Historically, medical records have been maintained by individual physicians to record specific information concerning patients. This information was often understandable only to the writer. The data were of outstanding events. This was thought to be sufficient documentation for patient care.

Records are now read by others than the individual physicians. Groups of physicians working together often share the same patients and their records. Patients may have multiple sources of care. Our population has become more mobile which makes it necessary to transfer vast amounts of medical information. The medical record many times is the one instrument which gives a complete and continuous documentation of the patient’s medical history.

Third-party payers are requesting access to medical records to document services provided. Chart audit is being tested as a mechanism for evaluating physician performance. Records must reflect what the physician does in order to be useful in such an appraisal. Much clinical research on the delivery of health care depends on accurately kept records which are easily interpreted. A chart is also a legal document for the protection of the physician as well as the patient. Thus, records will be used in other than traditional ways. Proper confidentiality must be maintained when such uses are necessary.

Physicians generally agree as to the essential content of a medical record. However, there is little unanimity as to the structure of the chart. No one system of keeping records is now appropriate for all situations.

The maintenance of adequate charts requires additional cost in both time and money.

Many commercial organizations are trying to develop better record-keeping systems. Many of these systems have been reviewed by the Committee. Each one has its own merits, but none has universal acceptability. Until more effective record systems become available, the membership is to be reminded as to the varied uses of a medical record, its essential contents, and the need for its completeness, legibility, and the easy retrievability of data. Current Pediatric Terminology (CPT3) as developed by the AAP may be recommended as a coding system for procedures. A diagnostic code such as ICDA8 may also be useful. More detailed statements in these areas will be forthcoming.

Medical educators must review and evaluate the content of the charts of their institution. They should also assist trainees in the transition from the recording of the voluminous data necessary in the initial learning process to the practical recording of the information required for ambulatory practice.

Since the exact form of a standard chart for child health care has not yet clearly emerged, it is recommended that the American Academy of Pediatrics keep itself informed of all new developments and be available as consultant to those devising record systems.

Committee on Standards of Child Health Care

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Pediatrics 1975;56:329

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