

AN ARCHIVAL INVESTIGATION OF HOSPITAL RECORDS

by

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B.A. (Hon), Acadia University, 1981

M.A., Queen's University, 1983

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARCHIVAL STUDIES

IN

THE FACULTY OF ARTS

ADMINISTERED BY THE SCHOOL OF LIBRARY, ARCHIVAL AND INFORMATION STUDIES

AND THE DEPARTMENT OF HISTORY

We accept this thesis as conforming

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THE UNIVERSITY OF BRITISH COLUMBIA

June 1985

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Date 29 September 1985

## Abstract

The importance of the hospital in Canadian society is undisputed. Despite this, the hospital has traditionally received relatively little attention from the archival community. It is only now becoming apparent to both hospital administrators and archivists that this situation must change if the valuable records contained in hospitals are to be preserved. This thesis examines the archival preservation of hospital records, concluding that their retention is of great benefit to those operating the institution as well as the rest of society and that this preservation can be effectively carried out if certain basic considerations are borne in mind.

Before archival operations are established in a hospital, it is necessary to investigate various aspects of the institution and its record keeping practices. It is only when the nature and uses of these records are understood that effective programmes can be implemented. A hospital archives will not achieve its full potential unless it is established on a sound foundation with adequate policy and resources. Similarly, the records contained therein must be properly appraised to ensure all the valuable material is retained and protected from improper access. Through an investigation of these and related issues, the viability of hospital archives will be confirmed.

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Supervisor

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## Acknowledgements

I wish to extend my sincere gratitude to all those who assisted me in the preparation of this thesis. All of my colleagues in the third class of the Master of Archival Studies programme deserve mention for their comments and contributions in and out of class during the past two years. Chris Hives and Glen Isaac were especially helpful as they shared the fruits of their research in the related areas of business and university archives. I would also like to acknowledge the advice and guidance of Mr. Charles MacKinnon, Chief of the Economic and Scientific Section, Public Archives of Canada, under whose practicum supervision I first began to grapple with the complex problems of access to and confidentiality of medical records.

It is to my supervisor, Terry Eastwood, that the greatest debt of gratitude is owed. His advice, guidance and support were vital to the eventual success of this project, just as they were to the success of the programme as a whole. Despite carrying the burden of supervising several theses simultaneously, he was readily available for consultation and constructive criticism. Without his assistance, this thesis would not have been developed to its present form.

My final thanks go to Hugh A. Taylor who, perhaps without realizing it, awakened my interest in the M.A.S. programme and a career in archives one evening in the spring of 1981 during an address to the History Club at Acadia University.

## Introduction

The time has come -- indeed some will argue that it has been here for many years -- for archivists, individually and as a profession, to cast their eyes outside the confines of "established" archives and realize the extent to which archival effort has heretofore overlooked much of Canadian society. There are untold organizations and institutions, to say nothing of individuals, whose records will never be preserved under our present archival "system." Efforts to rectify this situation are, more often than not, geared to accessioning collections into existing archival repositories. Less emphasis is placed on encouraging the retention of archives by the various creators. Even when this is attempted, attention focusses on fitting these organizations into the current archival milieu. Little real consideration is given to the reverse -- adapting archives to fit the institutional milieu. Perhaps this is because most archivists are tied, both physically and intellectually, to specific repositories and are either unable or unwilling to consider wider applications of their craft. Whatever the reason, it is time for change. The archival profession has a responsibility to investigate the part archives can and should be playing throughout all segments of society. By focussing on archives within specific types of institutions, a clearer understanding of this neglected role may well be achieved.

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The hospital has a pervasive influence on the lives of most Canadians. Once considered a refuge for the destitute, it now bears the brunt of the ever-increasing public demand for medical services. The contemporary

hospital exists at the center of the health care system and, to a large extent, it dictates how individuals understand and deal with the problems of sickness and disease. As such, it represents a monument to the medical initiatives of society. Despite this, the hospital has only recently been considered within the general purview of archival endeavour.

Because of its role, the hospital poses a clear challenge to the archival community. The desire to understand this institution, its origin, operation, and impact (past, present and future) originates from a number of sources. Hospital administrators, policy makers and staff members all have a vested interest in this regard, as do the members of society at large, be they social science researchers or the public generally. The valuable records of the hospital require appraisal and preservation if this understanding is to be achieved. The initiative may come from a variety of quarters but, regardless of the source, this is the realm of the archivist.

