August, 2003

PATIENT POWERline from the desk of Marie Savard, M.D.

RE: Dr. Susan Lark's Newsletter, "The Lark Letter"

Dear Friends,

I was invited to be a guest author for Dr. Susan Lark's newsletter, "The Lark Letter", August 2003 issue. Dr. Lark is one of the foremost authorities in the fields of clinical nutrition and preventive medicine. I'd like to share with you what I had to say.

The Information That Could Save Your Life

A few years ago my then 73-year-old father was rushed to the hospital after my mother noticed that something was "just not right". He had heart bypass surgery only a few weeks before. By the time I arrived at the hospital two hours later, he was gasping for breath, suffering from a potentially lethal arrhythmia. Doctors on duty were at a loss as to how they should treat him when the most likely culprit – a drug called digitalis – did not turn up in the bag of medicines that my mother had brought. "He is taking digitalis!" I said, but without the bottle present, and with doctor offices closed for the evening, I was helpless to verify that fact. Luckily my story had a happy ending and my father was treated as if on digitalis. However, not all of us have the memory for the medications that we take – let alone our parents take – in an emergency.

We keep financial, car and pet records, but how many of us keep our medical records? Most of us rely on strangers to keep our health information up to date and accessible – when the only person you can rely on for this information is you.

If you are like many people I talk to, you may be wondering why your doctor can't do that for you. In the three decades since I launched my health career, the practice of medicine has changed. It has grown increasingly complex and specialized; no longer can one doctor do it all. My own experience as well as recent research has shown that the more you get involved in all aspects of your health care – including collecting and understanding your medical records – the better off you will be.

As a family doctor I learned first hand the importance of my patients taking an active role in their health care and keeping copies of their health information. Many of my patients had complex problems requiring multiple doctors. Some of them were spending winters in the Sunbelt, which meant they saw a different doctor for half the year. A lot of them were seeing complimentary care practitioners and using complimentary therapies. New patients often came for an initial office visit with no paperwork at all. I had no concrete data to go on – no consultation reports from doctors, no X-ray reports, no test results, no list of medications or immunizations, no history of allergic reactions, no hospital discharge summaries.

Not only that, but when I shifted from a solo practice to a group practice (as did many of my colleagues during the last decades of the 20th century), my "panel" of patients was over one thousand strong. In contrast, Marcus Welby, M.D. had a few hundred patients he took care of from cradle to grave. He knew their names, he made house calls and he kept all their records tucked in his desk drawer. Without even referring to those records, he pretty much remembered who was allergic to penicillin and bee stings, who was on insulin, who had high blood pressure and even who was overdue for a check-up.

Today's doctors couldn't possibly carry all of those details around in their heads. We have lots more information about each patient to keep track of, not to mention keeping up with the near daily breakthroughs in medical research. Yet if you're like most people, you assume that your doctor does precisely that even though you probably don't know your own medical history or the details of your medical conditions by heart. (When was your last tetanus shot? What antibiotic successfully treated your last urinary tract infection? What is your LDL cholesterol level?)

The fact that doctors are dealing with information overload is only part of the reason you need to take charge of your health information. Doctors are further hamstrung because they don't even have a desk drawer or file cabinet full of comprehensive records to fall back on anymore. When patients move or change jobs and therefore have new insurance plans and family doctors, charts are not routinely transferred. Even if you sign a release to have your records transferred, complete records are rarely sent to your new doctor, and too often records are lost or not sent at all. Women often have their records divided between a gynecologist and family doctor. (Who has your last Pap test result? Mammogram report? Recent blood test results?)

Hospital discharge summaries, specialist consultation reports and critical emergency room findings should be sent to family doctors, but that doesn't always happen. Worse yet, in large practices, consultation reports and test results often get lost or filed in the wrong folder.

Did you know that 80% of what a doctor relies on to make an accurate diagnosis and recommend the right treatment plan comes from the information in your medical records? This information is arguably more important than any other. Imagine the difficulty of making a diagnosis – let alone recommending the right treatment - if information is unavailable, incorrect or incomplete.

I believe the solution to this crisis is a grassroots effort, with each of us taking medical matters literally into our own hands by compiling our own medical records. I developed a simple but revolutionary system that will teach you how to do it. This system grew out of my 30 years of experience first as a nurse, then as a doctor but also as a mother, daughter and caregiver. It is in response to these profound changes in the practice of medicine; changes that make it more important than ever that we, as patients, take charge.

