Medical Teacher, Vol. 24, No. 6, 2002, pp. 585–589

Taylor & Francis healthsciences

TWELVE TIPS

Writing effective consultation letters: 12 tips for teachers

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SUMMARY *Written correspondence is the standard mode of communication between healthcare providers. Despite the importance of this skill and increased emphasis on ambulatory care, communication skills and professionalism in training programs, there has been very little written on the teaching and evaluation of consultation letter writing. Consultation letter writing is an essential skill that cannot be learned simply by reading others' letters and should be taught in a formal manner. This article describes the authors' experience in teaching the skill of writing effective consultation letters to residents and describes strategies for evaluating this skill.*

Introduction

Written correspondence is the standard mode of communication between healthcare providers. The referral-consultation process relies on timely, effective communication between the referring physician and specialist. Despite the importance of this skill and increased emphasis on ambulatory care, communication skills and professionalism in training programs, there has been very little written on the teaching and evaluation of consultation letter writing.

In Canada, training programs have tended not to include this skill as a formal learning objective in their training programs. A survey of 300 physicians in Eastern Ontario, Canada in 1996–97 demonstrated that only 16% of specialists received formal education and only 49% received feedback on their own letters during their training. Some attending physicians actively discourage resident dictation in the clinic as it often takes more transcription time and needs extensive editing, resulting in delays in getting the letter sent out.

In 1993, the Royal College of Physicians and Surgeons of Canada began the CanMEDS 2000 project. This initiative established seven essential roles and key competences required of all specialists. Two of these—collaborator and communicator—highlight the need for well-functioning relationships between primary care physicians and specialists. All specialty training programs are required to include learning activities relevant to all of these roles. Consultation letter writing is an essential skill that cannot be learned simply by reading others' letters and should be taught in a formal manner.

This article will describe our experience in teaching the skill of writing effective consultation letters to residents and describe strategies for evaluating this skill.

What to teach about consultation letters

Role of the letter in the referral consultation process

Tip 1: Highlight the role of the consultation letter—who the potential readers are and how it will be used by the reader—to enhance the understanding by trainees of the importance of appropriate content and style.

Trainees who have limited experience in longitudinal patient care often do not consider the role of the letter in patient care prior to dictating it. Consultation letters may have many readers including the referring physician, the consultant, the patient, lawyers and insurance companies. All of the potential readers must be considered when constructing a letter; however, the focus should be on the needs of the referring physician.

The role of the consultation letter in facilitating ongoing care should be stressed to trainees. The primary care provider is often asked by the patient for an interpretation of what the consultant thought about his/her medical problem and is often responsible for implementing diagnostic or therapeutic suggestions. To facilitate continuity of care, letters must be received in a timely fashion, and have specific recommendations for investigations, treatment and follow-up.

Consultation letters may also be used as a tool for continuing medical education (CME) by family physicians. In 1995, Glaxo Wellcome conducted a survey of primary care physicians using a computerized interactive audience response system. Physicians were asked what they wanted compared with what they were currently receiving in consultation letters (personal communication). There was consensus that physicians wanted guidance and education from the letter, but rarely received this.

The consultation letter also serves an important role for the specialist. It is often the only record of the details of the patient's history and physical examination. A well-constructed letter will facilitate efficient follow-up and interpretation of investigations if the patient is being seen again by the specialist.

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ISSN 0142–159X (print)/ISSN 1466–187X online/02/060585–05 © 2002 Taylor & Francis Ltd
DOI: 10.1080/0142159021000063880

Patients may request a copy of their letter either initially or later on. This is becoming more common in the age of 'medical consumers' and with mobile populations. Most physicians do not recommend a copy of the letter be routinely provided to the patient. The letter must be written with the assumption that the patient will read it at some point.

Lawyers or insurance companies may request copies of letters and it is best to assume that this may happen. This has implications for the content and style of the letter. Derogatory language and comments on the quality of the care by other healthcare professionals should be avoided. In particular, do not speculate about 'if things had been done differently'. As Dr Parson of the Canadian Medical Protective Association stated: "Good work deserves good records, and good records are the cornerstone of a good defense" (*Canadian Medical Protective Association Newsletter*, 2001).

