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LECTURE TO ALL MEDICAL OFFICERS.

By Colonel K. Comyn.

There are some of you who have come direct from civilian medical practice into Army medical routine. It is to those I wish to speak of the intricacies of such routine in an endeavour to help you in your difficulties and make such routine easier for you. Of those of you who have already considerable Army experience I would crave your tolerance if I tell you much that you know already and I hope that perhaps you may glean a few tips that may be, even to you, of some benefit.

We all want our Service to be as nearly **100** per cent efficient as possible, and that efficiency, both from the professional and from the statistical point of view, begins with the work of the Ward Medical Officers in a hospital and with the Regimental Medical Officer in the field. It does not matter how efficient the senior staff officers either in a hospital or in the field may be if the ward or regimental medical officers are inefficient or do not show keenness and initiative in their work.

Difference between Civil and Military Patients.

You must first grasp certain fundamental differences between civil and military patients. You will then realize that your treatment of them varies to some extent accordingly.

The soldier must be either fit for full duty or else in hospital. He should very rarely be "Excused Duty" or on "Light Duty"—consequently civil patients are usually *more* ill, more seriously ill before you see them. There is a greater proportion of trivial cases among soldiers in hospital. A civil patient is generally better off in his own home than he is in hospital unless seriously ill: it is the reverse with a soldier—he is always better off in hospital than in a barrack room. In Army life, especially in war time, there is always a proportion who are malingerers—a small proportion—they are much rarer in civil life. Then there is a large number just now who either purposely with an eye to the future or subconsciously from lack of spirit or determination to fight against them, attribute all their ills to France and/or the Service. The true malingerer is very hard to detect. The one who is subconsciously making the most of his ills is much easier to detect and should be treated firmly and not pampered—many can thus be cured.

Functions of Military Medical Service.

Your essential basic duties as military medical officers must next be properly understood and your actions based accordingly. In civil life, the doctor's interests which guide his actions are threefold: (1) His professional interest in the case; (2) to a slight degree a financial interest; (3) the welfare

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of the patient. I do not know which is the correct order in which these interests should be enumerated. In military life we are servants of the Government and, through the Government, of the Public. Your interests or duties, for professional interests become duties when you join the military medical service, are threefold while the war lasts: (1) The prosecution of the war by whatsoever medical means you can; (2) the welfare of your patients and safeguarding of their interests; (3) the safeguarding of the Government and the Public against financial loss that can be avoided. That is definitely the order in which your interests or duties must be carried on. Hard though sometimes it may be, the welfare of your patients must at times be subordinated to the common good and the prosecution of the war.

Briefly speaking, your duty in the prosecution of the war is to get every man possible fit enough to do some form of military duty even if he cannot do the full normal duties of his arm or branch of the Service. Conversely, your duty is to get out of the Army as quickly as possible all men who are obviously unfit for any form of military service. Every sick man or man excused duty or on light duty constitutes a burden on his unit and delays that unit's training, efficiency, mobility and striking power. This duty of the medical officer whether regimental M.O. or M.O. doing duty in a hospital is of the utmost importance and constitutes the primary function of the military medical service, namely to maintain the strength and efficiency of the fighting forces. Hence the most important part of your work in a hospital is your decision as to the disposal of patients and what effect treatment will have on their disposal. On the one hand we have to avoid loss of man power and on the other hand we must avoid hampering units with unfits or semi-fits and lengthy occupation of hospital beds which may be required for emergencies or war casualties.

The question of disposal of patients, especially those that are unfit, is closely related to the third important part of your duties—that of safeguarding the State against undue financial loss. This is the main object to be achieved by invaliding and medical boards and depends upon the accurate recording of such data as will enable the Ministry of Pensions to fix the degree of attributability or degree of aggravation or otherwise of any disability with which a soldier leaves the Service or of which he may complain at any subsequent date. This is applicable both ways, not only to safeguard the State against the man who unjustifiably claims that his disability is attributable to service but also to safeguard the man who leaves the Service with his health broken through military service without compensation. The former is all too common—the latter very rare. A number of cases undoubtedly occur in which men claim compensation either after being demobilized or at the end of their military service in which insufficient recording of illnesses or injuries during their service prevents the Ministry of Pensions forming an accurate assessment of causation and the men have to be given the benefit of the doubt.

