Peer Assessment Committee
College of Physicians and Surgeons of New Brunswick

Adequate Medical Records

For the Peer Assessment Committee (PAC), the evaluation of patient records makes up a major portion of the assessment process. It is, therefore, essential to have some understanding of what the standards for patient records are – or should be – and for the PAC to be able to communicate those standards to our assessors, those physicians being assessed and others in our profession.

Many of us would agree that we "know a good medical record when we see it." If, however, we were asked to justify our position, it might be difficult to articulate exactly what has shaped our opinion and more difficult still to communicate the specifics to someone seeking guidance.

For a PAC assessor to explain to a physician that the patient chart must inform the reader "why the patient came, what was found and what was done" is only a part of the story. We believe that an adequate patient record must also be an accurate reflection of the intellectual process which occurred during the office visit.

In an article from *Members' Dialogue*, a publication of the College of Physicians and Surgeons of Ontario, the four primary purposes of a medical record are noted:

- It saves the physician time in recalling details of the patient's history and allows the physician to monitor the progress of a patient's treatment.
- Colleagues and locums can use the record when called on to treat the patient.
- It is useful for medical-legal reference, such as enabling the physician to provide a patient with a comprehensive report relating to an illness or injury. It can also help a physician called upon to present evidence in court.
- The record can be invaluable when responding to inquiries regarding the treatment of a patient from Medicare or a Medical Regulatory Authority, or in a legal action against the physician.

In "general", **a patient record should stand on its own as a chronicle of patient history and care, providing the reader with an understanding of how and why certain decisions were made – the intellectual process noted above. The overall content of a quality record should provide a clear and accurate guide which will enable an incoming physician to assume the care of that patient without hesitation and without difficulty.**

The "specific" contents of a quality record are harder to establish, although both regulatory bodies and Governments have determined certain basics which are either suggested or (in New Brunswick and elsewhere) form part of the regulations of the College of Physicians and Surgeons.

Based on a compilation of data gathered over the years, the minimum information required includes:

- the name, address, date of birth and sex of the patient
- the date of each visit in which the patient is seen
- an adequate patient history for each visit
- the particulars of each physical examination, including the significant positive and negative physical findings
- a diagnosis or provisional diagnosis
- investigation orders and the results
- the treatment prescribed, any referrals made and the plan of follow-up

Additionally, based on many years experience, the Ontario peer assessment program recommends that:

- the identity of the patient be clearly evident on each component of the file
- hospital summaries, pathology reports, operative notes, etc be retained by the physician; or that appropriate relevant information be extracted, documented and retained
- a system be in place to ensure - and provide evidence that - investigative results, letters from consultants and so on have been seen by the physician. In a paper-based practice, initialling or marking the reports is appropriate; in an EMR practice, a notation of some kind should be electronically inserted into the file

Our own assessors would also add the following:

- the presence or absence of drug allergies should be clearly evident on the paper or electronic chart
- in the case of paediatric patients, the use of growth charts is recommended

While it is not mandatory, the PAC supports and strongly recommends the use of Cumulative Patient Profiles (CPP's) where relevant; and the Subjective Objective Assessment Plan (SOAP) format for progress notes. It is our opinion that these represent the most appropriate way to document medical information in both general and specific terms.

And - none of the above will have any bearing if the record is not legible. Paper charts must be clearly handwritten, printed or typed. In the case of electronic records, legibility is, of course, not an issue. Users of these systems must, however, ensure that their charts still contain the adequate documentation required – not too many shortcuts or abbreviations, please!