

operating some three to five years, a group who often do not even have the luxury of being currently planned for, which can at least be said of those high dependency mentally ill who are likely to respond to short-term rehabilitation. This is a problem which members of the College have a responsibility to bring to the attention of the new purchasing authorities.

References

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MACMILLAN, J. F., CROW, T. J., JOHNSON, A. L. & JOHNSTONE, E. C. (1986) Northwick Park study of first episodes of schizophrenia. *British Journal of Psychiatry*, 148, 128-133.

A full list of references is available from the author on request and the paper has now become the subject of a College report, prepared by a sub-committee of which the author was Chairman.

Psychiatric Bulletin (1992), 16, 675-677

Original articles

Are psychiatric case-notes offensive?

PAUL CRICHTON, Senior Registrar in Psychiatry, Queen Mary's University Hospital, Roehampton Lane, London SW15 5PN; ATHANASSIOS DOUZENIS, Senior Registrar in Psychiatry, Gordon Hospital; CLAIRE LEGGATT, Social Worker, Gordon Hospital, Bloomburg Street, London SW1V 2RH; TIMOTHY HUGHES, Senior Registrar in Psychiatry, West Middlesex University Hospital, Isleworth TW7 6AF; and SHÔN LEWIS, Senior Lecturer in Psychiatry, Charing Cross and Westminster Medical School, St Dunstan's Road, London W6 8RP

During the last decade there have been a number of legislative changes establishing and extending the rights of patients to have access to their own medical and social service records. The Data Protection Act 1984, as modified by the Subject Access Modification Order 1987, gave patients access to computerised medical records with certain restrictions, in particular for information thought to be harmful to patients. The Access to Personal Files Act of 1987 granted access to Social Services Records. Again there were restrictions, e.g. to protect clients from serious harm or to protect confidential staff judgements. Finally, the Access to Health Records Act of 1990, which took effect on 1 November 1991 gives patients access to their own medical records and enables them to correct inaccuracies which they may find. Information likely to cause serious harm to the physical or mental health of the patient or of any other individual who could be identified can be withheld.

Since the late 1970s there has been an increasing number of publications on patients' access to medical records. Most have explored the attitudes of medical

and psychiatric patients and a few the attitudes of doctors towards patients' access to their own notes. Patients were reported to be mainly in favour of access, although not all would want to exercise this right to see their own records. Doctors, on the other hand, were divided in their opinions, some being opposed in principle.

In its guidelines on the Access to Health Records Act 1990, the Royal College of Psychiatrists (1992) emphasised the importance of avoiding "offensive pejorative comments" and encouraged case-note audit of this problem. We now report the first study of offensive comments in psychiatric and medical case-notes. In particular, we wanted to find out the following:

- (a) the nature and extent of comments which might cause offence to patients reading their own notes
- (b) whether psychiatric case-notes contain more offensive comments than general medical case-notes

- (c) how accurately and reliably doctors and non-medical staff members are able to predict what could cause offence to patients.

The study

Fifty sets of current psychiatric case-notes were randomly selected from the medical records department. These were case-notes of patients who had been seen in the general adult psychiatric department at Charing Cross Hospital within the previous year. Patients were excluded if they were younger than 18 or older than 65, or had an organic psychiatric diagnosis. Twenty-five sets of current general medical notes were also obtained randomly after being individually matched for age, sex and thickness in cm. with 25 of the 50 psychiatric notes. These were used as controls.

Three of the authors (P.C., A.D. and T.H.) scrutinised the case-notes. The notes were read from cover to cover, including nursing notes. All comments which these initial readers considered might possibly cause offence to the patient were recorded verbatim. Basic demographic data on each patient were also collected.

The word "offensive" was used here in the sense of "annoying" or "insulting", as defined in the *Oxford English Dictionary*, and was deliberately interpreted in a very wide sense, so that the initial list of comments would be over- rather than under-inclusive. The readers of the case-notes tried to put themselves in the position of the patients and to decide whether they themselves might possibly be offended if they were the patients to whom the comments referred.

In the second stage of the study, the list of all the possibly offensive comments abstracted was compiled in random order. There were 393 such comments. No information about the source of the comments was included, although in some instances it was possible from the content of the comment to deduce whether it came from a set of psychiatric or medical case-notes. The abstracted comments were then rated independently by a male consultant psychiatrist (S.W.L.) and by a female social worker (C.L.) according to the following 4-point scale:

- 0 = not offensive
- 1 = possibly offensive, e.g. Mr. X is well-known to the hospital
- 2 = moderately offensive, e.g. lots of cheap jewellery
- 3 = extremely offensive, e.g. a most unpleasant man.

Each of the two raters independently evaluated all of the 393 comments using this scale. After a period of 1-2 weeks each of the two raters rerated 100 of the 292 comments blind to their initial ratings. Interrater reliability and test-retest reliability were calculated using Kendall's correlation coefficient (τ).

In the third part of the study, one male and one female in-patient about to be discharged also rerated the comments. Their ratings were compared with those of the psychiatrist and social worker using Kendall's correlation coefficient. Kendall's τ lies in the range between -1 (total discordance) and $+1$ (total concordance) with 0 indicating chance agreement.