For these reasons a greater amount of recording, i.e. paper work, is

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necessary in the Army Medical Services than in civil life, and the greatest accuracy is necessary in such recording. Before speaking in detail of this paper or statistical work I must mention very briefly a few words of advice on the purely professional side of your work. In Army life we are much more liable to criticism, or rather of criticism being passed around, than we are in civil life and unfortunately adverse criticism goes round far more widely and much more quickly than favourable criticism. Bearing that in mind it is necessary for us to be a little more cautious in certain ways. Here are a few hints which may save us much adverse criticism even though quite undeserved. Never fail to see and speak to every patient under your immediate care every day, even if it is only to ask him how he is. Always fully examine every medical patient and every surgical case which is not obviously a trivial injury such as a cut finger or a sprained ankle. You will think it unnecessary to call your attention to this yet it is astonishing how frequently complaints are made after patients have left the hospital, especially officer patients; such complaints as "The Medical Officer never examined me," or "I was not told whether to stay in bed or what food to take," or "I was in hospital five days and only saw the medical officer once," etc. One case I remember of an irate C.O. of a cavalry regiment phoning me to come and see him because the regimental M.O. had visited him and had told him he had a feverish cold but did not take his temperature, did not look at his throat nor examine his chest, did not tell him whether to stay in bed or get up or what food to take. In this particular case the patient had only a slight cold, but that medical officer's reputation in the station was dead and the prestige of the whole medical service there also suffered considerably, though I helped to raise it somewhat by doing my best to choke the aforesaid officer with a spatula and throat swab, by pummelling his chest as hard as I could, by putting him to bed on a starvation diet and then giving him the most unpleasant concoction of sodæ salicyl. I could devise. He recovered from his cold and he thought me quite a good doctor.

Administrative Duties of Ward M.O.s.

Then there are certain administrative duties to be carried out by those of you who are in charge of wards or departments. As I said before, the efficiency of a hospital begins with the ward medical officers. Their duties are not only professional. Each ward medical officer should try to look upon his ward or wards as a separate hospital of which he is O.C. He should, on his morning round, have a keen eye for the general ward management, e.g. cleanliness and tidiness of the ward and of bed linen, sufficiency of pillows, cleanliness of patients, the warming and ventilation of the ward, cleanliness of annexes, bath, bedpans, urine bottles, W.C.s, sufficiency of latrine paper, effectiveness of flushes, cleanliness and orderliness of ward kitchens, crockery and utensils, prompt investigation and reporting of breakages. A great deal of this is the duty of the Sister in charge but it must be remembered that many of these Sisters have come straight from civil life and have not

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worked before in a military hospital. Then the M.O. should be sure that his diet sheets are kept up to date and that the dieting is strictly based on two considerations: (1) the patient's health; (2) hospital economy. Chicken, Low and Gastric Diets should only be ordered when thought absolutely necessary on medical grounds and not because the Sister thinks the patient "a nice man" or that he "needs feeding up." There is too great a tendency to leave the dieting entirely to the Sister in charge.

He must not forget too that the responsibility of training orderlies rests largely with him. Good nursing orderlies are not made by lecturing alone but actual practical instructions in wards by M.O. and Sister will create keenness and efficiency.

Statistical Side of Military Medical Service.

Now I come to the statistical side of military medical work. It is, of course, very irksome to all of us and much more so to those of you who have only recently come from civil practice and are new to what is commonly referred to as "Army Red Tape." Unfortunately the efficiency of a hospital is often judged more from unsatisfactory records and reports which leave it than from highly efficient skilled treatment that is enacted within it. Therefore efficiency in both sides of the work is essential.

The purposes or general principles for which these statistical records are required are:

(1) To keep every patient's unit and/or Record Office informed where he is when he is under medical care.

(2) To keep the War Department informed of the numbers off duty from sickness and therefore what reinforcements or replacements are required to maintain the unit's strength.

