

Why not let patients keep their own records?

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ALL the information held in the medical record pertains to the patient concerned and could therefore be said to belong to him or her. Why not let patients keep their own records?

The operational reasons for doing so are compelling:

1. In many surgeries about 10 per cent of the attending patients' records cannot be found.
2. Most doctors do not take records on home visits, let alone on out-of-hours calls.
3. Records take ages to arrive from the family practitioner committee after a patient registers with a doctor.

Therefore, the patient's record is often unavailable to the doctor, particularly in emergencies. Yet if the record is of any value it should always be available, and especially in emergencies. If patients always had their records with them, none of the above circumstances would arise.

"Wouldn't the patient lose the record?" Well, very few women lose their co-operation cards, do they? Patients who are given responsibility act responsibly.

The administrative reasons for letting patients keep their own records are equally compelling:

1. Every thousand records take up 5 metres (17 ft) of shelf space in premises whose office and records areas are too small.
2. Expensive receptionist and secretarial time is taken up extracting records from the files and refiling them afterwards.

"But the records are full of things that the patient shouldn't see, things that will confuse them, or frighten them, or depress them." Are they? Most patients' records contain little information which is emotionally heavily charged, because most people are pretty healthy for most of their lives. Most patients who do have serious diseases do need to understand them if they are to co-operate with treatment: going through the contents of the record with the patient would be an excellent basis for discussing the illness with him. "But wouldn't the record have to be sorted out? We couldn't really let

our patients see the jumble many of our records are in could we?" Well, certainly the pejorative statements, the unsubstantiated guesses, and the injudicious comments in letters between doctors would have to come out. "Yes, but what about *cancer*, or *multiple sclerosis*, or even a note about suspicion of such diseases or the need to exclude them? Surely they mustn't see these?" Sooner or later they will know anyhow, but by then they will often have lost faith in the doctor's veracity if not his competence. Even at the stage of suspicion their fears are often the same, and sometimes worse, than his. As in chronic disease, sharing the record would probably deepen the understanding and working relationship between doctor and patient.

The central idea is that sharing the records symbolizes sharing the responsibility for health—an adult-to-adult relationship which protects or restores the patient's autonomy and dignity. Information is power: to have information about someone which he does not have himself is to be in a powerful, controlling position. This is typical of the adult/child relationship, but inimical to the adult/adult relationship we should be developing with our patients.

How would one go about it?

1. Discuss with each patient seen whether he would like to keep his own record.
2. If he would, review it for tidiness and completeness.
3. Give it to the patient at the next visit and make time to agree the problem list with him.
4. Ask at the next visit if he wants to add anything or alter anything. (It is possible that quite often valuable information would be forthcoming.)
5. Papers such as laboratory reports and consultants' letters would be held for filing or typed onto self-adhesive labels to await the patient's next visit, when the results would be given to him and the label affixed to the record. Residual reports would indicate defaulters.

If this were done there would be space in which to put a small computer and staff time to run it. If it ran the practice age/sex index and FP1001 register it would probably earn its keep and could also be used to run the repeat prescription routine, a disease register, and some other systems too.

Well, why not?