STANDARDISATION OF MEDICAL RECORDS—A MEANS TO AN END

By JAMES F. KIRK (Glasgow).

In the consideration of this topic a few leading questions fall to be answered:—

1. Why should we think of standardisation?
2. What should be the extent of standardisation?
3. Where will it all lead to?

1. Why?

It is generally agreed that medical records can and should be used for a variety of purposes although opinions differ widely on which is the most important use. The degree of importance accorded to these uses depends on the interests of the individual and may be clinical, epidemiological, statistical, financial or medico-legal.

In many hospitals the present form of the record owes more to past tradition than to present requirements. There is, at the moment, in every records department a huge accumulation of information stored in unit records. In many cases no attempt has been made to link the various items of information in these records, either between specialities or even within the same specialty at different times, let alone with comparable information in other hospitals.

In brief, much information is being recorded which is not fully used and indeed cannot be used under the present system.

Interchangeability of records:

I wonder on how many occasions a doctor is able to have a patient’s previous medical history laid before him at the time of consultation, even in summary form?

I would suggest that on the few occasions when this happens it is only by virtue of the fact that the patient’s relevant history is documented on the records held by the particular hospital or general practitioner concerned; and in the case of hospital patients that the record concerned is not one of those which have mysteriously disappeared.

Standardisation could facilitate the exchange of medical records between different hospitals and between hospitals, local authority medical services and family doctors, in such a way that the record or a clinical summary would be meaningful to the doctor concerned; would be available when required and if the complete record was transferred would enable a doctor to know exactly where to find the information required.

At this stage of development, however, it is too much even to contemplate the possibility of raising a medical record for a patient at birth.

*A paper read at the Section of Epidemiology and Preventive Medicine of the Royal Academy of Medicine in Ireland on May 24th, 1967.
Complete Patient's Name, Address, etc., or attach Label in appropriate place.

<table>
<thead>
<tr>
<th>Surname (Mr./Mrs./Miss)</th>
<th>Forename</th>
<th>Unit Number</th>
<th>Type of specimen</th>
<th>Department Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Age</td>
<td>Sex</td>
<td>Ward/Dept.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>Consultant/G.P.</td>
<td>Date and time collected</td>
<td>Previous LAB/E.C.G./X Ray No.</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td>Date of Admission</td>
<td></td>
</tr>
</tbody>
</table>