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Chapter 1

The Patient Record: An Overview

It's About Sharing Information

Humans "cannot not communicate" (Watzlawick, Bavelas, & Jackson, 1967, p. 48). This axiom is central to our understanding of the audience's role in all types of communication. Everything humans do, wear, say, don't say, and write communicates to an audience. And, as communication scholars have noted for decades, it does not matter what the sender of a message intended to communicate, only what the audience perceives. The importance of this axiom with respect to this book is that everything a provider–author chooses to include or not include in his or her patient record communicates information not just about the patient's condition or treatment but also about the author. Therefore, understanding the critical role that audiences play in the communication of patient information is central to our work. As you know, professional schools are excellent at teaching future providers the necessary clinical skills to fulfill their particular roles; however, too few of these programs include authoring patient records as a core focus of their educational efforts. This book is intended to help you, either in a classroom, in a team, or individually, to improve your patient record authoring skills and to ensure that you understand what your documents communicate to readers about your patients and your ability and credibility.

Because the patient is the ultimate focus and raison d'être for all healthcare documentation–record keeping, this book will use the term *patient records*, not medical records, throughout. While it may seem an arbitrary, semantic distinction, in fact it is a biopsychosocial determination. Healthcare providers–authors need to consider the documents they create as primarily communicating information about an individual patient—an evolving record of a singular person's health. These documents, like all communication, are a continuous, flexible, history of a person's wellness, illness, or injury that may be used by countless provider and nonprovider readers. By emphasizing a patient-centered focus for

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these documents, it is the goal of this book to build on the current trend toward patient-centered (as opposed to provider-centered) health communication in all forms (verbal, nonverbal, written, electronic, etc.). In addition, if providers–authors adopt a patient-focused view of the records they create, they are much more likely to communicate more information about the patient, rather than less.

As we begin to discuss authoring patient records, we should understand the history of patient records in the United States. Requirements for maintaining patient records in America can be traced to this country's first hospital. Benjamin Franklin (1754) wrote a book describing the organization and construction of the hospital in Pennsylvania and documented the institution's only requirement for physician's record keeping:

> The practitioner shall keep a fair account (in a book provided for that purpose) of the several patients under their care, of the disorders they labour under, and shall enter in said book the recipes or prescriptions they make for each of them (p. 28).

Initially, the medical record served as a memory device for the patient's physician and as a source of information for other caregivers and the hospital's administrators. For nearly two centuries, these goals and uses for the medical record remained unchanged—it was primarily authored for readers within the author's institution. However, after World War II, the audience, purpose, and use for patient records changed dramatically.

Why would a change in the audience, purpose, and use matter to authors of patient records?

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With the postwar baby boom and the increasing shift in population, the patient record began to develop new audiences. These audiences were no longer limited to a single healthcare facility, but instead with the expanding ease of transportation, patients were moving around the country and, therefore, seeking medical care in multiple locales. So, the audience for patient records included future healthcare providers who might practice in cities that were hundreds or even thousands of miles from the record's author. And with this more mobile society, physicians (at the time, the predominant authors and users of patient records) began to demand access to patients' prior records. This change in audience, from only the author to a diverse possibility

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of readers, necessitated that records be more informative, rather than merely a cryptic memory device for the author.

In addition, with the creation and development of new, larger, and more geographically dispersed hospitals came an even more diverse and expanded audience for patient records. These new facilities brought an astronomic increase in breadth and scope of healthcare providers' roles, including physician assistants, advanced practice nurses, registered nurses, physical therapists, medical technologists, respiratory therapists, among others—all of whom needed access to a patient's health record. As the number of healthcare personnel involved in a patient's care increased, so too did the record's medical and extramedical audiences and the multiple uses for these documents.

How does the medical record impact the economics of healthcare delivery?

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As health care continued to develop and expand in the second half of the 20th century, health insurance companies were another audience requiring information about patients. In order for hospitals, clinics, offices, and healthcare providers to receive compensation for their services, insurance companies wanted access to patients' records. This new, extramedical audience created additional concerns for healthcare providers–authors. Suddenly, patient records were not being created to provide information just for other healthcare providers but also for extramedical readers with very different uses for the documents. The need to communicate patient information in a format that could be read and analyzed by insurers might have created too great a burden if the providers–authors did not get reimbursed for their services based on the communication of the medical information.

Why are patient records used by malpractice attorneys?

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Contributing further to the growing audiences, purposes, and uses for patient records were the exploding number of medical malpractice lawsuits. As patients complained about their outcomes from healthcare treatment, lawyers, for both the plaintiff (patient or his or her family or estate) and defense (hospital, institution, or provider), became a rapidly expanding new audience for patient records. However, with little or no course work in authoring patient records, healthcare providers frequently found themselves trying to communicate in patient documents not only the information needed by other healthcare providers and insurers but also information that would demonstrate the quality and effectiveness of the care provided for malpractice attorneys.

Furthermore, in the last decade, electronic forms of patient records have evolved and taken a variety of formats. Today, healthcare providers are communicating with and about patients in e-mails, instant messaging, and electronic medical or health records (EMR or EHR). And yet, few providers today are formally trained to author such unique and diverse documents. Nor are these authors educated about the additional risks attributed to creating electronic documents with their ease of dissemination and resulting privacy, regulatory, and legal issues.

The goal of this text is to help providers better understand the importance of the authoring process and how that process can be adapted regardless of the type of healthcare provider or the document or the required audience, purpose, and use. By understanding this process and utilizing it, an author can provide the information needed, in the expected format, and communicate clearly so readers can use the patient records as intended: to inform and persuade readers of the author's thorough evaluation, critical thinking, and credible decision making.

Skills Application

Ask a friend to tell you about his or her weekend or evening. After listening to the narrative, ask any specific questions you need to clarify your understanding of what occurred, where, and why. In the space below, document the story using quotes wherever possible for key elements and work to communicate the information as accurately, concisely, and clearly as possible. Your reader will be a peer (professionally and culturally).

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QUESTIONS

1. How did you decide what parts of the story would be important to your reader?

2. Did you find it difficult to determine what information to include and what to eliminate in your brief communication? What criteria did you use to make your decisions?

One of the most difficult tasks for healthcare providers is determining what information a reader needs to understand a patient's problem, the author's analysis, and the treatment plan. The author of patient records needs to meet diverse readers' expectations and still be clear and concise. The following chapters will help you better understand the needs of your audience and what information needs to be communicated to meet the readers' expectations and the document's purpose.

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