COMMENTARY

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Your Patient Is Now Reading Your Note: Opportunities, Problems, and Prospects

Patients have unprecedented online access to their medical records. More than 6 million Americans can now read their doctors' notes via patient portals, and continued rapid growth is likely.[1] Sharing notes with patients may yield important health benefits, including increased patient empowerment and improved medication adherence.[2,3] Seeing written information, including notes, helps patients remember the plan of care, reinforces patients' positive behaviors, and strengthens the patient–doctor alliance.[2,4-6]

As fully transparent medical records proliferate, many questions remain unanswered (**Table 1**). Such uncertainties create anxiety and apprehension among doctors at a time when many already feel overwhelmed. In an effort to ease the transition to what we believe will be a widespread and ultimately beneficial practice, we draw on over 5 years of the authors' clinical experience and conversations with clinicians around the country to offer suggestions for creating notes that can work for all concerned (**Table 2**).

BE CLEAR AND SUCCINCT

Clear and organized notes allow patients to identify key information, facilitating patient education and engagement. Brevity improves readability and speeds up documentation. Direct and simple language, with minimal abbreviations or medical jargon, helps prevent confusion for patients and for other doctors.

DIRECTLY AND RESPECTFULLY ADDRESS CONCERNS

While doctors have long struggled with recording sensitive issues, a good rule of thumb is to discuss what you write, and write what you discuss.[7] Candid wording and clearly written follow-up plans may allay fears among anxious patients who otherwise might feel overwhelmed or assume the worst possible scenario. Seeing a diagnosis codified in the note can feel more tangible to patients, and using frank but caring written words might help overcome denial, de-stigmatize a condition, or even motivate behavior change.[2,4,6,8]

Patients concerned that legally, financially, or socially sensitive information discussed during a visit will be added to the medical record might ask to have this information omitted. Patients should be reassured about the protections provided by federal law, including the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR part 2.[9,10] Documenting general statements about sensitive topics without elaborating on potentially humiliating details is a strategy that can allay patients' apprehension.[6]

Many electronic health record systems allow doctors to shield specific notes or parts of the record from the patient portal. This can be helpful in the uncommon instance when a doctor determines that reading a note may harm a patient. However, with rare exceptions, HIPAA gives patients the right to access notes,[8] so doctors who withhold a note from online viewing should discuss this with the patient beforehand.

USE SUPPORTIVE LANGUAGE

Rather than focusing exclusively on problems, the medical record can also underscore patient accomplishments, thereby encouraging and empowering patients to make positive changes.[2] Doctors often focus on positive change during conversations as a way of motivating patients, but including similar statements in visit notes adds a new dimension to the care we provide. Similarly, utilizing descriptive (rather than labeling) words can result in more objective, less judgmental notes.[11,12] Although it is not feasible to eliminate all potentially offensive terms, doctors who write notes while remembering that patients can read them may avoid obviously problematic words or abbreviations.

INCLUDE PATIENTS IN THE NOTE-WRITING PROCESS

Some doctors dictate, type, or review notes with patients during the office visit. Simply turning the computer screen

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Table 1 Outstanding Questions About Open Notes

- Should the content and format of notes be changed?
- Can the patient's "story" return to the medical record and if so, how, and to what degree?
- Which patients may benefit from reading notes, and which may not?
- Should some notes be hidden, and how can that be explained to patients?
- Will patients withhold important information if they sense that transparency poses threats to their privacy?
- Will they uncover errors that could diminish trust and even fuel litigation?

Table 2 Suggestions for Implementing Open Notes in Clinical Practice

Suggestion	Examples
Be clear and succinct	• When possible, enlarge the font size or use boldface text to emphasize important items such as "**Check your blood sugar twice a day**." • Consider beginning your note with the Assessment and Plan section. • Do not import multiple pages of data available elsewhere in the chart; instead, include only pertinent aspects of the current visit. • Avoid jargon. Use electronic tools to convert abbreviations to the full spelling. Use dictation or spell checking software to review note content. • Caution patients about misspellings and word substitutions or include templated statements explaining the potential sources of typographical errors. • Consider using second person instead of third person voice. For example, "Start taking lisinopril and check your blood pressure twice a week," rather than, "Initiated lisinopril and instructed to check her blood pressure twice a week." More direct language may help reinforce instructions for patients. • Insert links to reliable online resources for educational information and clarification of acronyms or medical terms.
Directly and respectfully address concerns	• **Obese patients**. Review their body mass index and the definitions for overweight, obese, and morbidly obese with patients so that they understand why these terms are in the chart. • **Possible cancer**. "You have some symptoms concerning for colon cancer (blood in stool, weight loss, family history of early colon cancer), so I will facilitate an expedited referral to the gastroenterologist. If it is colon cancer, we want to catch it early when there are more treatment options." • **Drug use**. "Cocaine use is causing your extremely elevated blood pressure and difficulty with relationships." • **Mental health**. "Increased feelings of worthlessness and thoughts of self-harm. No active suicide plan and willing to seek care if thoughts worsen. Your grandchildren remind you of reasons to live. Check in tomorrow with your counselor and don't forget the crisis line number." • If documentation could cause harm to the patient (for example, intimate partner violence if access to the patient portal is obtained by abuser), discuss this with the patient in advance. Consult with a social worker or legal counsel and consider blocking this note from the patient portal. • Remember that, with rare exceptions, HIPAA protects patients' right to view records. Shielding notes from an online patient portal does not prevent patients from submitting a written request for their records.
Use supportive language	• "The patient has lost 5 pounds and is motivated to continue this positive trend toward our goal of 20 pounds," rather than "The patient still needs to lose another 15 lbs." • "The patient chose not to pursue treatment," rather than "The patient refused treatment." • "The patient does not consume alcohol," rather than "The patient denies alcohol consumption." • Use terms that may be perceived as less judgmental or confusing: ○ "Shirt untucked" (rather than "disheveled") ○ "Short of breath" (rather than SOB) ○ "Follow up" (rather than f/u) ○ "Right eye/left eye" (rather than OD/OS) ○ "False alarm" (false positive) ○ "Enlarged heart" (rather than "cardiomyopathy"), "chronic kidney disease" (rather than "renal failure")
Include patients in the note-writing process	• Turn the computer screen toward the patient to show what you are typing. • Check for understanding and accuracy during the visit. • If dictation is available, consider dictating with the patient present. • Consider having the patient contribute to the note, if this option is available.

