For Doctors' Eyes Only?

By A/Prof Chin Jing Jih

A member of the public recently wrote to the *Straits Times* (ST), suggesting that patients should be allowed to read what doctors had written in their medical records. The writer argued that if patients are allowed to view their medical records, they would be able to verify the accuracy of the entries. He reasoned that this would lead to a more comprehensive understanding of their illnesses, which would, in turn, result in better patient compliance and prognosis. The writer also offered his own interpretation of why doctors refuse patient access to medical notes: to "prevent them from being psychologically scarred or discouraged by their illness". Therefore, he felt that by not allowing the patients to read their own records would instead cause deeper psychological misgivings, as well as suspicion, resentment and unnecessary anxiety.

Some highly provocative opinions indeed, which I suspect, most doctors here would have serious reservations with. This chasm in perspectives revealed in the letter is so glaring as to warrant a critical and objective analysis. It is worth considering why these points have been raised, and even more fundamentally, why the scope of routine doctor-patient communication, at least here in Singapore, does not include the direct viewing of medical records by patients.

The cliched joke of doctors' illegible handwriting aside, the first question to ask about the assertions in the letter is this: does patients' viewing of their own medical records truly improve the accuracy of the entries? The answer is probably a yes and no, which requires some qualification. While patients are certainly in a good position to check the medical (including psychosocial) history and responses that they have volunteered, and rectify any inaccuracies as far as their recall permits, it is important to acknowledge that these only constitute part of a much larger entity that is considered a complete medical record.

A medical record, as its name suggests, consists of a variety of systematic documentation of a particular patient's medical condition and its progression over time by doctors and healthcare professionals. In addition to medical history and symptoms reported by the patient, the medical record also consists of the doctors' observations and interpretation of physical signs, test results, x-rays, the doctors' assessments and diagnoses of the patient's medical problems and projected prognoses, medical management plans, including medication and surgical treatment (both consented to and declined by the patient), and response to these medical interventions. These are not information that the patient can verify by mere "viewing" of the medical records alone. In fact, given the technical language these documentation and recordings are compiled from, a patient who is not a healthcare professional is unlikely to comprehend the information, let alone verify the accuracy of these entries.

In spite of the above limitations, one might argue that a

patient's verification of some parts of the medical records is better than none. But one needs to think of the medical record as a whole entity, which has no clear separation into parts that are verifiable and those that are not. Perhaps the view held in the letter is influenced by the position in the US, where the Health Insurance Portability and Accountability Act (HIPAA) grants patients the right to ensure that the information contained in their records are accurate. Patients can therefore view their own medical records and petition their healthcare providers to rectify any factual inaccuracies in their records. The problem with this lies in the lack of clear definition of what patients can edit and what they cannot. In other words, there is no recognition of the intellectual property rights of doctors in creating the patients' medical records. In the absence of limitations, the patients may end up modifying professional opinions (in contrast to facts) that they disagree with, or which they misinterpret as being "inaccurate". Contrary to initial good intent, this would compromise the integrity of the records and possibly act against the patients' best interests.

The second point to address, with respect to empowering patients, is slightly more complex and challenging. Indeed, it would be difficult to argue against the position that enhanced comprehension by patients of their illnesses will lead to improved compliance, and potentially result in better prognosis. What is in doubt here is the assumption that patients viewing their own medical records would lead to better appreciation of their own illnesses.

To address this, we need to revisit the purpose and operational norms of medical record keeping. As alluded to the above points, a patient's medical record also contains a working journal of the doctor's observations of the patient's illness manifestations and his interpretations of these observations. More importantly, it also consists of documentation of the doctor's clinical impression, professional judgement and best possible plan of management, at different points and phases in the patient's illness. In a way, each entry represents the doctor's professional worksheet as he attempts to analyse the patient's data (symptoms, signs, investigation results and patterns of progression), and arrives at a logical conclusion after navigating numerous sets of pretest and posttest probabilities, and statistics on sensitivity and specificity. The methodology and approach in clinical Medicine is a complex one that even experienced doctors sometimes grapple with; which many senior and wiser doctors have described as a blend of scientific logic and intuition (or clinical acumen). In the face of intrinsic medical uncertainty, even the most logical approach may not necessarily end up with the most accurate diagnosis and best anticipated outcome.

