the correct patient and address.

## **RESULTS**

A total of 155 participants were enrolled in the study. 70 participants (45%) were successfully followed up with 36 in the 'correspondence' group and 34 in the 'no correspondence' group. 85 participants (55%) were lost to follow up for reasons including failing to return the final postal survey, failing to attend the post-endoscopy review and not going ahead with the planned endoscopic procedure (Figure 2)

The participants in the intervention and control groups were well matched in terms of age, country of birth and educational level achieved (Table 1). The median age was 44 years, with a range of 19 to 70 years. There was a predominance of females overall (43 females, 27 males), more marked in the 'correspondence group'. Approximately 50% of participants were born in Australia with 22 countries of birth altogether. The majority of participants had achieved at least secondary education, with almost 50% completing tertiary studies.

### ***Anxiety***

Depression/anxiety levels at the initial consultation were similar between 'no correspondence' and 'correspondence' groups, with comparable average HADS scores of 13.00 and 11.22 respectively ( $p = 0.27$ ). After receiving correspondence, there remained no difference in anxiety between groups at the post-endoscopy review (11.50 vs 8.00,  $p = 0.14$ ) or one month following the post-endoscopy review (10.00 vs 11.50,  $p = 0.52$ )

(Figure 3). The same outcome was reached when using the VAS to rate anxiety (2.05 vs 4.40,  $p = 0.26$ ).

### ***Understanding***

Subjective participant understanding was measured on the VAS and was similar at baseline (8.04 vs 7.88). At the post-endoscopy review (8.30 vs 9.15,  $p = 0.57$ ) and one month following (8.00 vs 8.15,  $p = 0.73$ ), there remained no difference in participant understanding between the 'no correspondence' and 'correspondence' groups (Figure 4). Perceived understanding scores were skewed towards high levels of understanding at all time points.

### ***Satisfaction***

Patient satisfaction with their care in relation to the gastroenterology clinic was measured one month after the post-endoscopy review using the VAS. There was no demonstrable difference in overall satisfaction between the 'correspondence' and 'no correspondence' groups (8.70 vs 8.50,  $p = 0.33$ ) (Figure 5). The majority of participants scored highly on satisfaction with an average satisfaction score of 7.98/10 in the 'no correspondence group' and 8.61/10 in the 'correspondence' group. A larger proportion of 'correspondence' participants rated 10/10 satisfaction while those with lower satisfaction scores were generally seen in the 'no correspondence' group, however this was not statistically significant.

### ***Post-hoc Analysis***

Additional subanalyses were completed to determine if age, educational status or whether a specific diagnosis had been provided had any significant impact on anxiety, understanding and overall satisfaction. None of these factors significantly affected the parameters.

### ***Patient recall and subjective value of correspondence***

Of the 36 participants in the 'correspondence' group, 87% recalled receiving their endoscopy report, 100% of those participants had read their report and 80% felt they understood the report. Similarly, 97% recalled receiving their clinic correspondence letters, 97% read their correspondence and 90% felt they understood the letters. Only a small proportion of participants discussed the endoscopy report (19%) with their gastroenterologist and no participants discussed their correspondence letters (0%). However, 43% of 'correspondence' participants did discuss their endoscopy report with their GP.

In the final questionnaire 97% of all participants (58/60) indicated they would like to receive correspondence in future. In addition, 94% of patients (29/31) in the 'correspondence' group felt that receiving the correspondence had helped them to better understand their medical condition.

Positive feedback comments included: "I wanted to know as much as possible about what was going on with my body", "reassuring", "I was able to give the results to my GP earlier" and "[correspondence] absolutely helped me to understand my medical condition". Some concerns were also raised regarding receiving correspondence, for

example “[correspondence] made me anxious because I didn’t understand the report” and “it would depend on whether the result was serious”.

## **DISCUSSION**

Our study findings indicate that patients would like to receive a copy of their medical correspondence, with 97% of study participants indicating that they would like to receive future medical correspondence. Furthermore, those who did receive the correspondence almost unanimously indicated that they read and understood the correspondence and report and that it enhanced their overall understanding of their condition. Despite this, we were not able to find any statistically significant improvement in subjective patient understanding, anxiety, or satisfaction in those who received a copy of their medical correspondence and endoscopy report compared to those who did not.

