Patient retained records—the health identity card

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SUMMARY. A system of patient retained health cards is described, with a view to improving the overall accuracy of medical records, patients' awareness of their health status and the transfer of records between doctors. Other systems of patient retained records in current use are discussed.

Introduction

WHEN was the last time that you saw a new patient and found it difficult to determine the medical history or current therapy? The patient said he or she had not been told and did not know? There are many instances where patient retained records would assist in transferring information to other doctors involved with a patient's care. The health identity card has been suggested as a way to help patients remember information about their past and present health problems and to help doctors to understand the problems of a new patient. This paper discusses the advantages of giving patients access to their medical records and presents an overview of similar systems in use.

Doctor retained records

There are several difficulties which can occur with the current system of doctor retained records. In many surgeries the records of up to 10 per cent of patients cannot be found.[1] Keeping a patient's records up to date, accurate and complete can be a great effort. Furthermore, when a patient is receiving care from several specialists it is important that all the doctors are aware of treatment received from other doctors. Most doctors do not take records with them to home visits, so that relevant past problems may be overlooked.[1] In addition, access to medical records after hours can be difficult. Patients travelling away from home find there are difficulties with a doctor who is unfamiliar with their medical history and duplication of previous investigations may occur.[2] There can be long delays in transferring medical records from one doctor to another, but many patients are unable to provide detailed information about their past health[1] and find it difficult to understand the medical jargon which is often used to instruct them about their medical condition and treatment.

Access to records

There is still a great deal of secrecy surrounding medical records both in hospital and general practice.[3,4] Much of the information in a patient's record is regarded as too sensitive or upsetting to the patient to allow him free access. Studies have shown that 50 per cent of patients discharged from hospital did not understand their illness and less than 30 per cent of patients could name the drugs they were taking.[4] The advantages of allowing patients access to their medical records have been proposed several times.[1,3-5] To improve patient awareness of their own medical problems and to improve compliance with treatment, Dr Weed has suggested that a patient could be told about all additions to their problem list and asked to countersign them.[6] Another solution is for patients to retain a copy of their medical records. Recommendations have been made for basic standards of patient held records,[5,7] although standardization is difficult because of the different emphasis placed on relevant information.

Patient retained records

Since June 1982, in the author's practice, patients over the age of 16 years have received a copy of their medical records on a health identity card (Figure 1). The basic personal data is checked by the patient and practice nurse for accuracy and the medical information is filled in by the doctor. Patients have been asked to return the card with each visit for updating.

The card contains a coloured passport photograph of the patient with the following details: signature, ID number, name, address, birthdate, home and work telephone number, marital status, religion, occupation, next-of-kin, family doctor plus information on Medic Alert,[2] passport, social security and health insurance numbers. A space is available for recording of immunization status, while the second part of the card contains details of current and past medical problems with the treatment given, plus details from a recent general physical examination: height, weight, blood pressure, pulse, peak expiratory flow rates, pap smear, recent blood screen, blood group, urine examination, ECG and chest radiograph. Space is available for the patient to record the last will and testament and life insurance details. The back half of the card contains a summary of patient–doctor contacts with the problem and treatment

HEALTH ID CARD

Name

Address

Birth Date - - D M Y | Sex M/F | Phone No. Home

Marital Status M S W D Sep. Def. | Work
Date of Change

Religion | Occupation

PLEASE RETURN TO OWNER IF FOUND

ID Photo

X
Signature

Next of kin Address | Phone No.

Family Doctor Address

Medic Alert

Passport No. Ethnics

Social Security

Health Insurance

Immunizations

DPT 1 2 DT

Tetanus

Polio 1 2 3 4

Rubella BCG

Misc.

