SURGICAL RECORD SYSTEM OF THE WOMAN'S HOSPITAL.

BY

LE ROY BROUN, M. D.,

Attending Surgeon, Woman's Hospital,

New York, N. Y.

THE value of the surgical and medical records of a hospital is in proportion to the thoroughness and accuracy with which they are compiled, not only for each individual patient, but in the painstaking bringing together of similar groups of diseases and treatments under their various heads.

It is only in this manner that the enormous material passing through the hospitals of the country can be made of value to the student of medicine, to the profession at large and to the patient in the future.

The patient as he or she enters the hospital should not be solely in the light of the recipient of our care, but also as one from whom something is to be learned, if not through the unusual condition found, certainly by associating the disease, the treatment and the result with those of a similar nature; and by the compilation of the cases to draw positive conclusions of value to the profession in general.

Unless every detail of the findings of the condition of the patient, of the treatment given and of the recovery is carefully noted in the records, the individual history is of little value for future reference. As an individual record no matter how carefully made, its scientific value is little, unless associated with and studied as one of a group of many of a similar character. It is here that the persistent care in filing becomes of so much importance.

It matters not what system is adopted, whether filing according to diseases or by hospital numbers with an added index of diseases, so long as the two essentials of a working system are fulfilled, that of

being able to refer to an individual history without loss of time, and that of being able at all times to study collectively diseases of similar groups with their treatment and their recovery.

The histories of the Woman's Hospital, until ten years ago, were no better than those of the average hospital, nor were they any worse. The method in use at this period was that of making a full record of each patient during her stay in the hospital and filing such records according to the entrance number of the patient.

The description of the operations were written up by the House Surgeon after his day's work, or as soon as possible thereafter. The pathological reports on specimens sent to the pathologist were properly filed, yet all specimens were not examined.

This was the method in vogue during the past decade. They were in the majority of instances as good records as those made in hospitals in general. From the standpoint, however, of lessons to be drawn from their study, they are practically valueless, in that it would be a hopeless task to attempt the study of large groups of similar operations. To make them of service for such a purpose the entire collection from the organization of the Hospital in 1856 would have to be examined and cross-indexed.

This method, which is to an extent in vogue in the large majority of the hospitals, admits of many inaccuracies. It is more than we can expect of a House Surgeon to obtain from him an accurate description of the findings at the time of operation and the method followed, especially if the field of work is in good view only to the operator.

Nor can we hope to maintain useful records so long as the responsibility is thrown on the House Staff, whose duty is primarily the care of the patients and whose interest in the written records is at a minimum.

This is the reason for the failure in most hospitals in the matter of histories. These young men spend only a limited period in the hospital, their primary duty is the care of patients, any additional work in history making does not appeal to them nor will it be well done.

The keeping of the detailed records of the diseases and treatment of the patients of a hospital for the care of whom the institution is being maintained, too often receives no consideration and is left to be cared for by the transient house staff, under the direction of the attending staff, who give but scanty thought to the subject. Under such circumstances we have no one to blame for the poor results but ourselves.

The governing board of a hospital is usually made up of business men who recognize the importance of providing for the accurate accounting of the economic and financial side of the institution. The medical and surgical matters are sealed books to them and they must of necessity place the whole responsibility for such upon their attending medical board. When the necessity of a specified course is laid before them it is as a rule gladly adopted, especially so when the importance of such a course is clearly explained to them.

This has been our experience at the Woman's Hospital and as a result the present system of maintaining the surgical records of the institution has been devised. The underlying basis of this system is the same as in a few other large hospitals, that of recognizing that a continued efficient work must be carried out by paid clerks, whose sole responsibility is that of the work before them. And furthermore where there is a large surgical board, as in our instance, the supervision of this work should be assigned to one of its members, aided by a younger assistant.

It is only by this method of fixing the responsibility that permanent and satisfactory results can be obtained. Toward this end, three stenographer historians are employed by the hospital, of whom one is responsible for the entire work of the department.