Our findings are pertinent given patients have previously expressed dissatisfaction with the relay of medical information from consultations with specialists (21-24). Insufficient and lack of supporting information; inadequate communication of diagnosis and treatment; and poor understanding and recall of information all contribute to patient dissatisfaction in relation to their medical care (21-24).

These findings are consistent with literature demonstrating a greater level of patient comprehension (25) and improved recall of information relating to medical care (18) in patients receiving copied correspondence. However, some participants expressed concern about receiving the results if they were more serious or life-threatening. Although no serious diagnoses were found amongst our study participants, the

provision of medical correspondence containing life-threatening or malignant diagnoses may not be appropriate, particularly if there is any uncertainty as to whether the contents of the letter may be misinterpreted, misunderstood, or cause the patient any unwarranted anxiety. To this effect, the NHS has recommended that that correspondence should not be copied to patients in certain circumstances including where “the letter contains abnormal results or significant information that have not been discussed with the patient” (2) and we believe that this approach is very sensible.

The two participants who declined to receive further medical correspondence reported increased anxiety at not being able to fully understand the correspondence and, although our study did not demonstrate a measureable reduction in anxiety in those receiving copied correspondence, it does highlight the importance of patients being given the option of whether or not to receive copies based on their personal preference.

### ***Limitations***

The lack of statistically significant improvements in subjective patient understanding, anxiety and satisfaction could have been attributed to the small sample size, potentially leading to type II error. As this study was designed as a pilot study to inform further studies, power calculations were not performed prior to commencement. The sample size of 70 was accepted, as it was felt that a statistically significant effect would be evident within this number, particularly given that previous studies have used similar sample sizes.

While many characteristics were well-matched between the control and intervention groups, the study did not account for certain patient variables, and the predominance of females in the “correspondence” group could have had an impact on results. Furthermore, patient compliance in attending appointments was quite variable so the timeframe was varied in the completion and return of surveys. This may have presented the potential for recall bias. There was no measure for any preexisting mental health illnesses which may have affected anxiety levels, however baseline anxiety was comparable between groups and each participant’s anxiety levels were also compared with their own scores overtime so this is unlikely to have significantly altered results. Finally, as the participants were recruited from an evening gastroenterology clinic which generally attracts younger and healthier patients, the cohort may be more representative of a private gastroenterology clinic rather than the wider public gastroenterology patient load.

Whilst the HADS is a standardised measure of anxiety and depression, it may not have accurately captured anxiety in relation to the gastroenterology issues alone, with external life stressors potentially impacting results. Additionally, the VAS tool lacked some accuracy in measuring patient’s ratings of anxiety, understanding and satisfaction levels due to the potential variability in patient estimations of 0-10. In future studies, a Likert scale and more specific questions or objective measures of understanding (i.e. recalling specific information relating to their consultation) could be used. The impact of clinician factors, including appointment duration and details of patient-doctor discussions, were also not examined in detail.

Overall we have demonstrated that overwhelmingly patients wish to receive copies of correspondence and those that do receive copied correspondence feel that it improves their understanding of their medical condition. As patient involvement and interest in their healthcare decisions continues to grow, patients should be given the choice whether or not to receive copies of their specialist consultation letters. This is likely to enhance doctor-patient communication and relationships, empower patients in making healthcare decisions and consolidate patients' understanding of their medical care.

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## **FIGURE LEGENDS**

**Figure 1: Study protocol.** a. Control group ('no correspondence'). b. Intervention group ('correspondence').

**Figure 2: Recruitment and follow up of participants.**

**Figure 3: HADS at each time point.** No significant difference in HADS between groups at the pre-endoscopy consultation ( $p = 0.27$ ), post-endoscopy consultation ( $p = 0.14$ ) or one month follow-up ( $p = 0.52$ ).

**Figure 4: Understanding at each time point.** No significant difference in perceived understanding using VAS between groups at the pre-endoscopy consultation ( $p = 0.88$ ),

post-endoscopy consultation ( $p = 0.57$ ) and one month following the second consultation ( $p = 0.73$ ).