Essential content of consultation letters

Tip 2: The essential content of the letter for each reader needs to be included and readily available to the reader. Emphasize that specific diagnostic and therapeutic recommendations with clear follow-up strategies should be included.

The content of the letter needs to meet the needs of all of the readers unless different letters are sent to different readers. Different specialties and different patient problems may have different needs in the amount and type of information included in the letter. Personal preference will dictate some of the content items, but each specialist needs to critically appraise his/her own letters to see if they are meeting the needs of the readers.

Three studies have examined the 'essential content' of consultation letters. Tattersall *et al.* polled 108 referring physicians (specialists and primary care physicians) of a single oncologist for their views on essential content items in letters (Tattersall *et al.*, 1995). They were asked to rank 14 content items as essential, useful, of little use or no use. The majority of respondents included diagnosis, clinical findings, test results, further tests, treatment options and recommendations, prognosis, benefits and risks of treatment as essential. Somewhat surprisingly, less than half regarded follow-up plans and what the patient had been told as essential.

Kentish *et al.* surveyed 51 general practitioners who referred to a child psychiatry service. The five most highly rated content items included treatment and management, specialist's understanding of the problem, diagnosis, what parents were told and the date of the assessment (Kentish *et al.*, 1987).

A more general survey of primary care physicians and specialists was done at the University of Ottawa. A random selection of 600 rural and urban physicians (300 GPs and 300 specialists) were surveyed in a referral catchment area in Eastern Ontario, Canada. The survey sample included urban and rural-based physicians. The response rate was 62%. Respondents were asked to rank order the seven items they felt were most essential (Dojeiji *et al.*, 1997). There was consensus on the top four items: impression, management plan, what investigations should be done and by whom, medication changes. Other content items that did not rank as essential but were considered important included: indicate if cross-referral was made, who will provide ongoing care for the problem, what the patient was told—especially in complicated situations.

None of these studies found that referring physicians wanted details on the presenting history, past history or social history. Referring physicians have their own records on the patient and may not need the same information in the letter as the consultant. For the consultant, the consultation letter often serves as the only record of the history and physical examination. Including a social history often helps jog the memory of the specialist on 'who the person is' for the follow-up visit. While the letter may include more details than required for the referring physician, this is not a problem provided the letter is easy to read.

Tip 3: Encourage trainees to view the letter as a powerful tool for educating referring physicians and demonstrating clinical expertise.

The other role of the letter for the specialist is to enhance the working relationship with the referring physician. It should show appreciation for the referral and demonstrate clinical expertise. Referring physicians rely on consultation letters for education around specific patient problems. Information on newly initiated therapy, new practice guidelines, evidence for suggested recommendations and diagnostic and therapeutic 'pearls' is appreciated. Strategies for incorporating CME include: attaching a copy or citing a specific reference, and incorporation of 'educational paragraphs' about specific treatments.

Approach to writing an effective letter

There are three stages to creating a consultation letter: planning, dictating and editing.

(1) Planning

Tip 4: Develop templates for common clinical problems to reinforce the importance of being organized prior to dictation and to highlight the important items of a particular patient problem.

Planning the letter requires assessment of the intended reader. It is essential to know what action or response you want from the reader. Planning the letter before starting to dictate will result in a more succinct, organized letter.

A template is a useful tool for organizing thoughts and saving time and energy. It forces the writer to include salient points under each of the preset headings. It has been shown that general practitioners prefer standardized (template driven) written documents—consultation letters and discharge summaries—compared with narrative ones (Rawal, Barnett, Lloyd, 1993; VanWalraven *et al.*, 1998; Ray *et al.*, 1998).

A template can be designed to be general and serve all types of disorders or specific for different types of illnesses (e.g. diabetes). It allows the author to highlight items of particular importance to the patient problem (e.g. cardiovascular

risk factors) and the headings allow the reader to scan the letter for points of interest. Also educational paragraphs can be routinely included without the need to repeat with each dictation. If a specific data-collection sheet for a particular patient problem is used, a template for dictation with similar headings makes the dictation easier and highlights the important aspects of the specific data collection to the trainee. Standardization will also improve accuracy as there is less risk of omission of important facts.

