Writing Fully Transparent Notes


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Since HIPAA entitles virtually all patients to obtain copies of their complete medical records at any time, it is always best to write notes with the assumption that patients may read them.

However, as electronic portals provide patients with easy access to their records, clinicians may feel new pressure to be more mindful about how they write their notes. They may alter their approach to or even omit sensitive information to avoid worrying patients unnecessarily. They may try to balance clinical and non-technical language to avoid confusing patients; they may feel they need more time to write notes that patients can read. They may be concerned about how patients might choose to share their notes, including posting a clinician's note on Facebook, medical forums, or other social media.

Most doctors in the OpenNotes study found that they generally didn't need to change how they wrote their notes. Patients did not expect doctors to write notes aimed specifically at them and were grateful simply to have a window into their medical record. However, a minority of doctors reported that they changed how they documented potentially 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.

Recommendations

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

When documenting sensitive behavioral health issues, we recommend trying to describe behaviors descriptively, rather than labeling them or suggesting judgments. We also suggest highlighting the patient's strengths and achievements alongside his/her clinical problems. This can help the patient gain a broader context within which to consider his or her illness and tackle difficult behavioral changes.

In addition, try to avoid excessive medical jargon, or acronyms (especially ones that may unintentionally offend patients, like SOB, or OD, or "patient denies," etc.). Patients are far more resourceful than many clinicians realize and will look things up, but communicating clearly can help avoid unnecessary confusion.

Providers occasionally have understandable concerns about whether their security could be put at risk by combative or potentially litigious patients. If you are unsure about how to document something in your notes, contact your supervisor or risk management officer.

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"I felt like my care was safer, as I knew that patients would be able to update me if I didn't get it right. I also felt great about partnering with my patients, and the increased openness."

A doctor

"Weeks after my visit, I thought, 'Wasn't I supposed to look into something?' I went online immediately... Good thing! It was a precancerous skin lesion my doctor wanted removed (I did)."

A patient

Improving Your Notes

Many clinicians may work to make their notes more educational and helpful for patients. Here are some basic principles that may prove helpful:

Keep It Simple:

- Avoid jargon and abbreviations, especially ones that might easily be misinterpreted (e.g., "SOB" or "patient denies").
- Briefly define or simplify medical terms (short of breath, rather than dyspneic).

Provide Context:

- Include educational materials or links to content that can help patients learn more about their illness reliably.
- Incorporate lab or test results to give patients the full picture.

A Balanced Perspective:

- Complement sensitive behavioral health diagnoses with non-judgmental descriptive terms, where possible, to avoid labeling.
- Highlight the patient's strengths and achievements alongside their symptoms and clinical problems to endorse patients' attributes and empower positive change.

Engage Patients:

- Talk about your notes. Investing a few minutes at an appointment can strengthen the connection between patients and providers. It can also encourage patients to reveal information they might otherwise be reluctant to bring forth, and allow providers to gauge the level of understanding or opportunities for education.
- Encourage patients to ask questions about what they've read.

Get Feedback:

- Get feedback from your patients. Did your patients understand their treatment plan? Did your patients feel your notes captured their visit accurately?

Correcting Your Notes

Changing a note is at the clinician's discretion. Patients and families may catch clinically important mistakes in notes, or find lapses in follow up that, once rectified, improve safety. Clinicians can often use existing mechanisms to modify a note (i.e., addenda or other institutional procedures). It is helpful to circle back with patients to let them know the change was made.