Guide to Written Communication

Written and electronic forms of communication

**Introduction**

In medicine there are a variety of other forms of communication (other than face-to-face) which shape and influence the transaction of medical treatment and inter-professional and doctor-patient interaction. For example, written materials typically document the purpose and content of interactions with health care professionals. Despite this, written communication in health care has received, until recently, much less attention than verbal communication. However, there are distinct parallels between written and verbal communication. Some of the principles you have already learned about face-to-face interaction (e.g. think about a structure, where possible avoid jargon) apply also when thinking about other forms of communication such as letters to patients.

Currently, most hospital-based patient records are kept in hard copy formats. However, increasing use is being made of electronic patient records although there is considerable variation in policy and practice between primary and secondary care. Already, in general practice, patient information is stored electronically and supplemented by handwritten notes. In hospitals, you will find different information technology systems and systems in primary care do not always ‘speak’ to systems in secondary care.

 In *Good Medical Practice,* the GMC (2006) stipulates that doctors must;

* keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment (para 3f)
* make records at the same time as the events you are recording or as soon as possible afterwards (para 3g)

Making notes based on a ten-minute consultation requires skill, which is worth developing early in your career. Try recording precise and accurate notes after your patient interviews. Ask a colleague to review them. It’s often easy for someone else to find the gaps. If you practise this regularly and seek feedback you are likely to develop the skill.

As a junior doctor you will work as a member of a team but you will also have individual responsibilities. It is important that you are aware of your responsibilities in recording your actions in medical records. You are advised to write complete and accurate information. There is a very strong chance that you will be involved in an adverse event that may lead to a complaint or to litigation. If you have not maintained complete and accurate records then you weaken your legal position from the outset. You will not necessarily see consistent evidence of complete records because many doctors have trained and practised in less litigious times. Be prepared. The Medical Protection Society (2002) provides clear guidance for junior doctors on writing reports and giving evidence in Court.

There is an increasing move to electronic means of communicating and record keeping and this is reflected in the DoH guidelines for record management which now covers an increasing list of modes of communicating (including text-messaging!)

These include:

* patient health records (electronic or paper based, including those concerning all specialties, and GP medical records);
* records of private patients seen on NHS premises;
* Accident & Emergency, birth, and all other registers;
* theatre registers and minor operations (and other related) registers;
* administrative records (including, for example, personnel, estates, financial and accounting records; notes associated with complaint-handling);
* X-ray and imaging reports, output and images;
* photographs, slides, and other images;
* microform (ie microfiche/microfilm);
* audio and video tapes, cassettes, CD-ROM etc;
* e-mails;
* computerised records;
* scanned records;
* text messages (both outgoing from the NHS and incoming responses from the patient).

**Abbreviations**

**1. Commonly used medical abbreviations**

Why do health care professionals use abbreviations?

* Abbreviations are used widely by health care professionals (particularly in written documentation) as practical way of exchanging information about patients.

What is the main problem arising from the use of abbreviations?

* The main problem is that they can cause ambiguities and misunderstandings as the same abbreviation can hold different meanings and the meaning of abbreviations is not always shared. Potentially this can have serious consequences for patients.

How should abbreviations be used?

* Make sure that any abbreviations used are mutually understood. Try to identify those abbreviations that are used in most places and those that seem specific to the clinical site or specialty you are working in. It is helpful to consider who the audience might be for what you are writing. Abbreviations can be helpful for note taking for personal use, but for permanent records consider who and when they may be read again.
* There are many advantages to the use of abbreviations, but, it’s important to note that the meaning of abbreviations is not always shared. This could lead to ambiguity and misunderstanding. When you present patients or write to patients you should not use abbreviations.

 **Examples of ambiguity include**:

 DIC

* + - * drunk in casualty
			* died in casualty
			* disseminated intravascular coagulation

 BS

* + - * bowel sounds
			* breath sounds
			* barium swallow
			* before sleep
			* bone scan
			* borderline schizophrenia
			* Bloom’s syndrome etc etc!

