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The patient's voice and the writer's role in mental health records

ORIGINAL ARTICLE

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Background and aim

Over recent decades, formal requirements for medical records have been strengthened, for example through patients' right of access. However, clinical documentation in mental health services has been criticised for becoming increasingly juridified and for failing to recognise patients as whole persons. The aim of this study was to conduct an exploratory investigation of current record-writing practices in mental health care.

Material and method

We reviewed the medical records of ten patients discharged from the Adult Inpatient Mental Health Unit at the Division of Mental Health and Addiction, Oslo, who had at least one previous inpatient admission. The material comprised more than 5500 pages in total. A multidisciplinary research group, consisting of a literary scholar and healthcare personnel, analysed clinicians' notes, ward staff's observational notes on in-patients, and outpatient records.

Results

The records contained overwhelming volumes of text, with extensive verbatim repetition resulting from copy-and-paste practices, which at times obscured inconsistencies and contradictions. New information could appear suddenly and disappear again without reflection. The texts often displayed an inherent unreliability, with contradictory statements appearing side by side. Considerable emphasis was placed on diagnosis and discharge, while reflective discussion of clinical processes was often absent.

Interpretation

Authors of medical records must balance medical, legal and patient-centred requirements. Artificial intelligence is increasingly being introduced into clinical documentation, with the potential to fundamentally alter practice. However, there is also a need for clinicians to reclaim ownership of the medical record. In this study, the patient record emerges as a document that often exposes the writer's sense of powerlessness.

Main findings

A review of ten patients' medical records comprising more than 5500 pages revealed an overproduction of text with frequent repetitions, which at times obscured inconsistencies and contradictions.

Information about the patients' lives and functioning often changed without explanation in the text, creating a fundamental lack of verifiability in the material.

'Things are stored, but not remembered. […] You store in order to forget.'

Geir Angell Øygarden: *Kentauromakhi* (1)

Patient records have seldom been the subject of scholarly study (2). An important exception is the first author's book *Pasienten som tekst* (the patient as text), published in 1997 (3). Through a narratological approach, the book shows how the patient's voice gradually emerges over a century in the records of Gaustad Hospital in Norway. The book, which has appeared in a second edition (4) and has also been published in English (5), has played an important role in the field of medical humanities and has been widely used and discussed in medical contexts. Subsequent studies have made valuable contributions (6–8), but our understanding of the patient record remains limited (2).

Over time, new medico-legal regulations concerning formal requirements for patient records have been introduced. For example, patients must now have easy access to their electronic health records – something the Norwegian Directorate of Health explicitly states is 'a benefit for patients' (9). As new formal requirements for record-keeping have been introduced, service user organisations have increasingly argued that patients do not feel recognised as whole persons and that medical records have become so structured and juridified that the patient's own story is lost (10, 11).

We therefore sought to conduct an analysis of patient records from recent years. The aim was not to examine the degree of compliance with the requirements of the many regulations, but to carry out an exploratory study of the text in contemporary mental health records.

Material and method

The Division of Mental Health and Addiction at Oslo University Hospital held a seminar on patient records in June 2019. Following the seminar, we discussed the possibility of conducting a study of contemporary patient records in mental health care and subsequently developed a study protocol.

The Regional Ethics Committee informed us in a letter dated 16 December 2020 that the project was outside their mandate. The project received approval from the data protection officer at Oslo University Hospital on 2 February 2021 (ref. 11850912, case number 21/02199).

Patients who had previously been admitted at least once to the Inpatient Adult Mental Health Unit, Division of Mental Health and Addiction, Oslo University Hospital, were invited to participate in the study. They were recruited consecutively, and all participants provided written informed consent.

The plan was to analyse 20 patient records, but it became clear that each record was so extensive that we only had the capacity to study ten records.

The records in our sample, which were anonymised before we accessed them, mainly consist of three discursive levels: clinicians' notes in the hospital, notes from district psychiatric centres (relevant in most of the records) and ward staff's observational notes of in-patients (typically three consecutive entries per day). In addition, there are extensive texts documenting special events, notes from social workers and occupational therapists, and occasional reports of contact with other agencies such as housing offices, the Norwegian Labour and Welfare Administration (NAV), etc.

We have consistently referred to the person generating text as 'the writer'. We did not attempt to identify the occupations or individual contributors involved in the texts: our focus was on the written record itself, not those who wrote it. This approach can be understood as an extension of literary studies' close reading method, where the aim is a detailed analysis of the text's individual elements without attempting to determine their origin (12).