**Figure 5: Satisfaction ratings.** No significant difference in overall satisfaction with their healthcare between 'correspondence' and 'no correspondence' groups ( $p = 0.33$ ).

## **TABLES**

**Table 1. Patient characteristics**

| Characteristic   | No Correspondence<br>(Control Group)<br>n (%) | Correspondence<br>(Interventional Group)<br>n (%) | Total<br>n (%) | P value    |
|------------------|---|---|----------------|------------|
| <b>AGE GROUP</b> | 34  | 36  | 70             |            |
| <b>18 - 39</b>   | 15 (44.1%)                                    | 9 (25.0%)   | 24 (34.3%)     | $p = 0.13$ |
| <b>40 - 69</b>   | 19 (56.9%)                                    | 26 (72.2%)  | 45 (64.3%)     |            |
| <b>&gt; 69</b>   | 0   | 1 (2.8%)  | 1 (1.4%)       |            |
| <b>GENDER</b>    |   |   | 70             |            |
| <b>Male</b>      | 17 (50.0%)                                    | 10 (27.8%)  | 27 (38.6%)     | $p = 0.06$ |
| <b>Female</b>    | 17 (50.0%)                                    | 26 (72.2%)  | 43 (61.4%)     |            |

|   |            |            |            |          |
|---|------------|------------|------------|----------|
| <b>PLACE OF BIRTH</b>                   |            |            | 70         |          |
| <b>Australia/New Zealand</b>            | 18 (52.9%) | 23 (63.9%) | 41 (58.6%) | p = 0.18 |
| <b>Other</b>                            | 16 (47.1%) | 13 (36.1%) | 29 (41.4%) |          |
| <b>HIGHEST EDUCATION LEVEL ACHIEVED</b> |            |            | 70         |          |
| <b>Primary</b>                          | 2 (5.9%)   | 1 (2.8%)   | 3 (4.3%)   | p =0.05  |
| <b>Secondary</b>                        | 14 (41.2%) | 19 (52.8%) | 33 (47.1%) |          |
| <b>Tertiary</b>                         | 18 (52.9%) | 16 (44.4%) | 34 (48.6%) |          |

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## **APPENDICES**

### **Appendix I - Initial Consultation (Pre-endoscopy) Questionnaire**

#### **Initial Consultation (Pre-endoscopy) questionnaire**

1. In what country were you born? \_\_\_\_\_
2. How long have you lived in Australia? \_\_\_\_\_
3. What language do you speak at home? \_\_\_\_\_
4. What is your highest level of education (please circle):  
(a) Primary/Secondary School (b) Bachelors Degree (c) Masters Degree (d) PhD
6. Do you feel comfortable reading English (e.g. letters, reports)? Yes / No
7. Do you ever receive copies of letters or reports from your doctors? Yes / No
8. Are you willing to complete another survey at your next consultation? Yes / No

#### **Before your consultation:**

9. How would you rate your understanding of the problem that you have attended the gastroenterology clinic for?

Please rate this on a scale of 0-10 below with a single vertical line



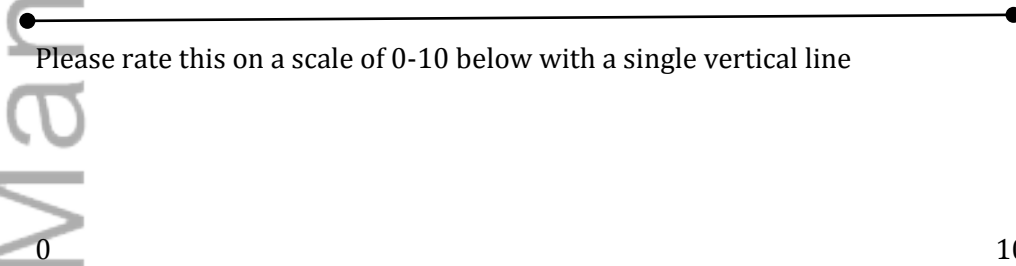
“No understanding”

“Complete

**After your consultation:**

10. How would you rate your understanding of the problem that you have attended the gastroenterology clinic for?

Please rate this on a scale of 0-10 below with a single vertical line



Understanding”