**Abbreviations used in the Medical History**

1. Ix Investigations
2. Rx Treatment
3. Hx History
4. BO Bowels Opened
5. PU Passing Urine
6. SI Sexual Intercourse
7. K=4/26-30 Menstrual Cycle (meaning period lasts, 4 days coming on every 26-30 days
8. 1/12 or 8/12 1 month or 8 months
9. @3/7 at around 3 days
10. HPC/HxPC History of presenting complaint

**Abbreviations used in the General Examination**

1. O/E or OE On examination
2. Ex Examination
3. T Temperature
4. P Pulse
5. BPM Beats per minute
6. R Respiratory rate
7. rpm Respirations per minute
8. BP Blood pressure
9. SOB Short of breath/shortness of breath or SOBOE – shortness of breath on exertion
10. NAD No abnormalities detected

Doctors spend a substantial amount of their time writing so it is worthwhile learning effective ways to record and give information in print.Further, many written materials are legal records of the care patients have received. Therefore, records should be accurate and comprehensible.

**2. Effective written communication**

* **Letters**

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| What is the purpose of this type of written communication?* To give accurate information to patients on investigations, results of tests, diagnosis, treatment, follow-up care, change of appointments etc.
* To inform another health care professional of the experience you have had with a patient (summary of treatment from specialist to general practitioner; seeking an opinion/advice etc)
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| What are the features of this type of communication that make it effective?* Correct grammar and spelling (!)
* Correct name/s of patient
* Clear – obvious statement of purpose
* Logical – moves from one topic to another in a comprehensible way
* Relevant information
* Accurate – represents treatment/interview/appointments/follow-up
* Results – clearly stated and unambiguous
* Specific versus general advice
* Avoids jargon or explains all medical terminology
* Indicates action (if any) for patient
* Clear contact information
* “Proof” that you were listening to the patient
* Summary
* Provides an opportunity for patient to respond
* Respectful
* Legible
* Print in a suitable font size (especially if patient has known visual impairment)
* Letters to doctors and other health care professionals

Remain non-judgmental about peopleBrevity (one page is optimal)ClarityLogical orderOrganise material in meaningful categories (Format of a structured history is appropriate)Identifying data, patient profile and reason for visit, course and reliability (relative, translator), present illness, past medical history, social history, systems review, physical examination, laboratory work, hospital courseAssessment (opinions about the significance of the data base, interpretations, impressions, discussions etc)Plan (actions undertaken as a result of the clinical evaluation e.g. diagnostic procedures, treatments, education of patient etc)* Avoid specialist jargon, neologisms, initials
* Make available the summarised record subsequently
* Provide relevant medical and other information, especially diagnosis
* Clearly specify reason for referral
* Highlight main points
* Clearly state recommendations
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| How could letters to patients be improved?* Letters should be patient-centred
* Some clinicians dictate letters in the patient’s presence so that the doctor and patient have a shared understanding of what is happening next and the task is completed.
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| What electronic alternatives are there?* Emails
* Scanned copies of paper version
* Scanned copies can be embedded in electronic patient records
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* **Medical record case notes**

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| What is the purpose of this type of written communication?* Accurate record/account of what you observed, concluded, and did for the patient (one measure of your clinical performance)
* Primary source of communication between health care professionals
* Allows information to be preserved
* Enables clinicians to organise and remember information about patients; develop clinical skills, reflect on diagnosis and management; and, plan continuous care
* Facilitates continuity of care
* Source documents when questions of medical negligence or malpractice arise
* Used by administrators for assessing disability, mental competency, eligibility for insurance billing
* Source of data for clinical research as well as research into the process of care (audit)