We treated the three main types of text equally, i.e. they were not placed in any kind of hierarchy. We read the records from the first to the last page, generally without regard to which discursive category the individual notes belonged. Apart from anonymisation, the records were identical to those accessible to patients, supervisory commissions and other authorised parties.

The ten records together comprised just over 5500 pages. In addition, each record included an appendix containing various (legal) decisions. The records are organised in strict chronological order. Each note is precisely dated, and ward staff's observational notes also included the time. Individual entries can span a wide time range, often referring backward to earlier events. For example, the patient's history is revisited with each treatment change (such as transfers between wards or similar events).

Methodologically, our study differs from the first author's previous work in that we were a research team of four with diverse disciplinary backgrounds: three healthcare personnel with extensive experience in writing and reading patient records, and one literary scholar. We each read and reread the medical records from our own perspective. This reading strategy has also been used in interdisciplinary analyses of other medical text genres (7).

After several readings, the first author wrote preliminary notes in the margin. These were then discussed by the research group. His external perspective of the patient records often focused on aspects of the text that healthcare personnel perceived as self-evident, but which during the discussions were revealed to be less self-evident. Ultimately, this process made it possible to produce a consolidated account of the distinctive features of each record.

We are unable to replicate that process in this presentation of our results. During the close reading, we delved into individual statements in the records and reflected on them more thoroughly. For confidentiality reasons, we cannot reproduce long quotes from the records. What follows is a summary of our findings. Its value lies in the fact that, from our respective professional perspectives, we have arrived at a shared understanding. Patient descriptions have been carefully modified with regard to person, time and place, to avoid the possibility of identification. No patient histories are presented in full; examples in the text are fragments drawn from different records.

Results

The texts are not particularly difficult for a layperson to understand (except for notes on medication use). The patient record is the patient's 'property', and perhaps for this reason, overly technical medical jargon is generally avoided.

Cascades of text

The most striking aspect of the patients' medical records is the large volume of text in each record. Sometimes a patient is readmitted just a few days after discharge. Nevertheless, the new entry, often serving as an introduction, largely reproduces verbatim what was written in the discharge note, sometimes over several pages. The most extensive records contain countless such repetitions.

Minor variations can also appear within these repetitions. In a record where violence plays a central role, each summary begins with a description of specific episodes of violence from several decades earlier. Each note consistently records the same year and the same episodes, even if only a few days have passed since the previous entry. It is as if the record steadfastly establishes a 'year zero', from which all subsequent events stem from. The record traps the patient in a fixed narrative. Then suddenly, the writer starts the background story in a completely *different* year, citing *other* examples of violent behaviour. The source of these other examples is never explained. This new narrative might continue in a few more rounds of admission and discharge notes, until, inexplicably, the record returns to the old pattern – the previous 'year zero' with its established episodes of violence. The record does not reflect on the existence of these two very different background narratives.

It goes without saying that in records approaching a thousand pages, inconsistencies and contradictions are bound to occur. Nevertheless, it seems as if the record does not take its own genre seriously. Inconsistencies and contradictions are overlooked and give rise to an absence of meta-reflection.

There is every reason to believe that the copy and paste capability offered by digital technology is used extensively. Yet surprisingly often, repeated passages show such considerable variation in wording that they must be derived from earlier entries rather than simply being copied and pasted.

Emergence and disappearance of information

In one record, it is repeatedly stated that the patient has no children. Nevertheless, the patient reports one day that he is trying to find his son, with whom he has had no contact for a long time. For someone reading the whole record in context, this comes as a surprise, as there had never been any suggestion that the patient had children. The writer does not react to this information, nor do they return to these statements about trying to find the son. It might be reasonable to expect a detail of this significance to be further explored in the record, but it is never addressed. Is the information not believed, or is it considered irrelevant? Some time later, the record reverts to the previous formulation: 'The patient has no children.' The son, who appeared suddenly and then vanished again, is however mentioned once more in a later entry, in which the patient describes a romantic relationship that resulted in a child. This time, the writer indicates that the topic should be addressed further: 'To be followed up in subsequent appointments.' However, no follow-up occurs. Perhaps the patient did not wish to pursue the matter; the record provides no information on this. It is better interpreted as the record showing little interest in adhering to the guidelines it sets for it itself.

