Viewpoint: **Patient-Centered Medical Care Requires a Patient-Centered Medical Record**

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Abstract

If patient-centered medicine is to become a widespread reality in academic medical centers, educational initiatives must include reform of the medical record. The medical record is part of the hidden, or informal, curriculum of medical school and residency that defines for students and residents the essential ingredients of competent medical care. Whatever its merits, the conventional, problem-oriented medical record (POMR) is a pathology-oriented record that helps perpetuate a disease-focused, biomedical model of practice

Patient-centered medicine requires a patient-centered medical record (PCMR), one that addresses the person and perspective of the patient as competently as it addresses the patient's disease. The author proposes a PCMR that includes a concise, upfront Patient Profile; speaks of "chief concerns," not "chief complaints"; makes Patient Perspective a captioned component of the History of Present Illness; replaces the POMR's formula SOAP (Subjective, Objective, Assessment, Plan) with HOAP (History, Observations, Assessment, Plan); includes important patient perspectives on the Problem List; and calls for additional, written attention to the person and perspective of the patient throughout the course of medical care

Patient-centered records can guide and teach clinicians at every level of training and experience to practice patient-centered medicine. Moreover, such records can also provide measurable evidence that this teaching has been successful.

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> Apart from the case record, no mechanism exists in medicine that brings its diverse elements together. Improving these clinical portraits and striving to enlarge their usefulness must be central goals of medicine, for case records are the works that define its essence.
>
> —Stanley J. Reiser, MD, PhD

Reiser's comment[1] above eloquently reminds us of the importance of defining the role of case records in medicine. Thus, if patient-centered medicine is to become a widespread reality in academic medical centers, educational initiatives must include adoption of a medical record that addresses the person and perspective of the patient as competently as it now addresses the patient's disease. In this article, I propose such a record.

Background

Despite numerous, compelling calls for "patient-centered" medical care during the past ten years or so, the Institute of Medicine (IOM) recently reported that "In general, comprehensive attention to patient-centered care in medical education is lacking."[2] According to the IOM, a major barrier to addressing this need is the "dominant biomedical model of practice, whereby patients are viewed in terms of signs and symptoms."

Why does the biomedical model of practice persist in academic medical centers, long after Engel[3] and, subsequently, many others, identified its inadequacy? One critically important, and easily overlooked, reason is the teaching provided by the medical record. That medical records do in fact "guide and teach" was more obvious in the early 1970s, when medical schools and teaching hospitals throughout the United States enthusiastically adopted Weed's problem-oriented medical record (POMR).[4] Moreover, the POMR taught not just medical students but also residents and attending physicians to identify, assess, and address a patient's medical problems in a more systematic, rational, and transparent way.

Today, however, its didactic role largely forgotten, the medical record has become part of the hidden curriculum constituted by the culture of academic medical centers, a complex medley of unspoken beliefs, everyday language, and taken-for-granted practices. Hidden in plain sight, the medical record continues to teach. Unfortunately, what the traditional POMR teaches doctors-to-be today is a grossly inadequate view of both the patient's plight and the physician's calling. Whatever its merits, the POMR did not challenge biomedicine's long-standing assumption that human sickness or disability is primarily, even exclusively, a matter of disordered biology, In practice, problem-oriented records continued to be pathology-oriented records, focused primarily (if not quite exclusively) on the physician's detection and correction of disordered biologic structure or function.[5,6] Thus pathology-oriented records help perpetuate a biomedical model of practice, one at odds with a more inclusive model of patient care, patient-centered medical care.

Fortunately, although it is at present a significant educational barrier to patient-centered care, the medical record can become an effective way of teaching both physicians-to-be and their mentors to practice patient-centered medicine—every day and with every patient. What's required is a patient-centered medical record (PCMR), one that both models and reflects a clinical method that addresses the patient's *illness* (the lived experience of sickness, disability, and medical care) as competently as it does the patient's *disease* (disordered biology).[6,7]

The Proposed Record

As shown in List 1, my proposal for a PCMR calls for an addition, change, or renewed emphasis in eight areas of the

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List 1

A Patient-Centered Medical Record

I. Introduction: Patient Profile

Introduce the patient as a person: Mr., Mrs., Ms., Dr., Reverend, Father, etc., using full name (plus phonetic spelling if appropriate). Include age (or birth date). Include a brief description of the patient's current home and family situation, occupation, special interests, etc. State how the patient wishes to be addressed. Update periodically.
Location: First or second page of the record, just before Problem List.

II. Chief Concern(s)

"Concern" says it more inclusively and less ambiguously than "complaint." Use the patient's own words. Avoid biomedical language unless used by the patient.