(3) To provide the War Department with accurate data from which (*a*) annual statistics of sickness from all over the world wherever our troops are, and (*b*) the medical history of the war, can be compiled.

(4) To complete an accurate medical history of each man serving in the Army, while he is so serving.

(5) To safeguard the State from undue wastage and unnecessary additions to the pensions bill.

(6) To compensate the individual soldier for disability or injury directly attributable to or aggravated by his military service.

First as regards the means by which every man's unit is kept informed. When a man is admitted to hospital, A.F. B-256 (Sick Report) should accompany him. One copy of this is signed by the M.O. receiving him at the hospital and returned to his unit, thus informing his unit of his admission. The second copy is sent to the ward with any notes on it as regards symptoms or treatment which the M.O. may wish to convey to the Sister or M.O. in charge of the ward. It should then be sent to the Statistical Office for filing. As a result of Army Form B-256 being received by the unit, three very important things are done: (*a*) The man is struck out of

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rations from the following day; (*b*) his kit is collected from his barrack room and put into the Quartermaster's Store and an inventory taken; (*c*) the Pay Serjeant makes any necessary adjustments to his pay. Then also A.F. B-178, the man's medical history sheet, is sent to hospital by the unit, if they have it, or by the O. i/c Records if it is there.

Secondly, to keep the War Department informed of the numbers off duty from sickness. On the morning after admisssion, A.F. W-3017, Report of Admission to a Military Hospital, is sent (i) in the case of officers and nurses, two copies to the War Office (Casualty Branch) and one copy to A.M.D.2 (Medical Statistical Branch), (ii) in the case of other ranks, two copies to Officer i/c Records concerned. The same form is similarly sent on discharge or transfer from the hospital, if it is a military one. In the case of admissions to/or discharge from an E.M.S. Hospital, Form E.M.S. 105 takes the place of A.F. W-3017.

These forms keep the War Office constantly informed of the numbers of men going sick, but not of the incidence of sickness, because many of these cases must of necessity be shown as N.Y.D. on the first day of admission. To supplement this information and give more accurate figures, A.F. A-2024, Return of Patients Admitted as Direct Admissions During the Week, is sent to the Under-Secretary of State, A.M.D.2, War Office, every week on Saturday mornings giving the total numbers by diseases admitted up to Friday midnight. This does not give names, but does give units. It also shows a small summary of beds equipped, available and occupied in military hospitals at home. This form does not show cases transferred from other units but only direct admissions. It is rendered by all field ambulances, C.C.S.s, general hospitals in the field, general and military hospitals at home and overseas. The numbers admitted to E.M.S. Hospitals are reported on E.M.S. Form 105, which takes the place of A.F. W-3017, and A-2024 has no counterpart in such hospitals. Military Hospitals at home also keep the A.D.M.S., D.D.M.S., and O.C. Station, and through these the G.O.C. Command, informed of the situation as regards numbers of sick and numbers of vacant beds by rendering A.F. A-27 daily. This is the Morning State of Sick, and shows the numbers of sick by units, officers and nurses by name and disease, cases put on the D.I. and S.I. List, and deaths whenever they occur. It also shows number of beds occupied and vacant.

When a patient has been off duty from sickness for twenty-one days (in the case of A.A., R.A. Units the period is three months), he is struck off the strength of his unit and placed on the "Y" List, coming automatically on the strength of his Depot. This enables his place to be taken by a reinforcement and the O.C. to gauge more accurately what his requirements are likely to be in the way of replacements. The striking off strength and placing on the "Y" List is done by the O.C. Unit in Part II Orders.

It will be seen how important it is that, whenever a patient is detained or admitted by a medical officer, whether an orderly medical officer or an

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officer doing out-patients, a B-256 or a slip in lieu, with the man's details, is sent as soon as possible either by the M.O. or the Sister i/c the ward to the statistical, chief clerk's or enquiry office and that diagnosis be written up on the diet sheets as soon as definite diagnosis can be made with accuracy.

Records of Sickness in the Army and Medical History of the War.

The next purpose for which medical statistics are required is to compile accurate records of sickness, with details of treatment and disposal, among British forces throughout the world.