The inherent unreliability of the text

Several records contained contradictory statements about family circumstances, including differing accounts of sibling numbers. The point is not necessarily to establish the exact number; the real problem is how unreliable the text becomes when read as a whole.

One patient's record notes: 'He currently has no friends'. This is repeated frequently. The record also mentions – again repeatedly, and almost in parallel – that the individual receives visits from friends. Why does the record not reflect on its own inconsistency?

One patient did all of her studies abroad. Adolescence is a formative time in any person's life, yet the record makes little attempt to form a picture of the experiences that may have shaped her during these years. It is mentioned sporadically that she was subjected to bullying during this period. At other times it is noted that she was *not* subjected to bullying. Some notes mention that she was lonely when she was a student. Others state that she was socially active during the same period. The sporadic element remains precisely that – sporadic. There is no reflection on the contradictory information.

One patient is described as being *proficient* in Norwegian. The medical record follows him through his struggle to complete upper secondary school. He also starts undergraduate studies but towards the end of the record it is noted that he has *poor* Norwegian language skills and that his IQ level is primary school level. This decline in functioning is not commented upon. Perhaps it is not possible to do so. A tragic life course unfolds silently and precisely, without the possibility of intervention.

The writer's authority and lack thereof

The author tends to write in the third person, thereby avoiding the more obtrusive 'I', which would draw attention to the person doing the writing. A statement may be more readily questioned or challenged when it is not generalised into a neutral third-person form.

The passive voice is often used: 'The patient is assessed as deteriorating'. The agent is concealed. 'Short-term physical restraint was necessary … The coercive measure was implemented [date and time] and terminated [date and time].' The restraint lasted two minutes. This is followed in the record by nearly three pages of standardised text containing formal information about the right to lodge a complaint, the supervisory commission, etc. The same procedure, i.e. the same form, is used for each new instance of 'restraint'. Whether a one-minute restraint event justifies a three-page note is debatable. In any case, the system diligently signals a clear safeguarding of the patient's rights and autonomy, while the actors behind the coercive intervention are concealed through the contrived passive construction (13).

In the material, we frequently encounter formulations such as the patient 'claims', 'reports' and so forth. This wording signals that the writer does not necessarily endorse the accuracy of the account. This could be considered an attempt at objectification: the neutral writer simply reports what he has been told (14). It is striking, however, that the record is often reluctant to clarify where the information originates. The source may be earlier documents, family members or the patient themselves, without this being made explicit. Sometimes we encounter formulations supported by references of the type: 'according to the record, the patient has […]'. This is a pseudo-reference. When the often-inconsistent medical record spans hundreds of pages and there is no indication of where in the record the information is sourced, the reference becomes meaningless.

We have, however, also identified exemplary presentations of source material. Under the heading 'Diagnostic meeting', for example, one entry reads: 'The reason for referral has been reviewed, together with the events leading up to it, background information and timeline, previous stressors, descriptions of developments in current psychiatric status, results from structured assessment, *as well as my diagnostic deliberations'* (italics added here). The first-person possessive pronoun lends a reassuring sense of authority. Moreover, the wording refers to 'deliberations' rather than simply 'stating' a diagnosis. The writer neither discredits nor downplays the significance of other sources. Meanwhile, other notes from 'diagnostic meetings' appear to offer a straightforward and unambiguous account: 'Unanimous consensus on diagnosis F.xx.xx'. No mention is made of who constituted the unanimous consensus, and no deliberations are recorded. A pleonastic expression of this nature gives the reader pause for thought: was it really that straightforward?

The first-person form can, however, also function as an empty rhetorical device. A patient 'wishes to recount a dream he had last night'. The writer responds with the sentence: 'I give him time and space for this', but without noting what the dream was about. Is the author thereby implying that they had to consider whether the patient should be allowed to describe their dream or not? Perhaps the writer is asserting their authority here, signalling that they are in control of the situation. The setting, however, does not justify such a stance.

It is striking how little the medical record engages with the patient's words. One patient reads aloud their own literary work to the writer. The event is noted, but the author's response is omitted.

At other times, the patient's stream of words can be overwhelming. They appear to be recorded conscientiously, despite the absence of quotation marks, but the writer reproduces the patient's words without probing their underlying meaning. He does not appear to possess sufficient authority to establish an alternative discourse, a kind of counterpoint to the patient's account. The writer is face with a dilemma. To avoid being consumed by the patient's words, the writer may deliberately use (unduly rigid) formulations such as 'I give the patient time and space'.