(2) Dictating

Tip 5: The need for clear, organized dictation to produce succinct letters and to avoid excess transcription time/cost should be reinforced to trainees.

Letters may be generated automatically from computer-based systems but, more often for trainees, the letter is dictated in clinic immediately after discussing the patient with the clinical supervisor. Dictating a written document requires an understanding of what you want the end product to look like. Too often there is excess information presented in a conversational style, with lack of structure and too many words (Manning, 1989). Dictating a structured letter requires discipline—it is not as natural as dictating a narrative report.

Dictation skills such as identifying yourself, speaking clearly, spelling long, difficult words or unusual drug names, indicating punctuation, paragraphs and headings need to be reinforced to trainees. It is important to indicate who should receive copies of the letter. The medical transcriptionist/secretary is an excellent resource for highlighting common dictation problems in your trainees.

(3) Editing

Tip 6: Establish a system that allows residents to edit their own letters. It reinforces the importance of good dictation skills and reduces errors in letters being sent.

Editing of the letter for content and style is the last step of consultation letter writing. This includes corrections and revision of grammar, punctuation, facts and layout. Redundancies and extra words are removed. Most writing experts would suggest that this is the most important stage of developing a document. However, in the 'real world' of busy clinical practice, too many editing changes add to the length of time before the letter is sent out and to transcription costs. As dictation skills improve, there should be less editing required.

Some physicians send their letters out prior to reading them with the proviso 'dictated but not signed'. This assumes that the dictated letter is transcribed without error and is in a reasonable format with no major omissions. This can result in dangerous transcription errors being sent out and may be perceived as discourteous by the referring physician (Shere, 2001). The legal implications of this must also be considered.

Important style tips for making letters 'scannable'

Tip 7: Visual layout of the letter is important in making the letter easier to scan for important information. Teaching should focus on paragraph length, use of headings and inclusion of point form, bulleted or numbered lists.

The time pressures of physicians require that the most important information in letters be easily accessible and not be buried in excessive detail. Most consultation letters are read by the referring physician when they arrive in the mail (Dojeiji *et al.*, 1997) and again the day the patient is seen in follow-up. The relevant information for each reader must be readily identifiable and redundancies eliminated.

To achieve visual impact there are four key elements: margins, paragraphs, headings and use of point form or tables. There should be a balance of white space and text. In our experience, paragraphs tend to be very long in consultation letters and often contain one or more thoughts (Myers *et al.*, 1999).

Structured letters are preferred over unstructured letters by most referring physicians although are rarely used by specialists (Penney, 1989; Lloyd & Barnett, 1993; Rawal *et al.*, 1993; Ray 1998; VanWalraven *et al.*, 1998). Headings should be used for different sections of the letter. One to four headings per page is what editing experts recommend. The type size or appearance (e.g. bold, underline or italicize) should be changed in headings. Use of point form, bulleted or numbered lists works well for items such as medications, past history, risk factors and management plan. It is not natural to dictate in a point form, but the benefits of the ability to scan the letter for the important information will be well worth the effort.

Tip 8: Reinforce important style issues that make the letter easier to read in a shorter length of time (ie shorten sentences, limit words >3 syllables, and remove redundancies or unnecessary words).

Clarity is important to get the message across. Choosing shorter words, avoiding redundancies (e.g. at this point in time), shortening sentences to two typed lines and limiting paragraph length to four or five sentences will get the message across faster and make the letter easier to read.

Learning methods for teaching consultation letter writing

Tip 9: A structured workshop provides the opportunity to stress the importance of good consultation letter writing skills. Highlight common problems by using different learning methods such as role playing a referring physician, listening to audiotapes of dictations and including other people involved in the consultation letter process (ie transcriptionist).

As with any skill, consultation letter writing requires practice and feedback to learn. Ideally the teaching and evaluation of

consultation letters should take place during an ambulatory-care-based rotation. This provides residents with real-time feedback but is often difficult owing to delay in transcription time and short rotations. A second approach is to teach in a more formal way with a structured workshop. This formal teaching helps to highlight the importance of this skill and may prompt residents to ask for more direction and feedback in clinical rotations.