In peace time, this is done in two ways: (1) by annual returns compiled from the Admission and Discharge Books (A.B. 27) accompanied by reports of specialists and of special cases, epidemics, etc., and (2) by A.F. I-1220, the Hospital or Sick List Record Card. In war time, the annual reports are done away with and I-1220 constitutes the main statistical record held by the War Office. This form is therefore one of the most important documents with which we have to deal. I-1220 is made out for every patient admitted or transferred to a general hospital in the field or at home and every military hospital at home. In the field every individual admitted to a Field Ambulance or C.C.S. has A.F. W-3118, Field Medical Card, and W-3118A, Envelope, made out, if he has not already got one. This, together with any temperature chart or medical notes follows the patient from one medical unit to another. When finally discharged to duty, died or otherwise disposed of, the W-3118 and notes in W-3118A are sent by post to the Under-Secretary of State, A.M.D.2, War Office, each Saturday.

A.F. I-1220 is prepared for every patient admitted or transferred to a general hospital. This replaces the W-3118 if the patient is admitted direct to a general hospital or is in addition to it if he is transferred from a Field Ambulance or C.C.S. The I-1220 does not accompany the patient from one unit to another, but on the Saturday in each week the A.F.s I-1220 relating to each patient discharged to duty, transferred to a convalescent or other Depot, or another hospital or hospital ship, or who died, will be sent to the Under-Secretary of State (A.M.D.2).

With regard to entries on A.F. W-3118, there is little space available and only essential notes should be made. The most important of these are date, time and place of wound, injury or onset of sickness; whether morphia, any such drug as M & B 693, Sulphanilamide, etc., prophylactic serum, etc., have been administered.

Entries on A.F. I-1220.

We now come to the compilation of A.F. I-1220. This is prepared in the first instance in the statistical or head office of the hospital from details in the A. & D. book, obtained either from the sick report sent to the hospital with the man, or from details taken in the reception office when the man arrives, or from a slip sent from the Ward. It is a remarkable thing how many errors occur in these A.F.s I-1220 of a patient's regimental num-

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ber, or initials or the spelling of his name, or his unit or whether he is transferred from some other hospital—frequently some such details are omitted altogether. It is essential therefore that all these details are checked up as soon as possible at the bedside with the verbal statement of the man himself. This should be done by the divisional wardmaster. The medical officer should also verify these details on the diet sheet, although this is not such an important document and does not usually go outside the hospital. They may however be called for by the A.D.M.S. or D.D.M.S. or Officer i/c Supplies periodically for inspection. It should be remembered that the more important of these cards are photographed to produce duplicates and, should any question be raised subsequently concerning any man's illness or accident, his treatment in hospital or the result of any such treatment, the duplicate may be called for. Also, should any statistical work on certain diseases or epidemics or group of disabilities or any research work be gone into, these photographed facsimiles may be obtained on loan from the War Office.

For these reasons all entries must be very legible, and written in good ink. The diagnosis should be in block capitals and must conform to the Nomenclature of Diseases. It should be remembered, too, that they may be studied either at the War Office or Ministry of Pensions, where names of local specialists, etc., are not known and mean nothing, but that it is the opinion of such officers or the result of their treatment that is essential. Such entries as "Will Major please see"—or "to see Medical Specialist," etc., with no further remarks as to result, mean absolutely nothing. Such entries should be as follows: "date . . . seen by Surgical Specialist . . . advised . . . ", or "date . . . treatment as advised by Medical Specialist . . . carried out . . . result satisfactory," or "Improved" or "Cured."

Then opposite condition on discharge, one often sees "I.S.Q." That will not do. If the patient cannot be shown as "Cured" or "Improved," then there must be some note as to the disposal or further treatment, i.e. "to attend M.I. room for further treatment"—"Medical Board recommended Category 'C'"—"to be seen by . . . Specialist at a later date for treatment, recommended light duty till then."

It is also of the utmost importance to record briefly all treatment given. The negative effect of treatment often affords as valuable information as positive effects—e.g. in arthritis cases the effect of salicylates, rest, radiant heat; and in gastric cases the effect of dietetic and medicinal treatment. There is often a great tendency to rush patients to the X-ray room, thereby causing a considerable expense in X-ray films, wear and tear of tubes, and strain on working time of the X-ray Department. At the same time the recording of any preliminary treatment and its effect on the disability forms a very important part of the patient's medical history.

