

## THE CORE MEDICAL RECORD: SEEING THE WOOD AND THE TREES\*

There is nothing new about medical records, as doctors have always kept some kind of *aide memoir* about the patients they have seen. However, the increasing complexity of medicine, the growing need for long-term care of chronic illness, and patients prepared to take legal action to redress inadequate care have all focused on the need for good record keeping. Medical records have been an interest throughout my professional life, and the views in this article are a product of that interest.

### THE PROBLEM

Few disagree that good medical records are intrinsic to good medical care, and the implication must be that poor medical records make good medical care more a matter of chance than intention. This is particularly the case where limitations on doctors' working hours, as with the European Working Time Directive, limit continuity of care, and in chronic disease where care over prolonged periods often involves several doctors. Unfortunately, anyone working in a hospital, or reviewing records for legal reasons, knows that standards of medical record keeping are often poor. For anyone who thinks otherwise, the reports of the Audit Commission (1995), the Kennedy Report on the Bristol Enquiry (2002), and the Royal College of Physicians of London's Health Information Unit (2003) make sobering reading.<sup>1</sup> Lack of structure, disorganisation, illegibility, absence of problems or diagnoses, and undated or unsigned entries were just some of the deficiencies found. Furthermore, this is not a problem peculiar to the UK. Wilson *et al.* found half the medical records reviewed in Australia had a serious deficiency;<sup>2</sup> Rodriguez-Vera *et al.* found 15% of the records reviewed in Spain were so illegible they were rendered meaningless;<sup>3</sup> and Birchard reported that the Irish Ombudsman told an Irish parliamentary committee that some of the medical records referred to him were 'atrocious'.<sup>4</sup> To put this situation right, we need to agree on the purposes, structure and content of medical records.

### THE OBJECT

The first, and most important, purpose of the medical record is to document the assessments underlying the progress of a patient's care and so contribute to the quality of that care. The evidence on which decisions have been made should be recorded as well as the decisions themselves, and it should be done in a way that can be communicated readily to those caring for the patient at any particular time, so ensuring good continuity of care. Medical records that achieve these objectives contribute

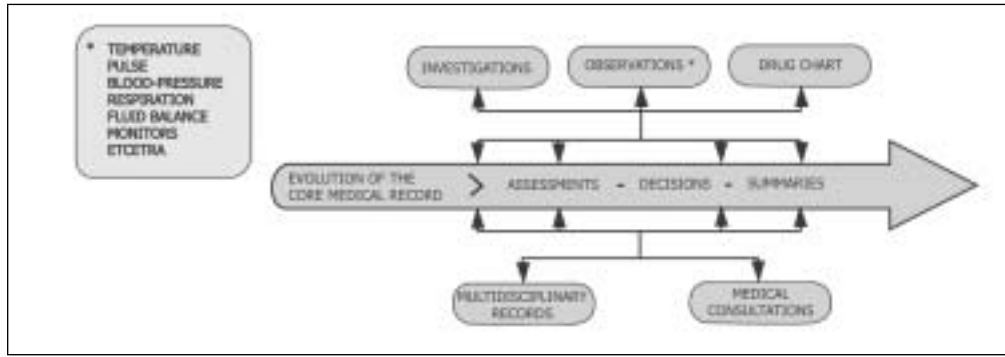
to good medical care in a very obvious way, but they also contribute in a less obvious way. Writing up a medical record is an important contribution to a doctor's self-education and personal audit. Making a clear assessment of a patient's clinical condition and interpreting the results of investigations in making decisions requires that doctors clarify their views before they can be written down. This is in contradistinction to the easy fudging of views in unrecorded discussions. Furthermore, as the patient's illness evolves, careful records allow outcome to be compared to earlier test results and clinical decisions and prevents hazy and malleable memory coming to the rescue of poor decision-making! Unfortunately, writing clear English is not a natural gift but a skill that needs to be taught and learned. This should start receiving the kind of attention in medical education it has not had up to now.

