

MEDICAL RECORD AND ITS VALUE

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With the phenomenal progress made in the recent past in the science of medicine, the importance of systematic and organised compilation and use of medical records has been felt, with the result that medical records now form the very backbone of clinical investigation, medical evaluation, medical education and research. These records of illness, methods of treatment and results of therapeutic efforts now afford a means of analysing and appraising quality as well as volume of medical service given by an institution and its personnel.

Dr. John R. McGibony, in one of his communications on medical records, states: "A chronicle of the pageantry of medical and scientific progress is found in hospital records. There may be found the running story—disconnected 'tis true—of the drama, the comedy, the mystery, the miracles of medicine and hospitals of the twentieth century."

Hospital care is not static, and records—both clinical and administrative—must keep pace with dynamic changes that identify the hospital of to-day.

Dr. Malcom T. MacEachern, considered to be father of modern medical records, has described them as a "clear, concise and accurate history of the patients life and illnesses, written from the medical point of view... and in its true form is a complete compilation of scientific data derived from many sources, co-ordinated into an orderly document by the medical record department and finally filed away for various uses, personal and impersonal."

Medical Record: Definition

The medical record is a clinical, scientific, administrative and legal document relating to patient care, in which are recorded sufficient data, written in the sequence of events, to justify the diagnosis and warrant the treatment and end results.

It is a document of facts, which contains statements by trained observers of conditions found and of the application and results of examination and therapy; and indicates whether or not the efforts of the doctors, supplemented by hospital and related facilities, are in accordance with reasonable expectations of present-day scientific medicine.

Medical Record: Importance and Purpose

Because 'patients forget and records remember', the medical record is of value to many groups: to the patient, to the doctor, to the hospital, to research, to the teacher and student and to the health authorities.

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To The Patient

The primary reason for record keeping is to improve the care of the patient. It is essential for the immediate diagnosis and treatment and for the future welfare of the patient. Every illness, even through minor, involves study and examination to the extent that it is impossible for any person to keep all these details in mind; the written report is evidence that the patient's case is being handled in a scientific, intelligent and systematic manner. Specifically, it aids the patient in that:

1. It serves to document the story of the patient and activities in his behalf.
2. It serves to avoid omission or unnecessary repetition of diagnostic and treatment measures.
3. It assists in continuity of care in the event that future illness requires attention or out of the hospital.
4. It serves as evidence if legal questions arise.
5. It supplies necessary information for employment purposes, insurance, etc.

To The Doctor:

The medical record serves as

1. An assurance of the quality, quantity and adequacy of the diagnostic and therapeutic measures undertaken.
2. An assurance of orderly continuity of medical care.
3. An evaluation of medical practice.
4. An aid in research and the continuing education of the health progressions.
5. A protection if legal question arise.

To The Hospital:

The medical record is necessary

1. To furnish proof of the type and quality of care rendered to patients.
2. To document the type and quantity of work undertaken and accomplished.
3. To evaluate the service of the hospital in terms of accepted norms and standards.
4. To protect the hospital if legal questions arise.
5. To serve as an administrative record of personnel performance and staffing needs for budget preparation and justification. For the allocation and utilization of physical facilities. For statistical data for administrative use and evaluation. For estimating the utilization of and needs in equipment and supplies.
6. To assist in future planning.

To Research:

Recorded observations are the basis for all clinical research.

To The Teacher and The Student:

Successive sensitive diagnosis in a record helps the medical student to follow the process of eliminating diagnostic possibilities while a case is being observed.

A complete medical record enables the clinical teacher to present the full range of subjective and objective symptoms of a case in its epidemiological extent to the students of medicine and nursing. Well-designed records will also guide the medical students into adopting a rational pattern of history taking and clinical examination.

Records are particularly useful to postgraduate students for preparation of case histories for submission to the Examination Board.

To The Health Authorities:

Governments require that certain reports be made available promptly. These reports may list births and deaths, infectious diseases, statistics regarding inpatients and the type and number of operations performed. Complete medical records facilitate preparation of accurate reports.

Medical records supply pertinent data in the control of diseases.

Medical Record: Ownership

The medical records, then, are primarily a medico-administrative instrument documenting what has occurred within the hospital. Administratively, if the hospital is to be successful, they are as necessary as are the purchase and supply records, personnel records and the budget and financial records.

The hospital has the right to demand adequate medical records in the same manner as it requires accurate accounting from its business office.

The record is made for the hospital and is the property of the hospital—not of any one else. The hospital is the sole owner of the record and custodian of the document.

The Need for a Medical Record Department

The primary purpose of a hospital is to provide medical care for the sick and injured. To fulfil this objective properly, the medical record department should be responsible for the completeness, accuracy and availability of the medical record at all times.

A medical record department can be defined as that part of the hospital responsible for the proper custody of the medical records of the patients, for making such audits and preparing such reports as may be necessary to demonstrate the quality and quantity of work done, and for assisting in the advancement of medical science, through providing accurately recorded data. A medical record department should be developed into a dynamic unit of the hospital which makes possible evaluation of medical and administrative practice. At the moment, unfortunately, in many institutions records are only considered a necessary evil, because of the legal protection they afford to the administration. Their value for improved medical care has been lost sight of.

Medical Record Officer—His Role

In order that he may render the best service possible to his institution, the medical record officer—a paramedical member of the hospital team—should be given adequate work

space and equipment, adequate personnel and essential supplies and be assured of the co-operation of the clinical, nursing, administrative and other paramedical staff. It should be realized that medical record-keeping is a co-operative venture, that the medical records officer cannot do it all alone, that administrative, medical, nursing, and paramedical staff must take a continuing interest and formulate policies and rules binding on their own members.

Conclusion

USE is the ultimate test of the medical record. The greater its use the more it will be appreciated, which will lead to an improvement in content. Any hospital which promotes the scientific use of medical records will reap great dividends. Medical staff meetings will be better because of stimulation in the practice of medicine. The quality of medical practice will improve as a result of mutually constructive criticism brought out in group studies of diseases.

Acknowledgements

My grateful thanks are due to Dr. B.B. Pradhan, Medical Superintendent, Bir Hospital, for encouraging me to write this article and also for his continued interest, enthusiasm and support in developing a good medical record department in the Bir Hospital and above all for his sympathetic understanding of problems involved.

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