Contemporary Themes

Some Reflections on Medical Records

SIR HERBERT SEDDON

British Medical Journal, 1971, 4, 103-105

From being the private property of the individual clinician medical records have become part of the fabric of organized medicine. Indeed, they now excite interest at national and even international level. Medical records have two aspects. The first is documentation, which is the responsibility of several breeds of medical folk—the clinician primarily, but also the pathologist, radiologist, and, less commonly, experts in other fields. The second is the handling of the records, which at first sight seems to be no more than a clerical job though calling for some skill in organization and method.

Though the temptation is strong I am not going to discuss what the doctor writes or—usually less successfully—dictates. But a few observations are irresistible. The first is that nothing more faithfully discloses the quality of a clinician's mind than his case notes. Some of the gems of medical literature are the stories of sick or injured people recorded by men with great powers of observation and uncanny ability to distinguish between the essential and the irrelevant. I remember how Lord Horder used quietly to write his brief but all-embracing case summary as he listened to a student reading out his account of a patient's illness and of the physical signs he had discovered. The art of note writing deserves more attention; even when well taught, competence comes only with long practice.

The second question is immediately topical. Is the keeping of medical records and all that has grown out of it something to be taken more seriously? In our health service do we need yet another auxiliary profession for this work? The unit system was an enormous advance. In any one hospital each patient has one continuous record and one number. In the United Kingdom the inception of the National Health Service seemed to be an even more appreciable step forward. It was heralded, so far as medical records were concerned, by a now famous circular (R.H.B.(49)56; H.M.C.(49)44; B.G.(49)48) from which, because it is regarded by some as a charter, I quote the significant second paragraph: "The Minister welcomes the growing interest of hospitals in the proper maintenance and organization of patients' records and the decision of many of them to overhaul their records systems and appoint designated records officers. If this development is not to go astray, however, it is essential that only adequately trained or experienced officers should be appointed; and Boards and Committees who are contemplating making such appointments should therefore defer doing so, unless there are exceptional reasons for immediate action, until the supply of really suitable candidates has improved." For obsessive scribes such as myself this was manna from heaven; now we could have a decent records system. What is the position today over 20 years later?

Royal National Orthopaedic Hospital, London W1N 6AD

SIR HERBERT SEDDON, C.M.G., D.M., F.R.C.S., Honorary Consulting Surgeon

We will start with what for the patient is the beginning—reception. Some months ago I attended the outpatient department of an outstandingly good teaching hospital by appointment. A surly woman said, "Well, who are you?" She looked tired; probably overworked and perhaps underpaid. A patient's first encounter at a hospital—and some are scared out of their wits—is usually with a junior member of the records staff. These young people have to be competent not only clerically but in handling human beings; a pleasant welcome helps. A few patients are downright offensive; they have to be managed coolly and firmly.

Medical secretaries must be competent and have a good knowledge of medical terminology. They have also to watch over two interdependent kinds of people—the patient and that unpredictable creature, the clinician.

Indexing and Filing

Names, numbers, diagnoses, and forms of treatment, such as operations, all have to be indexed. There was a time when the term registrar had some literal meaning; he was responsible for recording (at least) diagnoses correctly, taking account of such last-minute revisions as might emanate from some wily pathologist. The names of operations have always been particularly tiresome since there are so many synonyms. Much has been done by learned bodies to standardize nomenclature, but the ever-present difficulty is to achieve some uniformity in usage. The registrars, who are in a position to know, retired from the fray long ago. The medical records officer has had to take over. Take a look at your own hospital indexes; if, as is likely, they are confusing think twice before blaming the medical records officer.

Filing is a devilish business. Lack of space alone is a headache. But the problem of retrieval is even worse. My oddest experience was finding that I had included the dossiers of two patients (exceptionally interesting cases) in the suitcase containing my wedding clothes. I refrain from repeating the subsequent comments. Inevitably we come to microfilming—a skilled business, particularly when one is dealing with the tail end of a case record with all its bits of paper and with the stuff that accumulates in the pocket of a folder. And soon the computers will be storing information.

Research

Some of the high churchmen of medicine have little use for the ordinary medical record as a research tool. If medical research includes humble fact-finding—that will benefit patients; too often, alas, only future patients—they are wrong. Surgeons are by nature enterprising fellows; they enjoy doing things. It is possible—I have done it—to show by simple retrospective survey that a certain operation is valueless, perhaps even harmful. And now that the physicians have racks of therapeutic bombs at their disposal their capacity for knock-

ing patients about is awe-inspiring. The notes tell—or should tell—the story. In Britain we are good at conducting controlled clinical trials, physicians in this respect being well ahead of surgeons. But sometimes a clinical trial, a prospective survey, cannot be undertaken until a retrospective one—based on the examination of ordinary hospital records, perhaps from a large number of centres—has indicated how the prospective survey should be planned. Ordinary hospital records may be vital even in a planned trial. This was the case 15 years ago when we had only one opportunity of testing our home-made poliomyelitis vaccine in the field. It was necessary to work through the notes of every suspected case of poliomyelitis in the country during one “poliomyelitis session.” This was my job. It turned out to be pleasant; all the clinicians concerned were on the tips of their toes and the notes (which were not made to conform to a set pattern) were excellent. Then Sir Austin Bradford Hill was able to find out what protection had been given to the limited number of people for whom the vaccine was available.