There are several other objectives to be achieved in medical record keeping, and they are important but secondary to supporting directly the care of patients. They include the use of records in audit and research, for assessing factors such as quality, in planning services, and their value as medico-legal documents. The latter should commend itself to doctors, as was stressed by a medico-legal adviser who said, 'We cannot stress enough the importance of clear, concise contemporaneous notes which serve primarily to enhance patient care but are also useful in protecting a doctor's interests.'<sup>4</sup>

### THE CASE RECORD

A good medical record needs to make information central to continuing medical care readily accessible. This core comprises the assessments, decisions, progress notes and summaries that describe the continuity of the patient's care (see Figure 1). Particularly important are comprehensive records of the clinical assessments at first contact with the patient or at times of new developments in a chronic illness. They include the history, whether from the patient or others, and the physical examinations, and they need to lead to a statement of the patient's problems, the possible medical conditions underlying them, and decisions on how these problems are to be addressed. It is unusual for even the best investigative technology to rescue the adverse consequences of an inadequate clinical assessment or an inadequate clinical record. Summaries are also very important; these should not be restricted to discharge summaries after hospital admissions but should also be done at intervals during long-term follow-up.

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**FIGURE 1**

Information on which the core record depends – investigations, observations, drug charts, multi-disciplinary records and medical consultations – should be kept separate from the core record itself but should be available readily (see Figure 1). Whether this can be accommodated in a single volume or requires more volumes depends entirely on the complexity and duration of the medical care. Many case records currently include all written records in a single continuous narrative (multi-professional records), but my experience is that this breaks the continuity of the patient's care and makes the record difficult to read and to comprehend.

## THE STRUCTURE

Consideration also needs to be given to the structure of the components of the medical record, and this applies particularly to recording the clinical aspects of medical care. It is now some 40 years since a UK Ministry of Health report (Tunbridge Report) proposed that medical records be standardised and provided forms that are still in use, and since then several studies have found that structural forms can improve medical records with benefit to patients and doctors.<sup>1</sup> Currently, the Health Informatics Unit of the Royal College of Physicians of London is developing evidence-based standards for in-patient record keeping, and the continuing need for these reflects the limited extent to which structured record keeping has been adopted in practice. Structured forms can improve record keeping by making the recording process easier, by making information readily identifiable, and by acting as a memory prompt when items of evidence have not been collected. Why then have structured records not been accepted more widely? Patchy enthusiasm for record keeping and frequent lack of ready availability of forms when they are needed are important factors, but standard forms often fail to meet the heterogeneous needs of the whole spectrum of medicine. In general, standardised forms work best in well-defined or specialist areas of medicine, though such forms may pay scant regard to wider general medical factors. Perhaps the future of standard forms for medical records will depend on the production of care standards that can be adapted and elaborated to local or specialty needs. However this may be, standardised forms need to leave adequate space for free writing in order to accommodate the infinite variations encountered in clinical medicine.

## THE FUTURE

The increasing complexity of medical care and the likely growth in importance of the secondary objectives of medical records mean that good record keeping is likely to become more important and more difficult in future. Much is expected from the application of information technology to this problem, and indeed, the potential benefits are considerable. Weed pointed out long ago the major clinical, education, training and research gains are to be acquired from radically improved records, but it has been accepted that these could only be achieved by harnessing the power of computers.<sup>5</sup> However, on the 'rubbish in, rubbish out' principle, the benefits offered by information technology can only be realised by much improved record keeping now. How is this to be achieved?

Better education and training would be the standard, and correct, answer, but this recommendation in most instances pays only lip-service to the problem. Medical record skills could and should be introduced to undergraduate and postgraduate training purely by improving current training standards, and record audit should be part of training (and perhaps revalidation) assessment. Medical records and medical record departments have tended to have Cinderella status in the past; perhaps our Royal Colleges could do more to impress on our hospitals and on us as individuals that we are responsible for medical records and their place in achieving the ultimate objective of this college namely, the highest standards of patient care.

## REFERENCES

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