The duties of these stenographers are:

1. Receiving the dictation and transcribing the findings and various steps of each operation as given by the operator at the close of each operation.
2. Typewriting the histories of each new patient as furnished by the member of the house staff, whose duty it is to take histories.
3. Receiving the dictation and transcribing the pathological reports as given by the pathologist.
4. Making up the index cards for diagnosis and operation of all patients who have been discharged from the hospital and filing the same.
5. To be responsible for the proper filing and care of all surgical histories of the hospital.
6. Conducting all the details of the "Follow-up System" as introduced in the hospital for ward patients.

The "Follow-up" consists of

1. Making a short abstract of each discharged patient on the abstract card as furnished.
2. Making out and filing the "Return Card" for each patient.
3. Taking the dictation of the examiner and transcribing the results of all examinations of returned patients.
4. Notifying each patient at least a week or ten days ahead of her specified time for return, that she is expected to come back to the hospital for examination.

To amplify the above, that they may be the more clearly understood, let us take up the matter of the description of the findings and steps of operations. The old custom was that such accounts were to be written up by the House Surgeon, who acted as the first assistant to the operator. This method has many well-recognized weaknesses and gives rise to frequent erroneous statements, vitiating the value of the history for further study.

The method of requiring the operator to write up his own accounts or of dictating his findings and technic at a later time, while giving more accurate histories, is still open to serious criticism on account of the frequent interruptions and the press of engagements of the surgeon. This method is in use at one of our largest teaching hospitals and it is amusing to see the daily posting of surgeon's names as neglecting to give the time to dictate certain operations of the day previous.

The custom in vogue at the Woman's Hospital is that such dictations shall be given by the operator before he leaves the operating room, in fact it is usually given while the surgeon is closing the wound. The stenographer is notified toward the close of the operation. She comes at once to the operating room and signifies her presence by saying "stenographer." The surgeon can then dictate while he is finishing his work without interfering with the routine of the clinic.

The history as given by the patient on her admission to the ward is taken by one of the resident staff. As a guide for his questions a printed outline is attached to each sheet. This history as taken is turned into the history room, where it is typewritten and placed upon the individual chart within twenty-four hours after the patient's entrance.

No. 1

HISTORY

Name.....No.....Surgeon.....
Address.....Rec. By.....
Age.....Nativity.....M.S.W.....Admitted.....Occupation.....
Relative or friend.....
Physician.....

Outline to be Followed

Chief Complaints.....
.....
Family History.....
.....

Deaths—cancer, tuberculosis, syphilis. Nervous affections. Health of living members.

Previous History.....

.....

1. Menstrual—age at onset, duration, scant, moderate, profuse. No. of napkins daily (stained or saturated), regular or irregular, interval, pain, last period.

2. Marital—how long married, No. of children, ages, nature of deliveries, lacerations, repair, puerperia. Abortions or miscarriages—No., last, induced or not, infection. Venereal diseases. Husband's occupation.

3. Illnesses.—Circulatory, respiratory or renal symptoms, injuries, operations.

Present Symptoms.....

.....

1. Menstruation—how changed. Pain—when, character, duration, location. Menorrhagia, metrorrhagia.

2. Vaginal discharge—quantity, color, consistency, odor, time of.

3. Nervous and mental. Pain—character, location, constant, occasional, associated with. Backache—location, constant, occasional, associated with. Headache—location, constant, occasional, associated with. Intermenstrual pain. Bearing down or distress in pelvis. Dragging sensation or distress in flanks. Position of comfort when reclining—back, right side, left side. Position of discomfort when reclining, why? Nervousness—character of Flashes. Irritability. Easily tired by exercise. Insomnia—refreshed or not by sleep. Emotional control.

4. Gastrointestinal—appetite, digestion, gas, relation of gastric distress and pain to meals, nausea, vomiting—time of, character of vomitus. Jaundice, clay-colored stools. Bowels—control of, constipation, diarrhea, pain, blood, mucus.

