

In the present society we have come to appreciate the value of information and in fact a major part of the economies of industrialised societies are based and depend on processing of information. Most well-run businesses need to have a good information-base to stay alive in this competitive world. In the service organisations such as in clinical medicine information is the very soul of the practice. It is generally agreed that documentation of clinical

information is essential for the proper management of patients. This is obvious in the care of hospital patients and in those situations where several providers are looking after a patient. In general practice it had taken a bit longer to come to the realisation of the need to keep good records; and many general practitioners in ancient times hardly felt the need to do so, relying as they did on their well-trained memory. Even nowadays, many practitioners'

patient records do not have more form or content than a personal memo to jog their memories and assist them in their billings.

PURPOSE OF RECORD-KEEPING

In Primary Ambulatory Care, the physician usually takes on a patient for the long haul and 'contracts' to look after the future health care needs of the patient. The

patient record is the repository of all the information gathered over a period of time from various sources in one location. The doctor will then, having at his fingertips all the clinical information on the patient, be in a position to co-ordinate the management of any problems that arise. He will be able to provide a complete clinical picture, with the patient's consent, to other health care providers. In the case of absence, his/her replacement will be able to form an opinion, after consulting the record, of where the patient stands.

Continuity of care involves the bringing to bear of past experience with the patient on the current problem. The manifestation of symptoms and signs in a particular disease is oftentimes specific to the individual patient and tends to have similar pattern over different episodes. Many times we see patients, at about the same period of the year come with vague symptomatology which on consultation with the record show the onset and evolution of a recurring illness.

Information on sensitivity and response to treatments and medications, obtained from past experience, is valuable in the future care of the patient.

Baseline data on ECG, X-Rays, haematology, biochemistry, etc. produce a patient's own reference values for future comparisons.

Recording of risk factors, time of immunisations and revaccinations, screenings and special re-examinations will serve as reminder in monitoring the patient's health.

Patients are reassured and their confidence in their doctor increased when they know that their health record is in the safe keeping of their medical practitioner.

The totality of patients' records in one doctor's practice is a rich source of clinical information

for epidemiological studies and research interests.

Completion of forms on patients for purpose of disability reporting, pensions, insurance, transfer of patients, admission to nursing homes, social service applications, etc. is an on-going activity of today's general practitioner and requires the backup of well-kept records.

As more third parties become involved in the health care system, physicians are finding that they are accountable to more than their patients and are required to keep satisfactory records.

Auditing of practice records by self or by peers is a 'healthy' educational activity in the assurance of maintaining standards.

CONTENT AND FORM OF RECORDS

There are several systems of record keeping, almost as many as there are solo-practising physicians. One extreme consists of notes scribbled on 4" by 6" cards, placed in an envelope together with folded reports of consultants and investigations. The other extreme is the computerised complete medical record. And somehow we are finding ourselves drifting (willingly or cajoled) to the right side of this continuum.

Reluctance by doctors to be meticulous in this side of their practice has to do with the pressure of time on their hands, lack of education in their training, both in record-keeping and applications, preposterous illegibility of their handwriting and disorganised office management. There is a belief that good record-keeping is not essential for practising good medicine; but good general practitioners are very orderly in their thinking processes as usually reflected in the records they keep. Good practice records do not have to be voluminous and detailed to the extreme — in fact, too much information is most

distracting especially if presented in a disorganised state. The information is quite satisfactory if presented in item form, in a 'headline' type of style and in an acceptable abbreviation e.g.

36 yr. old female c/o
— headaches, 2/12 duration
— SOB, etc.

Many years ago, a group of health researchers met together in a conference with the view of defining an ideal health record. After many days of frustration they had to satisfy themselves with coming up with a consensus on what they called a "Minimum Basic Data Set" of components in order to achieve some degree of uniformity and comparability of ambulatory data. The content of the Minimum Basic Data Set is made up of 15 elements of data, divided into two categories: registration data and encounter data.

Registration Data:

- Person Identification
- Residence
- Date of Birth
- Sex
- Marital Status
- Race

Encounter Data:

- Place of Encounter
- Provider Identification
- Person Identification
- Billing Data
- Date
- Reason for the visit
- Assessment of the problem or diagnosis
- Management procedures, diagnostic or therapeutic
- Disposition of Patient

In our offices, on the first visit of the patient, registration data is collected by the receptionist on a card; together with the above data we ask for the health care number, home telephone number, business phone and we also find useful to have on hand the patient's pharmacy telephone number.

