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Medical Records: What Should it Contain?
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Last week, we discussed the history of medical records and we implied that medical records are important in indicating the quality of healthcare which you receive. Almost all of the measures of quality in healthcare today relate to the quality of medical records. In addition to being a record of the facts of the care which you have received, the medical record also demonstrates both the process of the medical-decision making which took place in your encounter with your health care provider and the medical record reflects the analysis which your provider undertook in arriving at a recommendation for your health. Sometimes that process and analysis is straightforward and simple. At other times, it is complex and convoluted.

The complexity of medical-decision making, even in straightforward and simple cases, has grown in the past fifty years. The amount of information which a healthcare provider needs in order to be able to make valid recommendations to you about your health has grown, also. It is this information which dictates what should be in your medical record. But, more than being in your record, the information must be accessible and it must be able to be brought to bear on the medical-decision making process every time you are given advise and/or counsel by your doctor, nurse practitioner or physician's assistant.

Take for instance, the simple case of a minor respiratory infection. While the complexity of the problem is straightforward, a large amount of information is needed in order to properly care for you. First, any drug allergies which you have must be foremost in the providers mind. While this seems so simple, and it is for one patient, how do you know the drug allergies of 10,000 people? And, particularly, how do you have that information easily and readily accessible every time you see the patient. Second, you need to know what other medications the patient is taking, if any. Perhaps more than medications an individual patient is allergic to is the knowledge of the interactions of all the drugs a patient is taking. This is a daunting task when you realize how many thousands of medications are available today. Third, before you can prescribe a medication, you must be certain that the patient does not have a pre-existing condition, such as glaucoma, which would require the patient to avoid certain classes of drugs. Fourth, your medical record should reflect your the medications with which you have been treated previously. The expense of pharmaceuticals today is such that few of us can afford to waste our money on a prescription which we know did not help us before.

Therefore, at the least, your medical record should reflect:

1. Your current active medications.
2. A list of all medications with which you have been previously treated.
3. A list of chronic conditions for which you have been and/or are being treated.
4. A review of all of your medications indicating that they have been checked for

drug/drug interactions.

5. Your history of allergic reactions to medications.
6. An interactive list of chronic conditions and the drugs which should not be used in those conditions.

If your life were static -- not changing -- these would be relatively easy pieces of information to gather once and then maintain. Unfortunately, your life is dynamic and it is always changing which complicates the task of maintaining this information.

In thinking about records -- whether medical or other -- it becomes obvious that paper progressively becomes a less desirable means of maintaining medical records. For instance, even though you may accurately record a patient's "medication list" on a piece of paper, it just sit there an looks at you. Line one of the medication list does not interact with line two. This brings us to the critical issue for your medical record: it must be dynamic and interactive. Your drug allergies must interact with your current medication list and with the list of medications from which your doctor is going to select your new prescription.

It is this "interaction" which allows the "data" -- the raw facts recorded in your patient file -- to become "information" -- relevant, related and useable sets of data -- which can be used in medical "decision making." It is this process of "data" becoming "information" becoming "decisions" which has driven "data processing" to the point where we have interactive records -- records where one part or subunit of the record can be checked against or automatically related to another part or subset of the record. This is the challenge, need and demand of medical records in this new millennium. It is the challenge which 19th Century technology, pens, pencils and paper, cannot meet. This is why in addition to the elements which your medical record must contain, the nature of that record must change. It can no longer be static, just residing on paper, and it can no longer be bound by the walls of a clinic, locked up and unavailable after office hours. The medical record must be interactive and it must be accessible twenty-four hours a day, seven days a week.

The nature of medicine has changed and it is unlikely to return to where it was before. In the 20th Century, patients selected a health care provider and stayed with that provider through dozens of changes in insurance companies. Due to the complexity of healthcare delivery today, in the 21st Century, it is more likely that patients will change doctors several times in their lives because of the requirements of the insurance which they and/or their company purchases. This "mobility" of patients between one doctor and another increases the value and importance of medical records.

First, it means that your new doctor needs to be "brought up to speed" quickly on your past medical history. And, because the physician does not know you well initially, she/he must be able to review your past medical history quickly and efficiently, every time you see the doctor no matter how trivial the reason is for your visit. Second, this patient mobility means that it is imperative that other pieces of data, such as your family history, which can be extremely important in predicting the conditions which you may encounter in life, be easily available every time you see the physician, nurse practitioner or physician assistant. Preventive health initiatives are driven both by issues which apply to everyone, i.e., immunizations, etc., and by issues which are unique to individuals, the health of your mother and father. Third, your medical record should reflect non-visit contacts with your healthcare provider's office, such as telephone calls, including who called, when the call was made and what the call was about, in addition to what the response to the call was.

This means that your medical record should also include:

1. Your past medical history and it should include it in such a way that it can be reviewed by your healthcare provider frequently.
2. Your family history, particularly documenting those conditions which have predictive value for illnesses which you may face in the future, .i.e., diabetes, maternal breast cancer, colon cancer, hypertension, and heart disease to name a few.
3. An ongoing record of your immunizations and preventive health care initiatives such as medical screening examinations and periodic follow-up of chronic illnesses. Again, this record must be easily reviewable by the provider and it must be well maintained in order to accurately reflect that your quality of care is being maintained.
4. Your medical record should also reflect all your contacts with your healthcare provider, by telephone, e-mail, letter or fax.

This is an impossible task with a paper-based record. But, it is imperative if you are to receive 21st Century healthcare. And, while this brief discussion has shown the complexity of medical record keeping, it has not yet addressed the need for accurately documenting the patient visit to the healthcare provider. That visit must be captured in detail to include at least the following:

1. The Chief Complaint -- why are you at the doctor's office?
2. The History of Present Illness -- the duration and details about your Chief Complaint.
3. Evidence that all of the ten issues above have been reviewed and that the data contained in that review has been brought to bear on the medical-decision making process taking place in the current visit.
4. The Review of Systems -- an extensive set of questions about your general well being and about specific body systems designed to further clarify the nature of your illness and/or condition.
5. The Physical Examination
6. The Assessment -- the doctor's, the nurse practitioner's or the physician assistance's diagnosis.
7. The Plan of Care -- what is going to be done for you or to you, along with follow-up instructions.

For your medical record to be complete these things must be in that record. And, while the medical record is maintained by your healthcare provider, because it is your property, you have the right and the responsibility to make sure that all of this information is in your medical record and that it is accurate and complete.

Next week, we will continue this three part series to discuss confidentiality of medical records in the new electronic age. Medical records are more important to you today than ever before in your life or in the history of medicine. Remember, it is Your life and it is Your health.