Medical records 1954 to 1974

Navigation of a "new" discipline

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What can changes in medical record keeping tell us about the evolution of family medicine in Canada? From the 1950s through the 1970s, general practice reclaimed a central role in primary care, and family practice emerged as an academic discipline. These developments were paralleled by changes in how medical records were kept and what they contained.

General practice, which became family practice in 1967, changed greatly between 1954, when the College of Family Physicians of Canada was formed, and 1974, when keeping "a legibly written or typewritten record" for each patient was legislated in Ontario.[1] A new self-consciousness about GPs' work and about medical records as the only tangible artifact of that work prompted an interest in medical records that paralleled the development of family medicine in Canada. Uncertainty and debate about the content of a "good" medical record reflected a larger debate about the content of family medicine and how best to ensure accountability, appropriate education, relevant research, and data collection for long-term use.

Chronology

Family medicine was emerging as a new specialty with very old roots. Through the 1950s, housecalls were still a substantial part of most GPs' practices, and their home offices generally required no appointments. Information in patient records was limited to diagnosis, treatment, and fee charged. Detailed records were more common for obstetric and pediatric cases.

In the 1950s and 1960s, GPs starting out in practice after a year of hospital internship (voluntary until 1956) were exposed to medical records mainly in hospitals or through the practices they joined. Charting techniques (or lack of them) remained diverse at the time of Clute's[2] 1963 study of general practice in Ontario and Nova Scotia. By the 1970s, transferring records was still infrequent, owing to their inconsistency. Frequently, what was useful to one GP was useless to another.

As family medicine became established as a distinct specialty, charts' primary use in individual patient care quickly expanded to applications in professional regulation and research.

Professional accountability

Chart quality has been persistently considered an indicator of practice quality. In fact, Clute[2] found that, of 44 Ontario GPs studied, 20% kept no clinical records, and 7% kept only obstetric or pediatric records. Content of charts ranged from notation of medication or fees only, to "scant records" of positive findings and medications, to "very good records" containing history and examination results and treatments. Roughly one third of Ontario practitioners were put into each category.

Better records were associated with better quality of practice. Nonexistent or inadequate records were found to be a limiting factor, as well as an "act of foolhardiness, from the medicolegal point of view, especially on the part of those men whose practices were of unsatisfactory quality."[2] Debates about charting techniques illustrate an important tension between medical records as a physician's tool and as a source of data for other uses.

General practitioners were considered independent business owners, whose practice organization and record keeping were largely determined by personal factors. Accustomed to a high degree of autonomy in community practice, the readiness of family doctors to support or adapt to bureaucratic demands depended on the value of charting or other data collection to their practices.

Regulation of record keeping by the province and the College represented a new exertion of authority over entrepreneurial family doctors. As certification of family physicians in Canada began in 1969, and as the Medical Review Committee (1971) and the Peer

Assessment Program (1977) were developed, medical records became the evidence of correct billing, competence, and quality of practice.

In 1972, Ian McWhinney wrote: "Even though good records may not be essential for good care, it may be argued that we can no longer tolerate a situation in which the quality of care is hidden from view. It may be necessary to say that, 'good care must not only be given, but must be seen to be given.'"[3] The principle of accountability took hold, and interest in medical audits to assess quality of care raised the issue of chart quality. McWhinney also noted that "general-practice record keeping will have to improve greatly, for the evidence suggests that in many practices the records are inadequate for any kind of audit."[3]

Peer evaluation was put forward as a means of identifying deficiencies in knowledge, so that continuing education could be tailored to physicians' needs. In a letter to the *Canadian Medical Association Journal*, Ron McAuley called for action: "Because most of the physician care received by patients today is given in the doctor's office, there is an urgent need to develop acceptable levels of management of common problems and to apply these standards in community practice. Although no one likes to be monitored, it is essential that this be done in order to ensure that standards are maintained. … If a peer group could agree upon standards then monitoring of records (on a routine or random basis) could take place."[4]

Research

In his 1975 series on "The Family Doctor in Canada," David Woods maintained that "Records … are the raw material of research. They are what makes it possible for family doctors, if they are so inclined, to seek first-hand knowledge from their own practices rather than relying exclusively on 'accepted' facts gleaned from textbooks or scientific meetings."[5]

McWhinney attributed the scarcity of research in family medicine before the mid-1970s to uncertainty about the appropriate focus of such research, as well as "suspicion on the part of the individual GP that his raw material, the medical record, may not withstand the process of extracting from it a precision instrument."[5] He qualifies that "much of the data collected by family physicians only becomes generally applicable when it is combined with the data collected by other family physicians. This requires close agreement on criteria and the careful definition of terms."[5]

Resistance to external demands

While studies seeking to understand the content of family medicine relied on abstracting data from medical records, records themselves were slow to change, likely because the information physicians needed for patient care did not necessarily overlap with the minimum data set imagined for family practice evaluation and research. Family physicians often resisted changing their recording habits; some considered structuring as "an infringement and stifling of the creative interaction between the doctor and patient."[6]

Conclusion

In some ways family practice records have changed greatly, from cards in various sizes to computerized files. As records became a routine part of practice, they became increasingly bulky—there is a pendulum swing from non-existent or inadequate records to those that leaned toward excess. The self-conscious attention to medical records during this period reflects a search for balance and manageability.

As this "new" discipline developed, the assessment of competency and practice quality, the advent of evidence-based medicine, the development of family practice research, and the introduction of electronic medical records gave new importance to the medical record.

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References

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