Editor's Note

Recording Patient Data: Get To the Point!

Key words: patient data

Clin. Cardiol. 2007; 30: 57–58.

© 2007 Wiley Periodicals, Inc.

This editorial is principally directed toward medical students, medicine housestaff, and cardiovascular fellow trainees. Those of us in academic medical centers are constantly reading documents put together by this group of students and trainees. Those of you, who are beyond training and are practicing medicine, may not deal with these

issues, but you may recognize some of what follows, since it probably occurred during your medical school years and subsequent training. As faculty, we have to sign off on these documents. I have often been concerned about putting my name on a document that may be redundant, incomplete, or incorrect. It is time-consuming to correct these documents in order to avoid embarrassment when colleagues read what is recorded over my name.

History

As a medical student in the late 1950s, I was taught to write a history by instructors whose emphasis was placed on completeness but also on conservation of words, for example: I was told that it is not necessary to indicate that “the patient states” prior to every sentence of the history. It was also urged that the history was to document facts. I got the distinct impression that quantity was not

necessarily equated with quality. It was made very clear to me that the purpose of the history was to communicate correct information to anyone reading the document relating to why the patient was being evaluated. Since we had to write all of these histories, redundancy was not one of the features of these documents.

Now, to fast-forward to the present. It seems as though our medical students are receiving a different message from those who instruct them on how to record a patient evaluation. I do not know how many thousands of histories I have read, written by medical students and housestaff, but there is a common thread in these histories that seems to ring true. The common thread is redundancy and excessive verbiage. For example, chest pain is a rather typical symptom for patients admitted to a cardiology service. More often than not, prior to reporting the present illness, there are four or five lines containing information about the past illnesses. This is then followed by the reason the patient was admitted to the hospital, i.e. the present illness.

The next history section usually is the past medical and surgical illnesses, which contains the identical material that was recorded in the first four or five lines of the present illness.

The remainder of the patient data recorded is generally fairly straightforward, but there is still a strong tendency not to conserve words. For example, in the social history, instead of reporting simple facts like “does not smoke cigarettes nor drink alcohol”, the sentence usually reads, “The patient states that they do not drink alcohol and the patient states that they do not smoke cigarettes.” Most of these additions are minor points and many will think they are of no importance. However, as one progresses in medicine through residency and beyond and begins dictating these reports, they seem to get wordier. As everyone knows, words cost money when they are transcribed by a medical typist. There are many other examples of excessive verbiage in histories that need not be listed here. My advice is “keep it brief”. The history is not supposed to be the great American novel. I think if one keeps in mind the advice that Sergeant Joe Friday gave on the *Dragnet* series, “Just the facts, ma’am”, the redundancy and excessive verbiage will diminish.

Published online in Wiley InterScience

(www.interscience.wiley.com).

DOI:10.1002/clc.20072

© 2007 Wiley Periodicals, Inc.

Physical Examination

Most of the time the physical examination is fairly concise and to the point. However, there are some important objective measurements that are often omitted, for example, height and weight, despite the fact that these are obviously two of the patient's most objective physical findings. Students and housestaff also use incorrect terms in some instances. For example, when describing heart rate and heart rhythm, the phrase, "regular rate and rhythm" is often used. There is no such thing as a regular rate. The heart rate is measured in beats per minute. The rhythm can be regular or irregular. Thus, if the patient is in atrial fibrillation, he/she may have an irregular rhythm but with a heart rate of 120 beats per minute. If the patient is in sinus rhythm, he/she usually has a regular rhythm and can also have a heart rate of 120 beats per minute. Murmurs sometimes are described as "soft". I do not know what a soft murmur is. Soft is the opposite of hard. I think what most are trying to convey is that the murmur is not harsh, not loud or may be difficult to hear, i.e. Grade I.

ECG and Chest X Ray

The Electrocardiogram (ECG), particularly in patients admitted to hospital for cardiac conditions, should be described in detail, if abnormal.

The chest X ray, which is also generally a part of the evaluation of a cardiac patient, should also be described in detail, if abnormal. In the cardiac patient, it is particularly important to describe the lung vascularity.

Assessment

The assessment of the patient's condition should be a diagnostic impression. It is a rare occurrence to read a diagnostic impression based on the History and Physical

(H & P), ECG, chest X ray, laboratory results, etc. It is much more common to read a listing of past illnesses and the admitting symptom. So, now we have three places where the past illnesses of this patient are documented, two of which are unnecessary. Back to our patient with chest pain. Chest pain is a symptom and not a diagnosis. Chest pain can be due to many things, and if it is considered to be an acute coronary syndrome, it should be stated. In other words, give the reader a diagnostic impression.

Plan

The plan is basically a strategy to evaluate and treat the patient based on the H & P, ECG, chest X ray, and other laboratory abnormalities. The plan should incorporate and integrate all the information to support the initial diagnostic assessment.

Summary

As the student moves on into further training as a house officer, it is important to follow the principles outlined above and not go on endlessly dictating redundant information, thus developing a sloppily written, difficult to understand, ponderous document, that very few will read or remember. If the idea is to communicate with each other about the patient evaluated, the evaluator needs to think critically about the information available before it is recorded. The best advice I can give is to record the information as if you had to write the document. It is amazing how much thoughtfulness this will require and how much this will cut down on redundancy.

In other words, get to the point, and remember that quantity does not always equal quality.

C. Richard Conti, M.D., M.A.C.C.
Editor-in-Chief