Findings

Of the 50 sets of psychiatric case-notes, 80% were found to contain either at least one moderately or extremely offensive comment (i.e. rated 2 or 3 by either professional) when rated by the two professionals. Of the psychiatric case-notes, 84% were found to contain such comments when rated by either of the two patients. The corresponding percentages of medical case-notes with definitely offensive comments were 24% and 36% respectively.

If one considers only the extremely offensive comments (rated 3), 62% of the psychiatric case-notes were found to contain extremely offensive comments when rated by the two professionals and 72% were found to contain such comments when rated by the two patients. The corresponding percentages of medical case-notes were 24% when the comments were rated by the two professionals and also 24% when the comments were rated by the two patients.

For the 25 matched pairs of medical and psychiatric case-notes, the latter were shown to contain significantly more moderately or extremely offensive comments as rated by professionals ($P < 0.001$) or by patients ($P < 0.05$).

We attempted to examine how reliable these ratings were. The two professional raters were each asked to rerate a subset of the comments after two weeks, blind to their original ratings. Test-retest reliability was shown to be good (Kendall's $\tau = 0.91$ and 0.78 , both $P < 0.0001$). Agreement between the two professional raters was also high (Kendall's $\tau = 0.53$, $P < 0.0001$). Interrater agreement was intermediate between professional raters and patient raters (Kendall's τ range 0.18 to 0.22 , $P < 0.0001$) and actually lowest between the two patients (Kendall's $\tau = 0.10$, $P < 0.01$).

Overall, there was a tendency for patients to give comments a higher offensiveness rating than did the professionals, the patients scoring comments 2 or 3 more frequently. This difference, however, was not significant ($0.5 > P > 0.1$).

Comment

In this study we have attempted to throw some light on an unresearched area: namely, do hospital case-

notes contain material which patients might find offensive? The answer was "Yes"; at least 80% contained comments judged to be offensive both by professional raters and patients themselves. General medical case-notes of similar bulk contained significantly fewer offensive comments. We also found that the formulation of some psychiatric diagnoses, such as "chronic schizophrenic" or "psychopathic personality" were considered offensive by patients and raters, whereas formulations such as "chronic diabetic" or "known case of SLE" (systemic lupus erythematosus) were not considered offensive.

Secondly, patients and raters had a statistically significant agreement in their ratings. This is of importance from the point of view of patients' right to access, as it suggests that the raters were able to identify most of the comments which the patients too would consider offensive.

Nonetheless, the finding that the patients rated the comments more highly suggests that the raters tended to underestimate comments which the patients found offensive. Again this has obvious implications for patients' access and staff members may need to take greater care in formulating entries into case-notes, e.g. in choosing diagnostic labels.

The professional raters were able qualitatively to categorise the remarks they rated moderately or extremely offensive into four main classes:

- (a) patronising ("this pleasant young lass"; "her newly-won sanity")
- (b) stigmatising ("a known schizophrenic"; "a known alcoholic")
- (c) flippant ("her usual somewhat paranoid self"; "he is one of life's victims")
- (d) pejorative use of lay terminology ("weak-willed"; "scatty"; "hysterical outburst"; "inadequate").

Patronising comments appeared equally in medical and psychiatric notes and were often made by male doctors about women patients. Stigmatising comments often comprised the use of adjectives as nouns, particularly as in "a schizophrenic". Flippant remarks represented the smallest category. Lay terms used pejoratively appeared surprisingly frequently and were made by all grades of medical and nursing staff. Uniting all these categories was an over-readiness to use clichés.

Some clinicians may object to our findings on the grounds that psychiatric case-notes by their very nature are likely to offend or that psychiatric patients

are particularly easily offended. However, we were able in all cases to rephrase the comments we found to a less offensive form without recourse to euphemism or longwindedness: "a schizophrenic" became "a schizophrenic patient", to choose the most frequent example. We contend that this represents good practice not merely from a negative medico-legal viewpoint, but more importantly because it encourages clinical objectivity and precision.

In summary, this study draws attention to a topical and important problem: the need to be aware of what might cause offence to patients when they read their case-notes and to exercise greater care in formulating entries into these notes. It is hoped that the findings might inform doctors, in particular psychiatrists, but also others involved with the care of patients by offering advice and guidance on what might be offensive to patients. The appendix contains some examples of comments which were rated as extremely offensive (rating 3) by all four raters.

Reference

- ROYAL COLLEGE OF PSYCHIATRISTS (1992) Access to Health Records Act 1990. College guidance. *Psychiatric Bulletin*, 16, 114-123.

A full list of references is available on request to Dr Crichton.

Appendix

Some examples of comments which were rated as extremely offensive by all four raters.

1. He is a known schizophrenic.
2. Patient is a known depressive.
3. Mr A. has a damaged personality.
4. My greatest fear is that A. was unwell when she decided to marry this individual.
5. Her newly-won sanity.
6. 22-year-old single, unemployed, chronic schizophrenic.
7. I am extremely interested in patients like yourself who have been abandoned.
8. She has become odder and odder over the past year.
9. He is a pitiful and lonely man.
10. Patient talks rubbish.
11. Weird and wonderful collection of physical symptoms.
12. Tendency to become seriously disturbed.