Health Communication Issues: Collecting & Remembering Medical History

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Why did you have a hospital visit when you were 14 months old? Did your great-grandmother have blood pressure issues? What did your urologist read on your most recent ultrasound? What's the name of the medication you take and how many mg? All of these questions are buried within the medical history portion of patient paperwork. Whether asking for past surgeries and hospitalizations or confusing medical information, the physician needs this information to accurately and efficiently diagnose the patient and recommend treatment options (Medline Plus). Not having access to the correct information can actually harm the patient if, for example, the medication used to treat the illness reacts with other common antidepressants that the patient is also on, they just forgot to put it in their medical information(Twomey et al., 2018, p. 2-3). So why is it that providers expect patients to remember all of this information while sitting in the waiting room when there are more efficient ways that require only the click of a button?

Collecting Medical History: Currently

Anyone who has ever attended a medical appointment knows that right after check-in, the patient is handed a stack of papers and expected to fill out *all* of the information. For many, recalling proper medication names, diagnoses terms, and family medical history can be difficult. While the patient may know that they take their anxiety medicine once a day, they may not know that they are taking 100mg of Zoloft, at least without looking at the bottle. With it being the 21st century, there have been numerous technological advances, so why is it that medical history is to be filled out on the spot when there is a limited time slot allocated to each patient and anxiety is high(Kessels, 2003, p. 220)? The inconsistencies and inefficiencies that occur during this process cause harm to both the patient and provider, but neither is to blame. The system is at fault.

Consequences of These Methods

Though not always obvious, there are a multitude of issues associated with this method of receiving medical history. For one, incorrect recall of medical history can be detrimental to a person's health, even fatal(Medline Plus; Twomey et al., 2020, p. 148-150). For example, if a female patient incorrectly assumes that their provider knows they are pregnant, the provider can recommend otherwise effective treatment options that can harm the unborn child. Failure to mention a specific medical state or medication can leave the patient worse off than they were when they entered the office. Then, the patient may require more visits to fix the problem; meaning more time, more money, and more paperwork(Nichol et al., 2022).

While the patient may seem to be most at risk, there are still significant impacts on the provider and their office as well. After receiving the paperwork during check-in, office staff are expected to enter the information into the, usually, *electronic* medical record system which is a recipe for disaster. This process sets staff up for failure concerning miscommunication and mistakes because it is so easy to forget a line in translation or shorten the information when details are necessary. If the information happens to be insufficient, then the diagnosis and treatment may be wrong, meaning that more time and resources must be allocated to the same patient for the same illness at a future appointment. In all, this system is a waste of time and resources as well as a cause of frustration and anxiety for patients and their providers.

Collecting Medical History: For the Future

So we know that there is an issue with the current system, but then arises the question of what can be done. There have been a few models in healthcare that effectively show a more proper way to complete this process. Something increasing in popularity within hospitals and larger health groups is the implementation of online health portals(Helmers et al., 2019, p. 319).

With the portal, patients can insert their medical history online and a provider within the same system can edit the information. The Mayo Clinic uses this system and requires all of its campuses across the U.S. to use an interconnected and streamlined medical record system so that each office holds the same information(Helmers et al., 2019, p. 325). This way, patients do not have to answer the same questions for each department about their medical history and notes from each appointment can be easily shared with other providers(Helmers et al., 2019, p. 319).

Another well-researched plan is to collect medical record information at specific points in time, not just fifteen minutes before an appointment. Sending a form to be completed every 3-6 months would allow patients to review information already recorded and add anything that may be notable from the past few months. After submitting or returning the documentation, medical record employees could review the information and enter it into the system.

Possible Setbacks

Though the idea seems great, there are always setbacks in innovation. For one, creating an electronic medical record system would require every healthcare facility to learn the system, train for the system, and convert thousands of data entries over to another format. Most health providers would not be willing to undertake this task within their office especially if they are already comfortable with the format of their current system(Weiner, 2019, p. 2299-2300). Even having the patients do this online could take a lot of time and lots of information would be at risk of getting misplaced or lost in translation.

