HOSPITAL RECORDS: RECORDS OR A SCIENCE OF DISEASE

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Summary

The findings of an attempted retrospective study of medical records of 1,107 patients admitted to the Universitv Teaching Hospital during a two year period have been elaborated. As a result of a poor filing system only 734 case notes could be traced. Of the latter, due to inadequate and inefficient clinical entries into the files only 369 files were found to contain enough information which could have formed a basis for any meaningful clinical study. The importance of medical records had been stressed. It has been suggested that a clinian's responsibility does not end merely by being involved in the medical care of a patient. A physician should ensure proper entry of the daily events into the file, as well as feel responsible for the way hospital records are filed.

Introduction

All too often, the subject of hospital records is "obviously" a matter for records clerks and some other non-medical or even paramedical personnel. They are the people who "should and must" take care of the hospital records. The people who are usually employed in records' departments tend to have minimal education and usually have no idea of what is contained in the files and documents they keep. Hence the tendency for them to "just get on" with their jobs.

The medical and clinical sciences have developed over a long period of time. It has been a slow and tedious process in some cases. The early practioners of medicine described and wrote down their observations in a very precise manner.

In some cases these have turned out to be the CLASSICAL descriptions of syndromes even to-date. In some cases people have been able to look back at past records and then compare them with the present findings. This has led to a clear understanding and elucidation of various disease conditions.

It is for this reason that in most developed and third world countries, the authorities have paid careful attention to the manner in which hospital records should be kept. It is these precise observations which ultimately constitute SCIENCE.

Science is made by people who live in a specific time and place. It involves a highly selective rendering of nature, arising out of an interpretation of the events as seen by a circumscribed group of people. Doctors are not just medical practioners, they are scientists. Besides providing for preventive and curative services to their community, doctors have a duty to contribute to the development of medical science in their locality. They have the authority to define the truth and reality of the various clinical conditions that they see in their locality. It is, therefore, imperative that doctors must put down clearly their thoughts and observations in the records they help to make during their working lives.

However, the situation does not seem to be so encouranging for most hospitals in this country. This situation becomes all too obvious to those who have tried to look back over a period of time and study the behaviour, management approach or incidence of various disease conditions. One can meet an endless string of problems. It is these problems, which were encountered while conducting a retrospective research in the University Teaching Hospital, that has prompted the author to share them with readers of the journal.

Material and Methods

The study covered a period of two years, January, 1981 to December, 1982. A total of 1,107 admitted cases were selected for a study. Of these, 373 had no hospital numbers and as a result neither these files or the patients could be traced. Of the remaining 734 traceble cases only 408 files could be located and of these only 369 notes were found to contain information and has formed the basis of the present study.

Findings

a) The absence of laboratory results in the patient's file was a common feature. It was dif-

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ficult to know what laboratory investivations had been undertaken.

b) There was frequent absence of dates of commencing any treatment or undertaking any special procedures. All too often the description of a procedure left much to be desired.

c) There was indiscriminate use of unapproved/unscientific abbreviations. These abbreviations even varied from one doctor to another of the same word.

d) Illegible writing — "The doctors' writing". Because of poor spelling or figures, patients names and/or ages changed frequently as different people copied these detail onto new sheets of paper. This also made tracing of loose or stray papers difficult. It would obviously be better to write small, legible summaries than a mass of illegible entries.

e) Lack of provisional diagnosis or clinical impression despite the patients long hospital stay or treatment. One wonders whether the treatment given was non-specific or directed at a certain suspected or diagnosed condition.

f) Wrong (or different) diagnosis on the file. This was not altered as opinions changed during the patients' hospitalisation.

g) Lack of patients identifying data — such as names, hospital number, age and sex — with subsequent continuation sheets. This made filing of stray papers difficult as one would not know where to put them.

h) Incomplete statements of fact — for example — "home on ampicillin" or simply "home on treatment". This does not state the dosage and duration of the medication. Neither does it give any indication of whether a review of the patient was arranged or felt not necessary. Such information would be useful to someone studying the patterns of drug sensitivities by the various micro-organisms or the drug efficacy in other types of disease.

i) Omission of relevant clinical information such as the date of the last menstrual period (LMP) prior to carrying out a D & C procedure for diagnostic purposes. The LMP is a very important fact in obstetrics and gynaecology. Yet, this piece of information was absent in most of the gynaecological records utilised in the aforementioned study.

Discussion

Some of the above mistakes may be apparently "too obvious" to the doctor in-charge at the time. But this would not be so to someone who may take-over the care of the patient later. Let us take AGE as an example. This was one of the most common mistakes; it either did not appear or was represented simply as "A" (implying adult). This merely tells us that the patient was aged 15 years or more. Age is important in many respects; for example in communal diagnosis. Here one can later be in a position to tell of the kinds of diseases which are common in a certain age range in a particular locality. For such purposes an educated guess, based on certain events in the patient's life, is more important than merely indicating as "adult". In the absence of some of these facts the observations, impressions and trend of thought of previous doctors will not have contributed much to the science of disease at the particular time and in the particular locality. This will pass on as hidden knowledge.

As doctors, we must not hide out knowledge. We have been entrusted with authority to define truth and reality as it pertains to the health of a community during the period that we practice in that commnity. Our responsibility in this regard should not end with ward round entries in files; rather, we should help to develop and ensure that the methods for entering and keeping of hospital records should be of value in the development of the medical and clinical science in our communities. It is not just a matter for the records clerks and their supervisors. The concern for hospital records should start with the doctors; making careful file entries. Where possible, we should try to take an interest in the way hospital records are kept; the doctor should express concern if he sees to many torn files or loose/stray papers in files.

Usually corrective measures would be taken. It would also be better for the hospital administration to put up short courses (in service) in order to familiarise the records clerks with common hospital terminologies and also as a way of stimulating interest, enthusiasm and efficiency in the records clerks. Following such sessions, the clerks would be posted to the various departments, where arrangements should be made (at ward sister level) to acquaint them with the commonly used terminologies in that Department. Whenever practicable, assessment for promotion should include attendance and/or performance at the in-service courses.