The archival preservation of hospital records will benefit those responsible for the operation of the institution as well as those who are on the receiving end of its care. In all but the most unusual circumstances, the establishment and maintenance of such archives should be the responsibility of the hospital itself. Most archivists will, in all likelihood, acknowledge the importance of preserving hospital records and, especially if it lessens their workload, agree to their retention by the hospital. It is less probable, however, that in encouraging and assisting hospitals to set up archives, these same archivists will try to understand how they are best suited to meeting the needs of the institution itself. Rather, one suspects that such advice will be based on experiences in the mainline repositories, particularly the large government archives, and

transferred, with little modification, to the hospital. Yet a hospital archives is not the same as one operating for a government. It may well be called upon to carry out functions which, while not diametrically opposed to those of traditional archives, may nonetheless appear less than truly "archival" to the purist. Thus, archivists must come to some understanding of the reality of and potential for archives in hospitals, an understanding based on an appreciation of how archives can and should be adapted to fit within the framework of hospital administration.

Canada's early hospitals were little more than charitable institutions for those who could ill afford to be under a physician's care.<sup>1</sup> Many operated under the auspices of religious orders while others were eventually established by various levels of government. The sick poor were collected with others in need of public charity and, more often than not, were housed in an infirmary which represented little more than an annex to the almshouse.<sup>2</sup> Those able to pay for a doctor's services were treated in their homes. Until the late nineteenth century, the hospital was generally regarded as a symbol of poverty, a "gateway to death," and often the reality behind its walls did little to allay fears as to the effectiveness of the treatment dispensed. Whether this reputation was deserved is now a matter of some debate, but the fact that the hospital was regarded in this way is significant in itself.<sup>3</sup>

Only gradually, and by no means uniformly, was the hospital accepted as an institution of superior medical care. This newfound status has been attributed to the innovations of modern technology and the advances of medical science, manifested most dramatically in the introduction of anaesthesia, antiseptics, and techniques of aseptic surgery.<sup>4</sup> While these

discoveries certainly had an influence, recent research suggests that the shift in attitude toward the hospital may well predate the scientific discoveries which made it the source of the most effective care. Rather, it is contended that the increased use of the hospital resulted from demographic changes which weakened the traditional familial ties and corresponding care in time of illness. This process, which dates from the mid-nineteenth century, was accelerated by urbanization and industrialization. These social changes caused people to patronize hospitals before the advances noted above.<sup>5</sup>

Whatever the exact cause and timing of the hospital's transformation from the "antechamber to the tomb" to the site of scientific medical care, its impact was of great significance. Yet this influence was not uniform throughout the country. Most hospitals remained concentrated in and around the larger population centers, and by 1900 usage was still by no means universal. Indeed, for much of the early part of this century, particularly in rural Canada, the general practitioner with his limited equipment and facilities remained the sole provider of health care.<sup>6</sup> Until well into the 1920s and 30s home care remained a viable alternative to hospitalization. As had been the case for all previous generations, it was still possible to be born, live a full life, and die without ever being admitted to a hospital.<sup>7</sup>

Soon, however, the hospital assumed its dominant position. Advanced, expensive medical technology could only be obtained by large, centralized institutions. By the end of the Second World War, hospitals were established in most regions, largely through the auspices of various levels of government. The hospital also became the center of both medical

education and research. This further strengthened its position within the health care system. Combined with the introduction of various health insurance programs, these factors had a dramatic impact on hospital utilization. Through both inpatient and ambulatory services, providing for the treatment of chronic disease and acute transient illness, the hospital began to undertake the wide range of functions required to meet the needs of almost all segments of the population. While there has been recent criticism of hospital orientation -- that it is not reflecting the changing nature of illness -- the institution remains the central bastion of medical care in Canada.<sup>8</sup>

The modern hospital is a phenomenon of the last two decades.<sup>9</sup> It has undergone a number of significant changes in a relatively short period of time. Once seen primarily as an instrument of social and moral control, rather than of active medical treatment, it has evolved to the point where it has become the focal point for most health care activities.<sup>10</sup> Today, an average of one of every six Canadians is admitted to hospital annually. This represents the highest rate of hospital use in the western world. In addition, it is estimated that non-emergency outpatient visits number upwards of ten million per year, or almost one for every two Canadians.<sup>11</sup> Statistics such as these bear witness to the dramatic influence of the hospital. At the same time, the hospital is not insulated from the community it serves. Indeed, it is very much "a product of its environment and is subject to its influence, social, economic, and even political, for better or for worse."<sup>12</sup> The hospital is, therefore, a mirror of public perceptions of and responses to the challenges of medicine and health.

