

Editorial

Problem Oriented Medical Records

The problem oriented record keeping system originally introduced by Weed and developed, refined and popularized by Hurst has become a powerfull learning, teaching and auditing tool. To the people not exposed to this system of medical data collection, Weed's original book and books by Walker and Hurst would serve as good introduction.

Briefly stated, the problem oriented system tends to indentify medical problems in the patients at various stages of resolution as and when the patients presents to the treating physician. The problem may be a symptom or a sign or an abnormal laboratory value the cause of which has not yet been established. Or, it may be a fully diagnosed disease state. The problem may be old or new. It may be active or resolved. All such problems, past or present, are assigned a number each. They are serialized, preferably chronologically, on the front page of the patient's case-sheet. This is called the "Problem List". This problem list, which is continously updated, becomes a "living" account of the patient's health record.

The history and physical examination are documented as is done in the usual routine fashion. At the end of the history-physical is stated the provisional diagnosis and the differential diagnosis as is normally done. This is followed by a clear statement of a plan in three parts. The first part is the immediate treatment plan. The second outlines the diagnostic plan to further workup the problems so as to resolve the list of differential diagnoses to the least possible number. And, finally plans for patient education both as to understanding his disease state as well as any active participation in remedial measures.

From then onwards, all progress notes are recorded in the "S.O.A.P" format i.e. S-subjective complaints; O-objective physical examination or laboratory findings; A-assessment of the evolution of the problem, and, P-plan for further action under the same sub-heads of therapeutic, diagnostic and patient education. There is a SOAP for each of the patient's problem. When the patient is discharged, a discharge summary is dictated in the SOAP fashion. After a small introductory paragraph, each problem is listed serially with a SOAP note following it. The problem list is kept alive and used for subsequent outpatient visits or any further re-admissions. Information of visits to physicians or admissions elsewhere are recorded as this information becomes available.

Reviewing the entire system you will become aware that you may have been unconsciously doing this all along. Well, now here is a tool which has been de-bugged and put to field testing and available for your use to consciously, reliably and consistently do the same. The learning, teaching, research, self and peer audit possibilities of the system are awesome enough to stir up the most reticent amongst us.

Try it, you'll like it!

Editor.