

Twelve Commandments for General Medicine Clinical Record: Some Suggestions that are Not in the Text books

Jose Luis Turabian

Specialist in Family and Community Medicine, Health Center Santa Maria de Benquerencia, Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain.

jturabianf@hotmail.com

Corresponding Author: Jose Luis Turabian, Specialist in Family and Community Medicine, Health Center Santa Maria de Benquerencia, Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain.

Abstract

The aim of this article is to describe the main features of the family physician approach in taking clinical record of the patient that is not always cited in textbooks, and it allows among other things to differentiate the general practice from the one of other medical specialists. The following concepts are shown: 1) the clinical history have to starting from the context, before facing the medical complaint; 2) the consultation must be prepared before the patient is admitted, memorizing his previous history, so that we can dedicate all our attention and be able to integrate his communication mentally in his previous clinical history; 3) it should always be annotated the clinical history "as if that case you were going to publish", to achieve a complete, lively and rich story; 4) it may seem that only one person - the patient - enters the consultation, but it is only apparently: with him enters his family or companions and other relevant actors, and this always has important meanings; 5) the individual clinical history is always familiar, and should integrate the exploration of contextual and psycho-social data, and of genetic risk assessment, being a useful tool the genogram; 6) the clinical history must be "decentralized" (from the point of view of the other); 7) in the clinical record should be collected the health resources / strengths of the patient (non-specific positive health resources, support network that the patient has, individual characteristics of the personality, their disease and the situation of the environment) ; 8) biographical and psycho-social registry (concerns, illusions, projects, priorities, wishes, etc.), social data (poverty, social isolation), and Impact of disease in patient-family, labour, and relation-life (disease understanding, fears, hopes); 9) the "master-problems" or health problems that concentrate the greatest importance, power or significance should be recognized and noted; 10) doctor-patient-family relationship; 11) It must be remembered that the clinical history is constructed and reconstructed as a sculptor sculpts a sculpture (continued attention); and 12) should be annotated, at the end of the consultation, certain security elements, such as what will I do if the patient returns for the same problem?

Keywords: Family physician; Family practice; Family Medical History; Medical Record; Personal Health Records; History Taking, Medical.

INTRODUCTION

The information system in medicine is a mechanism for the collection, processing, analysis, interpretation and transmission of the necessary and essential information for decision making and its subsequent evaluation. Health / disease records in medicine are not information systems, but they are the support of these systems. Among these health / disease records, the clinical record (CR) is the main (1).

CR is a working tool of health professionals that reflects the theory of the disease and the dominant health paradigm. It is necessary to remember that most human reasoning is based on cases rather than rules (2).

Health professionals know since time immemorial that the information obtained from a patient will be different depending on where the attention is placed. Thus, a clinical history of general medicine / family medicine

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is different from a hospital history and should include most of the following aspects: biopsychosocial data; quantitative and qualitative data; experience of the disease; various actors (patient, family, community); biographical history (projects, expectations...); doctor-patient-family-context relationship; and assessment of family and community aspects (resources, strengths and weaknesses, relationships) (3-5).

If in each consultation the general practitioner (GP) had a clear and comprehensive CR, his medical tasks would be easier. GP practitioners veteran know that they treat patients who have the same health problems for years, so it is enough to read in their clinical history the repetition of the same constellation of symptoms and the diagnosis that gave rise to the previous intervention and its result, having immediately the diagnosis of the current problem, as well as its treatment and its foreseeable results; what was previously useful could also be useful in the new episode. So, what can be the tool to achieve assistance in an easy and effective way? The CR. But, in addition, the CR is one of the most important elements of the doctor-patient relationship (6).

So, why do not we give the importance it deserves to the general medicine clinical record (GMCR)? Why do not defend and systematize and deepen the own and differential elements of clinical history at this level of care? We must achieve certain habits of thought about key tasks and crucial concepts in the GMCR to incorporate them into daily practice and teach them to young physicians. We must not let these elements get lost; the specialty of general medicine / family medicine will only last and will be justified if it gives an added value, differential and proper to your task.

In this scenario, the aim of this article is to describe and systematize some concepts, which are not always shown in textbooks, for GMCR, which differentiate it from the practice of other medical specialties.

DISCUSSION

Twelve suggestions are proposed, which do not usually come in textbooks, for GMCR (TABLE 1).