There are, of course, records which are useless for any sort of investigation, though not as many as one would think. In the United States of America it has been shown from the records¹ that the number of ordinary run-of-the-mill operations in relation to population is roughly proportional to the wealth of a community, the distribution of surgeons being largely governed by the latter. Comparisons were also made with what happens in our health service,² and though Bunker² did not express any fondness for it he was thoroughly dissatisfied with the predominant payment-for-service system in the United States. The point is that any medical records system must be all-embracing; selectivity is out of the question.

Confidentiality

The evanescent fuss about the Census was symptomatic of the vague, widespread and possibly justifiable fear in the community that the shadow of 1984 was getting uncomfortably close. It is axiomatic that medical auxiliaries, like doctors, respect the confidence of patients. But the worker in the medical records department is in the exceptional position of having access to the whole of many patients' stories; the physiotherapist or the radiographer, for example, knows only bits of them. Hospital administrators do not tell clinicians how to look after their patients. But it is no part of their business to pry into the record of what is done except in medicolegal affairs. I recall a house-governor years ago who caused a slip bearing the inscription “This patient is not to be discharged without reference to the house-governor's office” (or words to that effect) to be gummed to the notes of certain patients. This meant in practice that the notes went, quite improperly, to his office. There was no doubt some administrative reason for this action, which may explain why the medical staff tolerated it. One surgeon, an old friend of mine, combined poor handwriting with an excellent knowledge of his native language, Welsh. Notes were hand-written in those days, and anything he wished to keep to himself was recorded as a sort of Celtic fringe on his case sheets. But it was hard on us poor Anglo-Saxons when we deputized for him.

A recent development, beneficent in concept, contains the seeds of the ultimate threat to the privacy—one might almost say the sanctity—of the individual. This is medical record linkage. In Oxford there is a record linkage unit and its aims are well described by its director, J. H. Baldwin;³ I cannot do better than quote him.

“The need for, and importance of, medical record linkage are now fairly generally recognized. In hospitals, unit systems of record keeping are commonplace; systems which link together records from different services within a particular specialty are also quite common, such as psychiatric case registers, cancer registries, and registers of heart disease; a few systems exist, such

as the Oxford Record Linkage Study, which routinely carry out linkage on records from a very large range of services covering numerous specialties, thus going some way towards the creation of cumulative personal health records beginning with the birth certificate and ending with the death certificate. The next step, the generation of comprehensive health information systems for whole communities in which the cumulative personal health record of each member of the population is constructed, have scarcely made their appearance. Nevertheless, it is toward this end that we are now beginning to move, though such developments are likely to be contingent on the evolution of integrated health services.”

He then goes on to discuss the desirability of a national number; in fact, we already have it in the National Health Service number. But there is something rather apocalyptic* about a number linked to an all-embracing medical record.

There is enough evidence now of the intrusiveness of behind-the-scenes information services to make us queasy. The comprehensive, instant medical record—which would save us no end of trouble in our dealings with members of an increasingly mobile population—would be meat and drink for the information sleuth.

Medical records should be honest and complete. The omission of potentially embarrassing information is a sin. It can work against the patient's interests: a clinician's being misled is awkward but of secondary importance. I see only one safeguard—that the people who handle medical records should be of the highest integrity, proof against the wiles of an intruder, and in a position of sufficient independence to rebuff the most august people in the hospital hierarchy (I have had recent experience of their inquisitiveness) in this one matter of the confidentiality, the sanctity of records.

The Position Today

During the past 20 years there has been a gradual change. Not from self-seeking, but in response to the pressure of developments the medical records officer now has a wide range of activities. The efficient management of admissions and discharges can greatly improve the utility of that most expensive piece of apparatus, the hospital bed. The quality of the correspondence service can make or mar the delicate but invaluable relationship with family doctors in the hospital's catchment area. In some hospitals the catchment area is international. A doctor writes from, say, Iraq about a patient, not to an individual consultant but to a hospital. Who deals with this? The medical records officer; he or she will know or find out who is the most appropriate member of the staff to approach and who will be available and whether direct admission or preliminary investigation will be required. An awkward telephone call comes from some statistically-minded denizen of the Health Department. It is about allocation of beds. Who deals with this? The medical records officer.