III. History of Present Illness (HPI)

Describe the patient's sickness, disability, and previous medical care from both a conventional, biomedical perspective and the patient's perspective, as outlined below. In some cases, the "patient perspective" paragraph might logically come first. Avoid language that repetitively and nonreflectively casts doubt on the reliability of the patient's testimony (e.g., "Patient 'denies' or 'claims'").

Biomedical (or biological) perspective (the "disease")

1. A chronological account of the onset and course of symptoms of disease or disability, including location, quality, intensity, timing, setting, aggravating or alleviating factors, associated symptoms, and pertinent positives and negatives
2. Information about previous diagnosis, treatment, and course of the "disease"

Patient Perspective (the "illness"). Possible subjects include:

1. The patient's understanding of the disease or disability (causation, diagnosis, prognosis, role in management)
2. The impact of disease or disability or medical care on the patient's life, work, and relationships, especially important physical, mental, and emotional suffering, e.g., the patient's specific experiences of loss (independence, function, role, status, certainty, or control), pain, worry, and fear
3. The patient's personal goals regarding health
4. The patient's expectations of medical care
5. If appropriate, the patient's preferences for end-of-life care and proxy decision making, whether or not the patient has executed a written advance directive for health care

IV. Assessment and Plan

Clinically significant "patient perspectives" (e.g., a poor understanding of a medical condition, an important worry or fear, or an unrealistic expectation of medical care) identified in the HPI or later in the course of medical care may warrant a written assessment and plan analogous to that customarily given to biomedical problems.
For both biomedical problems and patient perspective issues, use the formula HOAP: History, Observations, Assessment, and Plan. Do not use SOAP (Subjective, Objective, Assessment, Plan), which harmfully and inaccurately categorizes clinical knowledge as either "subjective" (untrustworthy) or "objective" (indisputably factual).

V. Problem List

As in the POMR, maintain an up-to-date list of all major active and inactive medical problems, but also list important "patient perspectives" (e.g., preferences regarding end-of-life care).
Location: Front of the record, perhaps right after Introduction (Patient Profile), perhaps adjacent to a list of all current medications, including over-the-counter drugs.

VI. Progress Notes

Continue to use HOAP: History, Observations, Assessment, and Plan. Caption information coming from the patient or family as either "History" or as "Patient (or Family) Perspective."

VII. Attending Notes on Teaching Services

Begin attention to the person and perspective of the patient in the initial attending note and continue to do, when appropriate, in subsequent attending notes.

VIII. Hospital Discharge Summary

Include a summary of professional attention to the person and perspective of the patient. Note important ongoing concerns, fears, and hopes that need to be addressed during outpatient care.

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traditional POMR: Introduction: Patient Profile; Chief Concern(s); History of Present Illness; Assessment and Plan; Problem List; Progress Notes; Attending Physician Notes on Inpatient Teaching Services; and Hospital Discharge Summary. Examples of questions useful in eliciting and recording professionally relevant information about the person and perspective of the patient are shown in List 2.

My proposal includes two previous, limited reforms of the medical record: (1) making the Patient's Perspective a separate, captioned paragraph in every History of Present Illness composed by medical students and, to some extent, by residents in the course of their training or patient care in the courses and programs directed by the Department of Medicine at Loyola University Medical Center[5]; and (2) requiring attending physicians on the teaching services of the medical service of the Edward Hines, Jr. Veterans Affairs Hospital to address the Patient's Perspective in their initial "on service" progress note. The proposal also includes additional changes in the language and format of medical case histories that I advocated in a previous publication.[6]

The proposal addresses only what medical professionals (medical students, residents, and attending physicians) write in the record. Other health care professionals, such as nurses, therapists, pharmacists, social workers, and chaplains, should also be able to make their contribution to patient-centered health care an explicit part of the record. The reforms I suggest can be made part of either conventional or electronic medical records. Electronic record-keeping can facilitate

List 2

Examples of Questions Useful in Eliciting and Recording Information about the Person and Perspective of the Patient during both Initial and Subsequent Conversations

Mr. Jones, before we talk about your medical problems, can you tell me a little about yourself? Your work, interests, who's at home, etc.? Or, Now that we've talked about your medical problems. . .

Mr. Jones, what is your understanding of your condition? (Seek patient's knowledge of condition, beliefs about causation, future course, his role in management.)

Mr. Jones, how has your condition (illness or disability) affected your life? Your family and personal relationships? Your work?

What do you worry (fear) most about your condition or your medical care?

