Abstract

I’ve previously argued that there are at least three realities to a patient’s healthcare: 1. patients’ physical condition as reflected in laboratory reports, X-rays, observations; 2. clinicians’ mental models of patients’ conditions, including possible diagnoses; and 3. representations of patients in the medical record... usually the electronic health record (EHR).

In this presentation, I’ll discuss that triangular model, and then expand it to include a fourth participant: the patient and the patient’s family. The patient of course was always a stakeholder but was previously usually prevented from participating in an active role. However, changes are afoot: 1. Patients increasingly provide data from wearables and other digital devices that some seek to incorporate as active parts of the medical record; and 2. “open notes” – where patients have access to the physicians’ notes and discussions – changes the landscape in several ways. Physicians, aware that they can be read by patients, may avoid belittling observations and terms, and have sometimes cloaked their comments in ways that may not be obvious to patients. On the other hand, to the extent that the notes serve primarily as a record and guide for other clinicians, any alteration or ambiguity of the notes may adversely affect patient care. Added to this, physicians and IT staff must also now develop ways of incorporating patients’ efforts at corrections, additions, and demands for deletions—some of which are of unknown validity.