With regard to diagnosis on A.F. I-1220. If a diagnosis once made and entered proves to be wrong, the first diagnosis is crossed out on the A.F. I-1220 in such a way that it is still legible and the new diagnosis is

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written in block capitals above it, the correction also being made on the diet sheet and a slip sent to the statistical office. When a patient is suffering from two diseases, he will be shown as admitted for the more important or serious one and the second one mentioned stating on the A.F. I-1220 its treatment and progress. Should the second disease persist after his recovery from the one for which he was admitted he will be shown as discharged on the date on which he recovered from the first disease and as readmitted the following day for the other disease.

Should another disease supervene on that for which the patient was admitted, the fact will be noted in the "remarks" column of the A. & D. book and on the A.F. I-1220. Should the new disease persist after the patient has recovered from the first disease, he will be shown as discharged on the date on which he recovered from the first disease and readmitted the following day for the new disease.

A.F. I-1220 must be made out for every case admitted or transferred to hospital. This includes cases as above in which a second disease persists or a new disease supervenes and persists, for which a new card must be made out to agree with the new entry in the A. & D. book. Every admission in the A. & D. book has a serial number and this must agree on the A.F. I-1220.

On January 1 each year a new card with a fresh serial number is made out for every patient in the hospital.

To summarize the requirements of A.F. I-1220:

(1) Legibility with good ink.
(2) Accuracy of man's details of number, rank, name and initials.
(3) Correct diagnosis in block capitals and in accordance with Nomenclature.
(4) Statement of treatment given and results thereof.
(5) Disposal and condition on discharge.

A.F. I-1220 must not be kept at the bedside or where a patient can get access to it.

Military Patients in E.M.S. Hospitals.

Military patients admitted to E.M.S. hospitals and civilian casualties admitted to military hospitals have slightly different forms and they do not have A.F.s I-1220.[1] These forms are chiefly E.M.S. 105, M.P.C. 46, 47 and 42. E.M.S. Form 105 takes the place of A.F. W-3017 and is sent in duplicate to the Officer i/c Records for a soldier in an E.M.S. hospital. M.P.C. 46, casualty card, is made out for every casualty whether military treated in an E.M.S. hospital or civilian treated in a military hospital. This is in the form of a tie-on label which is made out at the first aid post or dressing station. All medical documents are placed in a war casualty cover or envelope—M.P.C. 47—which is transferred with the patient wherever he goes and on final discharge is sent to the Ministry of Pensions Casualty Records Section.

[1] A.F. I-1220 has now been adopted by the E.M.S.—*Ed.*

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On discharge of the patient, a form M.P.C. 42, classification of injuries schedule is made out and sent to the Casualty Record Office, Ministry of Pensions and a discharge certificate M.P.C. 43 in triplicate is prepared. One copy is given to the patient as evidence of hospital treatment in any claim he may make for compensation. The duplicate of this, on which the patient acknowledges the receipt of the original, is attached to the hospital case sheets and forwarded to the Casualty Records Office, and the third copy is left in the hospital file.

The Medical History of Each Soldier.

The fourth important duty of a statistical nature is to compile an accurate medical history of each soldier while he is serving in the Army. This is done on A.F. B-178, the medical history sheet, a very important document which should move with the soldier wherever and whenever he moves, except when he goes on active service overseas. It is normally kept in the Medical Inspection room by the M.O. i/c unit whose job it is to keep it up to date. It must be sent to hospital (except E.M.S. hospitals and Civil Infections hospitals) as soon as the man is admitted. When the man proceeds overseas on active service it is sent to his Officer i/c Records to be retained with his other documents. It is made out in the first instance when the man is medically examined on enlistment or when joining up for service. It gives a medical description of the man with reference to certain Army standards. Chest measurements, height, weight, eyesight, etc., and any minor defects detected on preliminary examination should be noted, such as varicocele, varicose veins, scars, hammer toes, flat foot, etc., as these may have an important bearing should the man come up for medical boarding at a later date. In preparing board papers, the medical history sheet should always be looked at for any such entries.