Mr. Jones, with regard to your health and your medical condition(s), what are your personal goals? What do you expect (hope to obtain) from medical care here at our hospital?

Mr. Jones, do you have a Living Will (or other formal advance directive like a Durable Power of Attorney for Health Care) that we should know about or discuss with you? (The primary purpose of this question is to initiate dialogue about therapeutic options and patient preferences, so that accurate, up-to-date information can be recorded in the chart and appropriate orders, like "No CPR," can be written in a timely manner.)

Mr. Jones, if you become too sick to speak for yourself, who will speak for you? (Spouse, other family member, friend?) Is she/he here now, so that I can meet her/him? If not, how can I (we) get in touch with her/him should the need arise (name, phone number)?

adoption and monitoring of the reforms. It can also improve patient access to the record, an important consideration when many patients now find it advisable (even necessary) to create and maintain their own transportable, electronic medical records.[8] Although designed primarily for use on the adult inpatient services of a teaching hospital, the proposal could be easily modified for use in other settings.

Before discussing the individual components of the PCMR outlined in List 1, I want to comment on the proposal as a whole.

As suggested earlier, pathology-oriented medical records model pathology-oriented medical care. If reform of the record does not accompany, say, the teaching of patient-centered interviewing, medical trainees receive two very different messages about what constitutes adequate medical care. To be sure, many physicians learn to practice patient-centered medicine despite what pathology-oriented records teach them. On the other hand, many do not. Witness the fact that the editors of *Annals of Internal Medicine* recently found it appropriate to publish an article outlining the *basics* of patient-centered interviewing![9] Why is such remedial instruction necessary? Because, the authors of that article say, "Current social and economic constraints on practice, along with *medical training that does not equip physicians to deal with the patient's expression of values, ideas, or feelings, lead to clinical interviews that focus on understanding only the patient's disease.*" (Emphasis added.) Regarding "current social and economic restraints on practice," let me say that my own experience, as both physician and as patient, has convinced me that meaningful attention to the patient's perspective does not, in fact, require a great deal of additional physician time with the patient. Furthermore, talk about "lack of time" may be a way for some physician faculty to express their own discomfort or resentment when asked to do something that their own medical education convinced them was peripheral to the real business of medical care.

My proposal for a PCMR calls for a comprehensive reform, one that is clearly designated as a *patient-centered* record and that clearly signals a medical center's serious commitment to the teaching and practice of patient-centered medical care. Partial reforms, like those introduced at Loyola and Hines, do have value. They demonstrate the feasibility of using the record to help both students and practitioners of medicine ascertain and address key aspects of the patient's perspective. However, such limited reforms may lack durability (see discussion of Parts III and VII below).

In recent years others, notably Smith and Hoppe,[10] Delbanco,[11] and Tauber,[12] have also advocated explicit attention to the person and perspective of the patient in the medical record. Why is written, rather than simply oral, attention so important? I offer several reasons:

- Writing preserves knowledge. What the physician learns about the patient's understanding of the medical condition, concerns, or needs are as important to remember as the patient's signs and symptoms.
- Writing extends communication beyond face-to-face contact. This is a particularly important consideration nowadays, when many different physicians, nurses, and other health care professionals may be caring for a patient in both hospital and clinic.
- Writing about such matters as the patient's knowledge of the medical condition, needs, or preferences raises consciousness, encouraging additional thinking about these subjects.
- Finally, written attention to the person and perspective of the patient in the medical record provides measurable evidence of patient-centered medical care. This is an important consideration at a time when certifying bodies like the Accreditation Council for Graduate Medical Education are requiring training directors to demonstrate that trainees have, in fact, learned to provide "patient-focused care."[13]

Components of the Proposed Record

Let us now turn to the individual components of my proposed PCMR. I will dis-

cuss each component, following the arrangement shown in List 1.

I. Introduction: patient profile. Weed's original proposal for the POMR called for a biographical sketch of the patient, the Patient Profile, that would *precede* the record's HPI. While Billings and Stoekle continue to advocate this practice,[14] others have reduced the Patient Profile to a few words and phrases in the record's Social History.[5] Today, the need for a concise, upfront introduction of the patient as person is greater than ever. During the 30-some years since the advent of the POMR, medical care has become increasingly fragmented, largely because of the growth and development of myriad health care specialties. No matter how well a particular patient and his or her primary care physician know each other (if indeed the patient is fortunate enough to have such a physician), hospitalization (or referral to specialists) makes the sick person a stranger in a strange land. A readily accessible Patient Profile can help all caregivers know and address the patient as a person. Knowing that their caregivers do, in fact, know them as persons can help relieve much of the alienation and loss of identity now experienced by sick persons in the course of their medical care.