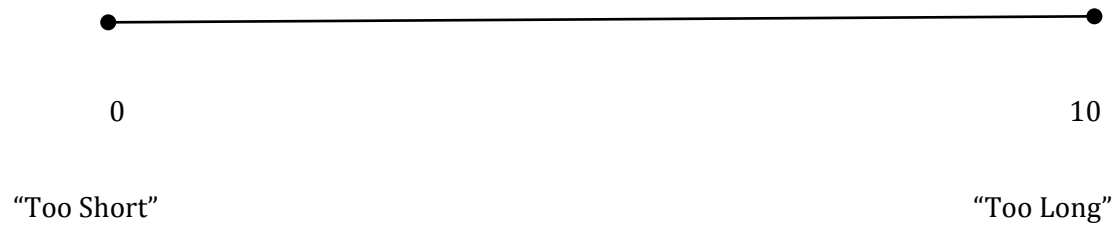
“No understanding”

“Complete

Understanding”

11. How would you rate the length of your consultation today?

Please rate this on a scale of 0-10 below with a single vertical line



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## Appendix II - Post-endoscopy Consultation (Post-endoscopy) Questionnaire

### Follow up Consultation (Post Endoscopy) Questionnaire

1. Did you see the same doctor at your last gastroenterology clinic appointment?

Yes / No

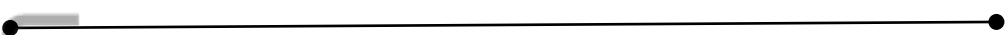
#### **Prior to this consultation:**

2. Were you anxious about receiving and discussing the results of your recent endoscopy?

Please rate this on a scale of 0-10 below with a single vertical line

0 10

“No anxiety” “Extremely  
Anxious”

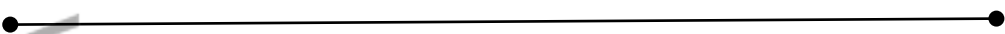


#### **Following this consultation:**

3. How would you rate your understanding of the problem that you have attended the gastroenterology clinic for?

Please rate this on a scale of 0-10 below with a single vertical line

0 10

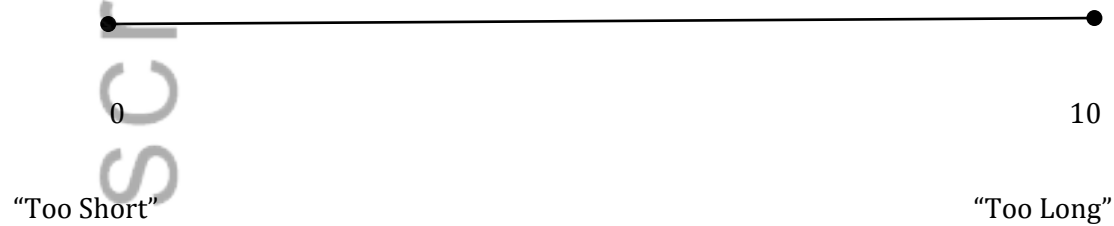


“No understanding”  
Understanding”

“Complete

4. How would you rate the length of your consultation today?

Please rate this on a scale of 0-10 below with a single vertical line



5. Did you receive a letter written by your doctor in the mail following your most recent consultation at the gastroenterology clinic?

Yes / No [ONLY ASKED TO PATIENTS IN INTERVENTION GROUP]

If you answered yes, please answer the following questions:

(a) Did you read the letter?

Yes / No

(b) Did you understand the letter?

Yes / No

(c) Did you find the letter helpful?

Yes / No

(d) Did you discuss the letter with your GP?

Yes / No

6. Did you receive a copy of the endoscopy report in the mail following your recent endoscopy?

Yes / No [ONLY ASKED TO PATIENTS IN INTERVENTION GROUP]

If you answered yes, please answer the following question:

(a) Did you read the report?

Yes / No

(b) Did you understand the report?

Yes / No

(c) Did you find the report helpful?

Yes / No

(d) Did you discuss the report with your GP?

Yes / No

7. Following your recent endoscopy, do you recall:

(a) If the endoscopy doctor spoke to you after the procedure?

Yes / No

(b) If the endoscopy nurse told you the findings of the procedure?

Yes / No

(c) If you were given a copy of the endoscopy report after the endoscopy?

