

## Importance of Patient Medical Data and Records

Health records are extremely important databases for health providers to improve the quality of medical services provided to patients. With a continuous recording of a patient's medical data by medical staff and clinicians, the healthcare systems can ensure a proper diagnosis, monitoring, and treatment. Recently, recording medical data has become more developed and involves advanced technology. In the past the doctor was the only one who writes medical information but now all clinical staff participates in this task. Furthermore, medical records are now kept since the birth of an individual until his/her death and are extended to be included in the history of diseases in other family members (Marinič, 2015).

All clinical data, diagnostic images, lab tests results, and other health information are recorded in either paper or digital forms. These records can be used to improve the quality of patient care and can be involved in educating the clinical staffs as well (Donaldson & Lohr, 1994). As a part of medical education, it is crucial to teach medical students how to write up a problem, focus on the related clinical data, and produce a good audit, then move on to next problem.

Good records of a patient's medical data on admission containing all presenting health problems are important for the follow up of the patient. These records can be used afterward to assess the state of any given health disorder and decide which problem is still unresolved. What's more, the patient will not be discharged until updates about all of his recorded health problems are solved and until the records for future follow up are made (Weed, 1969).

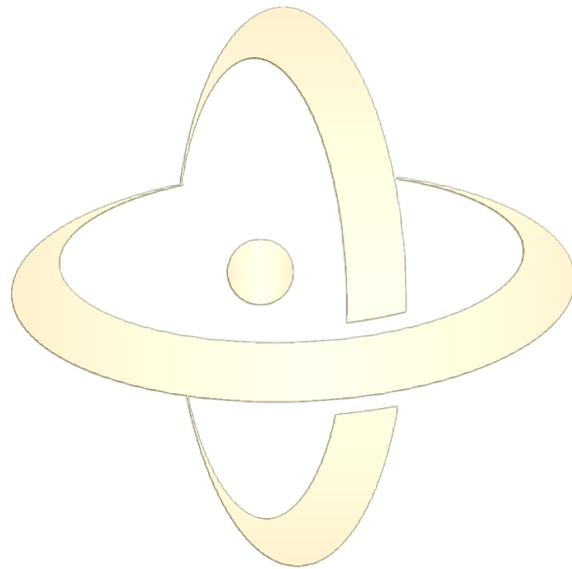
Another beneficial role of the health record is to confirm the patient's right to know if his medical problem was treated well or not. Every patient has the right to access his health information, know about who was acquainted with his medical data and consult his health records when needed. Moreover, patients also have the right to request blocking, erasure, or amending of their records if they include inaccurate facts (Marinič, 2015), since keeping accurate health data is crucial for the patient's privacy and work performance. A well-managed health records are also essential for quality assurance of medical services and monitor the standard of health-related processes such as diagnosis pattern, type of treatment, and performance of medical staff.

On a larger scale, health records can play a key role in health development in the whole country. The saved health information such as patients' details, diseases, diagnosis, investigations, and medications prescribed by clinicians are vital data to decide general health strategies and researches (Karki, n.d.). Either short-term or long-term health development plans can be constructed based on the interpretation of these records that can indicate diseases outbreaks, the seriousness of illnesses, and the effectiveness of medications. Furthermore, the study of health records in all medical service providers can provide accurate information about the health condition of certain demographics, reasons for diseases, and the medical coverage of the population by sufficient health providers and workers. Above all, many research organizations can depend on health records conducting clinical and research studies to enhance the quality of medical devices and pharmaceutical industries

### References:

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