Teaching by Chart Review in a Family Medicine Residency Program

Joseph R. Morrissy, MB and Dennis McCullough, MD
London, Ontario and Lebanon, New Hampshire

Our clinical team at St. Joseph's Hospital Family Medical Center in London, Ontario was dissatisfied with the quality of our record keeping and decided to institute weekly chart review to promote the problem-oriented system. As the quality of the records improved over the first few months, the group expanded its purposes, and other educational and patient care goals were addressed. This communication describes the style of these chart reviews and our experience with their educational value.

The Chart Review

The participants in the review sessions are the staff physician, the family practice nurse, and team residents in the center. The group meets for one hour weekly. The review process begins with the random selection of charts of two patients seen by each of the physicians during the week prior to the review. These charts are then distributed to all participants, with no member reviewing his/her own charts. Usually four or six charts are reviewed during the hour, although flexibility is allowed, depending on the productivity of the discussions of particular charts and problems.

Early objectives for chart review were: (1) to improve the quality of record keeping and encourage use of the problem-oriented system; (2) to initiate residents into the process of peer review and encourage its use as a continuing education device; (3) to improve the quality of patient care and specific problem management; and (4) to provide an additional means for monitoring care given by team members. Later objectives included: (5) to create a dialogue on practical standards for record keeping (applicable to practice settings with 20 to 40 patient visits per day); (6) to review individual patient preventive care programs; (7) to establish a forum for discussion of difficult problems and patients; (8) to encourage an overview of patients as individuals and of patients within their families; and (9) to learn to detect illness behavior patterns.

The review has been in effect for one year and has been well accepted by all members of the team. Other teams are now beginning to adapt it to their purposes.

Evolution of Review

The idea of a random chart review was accepted enthusiastically by the team. Peer or colleague relationships were already in existence on the team. The residents, family practice nurse, and staff physician were already viewing each other through one-way mirrors, so that chart review was a logical extension of the critical review that was already taking place.

The objective of improving record keeping was met immediately, and after the third or fourth session problem lists and medication lists were usually up to date. The progress note from the last patient visit was the only note reviewed in the early months, because it was felt that a more extensive review would probably prevent discussion of more than one chart. At this stage, concentration focused on the structuring of the record.

From the Department of Family Medicine, University of Western Ontario, London, Ontario. Requests for reprints should be addressed to Dr. Joseph R. Morrissy, Department of Family Medicine, University of Western Ontario, London, Ontario, N6A 1V8.

Slowly over the first few months, discussions turned more and more to the substance of notes and patient encounters. General discussions of clinical topics emerged. These topics ranged from well-defined problems, such as urinary tract infections, to more complex, chronic, and difficult-to-define problems. At this point, recognition of the usefulness of the linkage between progress notes and problem lists emerged. Until then, this had been a somewhat neglected part of the system.

Rapid problem reviews were more easily accomplished with well-linked charts. Handwriting problems also received attention. Confrontations over shortcomings in charting became effective when openly discussed from the point of view of team members who must use the chart in the absence of the patient's usual physician. Detailed information about the management plan began to appear more regularly in the notes. This improvement facilitated interaction with patients. Thus, chart use became quicker, and the patient's problems were perceived more readily.

Once a pattern of accurate record keeping was established, we were able to concentrate more on the patient problem and less on the accuracy of the record. Because of the initial experience, we were able to evolve another set of objectives.

It was apparent that needless information was being charted, and members began to confront one another with the question, "Do you really think you will be able to do that in full-time practice?" A more practical standard for record keeping was discussed.

Preventive care needs were routinely assessed. Out of this grew registers for pap smears and influenza immunization for high-risk patients. Residents began to better appreciate the importance of practice organization.

Comment

In the process of improving our record keeping, we have developed a useful method of teaching in several areas of importance to family medicine.

Particularly difficult patients or problems became more easily recognized, and the review sessions were used as a forum for discussion of them. While doubts existed about the usefulness of some parts of the record, these were dispelled by the review. The minor problem list was perceived as useful for alerting physicians to unusual illness behavior patterns. A patient presenting with multiple minor (or self-limiting) problems over many months was recognized as being likely to have some other family or intrapersonal difficulty that was previously unrecognized. The family data sheet and family charting system helped us to see how a rapid overview of an individual in his family could be obtained.

By the process of random selection and critical reflection, we frequently encountered hidden dimensions of physician/patient relationships. Comments such as, "Repeat blood pressure check" or "Another episode of vaginitis" often disguised other problems. The randomicity of chart review helped to jar physicians from chronically comfortable relationships. We repeatedly encountered two types of problems important for discussion in resident training which would seem to be overlooked by the usual formal chart audit. The first is the "undifferentiated illness"—the early, vague presentation of an illness at a stage before either symptoms or signs are easily categorized. The second is another difficult-to-define problem—the one that defies the disease-oriented taxonomy of most classification systems. In these instances, etiologies are often both complex and mixtures of social, psychological, and physical factors. Both of these difficult areas are uncovered by random chart reviews.

One of the major burdens that all primary care physicians must bear is the difficulty of living with the uncertainties which are so often associated with the early stages of the diagnostic process. Management decisions in these instances can be difficult to make. "To investigate or not to investigate?" "How far to investigate?" "To hospitalize or not to hospitalize?" Sharing these decisions with a group of peers serves as a supportive mechanism for the new resident.

Record review can help to illustrate problems in the individual or the family, either by the observation of "process" in the physician/patient relationship, or by the observation of the "process" by which a family receives its medical care. Furthermore, discussion of these topics by the team can help the coordination of the management plan. There is great teaching value in this process.

Acknowledgment

The authors wish to acknowledge the helpful criticism offered by Dr. Martin Bass during the preparation of this paper.