Table 1. *Suggestions, Which Do Not To Be In The Textbooks, For General Medicine Clinical Record*

1. Contextualized clinical record
2. Prepare the consultation before entering the patient, memorizing the patient's previous history

3. Always record in the clinical history "as if this case you were going to publish it"

4. It may seem that only one person - the patient - comes into the consultation, but it is only apparently: with him enters his family or companions and other relevant actors

5. "Individual" clinical record is always "familiar"

6. Clinical record must be "decentralized"

7. Health resources / strengths

8. Biographical and psycho-social registry

9. Recognize and record the "master-problems"

10. Doctor-patient-family relationship

11. Clinical record is constructed and reconstructed as a sculptor sculpts a sculpture

12. Safety net

Contextualized Clinical Record

The first is to understand "who is, and where is the patient" (its context), and then the doctor can move on to the topic of "what's wrong." To understand the health problem, from the point of view of the GP, the first thing is to know the "context of the patient". The clinic emerges, that is, it is perceived by the clinician within a framework that clarifies reality. The diagnosis is made by a mechanism similar to that of the painter when he manages to highlight a figure on a background: "when recognizing the edges by contrast". Thus, the same problem takes different forms according to its background; different diagnoses according to contexts (7). In this way, the clinical interview should be a "contextualized interview", and the data obtained that will be reflected in the CR that will be a "contextualized clinical record" (8).

Patient-centered care requires a "context-focused medical record". We want to suggest that individual clinical circumstances are always "in context", and medical records should be records of patients' medical care in the context of beliefs, family dynamics, psychosocial situation, disease experience and community culture, to become a real tool to make good decisions (with people in contexts). There is no disease without a natural history of cultural and social factors. The main factor in the diagnosis and treatment of family medicine is to recognize the patient's relational experience and consider it completely.

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We must bear in mind that the significance of symptoms (and signs) only become evident when viewed in context. Symptoms are both expressions of biochemical alterations, as symbols for the patient, expressions of the group context, ways of dealing with a situation or event (whether or not patient is aware of it), depend on the patient's previous psychological functioning, severity of the deficit and the psychological function associated to the disease, of the residual abilities, of the adaptation and of the confrontation of the functional deficits. Therefore, it is not a question of achieving a clinical history focused on problems, but rather on clinical histories oriented towards people, that is, contextualized (9, 10).

Prepare the Consultation before Entering the Patient, Memorizing the Patient's Previous History

We must have in our mind the patient's previous biopsychosocial history when he or she entering the consultation, so that we do not need to read computer screens, not written documents, etc. In this way, the doctor can focus all his attention on the patient and can integrate his verbal and non-verbal communication, mentally in his previous clinical history, immediately, which will allow us to be more effective and will be understood by the patient as we recognize and remember him as a person and as a sick person (affective and cognitive competence of the doctor).

Before each patient goes into to the consultation, the GP has to concentrate and "position" himself in a suitable position to adequately "receive and respond" to the patient. Receiving the patient every time he comes to the consultation as a "new" visit and meeting the demand as a punctual visit, without any previous preparation, having to make very quick decisions, in a matter of minutes, implies a high risk of omitting data and make inappropriate decisions. So, check the personal history or list of the patient's problems, their last visits with the GP (based on the continuity of care), and visits with other specialists, their treatments, their work and family situation, etc. After this, "almost" the GP can predict the reason for visiting to doctor in a large part of the patients (1).

Always Record in the Clinical History "As if this Case You were Going to Publish it"

The medical chronicles of the 19th and 20th century tends to be much more complete, more alive and

richer in their descriptions than modern ones. Thus, by abandoning a purely descriptive period to enter a phase of research and active explanation, diseases are fragmented, and are no longer conceived as a whole. By studying the medical records of inpatients in nursing homes and in public hospitals during the 1920s and 1930s, we found highly detailed clinical and phenomenological observations, often presented in the form of accounts of wealth and almost fictional density (such as the "classic" descriptions of Kraepelin and other authors at the end of the 19th century).

But, now there is contempt of the "hard" science towards clinical medicine, and especially towards specific cases (clinical histories). Freud himself wrote: "It continues to surprise me that the clinical histories I write are read as if they were stories, lacking, we might say, of the rigorous seal of science. I console myself thinking that this is due to the nature of the subject and not to my personal inclinations." It is evident that the clinical cases of Freud are rigorously scientific and embody a science of the individual as "hard" as the physical or molecular biology (11).