Consider:* May be read by patients and relatives
* Use quotes from patients to personalise the materials and to promote objectivity
* Confidentiality – Medical records can be accessed by secretaries, orderlies, laboratory personnel, record librarians (patient services) AND lawyers, insurance companies, government agencies
* Long history of written records in medicine
* Accuracy of medical records as a reflection of care for the patient is well studied - Range of results but generally point to better quality of patient care by doctors who keep accurate records
* Patient knowledge has been shown to be higher in patients whose doctors recorded complete information.
* Record the information as close as possible to the interview to ensure accuracy
* SOAP – subjective (what pt says); objective (what you detect); assessment (your conclusions/diff diagnosis) problem list and plan (management and follow up) (MPS guide)
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| What are the features of this type of communication that make it effective?* Meets the purpose
* Clear
* Complete
* Legible, accurate, indelible etc
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| How can medical records be improved?* Electronic records
* Typed or at minimum neater writing
* Indexed or summarised
* Colour coded
* Page dividers
* Include names and signatures and other identifiers of clinicians
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| What electronic alternatives are there?* Electronic patient records commonplace now
* Old paper based records and other material can be scanned to supplement electronic records
* Most effectively used if patients can view – consider the positioning of he screen and typing up noted whilst summarising so pt can check what is being recorded
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| Consider the purpose and audience – the material should have appropriate:* Language (+/- medical terminology appropriate for audience)
* Length – enough information, but no longer than necessary
* Relevant information
* Appropriate format (layout, type/hand written legibly)
* Grammar, spelling correct
* Logical, clear, unambiguous
* Respectful to patient
* Fit for purpose
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Ways in which a patient’s individuality can be maintained in written communications

* Correct spelling of patient’s name
* Accurate reflection of what took place
* Language and terms that the patient can understand (if sent to patient)
* Use quotes from the patient where suitable
* Use “you” to be specific (when writing to patients)
* Be sensitive to issues of confidentiality
* Suitable font size

The case and the vision for patient-focused records

Royal College of Physicians January 2010

In recent years many national initiatives have stressed the importance of greater focus on high quality care, the needs and wishes of patients in the delivery of health services, and more patient empowerment and choice. If such requirements are to be met electronic records that are focused on the patient, rather than their disease, intervention or location will be essential. Such records must cross organisational boundaries, so that appropriate information can be recorded by both practitioners and patients, and accessed by them, in a wide variety of clinical and care contexts. Currently, in hospital care, electronic patient records that comprehensively support the management of individual patients are few and far between, seriously limiting the opportunities to develop integrated services that cross traditional service boundaries.

The record of the dialogue between the clinician and the patient, the decisions made and the actions taken, is the cornerstone of the patient record. The information that is recorded should be accessible whatever the setting or context. This information can take the form of free text, or of structured data that is completely interoperable, and transferable between clinical applications, contexts and settings without ambiguity. Structured clinical data collected in this way also provides the best source of information for the many purposes that underpin service evaluation and research.

To achieve clinical interoperability, and to ensure the validity of aggregate information when data from many records are integrated and analysed, the structure and content of the record must be standardised. To achieve wide acceptance, such standards must reflect clinical practice, be evidence based, developed through consensus and professionally endorsed.

Effective implementation of standardised, structured, patient focused records requires strongly led culture change, embraced by all medical and clinical staff. They are essential prerequisites for safe, high quality care and for the safe, efficient and effective migration from paper to electronic patient records. Such records will also enable innovative development of services that cross traditional boundaries and, by giving patients access to their record, empower them to take more responsibility for their own care.

References and further reading

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Medical Records

The Royal College of Physicians has recently developed standards for the structure and content of medical records recently approved by the Academy of Medical Royal Colleges. The guide can be downloaded from the RCP website:

www.rcplondon.ac.uk/clinical-standards/hiu/medical-records

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Prescribing

The British National Formulary (BNF) <http://www.bnf.org>

Patient Information

NHS: Toolkit for producing patient information.
<http://www.nhsidentity.nhs.uk/patientinformationtoolkit/patientinfotoolkit.pdf>

NHS Direct <http://www.nhsdirect.nhs.uk/>