The Department of Health is constantly examining the Health Service and, in particular, hospitals. It is sharply aware of deficiencies for which remedies must somehow be found. The Department has recently introduced a system for collecting information known as hospital activity analysis. Though it is outside the scope of these ruminations I am obliged to observe that a disquieting feature of the Health Service is what Sir George Pickering⁴ has called “the extraordinary proliferation of non-producers”—that is, people who sit in offices. It is possible that hospital activity analysis could merely aggravate this and at the same time irritate the producers. The point is that if the Department is sure that this innovation will make the Health Service better they need not look far to find the necessary collectors of information. The system is concerned

*“And he causeth all, both small and great, rich and poor, free and bond, to receive a mark in their right hand, or in their foreheads: and that no man might buy or sell, save he that had the mark, or the name of the beast, or the number of his name”—Revelation xiii, 16, 17.

with the collection and analysis of information about patients treated in general hospitals. It is intended to become a "tool of management" for both clinicians and administrators, and the hope is that this information can be provided, with the aid of computers, speedily enough to make it realistic for action at both group and hospital level. Hospital activity analysis, however, can supply neither common sense nor courage.

While it is important to have this information quickly it is even more important that it should be accurate and complete, otherwise wrong conclusions might be drawn from these analyses. Who is to watch over the assembling of this great array of information about patients? Who will ensure that what is written down is both correct and complete? There is only one person who is already trained for and involved in dealing with admissions, discharges, bed-occupancy, diagnostic and operation indexes, and many similar and equally complicated matters of fact; it is the medical records officer—a name now clearly becoming out of date. Only such a person is able to guide and support the computer team when they try to unravel and analyse the manifold procedures of which they themselves have no first-hand experience. Tomorrow's hospitals will realize more and more the need for this experienced person who, with simpler and humbler tools than the computer, has over many years been collecting reasonably good and accurate information about patients and their illnesses.

The hospital activity analyst already exists under the name of medical records officer, and when this sophisticated tool of management known as hospital activity analysis becomes available for "performance monitoring" by clinicians and administrators, the medical records officer will be recognized as an essential member of the hospital administrative team.

The medical records officers have faced up well to their responsibilities. Some might say that they take themselves too seriously; maybe, but they cannot take their work too seriously. They formed an association over 20 years ago. They hold examinations; they confer locally, nationally, and now as a European participant. It would weary the reader to catalogue all their activities.

What is so remarkable is that the medical records officer is still regarded as no more than a cog in the administrative

machine. Unlike, say, physiotherapy or radiography this is not a recognized auxiliary profession. One consequence of this is that at the lowest level members of the medical records staff come and go with disconcerting frequency; yet these young women handle confidential documentary material. I find this frightening. A girl wishing to become, for example, a physiotherapist goes through a recognized course of training; she belongs to a profession with all that that implies. Most training for work in a medical records department is by haphazard apprenticeship, though there are honourable exceptions—for example, at St. Bartholomew's Hospital, in Bristol, and in Scotland. But most of the full-time students come from overseas. The profession must be made attractive here at home.

One cannot but feel deep sympathy for the Secretary of State; his predecessors concerned with health alone had plenty to occupy them. The permanent staff of the Department of Health are busy enough too. Among many other things they are faced with demands, each of which considered in isolation is reasonable enough, for new kinds of medical auxiliaries. And the Health Service has turned out to be extremely costly; but it is the increasing complexity of medicine that has created these demands.

What if anything should be done about the people we call medical records officers (now due for a change of name, like the former lady almoners)? They can go on beating their own drum; loud bangs instead of a demure tattoo. The effectiveness of this is limited. The second, and the best, is for the Department to establish the medical records officers as a profession ancillary to medicine with all that that implies. Otherwise only one course remains—for us, the medical profession, who write the records and guard the confidences of our patients, to make such a rumpus that the Secretary of State will listen and act; so that in quietness and confidence we may write the truth, the whole truth, and nothing but the truth and make the best possible use of it.

References

- ¹ Bunker, J. P., *Pharos*, 1971, **34**, 20.
- ² Bunker, J. P., *New England Journal of Medicine*, 1970, **282**, 135.
- ³ Baldwin, J. A., *Proceedings of Second European Conference on Medical Records*, 1970.
- ⁴ Pickering, G. W., *British Medical Journal*, 1971, **1**, 191.

Problems of the Newborn

Prenatal Influences and Prenatal Diagnosis

R. W. SMITHELLS, B. D. SPEIDEL

British Medical Journal, 1971, **4**, 105–108

Perinatal mortality has fallen dramatically since the turn of the century and is still falling. The present rate of 23 per 1,000 births is accounted for largely by babies of low birth weight, those with major congenital anomalies, and those subjected to severe hypoxia. Haemolytic disease and infections are responsible for a diminishing number of perinatal deaths. All

these conditions are capable of causing physical or mental handicap in survivors. Further progress can be made, firstly, by identifying and correcting any influences which are harmful to the developing fetus before and during birth and, secondly, by recognizing and treating disorders at the first possible moment. These require continuing research, the implementation of existing knowledge, and unceasing vigilance.

Fetal Growth

PRENATAL INFLUENCES

The relationship between low birth weight and maternal height, age, parity, and socio-economic status shows that maternal

Department of Paediatrics and Child Health, University of Leeds, Leeds LS1 3ET

R. W. SMITHELLS, F.R.C.P., F.R.C.P.E., Professor of Paediatrics and Child Health
B. D. SPEIDEL, B.M., M.R.C.P., Tutor in Paediatrics