Annals of Internal Medicine

EDITORIAL

When Patients Read Their Story in Clinical Notes

Current clinical notes often attempt to check off many requirements related to reimbursement: documentation of current medications, documentation of organ system review, documentation of test results, documentation of fulfillment of performance measures, and, somewhere in the mix, an assessment and plan. Social history is often relegated to simply updating smoking status.

But as Blease and colleagues point out in their article (1), the cloak that effectively covers many notes will be lifted on 2 November 2020, when the 21st Century Cures Act is implemented and patients are to have ready access to their medical record, including the clinical notes (2). Patients often misunderstand medical jargon. Will reading notes cause them confusion and distress? Physicians are already experiencing burnout from spending hours at the end of the day completing documentation for the electronic health record. Will writing notes with the realization that the patient may be reading them be one more burden for physicians?

The answers to these questions lie in the structure, the content, the style, and, most importantly, the goals of the notes. Increasingly, most regulatory requirements can be met elsewhere in the medical record. The note can now become a story in which the hopes, fears, values, resources, challenges, and context of the patient are shared as appropriate; the narrative of the disease course is clear; the key medical features of the case are highlighted; a thoughtful differential diagnosis and assessment is created; and a course of action is advised (3).

What about causing confusion and distress for patients? An early study of OpenNotes was reassuring on this front, with patients feeling there was far more benefit than downsides (4). What about increasing burden for physicians? A thoughtful approach is needed to realize the potential for benefits for physicians, which could include better outcomes with truly patient-centered care, reduced risk for medical error by relating an accurate history and working through the assessment and plan, improved communication between physician colleagues and other team members by having an understandable narrative, and a stronger connection between patient and physician.

There will be challenges. Patients may point out inaccuracies in our notes, such as an appendectomy mistakenly listed that had not been performed or a different course of events than we had understood—but that is a backup that can help us reduce errors. Patients may disagree with labels we apply—but then an explanation for the appropriateness of the label can be given. Or more often, we may wish to reconsider whether labels we often use from convenience and habit are actually helpful or are inadvertently disrespectful. Physicians may be concerned that they are not to use words that require a medical education. Of course, we need to use the most accurate language for the case, but the overall sense of the situation should still be understandable.

To write notes that are useful for medical care yet still of some value to the patient reading them could initially take more time and thought. But it also has the potential to bring a sense of meaning to the task, rather than rote documentation. Our current unhappiness with note-writing is certainly in part the time required, but also what we achieve by it: not always a thing of beauty or of use. We can revise note templates to serve as supportive structures, not creating note bloat. We can develop habits of clear writing and truly respectful (not coded) wording. We can make it a priority to consider the person with the illness, not only the illness. We can enjoy the fascination of trying to solve a mystery, one of the joys of medicine. And we can strengthen the trust between patient and physician by our notes reflecting that we listened, we observed, we thought, and we cared, which I contend is what each human being hopes for when putting their life in the hands of their physician.

Heather E. Gantzer, MD
Park Nicollet Clinic
St. Louis Park, Minnesota

Disclosures: The author has disclosed no conflicts of interest. The form can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M20-6632.

Corresponding Author: Heather E. Gantzer, MD, 3800 Park Nicollet Boulevard, St. Louis Park, MN 55416; e-mail, hgantzer@mac.com.

Ann Intern Med. doi:10.7326/M20-6632

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This article was published at Annals.org on 13 October 2020.