Despite the acknowledged importance of the hospital, to date there

has been remarkably little conscious effort devoted to developing a clear understanding of the issues, problems, and potential of its archives. This is reflected by the paucity of literature on the subject. Perhaps it is the result of the relative youth of most Canadian hospitals. More probably, however, the dearth of material on hospital archives reflects the relative youth of archives as a generally accepted part of our cultural heritage. The value of archives for public and private institutions, particularly as more than just a cultural resource, is by no means firmly established. In this context, it is perhaps not surprising that hospital archives have largely been neglected in archival and hospital administrative literature.

The first notable work on the subject dates from the late 1950s and early 1960s, primarily in the United States and, to a lesser extent, in the United Kingdom. Since then, the topic has been addressed only sporadically in archival journals, although there are indications that this pattern is changing. Much of what does exist comes from the medical library field where, while there may be some misunderstanding of archival principles, there is nonetheless an appreciation of the value of archives in a hospital setting.<sup>13</sup>

In Canada, formal interest in hospital archives is a recent development, fostered in part by two noteworthy efforts. The summer 1980 issue of Archivaria, devoted to the theme of "Archives and Medicine," was a rather dramatic breakthrough. Although dealing with medicine generally, it did address some of the fundamental issues relating to hospital archives. It also examined both the historical value of hospital records and the requirements to ensure their preservation. On the other side of the equation, prompted in part by a survey of hospital

records-keeping practices carried out by the Association of Canadian Archivists, the journal Dimensions in Health Service published a series of three articles on aspects of hospital archives in the fall of 1982. These articles, which were aimed at hospital administrators, illuminated the benefits of the systematic management of hospital records and preservation of archives. Taken together, these publications articulated both the cultural and the administrative justifications for preserving hospital archives.

Subsequent works, such as the recent Hannah Institute for the History of Medicine Directory of Medical Archives in Ontario, have endeavoured to build on the awareness fostered by the Archivaria and Dimensions articles. In his preface to the Directory, Dr. G. R. Paterson, Executive Director of the Hannah Institute, stated that one of the publication's aims was to help hospitals appreciate the archival value of their records.<sup>14</sup>

Yet despite the positive signs, most of the real work in establishing hospital archives on a firm foundation remains to be carried out. Unfortunately, the recent flurry of publishing activity may well mask this fact. Literary discussions do not always reflect actual practices, as most archivists can attest. The apparent concern about hospital archives should not lull archivists into a false sense of security. The result can, as Barbara Craig recently illustrated in a review of the Hannah Directory, have an adverse effect on the future. While praising the intentions of the work, she cautioned that "the mere existence of such a substantial printed reference tool gives an unfounded illusion of permanence to the archival scene so adroitly sketched for the eager researcher. Just the opposite is the case."<sup>15</sup> Certain items listed in the Directory, such as the early Board



Minutes of the St. Catharine's General Hospital, have apparently been destroyed or lost since the survey was carried out.<sup>16</sup> This message is equally applicable to hospital archives as a general field of enquiry -- the literature is a sign that progress is being made, but not that it has been achieved to the point that further effort is no longer needed.

An important prerequisite for a successful hospital archives is the fostering of a rudimentary degree of archival awareness in the medical community generally and hospitals specifically. In all too many instances outside the archival or historical spheres, one encounters otherwise well-informed individuals who have at best extremely vague notions of what properly constituted archives represent. Often this leads to images of museum work and artifacts, with concomitant proposals and actions which have little relevance to the preservation of valuable records.<sup>17</sup> Thus one of the first tasks facing archivists attempting to penetrate the confines of the nation's hospitals is ensuring that those involved are made aware of what archives represent.