Yes / No

8. Do you feel that sending copies of the consultation letters and endoscopy report directly to you in addition to your GP would help you understand your medical condition?

Yes / No

9. If we were able to offer the service, would you like to receive copies of correspondence and test results in the future?

Yes / No

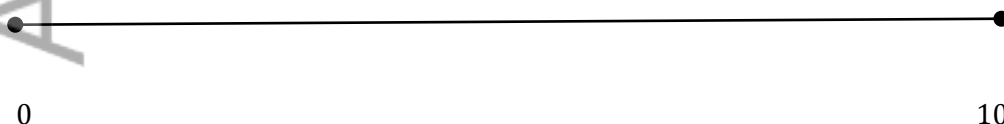
**Appendix III - Postal follow-up (1 month following post-endoscopy consultation)**

**Postal Questionnaire**

*Please answer the following questions with respect to your recent endoscopy and gastroenterology clinic experience.*

1. How would you rate your understanding of the problem that you have attended the gastroenterology clinic for?

Please rate this on a scale of 0-10 below with a single vertical line

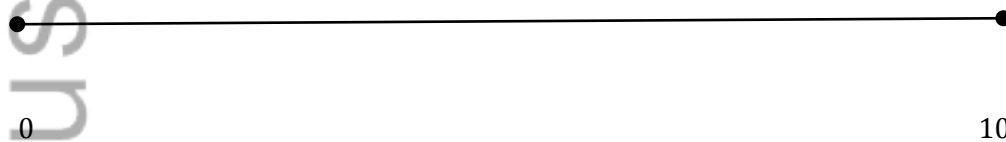


“No understanding”  
Understanding”

“Complete

2. How would you rate your satisfaction with your gastroenterology clinic and endoscopy experience.?

Rate this on the 0-10 scale as illustrated below with a single vertical line



“No Satisfaction”

“Complete Satisfaction”

3. Did you receive a letter written by your doctor in the mail following your most recent consultation at the gastroenterology clinic?

Yes / No [ONLY ASKED TO PATIENTS IN INTERVENTION GROUP]

If you answered yes, please answer the following questions:

(a) Did you read the letter?

Yes / No

(b) Did you understand the letter?

Yes / No

(c) Did you find the letter helpful?

Yes / No

(d) Did you discuss the letter with your GP?

Yes / No

4. Do you feel that sending copies of the consultation letters and endoscopy report directly to you in addition to your GP would help you understand your medical condition?

Yes / No

5. If we were able to offer the service, would you like to receive copies of correspondence and test results in the future?

