VIEWPOINT

Sharing Clinical Notes
Potential Medical-Legal Benefits and Risks

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As of April 2021, a new federal rule mandated that US clinicians and health organizations make electronic health records much more accessible to patients without charge. Part of the bipartisan 21st Century Cures Act of 2016, the new rule seeks to promote patients' access to their health information and to prohibit information-blocking practices in health systems. With a few permitted exceptions, clinicians are now required to provide full access to 8 types of notes: those relating to consultation, discharge, history and physical examination, imaging, laboratory tests, pathology, procedures, and progress.[1]

The new rule constitutes a substantial culture change for both patients and physicians. Yet, thus far, limited attention has been given to the legal implications of offering more complete access to patients' health records. In particular, many physicians are rightly wondering what this might mean for medical malpractice claims against them. This Viewpoint examines the potential legal benefits and risks of sharing notes and offers recommendations for ensuring that the new rule advances the interests of both patients and clinicians.

Potential Medical-Legal Benefits of Sharing Clinical Notes

Increased access to clinical notes could reduce malpractice claims by (1) reducing diagnostic delays, (2) reducing medical errors, and (3) improving patient-clinician relationships. Misdiagnosis and delayed diagnosis are leading causes of malpractice claims,[2] and failure to track and follow up on diagnostic information such as tests, results, or referrals is reportedly a major source of medical error.[3] In a survey of 6913 adult patients at a hospital (28% response rate) and 3672 parents at a children's hospital (17% response rate), 53.8% of adult patients and 58.4% of parents reported that reading notes helped them to remember referral appointments, and 43.3% of adult patients and 44.8% of parents reported that access helped them remember scheduled tests.[4] More informed patients and caregivers could be more engaged in the diagnosis and treatment processes and thereby potentially help reduce the risk of delays and missed diagnoses.

Patients who identify mistakes in their records could also help prevent medical errors. In a survey of 29 656 patients (22% response rate) of whom 18 301 had read at least 1 ambulatory note and answered questions on errors, 1 in 5 found an error and 42.3% of the patients perceived the identified errors to be serious.[5] The most common errors were related to diagnoses, medical histories, medications, test results, notes on the wrong patient, and notes pertaining to the wrong side of the patient's body (left vs right). Under the law, a finding of malpractice liability requires a finding of patient injury. Patients who report errors in their health information could therefore prevent physicians from relying on erroneous data that may lead to poor diagnostic or treatment decisions and legal liability. An analysis of 20 randomized clinical trials related to sharing clinical notes (involved 17 387 patients) supports the conclusion that sharing electronic health records could improve patient safety.[6]

Even when errors do occur, more open communication with patients may potentially diminish liability risks. An evaluation of the performance behaviors of 264 surgeons by their peers, colleagues, and trainees identified a range of interpersonal skills (openness, respect, humility, and teamwork) associated with reduced risk of malpractice claims.[7] Conceivably, the invitation to read clinical notes signals openness and respect, but robust studies are needed to determine whether access enhances positive perceptions of physicians and whether this is associated with decisions to pursue claims.

In addition, the sharing of clinical notes could make it easier for patients to obtain sound legal advice about potential malpractice cases. Attorneys have an important role in advising potential clients about whether they have a valid or frivolous case. Access to patients' clinical notes could potentially enable them to perform that function more accurately.

Potential Medical-Legal Risks of Sharing Clinical Notes

Offering patients full access to their health information might also invite new legal concerns for clinicians. Litigation risks could increase if (1) data release causes harm, (2) physicians make changes that reduce the quality of documentation, (3) access strains patient-physician relationships, (4) physicians fail to correct errors that later cause harm, and (5) access increases physician burnout leading to errors.

Under the new legislation, clinicians are permitted to block full access to patient notes under specified conditions.[8] These conditions include denying access requests to prevent physical harm to patients or third parties or to safeguard privacy. For example, complex legal cases may arise from claims that data were released inappropriately, exacerbating acute psychiatric conditions leading to self-injury.

Knowing that patients are reading what clinicians write in medical records may cause physicians to alter the contents of clinical documentation. One survey examined the attitudes of 192 clinicians (65% response rate) before and after a note sharing policy was implemented.[9] Of these clinicians, 52% reported being less candid in their documentation, 55% reported

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changing how they addressed mental health topics, and 44% reported modifying how they addressed overweight or obesity. Although the reasons are unclear, it may be that some physicians amend documentation to avoid causing patients offense or raising concerns. Medical records that are tailored to satisfy patients could mislead other treating clinicians and diminish the quality of care. Furthermore, records that are inaccurate or incomplete because of physicians' concerns about sharing clinical notes could hamper both plaintiffs and defendants in malpractice litigation.

However, failure to modify the tone or content of documentation in light of sharing clinical notes might strain patient-clinician relationships and influence decisions to pursue claims. For example, physicians who include notes about overeating, risky sexual behaviors, firearm ownership, or poor health habits could offend patients. Patients who feel they do not have a good relationship with their physicians are more likely to sue if they are dissatisfied with treatment outcomes.

