What effect does patient access to medical records have on their content?

Patients can now read their own medical records at home on their computer and follow the examinations and diagnostics as the process unfolds. This technological opportunity has been driven by forces other than doctors. What we include in the records and the formulations that we choose are changing, but there has been little focus on the unwanted effects of these changes.

On 1 April 2016, Oslo University Hospital started to permit patients to read their own medical records on the minjournal.no website (1). Other hospital trusts have followed suit.

Patients have also previously been granted access to their own records, but always in retrospect, in paper format and only on request. This access has now been made simpler as well as quicker, providing patients with opportunities to monitor ongoing examinations and diagnostics on their home PC, tablet computer or smartphone. Outpatient assessments with preliminary diagnoses, radiology and pathology reports can be studied immediately once they have been signed by the doctor. The web page states that you can read «information in recorded documents that the therapist has not yet had the time to communicate» (1).

Project collaborators who facilitate patient access to medical records on the Internet have enthusiastically informed hospital departments about the advantages of such open records. At the same time, any objections voiced by older clinicians are brushed aside. We are encouraged to use simple language, make good summaries and draw clear conclusions in patient record notes and patient medical histories to ensure that the patients themselves and their next of kin will understand the content. As hospital doctors, we feel that it is no easy task – and perhaps not even desirable – to draw any cut-and-dried conclusions after brief outpatient consultations or before the patient has been fully examined.

What happens to the content of medical records?

Medical records have developed from brief, handwritten doctor's notes to a wealth of documents authored by various types of health personnel, and they need to comply with a number of requirements (2). Although well aware of their legal nature, doctors regard medical records first and foremost as a tool for medical documentation and communication. Now, we increasingly need to relate to a third function: that of patient information.

We ought to ask ourselves what effects these various roles and the increasing and immediate availability of everything we write during a busy working day have on the words we choose, the content of the records and their quality.

Could it be possible that certain types of information are omitted? It might be important to document the therapist's perceptions of the patient's personality traits and degree of insight into his or her disease, especially where this may impact on the progress of the disease and the prognosis. Similarly, other potentially important information, such as suspicions of substance abuse, early dementia or a reminder to exclude cancer, might be omitted out of fear of invoking strong emotional reactions in the reader,

A further consequence could be that in their efforts to produce flawless patient record notes – and out of fear of reactions to what is written – health personnel *refrain from communicating clinical reflection or doubt*. This applies especially to patients who are under examination or suffer from conditions not yet determined, who often encounter specialty registrars for their initial assessment. A fear of writing anything that later might be construed as erroneous assessments might be a threat to entering good preliminary diagnoses, differential diagnosis discussions and clinical reflections in the records. It will be safer to focus exclusively on objective examinations and negative findings in convoluted record notes, often on the basis of a pre-defined template. Once these records have been signed, they will forever remain correct and unassailable.

So how should this uncertainty, the discussions with colleagues, the differential diagnosis discussions and the complicated prognostic thinking be recorded? On a slip of paper as «double-entry bookkeeping»? These are elements that ought to be documented in the hospital records, in the best interests of the patient.

Making a diagnosis has consequences. The patient may perceive it as stigmatising, but it may also trigger entitlements. Excessive caution in doctors when writing records may at worst cause a final diagnosis to be delayed. If we are increasingly reluctant to trust the clinical diagnosis, we are also apprehensive that the volume of unnecessary supplementary examinations will increase.

Traditionally, doctors have used medical histories and outpatient notes to provide positive or negative feedback to the referring doctor about medical and practical concerns that are not directly associated with the patient, for example constructive criticism of appropriate or less appropriate referrals. The outcome could be that we establish a number of information channels that bypass the patient records to provide clinical information between colleagues. There is little research on electronic access to records for patients, but some studies emphasise that the patients primarily regard it as positive. On the other hand, it has not been found that the quality of the content has improved or that this has brought health gains (3, 4).

Doctors need to take responsibility

Society's calls for transparency have transformed medical records. Have doctors already lost when it comes to the design of the profession's most important tool? Have we resigned ourselves to this development? Is it acceptable if information that is relevant to patients and colleagues, as well as discussions of complicated clinical issues, are omitted from the official patient records?

Doctors need to wake up and address the role, content and quality of patient records. Otherwise we may risk that other stakeholders transform it into a meaningless collection of documents with limited medical utility.

Jon Klokk Slettedal
jon.klokk.slettedal@gmail.com
Dag Fosmark

Jon Klokk Slettedal (born 1973), senior consultant at Oslo University Hospital and associate professor at the University of Oslo.
The author has completed the ICMJE form and declares no conflicts of interest.

Dag Sigurd Fosmark (born 1959), PhD and senior consultant at the Department of Ophthalmology, Oslo University Hospital.
The author has completed the ICMJE form and declares the following conflict of interest: He has received a fee from Bayer as a member of the company's advisory committee.

>>>

References

1. MinJournal. https://www.minjournal.no/ (27.9.2016).
2. Janbu T. Hva skal en journal være? Tidsskr Nor Lægeforen 2006; 126: 2847.
3. Davis Giardina T, Menon S, Parrish DE et al. Patient access to medical records and healthcare outcomes: a systematic review. J Am Med Inform Assoc 2014; 21: 737–41.
4. de Lusignan S, Mold F, Sheikh A et al. Patients' online access to their electronic health records and linked online services: a systematic interpretative review. BMJ Open 2014; 4: e006021.

Received 19 September 2016, first revision submitted 2 October 2016, accepted 4 October 2016. Editor: Ketil Slagstad.