Date	Present Problems	Treatment	Specialists

Date	Past Problems	General Exam	Date
		Ht	Wt
		BP	Pulse
		PEF	Pap
		CBS	
		Blood Group	
		MSU	
		ECG	
		CXR	

Last Will & Testament | Life Insurance

PLEASE BRING HEALTH ID CARD WITH YOU TO ALL HEALTH CONTACTS (i.e. Doctors & Nurses)

Notify Family Doctor of any changes in personal status:

- Name
- Address & Phone Number
- Occupation & Phone Number
- Change in Marital Status
- Immunizations
- Social Security
- Health Insurance
- Life Insurance
- Last Will & Testament
- All Other Health Contacts or Hospitalization

KEEP IN SAFE PLACE WITH YOU AT ALL TIMES

Misc.

Chemist Phone

Dentist Phone

Lawyer Phone

Date	Problem	Treatment	Date	Problem	Treatment

Figure 1. *The health identity card.*

given. There is a reminder to the patient to notify the doctor of any changes in personal status. A section is also provided for miscellaneous details such as telephone numbers for chemist, dentist and lawyer.

The card is folded and enclosed in a clear plastic envelope. A handout accompanies the card to tell the patient what the card is for and how to use it. The card costs little to produce and can be filled out in five minutes if standard problem-orientated records are in use. The overall response from patients has been favourable.

There have been a few problems with the introduction of the health identity card. Financial problems include recovering the cost of filling in the card and resistance by patients to paying for cards for which they may not feel a need. Sensitive problems such as terminations of pregnancies, psychiatric illnesses and venereal disease are difficult to include on the card. Cards can be lost and confidentiality can be a problem.

Other systems of patient retained records currently used or suggested for use, include:

1. *Medic Alert.*[2] This is an international system established in 1956 consisting of medical information available on an emergency hotline. The patient carries a wallet medical card with an identification bracelet or necklace. The system is very useful if the patient is unconscious or unable to speak but there can be some delay in updating information.

2. *Portable medical record system for the elderly.*[8] The use of Medic Alert bracelets and wallet cards has been studied in the elderly, including the holding of a copy of the card by a close friend.

3. *The Talisman.* Developed in the UK, the Talisman consists of a paper pull-out record from a watch-strap locket; this is also an advantage in unconscious patients.

4. *Patient retained medical records.*[1] Dr Metcalfe suggested that patients be allowed to keep their medical records, thus saving on storage space for medical records in the surgery, reducing time spent by receptionists in handling notes, and perhaps improving doctor–patient relationships.

5. *Hospital discharge notes.*[9] Many hospitals supply a list of medical problems and a summary of prescribed medications to overcome some of the delays in transferring detailed medical discharge summaries from hospitals to general practitioners.

6. *Pocket medication profile cards.*[10] Developed by Bronson Methodist Hospital in 1974, this card lists general medical and personal data, allergies and other medical conditions, with a detailed list of drugs taken including directions and starting and stopping dates.

7. *Micro-medic card.* (Supplied by Control-O-Fax, Micro Medical Record, Box 778, Waterloo, Iowa, USA.) This card consists of a microfilmed copy of the patient's records enclosed in a credit card sized plastic card. The information can be viewed with a special viewer, a microscope, ophthalmoscope or slide projector. This system can be expensive and difficult to update.

8. *Traveller record.* (Supplied by International Association for Medical Assistance to Travellers, Traveller Record Card, Head Office, Empire State Building, 350 5th Avenue, Suite 5620, New York 10001, USA.) The IAMAT traveller record card contains a detailed summary of personal and medical records with space available for ECG readings, immunization records and alerts for conditions such as diabetes, allergies or anticoagulant drug therapy.

9. *Viva.*[11] A summary of medical records has been produced by Dr Simcock with translations into French, German and Italian for patients travelling into areas where language problems can arise.

10. *Mother's card.*[12] Used in India and Somalia, this is a record of a mother's family planning measures, menstrual period, pregnancy status with risk factors, nutrition and immunization status.

11. *Health and development record.* (Supplied by Division of Health Promotion, Health and Development Record, Department of Health, PO Box 5013, Wellington, New Zealand.) This book, introduced by the Plunket Society and Health Department of New Zealand in June 1982, is a detailed record of growth and development of a child up to the age of 16 years, with many sections for the parents to read about commonly encountered problems in this age group, as well as a section on emergency procedures for rescuscitation, burns or poisoning.

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