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CORRESPONDENCE

Correspondents are asked to be brief

Problem Oriented Medical Record

SIR,—Having taught for three years at Case Western Reserve University, Cleveland Metropolitan General Hospital, where the problem oriented medical record was routinely used in the hospital notes and where Dr. Larry Weed was one of my colleagues, I cannot share Dr. Neil McIntyre's enthusiasm (9 June, p. 598).

I agree with Dr. McIntyre that this method of writing patients' notes has several advantages. When multiple problems are present at the same time in an individual patient a summary at the front of the notes of the different problems and their method of disposal is quite invaluable. The method employed, however, does not have to be along the lines which are suggested in the article, and a decent admission record and discharge summary should list the solved and unsolved problems. Second, when an individual patient has had many admissions to hospital and the notes are thick, it can be difficult and time-consuming to get a clear picture of what has happened in the past and its relationship to the present problems; this too, however, does not demand the system which Dr. Weed and his "followers" (to use Dr. McIntyre's term advocate. It should be the task of every medical resident who has admitted a patient to review completely the past hospital notes and to make a summary of the salient features in the records of the present hospital admission. Nevertheless I agree that both these features can be conveniently achieved by using the problem oriented medical record. Third, I agree that this system lends itelf easily to entry into a computer, but ease of computerization and the value which may result from so doing are not necessarily synonymous.

Dr. McIntyre states that by using this system it is possible to "audit" the quality of medical care. I suggest that it is the ability to comply with the system that is "audited" and not the quality of medical care. The latter is very difficult to assess and is certainly not only dependent upon the medical records. Quoting Dr. Weed, Dr. McIntyre states that the efficiency of a doctor "can be assessed by determining the time taken to see a patient and to make a thorough, reliable, and analytically sound entry into the record." Obviously there is an element of sense about this but to suggest that the most efficient doctor is one who can spend the least possible time with his patient and still achieve proper records is, in my opinion, obnoxious, and few patients would assess their doctors' efficiency by these criteria.

My main criticism of this system is that it very easily can concentrate the attention of students and doctors in training to the notes and away from the fundamental problems which the notes themselves are meant to be dealing with. It is common knowledge that the errors and difficulties in the practice of medicine are frequently due to inadequate or incorrect collection of all the information which is available about a patient or to incorrect interpretation and assessment of this information. Whether we decide to call the information "the data base" or not is irrelevant, but many may object to its pseudo-scientific ring. I know from experience that Dr. Weed and his "followers" would not accept this criticism. They would claim, and rightly so, that the better the hospital notes the better should be the care of the patient, and important facets should be less easily overlooked. In practice, however, it is not uncommon, when the system is being used, for the students and young doctors to concentrate more on the format of their records than on the quality and assessment of the "data base" (ugh!). In my own specialty, cardiology, the commonest problems are in this field. How much weight should be put on different factors when the information is conflicting? Can a mother of young children have potentially hazardous cardiac surgery delayed for a few years until the children are older without increasing the risks of operation? These problems would be difficult to record with the Weed system though I admit that they could be. They are, however, best described in prose form even if such prose contains the abbreviations which are beloved by cardiologoists.

These comments are not intended to detract from the stimulus which Dr. Weed has brought to our profession. He is an invigorating, enthusiastic, iconoclastic, and inspiring man. I remember well that his motives are entirely dedicated to the improvement of patient care. I merely wish to point out that in my opinion hospital notes on the traditional lines can fulfil the same aims—I am, etc.,

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SIR,—The problem oriented medical record, so well described by Dr. Neil McIntyre (9 June, p. 598), is an advance over the traditional arrangement of case records and should be adopted. I have been using it for over a year. The problem list at the front of the notes is indispensable. It reminds one of all the patients' problems without having to fumble through the notes. Sometimes my staff—house physician, sister, and registrar—may all have to disappear because of attending to emergencies or suchlike. Then I can triumphantly carry on the ward round alone without any prompting from the H.P. or anyone. The problem list completed during the round before discharge is an invaluable aid for writing the discharge letter or preparing the registrar's summary. Summaries are more useful to general practitioners when all practical details about patients are included. The problem oriented medical record is especially suited for certain patients—for example, those with rheumatoid arthritis, whose disease is often life-long, and old people who may have several disorders, some trivial and some serious. But it is usually unnecessary for conditions like simple appendicitis or piles.