Before any systematic effort is undertaken in this regard, it is essential for the archivist to become familiar with hospital operations and records practices. In addition, effort must be made to consult with and learn about the potential users of hospital archives -- who they are and what type of information they are likely to desire.<sup>18</sup> Only then can well-informed proposals be advanced and reasonable policies implemented. Just as the archivist winces at the archivally-naïve hospital administrator, that same official will have a low opinion of the archivist who demonstrates his or her lack of appreciation of the complexities inherent in the modern hospital environment. Archivists can do

themselves and their cause a disservice, in both the short and the long term, if they forgo this methodical approach. Indeed, as the editors of the "Archives and Medicine" issue of Archivaria warned, "great damage could be done to the preservation of medical archives in Canada by a sudden avaricious rush of archivist and historian alike into the nearest records of medicine outside an [established] archival repository."<sup>19</sup> As the hospital is a prime target for such activity, care must be taken to avoid alienating a potentially rich source of archival material, as well as a possible home for a new repository.

In a topic as complex as that of hospital archives it is necessary to address a number of important issues. As with archives in any institutional setting, it is necessary to become familiar with the various types of records that exist in the hospital and how they reflect structure and function. Only when the nature of the records is understood can subsequent discussions of the values of archives in and for hospitals be intelligently advanced. Once this is achieved, we can examine questions of where and how hospital archives should be established.

In light of this investigation, the premise that hospital archives are a necessity, and one which should be established by the institution itself, can be assessed critically. The extent to which hospitals are "ripe" for archival development, and the extent to which the archival profession is ready to foster hospital archives, can only be revealed by an informed analysis of the relevant issues and concerns. It is, therefore, incumbent upon archivists to undertake such investigations. This constitutes the rationale for the enquiry which follows.

## Notes for Introduction

<sup>1</sup> G. Harvey Agnew, Canadian Hospitals, 1920 to 1970: A Dramatic Half Century (Toronto: The University Press, 1974), p. 1. This volume provides, as the title suggests, a good, if occasionally too optimistic, overview of the more recent development of hospitals in Canada.

<sup>2</sup> See, for example, Harry F. Dowling, City Hospitals: The Undercare of the Underprivileged (Cambridge: Harvard University Press, 1982), pp. 13, 35. It is generally conceded that, where evidence or research is lacking, Canadian patterns can be extrapolated from the British and American experiences. On this point see S. E. D. Shortt, "The Canadian Hospital in the Nineteenth Century: An Historiographical Lament," Journal of Canadian Studies 18 (Winter 1983-84): 10.

<sup>3</sup> The phrase "gateway to death" appears to have originated in K. F. Helleiner, "The Vital Revolution Reconsidered," Canadian Journal of Economic and Political Science 23 (February 1957): 6. It is most widely known from E. M. Sigsworth, "Gateways to Death? Medicine, Hospitals and Mortality, 1700-1850," in Science and Society 1600-1900, ed. Peter Mathias (Cambridge: The University Press, 1972), pp. 97-110, in which the author challenges the validity of the label.

<sup>4</sup> See Lee Soderstrom, The Canadian Health System (London: Croom Helm, 1978), p. 25; and Erwin H. Ackerknecht, A Short History of Medicine, rev. ed. (Baltimore: Johns Hopkins University Press, 1982), pp. 187-91.

<sup>5</sup> Morris J. Vogel, The Invention of the Modern Hospital: Boston, 1870-1930 (Chicago: The University Press, 1980), pp. 2-4.

<sup>6</sup> S. E. D. Shortt, "'Before the Age of Miracles': The Rise, Fall, and Rebirth of General Practice in Canada, 1890-1940," in Health, Disease and Medicine: Essays in Canadian History, ed. Charles G. Roland (Toronto: Hannah Institute, 1984), pp. 131-32.

<sup>7</sup> See, for example, Sally Carswell, The Story of Lion's Gate Hospital: The Realization of a Pioneer Settlement's Dream, 1908-1980 (Cloverdale,

B.C.: D. W. Friesen and Sons, 1980), p. 42.