Secondly comes the issue of privacy and security. Everything seems fine when we think of the benefits of having all information in one spot, but what happens when there is a hole and figures out a way to hack into the system? Not only would they be able to find records from one

visit, but all records up to date for all departments and facilities. Patients and their providers may be reluctant to create such a system that gives criminals access to all information so easily.

Finally, in relation to the recurring collection method, this would require more medical record staff per patient to handle the information. There would have to be enough personnel to request the medical history, check the information, and then again, put it into the electronic system. This change would increase costs per patient, which is another challenge that the American healthcare system does not need to magnify anymore.

How Providers Can Help

Even if our healthcare world is not ready for a drastic change, there are still advancements that individual providers can implement in their offices to help make medical history more recallable and accurate. For one, providers can enhance communication with other providers prior to patient appointments to crosscheck information about recent diagnoses or treatments that the patient may forget. If there are any notable diagnoses or treatment regimens to consider, such information can be faxed over so that the patient is not solely responsible for remembering all of the details(Twomey et al., 2018, p. 2-3). If providers are looking for a quicker and easier method to help patients, they may want to try providing patients with a list of what should be known and included in medical history or even encourage patients to take notes to help them remember what exactly to mention in medical history paperwork for future appointments(Laws et al., 2018, p. 1-10).

How Patients Can Help

In recent years, patients have been encouraged to be better advocates for their health, so many may find themselves asking what they can do. Patients hear a lot of confusing terms and directives at each medical visit making it difficult for them to understand, let alone recall this

information for the future, but there are many ways to overcome this dilemma(Twomey et al., 2020, p. 152-153). For one, patients should not be afraid to ask questions and clarify what they are hearing(Bergerum et al., 2019, p. 959-960). If something sounds wrong or confusing, then ask the provider for further understanding. Similarly, having another set of ears at highly important appointments may be beneficial later on when the patient is trying to remember medical history(Bergerum et al., 2019, p. 959-960). And if this is not an option, then taking notes to refer to later can also help.

With that being said, even if someone understands what is being said at a previous appointment, the craziness of the office when they are filling out paperwork may distract them or make them anxious, causing them to forget certain medical-history-related information(Hopkin's Medicine; Twomey et al., 2018, p. 2-3). In this case, patients have the ability to keep a medical file on their own at home that includes family history, allergies, medications, and important diagnoses or treatments that they can then print out and bring to every appointment(Hopkin's Medicine). If they are not aware of what to include on this file, asking for a copy of medical history paperwork from a provider or looking online can help answer many questions and create a good guide. Having this sheet would allow patients to record their medical history without much thought and update the information as appointments occur.

Conclusion

Why Should We Change

Without this change, medical history will continue to be inconsistent and inefficient, which can harm the patient’s health outcomes. Providing adequate health history, especially family history, can be the answer to so many diagnoses. This information makes knowing risk factors easier and recognizing early signs of illness quicker, which in turn can increase the

effectiveness of preventative care and lifestyle changes to help the patient(Medline Plus). The communication between all healthcare-related occupations would improve, including health insurance coders. Likewise, this intercommunication and teamwork will reduce stress, frustration, and waste within healthcare facilities since many resources, including time, could be better allocated(Medline Plus).

How Does This Ultimately Affect Healthcare

In reference to the larger picture, there is also the fact that providing caretakers with a more detailed and accurate health history, actually reduces resource use. With the right information, a provider can give diagnoses and treatment options better suited to the individual so that they do not require as many return visits. As many know, time is already a lacking resource in healthcare, especially in American healthcare, so it is adamant that they conserve as much time as possible(Nichol et al., 2022). Likewise, having a universal system for medical information or obtaining records in periods, not all at once, reduces a patient's time spent in the waiting room filling out paperwork, another time-conserving activity. Making this information more easily accessible and accurate can grant providers the opportunity to not waste valuable resources and treat patients in a quicker, more efficient manner.

Do Better

Now is the time to make the change. Do what needs to happen at an individual level and encourage larger systems to create an online medical record system. A lack of communication regarding medical history can create struggles that neither the patient nor the provider wants to experience and can even include physical harm being done to the patient. Without a change, these adverse events will continue and resources within our precious healthcare system will continue to go to waste.

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