Other legal concerns are associated with patients' requests for changes to their records. In some instances, patients may correctly identify serious errors in the clinical notes and request that their records be corrected, but physicians might fail to do so. If patients experience harm because of documentation inaccuracies, written requests for corrections from patients that were ignored by physicians could serve as powerful evidence of physician negligence. On the other hand, interesting legal questions will arise if requested changes are made despite being problematic and later lead to medical errors. It is unclear whether a patient's contribution to the problem will serve as a defense or whether clinicians will be deemed blameworthy for granting the problematic request.

In addition, it is possible that sharing clinical notes will contribute to workplace-related stress and professional dissatisfaction (ie, burnout) because clinicians spend more time on documentation or because patients frequently contact physicians with questions about their records. Burnout can increase medical error and related liability risks, and thus the demands sharing clinical notes places on physicians should be subject to future study.

Suggestions to Enhance Benefits and Reduce Risks of Sharing Clinical Notes

Although many physicians may be concerned about the potential increased litigation risks associated with sharing clinical notes, the benefits of doing so may outweigh the risks, so long as the new mandate is implemented appropriately. Several suggestions could be considered.

First, health systems could hire additional support personnel to answer patient queries and evaluate and address record modification requests. Technology should be used to facilitate error correction and ensure that approved corrections are incorporated throughout the electronic record. These measures might also help reduce clinician burnout and strengthen teamwork with patients.

Second, clinicians could be provided with resources to ensure that documentation can be completed efficiently while maintaining accuracy, clarity, and sensitivity to patients' needs. Some clinicians may feel uncomfortable with the notion of having all their notes visible to patients, and training could provide much needed support, including on how to manage disagreements constructively.

Third, the benefits of sharing clinical notes will not materialize if patients do not access their medical records. Thus, patients could be offered training or assistance such as from digital navigators to learn how to use their personal health portals.[10] This type of patient training should include information about how to report documentation errors to clinicians. Innovative patient portals should make it easier for patients to report inaccuracies.

Conclusions

It is uncertain whether enhanced patient access to their health information will generate more benefits than litigation risks and contribute to a culture of greater transparency and trust in medicine. It is possible that greater mutual understanding and strengthened patient-physician communication could promote better health outcomes and reduce patients' inclination to litigate even when medical errors do arise. Verifying the potential effects of sharing clinical notes on malpractice liability risks will require thorough study and monitoring.

ARTICLE INFORMATION

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REFERENCES

1. US Department of Health and Human Services. 21st Century Cures Act: interoperability, information blocking, and the ONC Health IT certification program. Published May 1, 2020. Accessed July 15, 2020. https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-07419.pdf

2. Gupta A, Snyder A, Kachalia A, Flanders S, Saint S, Chopra V. Malpractice claims related to diagnostic errors in the hospital. *BMJ Qual Saf*. 2017;27(1):53-60. doi:10.1136/bmjqs-2017-006774

3. Singh H, Schiff GD, Graber ML, Onakpoya I, Thompson MJ. The global burden of diagnostic errors in primary care. *BMJ Qual Saf*. 2017;26(6):484-494. doi:10.1136/bmjqs-2016-005401

4. Bell SK, Folcarelli P, Fossa A, et al. Tackling ambulatory safety risks through patient engagement: what 10,000 patients and families say about safety-related knowledge, behaviors, and attitudes after reading visit notes. *J Patient Saf*. 2021;17(8):e791-e799. doi:10.1097/PTS.0000000000000494

5. Bell SK, Delbanco T, Elmore JG, et al. Frequency and types of patient-reported errors in electronic health record ambulatory care notes. *JAMA Netw Open*. 2020;3(6):e205867-e205867. doi:10.1001/jamanetworkopen.2020.5867

6. Neves AL, Freise L, Laranjo L, Carter AW, Darzi A, Mayer E. Impact of providing patients access to electronic health records on quality and safety of care: a systematic review and meta-analysis. *BMJ Qual Saf*. 2020;29(12):1019-1032. doi:10.1136/bmjqs-2019-010581

7. Lagoo J, Berry WR, Miller K, et al. Multisource evaluation of surgeon behavior is associated with malpractice claims. *Ann Surg*. 2019;270(1):84-90. doi:10.1097/SLA.0000000000002742

8. Office of the National Coordinator for Health Information Technology (ONC). ONC's Cures Act Final Rule. Published 2021. Accessed December 4, 2021. https://www.healthit.gov/curesrule/final-rule-policy/information-blocking

9. Ralston JD, Yu O, Penfold RB, Gundersen G, Ramaprasan A, Schartz EM. Changes in clinician attitudes toward sharing visit notes: surveys pre-and post-implementation. *J Gen Intern Med*. 2021;36(11):3330-3336.

10. Denneson LM, Pisciotta M, Hooker ER, Trevino A, Dobscha SK. Impacts of a web-based educational program for veterans who read their mental health notes online. *J Am Med Inform Assoc*. 2019;26(1):3-8. doi:10.1093/jamia/ocy134

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