<sup>8</sup> The growing concern about hospitals' continued orientation toward the treatment of acute transient illness, rather than the increasing numbers of chronic patients, is reflected in Agnew, Canadian Hospitals, pp. 200 ff. Specific instances are illustrated in George M. Torrence, "Hospitals as Health Factories," and Joan Eakin Hoffman, "Care of the Unwanted: Stroke Patients in a Canadian Hospital," both in Health and Canadian Society: Sociological Perspectives, ed. David Coburn, Carl D'Arcy, Peter New, and George Torrence (Toronto: Fitzhenry and Whiteside, 1981), pp. 254-61; 292-95.

<sup>9</sup> James E. Bennett and Jacques Krasny, "Health Care in Canada," in Health and Canadian Society, ed. Coburn et al., p. 59.

<sup>10</sup> Harry F. Dowling has defined four distinct periods of hospital development: the poorhouse period, to 1860 when the hospital existed as part of the almshouse; the practitioner period, when providing medical and nursing care became the dominant purpose; the academic period, dating from 1910 and the Flexner Report when medical staff came under the control of medical schools; and the community period, from the 1960s as hospitals shifted from academic medical centers to community health centers. See Dowling, City Hospitals, pp. 2, 9 ff. The social control versus medical treatment dichotomy is noted in, among other, Morris J. Vogel, "Machine Politics and Medical Care: The City Hospital at the Turn of the Century," in The Therapeutic Revolution: Essays in the Social History of American Medicine, ed. Morris J. Vogel and Charles G. Rosenberg (Pittsburgh: University of Pennsylvania Press, 1979), p. 160.

<sup>11</sup> All statistics are from Bennett and Krasney, "Health Care," p. 56.

<sup>12</sup> Gerald P. Turner and Joseph Mapa, eds., Humanizing Hospital Care (Toronto: McGraw-Hill Ryerson, 1979), p. 38.

<sup>13</sup> See, for example, the various bibliographic citations from the Bulletin of the Medical Library Association (hereafter BMLA) and the medical library practice Handbooks. Other library journals, such as Illinois Library (hereafter IL), have also contained articles dealing with

medical and hospital archives.

<sup>14</sup> Dr. G. R. Paterson, "Preface" to A Directory of Medical Archives in Ontario, comp. by Margaret Dunn and ed. by Mary Baldwin (Toronto: Hannah Institute, 1983), p. vii.

<sup>15</sup> Barbara Craig, review of Directory of Medical Archives, in Canadian Bulletin of Medical History 1 (Winter 1984): 105.

<sup>16</sup> Ibid., p. 106.

<sup>17</sup> As one example, a 1982 article entitled "The Healing Archives" deals almost exclusively with memorabilia and museum artifacts, including a "historic appendix" and a completely restored apothecary shop. There is only passing reference to one collection of personal papers, the contents of which are not revealed. See Eileen Pettigrew, "The Healing Archives: Exploring Our Medical Past," Imperial Oil Review 66 (1982): 10-13.

<sup>18</sup> With respect to the importance of the user, see the comments in Hugh A. Taylor, Archival Services and the Concept of the User: A RAMP Study (Paris: UNESCO, 1984), particularly Chapter 3, "User Needs and User Behavior," pp. 21-34.

<sup>19</sup> Gordon Dodds, Peter Bower, and Barbara Craig, "Archives and Medicine," Archivaria 10 (Summer 1980): 4.

## Chapter One

### THE NATURE OF HOSPITAL RECORDS

It would be folly to embark on an investigation of hospital archives without first coming to some understanding of the institution and the types of records that exist in it. Without knowing how the hospital is organized and performs its functions, it would prove extremely difficult, if not impossible, to evaluate the relative importance of its records. In his 1979 enquiry into the hospital record keeping process, Stanley Raffel asserted that "a successful analysis of the uses of records requires references to the grounds of the activity of recording."<sup>1</sup> In a similar vein, Francis Blouin has concluded that a study of structure is essential to the understanding of institutionally produced records. Furthermore, an examination of the relationship of this structure to the record keeping process is vital to the comprehension of the records themselves.<sup>2</sup>

In terms of organization, any hospital can generally be divided into three sections, based on the functions performed by the various departments. While the actual names may differ, these categories may best be termed Hotel, Diagnostic and Therapeutic, and Nursing.<sup>3</sup> Hotel Departments are those which deal with the operation and maintenance of the institution and its facilities. They range from such branches as administration, planning, and personnel, to laundry and housekeeping. The Diagnostic and Therapeutic Departments are those which, as the name suggests, provide health services to the patient, but only in support of the main treatment functions. Radiology, occupational therapy, and the various laboratory sections are examples. The Nursing Departments are

those which carry out the actual treatment of the patient. These include the various medical and surgical wards and units. For a more detailed list of the departments found in each of the three categories see Appendix A.

