

LOCAL

Minnesota doctors sharing medical records with patients weigh changing how they take notes

Seeing what a doctor says can help patients — if they can decipher it.

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APRIL 6, 2016 — 9:18PM

A growing number of Minnesota doctors are giving patients unfiltered access to their clinical notes in an effort to help them understand and follow treatment recommendations. But they are reaching a dilemma in the process:

Do they switch to layman language, or continue to write notes in expedient jargon and acronyms that are familiar to colleagues but Greek to patients?

“To many patients, SOB does not mean shortness of breath,” warned Dr. John Santa, a Portland, Ore., physician and national advocate for a movement, known as OpenNotes, to share medical records.

Finding the happy medium could have immense benefits, Santa said in a presentation to Minnesota health care leaders this week, because studies show that patients are more likely to trust their doctors and follow their advice if they can see what the doctors wrote about them.

A national study of 20,000 patients in 2010 found that as many as 80 percent of those who viewed clinical notes felt they took better care of themselves and showed up more prepared for clinic visits as a result.

“Everybody, I think, has an interest in this kind of transparency,” Santa said. “[But] you do have to change the culture of doing notes. Acronyms are a problem. Culturally insulting language is a problem.”

The word “fat,” for example, won’t fly in describing patients, and even a term like “obese” can seem judgmental, he said. A factual alternative such as “BMI too high” would work, he said. A confrontational term such as “noncompliant” in describing a patient could be replaced by saying the patient “chooses not to” do something.

Stigma over ‘depression’?

Santa is traveling nationally to promote OpenNotes, which isn’t a product but a philosophy of record-sharing that is funded by the Robert Wood Johnson Foundation and three other nonprofits. Technically, patients have always had the right to their records, but OpenNotes endorses making them available without patients asking.

Some large Minnesota medical groups have already adopted the practice. Mayo Clinic uploads outpatient lab results to an online portal so quickly that patients theoretically can see them before doctors have analyzed and interpreted them. Patients admitted to the University of Minnesota Medical Center receive daily printouts of their care records.

The need to rephrase wording in records concerns some doctors. Dr. Pamela Doorenbos strongly supports record-sharing at The North Clinic in Maple Grove, where she sees patients. But she said changing the vernacular could be time-consuming.

“If I end up having to document a ‘noncompliant patient’ as ‘patient declines this offer’ ... that is a change and will increase the note length,” said Doorenbos, who also is exploring the concept on behalf of Maple Grove Hospital.

The doctor’s SHorthand

Doctors use acronyms to save space and time in writing medical records, but they could confuse patients who are unfamiliar with the terms.

- PRN: (as needed)
- C/O: (complaint of)
- VSS: (vital signs stable)
- FX: (fracture)
- NPO: (nothing by mouth)

Written terms such as “depression” could provoke an argument, Doorenbos added, because they carry stigma for some patients but are necessary to record for diagnostic and billing purposes.

Santa said doctors shouldn't change their judgments or diagnoses in records, even if they adopt patient-friendly words. If a provocative description in the record troubles a patient, he said, that could provide the chance for a valuable conversation.

Fewer lawsuits

Other doctors at the OpenNotes presentation said technology can address language issues. Dr. Craig Weinert, who incorporated OpenNotes into inpatient care at the university hospital, said record-keeping systems can be set to automatically convert terms such as SOB into shortness of breath when doctors type them.

Santa said most patients in surveys have expressed a basic understanding of their doctors' notes, even if they had to gloss over or Google some terms. “The Internet's a wonderful tool,” he said.

Open access to medical records has attracted many supporters, including some malpractice insurers who surmise that informed patients might be less likely to sue.

An East Coast insurer has funded research by Dr. Sigall Bell of Harvard about patient safety implications of record-sharing. Anecdotally, some patients have found errors when doctors wrote information about other patients into their charts, she said.

Then, too, 40 percent to 80 percent of patients suffer “amnesia” after clinic visits about what doctors told them to do. So the records are invaluable reminders.

“Its shocking that we don't have a solution for that,” Bell said, “because it happens every day.”

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