The Linacre Quarterly

Volume 30 | Number 3 Article 2

August 1963

"Gitting Thar Fustest with the Mostest"

Robert S. Myers

Follow this and additional works at: http://epublications.marquette.edu/lnq

Recommended Citation

Myers, Robert S. (1963) ""Gitting Thar Fustest with the Mostest"," *The Linacre Quarterly*: Vol. 30 : No. 3 , Article 2.
Available at: http://epublications.marquette.edu/lnq/vol30/iss3/2

"GITTING THAR FUSTEST WITH THE MOSTEST"

ROBERT S. MYERS, M.D., F.A.C.S.*

This article's title, which Confederate General Nathan Bedford Forrest allegedly used as the reason for his successes on the Civil War battlefields, is equally applicable to the field of data processing in today's modern and progressive hospitals. Now is the time to use business machine methods to obtain the most information the most quickly about multiple aspects of patient care. The traditional methods of gathering and correlating data by hand are not sufficiently accurate, rapid, or economical to warrant their use.

This does not imply in any way that computers are going to replace doctors in the care of their patients, for physicians will still have to examine the patients, make the diagnoses, write the medical records, and prescribe therapy. What it does mean is that modern business machines are able to record, recall, and reproduce the data which the medical staff and record librarian have gathered about the care of patients, much more quickly, more cheaply and more efficiently than can human beings using hand-tabulating methods. Any doctor who has ever struggled through a hand tabulation of six or seven factors of patient care of even 100 patients and then has tried to correlate the results by sex, age, length of stay, justification for surgery, etc., knows the back-breaking effort which such antiquated methods entail.

During the past ten years, the use of business machines to provide ready access to the information in the hospital's clinical records has developed with breathless rapidity. In particular, the last two to three years, since electronic computers have become commonly available, have witnessed revolutionary changes in the gathering of data about patient care.

I am particularly acquainted with one system of handling medical record data for the hospital's medical staff and administration, since I have been associated with it in one form or another almost since its beginning in the year 1950. This is the Commission on Professional and Hospital Activities' Professional Activity Study (PAS) and Medical Audit Program (MAP). The Commission is sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the Southwestern Michigan Hospital Association, and is located in Ann Arbor, Michigan. Its staff numbers nearly a hundred of which, nearly half, are highly trained and skilled specialists.

Working with abstracts of the individual patient's records, and using an electronic computer to handle the data, PAS and MAP together offer to all hospitals in the United States and Canada:

1. A professional service accounting system for the individual hospital.

2. A source of "'yardsticks for the hospital's own clinical statistics.

3. A time-saving method for evaluating the quality of patient care.

4. A research arm for the participating hospital.

5. Research studies on the clinical data from many hospitals.

6. Work simplification for the medical record department.

7. A convenient reference on individual patients which often makes chart-pulling unnecessary.

Important data upon many aspects of patient care are returned from the Commission to the doctors and the administration of the individual hospitals with the identities of patients and doctors concealed. The object is to put into the hands of the staff and administration tools which will help in the improvement of patient care.

As of today, there are 272 hospitals participating in PAS. They represent 37 states, the District of Columbia, Puerto Rico, and 5 Canadian Provinces, and discharge 2,367,400 patients annually. This is the world's largest, most diversified, and most accessible source of case by case data on hospital patients.

The cost to the hospitals for PAS is small indeed for the benefits obtained. Hospitals pay a fee of 30c for every patient discharged; therefore, if a hospital discharges 10,000 patients each year, it pays the Commission $3,000. This fee, however, is offset by a reduction in the work of the medical record department of the hospital, for from PAS the hospital receives its routine discharge statistics, and its disease, operation, and physician indexes, all produced rapidly and accurately by the Commission's computer.

If the hospital wishes to add the Medical Audit Program to PAS, it pays an additional 10c for every discharge, making a total fee of 40c. For this, the hospital receives a further tabulated review of all of the cases handled by each department of the medical staff in addition to the material returned by PAS. Case review forms are also supplied for optional use.

One word of caution is proper at this particular point. Individual hospitals should squash promptly any enthusiasm to install their own business machines to conduct evaluations on their own. Machines are very expensive equipment, but more important and costly than the "hardware" is the *system* of data processing in which it is to be

*Dr. Myers is Executive Assistant Director of the American College of Surgeons; President of the Commission on Professional and Hospital Activities; a member of the Medical Advisory Committee of the Catholic Hospital Association.

John J. Flanagan, S.J., Editor of LINACRE QUARTERLY, is Vice President of the Commission on Professional and Hospital Activities.

employed. Even the largest hospital cannot justify the cost of developing the system, keeping it modern, and renting and operating the equipment. While the Commission's computer rental exceeds $11,000 per month, an almost equal amount is expended on *just* the process of keeping the system up to date—determining what to abstract from each clinical record and designing the form, working out the most useful report data and format, and writing the necessary computer programs (in 1963 the PAS and MAP programs exceed 250,000 separate machine language instructions). It is this meticulous attention to detail which makes PAS and MAP simple and effective—and the investment required for the *system* is as great for a one-hospital system as for the entire family of PAS hospitals. In addition, PAS and MAP supervise and control the quality of the data, both incoming and outgoing, solve the individual hospital's needs for data with special tabulations and studies, and offer instruction to medical staff, administration and medical records personnel in the use of the new tool.

Neither the medical staff nor the administration should view PAS or MAP as entirely painless solutions to the problems of the evaluation of patient care. They aren't. The records have to be carefully abstracted (and the abstracts can be no better than the records they condense). The information from the abstracts, after it has been compiled and displayed by the computer, must be conscientiously studied back in the hospital. The medical staff must answer to itself the questions "What quality of care does our record reveal?" and selected individual charts will still require committee review. But if the staff and administration wish to receive adequate and useful information about the quantity and quality of patient care, and they can through PAS and MAP, then hospitals should be anxious to participate in these programs.

The way to do the job is to "git thar fustest with the mostest" and this means using modern business machines. There just isn't any excuse now to waste the time and effort of busy doctors and medical record librarians in futile and obsolete methods of evaluation.