While Canadian hospitals vary in size, all are notable for their internal structural complexity. The Kingston General Hospital, a relatively large institution with 508 beds, boasts a total of 63 departments: 16 medical and a further 47 non-medical.<sup>4</sup> Within each such department, there may exist many additional branches or agencies. At St. Joseph's Hospital in London, Ontario, the Outpatient Department alone oversees the operation of some forty separate clinics.<sup>5</sup>

Each of the numerous subcomponents of the hospital receives and generates documentation relating to its specific function. In this light, it is clear just how difficult it is to describe hospital records. To attempt to separate their discussion from the agencies that produced them is to lose the context of their creation. It is this knowledge that anyone concerned with hospital archives must endeavour to master.

Fortunately, despite the hospital's unique position and role in society, in terms of the records it produces it can be characterized as essentially just another type of business, although in this particular instance the "business" is the provision of health services. The records of a hospital are, therefore, not dissimilar, in form and function, to those of any other agency as they accrue as part of day to day operations.<sup>6</sup> In his classic 1956 work entitled Modern Archives: Principles and Techniques, Theodore Schellenberg defined records as:

all books, papers, maps, photographs, or other documentary materials, regardless of physical form or characteristics, made or received by

any public or private institution in pursuance of its legal obligations or in connection with the transaction of its proper business and preserved or appropriate for preservation by that institution or its legitimate successor as evidence of its functions, policies, decisions, procedures, operations, or other activities or because of the informational data contained therein.<sup>7</sup>

In 1983, the Canadian Government released its own more detailed, if less eloquent, definition of institutionally produced records which focusses on the diversity of material encountered:

Record means any information contained in any physical medium which is capable of preserving such information and includes any information contained in the original and any copy of correspondence, memoranda, forms, directives, reports, drawings, diagrams, cartographic and architectural items, pictorial and graphic works, photographs, films, microforms, sound recordings, video-tapes, video-disks and video-cassettes, punched, magnetic and other cards, paper and magnetic tapes, magnetic disks and drums, holographs, optic sense sheets, working papers, and any other documentary material or electro-magnetic medium, regardless of physical form and characteristics.<sup>8</sup>

Leaving aside for the moment the issue of the specific contents of these documents, it is apparent from these definitions that the records of any body such as a hospital will be extremely diverse. Yet at the same time they also fit within the general parameters of archival endeavour.

Hospital records can be considered to fall into one of two distinct categories: administrative, pertaining to the operation of the institution itself; and medical, describing all activities involved in the treatment of those admitted for care. Again drawing on the business analogy, the former concern the maintenance of staff and facilities, whereas the latter



refer to the production of a finished good which, in the case of a hospital, is a healthier or cured patient. In both instances, the records are of varying ages, dating from the birth of the institution to the present day.

Of the two basic types or categories of records encountered in hospitals, it is the medical or patient record that usually springs to mind when one considers hospital archives. It is this document that is normally accorded priority by the staff. Administrative records usually lag far behind in terms of proper management within the hospital.<sup>9</sup> This is particularly true after their immediate usefulness has passed.

Despite this fact, administrative records represent a vast and all too often overlooked part of the documentary output of the hospital. They are produced by, or relate to, the various branches of the institution. Some, such as the governing board, senior administration, public relations, engineering, finance, personnel, legal affairs and maintenance, are similar to departments found in any large organization. Others are specific to the hospital. These include radiology, dietary services, pharmacy, various laboratories, and volunteer or auxiliary bodies, as well as the specific functional divisions such as medicine, surgery, nursing, and the various special clinics. Hospitals are also often associated with bodies or institutions such as universities, medical or nursing schools, churches or religious orders, and government agencies.

