Doctopic: Analysis and Interpretation
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Sharing notes with mental health patients: balancing risks with respect

In the past decade, health institutions in over ten countries—including Australia, Canada, Sweden, and the USA—have begun to provide patients with access to their clinical records via secure online portals.[1] So far, however, few health organisations have chosen to share clinical notes written by mental health professionals. Clinicians, especially those working in psychiatric settings, remain concerned that patients could become anxious, confused, or offended by what they read, and that sharing notes will create an extra work burden for mental health professionals.[2,3]

Currently conceived, the decision to afford optional access to mental health notes can be reformulated as an ethical dilemma around patient autonomy balanced with harm prevention.[4] This dilemma might be avoided if two underlying assumptions are considered: first, that reading notes is harmful to mental health patients; and second, that record keeping cannot be adapted to avoid negative effects.

Addressing the first consideration of potential harm, preliminary research suggests that sharing notes might well benefit patients in mental health settings. A study[5] done at a psychiatric outpatient clinic found that, after 20 months, most patients reported increased understanding of their mental health, better remembered their care plan, and had better awareness about the potential side-effects of medications. Qualitative research also shows that, as a result of reading their notes, many mental health patients describe feelings of validation, greater engagement, and enhanced trust in clinicians.[6,7]

Notwithstanding promising early findings, current studies are limited by small sample sizes and responses might be biased in favour of patients who are already more engaged with their health care. Furthermore, some patients describe feeling more worried or offended as a result of what they have read.[5–7] For example, in an investigation into patient access to psychotherapy notes, over half of the surveyed patients reported that reading their notes was "very important" for feeling in control of their care, trusting their clinician, and understanding what goes on in therapy. However, some patients perceived notes as inaccurate, disrespectful, judgmental, or were surprised by perceived incongruencies with what was communicated face-to-face.[6]


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Addressing the second consideration of adapting record keeping, evidence indicates that some clinicians change how they write notes to protect patients from such risks. In a survey at a medical centre in the Veterans Health Administration—the nationwide health-care system that offers veterans portal access to mental health notes—nearly 63% (127 of 201) of clinician respondents reported being less detailed in their documentation and nearly one in two (98 [49%] of 201) admitted that they would be "pleased" if the practice of open notes discontinued.[2] Similar results have been seen in Sweden where clinical psychologists (39 [62%] of 63) reported being less candid in mental health documentation after the implementation of open notes.[3] Strategies intended to avert harm or offence are understandable, yet such practices might inadvertently pose greater risk to patients by undermining the quality of clinical documentation and patient transparency. The original function of clinical notes, to archive the patient's health history, and to serve as an aide memoire and communication tool with other health professionals, must be preserved. Still, those who prefer to uphold paternalism need to provide strong arguments to justify it; similarly, decisions to restrict portal access (eg, in patients perceived to be at higher risk) would require robust justifications. Exclusively denying access to mental health patients could increase stigmatisation under the mistaken presumption that the patient cannot cope with reading what is written about them.

Resolving the tension between patient transparency and potential harm requires mental health professionals to reimagine notes as a multi-purpose tool. Upholding accuracy in clinical record-keeping is imperative. The challenge we face is how to evolve and even improve the standards of documentation while respecting patients and optimising clinical benefits.[8] For example, incorporating patient feedback could improve precision in clinicians' interpretations of patients' subjective states. Just like a new medication that might be useful for most, with side-effects in some, sharing clinical

notes should be conceived as a relational tool—one that requires training in skilful use. Reconceiving access as an extension of the therapeutic clinical encounter means that patients should receive guidance on how to access their records, on the benefits and potential downsides of reading notes, and on how to constructively raise concerns with clinicians.[9] Likewise, clinicians will need patient-informed training on how to augment care via clinical note-sharing. A web-based course in how to construct notes that are direct, accurate, and understandable, while using respectful and supportive language, resulted in increased confidence in clinicians to share online access and communicate difficult information.[10] Sharing clinical notes in mental health settings will be more complex than in other clinical specialties; however, for most patients it will be feasible and, if carefully implemented, an empowering tool that could improve care.

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