In the middle of the form are entered records of all admissions to hospital. It is most essential that these records should be short, concise and strictly relevant. The important details are name of hospital, dates of admission and discharge and number of days under treatment, diagnosis and probable cause, e.g. constitutional or trauma or infection, etc. If the admission was due to an accident you should state if A.F. B-117 has been rendered; then very short notes as to the illness or injury. These notes should rarely be more than three or four lines and not like A.F. I-1220 or Case Sheet A.F. I-1237. Treatment, progress and result are the important details; whether cured or improved; whether operation performed, splints, plaster, X-ray or not; findings of examination of sputum, fæces, urine, blood if relevant, but not if results negative or of no importance.

Other details that have to be recorded on A.F. B-178 are records of blood transfusions; records of all inoculations and vaccinations; dental condition and treatment; prescription for spectacles; medical boards; Courts of Enquiry on injuries; regrading of category on leaving hospital.

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THE SAFEGUARDING OF THE STATE AND THE INDIVIDUAL.

The fifth and sixth principles or purposes for which accurate records must be kept are closely allied, namely the safeguarding the State from undue additions to the pensions bill, undue wastage of manpower on medical grounds, and to compensate the individual soldier for disability attributable to or aggravated by his military service.

The two important Army forms connected therewith are A.F. B-117, report on injuries (other than wounds received in action) and A.F. B-179, medical report on a soldier (for officers A.F. A-45).

A.F. B-117 is designed to record two important facts with regard to any injury however trivial: (1) Did it occur on duty? (2) Was anyone else to blame? These records are necessary to enable the Ministry of Pensions to decide on any subsequent claims that may be put forward by a soldier. These two facts are decided by the man's C.O. as far as possible. The M.O. is required to state the nature of the injury, whether trivial or serious and whether likely to interfere with his future efficiency. This is asking for a prognosis at a very early stage when it is not always possible to give an accurate one, but such a prognosis need not be accurate and is only required to determine whether the injury is serious enough to require further investigation. If the injury is stated by the M.O. to be serious or likely to interfere with his efficiency, then a Court of Enquiry is held under the orders of the man's C.O. Apart from establishing those two facts, whether on duty or whether there is anyone to blame, this Army form is not concerned with the ultimate progress or eventual result of the injury. On completion it is sent to the man's Officer i/c Records and retained there for future reference. In the case of officers it is sent to the War Office.

The second Army form connected with recording the attributability or otherwise of injuries or disabilities is A.F. B-179, medical report on a soldier (for officers A.F. A-45). This is the bugbear of all O.C.s hospital and A.D.M.S.s alike, not to mention such lesser lights as officers in charge divisions and even ward medical officers. Medical boarding bristles with difficulties but, if certain fundamental principles are grasped and kept in mind, these difficulties become minimized.

First of all you must remember that these board papers are finally scrutinized by the Ministry of Pensions who are not concerned with elaborate histories, with a concise symptomatology from A to Z, nor a carefully taken case sheet from a professional standard filled with a number of negative records and obstruse tests that may or may not be relevant to the final issue. In this respect A.F. B-179 is exactly the opposite of a well-written case sheet—A.F. I-1237. So consider first what details the Ministry of Pensions DO want to know. Briefly they are as follows:

(1) That the man who is applying or may subsequently apply for a pension is the man whose disability is recorded on A.F. B-179.

(2) That the disability described is the one for which he is claiming a pension.

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(3) That any other disabilities claimed or discovered do or do not affect his efficiency.

(4) Whether the disability or disabilities were attributable to or aggravated by military service.

First of these then is that the Ministry of Pensions can be sure that the man applying for or drawing a pension is the man who was boarded on A.F. B-179. To this end great accuracy is necessary in recording the man's number, surname and christian names, also the signing by the man and witnessing of his signature in Part 2. It is astonishing how many men there are in the Army with the same surname and combination of christian names. It is equally astonishing how frequently wrong regimental numbers are recorded. The only way to get accuracy is to check all these details with the man himself verbally. Never copy them from the A.F. I-1202 (diet sheet) or A.F. I-1220 (case card), which are filled in by a clerk in the hospital record office from details taken on admission in the reception room and are frequently incorrect.