There is considerable variation in how the patient's words are recorded. Sometimes quotation marks are used, but often in a hybrid form in which 'he' rather than 'I' appears as a direct quote. In one record, the writer is meticulous in recording the patient's account for a brief period. For example, he distinguishes between 'verbatim quote' and 'quoted from memory'.

An external reader may be struck by the writer's lack of situational authority. For instance, asking a patient to do something as routine as putting away their mobile phone during meals is pointless. A formal decision must be made – a multi-page one at that – stipulating that mobile phone use is to be limited to a certain number of hours per shift.

'Eating is sensible', the patient is told, 'but the choice is yours'. Why does the writer feel compelled to add this qualification? Perhaps it is considered essential in this patient–clinician relationship to avoid any hint of correction on the clinician's part? It seems reasonable to assume that the writer could make perfectly ordinary, self-evident statements, such as that eating is sensible, without compromising the patient's autonomy.

The patient and clinician are repeatedly noted to have agreed that it is important to get enough sleep. However, in a subsequent conversation, the patient might report experiences and activities that clearly reflect a lack of sleep, and the record does not refer back to the earlier agreement. The author seems unconcerned by this inconsistency.

Patient versus writer

We often observe that the picture painted of the patient changes when there is a change of clinician. 'The patient appears irritable and quarrelsome', asserts a new clinician. A doctor who was also present, however, assesses the patient as being in their usual state: 'Slightly irritable and cranky, as already established, can fluctuate somewhat'. The doctor qualifies their impression, but later entries in the record give increasing prominence to the quarrelsome and irritable behaviour, which is also reflected in the ward staff's observational notes. The question is whether the patient has actually changed or whether the new perspective on the patient is more critical. Perhaps a dynamic interaction is at play: does the patient become like the picture being painted of him? Or has he changed enough to justify the new perspective?

In another very extensive record, the patient is characterised in every single summary as someone with 'no insight into their illness'. Strikingly, the record then suddenly arrives at a diametrically opposite conclusion: 'The patient appears to have good insight into their illness'. This is repeated the next day and remains unchallenged. A few days later, the patient is again described as lacking understanding of their own condition. This patient is considered to have good insight into their illness for just a few days of their long 'hospital career'. Viewed against the vast amount of text stating the opposite, these statements are lost. The medical record genre thus appears to be based on quantity rather than quality.

The pursuit for a diagnosis

Most medical records are intensely focused on arriving at a diagnosis. The norm is that 'everything' is reported at the outset and reiterated with every change in treatment, but in one record, new information about the patient's earlier life continues to emerge over time. However, this record is relentless in its pursuit of a diagnosis:

'The final diagnostic assessment of the structured evaluation has not been concluded at the time of discharge, as it was deemed at the section's diagnostic meeting [date] that a further review would be needed to reach a diagnosis at the diagnostic meeting [date, one and a half months later].'

When the final diagnosis is eventually established, it is identical to the initial tentative diagnosis. By that point, the patient has long since been discharged.

We have also seen examples of the opposite tendency. In some records, multiple different diagnoses are given without markers of uncertainty. Later entries may simply repeat these diagnoses verbatim, but sometimes additional or fewer diagnoses are recorded, without any explanation for the discrepancies.

One record appears to push the diagnostic focus into the background: 'Questions regarding psychosis may be more reliably answered by assessing the patient's level of functioning, as revealed when the patient returns to work'. The writer subsequently emphasises explicitly that *functioning* is more important than *diagnosis*.

Everyday life

Occasionally, small, concrete glimpses of everyday life emerge, such as the enjoyment of feeding the horses on the hospital grounds, the pleasure of having baked a cake that everyone liked, or walking trips in the area:

'The patient is tasked with setting up a lavvu [similar to a tipi] and making tomato soup on a fire [...]. He takes the initiative to gather all the utensils for making the soup and begins mixing the contents of the packet with water. He finds it challenging to estimate the amount of water using soda bottles as a measure.'

In such brief notes, tangible aspects of everyday life emerge. For a moment, the record offers a pause from the focus on mental illness. We see the patient as more than simply a patient. It is predominantly the ward staff's observational notes that convey the ordinariness of everyday life. However, the writer of the clinician's notes rarely engages with the interests and positive experiences identified by the ward staff, which also form part of the hospital stays.