Yes / No

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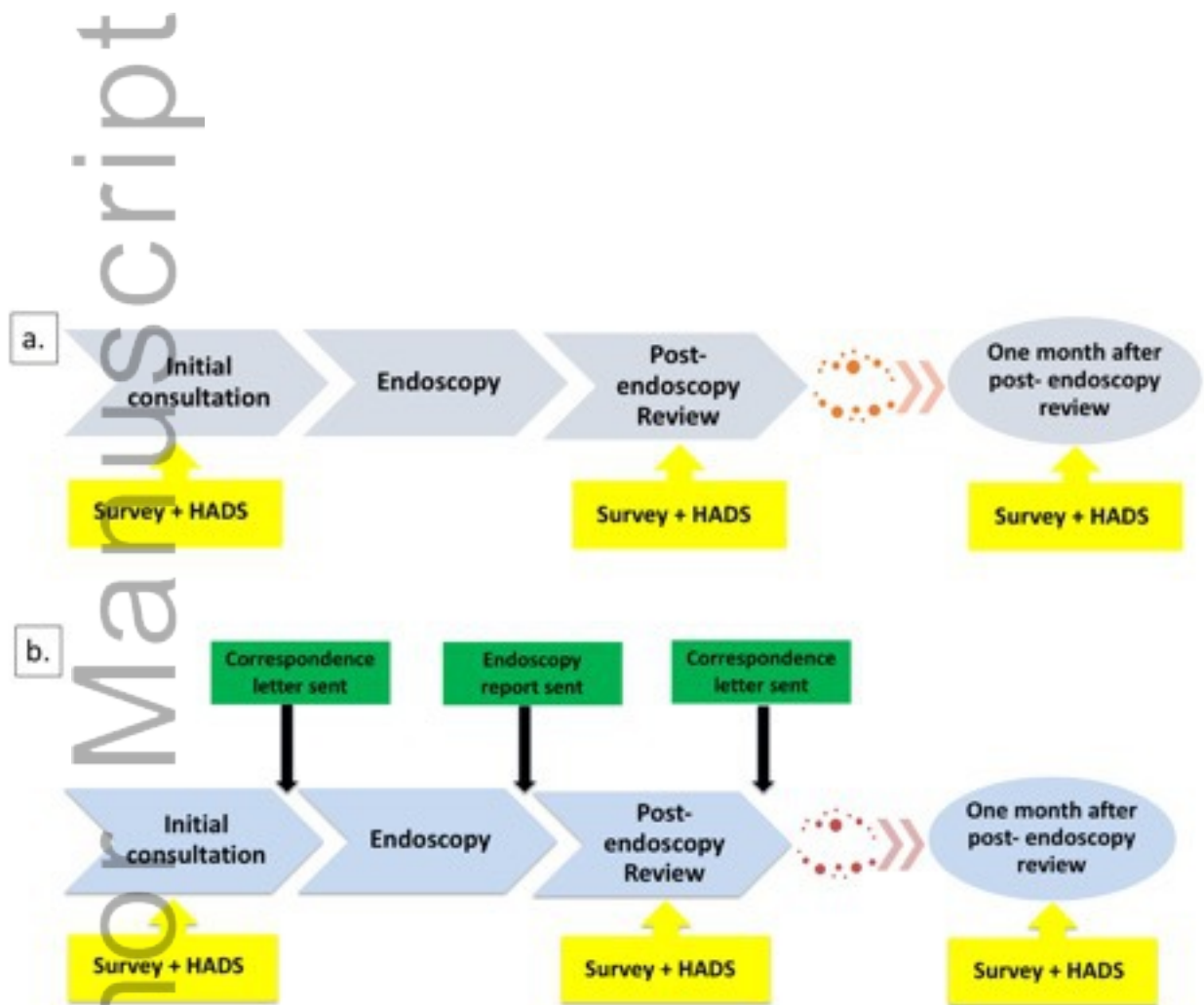


