CLINICAL RECORDS IN SURGERY

BY
Professor Sir HUGH CAIRNS, K.B.E., F.R.C.S.
Nuffield Professor of Surgery at Oxford

I am glad to have the opportunity of talking to records officers about the subject of clinical records for it is important that you should understand how deeply the clinical life of a surgeon is bound up with his case records; and it is important also that clinicians should understand the problems of the records officer with whom they work.

Of the value of good case records to the individual patient there can be no doubt. Life has been lost through lack of precise knowledge of the previous illnesses and operations of a patient. It is the bounden duty of the surgeon to place on record what he has found and what he has done when operating on a patient; and in the interests of the patient it is the duty of the hospital to conserve such records in such a way that they can be promptly referred to if the patient falls ill again in later years. I have never found patients unwilling to have their medical history placed on record, whatever their station in life. When they give us their history they are placing their trust in you as well as in the doctors, and the records officer like the doctor must regard such confidences as sacrosanct. This should be the first rule for all who work in records offices.

Of the value of hospital case records from the point of view of hospital statistics there can also be no doubt, but it must always be borne in mind that these statistics refer to a highly selected sample of individuals. They tell more of the activities of the hospital concerned, and of the interests at the time of the doctors who work in the hospital, than they do of morbidity and mortality in the population at large.

CASE RECORDS IN THE TRAINING OF THE DOCTOR

I am more concerned with the value of clinical records in the training of the young doctor and for purposes of medical research and it is on these aspects of our joint work that I wish to give you something of my reflections during the last thirty years.

What is a good case record? I will consider only in-patient records; outpatient notes are important both to patient and doctor but in my experience they are in general of little value either in training the doctor or in medical research. I exclude from this statement the out-patient follow-up notes after the patient has left hospital. Also I do not wish to imply that research cannot be advanced by ad hoc investigations on out-patients. What I mean is that I have rarely found the ordinary out-patient note of a patient of any value in clinical investigations.

A good case record gives comprehensive and accurate information about the patient's civil state. It gives a picture of his background—of his family and past history, of his daily life. It gives in detail the history of the illness
for which he has come to hospital, the physical signs found on examination at the bedside, and, in easily conservable form, the results of laboratory, radiological, ward and other special investigations.

Then should come a short summary of the positive findings and a reasoned statement of the diagnosis, the treatment recommended, and the prognosis; this is from many points of view the most valuable part of the note and the part that is most often neglected; without it it is often not possible in reading old notes to see how the surgeon's mind worked or why he did such and such an operation; without it the house-surgeon, for it is he who should write this summary, may not learn as quickly as he should to integrate the clinical and laboratory evidence about the patient's illness, to give each symptom and sign a graded value, and thus to produce a clear clinical picture for which some pathological explanation must be found. That is how a diagnosis should be made—by a careful synthesis of all the facts about the patient and then by finding the best explanation of those facts in terms of pathology. I have no use for the long clinical note which is a mass of ill-digested facts; some young doctors—and this seems to happen more often in some medical schools than in others—produce with long toil a massive clinical note about a patient, and at the end of it have no clear picture of the essential points in the illness, or of what is the matter with the patient. The summary of the positive findings should not be a repetition of the important findings in the same terms as were recorded in the examination but should integrate these facts, placing the emphasis on the pathological or syndromic aspects rather than on the individual facts.

**LEARNING TO TAKE CLINICAL NOTES**

In learning to take clinical notes the student of medicine usually goes through three stages. At first his clinical note is usually too short and lacks essential information. As he learns to be systematic in examination and learns how to elicit the points of a clinical history his note eventually becomes good but long. The final stage in note taking, which usually only comes after years of experience, results in the case record which is good but short—compiled with great economy of words but omitting nothing either of a positive or a negative character which is essential. In writing such a note the experienced clinician sifts, weighs and integrates the information as he receives it from the patient; as a result of long practice and wide knowledge he summarizes the clinical picture as he proceeds with the history and the examination, and at the end he has a fairly sharply defined clinical picture for which from his pathological experience he can find an explanation.

This is the most important part of the clinical art. It is a highly specialized process of inductive reasoning. In some quarters the fashion is to belittle its value to the advancement of medicine, and the modern laboratory aids to diagnosis tend to conceal its importance, not only to each and all of us when we are ourselves the patient, but also to any serious clinical student of disease. The quickest and easiest way to acquire the art, or technique of the clinician, is by systematic note taking on the lines which I have described.
So far I have described only those parts of the clinical record which deal with diagnosis. The treatment should also be meticulously recorded, and in this connexion I wish to state my belief that the only person who is competent to record the pathological findings and the treatment carried out at an operation is the surgeon who performs the operation. The practice of delegating the recording of an operation to the surgical dresser or house surgeon is in my opinion a bad one.

