Research Article

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Patterns of Outpatient Rheumatology Practice: A Pilot Assessment of Clinical Record Content

Objectives

For high-quality patient care, high-quality medical records with detailed information about the patient and the disease are essential. RHEVER is a network of hospital- and office-based rheumatologists that was established in 1999 with the intention of pursuing a number of goals. One of those goals is the creation of recommendations regarding things that ought to be recorded consistently at each patient visit. In this way, one of the RHEVER individuals explored whether these suggestions were trailed by RHEVER members at an educating clinic.

Methods

At the rheumatology clinic of the Cochin Teaching Hospital in Paris, France, a sample of paper-based outpatient records was examined. The sample consisted of 30 rheumatoid arthritis patients' files and 50 files chosen at random.

Conclusion

The feasibility of rheumatologists evaluating practice patterns is demonstrated in this pilot study. Participants in the office-based RHEVER study ought to be the subject of a similar study. Evaluations of medical records have an effect on the quality of care, but further research is needed to assess the impact.

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Introduction

The Persian physician Avicenna (980–1037) kept clinical notes to track his patients' progress as early as the century [1]. For high-quality patient care, high-quality medical records with detailed information about the patient and the disease are essential [2]. In addition to assisting in the best possible care for each individual patient, good medical records also make it easier to share information among healthcare professionals and carry out retrospective studies. The items that should be recorded must be defined in order to improve the quality of medical records, and then the records must be checked for those items [3]. A good medical record is just one of many factors that contribute to the quality of care, and medical record audits do not provide information on this aspect. There have been published evaluations of the best format for medical records, particularly those intended for sharing among healthcare professionals; however, content has received significantly less attention. It is difficult to organize evaluations of compliance with recommendations regarding the content of medical records. In order to increase practice uniformity among network members and improve patient care, the hospital- and office-based rheumatologists' network was established in Paris, France [4]. Members agreed on a list of items that should be recorded in the patient's file at each visit for each disease to ensure that all healthcare providers have access to pertinent information. Members were asked to evaluate the recording of the selected items in the medical records of outpatients seen at a teaching hospital clinic. The items were chosen based on a literature review and the opinions of the members [5]. The network conducted this study with the intention of determining the items that ought to be recorded in medical files that are meant to be shared among healthcare professionals, determining whether members at a teaching hospital recorded these items, and assessing the viability of evaluating the medical-record

practices of its members at a teaching hospital, with the intention of subsequently carrying out a similar evaluation on records that are kept by office-based members [6]. The study was designed to be carried out in tandem with the previous one.

Methods

At the Cochin Teaching Hospital in Paris, France, we conducted a cross-sectional descriptive study of rheumatology outpatient files. During each patient visit at the rheumatology outpatient clinic, doctors manually enter data into paper-based records. An electronic database contains information about the visit and the diagnosis [7]. After reviewing the paper-based records, we selected patient names from the electronic database. There were two evaluations. First, we looked at 50 randomly selected.

Experimental design

One of us, JF, coordinated this evaluation, a cross-sectional study of medical facts, in June 2006. Beginning in March, each physician selected the five RA patients who had attended their previous five follow-up appointments [8]. Information were anonymised and recreated and fi les were looked for the significant things. We also asked each doctor how long they thought the whole thing had taken.

External evaluation versus auto-evaluation

We conducted a second evaluation: Auto-evaluation was used to evaluate the files; external evaluation was performed by a random network rheumatologist using the same grids for data collection and unaware of any other results [9].

Analytical statistics

Interobserver agreement statistics on paired data were used to compare auto and external evaluations using the Cohen's Kappa score. However, another agreement statistic, S of Bennett, was utilized in a manner that was comparable in some instances when kappa statistics were not interpretable.

Discussion

We discuss the efforts made by a network of rheumatologists to enhance and evaluate the content of rheumatology outpatient records. Clinical record quality is producing extensive interest. Although there are a number of publications on the best electronic format for medical records, the content of those records has received little attention [10]. The viability of rheumatologists' practice pattern assessment is demonstrated by our pilot study. In a significant number of instances it was also essential to demonstrate that a physician-led evaluation could yield results that were very comparable to those of an external assessment. Particularly with regard to the name of the physician, differences emerged. This item was kept because it was consistent with the hospital-based study and to educate the physician about the upcoming French shared medical appointments. This leads to a discussion of, among other things, the significance of some items and the potential benefits of computerized files.

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