Let us avoid that this detailed and rich description of phenomena disappears and be replaced by brief notes that do not offer a real image of the patient or his world, but rather they reduce him and his illness to a mere list of diagnostic criteria. The GMCR must have the depth and informative richness of yesteryear, so that they are useful to realize that necessary synthesis between science and medicine (12).

The clinical encounter consists of stories within stories, and a "narrative reasoning" is carried out; each patient tells a story and the clinician intuitively uses patient' narrative cues for assistance. The patient is seen as "a page of a book of nature, a text to read". It is important to maintain the narrative rather than reduce its semantic richness and degrade the story by limiting it to short codes and phrases. Thus, the GMCR should be able to facilitate the clinician to easily take the narration (13-16).

It May Seem that Only One Person - The Patient - Comes into the Consultation, but it is Only Apparently: with him Enters his Family or Companions and Other Relevant Actors

Conventionally, physician training focuses on an encounter between two people: the patient and the physician. In practice, a third person frequently

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accompanies a patient during medical encounter. Family members normally accompany the patient to the consultation, and provide valuable information about the psychological and socio-cultural dimensions of the patient, and personal relationships that contribute to the functional autonomy of the patient. A second adult-usually parents or husband or wife accompanying the patient consultation is always significant and deserves the attention of the doctor. It can be understood the presence of the companion of the patient in consultation, as a metaphor from the patient. The companion of patient is perhaps his “guardian angel”, or he can be understood as a “listening device”. Also the presence of a companion is an indicator of potential problems in the context of the patient, and it suggests investigating further psychosocial patient data and family (17). The focus should be on the ways in which the problem is told by the different family members in their different positions of the social structure and about the patient health problem. The meaning that people give to the events of their lives and how they talk about them is fundamental to understanding their interactions (18-23).

“Individual” Clinical Record is Always “Familiar”

Historically GPs have asked patients about their family history to obtain a vision about their psycho-social background, so that the symptoms of the patients could be contextualized, both in terms of possible environmental causes and lifestyles related to the health problems, such as patient’s concerns about the nature of the disease, the relationships between significant actors, the available resources, etc.

Patients already understand that their family history is in some way an element that predicts their personal risk of illness, linked to inheritance and beliefs. Recent advances in molecular medicine and their application in the assessment of genetic risk broaden the role of family history in primary care. Therefore, family history should integrate the exploration of contextual and psychosocial data, and genetic risk assessment. A possible way or tool for the integration of these two types of information is the genogram, which also gives us information about the family’s life cycle (24-25).

Clinical Record Must Be “Decentralized”

The GMCR and the interview should be centered on the patient. Better said, they should be “decentralized”

(26-27). Thus, the “decentralized” interview (from the point of view of the other) will allow us to determine the decentralized problem: “What do you blame the problem?”, “What do you think about it?”, “What does your family think about this problem?”, “What do they say?“, “How does it affect you, your family, your friends, your work?”, and the decentralized determination of the solution: “What did you do to solve it?”, “What can you do?”, “What can your family, friends, etc. do?”, “What resources do you need to solve it?”

Health Resources / Strengths

Positive nonspecific health resources can be collected relatively easily. These health resources are: stable humour, optimism, positive (observe if expressed in positive or negative terms), special abilities, significant hobbies, their state of anxiety (something very related to the inability to relax and laugh), the support network available to the patient (family members with whom they can count and the role they play), adaptation to the situation, possibilities identified by the patient to overcome the situation (8, 28).

Biographical and Psycho-Social Registry

A biographical record of the patient should be made, even partial: worries, illusions, projects, priorities, desires, knowledge, thoughts, attitudes, beliefs, emotions, behaviors), a social data record: poverty, social isolation, etc. and a record of the impact of the disease on the patient and family, work and the relationship with other people; understanding of illness, fears, hopes, etc. (2, 8, 26, 28).

Recognize and Record the “Master-Problems”

Multimorbidity is presented as non-operative to make useful decisions. Patients with multi-morbidity produce feelings of despair and impotence in the doctor. A major problem or energy or “master problem” is one in which, in the clinician’s judgment, for that patient, at that time, and that context, concentrates the greatest importance or significance for the patient’s health / illness, and that allows “advance” (open doors, change scenarios). A “master” problem is one that allows us to address or “cure” or “solve” facilitating the unlocking of a situation, change or move from one scenario to another with new perspectives or restore interrupted connections. So, finding the problem “with energy” is a subjective experience (29). In many occasions, we

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can find in the clinical interview and the taking of the clinical history, a series of signals that direct us, whether we like it or not, towards the “master-problem” (30). Having a record of “master-problems” implies that we could carry out selective or preferential interventions on these problems.

