- 8 Acheson ED. Edwin Chadwick and the world we live in. *Lancet* 1990;336: 1482-5.
- 9 Office of Population Censuses and Surveys. *Classification of occupations, 1980*. London: HMSO, 1980.
- 10 McCullagh P, Nelder JA. *Generalized linear models*. London, New York: Chapman and Hall, 1983.
- 11 Baker RJ, Nelder JA. *The GLIM system: release 3.77*. Oxford: Numerical Algorithms Group, 1978.
- 12 Aitkin M, Anderson D, Francis B, Hinde J. *Statistical modelling in GLIM*. Oxford: Oxford University Press, 1989.
- 13 Wilcox AJ, Russell IT. Birthweight and perinatal mortality. III. Towards a new method of analysis. *Int J Epidemiol* 1986;15:188-96.
- 14 Morris JN, Heady JA. Social and biological factors in infant mortality. V.

- Mortality in relation to the father's occupation, 1911-50. *Lancet* 1955;i: 554-60.
- 15 Pharoah POD, Morris JN. Postneonatal mortality. *Epidemiol Rev* 1979;1: 170-83.
- 16 Brooke OG, Anderson HR, Bland JM, Peacock JL, Stewart CM. Effects on birth weight of smoking, alcohol, caffeine, socioeconomic factors, and psychosocial stress. *BMJ* 1989;298:795-801.
- 17 Malloy MH, Kleinman JC, Land GH, Schramm WF. The association of maternal smoking with age and cause of infant death. *Am J Epidemiol* 1988;128:46-55.

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Patients' access to their own psychiatric records

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The Access to Health Records Act 1990 takes effect on 1 November 1991.¹ From that date people will have the right of access to their own manually held health records, but not to information collected before that date. Whether we need to alter what we write might depend on what patients think of what we write now, and we decided to elicit patients' opinions about psychiatric case records as currently compiled. We also wished to see whether adverse patient responses depended on diagnosis or demographic details such as social class.

Patients, methods, and results

We recruited 72 general adult psychiatric outpatients who were consecutive attenders at a small district hospital. They first rated the routine face to face clinical interviews they had had and then the main written clinical summary about themselves which had originally been sent to their general practitioners. There were matched questions concerning understanding, accuracy, omissions, upset caused, wrong emphasis, opinion on access, helpful information, and outlook. Thirty two patients were posted their inpatient summary, 31 the outpatient letter that had been written after their first attendance, and nine a domiciliary visit letter. Patients did not have access to other parts of their records.

There were 48 women and 24 men, and their mean age was 46.8 years (SD 14.5). Most of our questions had five options, and we regarded a rating of the two most favourable options as indicating a "favourable" response. For their main written summary patients gave favourable ratings for most questions—for example, all 72 patients for understanding what had been written, 69 (96%) for wrong emphasis, 64 (89%) for omissions, 61 (85%) for accuracy, and 55 (76%) for having been granted access to the information. Only 37 patients (51%), however, rated the written assessment as having provided helpful information, and 20 patients (28%) were upset by what they had read. The most pronounced contrast with ratings of the clinical interview was that only three patients had been upset by what had been said at the interview (Wilcoxon matched pairs test: $z = -3.25$; $p = 0.0012$).

Upset caused by the written summary was significantly associated with younger age, unmarried state, lower social class, and a diagnosis of non-affective functional psychosis (table). As some of these variables were interrelated—for example, those who were single were younger—they were entered into a stepwise logistic regression. The model gave a reasonably good fit. Adding age caused a significant improvement in fit (improvement in $\chi^2 = 5.62$; $df = 1$; $p = 0.018$), as did adding diagnosis (improvement in $\chi^2 = 5.85$; $df = 2$;

Diagnosis and numbers of patients giving favourable* ratings

Diagnosis†	No studied	No (%) not upset by written summary
Affective illness	45	36 (80)
Alcoholism and miscellaneous	13	10 (77)
Non-affective functional psychosis	14	6 (43)
χ^2 test ($df = 2$)		7.52‡

*"Favourable" means patient chose one of two most favourable options for question.

†Diagnoses were according to Research Diagnostic Criteria but were condensed into three categories.

‡ $p = 0.023$.

$p = 0.054$). For a given age a diagnosis of non-affective functional psychosis was more likely than the other two diagnoses to be associated with an unfavourable rating on upset caused. The probability of a favourable rating increased as age increased. Whether patients initially were or were not in favour of seeing their records made no difference to subsequent ratings of the written assessment.

In a follow up study we contacted the 30 general practitioners whose patients had been recruited. Only three of the 72 patients had spontaneously discussed the written assessment with their general practitioner, who in each case rated the effect of the patient having read the letter as "beneficial" (other choices were "neutral" and "harmful").

Comment

The few reports that there are about the consequences of patients having access to their medical records, though dispersed among different specialties, are mostly sanguine. Our finding that only about half of patients thought that the written summary provided helpful information agrees with a study of rheumatology outpatients,² in which 20 of 42 patients gave a favourable rating for the amount of information provided by the physician's letter and there was a preference for discussion with paramedical staff. No study has systematically examined the influence of demographic data and diagnosis. We know of only one study which examined patients who requested to see their records as opposed to research recruits who were sent information without their having asked, and more problems were recorded.³

Although the act specifies that "health professionals" can deny patients access to their records if "serious harm to the physical or mental health of the patient or any other individual" would be caused, the act does not define what "serious harm" is. Would being made upset or pessimistic about the future count?

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1 Access to Health Records Act 1990. London: HMSO, 1990.

2 Gill MW, Scott DL. Can patients benefit from reading copies of their doctors' letters about them? *BMJ* 1986;293:1278-9.

3 Altman JH, Reich P, Kelly MJ, Rogers MP. Patients who read their hospital charts. *N Engl J Med* 1980;302:169-71.

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