5. Urinary—painful or frequent micturition, day, night, blood, control, retention.

6. Abdominal swelling or tenderness.

7. Vaginal protrusion, when?

8. Fever, chills.

9. General condition—loss of strength, weight—maximum, present.

The index cards for diagnosis and operation (Nos. 2 and 3), are made out by the stenographer historians under the instruction of a junior member of the attending staff. The "International Nomenclature" is the one in use with some minor additions. The operations

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No. 2

Hist. No. **DIAGNOSIS** Dr.

NAME ..... Operator.....

	Condition upon Discharge			
	C	I	UI	D
Laceration of Cervix.....	#			
Myoma Uteri.....	#			
Cervical Polyp.....	#			

on the majority of patients are usually multiple. In order to make the proper filings of each operation and at the same time to show its relation to the several other operations on the patient, the complete

No. 3

Hist. No. Date	OPERATION Dr. Operator	Suc's	Par'l Suc's	Fail'r
	D. & C.			
	Trachelorrhaphy			
	Perineorrhaphy			
	Myomectomy			
	Appendectomy			

list is tabulated on as many cards as there are operations. On each card one of the operations is typed in rotation in red. The filing of the card is as the red typing indicates. The same system is followed in instances of multiple pathological states on the diagnosis card.

It is impossible to get a large staff of operators to use the same terminology in diagnosis or operations. The terminology of the surgeon is, therefore, accepted as given and subsequently changed to that of the "International Nomenclature" in use. There is little difficulty in doing this; it is a matter of training of the stenographers and some counsel when at times they are in doubt.

At a specified daily hour a stenographer is sent to the pathological laboratory to type the dictation of the pathologist, on the macroscopic and microscopic work of the day.

The complete physical examination is made on a sheet for the purpose, as are also all other scientific and laboratory studies, and reports from the *x*-ray department, the cystoscopic department, etc.

The history of the patient as now completed with the attached bed-side notes of the detail of her treatment, together with her temperature and pulse record, is sent to the record room on the discharge of the patient from the hospital.

It is now the duty of the junior attending surgeon of each division to go over such histories within a few days to see that no errors appear.

After receiving his signature, the stenographers make a cross-index of all operations done and of the diagnosis made of pathological conditions present, by following the method previously described of filing multiple conditions and operations under their various and separate heads.

THE "FOLLOW-UP SYSTEM."

To keep in touch with the patients after they leave the hospital requires something more than the giving of a card of reminder and a request that they shall return at a specified time for reëxamination. The personal element enters largely into the success of this effort. When this system was first inaugurated in the hospital, the return card was given by one of the nurses of the ward, who was expected to explain to the patient the object of her returning. The nursing force of every ward, as in all training schools is constantly shifting and it is a question as to whether all of them entered closely into the spirit of the return of patients for examination. The necessity of some responsible person for this purpose being evident, the matter was presented to the Board of Governors, who authorized the assignment of one nurse from the social service department for this purpose.

The duties of the nurse thus assigned is to make daily visits to the wards, to explain fully to each outgoing patient the object of her returning and the patient is given by her the 'return card' as here shown. The personality and interest of the nurse assigned to this duty enters greatly into the number of returns. The nurse in question also visits all patients at their homes who after a second notice fail to return. As a result of looking up such patients the social service, reports for six months, 245 patients found, of whom 208 returned and six had died, only thirty-one would not give the time to return.