Very early in our acquaintance with the patient we

make arrangement for a general examination in order to start to form a baseline for assessing the health risk factors, personality characteristics and life-style on which we can formulate a plan for counselling on preventive measures and patient education. This information is collected on a separate general assessment form which is placed in a prominent place in the patient's file.

As the first page in the file, as an index to the rest of the chart, we have a one-page form, which is called the **Cumulative Patient Profile (CPP)**. This form is divided into several sections:

1. identification, address, etc.
2. psycho-social section for data relating to occupation, living situation, hobbies, etc.
3. past medical history, risk factors (including family traits)
4. allergies and immunisations
5. date of first visit, dates of general physical examinations
6. list of on-going long-term problems and diagnoses,
7. list of continuing medications
8. names of other health care providers and lastly
9. the name of the most responsible health care provider.

The CPP is started after the first few visits and is updated whenever a change of status occurs.

Information collected on regular office visits are recorded on a progress notes form in a **SOAP** format (as of Problem-Oriented Medical Record), **SOAP** standing for

Subjective — symptoms, reason(s) for the visit,
Objective — signs and results of the examination,
Assessment of the problem, diagnosis (es) and
Plan of management and disposition.

The rationale and adequacy for writing these notes involves a chain of justification going from step to step — (going backwards),

the patient was given a certain therapy for an assessed condition which was arrived at through an examination and history.

The progress notes form is a sheet of paper with the patient's name and age on top, vertically ruled in four columns — leftmost for the dates, next for subjective and objective data, then a column for the assessment/diagnosis and lastly for the management plan. This arrangement is found useful in reviewing past visits, as glancing down the columns one can tell easily the dates of the various problems and medications.

There are other useful forms used by other family physicians. One of them is the flow sheet for following up patients with chronic conditions such as diabetes, hypertension etc. These forms usually have a wide column on the left side of the page for writing down a list of clinical parameters that one is interested in monitoring, e.g. weight, BP, BS (Blood Sugar), urinalysis, recurring symptoms, such as headaches, dysuria, blurring of vision etc., biochemical values, screening tests etc.

The rest of the page is ruled vertically to enter various codes or check marks, headed by the dates of the visits. Glancing along horizontally across the sheet one can easily see the progress of the patient over time. There is no reason why one cannot make a general sheet for all kinds of patients who are seen on a regular basis. Other forms for special types of patients are widely used: prenatal forms, well-baby visit forms etc.

As one ages with one's patients, the charts tend to become thick, overflowing with information, and difficult to sort through. It is recommended that periodically, or at times of special events, such as on hospitalisation, referral to a consultant, etc. a synopsis or summary of the record be made. This practice will be found very useful when one wants to review a patient or has to fill

some third party forms. This is the equivalent of a discharge summary from hospital.

Designing a practical encounter form for capturing relevant information at each visit is very important nowadays for billing purposes and as we are on the verge of a computerised office, will also serve as a data entry form. As the legibility problems will in this fashion be overcome, we hope that the attention given to the quality of the information recorded will improve and will be self-rewarding in the feedback we will be getting from practice records.

SOME DEFINITIONS

Datum (plural **data**) is the symbolic representation of a factual characteristic about a patient: 50 Kg is the weight of the a patient, 30 years is the age, female is the sex etc. Data are gathered by a process of measurement.

Information is made up of the assertion or negation of a combination of data: has blue eyes, does not have a gall-stone, has systolic murmur, etc. and is usually of a derivative, comparative or referential nature: splenomegaly (mass in LUQ), severe pain, grade II/IV etc. Information requires some process of interpretation of the results of an examination done on the patient (expertise obtained during medical education).

Making an assessment of a patient's condition and arriving at a diagnosis is a complex act of **medical intelligence** which requires training and insight.

Patient record is the documentation and collection of information in a standardised mode for the purpose of the management of the patient.

Patient chart (file) is the paper collection of various forms, reports on one patient placed in one file. ♦