Problem-Oriented Medical Record in Electronic Healthcare System

Guide to Systematic Writing

Gheun-Ho Kim

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Gheun-Ho Kim
Internal Medicine
Hanyang University
Seoul, Korea (Republic of)

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Preface

As clinicians, we should document medical records for every patient encounter. The medical record contains a variety of data from both the patient and healthcare providers. It is not just a collection of data; it also involves data analysis and interpretation for decision-making. For this purpose, a well-structured format is necessary to present scientific reasoning. The Problem-Oriented Medical Record (POMR) has been a standard for physicians' records since its introduction in 1968 by Dr. Lawrence Weed. It appropriately reflects the processes of clinical reasoning. The significance of medical records cannot be overstated at any given moment, yet not every medical student and resident may be educated on the proper utilization of the POMR system.

I learned about the POMR during my second year as a medical student in 1981. Thanks to my esteemed mentors, I have gained valuable insight into the POMR and have been utilizing the system in my clinical practice for the past 40 years. Despite my efforts to educate my students and medical residents about the POMR over the course of several decades, many physicians remain unaware of its real concepts and principles and do not properly implement them in their clinical practice. Furthermore, experienced clinicians did not reach a consensus on the POMR system and its terminology. I regret these issues and have decided to write a book that will provide a comprehensive understanding of the POMR and the proper techniques for medical writing that are in line with the principles of POMR. This book covers the principles and practices of POMR and describes how to systematically write medical records for diagnostic and therapeutic purposes for both inpatients and outpatients.

Medical records have recently transitioned from paper to electronic systems. Electronic health records (EHRs) offer numerous advantages in the digital era, but I do not think that they currently adhere to the principles of POMR. I believe that clinicians who have insights into POMR should participate in the development process of electronic medical or health record programs. Artificial intelligence (AI) technologies are being applied to the field of medical records. Although there are many limitations to integrating them into the complex POMR system, the field of AI in healthcare is still evolving. I believe that the concept and principles of POMR can be pre-

served in future AI-based EHR systems. I hope this book will provide insights into the development of more advanced digital-based electronic medical record programs.

Finally, I am grateful to my wife for her understanding and support throughout my professional career.

Seoul, Republic of Korea Gheun-Ho Kim

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Patient Medical Record

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The medical record is a systematic documentation of a patient's medical history and care over time, written by healthcare providers. It is a fundamental part of a clinician's duty to provide optimal patient care, which includes taking various types of notes. These notes consist of clinical findings, decisions made, diagnostic workup, information provided to patients, agreed-upon actions, prescribed medications, surgical procedures, and treatment outcomes. These processes should be summarized in a sequence.

Medical records are confidential and should only be accessed by authorized healthcare professionals who communicate with each other for team-based care. The patient has the right to access his or her medical record and request a copy for various purposes. Therefore, clinicians must be cautious and diligent when writing their medical records. Box 1.1 presents the major contents of the medical record.

Box 1.1 Major Contents of the Medical Record

Identification information
Clinical findings: medical history, physical examination, laboratory data
Decisions made
Diagnostic workup
Information provided to patients
Agreed-upon actions
Prescribed medications
Surgical procedures
Treatment outcomes

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