The second guiding factor required by the Ministry of Pensions, is "for what was the man invalided?" We must be perfectly definite in this. Practically every man has some minor malady—perhaps a hammer toe, or flat feet, varicose veins, varicocele or slightly defective hearing, etc., but unless these would be or are causes for invaliding they should not be mentioned unless they occurred as a result of service. If, on the other hand, there are two or more disabilities both or all of which are sufficient causes for invaliding or which might have been caused or aggravated by service, then they must be mentioned and numbered throughout the form so that the answer to questions on the form shows clearly to which disability they refer.

All diagnoses must be in accordance with the Nomenclature of Diseases.

Once having arrived at a definite diagnosis, the answers to the questions should be strictly relevant to that or those disabilities. For example, it is useless to make a diagnosis of dyspepsia followed by a strong history of T.B.; then, in the present condition, bring out a weak statement showing vague symptoms of dyspepsia with no report of the effect of treatment; then an X-ray report showing indications of a chronic bronchitis or fibrosis and then a Psychiatrist's report showing psychopathic personality. Such a case came before me recently. As another example, in a case discharged as pes planus, in the history reference was made mainly to arthritis and, in the "present condition" reference to a possible gonorrhœa and a doubtful positive complement fixation test. These facts would be all right if they established a definite decision or diagnosis but they only throw doubt on the nature of the disability or bias the opinion of anyone perusing the report at a later date and the whole object of the form is thwarted, namely to fix the degree of attributability of the disability to Army life.

Thirdly, to record whether any other disabilities claimed or discovered do or do not affect the soldier's efficiency. If they do affect his efficiency then they have to be dealt with as described above. If they do not affect the man's

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efficiency, they should be noted and a statement made whether they are actually observed or whether they have been complained of by the man himself and that they have had no bearing on his efficiency as a soldier. Such disabilities must on no account be mentioned unless such statements are added.

The fourth object to be attained in completing A.F. B-179 is to aid the Ministry of Pensions in deciding the attributability, or degree of aggravation by service of the disability. The important factors to bring out are the man's own statement, his previous service, if he ever served in any other of the Services and if he was ever invalided from it, and his work before he joined the Army. One quite often finds that a man claiming that his chronic bronchitis was caused by a drenching at Dunkirk or night guards in France was many years ago invalided from the Navy for T.B. or had been a coal-miner or steel worker before enlistment. X-ray reports would be essential in such cases.

Under history and present condition, notes must be short, very concise and absolutely relevant and they must give a very definite picture of why the man is unfit for service and must establish the diagnosis. The first sign or symptom mentioned should be the most important one, e.g. in T.B. cases either sputum if positive or X-ray report if definite; in malaria, the blood examination; in dysentery, the stools examination; in arthritis, X-ray examination, size of joint, limitation or otherwise of movement. Full details of analysis of urine or gastric fluid unless conclusively pathognomonic or relevant to the case should not be given but only referred to at the end as "urine and gastric fluid nil abnormal." In gastric cases, under present conditions, don't give first of all negative details such as "no vomiting," "physique good," and a full test meal analysis with nothing symptomatic, and then, at the end of this description, barium meal X-ray shows "Ulcer of 1st part of duodenum"—Put the last definite information first. It is bad case taking but it is good recording. In this respect the notes on A.F. B-179 differ markedly from those on a Case Sheet A.F. I-1237 or civilian case card which should, of course, be comprehensive.

In all cases the effect of treatment should be stated, e.g. arthritis, treatment with salicylates, radiant heat or infra-red rays gave no improvement; in chronic gastritis that careful dieting and treatment with sedatives did not cure the condition; in chronic malaria, that prolonged treatment with quinine, atebrin, plasmoquine, etc., did not effect a cure or prevent relapses.

