Clinician FAQ

This FAQ addresses questions posed commonly by clinicians. It also highlights policy decisions institutional leadership may need to consider and communicate to clinicians prior to launching OpenNotes.

The Basics

- OpenNotes: What is it?
- OpenNotes: Why do it?

Questions You May Have

- How should I approach writing about sensitive issues?
- Will I need to change the way I write notes?
- How should I address abbreviations?
- What if patients disagree with what I wrote and want the note changed?

Issues Raised by OpenNotes

- Will sharing notes with patients take more time?
- Will patients contact me more between visits?
- Will reading their notes make patients more confused or anxious?
- Will this practice affect my liability?

OpenNotes Institutional Policies

Further questions that you may need to address follow. We have left the responses blank because they rely on institution-specific policies and information systems. You can e-mail myopennotes@bidmc.harvard.edu to request a more detailed example of BIDMC's clinician FAQs.

- When will this practice start, and with which clinical services?
- Where will patients read their notes?
- Will my notes be available to my patients if I am not a [name of patient portal] provider?
- How will notes be shared with patients?
- What notes will be available to my patients?
- Do I have to participate in OpenNotes?
- Will medical student notes be viewable by patients?
- Will notes by trainees or practitioners requiring co-signature be available and when?
- How are we communicating to patients about OpenNotes?
- What if I want to write something I don't want my patients to read?
- If I choose not to share some or all of my notes with a patient, what will the patient see?
- Can I exclude specific patients whom I feel should not read their notes?
- Will I be able to see when a patient has read a note that I have written?
- Given that patients read their notes on a patient portal, which includes secure email capabilities, does being on OpenNotes require me to start emailing with my patients?
- How do I know if my patient is on our patient portal? Has read a note?
- I have pediatric/adolescent patients. Will my notes be available to them?

This document is geared toward practicing clinicians. Please see the "Patient FAQ" for additional content geared toward patients.

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The Basics

OpenNotes: What is it?

OpenNotes is an initiative that starts by offering patients ready access to the health care notes doctors, nurses, and other clinicians write after a clinical appointment or discussion. Opening notes helps patients to read material that, through the federal Health Insurance Portability and Accountability Act (HIPAA), is already theirs to review and copy.

In 2010, 100 volunteering doctors and 20,000 of their patients completed a one-year, multicenter trial of OpenNotes. In this research and demonstration project, primary care physicians invited patients to read their signed visit notes. At the end of the year, patients overwhelmingly supported the program and cited multiple health benefits. Doctors saw benefits for patients and little burden for themselves. At the end of the study, both patients and doctors wanted to continue to share notes.

Read the study results.

OpenNotes: Why do it?

- **Engage your patients.**
  - The yearlong, multicenter OpenNotes study found approximately 4 out of 5 patients, when actively offered the opportunity, read their notes. And more recent data, still unpublished, indicates they keep reading notes.
  - Patients in the study reported that they:
    - Had a better understanding of their health and medical conditions.
    - Recalled their care plan more accurately.
    - Prepared better for visits.
    - Felt more in control of their care.
    - Took better care of themselves.
    - More frequently took their medications as prescribed.
  - Many doctors said it strengthened their relationships with their patients.
- **Improve communication and patient education.**
- **Promote patient safety.** Patients may notice errors in their notes; correcting them and making the record more accurate may improve patient safety.
- **Help caregivers optimize care.** Many chronically ill or elderly patients rely on family members or other informal caregivers to coordinate appointments, tests, medications, and general care plans. If these patients choose to share their notes, the notes may help caregivers better coordinate the patient's care.
- **Patients want it.**
  - The vast majority of patients want ready access to their notes (and they have the legal right to such access). In the OpenNotes study, approximately 4 out of 5 patients read their notes.
  - Even if patients may not understand everything in the notes, patients indicate strongly that this type of transparency and partnership is valuable to them.
  - In the study, a great majority of patients said the availability of open notes would influence their future choices of doctors and health plans.

Questions You May Have

How should I approach writing about sensitive issues?

A minority of doctors in the OpenNotes study reported that they changed how they documented sensitive topics; these included mental health, obesity, substance abuse, sexual history, elder, child or spousal abuse, driving privileges, or suspicions of life-threatening illness. These are not new dilemmas, but they gain urgency in an era of shared visit notes.

Some things to consider:

Unless you believe a conversation might harm your patient, a good rule of thumb is to write about things you discussed (and conversely, to talk about content you will write about) with your patients. Many clinicians already follow this practice. For instance, some dictate notes with their patients present.