Table 2 Continued

Suggestion	Examples
Encourage all patients to read their notes	• "I want you to look at my notes and make sure we are both on the same page." • "Reading your notes may remind you about what we discussed when you get home. You can also share it with your family or caregivers if you would like." • Advocate to have the electronic medical record configured to automatically send reminder messages to patients after visits or prior to follow-up visits.
Ask for and use feedback	• "I see us as a team working together to improve your health, so your feedback makes a big difference! Accuracy is important to me, so if you see something you think might be a mistake in your note, please let me know so we can work together to fix it." • Give the patient a copy of the prior clinic note (paper or electronic) to review while in the waiting area. • Ask, "Did you have a chance to read my note from last visit? What questions or concerns do you have about what was written?"
Be familiar with how to amend notes.	• "Thanks for pointing out that I wrote 'right knee' rather than 'left knee'; I'll be sure to note the correction in your chart." • "I understand you want your history of cocaine use removed from the medical record, but this information has important implications for your blood pressure and chest pain." • "I'm sorry you disagree with my assessment that alcohol contributed to your fall. While I can't change my medical opinion, if you'd like I can add that you disagree with it."

HIPAA = Health Insurance Portability and Accountability Act.

toward the patient takes advantage of natural opportunities to check patient comprehension. Such approaches help patients understand how notes are generated and can save doctors time by completing portions of the documentation during the course of the visit. Some practices ask patients to type their agenda into the medical record prior to meeting as a way of prioritizing patient concerns and encouraging reflection on visit goals.[13,14] Moving forward, patients will upload data to their medical record from myriad electronic health applications.[15] By actively involving patients in documenting their clinic visits, doctors could help patients organize, interpret, and prioritize this deluge of information.

ENCOURAGE ALL PATIENTS TO READ THEIR NOTES

We suggest that all patients should be invited to join portals, review their notes, seek clarification, and act on mutually agreed-upon plans. Each are crucial steps for helping patients to realize benefits from reading visit notes. Electronic systems that notify patients when notes are available can substantially increase reading rates.[16] By personal preference, some patients will choose not to read their doctors' notes. This may be particularly true for patients with less education, poorer self-reported health, and poor health literacy.[17] Involving family, friends, or health navigators in the dissemination of notes should be considered, but further research and innovation is needed to encourage all patients to examine the benefits of viewing notes.

ASK FOR AND UTILIZE FEEDBACK

Requesting patient feedback to clarify potential misunderstandings may better inform the doctor about the patient's level of understanding of her health and the care plan. Encouraging patients to reflect on the visit afterward may uncover missed information, improve mutual understanding, and strengthen a sense of partnership.[18] Thus, in addition to improving patient–doctor rapport, this type of feedback has important patient safety implications.

BE FAMILIAR WITH HOW TO AMEND NOTES

Although experience to date suggests that remarkably few patients request changes,[2] doctors should be familiar with the note amendment process within their own practice setting. Not all requests for amendments must be accommodated. For example, helping patients distinguish between factual inaccuracies (appropriate to amend) and clinical judgment (amended at the doctor's discretion) sets expectations for patients. More substantial or adversarial addenda should follow practice policies governing modifications of the medical record. Often, patients may submit their own statement through a formal amendment request.

CONCLUSION

While medical records will continue to serve a central role for doctors, they can also be a powerful tool for patients.[2,4] Substantially more experience and evidence is needed to further guide the content and format of clinical notes and the entire electronic health record. Although the thought of adding yet another dimension to our notes likely induces anxiety (if not ire!) for many doctors, we hope our suggestions will stimulate discussion about this topic. We encourage doctors to share their collective experience and insight as we move into a new era of fully transparent medical records.

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