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


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, SeniorRegistrar 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 medi-
cal notes were also obtained randomly after being
individually matched for age, sex and thickness in
ln. 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 com-
ments 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 psy-
chiatrist (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 al-
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. Inter-
rater reliability and test–retest reliability were cal-
culated using Kendall's correlation coefficient (tau).

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 tau 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 pro-
fessionals. Of the psychiatric case-notes, 84% were
found to contain such comments when rated by
either of the two patients. The corresponding per-
centages 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 per-
centages 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 sig-
ificantly 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 tau 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

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 pityful and lonely man.
10. Patient talks rubbish.
11. Weird and wonderful collection of physical symptoms.
12. Tendency to become seriously disturbed.