Figure 1.jpg

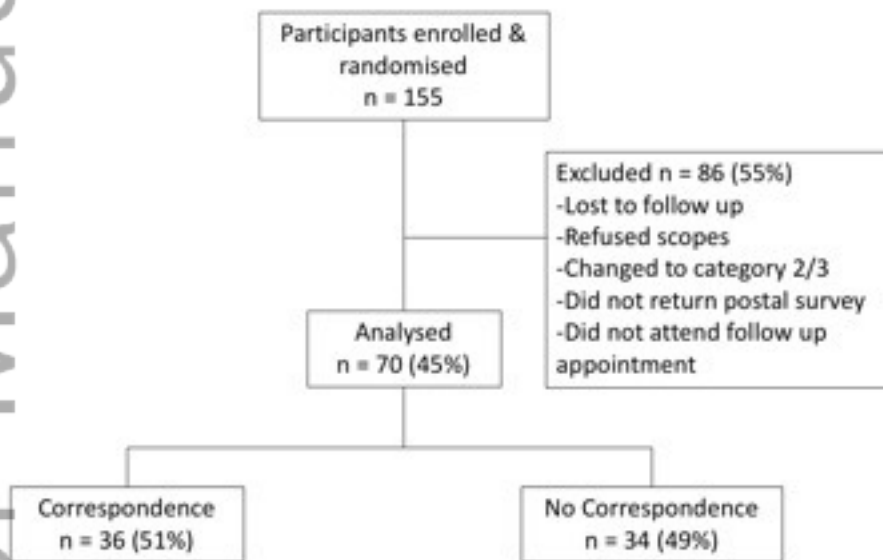


Figure 2.jpg

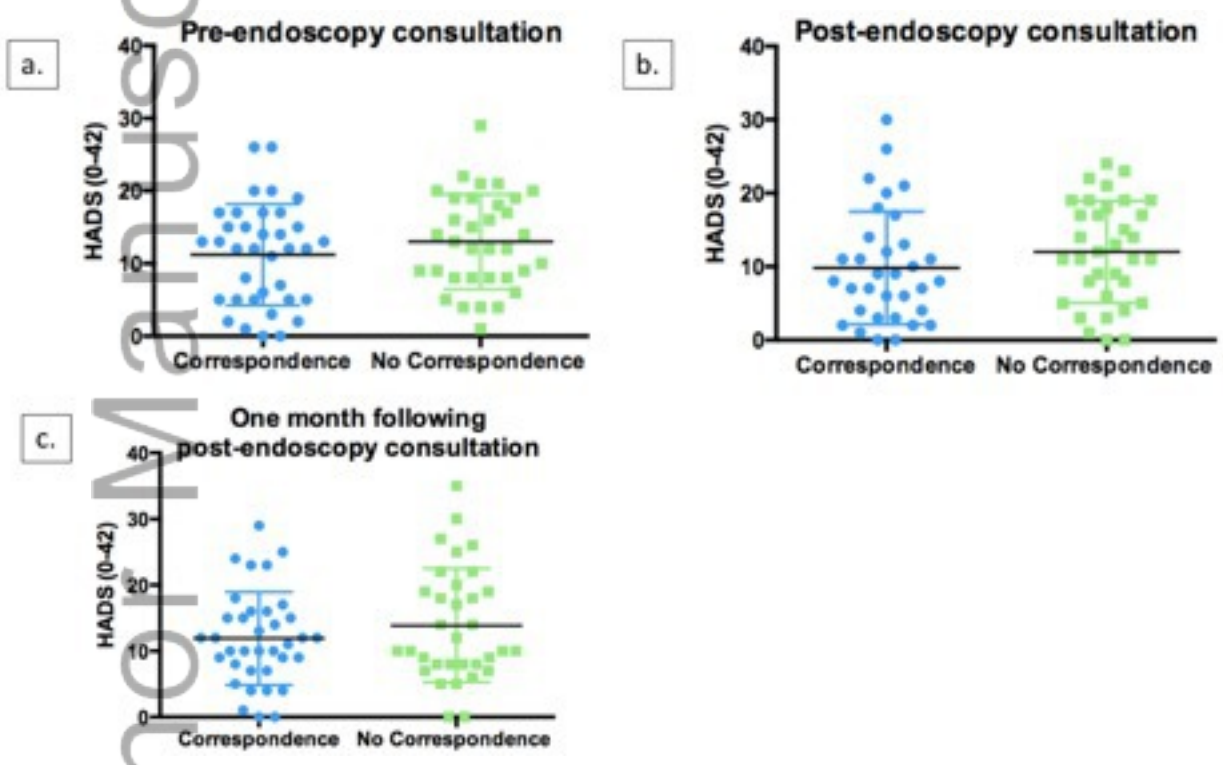


Figure 3.jpg

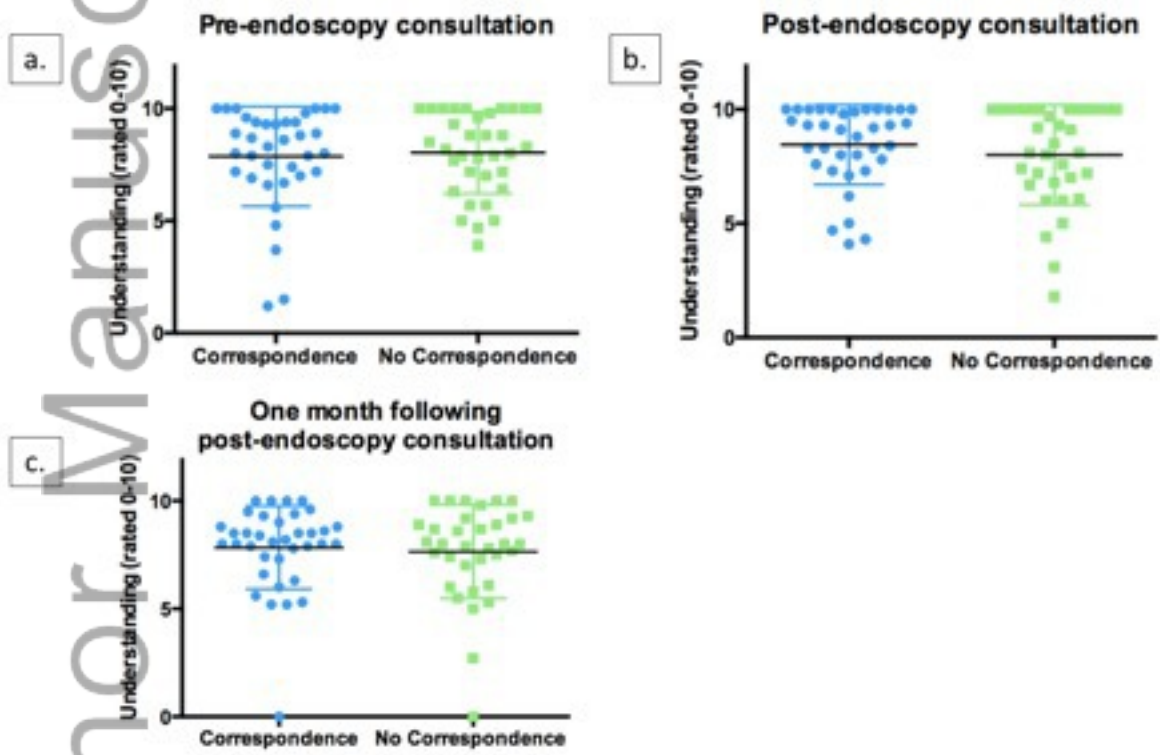


Figure 4.jpg

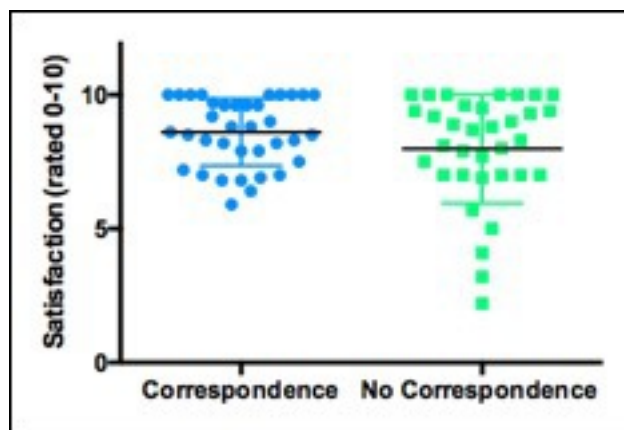


Figure 5.jpg

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**TITLE:** *The impact of providing patients with copies of their medical correspondence: a randomised controlled study.*

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## **ABSTRACT**

**Background:** In Australia, correspondence is routinely sent to general practitioners following a specialist consultation. Written communication is an important way to enhance patient experiences and understanding, yet most patients do not receive copies of their medical correspondence.

**Aims:** Determining whether providing clinic correspondence and endoscopy reports to patients leads to improved understanding, satisfaction or anxiety.

**Methods:** Prospective, randomised controlled study conducted at an Australian tertiary hospital from October 2013 to February 2015. New adult referrals to the general gastroenterology clinic requiring an urgent endoscopic procedure were eligible for the study. The intervention group received a copy of their clinic correspondence and endoscopy report, while the control group received neither. Participants completed questionnaires, including visual analogue scales and the Hospital Anxiety and Depression Scale at three time points. Primary outcomes were patient understanding, anxiety and satisfaction.

**Results:** 70 participants were included in the study. There was no reduction in anxiety levels ( $p=0.52$ ), no increase in understanding ( $p=0.73$ ) nor any increase in satisfaction ( $p=0.33$ ) in participants receiving correspondence. However, 97% of participants indicated they wished to receive correspondence in the future and 94% of participants in the correspondence group reported receiving correspondence had helped them to understand their medical condition.

**Conclusion:** Patients wish to receive copies of their correspondence and feel it improves their understanding of their medical condition. Although we were unable to demonstrate a measurable reduction in anxiety, increase in understanding or satisfaction, we recommend patients be offered the choice of receiving copies of their clinic correspondence and endoscopy reports.

## KEY WORDS

- Communication
- Endoscopy
- Medical correspondence
- Patient satisfaction
- Referral and consultation

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