Doctor-Patient-Family Relationship

What type of doctor-patient-family relationship exists? This information should be written in the medical record. Doctor’s communication style is an essential factor predicting patient satisfaction and compliance. Further more, a good physician-patient relationship and high communication quality seem to be crucial elements fostering the activation of patients’ self-healing powers (31).

The types of doctor-patient relationship according to the control exercised by the doctor or the patient are: 1) when the doctor dominates the relationship when making the decisions that he considers most convenient for the patient, it is a “paternalistic” relationship; 2) The co-participation model (“mutual” relationship), in which control and power in the relationship are balanced between doctors and patients; each one strives to contribute and take responsibility as much as possible; 3) Patients or doctors do not exercise sufficient control, so the relationship is considered “absent” and patients can leave treatment thinking that they have not been given adequate care or that the doctor is incompetent or insensitive (31-33).

Clinical Record is Constructed and Reconstructed as a Sculptor Sculpts a Sculpture

The GMCR is like a puzzle that represents the totality of a person’s life. The various pieces are completed as the patient’s health biography is completed. They are added as time progresses and allow continued attention (1, 34, 35). On the other hand, remember that every bit of information you obtain from your history or physical examination that you do not record disappears with you and is irretrievably lost. The observation and recording of a certain sign or symptom at the initial visit, and days after the start, and even months later, can facilitate the recognition of the course, even aberrant, of a disease, helping a lot in decision making, for example on whether perform or not complementary tests (36).

Safety Net

At the end of the consultation, establish safety elements and write them down in the GMCR. It should be noted in the clinical record document, “what will I do if the patient returns for the same problem?”, “What will I do if my therapeutic intervention is not successful?”, “If I was wrong what will happen?”, “What will I do?”, “How will I know?” Thus, it is about establishing a “safety net” (37).

CONCLUSION

The most common form of narrative or biography of the disease consists of the CR; it is the official text of the experience of the disease. Since becoming a student, it is known that the taking of the CR includes elements such as: the main reason for consultation, the medical history that includes allergies, immunizations, previous illnesses, hospitalizations or previous surgical interventions, and medications usually taken, information on work situation, life situation, health habits, etc., and a family history that collects the health situation of close relatives (38).

But, a homeopathic doctor will take the CR in a different way than an allopathic doctor does, and even among these, an infectious specialist and a GP will make it different. Each CR could be adequate, but each professional selects different data as relevant. In all cases it is a narrative. The narrative of the patient is a tool that helps the professional to face the consultation: to make the diagnosis and treatment. The taking of the clinical history should make the patient’s experience more manageable by organizing it in a chronological sequence of events connected by causes, in addition to making it possible for the patient to relive his experience in the consultation, supported by the cognitive and affective competence of the doctor. It is also known that the rate of functional recovery of health problems is correlated with the story telling of the patient (39, 40).

In this article, we suggest a series of “twelve commandments” for the taking of medical history in the field of family medicine / general medicine, which are specific to this specialty, and which are not always explicit in the books of usual text, which are: 1) The contextualized CR: 1) First understand “who is and where is the patient” (its context), and then the doctor can move on to the topic of “what’s wrong”; 2) The consultation should be prepared before entering the

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patient, memorizing his previous history, so that we can devote all our attention; 3) It should always be noted in the clinical history “as if that case you were going to publish”, so that you have a full story, alive and rich; 4) Remember that it may seem that a single person -the patient- comes into the consultation, but it is only apparently: with him enters his family or companions and other relevant actors; 5) The individual GMCR is always familiar, and should integrate contextual and psycho-social data, and assessment of genetic risk, being a tool or for this, the genogram; 6) The GMCR must be “decentralized”: it is not about achieving a CR focused on problems but rather CR oriented towards the person in their context; 7) In the GMCR should be collected health resources / strengths of the patient; 8) GMCR should have biographical and psycho-social registry (concerns, illusions, projects, etc.), social data (poverty, social isolation), and Impact of disease in patient-family; 9) Recognize and record the “master-problems”: where are concentrates greatest importance or significance; 10) Doctor-patient-family relationship should be collected; 11) GMCR is built and rebuilt as a sculptor sculpts a sculpture, and thus the various pieces are completed as the patient’s health biography is completed (continued care); and, 12) At the end of the consultation, certain security elements should be noted in the GMCR (safety net).

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