

What is Open Clinical History?

Open Clinical History is a working proof-of-concept platform for turning fragmented, unstructured health information into a coherent longitudinal clinical history.

Health information is often spread across scanned letters, discharge summaries, pathology reports, specialist correspondence and records from different hospitals or clinical systems. Even when the information exists, it can be difficult for a clinician or patient to quickly understand the complete history.

Open Clinical History is designed to take those source documents and transform them into a structured, navigable clinical timeline while preserving the relationship back to the original source material.

The platform combines document ingestion, clinical event extraction, terminology classification and anatomical visualisation to make a patient's history easier to understand.

What the platform does

At a high level, Open Clinical History:

- ingests raw and unstructured clinical documents;
- identifies individual clinical events from those documents;
- records dates, event types and supporting source information;
- classifies clinical concepts using SNOMED CT;
- associates relevant events with anatomical structures where possible;
- presents the resulting information as a longitudinal clinical history;
- provides anatomical visualisation to help show where relevant events occurred;
- retains provenance so extracted information can be traced back to its source.

The goal is not simply to summarise documents. It is to create a structured clinical history from information that was never originally designed to work together.

A longitudinal view instead of a document list

Traditional record repositories often present health information as a collection of documents.

A clinician may need to open multiple PDFs, letters or reports and reconstruct the patient's story manually.

Open Clinical History instead focuses on the clinical events contained inside those documents.

A discharge summary, specialist letter or pathology report may contain several clinically meaningful events. These can be extracted, dated, classified and positioned within the patient's history.

The result is a timeline that can show how the patient's health has changed over months, years or decades.

SNOMED CT classification

Open Clinical History uses SNOMED CT as its clinical terminology foundation.

Rather than relying only on free-text labels, the platform attempts to associate clinical events with recognised SNOMED CT concepts.

This provides a consistent terminology layer that can support:

- clinical classification;
- terminology searching;
- anatomical relationships;
- future interoperability;
- more reliable analysis of longitudinal health information.

The platform maintains a local SNOMED CT terminology database and uses that local terminology as the authoritative source when validating classifications.

Anatomical visualisation

Where a clinical event relates to a part of the body, Open Clinical History can associate that event with an anatomical structure.

The platform maintains an anatomical image catalogue linked to clinical terminology concepts. Relevant anatomical layers can then be highlighted when viewing a patient's history.

This provides an additional visual way to understand the patient's clinical story rather than relying entirely on text.

Source traceability

Clinical information should not become disconnected from the document from which it originated.

Open Clinical History therefore retains provenance information linking extracted events back to their source material.

The structured event is intended to help a user understand the history quickly, while the original source remains available for verification and clinical context.

A working proof of concept

Open Clinical History is currently a working proof of concept.

It demonstrates that fragmented clinical information can be:

1. ingested from unstructured source material;
2. converted into discrete clinical events;
3. classified against a recognised clinical terminology;
4. associated with anatomical structures;
5. presented as a coherent longitudinal history.

The project is continuing to evolve, particularly around clinical validation, interoperability, terminology governance and the safe use of AI-assisted extraction and classification.

What Open Clinical History is not

Open Clinical History is not intended to replace a clinician, electronic medical record, diagnostic system or source clinical documentation.

It is a tool for organising and presenting existing clinical information in a more understandable form.

Any extracted or classified information must remain traceable to its source and should be reviewed in the context of the original clinical record.

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