When the patient leaves hospital a discharge note should be written. If the patient dies the discharge note should give the details of the final stage of the illness, and the clinician’s first impression of the findings at post-mortem examination. It is most unusual not to learn something of value at a post-mortem examination which will assist one to get a better result in the next case of the same disease, or will provide material for a better knowledge of the pathology of the disease. During the last thirty years the leading American medical schools have affirmed that the keenness and efficiency of a hospital may be gauged by the percentage of post-mortem examinations in its fatal cases.

If the patient survives the discharge note should contain a detailed account of the effect of treatment on the symptoms and signs as set out in the summary of positive findings. This helps to inculcate the critical attitude in the house officer. The discharge note should also state what is to happen to the patient and, whenever applicable, what steps should be taken to prevent recurrence of the illness for which the patient has been treated.

Finally there should be the disease indexing of the case record and a letter to the patient’s doctor. This is best done at a weekly history-meeting attended by all the doctors of the firm or department. For me this history meeting has always been one of the most interesting hours of the week, when all attending speak their minds about the cases, and problems for future investigation are often crystallized.

No clinical record can be regarded as complete without follow-up. Otherwise how may the hospital doctor judge whether his treatment is really satisfactory, or gain an intimate knowledge of the life history of disease? There is enormous labour for records officers and social workers in the follow-up, and I doubt whether it is yet well done in many clinics in this country.

**Records for Research**

Much can be learned about disease from clinical records. There are few diseases of which the life history has yet been thoroughly studied. From time to time good clinical records, well preserved, will provide evidence of heredity of diseases in which the heredity or familial aspect could not be discovered by the family itself. Polycystic kidneys and German measles provide two dramatic examples of the value of clinical records in assisting important discoveries and it is necessary to sound a warning note, for this does not happen often. I do not believe that it is right to include in a clinical record masses of detailed information, e.g. about the patient’s relations, in the hopes that, in some way
as yet undefined, it may be useful to future workers. More often than not if years later these facts are reviewed it is found that some essential piece of information is missing. Recording of masses of facts is a snare for the enthusiastic, hard-working but intellectually lazy doctor; and also for the bureaucrat who sits in some room a long way away from any hospital, and does not have the labour of compiling the information or, usually, the responsibility of producing any conclusions from the information. (I do not decry the routine recording of details for carefully thought-out ad hoc investigations.)

**How May Good Hospital Records be Obtained?**

Most of the work of clinical recording is done by medical students and by young doctors in their early years of post-graduate training, and every inducement should be given to them to write good notes. First there must be a system of case-taking which, while it need not be adhered to rigidly by the initiated, nevertheless provides a guide for the young student. The next essential is that the notes of the students and house officers should be read by their chiefs; persistent neglect of this obvious maxim can have a most disheartening effect upon a beginner. For the house officer in hospitals where notes are typewritten it is a good idea to provide a carbon copy which the house officer may retain. For over twenty years I have used a dictaphone for recording and have found it a great advantage, particularly in cases requiring a long note; the physical labour of writing a description of an epileptic attack or of a long operation is a deterrent to detailed recording which is easily overcome by the dictaphone.

The establishment of a good tradition in regard to the quality of clinical records in any hospital is a slow and difficult business, and can only be achieved by whole-hearted co-operation of all the medical staff. The difficulty increases enormously with the size of the hospital, and I think it is seriously open to doubt whether hospitals as large as 1,000 beds can develop a high standard of clinical notes throughout the hospital, even though the standard in some individual units of the hospital may be high. In such hospitals individual units tend to contract out of the general system and to maintain their own unit records separately. This is not good for the hospital.

There are certain obvious duties of the records officer which you are more familiar with than I am, and I need not adumbrate on the safe-keeping of notes, the preparation of a consistent disease index, an accurate name index and so on. There are, however, certain duties of the records officer which are insufficiently stressed.

**Completion of the Case Record**

The first of these is what we may call the completion of the case record. By this I mean that before the note is filed its various components must be arranged in order according to a pre-arranged system. A check must be made by an experienced records officer to ensure that the note is complete, that the operation notes have all been written, that the pathological reports are complete,
in cases of death that the post-mortem report is included or that there is a note to say that post-mortem examination was not held, that the diseases from which the patient suffered have been correctly indexed—and so on. Where there are deficiencies they must be made good, and here though the records officer can do much by tact and persuasion, in the final analysis it is necessary that the medical staff of the hospital must set up a disciplinary machine in the form of a records committee which has the duty to report to the central administration of the hospital any serious dereliction of duty in regard to notes.

Notes should be stored and preserved with the same high standard of care as pertains in medical libraries. This cannot be carried through unless the records department has a most efficient calendar index for checking in case records after the patient has been discharged from hospital or the case record has been borrowed for one purpose or another. Nor can it be carried through without the active co-operation of the medical staff. I would go so far as to say that I would not recommend anyone to apply for the post of records officer at any hospital in which the medical staff of the hospital had not given evidence, as for example by the establishment of a records committee, that they were prepared to sink their individual whims and fancies for the good of the hospital as a whole, and conform to rules for the maintenance and safe keeping of clinical records.

(To be continued.)