In light of the abovementioned, would direct viewing of the medical records assist a patient in understanding his illness? My guess is that, instead of achieving comprehension, it will more likely lead to confusion and misunderstanding. Without the right context, or more critically, the right analytical skill acquired after five or more years of medical training, the patient may mistakenly think that there has been a delay in diagnosis or misdiagnosis due to the doctor's negligence or incompetence. In this respect, the doctor may refuse direct viewing of the medical records, not so much to prevent psychological trauma and pessimism in patients, but more to avoid misconception and erroneous belief that could ironically lead to the psychological misgivings, suspicions and anxieties that were expressed in the ST letter. Certainly, the doctor can provide guidance and explanation during the viewing, but for the average patient, it will be quite impossible to close that knowledge and skills gap.

What about simplifying the entry and adopting a language in medical documentation that the patient can understand? These days, the medical record is frequently a medium or platform for inter-professional communication. Entries made in medical records tend to be in a working language that is intentionally precise and technical to avoid ambiguity and to facilitate inter-professional communication. To do otherwise or to use a simpler lay language that caters to the patient's understanding would inevitably compromise the professional quality of the documentation and communication. This can only impair the quality of professional care rendered to the patient.

An exception I have encountered thus far was at a hospital I visited in Japan earlier this year. There, patients are allowed to get printouts of their doctors' entries into their electronic medical record soon after the clinic encounters or hospitalisation. Both doctor and patient see the same information. The hospital administration explained that this astonishing level of openness and transparency was possible due to the presence of several ingredients. Firstly, there is a strong sense of social solidarity and desire to preserve social harmony in the community served by the hospital, which meant a strong reluctance to resort to litigation as a means of resolving any misunderstanding or perceived medical mismanagement. Instead, the patients would either trust and accept, or make gentle enquiries, using communication as a means of resolving differences. Secondly, there are high levels of literacy, education and maturity among patients and members of the community. This helps them to appreciate peculiar nuances of medical practice and stomach statistical uncertainties. And whatever they could not grasp, they duly compensate with trust. This almost utopian social solidarity between hospital, doctors and patients, is to the best of my knowledge, highly exceptional, even in Japan.

Is this possible in Singapore? Perhaps not immediately, but possibly sometime in the near future. We should remain optimistic, but until we get there, we need to

find a balance between allowing patients to view medical records and safeguarding the integrity and utility of the records for the benefit of patients. The Public Hospitals and Medical Clinics Act dictates that the licensee of the medical facility has the duty and responsibility to maintain the integrity and accuracy of the medical records under its ownership. Patients do have the right to access their own medical information, and in general, this right of access is operationalised via a request for medical reports written by the relevant doctors. Thus far, this framework has served the interests of patients well. What is critical is the accuracy and integrity of the medical documentation. The quality of the records should go beyond merely for "personal use or reference" by a doctor, but be reasonably clear and adequate to allow continuity of care by another doctor if the need arises. Professional guidelines or best practices on standards and clarity of medical records could be helpful here.

Whatever solution we seek for the future, whether it is something along the line of a patient-health record platform or a trust-based direct access model, it is clear that we should actively avoid bridging that gap with a rights-based adversarial approach in the form of complaints and worse, medical litigation. A purely regulatory approach is also likely to be problematic. Some years ago, when HIPAA was on the horizon of implementation in the US, a senior physician who I was chatting with at a conference confided that he had planned to keep two separate sets of medical records for each patient: one set with skeletal information for the patient ("and maybe his lawyer", he said with a wry smile), and another set – the real set – for his own reference and working out the patient's problems. I never checked with him later if he actually carried out his cumbersome plan of dual record-keeping, but the irony of the situation was not missed on me.

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Coming back to the ST letter, notwithstanding the counterarguments I have raised above, I think the profession should avoid dismissing it as just another frivolous ventilation from an ignorant layperson. We should view it more constructively as an expression of need and anxiety, and a deeper reflection of deficiencies in our communication with our patients. To his credit, the writer of the letter expressed a keen interest to participate actively in the care of his health. All he wants is more information and to know what his doctor is thinking. Therefore, in my view, the solution is clearly not direct viewing of medical records, nor will a detailed medical report always be adequate. Perhaps what is yearned for is more open, honest and informative dialogue during routine clinical encounters between patient and doctor. No more, no less. Patient education and communication should be far more effective in improving patient comprehension and compliance than mere reading of medical records by patients. SMA

A/Prof Chin is President of the 53rd SMA Council. Like most doctors, he too has bills to pay and mouths to feed, and wrestles daily with materialistic desires that are beyond his humble salary. He, however, believes that a peaceful sleep at night is even more essential.