II. Chief concerns. "Concern" says it much better than "complaint."[6] What person today speaks of the distress or condition that prompts him or her to seek medical care as a "complaint?" Although it is true that one meaning of the word "complaint" (dating from the early 18th century) is "a bodily ailment,"[15] in everyday parlance "complaint" means an expression of dissatisfaction or a grievance. Referring to the patient's concerns as "complaints" labels the patient a "complainer, with its implication of whining or self-pity."[16] Moreover, "concerns" can include the important worries, fears, or hopes, not just the symptoms or previous diagnosis, that prompted the current medical encounter.

III. History of present illness (HPI). Definitive attention to patient's lived experience of sickness, disability, or medical care begins by making the Patient's Perspective a routine part of every HPI. Since 1992, students in courses directed by the Department of Medicine at Loyola University Stritch School of Medicine have learned to make a "two-perspective HPI" part of every one of their case write-ups. This practice began in what was then the physical diagnosis course. It continues in the current first- and second-year "Introduction to the Practice of Medicine" course, the third-year medicine clerkship, and, to a lesser extent, the internal medicine residency at Loyola University Medical Center. A two-perspective HPI consists of

- a biomedical (or biological, if you prefer) perspective (the "disease"), i.e., a narrative whose subject is primarily the onset and course of symptoms and signs of biologic dysfunction (including, if related to the "present illness," previous diagnoses and treatments); and
- the patient's perspective (the "illness"), i.e., a narrative that summarizes professionally relevant knowledge about such matters as the patient's understanding of the sickness, its effect on the patient's life, work, and relationships, and the patient's fears, expectations, and, if appropriate, preferences for end-of-life care.

Giving the patient's perspective specific, captioned attention in the HPI rather than, say, in the record's Social History or Review of Symptoms, is appropriate for three reasons:

- Such prominent attention immediately signals the fact that adequate medical care includes explicit attention to the "illness" as well as the "disease."
- Identifying each of these two different narratives as a "perspective" reminds the writer or reader of the HPI that neither point of view provides the "whole story." Citing Ortega y Gasset, historian John Lukacs[17] tells us:

> Perspective is one of the components of reality. Far from being its deformation it is its organization. A reality which would remain always the same when seen from different points would be an absurdity. . . . This is a twentieth-century recognition, a condition which is important for us to keep in mind as even the more intelligent historical thinkers among us cannot quite detach themselves from the terminology of objectivity.

- The HPI's narrative format makes it the appropriate place to initiate definitive attention to the patient's illness experience. An adequate description of the patient's perspective requires a narrative, not just a few words or phrases. Only a narrative, however brief, can adequately convey (to themselves and to others) what particular human beings know, think, or feel, or do not know, think or feel about themselves and particular events in their lives.[18] For example, in the case write-up of a 62-year-old man with a history of myocardial infarction and recurrent chest pain, a third-year medical student recorded as Patient Perspective this narrative:

> Mr. L *understands* that his chest pain is due to blockages of his coronary arteries. The patient *understands* the relationship of diet, cholesterol, and blood pressure upon his illness. He *wishes* that angioplasty with possible stent procedure will alleviate his symptoms as he becomes frustrated when he is unable to walk short distances. He is *concerned* that this procedure may fail to correct his disease. In addition, the patient is *worried* about undergoing the cardiac catheterization given the fact that *his brother died due to complications secondary to an angioplasty*. (Emphases added.)

Clearly, one can successfully teach medical students to make informative, helpful accounts of the patient's perspective a prominent part of their case write-ups. In the early years of their training the students' special "history and physical" forms call for this component in the HPI. As they enter the third-year medicine clerkship (and use regular hospital forms that do not call for Patient Perspective), they continue to do so. The evaluation form used by faculty who review the students' case write-ups requires the instructor to evaluate and grade the history's Patient Perspective as explicitly as the traditional components of the write-up. It is thus possible for the clerkship director (who receives copies of each student's work along with the instructor's evaluation) to evaluate both the students' and the instructors' attention to the reform. Notably, over a period of years the quality of the instructors' attention to what the students record as Patient Perspective has steadily improved.

In Loyola's internal medicine residency, the practice has been less successful, despite an official requirement to continue the practice. In the "real world" of wards and clinics, practicing clinicians, not course or clerkship directors, define what counts in medical care for residents and fellows. The chief resident in 2004 told me that residents currently record information about the patient's perspective in

only about 25% of their case histories, primarily when such information has diagnostic value.