The asylum as an immanent idea

In many of the records, a potential discharge date is suggested upon admission. The date might remain the same, almost independently of the description of the patient's clinical course. It is not uncommon to see a new admission soon after discharge, with a new discharge plan immediately initiated, and no consideration given in the record to the accuracy of the previous plan.

The word *asylum* does not appear in our material. Yet in several records, we see glimpses of the patient unconsciously experiencing the institution as a 'safe, protected place', in line with the dictionary definition of asylum. An otherwise utterly despondent patient is described as enjoying games, conversations and walks: 'He seems to enjoy himself'. And he summarises it as follows: 'It's nicer here than at home'. It is particularly in the ward staff's observational notes that the idea of asylum is observed. For a few moments, the perpetually intense pursuit of a diagnosis and the equally intense underlying discharge plans are temporarily put on hold.

Fear of contact

Patients' families also feature prominently in the medical records, with their perspectives clearly documented. There is an underlying tendency for the family's attitudes to be presented as normative for the patient. In the material, there are only a very few instances in which the writer suggests that more distance from the patient's closest relatives might be valuable. Far more common is the admonishing formulation: 'The undersigned states that it is important for the patient to be honest with their parents'. The patient in question lives under a strict family regime and has shown tentative efforts to make their own life choices, which raises the question of what considerations underlie the journal's paternalistic phrasing, given that the patient is an autonomous adult.

Some records indicate that the family plans to find a spouse for the patient in their parents' country of origin, an arrangement in which the patient shows little interest. In common public discourse, such behaviour is associated with the concept of *forced marriage*. The writer does not appear to explore this sensitive issue further. (Re)establishing a good relationship with the family takes precedence over the patient's tentative efforts to maintain a distance.

A patient from a strictly religious family fears that her family will discover that she is no longer a believer and is anxious about the consequences of them finding out. Through her words, the patient expresses profound existential suffering, a total lack of belonging, and a strict religious family, whom she loves but cannot communicate with. The note ends there. It is as if the writer records a verbalised expression of suffering but fails to acknowledge it. The record responds in its usual way: with silence (4).

Discussion

It is surprising how little has been written about the patient medical record, which is a key tool for healthcare personnel (15).

In recent years, narrative medicine has gained ground as a field, both in research and in healthcare education. Considerable attention has been paid to the central role that storytelling plays in the interaction between patient and clinician (16).

Our analysis does not have this pragmatic approach. Our object of study is the text itself: neither patients, diagnoses nor clinicians are of intrinsic interest in this study. We read and re-read the texts in the tradition of close reading and the structuralists' further development of the concept. Identifying the passages that we found to be representative and worthy of further discussion was time-consuming, and presenting such a large volume of material within the scope of an article has been a challenge.

A strength of this study lies in the composition of authors, which includes healthcare personnel and a literary scholar. All are researchers within their respective fields. Nevertheless, we experienced the challenging nature of reconciling these two cultures. As early as 1959, C.P. Snow (1905–1980) observed that the scientific and humanistic cultures are sharply opposed: they do not understand one another and are unable to communicate, he argued (17). His ideas are frequently cited in discussions on the difficulties of interdisciplinary research. During our analytical work, we became acutely aware of how differently our scientific perspectives could manifest. Yet it was also gratifying to find that, in our work, we did not ultimately have to agree with Snow.

All the medical records consisted of an overwhelming volume of text, much of which was verbatim repetition from a few pages earlier. Within this mass of text, however, we discovered that the apparent repetitions could conceal inconsistencies and contradictions. New information would appear only to disappear again, without the record reflecting on its conflicting statements. At times, the text gave rise to an inherent unreliability. Coherent interpretation was impossible when, in almost the same place, the reader encountered statements such as: 'He has no friends' and 'Friends visit him regularly'.

The cut-and-paste technique was frequently used in our material. However, the technique is never commented upon. There is no trace of reflection on the technological tool itself (18). This is somewhat surprising given that research articles were already claiming in the 1960s that fully automated medical records were 'just around the corner' (4). Several decades have passed, yet in our material there is no indication that the written medical record is about to disappear.

We are now likely facing a major change in the way patient records are kept. Artificial intelligence has already been introduced in general practice, where journal notes are generated automatically during consultations (19). Similar systems may be introduced in psychiatric hospital clinics. This will open up many new possibilities beyond those described in this article. However, there is also a need for clinicians to reclaim medical records. In our study, the patient record often reveals the writer's sense of powerlessness.

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