The use of electronic health records will become as commonplace in doctor offices as the stethoscope before 2015 and with it will come a mutual expectation by doctors and patients that patient information, with their permission, will be available for both to share.

Patients will expect to have their health information readily at hand when seeing any health care professional. Patients will own their electronic health information and it will be available to them from home, office, anywhere, no matter where they travel in the world through the power of patient portals on the internet, flash drive technology, and/or secure cell phone transmission.

Because it is readily available, patients can contribute to the accuracy of the information, making it safer for them to receive care. They will own more responsibility for their health and their healing by having this information, and will be contributors to their medical record along with their doctor. This secure shared access will open up new possibilities for how the doctor and patient interact and will create new options for how medical care is delivered in the community, the state, the nation and the world, through methods like the internet, cellular phone technology, telemedicine, and other solutions.

Doctors will have an open and collaborative relationship with patients, sharing the information and making decisions together about patient health. They will have easy-to-use tools to support them in knowing the most current information and in making medical decisions so that they can "do the right thing. The information, with patient permission, can be shared across health care providers providing continuity for patients as they move about the country and the world.

Reimbursements for services will be aligned with this new information access approach, streamlining the process for submitting claims for reimbursement and rewarding participation in a community record approach to medical information sharing.

Patient safety will be improved because legible, transmittable information can be shared from primary care physician to specialist to the hospital emergency room to the long term care facility.

Electronic medical records systems will contain functionality that allows the physician, with the patient's permission, to share key clinical information with a specialist when they refer. And, the consultant, upon completion of their visit with the patient, can elect to return the consult note, fully integrated into the patient's electronic record. The primary care physician, the specialist and the hospital-based physician will all see pertinent elements of the patient's record including test results, prescriptions, allergies, problem list and progress notes.

Purchasers of electronic health records will realize a return on their investment beyond what could be imagined, and the care delivery process will be optimal for those who provide and those who receive care.

Overall, the health of patients and the health care system will be enhanced and the health care system will be a safer place to receive care, permanently altering how physicians and patients relate to each other and meeting many of the Institute of Medicine recommendations to restore quality to the delivery system.

©The Robertson Group LLC 2006