IV. Assessment and plan. The key reforms introduced here are

- giving clinically important "patient perspectives" the same kind of orderly appraisal customarily used for each biomedical problem identified during the course of medical care, and
- replacing the POMR formula SOAP (Subjective, Objective, Assessment, and Plan) with HOAP (History, Observations, Assessment, and Plan).[19]

As previously pointed out,[6] categorizing what the patient says as "subjective" and what the physician learns from physical examination and laboratory studies as "objective" can be correctly understood to distinguish two quite different realms of reality. However, in a science-using activity like medicine, the subjective–objective distinction is more likely to be understood epistemically, suggesting that the patient's testimony is untrustworthy while physical and laboratory observations are indisputably factual.

V. Problem list. Although the POMR's Problem List is typically a list of pathologies (symptoms, signs, and diagnoses), nevertheless clinically important "patient perspectives" should also be listed. Captioning each such entry as "Patient Perspective" will distinguish it from the items usually found on the POMR Problem List. Alternatively, one might construct a separate "Patient Perspective List."

VI. Progress notes. During the course of medical care, such matters as the patient's suffering, understanding of a medical condition, worries, preferences, and expectations will inevitably change. Important changes in the patient's perspective should be recorded as thoughtfully as are changes in the medical conditions.

VII. Attending notes on teaching services. In an academic medical center, part or all of the record's "complete history and physical" may have been performed by junior members of the medical team or nurses. In that case, the attending physician's bedside review of the team's findings and plans should include conversations with and about the patient that address the patient's perspective. Moreover, written, captioned attention to the patient's perspective should be included in the attending's initial "on-service note" and continue, as appropriate, throughout the subsequent course of medical care. This does more than bring the experience and expertise of the attending physician to the task of identifying and responding to the human needs and expectations of a particular patient. It signals to everyone that such attention is an integral and customary part of medical care. Just as important, the attending's personal attention to the human situation of the patient helps build a healing relationship between that physician and the patient. This is particularly important when much of the relationship-building history and physical examination has been delegated to someone else.

My own experience with the attending notes reform just described is instructive. In June 1996, attending physicians on the inpatient teaching services of the Edward Hines, Jr. Veterans Affairs Hospital's Medical Service began to include written attention to one or more aspects of the patient's perspective in their initial note. This practice was initiated by the then-chief of the medical service at my suggestion, at a time when I was a consultant to the medical service. Attending physicians were given detailed instructions about the purpose and nature of such attention and copies of exemplary third-year students' case histories. At a regularly scheduled medical service staff meeting, the chief of the medical service sought and obtained the approval of the attending physicians present to make this reform official departmental policy. In practice, the majority of medical service attending physicians responded positively to this requirement. Some did not. One hematology–oncology attending physician told quality assurance staff that dealing with the patient's perspective during his rounds with fellow, residents, and students would be an inappropriate use of his time and talent. Although many "Patient Perspective" notes were brief, consisting of only two or three sentences, what was recorded was often significant. Important fears, questions, and concerns that the routine history had not disclosed now became matters calling for a professional response. Interestingly, one physician even devised her own one-page form for her initial note that included a category labeled "PPI [patient perspective on illness]: Fears/Hopes/Goals/Advance Directives."

After Hines medical records became fully electronic, monitoring by quality assurance staff increased attendings' compliance to 80% or more. (Quality assurance staff did not attempt to assess the actual *quality* of the attendings' attention to the person and perspective of the patient, but only whether or not the attending had recorded such attention.) Unfortunately, after the tenure of the chief of the medical service at that time ended in 1997, the practice gradually declined. I left Hines a few years later. I have recently been told that quality assurance staff no longer monitor compliance. Clearly, to survive, even a limited departmental reform of the medical record requires ongoing support by leadership convinced of its merit.

VII. Hospital discharge summary. Here one should record what the patient actually understands (not simply what he or she has been told) about the current status of the medical condition, its management at home, and any new prescriptions. Special worries or concerns at this time also need to be identified and addressed.

Coda

If patient-centered medicine is to become a widespread reality in academic medical centers, educational initiatives must include reform of the medical record. The medical record is part of the hidden, or informal, curriculum of medical school and residency that defines for students and residents the essential ingredients of competent medical care. The conventional, problem-oriented medical record teaches both doctors-to-be and their teachers to practice medicine in a limited, disease-focused manner. If patient-centered medicine is the goal, what's required are patient-centered medical records. Patient-centered records can "guide and teach" clinicians at every level of training and experience to address the patient's illness as competently as they address the patient's disease. Just as important, such records can also provide measurable evidence that this teaching has been successful.

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