

## The times

### Patients' access to their psychiatric notes: a review

JEFFREY R. JONES, Consultant Psychiatrist, The North Wales Hospital, Denbigh,  
Clwyd LL16 5SS

Recent legislation, the Access to Health Records Act (1991), which came into force in November, will mean that patients will be able to apply for access to their written case file. This law will not be retrospective, and notes written before this date will not therefore fall under the scope of the act. Similar legislation has already been passed enabling access to Social Services case files (Access to Personal Files Act, 1987). The legislation follows increasing pressure for consumer rights in various areas and follows similar developments allowing access to health records in other countries.

Medical practice in this country has traditionally restricted access to casenotes except in exceptional circumstances. In certain specialities patients have been allowed access to their casenotes, e.g. antenatal records which were held by the patients. Also in certain medico-legal cases patients could obtain access to their files by means of a court order. In the field of psychiatry patients may have access to reports written on them in certain circumstances, e.g. psychiatric reports for employers, solicitors, or mental health review tribunals. This can lead to patients correcting inaccurately recorded facts, disagreeing with opinion, or wishing to edit reports to leave out material they regard as sensitive or inappropriate.

There have been a few studies looking at the effects of allowing patients some form of restricted access to their psychiatric casenotes. Although most have been small and uncontrolled, the results have generally been favourable with benefits of patient access reported including patients feeling better informed, more involved, and more in control. Patients generally described it in positive terms but fewer than expected were interested. Although some patients were upset by reading their notes, no serious harm occurred and it did not lead to an increase in anxiety. Most studies reported patient preference for an open access system and one study also examined staff attitude which was reported as favourable. A saving in clerical time was noted in one study. The notes in these studies were made available with a member of staff present to interpret them. Where access to casenotes was allowed there was no significant increase in

litigation. In addition, access allowed the correction of inaccurately recorded basic data.

The case against open access to casenotes policy has been given by some writers. The arguments against open access include the risk of serious harm to patients or others, undermining the patient-doctor relationship and patients relying more on the notes than on what their doctor says. Concern has also been expressed in that the nature of the medical record might change reflecting a defensive attitude with the content becoming more restricted and more reliance on memory or word of mouth. Speculative notes and differential diagnoses necessary in a proper exploration of a case may be more difficult as doctors may try to protect patients from such information. Psychiatric records in particular have been seen as being particularly sensitive and this has been reflected in legislation passed in some states in the USA where mental health records and other health records were treated differently. Reasons for increased sensitivity of mental health records include the nature of the patient's diagnosis, the patient's mental state and response to disclosure, and also the greater use of third party information. Showalter (1987) also examined the psychodynamics of patients requesting access to their psychiatric records suggesting that, in allowing access, psychiatrists need to assess motivation, possible reactions and exceptional circumstances in which access would be refused.

The Data Protection Act (1984) allowed subjects to have access to data held on them on computers except in certain well-defined situations, e.g. where national security was involved, or police records. For medical data held on a computer a special case was made for restricted access. This allowed the doctor in charge of the case to be able to restrict access to the data in special situations, e.g. if the data could be harmful to the patient or could reveal confidential third party information. If access was granted then the doctor was obliged not only to supply the patient with these data but also to interpret them in a way that the patient could understand. This task was often delegated to doctors by health authorities who registered as data user, the doctor becoming a 'data custodian' deciding on the appropriate access.

The new Act extends the same principle of access to manually held records in the National Health Service. It will bring further pressure on doctors to change their current practices and have radical effects on the way that sensitive medical information is handled. Some professional staff of other mental health disciplines expect doctors to share all clinical information, for instance in multidisciplinary team work. There is general acceptance that certain information necessary for patient care needs to be shared with other professionals. However, with the rapid development of multidisciplinary community team work there is a growing demand for shared record-keeping, although different disciplines may have very different policies about client access and confidentiality. This is especially the case with regards to Social Services records and Health Service records. Thus the pooling of data in such shared records could lead to problems of access and confidentiality as material which was previously restricted to one discipline is shared, and different professions may have different access policies with some allowing open access.

Communication with patients is not always easy and a recent survey by the Consumers' Association (1991) suggests that many patients are dissatisfied with what they are told by their doctors, and would like to be told more about their condition. The doctor-patient relationship is important and there is obviously scope for improvement in the way patients are provided with information. Individuals vary greatly in their ability to understand and this may be affected by their condition and anxiety in the consultation setting. Patients may need to have information pitched at their level. Complicated clinical information may need to be interpreted to the patient and/or family. It is often useful to have a dialogue with the patient so that he/she can ask questions and clarify items. This involves valuable time, but time well spent and it may avoid problems later. Some information may be given preferably in writing but again needs to be pitched to the patient's level of education and literacy.

In the same way that the Data Protection Act allowed restricted access to medical data, so will this Act allow restricted access to written casenotes, although there are subtle differences. Doctors, in writing their notes, may no longer be doing so purely for their own use and communication with colleagues. The records may offer another opportunity for communication with patients who apply to see them. There is evidence that patients' beliefs can

affect as well as be affected by their condition and thus it offers an opportunity to change or challenge those abnormal cognitions that patients may develop. Doctors will need to interpret the notes and have a prime role in communicating with their patient as well as being able to decide what information will be harmful to release. In addition, the Act will allow non-disclosure of information given by a third party. It is difficult to predict the effects of the Act from studies carried out so far as these usually allowed access in the presence of staff. There may well be as many potential pitfalls as benefits. Problems may arise in exceptional cases, for instance in applications for access by patients suffering from Munchausen's syndrome.

When the new Act comes into force much work will need to be done to change current practices to meet requirements. Although the Act will allow patients access to their casenotes, from the research done so far, access, if allowed, would probably be best provided by having the patient's doctor available with the notes to interpret them and discuss any anxieties that the patient may have. In addition to this suggestion, Schwartz & Rachlin (1985) made ten recommendations for safe access statutes including asking the patient for his or her reasons for seeking access, and the keeping of personal notes that are not accessible to the patient. The various disciplines involved in community and multidisciplinary team work will have to recognise and respect their different obligations as far as records both written and computerised are concerned. With the development of computerised databases for audit and other purposes in the Health and Social Services in future it may be possible to have large databases which are linked. However, although certain data may be held in common, there may need to be a separation of the data into smaller files as the different services have different requirements for access to data and confidentiality.

## References

- CONSUMERS' ASSOCIATION (1991) What's up Doc? *Which?*, February, 94-97.
- SCHWARTZ, H. I. & RACHLIN, S. (1985) Patients' access to mental health records: impact on practice. *New Directions for Mental Health Services*, 25, 79-88.
- SHOWALTER, C. R. (1987) Patient access to their psychiatric records - a psychodynamic perspective. *Medicine and Law*, 4, 351-360.

*A full list of references is available on request to the author.*