Patients should be able to add notes to their clinical record

Dr Oliver Frank
20 March 2017

THE ISSUE

Patients have their own agenda for what they plan or hope to do in a consultation, but most clinical software packages don't provide any means for them to enter this into their clinical record.

Instead, for most clinical software systems, GPs and practice nurses act as the patient's scribe, with an attendant likelihood of errors, bias, mis-emphasis and selective recording tailored to fit with the GP's or practice nurse's agenda.

Sometimes the patient's agenda or reason for consultation is not recorded at all.

The Health Engine online appointment system allows patients to add notes to their booking with their reason(s) for making the appointment, but those notes do not automatically become part of the patient's clinical record. As with all communications with or about patients, they should.

PROPOSED SOLUTION

Enabling patients to add their own notes to their clinical record about their reasons for making their appointment and about what they want do in the consultation will help GPs and practice nurses to avoid misunderstandings and to ensure they address all of the patient's concerns and needs.

VENDOR RESPONSES

MEDIRECORDS

Jon Marshall, Director

When using MediRecords, a patient can add notes to their own clinical record and in some cases enter clinical data using a smart phone app.

We see health as a two-way street where patients can engage more meaningfully with health professionals.

In turn, health professionals can interact with patients and monitor or seek to modify their health behaviours.

However the MediRecords patient management system does not go so far as to link any comments as a reason for the appointment. This kind of information would be added to the record by the doctor or practice nurse.

We have not seen any demand for patients to add specific details regarding their reason for the appointment.

In fact, we believe there may be resistance to this kind of feature, as it could result in potentially sensitive clinical information being shared with non-clinical reception staff when an appointment is being booked.

DOCTORS CONTROL PANEL

Dr Anton Knieriemen, Director

Involving the patient in the process of defining the agenda is a good idea. A possible approach could be that, at the time of making the appointment and/or on arrival, the practice automatically sends an SMS message that links to a secure website with a free text area for the patient's notes, as well as a summary of the patient's health, including preventive care status.

Check boxes could allow the patient to mark items of concern, including outstanding preventive activities, re-prescriptions and re-referrals.

At the start of the consultation, this information could pop up, allowing the GP to simply paste it into the patient's record, no matter what clinical system is in use.

VISUAL OUTCOMES

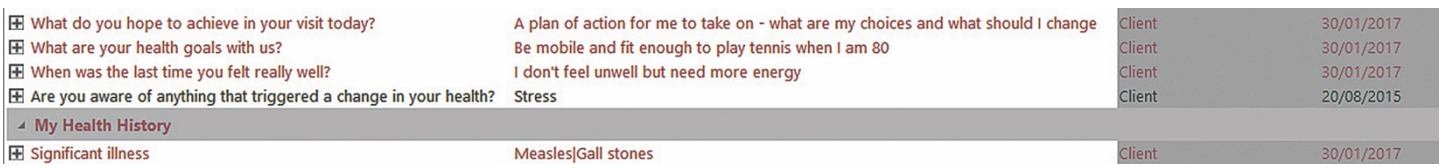
Peter Bunting, Executive Director

We agree that clinicians not working in tandem with client input miss opportunities for better outcomes, and not just in terms of a single visit agenda.

This philosophy of care has always underpinned the design of Visual Outcomes and its online client portal.

Patient-centric care goes beyond ethical concern for an individual's health management — an engaged patient is an active client.

Clients contribute directly to the file, visible to the clinician in session or anytime, separately identifiable from each clinician's notes and fully audited.



Clients may share health goals (pictured) for this session and generally, progressive satisfaction/QOL questionnaires, images of symptoms, compliance confirmation on medication/supplement regimes, interactive messaging and more.

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Dr Oliver Frank is a GP and member of the RACGP Expert Committee — eHealth and Practice Systems.

Comments

Fabulous idea so long as the patient is happy to pay for reading time with long and complex histories.
(This is a modern variant of the patient who arrives with a list ... which I also welcome... unless it is a LONG list and a SHORT appointment.)

*

If a patient presents with hand written or electronic notes, I would happily add it to the file.

*

This is ridiculous. Who has got time to read more notes. Perhaps made by a manic depressive during a manic episode or schizophrenic jargon or half demented person with dyslexia or even notes from a poorly educated individual. I would not want it to be part of my notes. If anything they could go into Correspondences In but not the clinical note section. Presenting scribled notes, which they make to remind themselves of the issues they wish to discuss is fine. Because mostly there is no exchange of money with bulk billing, they often think they can waste the doctor's time with trivial nonsense. If they had to pay for inclusion of the notes, perhaps $20 for every 100 words, which we would have to read and digest, then I submit that the notes would get shorter and shorter.

*

Patients may be allowed to add to electronic notes but should not have the power to remove what other people has written.

Medical records are still legally aide-mémoire of clinicians; whether electronic or paper form, patients has the right* to access them, makes notes of them and insert their comments and perspective or proposed correction to any mistakes they see.

*but not necessarily free, and certainly if they want you to certify whatever they printed out as true copy, the doctor should do due diligence and check the print out word for word with what is on the screen; and of course this time consuming task should be charged accordingly.

However they should not have the right to remove or modify the clinicians' entry.

*

That is exactly why we have history as part of the consult, right? To hear what the patient's reason is for making the appointment. Then we ask the patient further more questions about it and proceed with the rest of the consult.
If someone comes in with notes in their hands, after looking / reading the notes, I would gladly put that on the file.

*

I expect those that spend the time to amend and edit their own medical record, with addition comments etc will be precisely those patients that least need to do so.
Probably the 23rd item on a already over-long agenda or list of symptoms.
Those laconic individuals whom we wish would say more probably won't use their own notes to convey their feelings on a particular topic.
Typical RACGP touchy-feely garbage.

*

Patients can and do, it's called a written note and it can be scanned into the notes at our request. Not rocket science really.

*

Seriously?? Isn't that what part "the art of medicine" is- working out the patient's agenda(s)?

*

Although my first response was to vomit at the thought of what many patients would make of that opportunity, my considered thought is - why not.

It would actually transfer some of the responsibility for the outcome, when the history is vague or otherwise misleading.

If someone fails to mention rectal bleeding, I wouldn't mind having a record of what the patient thought they came for.

A simple way to limit abuse is to impose a character limit on the text window and have a tablet on which patients can type their presenting complaint into the system, then return it to reception. It surely doesn't take long to read 500 characters - and might even save typing out stuff for us.

It might limit the number of times the patient wishes to repeat their presentation (you know the classic, thank you for that script doctor, I've been so sick since it started on Monday and

[repetition of the entire history plus embellishment] - maybe typing it out might get it out of the system faster.

It may make more than a few people more certain that they've been heard and understood.

Triage will be a hell of a lot easier. Where I am at the moment (a remote location staring into a NZ winter), we are trying to triage infectious cases away from the waiting room. If one person here gets influenza, it will spread like wild fire. Patients are reluctant to say what they want to receptionists (and are asked), but they may not mind typing it out online.

Plus the odd entry like "sudden headache, really sore, can't bear bright light" could be yanked out of tomorrow's book and ordered in urgently.

Scanning notes is okay, but you can't copy and paste, and they take valuable space in image formats.

Yeah, go for it, boys.