charting. There might have been an age when memory served as a reference storehouse for information of past events regarding the treatment and symptoms of patients, but we fully realize the delusiveness of our memories, and the necessity of recording such facts as may be of present as well as future benefit to the patient, the physician, and the hospital. Nurses can be taught to jot down notations of symptoms and treatments at the time they have made their observation or carried out orders, and their actual charting time will be lessened, and more definite, concise, and accurate information will be recorded, which will be of value, not only to the physician at the present time, but also in legal cases, insurance cases, reentries of the patient, and future study and research for the physician.

This carries us to two other problems. The first is that of the Insurance Companies and lawyers. How much information of the patient's record should be given by the hospital to these respective parties, and whose consent is required to give this information? Some Insurance Companies send a statement, signed by the patient, authorizing the hospital to give the respective Insurance Company a copy of his or her hospital record. Other Insurance Companies simply ask for a copy of the record, without a signed statement from the patient. In either case it has been our custom not to give an information from the record without the attending physician's permission. The second problem presents itself in hospitals where each physician cares for his own private patients, and the patient later returns under the care of some other physician. Is the second physician entitled to the record of the patient's first entry without the consent of the first physician?

I have attempted to offer a solution for some of the problems here cited, others are left unanswered. In general, we may say that most minor problems, and many major ones, will readily solve themselves, where there exists wholehearted cooperation, good will, and understanding between the staff, the hospital authorities of various departments, and the record librarian.

A Meaningless Record

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The Chairman of a Record Committee once remarked to me that he could show me a record that would be passed upon by any group of librarians as an excellent record because of its completeness and detail, but it would not mean a thing because it was not a true story of work actually done for the patient. Although I am a worshipper of the completely detailed record, I would rather a record would be filed with very little information on it, providing it reflected a true picture of work done for that patient, than to have a very detailed record which I knew was not true.

I wonder if I might not give you a better idea of what I term a proper hospital record by explaining how I think a patient should be cared for in the hospital—for the sake of an example let us say for twenty-four hours—and at the end of that time showing on the hospital record what has been done for the patient. After the necessary data is obtained on the admission of the patient, the interne is immediately called and the history and physical examination are taken. There is no loss of time before the preparation is started for the examination or medical treatment of the patient. The attending doctor is notified and he either visits the patient and makes his examination or discusses the case with the interne and gives his instructions for treatment. These instructions are carried out in minute detail. The interne writes the history and physical examination as he obtains them and places them in the patient's chart. He then records an admission progress note incorporating in it reasons for hospitalization and a summary of significant findings with his impressions for differential diagnosis. As each procedure is carried out in the course of the treatment, it is promptly recorded, and as each observation is noted it is carefully written into the record. All those concerned with writing the record must keep in mind at all times that the purpose of whatever record is to be made is to reflect work done for the patient and that the hospital record is going to be nothing other than a recording of actual observations and necessary procedures in the examination and treatment of the patient.

This may sound rather academic, but have you ever attempted as you examine a record after the discharge of a patient, to evaluate that record? Have you ever wondered just how much of that record was written as a day by day account of the patient's clinical course, or was a true account of work done, and how much of it might have been written merely to edit the record? Were the history and physical examination taken at the bedside of the patient and promptly placed on the chart, or were they written from memory a few days, or even weeks after the admittance of the patient? Were those the actual symptoms experienced by the individual or was the case written up after the diagnosis was recorded and had the interne from his textbook knowledge of the disease recorded the symptoms to fit the diagnosis? Unfortunately that is too often the case.

Have you ever read over the notes of the progress of the patient and wondered just what they meant from the standpoint of the patient's actual

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clinical course? It seems to me that there is too much tendency toward using stock phrases, such as "condition satisfactory," and "no complaints." Many hospitals enforce the rule writing daily progress notes on all cases. Of course these notes will vary according to the type of case. Often in cases making an uneventful post-operative convalescence, and in some chronic cases, there will be noted on the progress sheet "condition satisfactory," or "no complaints," or "condition unchanged" day after day. But what does "condition satisfactory" mean? What observations have been made on which the doctor or interne making that note has based his opinion? Personally, I should prefer to see progress notes made at intervals of a few days (providing that nothing of importance has occurred each day) and have those notes really tell why the patient is in satisfactory condition, and what findings have been noted, what facts checked to warrant making such statements.

Have you ever stopped to wonder if the surgeon recorded the details of the operation performed immediately after completing the operation, or did he manage to slip away from the operating room without being caught, and write up the record—with much difficulty in recalling the details—a week or so later? Dr. John B. Murphy always said that a few words written at the time of operation were worth several pages written some time later. At St. Joseph Hospital we insist that all operative records be dictated by the surgeon immediately after the operation and promptly written up and placed in the patient's chart.

Have you ever had to hold up a chart for a few weeks till you could get the pathologist to write up an autopsy report? How much better it would have been if you could have persuaded him to write it while the anatomical picture was fresh in his mind. At our hospital we have been following a plan for the past few years whereby the record librarian attends all autopsies and takes the pathologist's dictation of a running description of the anatomical findings as he sees them. Three copies of this detailed report are made, one for the patient's record, one for the doctor and the third for the pathologist's files.

The nurse in her daily work may be too busy to do her charting immediately after she administers a treatment or makes an observation, and by the time she does her charting she may have forgotten the details of the procedure or how the patient responded. If a nurses' record were properly and promptly written the attending doctor would not need to see the patient to know exactly what had been done and what the condition of the patient was at any time during the day. I have observed cases in court where the nurses' notes have played an even more important role than the doctor's or interne's notes.

The American College of Surgeons is constantly increasing its vigilance in the matter of obtaining good, scientific records. But any hospital hoping to meet those standards must have some definite system whereby the record department will have a daily check on all records in the hospital to see that all parts of the records are being promptly and accurately written. A few years ago we started a system whereby the supervisors on the halls are required to check the charts and report to the Record Department any deficiencies noted. A notice is posted on the internes' bulletin board calling attention to deficiencies and a copy of the report given to the Record Committee. This is done every 48 hours. If the interne has not brought his work up to date before the next check he is called by the Chairman of the Record Committee and told to take care of the work immediately.

In the interest of obtaining good records I believe that every interne should be impressed with the importance of writing his history as he questions the patient at his bedside and also recording his physical findings on examination at that time. As one member of our Record Committee says "every patient is a textbook in himself, and the more we can delve into the details of his story, the more we are going to get out of the case from the standpoint of actual experience." And, after all, isn't that what every doctor wants, and doesn't he find it of much more value than reading up a case in a textbook?

Although the interne is under the guidance of the attending physician who supervises his work, the record librarian can do much to stimulate his interest in studying records. She can help him to realize the wealth of material of real value to him as a clinician, which can be obtained. If she can arouse the interest of the intern she will find that when his internship is completed and he is attending his private patients he will be willing to cooperate in keeping accurate and good records.

In conclusion let me repeat that a good hospital record reflects a true story of the patient's history and a clear picture of procedures actually carried out in the course of his treatment.

Let us strive to keep our records practical and to stimulate our doctors and internes to study them. We should not let our departments become "lands of missed opportunities."

Why Register

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It is highly appropriate at this time when our local branch of the Association of Record Librarians of North America is still in process of formation that some attention be paid to the subject