In addition, most hospitals have an elaborate framework of committees which formulate or advise on policy or review current practices. They are fast becoming the focal points for the improvement of health care.<sup>10</sup> As Terry Cook recently postulated, such committees are revolutionizing modern institutions. As more power devolves to these

bodies, the decision making (and record generating) functions are increasingly being carried out outside the regular administrative hierarchy.<sup>11</sup> This is just as true for hospitals as it is for other large organizations.

In all such instances, vast quantities of records are generated as these various hospital departments or agencies go about their regular operations. For a list of some of the various bodies involved and the types of records they produce, see the "Master Series List" prepared by hospital archives consultant Ron MacLeod and reproduced in Appendix B. All of these constitute the sources of hospital administrative records.

Within each of the above noted departments (and there are doubtless many others in a large modern hospital) there exists a diverse range of documents. Included are various types of textual records such as correspondence, minutes, memoranda, reports, directives and guidelines, surveys and studies, as well as general and special purpose subject files. With regard to the latter, it has been determined that the larger the volume of records produced, the greater the tendency to maintain more special purpose files, as opposed to keeping all records in general files.<sup>12</sup> Such is most often the case with hospitals.

Individual departments also produce or accumulate a plethora of documents relating to their specific function. As one example of the size and complexity of the records series produced by the components of a modern hospital, a recent inventory of the Accounting Service at Kingston General Hospital revealed that 113 separate categories or series of records were administered, ranging from pharmacy usage reports to the numerous health insurance forms.<sup>13</sup> In addition to current records, many

departments also store material from years past, including such traditional documents as the admission and discharge registers (which can compress the sum of a patient's history into one line), letterbooks, and numerous order and report books.

Other specific administrative documents that may be found in a hospital include mortality reports, operating room logs, staff registers, account books and audit reports, legal documents of incorporation and accreditation, contracts, charters, deeds and releases, agreements with other facilities, menus and diet sheets, drug and stock files, procedure manuals, policy directives, bylaws, and personnel files, to list but a few of the most common.<sup>14</sup> The records required by licensing bodies abound and, as the health care field is one of the most closely regulated, these alone can constitute a significant volume of material. In addition, one also encounters a whole range of what could be termed public relations documentation, such as newsletters and other publications, as well as items relating to lectures, addresses and other special events.

While there is an understandable tendency to think of hospital records as being solely or primarily in textual form, those of an administrative nature are encountered in a number of media. Photographs are perhaps the best example. Although one could categorize many institutional photographs as being of antiquarian interest, some play a part in the operation of the hospital, either directly, by recording aspects of building or equipment design, or indirectly, by depicting the functioning of the institution and its staff.<sup>15</sup> Similarly, every hospital has a collection of drawings and paintings, most often comprising portraits of individuals or of buildings. Some films and video tapes also form part of the

administrative record of the hospital. Sound tapes, recording both regular meetings, lectures, or special events, and the increasingly popular oral history interviews, add to the variety of records encountered. Other valuable, but often neglected, administrative records are the blueprints and floorplans which preserve the construction details of the physical facilities of the hospital.<sup>16</sup>

Modern microphotography and automation techniques have had a dramatic influence on the nature of hospital records. Microform records, such as aperture cards, jackets, film or fiche, have been used by hospitals as a space saving device for more than two decades. While much of the early usage was simply as a storage medium for inactive records, today it is often combined with computers to produce Computer Output Microfilm, or COM. This enables the information in the computer to be transferred to microform for reference purposes, thus eliminating the requirement for paper records. Many hospitals use this direct method to produce working microform records for such administrative functions as finance, payroll, and personnel. These records are updated on a regular basis, daily if necessary, with replacement fiche generated as required.<sup>17</sup>

Still other hospitals have embraced computerization in rather more dramatic fashion. Many have certain administrative functions fully automated, with all work done in batch mode at a central computer or on-line at terminals located throughout the institution. New York's 6500 bed Rockland State Hospital makes use of such a system for such tasks as patient admission, transfer and discharge, drug ordering and inventory control, and the production of census reports.<sup>18</sup> The use of computers for all levels of hospital administration is continuing to accelerate. In

Canada, most hospitals have embraced this technology in one form or another.<sup>19</sup> Newer hospitals, such as the Health Sciences Center Hospital at the University of British Columbia, have incorporated advanced computer systems as part of their design.<sup>20</sup>

Although the basic information contained in these records remains unchanged from their textual predecessors, their format does present new challenges, particularly to those not yet comfortable with today's technology. Thus one is likely to encounter records in the form of punch cards, cassettes, tapes, or disks, depending on the age of the equipment used.