Key among the steps to my system is collecting and reading copies of your medical records and making them available to everyone involved in your care. I first wrote about

this in 1996 in Women's Day magazine and have been on a mission to teaching patients how to take charge of their own health since that time.

People are often surprised to learn that ethically and legally they are entitled to copies of the information in their medical records. Despite that fact, doctors and nurses often hesitate to let patients have a look at the vital information that rightfully belongs to them, fearing they will not understand or become unduly alarmed. I have found that almost everyone wants to know the truth about his or her medical condition, no matter how serious it may be.

To make matters worse, after reading their records, some people discover incorrect information about medications and allergies. Others learn that their doctors overlooked critical findings in x-ray or blood test results. Still others learn about misleading or missing information in their records only after mistakes happen that could have cost them their lives.

When my father-in-law was hospitalized recently in Florida for a serious knee infection, the nurses initially refused to let me review his medication record despite his approval (patients must authorize family members to look at their records). I persisted and upon review of his records quickly discovered what I suspected. He was receiving large doses of narcotics to relieve his pain at night – which caused him to become confused and disoriented. The daytime nurses insisted he wasn't receiving anything out of the ordinary – forgetting that pain medication can have a much stronger and prolonged effect in the elderly.

By now you may be asking yourself, "What will my doctor think about me asking for copies of my medical records? Will he refuse to give them to me?" Time and again when I lecture or conduct seminars, I hear people voice a fear of antagonizing doctors and hospital personnel by requesting records. Ironically, however, when I speak to most doctors on this topic, they react with enthusiasm and relief. They understand immediately that patients who collect and study their own records and who make it their business to become well informed about their health concerns will be in a better position to join forces with them instead of worshipping them or seeing them as the enemy.

As women, we make most of the health care decisions (and provide most of the care) for our selves, our children, our parents and our partners. So let's face it, we are in the best position to ask for and begin keeping records for everyone in our care. What better gift to give a child going off to college or starting out on their own than a complete medical record. Imagine the comfort an elderly parent will feel knowing that you are helping them keep track of their medical information and test results. I know that my parents, previously afraid to question their physicians, feel a tremendous piece of mind having a copy of their vital information at their fingertips to share with the many specialists and practitioners they see.

And if your doctor questions or disagrees with this newly found power – maybe it is time for you to question whether your doctor is right for you. The long-standing paradigm of

the all-knowing physician as the authority figure in a white coat simply doesn't work anymore.

Next month I will teach you how to be at the center of your own health care. I will give you helpful tools and show you how to:

- get your test results and specialist's consultation reports starting with your next doctor visit
- locate as many existing records as possible, and fill in the gaps on your own.
- keep on-going logs, journals and information sheets which contain life-saving facts that only you can provide.
- fill out an emergency health information card to carry with you at all times.
- take an active role working with your health care team in preventing and managing health problems.

This may sound daunting but it doesn't need to be. In the process, I promise you will become a fully informed participant in the decisions and care that could someday save your life. My dad now carries an emergency health card in his wallet listing all his medications, allergies and medical conditions; he literally, "won't leave home without it".

I think of you as a Patient Power™ pioneer. My hope is that someday soon, with your help, patient-held medical records will be the rule instead of the exception. Congratulations for being among the first to take control of your health information.

Warm regards,
Marie Savard, M.D.

To learn more about Dr. Savard's health management system, download free forms and a sample letter to your doctor, or to order her book How To Save Your Own Life: the Savard System for managing – and controlling – your health care (Warner Books, Inc. 2000), visit http://www.drsavard.com. To order a copy of the Savard Health Record: a six-step system for managing your healthcare (Time-Life, Inc. 2000), email info@drsavard.com or call 1-877-728-2737 and ask about how you can purchase a copy for just $5.00 each, with a purchase of 2 or more copies.

By using the information and forms, in "The Savard Health Record", you will learn to how to prepare for office visits, set your target goals, collect and read your medical records and understand your test results. In short – you'll have everything you need to manage your health care right at your fingertips.

Marie Savard, M.D. is an internationally known internist, women's health expert and champion of patient empowerment. She is the founder of The Savard System, dedicated to teaching patients how to manage their own healthcare. She is the author of two highly acclaimed books, How to Save Your Life: The Savard System for Managing-and Controlling-Your Health Care (Warner Books, Inc. 2000) and The Savard Health Record: a Six-Step System for Managing Your Health Care (Time-Life, Inc. 2000).

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