The Finnish Hospital League set up in 1971 a committee with the following three tasks:

1. To present a proposal for an unit medical record system for all the general hospitals in the country;
2. To establish to which extent it would be possible to use this system for introducing a so-called problem-orientated approach in the care of the patient;
3. To make a proposal about how the medical record system could be expanded to cover the different medical institutions, i.e. to find out whether it would be possible to have one medical record per patient in one medical district.

The committee submitted its proposal for a unit medical record system to the National Board of Health in 1973 and it was adopted by most of the general hospitals by 1977. The system has become compulsory and should be in general use by 1981.

It was, however, found out that the unit medical record system could not be used in all the regional hospitals without being connected to the regional medical data-base. For this reason a committee was set up by the Finnish Hospital League to outline and make a proposal for the connections. Meanwhile, the committee was given also other tasks and all the different items proposed by the committee have not yet been accepted by the authorities. It seems, however, that any attempt to produce a unit medical record system requires its connection to the persons "health record". The National Board of Health has, accordingly, set up a committee with the tasks to propose a structure for a health record and to outline its connection with the unit medical record system.

A complete unit medical record system should naturally also include the records of psychiatric patients. Because the psychiatric care is given by a separate organization in our country the newly developed psychiatric medical record is kept in a separate file and connected through the computer system to the unit medical record.

As to the principles of the new psychiatric medical record it is quite similar to the unit medical record and thus it may, later on, make a real part of the unit medical record system.

The unit medical history system

The different levels of information can be seen in Fig. 1. Each patient is supplied with a cardboard or plastic file, red for women and blue for men. On the file is indicated with
black tape the subject's date of birth, i.e., the first digits of the Finnish personal identification number. The National Board of Health requires that the patient's personal identification number is controlled at the various contacts.

The first real information level (Fig. 1) is represented by the blank form called SUMMARY. The summary is a collected review of all the medical consultations of the patient at both the outpatient department and in the ward.

On the following level there are the forms for the use of the clinics. All the clinics of the hospital are spread out on this level. The forms are blank and may be printed according to the needs of the clinic. However, a problem-orientated approach has been suggested. The forms of the different clinics are identified by colour e.g. brown is for surgical forms throughout the country and green for x-ray, each service department has a form of own colour etc. The 3-letter abbreviations of the specialities have also become standards.

A feature common to all level B forms is that they are bundled together after each visit to the hospital. B forms contain in principle basic data. They are evaluated by the physician who makes the summary which for its part is recorded on the level A forms.

For the registration of every medical event there is a set of special forms marked XYZ:

X  Data needed for accounting the patient.

Y  Data needed to produce the necessary statistics for planning, etc.

Z  Minimum data needed for the acute treatment of a patient while waiting for the complete unit medical record to be transported from the previous hospitals or health center.

X and Z contain entirely patient-bound data, while Y data are relevant without identification of the patient.

The data on the form Z are collected to make a minimum database for the ADP. Thus it must contain information that is important for the patient's later treatment as well as a statement, where the patient's paper-bound unit medical record is filed. The data on this form are the basis for a later expansion of the system to the whole region (one medical record per patient and region). Furthermore, a similarly constructed public health record that is connected to the unit medical record, will be necessary. Accordingly, if the patient has permanently settled down in a new district his health record has to be sent to his new health center.