No. 4

DISCHARGE CARD

KEEP THIS CARD

Hospital No._____ Surgeon_____
Name_____
Address_____
Date of Discharge_____
Return to Hospital for examination at 10 o'clock_____

The utilization of the services of the social service department of the hospital in our "Follow-up System" is of greatest value not only in having the service of one of their nurses assigned for this purpose, but also in looking after the convalescent and needy patients, the purpose for which this department was organized. For the

No. 5

RETURN CARD

Date of Operation_____ Discharged_____
To Return for Examination_____
_____
_____
Name_____
Address_____
Friends Name_____
Address_____
Referred by_____
Address_____
Surgeon_____

purpose of the records of the "Follow-up System" a return card is made out for each ward patient and filed under a date ten days previous to that on which she is told to return. Each morning notices are sent to all patients whose return cards are on file under this date. The notice is as follows:

No. 6

WOMAN'S HOSPITAL
IN THE STATE OF NEW YORK
110TH STREET
BETWEEN AMSTERDAM AND COLUMBUS AVENUES

New York_____ 191__

_____
_____
Dear_____

You are requested to return to the Hospital at 10 o'clock in the morning, on or about_____ for the purpose of examination, in order that we may know the result of your operation and treatment.

You may need advice, and by returning as we direct, you will not only be doing something for yourself but possibly for others.

Bring your card with you.

Very truly yours,

If the patient does not respond within two weeks a second notice is sent out. If this is not answered the patient's name and address as also that of the friend are given to the social service for the purpose of tracing, with the results I have given above.

We have found that for our purposes it is better that the histories be bound in serial numbers of fifty histories to the volume. It is necessary, therefore, that an abstract card be made out from the history of each patient for the purpose of the "Follow-up System." These cards are 9½ by 7½ inches. On the back of this abstract card is typed the findings on each subsequent visit of the end results of the operations done (No. 7).

No. 7

Name.....Hospital No.....

Address.....Referred by.....Admitted.....
S. M. W.....Address.....Discharged.....
Age.....Friend.....Operator.....
Chief Complaint.....Address.....Anes .....
Preop. Diagnosis.....
Postop. Diagnosis.....
Path. Diagnosis.....
Operation.....
Impor. Points.....

Convalescence.....

These cards are filed in alphabetical order.

There are positive labor disadvantages in making out these abstract cards. In many ways it would be better to add the end results to the surgical history by the insertion of an extra sheet. This is done in some hospitals, notably the Presbyterian. There are, however, some disadvantages in this, and after viewing the matter from various angles it was thought better from the standpoint of collective study and in the end to be more economical, to follow the plan we have adopted.

The "Follow-up System" has upon its files for the past year 1280 ward patients. Of these 240 had given wrong addresses, as also incorrect addresses of their friends. We have records of the returns and end results of 880 of the patients, or about 87 per cent., which is very satisfactory. The reëxamination of patients takes place each morning at a definite hour with the exceptions of Sunday. If the result is not satisfactory the operator is notified by letter, the name and address of the patient being given, that he may have her seen and sent back to the hospital if he thinks it best (No. 8).

No. 8

WOMAN'S HOSPITAL

IN THE STATE OF NEW YORK

110TH STREET

BETWEEN AMSTERDAM AND COLUMBUS AVENUES

_____ 191__

_____

_____

My Dear Doctor:

The present condition of _____

_____ at (Address) _____

does not appear to the examiner to be all that you may wish (surgically, symptomatically).

The patient has been instructed to call upon you at your office.

This notice is sent that you may communicate with her if you desire.

Date of Operation _____

Character of _____

_____

_____

Remarks:

_____

The method of keeping our surgical records as described above we are fully aware is by no means perfect, nor am I aware of any system that is in every detail ideal. The method best suiting our hospital may not be at all practical in another, as for instance in a general hospital a patient in the large majority of cases enters its wards for one condition and all other concurrent troubles are complications and are to be classed as such. With gynecological hospitals such as the Woman's the majority of our patients have multiple conditions no one of which can be classed as the major disease. Evidently the method of filing the records of the general hospital with its single diagnosis and complications is not applicable to the gynecological service with multiple diagnosis.

Our present method though not thoroughly satisfactory in every detail even to ourselves gives us an easily accessible large collection of accurate data on all the phases in our specialty. The files in the record room are for the common use of all the surgical staff of the hospital and each member is urged to utilize them freely for his own study and for the purpose of papers he may be preparing.

148 WEST SEVENTY-SEVENTH STREET.