From the Editor

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Medical records

Criticisms of medical record-keeping are readily found: the Kennedy report on Bristol paediatric cardiology was highly critical of record-keeping practices; the Audit Commission has found much fault with medical record-keeping; and many medico-legal issues are hampered by the inadequacy of medical notes from both general practice and hospital. Indeed, almost any audit of clinical records quickly exposes their inadequacies, amply listed in the article by Mann and Williams in this issue:[1] prominent among them were omissions of diagnosis, follow-up, and communication with general practitioners (GPs). Yet maintaining high-quality medical records is clearly an essential part of good clinical practice: they are needed not only for good clinical communications, but also to build the complete picture required for appropriate diagnosis and treatment. So what can be done?

Medical records lie at the heart of communications in clinical practice – communications with patients, with other doctors in the hospital, and with GPs – and they are needed for audit and research.[1] It seems astonishing that hitherto there have been no set standards for medical records, and no criteria by which to judge them. These issues are now addressed by Mann and Williams[1] who are piloting new standards for record-keeping for inpatients (available in draft form on the College website at www.rcplondon.ac.uk/college/hiu/recordsstandards). They advocate structured medical records, which have recently been shown to be much more efficient than conventional methods of writing case notes.[2]

Confidentiality of medical records is a key requirement for maintaining a professional relationship with patients. It also allows physicians to share a frank analysis of an entire case with patients' GPs. In earlier years, this confidentiality was protected by physicians who themselves held their patients' records; hospital records are now the property of hospital NHS trusts. Access to medical records (regulated by the Data Protection Act of 1998) was only relatively recently permitted to patients who can now see their own records and read the content of letters between doctors, leading to the current practice of sending copies of the letters to the patients themselves. Such openness now seems right, although not all patients want to read an analysis of their condition. Also, doctors' awareness of the patient as a recipient must surely inhibit this important act of recording and assessment.

Continuity of care, already at risk in the current climate of shortening working hours, is heavily dependent on good case notes. Comprehensive medical records are therefore particularly necessary to describe the evolution of both acute illness in hospital and chronic illness over many years in hospital and/or general practice. This type of record keeping is often poorly performed and has been little studied. However, careful record-keeping over many years on those with chronic diseases provides a unique opportunity to gain deeper insights into patients and their illnesses. Such records can 'capture individual human lives as they change and as they age, finding some meaning in the random events that happen in them'.[3] William Osler described the importance of reflection and the value of 'note-taking',[4] while the great clinician, Professor A Trousseau (1801–1867, Professor of Medicine in Paris) published a series of masterly case descriptions ('the face was flushed, the eye expressionless, and the brain empty'),[5] showing how meticulous attention to detail enhances understanding of patients.

Will the new world of the electronic patient record lead to the disappearance of high-quality

clinical descriptions in cyberspace, and to the loss of shrewd clinical insights in favour of hard technological datasets? One forensic physician believes that such deficiencies may become an impediment in medical negligence litigation and when medical evidence is needed in criminal cases.[6] The drive by hospital trusts to train doctors and nurses to write better notes should therefore be applauded.[7]

The debate on good clinical record-keeping is only just beginning. The production by the College of a structured programme for training senior house officers in standards for medical records[8] represents an important initiative in this key area of clinical practice.

References

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