How should I approach writing about sensitive issues? (continued)

If you have concerns about how to document encounters that may relate to potential litigation, please contact a risk manager.

Although it is natural to want to curb or avoid some challenging conversations with patients, patients may benefit from direct dialogue. For example, when a clinician notices signs of dementia, malignancy, or impaired driving, chances are good the patient or family members already worry about these possibilities. They may find a balanced discussion helps with the anxiety they may otherwise hold alone.

In addition, providers in the OpenNotes study found that reading their notes about obesity or substance abuse motivated some patients to attempt difficult behavioral changes. Some patients reported that "seeing it in black and white" made it more real. As an overarching strategy, promoting transparency may encourage more open and active communication in these challenging areas.

But some patients may not benefit. You can compare open notes to a "medicine" – helpful for most, but harmful to some, with "side effects" and "contraindications" to consider. If you believe that accessing a specific note may harm a patient, you can consider using your usual EHR mechanism (or talk to an institutional representative on how) to write a "private" note. Remember that HIPAA entitles patients to obtain copies of their complete medical records, including such private notes. Therefore, independent of OpenNotes, it is best to write notes with the ongoing understanding that patients may read them.

Without a doubt, documentation of "sensitive topics" warrants more research. Some studies are underway nationally, but we have a lot to learn about eliciting and responding to patient preferences and how documentation affects desired health outcomes. In the meantime, sharing stories about OpenNotes (good and bad) in appropriate settings, and incorporating such experiences in case discussions, conferences, team meetings, etc., will over time bolster our collective wisdom and skill.

Will I need to change the way I write my notes?

Patients in the OpenNotes study generally regarded the notes as belonging to doctors rather than patients. One consquence was that patients did not expect doctors to write notes in layperson language. Regardless of whether a patient understands every word in the notes, patients felt fortunate to have a window into more information about their own health. Nonetheless, the following suggestions may help maximize the educational potential of notes:

- Avoid jargon or abbreviations, especially ones that patients might easily misinterpret (e.g., "SOB" or "patient denied").
- Briefly define medical terms when feasible.
- Incorporate lab or study results in your notes to give patients the full picture.
- Include educational materials or links to content for your patients.
- Be mindful of sensitive topics and remember patients have rights under HIPAA to access their record.

How should I address abbreviations?

Please see "Will I need to change the way I write my notes?" Patients may also benefit from the list of common abbreviations on MedLine Plus (where they may also look up medical terms or diagnoses). Nevertheless, it is a good idea to avoid easily ministerpreted abbreviations (e.g., "SOB").

What if patients disagree with what I wrote and want the note changed?

Changing a note is at the clinician's discretion. If you feel the change improves the note, you can simply document the change as an addendum or use the usual mechanism in place at your institution to edit/correct a note. In the OpenNotes study, patients rarely requested that clinicians change the record. When such requests are made, patients and families may catch clinically important mistakes in notes, or find lapses in follow up that, once rectified, improve safety.

Issues raised by OpenNotes

Will sharing notes with patients take more time?

Patients generally respect clinicians' time, and most physicians who participated in the OpenNotes trial reported little, if any, impact on their daily practice. Indeed, many physicians reported forgetting they were participating in the study once it was underway. But some physicians said they took more time to write notes, and many reported writing better and more educational notes. After a year, only a small minority reported that participating took more time, while others thought it saved time.

Will patients contact me more between visits?

While some patients may contact you after reading their notes, participants in the OpenNotes study found this uncommon. Moreover, many providers found these communications improved patient care and satisfaction. Contrary to what some clinicians might fear, patients may contact you less by virtue of ready access to their notes.

Will reading their notes make patients more confused or anxious?

Of the 20,000 patients in the OpenNotes study, only a small minority found the notes more confusing than helpful, felt offended, or felt more worried as a result of OpenNotes. Medical terms did not bother patients, and patients reported looking up or "googling" medical terms to learn more about their doctors' notes and their conditions. On PatientSite, BIDMC's patient portal, the Medline Plus tool is available to help patients better understand medical terms or diagnoses.

Will this practice increase my liability?

Data on liability risk with other forms of transparent communication in health care (such as disclosure of medical error) suggest open and honest communication may decrease lawsuits (Kachalia Ann Intern Med 2010). Some providers listed improved patient safety as the "best thing" about OpenNotes. For any specific concerns about how to document something in your notes, contact your supervisor or risk management officer.