So much for the most important documents with which you have to deal. There are three other less important ones which nevertheless should be done carefully and thoroughly. These are the Case Sheet, A.F. I-1237, the diet sheet A.F. I-1202 and the Transfer Certificate A.B. 172. One need say very little about these.

First, the Case Sheet. This form is not made out for every patient admitted to hospital but only for cases of professional interest and serious illness and such others as are likely to be required for future reference; also

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for patients transferred to another hospital. When a patient is admitted who is obviously very ill a case sheet should be started as soon as possible and kept up with daily entries. It frequently happens that a patient dies and the case sheet is made out afterwards from memory with only scanty, if any, record of condition on admission, progress of the disease leading up to death and details of treatment given.

The important details required on A.F. I-1237 are accurate details of the man's name, service, age, unit and station; date of admission and date of first entry on the case sheet. One's first entry should be signed by the officer making it. It is remarkable how often one sees a case sheet with no note of station and date of admission or date of first examination. When cases are handed over from one officer to another the case sheets should be signed by each with date—case handed over—case taken over.

It is advisable, though not imperative, that all officer patients have case sheets made out for them.

These forms are filed and retained in the hospital, usually for two years. They constitute the only record retained in the hospital of the illness of any particular patient and sometimes, when complaints of claims against the Government or medical service are raised at some subsequent date, a War Office demand on the hospital for a full report can only be met or answered if a case sheet has been made out.

In the case of death, the case sheet and other medical records, such as temperature charts, laboratory and X-ray reports, etc., are sent to the A.D.M.S. and D.D.M.S. for perusal and return.

Cases of typhoid and paratyphoid have a special form of case sheet made out and venereal cases all have venereal disease case cards A.F. I-1247 (these are in addition to A.F. I-1220). The instructions for maintaining and disposal of these are laid down in Regulations for the Medical Services of the Army, Appendix 12.

With regard to A.F. I-1202—the diet sheet. The important things here to remember are that it is the only document other than the temperature chart, and not always that, which is kept at the man's bedside. It is an important label, apart from its dietetic purpose. It should therefore have correct details of the patient's name, length of service, unit, date of admission to hospital; then, in the margin, notes for the sister in charge of the ward such as hours allowed up, whether he can be used for light duties, and under present war conditions a distinctive sign as to whether he can go as a sitting patient to the shelter in case of enemy air action. It should be remembered, too, that medical officers are responsible for the dieting of patients and should not permit sisters to do this or make alterations without their knowledge or advice. Further, the A.F. I-1202 is a bedside label by which the man's diagnosis is readily available when required by divisional officer, wardmaster or statistical office. For this reason diagnoses when made should be recorded on the diet sheet as soon as possible, unless there is any special reason why the patient should not know it. Any changes of

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diagnosis should similarly be recorded as soon as possible. A fresh diet sheet is made out for each month, the month dating from the day after the last Friday in each calendar month, up to and including the last Friday in the following month.

Diet sheets are filed in the hospital but may be called for at any time for checking and perusal by the D.D.M.S. or by Officer i/c Supplies or by the War Office.

The last of these forms to be referred to is A.B. 172. This must go with the patient when transferred to another hospital or convalescent hospital. It must show all the patient's particulars and his diagnosis. It is also important for the medical officer to enter on the form the patient's diet, his treatment, if any, that he is still undergoing or needs, and whether up or bed patient.

That concludes all that need be said about these troublesome Army forms —there are others, of course, but these are the ones that practically all medical officers, sooner or later, have to deal with, and if you can only master the fundamental principles on which they are based and the objects to be gained by their completion, then your paper work will become much easier and a great deal of time and trouble be saved throughout the channels by which these documents have to pass to reach their final destinations and before they are finally disposed of. One other bit of advice—don't leave your paper work to the end of your day's work—make good use of that hour in the morning before your wards or your departments, as the case may be, are ready for you—papers and documents 9-10 a.m.; ward 10 a.m., a first quick round to relieve the sister and ward staff to get on with their duties, then take your new cases, see your out-patients or whatever other work you may have. If you leave your papers till the end of the day or till the middle of the morning, they will become rushed and carelessly done, or perhaps you will become irritated as many have done at what those who do not understand the importance of them call Army red tape.

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