We have developed a teaching program, complete with instructor and resident handbook, for use in a 4-hour teaching session. This has been done in several groups of residents including Internal Medicine, Physical Medicine and Rehabilitation, Palliative Care, Surgery and Obstetrics and Gynecology. The program focuses on the needs of the reader, essential content of letters and effective dictating/writing styles.

To address the importance of the role of the letter in the consultation process a role play is undertaken. A resident is put in the position of the family doctor who has received a letter about a patient that is difficult to read and non-specific in the diagnosis and recommendations. The patient has returned to the referring physician and is asking for clarification as to what will happen next. It is a powerful tool for highlighting the importance of the referring physician for providing ongoing care and the importance of the letter in facilitating this.

Another important area to highlight is dictation skills as these vary widely and are key to producing the final document. Inviting a medical transcriptionist to the workshop and/or bringing an audiotape of some dictation styles may highlight the common problems that occur in consultation letter dictations.

Tip 10: It is important to provide trainees with the opportunity to edit letters focusing on essential content and effective writing style. Arrange for trainees to bring their own letters if possible as this will add validity to the discussion. Patient identifiers should be removed.

The content and style of consultation letters forms the main part of our workshop. In small groups or individually, trainees should be able to identify excessive or insufficient content of a letter, develop templates relevant to their area of specialty and edit letters to improve readability. It is a much more meaningful exercise if the residents bring their own letters to the session as opposed to general samples being provided. The residents may collect these through their clinical rotations or be given the opportunity to see a real or standardized patient prior to the workshop and then bring the letter with them.

Evaluation of consultation letters

Tip 11: Evaluation of consultation letters should be part of any ambulatory-based specialty rotation. The use of a rating scale facilitates detailed, formative feedback.

It is essential that consultation letter writing be evaluated as a core clinical skill for specialists. This can be formative or summative. Ongoing feedback from clinical supervisors is essential but may be hampered by short rotations, which limit the number of letters that will be available prior to the resident leaving the rotation. Some supervisors may not value this as an important area of teaching in a busy clinical setting.

More structured feedback can be provided by use of a rating scale. Two tools have been reported which appear reliable and valid (Myers *et al.*, 1999; Crossley *et al.*, 2001). We developed a 34-item scale including content and style items that were generated from a variety of sources including a literature review, survey of specialists and family physicians, communication experts and our own experience. This rating scale is validated and reliable when used to evaluate eight or more letters by the same resident. It has helped provide structured, detailed feedback on individual letters.

Tip 12: An OSCE station examining consulation letter writing skills is a feasible way of systematically evaluating trainees' skills. Including it in formal examinations highlights the importance of the skill but does not replace the importance of feedback in the clinic setting.

More formal and widespread evaluation of consultation letters can occur through objective structured clinical exams (OSCEs) (Bourdreau *et al.*, 1994; Keely *et al.*, 2002). The OSCE provides a unique opportunity for evaluation of all residents and to provide all residents with their own letters and individual feedback.

We have developed and implemented consultation letter dictation OSCE stations for Internal Medicine, Obstetrics and Gynecology and Physical Medicine and Rehabilitation residents. In all cases these were formative OSCEs done on a regular basis (every 6–12 months) in the training program with mandatory participation.

Residents were provided with the history, physical examination and investigation results. They were expected to determine impression and plan and dictate the letter. In one situation (Physical Medicine and Rehabilitation program), the letter station followed two other stations where the resident elicited the history and physical findings from a standardized patient. A minimum of 18–20 minutes is required for dictating a letter in an OSCE situation. The rating scale served as the evaluation tool of the station and demonstrated good inter-rater reliability. The feedback from the residents was extremely positive.

Conclusion

Consultation letter writing is a core clinical skill for specialists and should be included formally in all training programs. Specific teaching points should include the role of the letter in enhancing the referral-consultation process, and specific content and style issues that improve the readability of the letter. Evaluation should be ongoing throughout clinical training but also occur in a structured examination. Improving resident written communication skills should receive more attention in postgraduate curricula.

Acknowledgements

The authors are grateful to Glaxo Wellcome, the Royal College of Physicians and Surgeons of Canada and Educating Future Physicians of Ontario for support.

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