View of HIM From the Early Days

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by Harry Rhodes, MBA, RRA, HIM practice manager

Recently, I had the opportunity to visit with two longtime AHIMA members: Earline H. Earhart, RRA, a member since 1937, and Mildred P. St. Leger, RRA, who joined in 1953.

Earhart became a member under the organization's original name—the Association of Record Librarians of North America. St. Leger joined just after the first executive office opened and slightly before the first ART educational programs were established.

Interviewing both of these professionals, I asked them to recall changes in practice that they have seen over the years.

How were charts completed at the beginning of your career?

"When I first started working in medical records, the physicians did not complete the history portion of the History and Physical. The medical record librarian was designated to go to the patient's room to obtain the patient's medical history. This practice continued until the Joint Commis-sion began to require the physician complete the history," Earhart says.

Earhart adds that in the early days, dictation equipment was unheard of. "I would take shorthand notes of the doctor's dictation by actually going into the surgery or autopsy suite as they performed the procedures," she says. For St. Leger, dictation technology took a different form. "Our first dictation equipment used wax and plastic cylinders to record the doctor's voice. And transcription was done on manual typewriters," she says.

"When I arrived at my first job in medical records," St. Leger continues, "the facility was still storing records in leather-bound jackets with gold leaf lettering. Records were stored 150 cases to a volume, and reports were typed on onion-skin paper to save space.

"I believe that physician penmanship was actually better when the entire chart was handwritten," St. Leger says. "And less emphasis was placed on signing every entry in the medical record. However, the date of the entry was considered very important."

Earhart adds one more memory: "Before discharged medical records were filed away as completed, each record was first reviewed by a committee of medical staff physicians," she says.

How did you release information?

"I remember a time when patients were not allowed a copy of their own medical record," Earhart says.

"Before we bought our first copy machine," St. Leger explained, "we would rely on carbon copies to release information to other parties. If we didn't have a carbon copy, we would either type an abstract of the record or retype the entire record depending on the need.

"Our first copier was a 'wet copier' and it was not unusual to walk into Medical Records and see wet copies spread all over to the floor to dry," she adds.

How did you compile census and statistics data?

"We would record our statistics in large ledgers of our own design and prepare them manually," Earhart remembers.

"We recorded the daily census in huge ledger books. Sometimes you would discover an error near the end of the month that occurred at the first of the month. The entire month's figures would have to be corrected," St. Leger says. "It was very

frustrating."

How has the workplace environment changed?

"When I first started to work in medical records," Earhart says, "we did not have temporary, part-time, or volunteer staff working in the department. Everyone was full time."

"You never encountered any HIM professionals who were entrepreneurs," St. Leger adds. "I believe that over the years we have become more sophisticated, as we acquired new skills and responsibilities."

St. Leger, who teaches in an HIM program, says, "I see many more adult students than I used to." To students of all ages, she has the same message: "Because they have chosen this career, they will be able to participate in history making and medical advances."

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