While the specific contents of hospital files reflect the unique character and function of the institution, in terms of volume, organization and format, they are nonetheless similar to those encountered in the administration of any large agency. The hospital, in common with all institutions, has a requirement to keep certain records as archives, which Schellenberg defined as "those records of any public or private institution which are adjudged worthy of permanent preservation for reference and research purposes."<sup>21</sup>

It is thus apparent that the administrative records of a hospital bring little new to either the theory or the practice of the archivist. Indeed, were hospital archives to include only these records, there would be little requirement to discuss them further as they are essentially no different from those of other "businesses." The subject would merit no special attention as the current literature is replete with information on various aspects of corporate archives. It is therefore revealing that almost without exception, references to business archives, in the archival

literature at least, omit any mention of hospitals.<sup>22</sup> They are considered to be outside the general framework of business archives and -- to an extent -- this view is justified.

Yet, what attention archivists have thus far focussed on hospitals has concentrated almost exclusively on these same administrative records.<sup>23</sup> This is, in all likelihood, the result of two important factors. First, archivists who have worked in an institutional setting are used to dealing with this type of record. Second, and of far greater significance, hospital personnel have, for a variety of reasons, kept extremely tight control on their medical records. They are wary of permitting these documents to be handled by other than medical and specifically trained support personnel. Administrative records, being generally less sensitive, are not considered to be threatened by archival interest. Traditionally most archivists have been content to accept this situation and its resultant division of responsibility and activity. However, if the total picture of the hospital and its functioning is to be preserved, this must change.

It is the existence of medical records that sets the hospital apart from other institutions as far as archives are concerned. While Janice Dickin McGinnis has contended that they are "just a special type of administrative record,"<sup>24</sup> these files are distinguished from all others in the hospital and this distinction must constantly be borne in mind. Their importance for the operation of the hospital should not be underestimated, for they have three complementary but distinct purposes: treatment of the patient, clinical research, and administrative management.<sup>25</sup> In the opinion of Dr. James Hansen, within the medical information system of the hospital, "the medical record is the cornerstone to which everything else

must relate," a fact, he goes on to lament, which is all too often overlooked.<sup>26</sup> In the context of the subsequent analysis, the term "medical record" will be applied to both the patient chart or file, in which the case history of each individual is recorded, and the related supporting medical documentation. It should also be noted that medical records, like their administrative counterparts, vary in format and content according to their age.

The medical record is an extremely complex, and in many cases, detailed instrument. In paper form, the average patient file is fifteen to twenty pages long, although some have been found to fill three or more volumes.<sup>27</sup> Extensive files are most often associated with long term or psychiatric patients. In the latter case, the record includes detailed narrative passages that are not normally found in a regular file.<sup>28</sup> The medical record contains a wide range of information, detailing the various aspects of the patient's illness and treatment in the hospital. Raffel summarizes the contents of medical records in this way:

There are daily notes by doctors and nurses concerning the health of all patients, past and present. These make up the bulk of what hospital personnel call the 'medical record.' In addition, there is a plethora of records recording most of the important events in a patient's hospital career. Long notes reporting on admission and discharge are entered into the 'record' by doctors. When the patient is admitted, he is supposed to have an extensive physical examination, which is duly described for the record, as are any operations the patient may have. Pathologists, social workers, and psychologists enter reports of examinations. If a patient dies, that too will be described in detail for the record. If discharged patients are seen in out-patients' clinics, reports on these examinations are entered as well.<sup>29</sup>

For an example of the contents of a series of patient records, in this case tuberculosis files from the Baker Memorial Sanitorium near Calgary, see Appendix C.

The actual patient file or chart is the single most important component of the medical record system. It normally contains two basic types of data: informational, revealing the identification of the patient and the basic facts of hospitalization; and clinical, relating that which is obtained by the medical staff in the course of treatment.<sup>30</sup> The latter usually comprises detailed comments and results and a brief discharge summary. The modern patient file is designed to convey a "clear picture of the patient's condition on admission, the history, the physical findings, the investigations undertaken and results obtained, the conclusions reached, the treatment employed, the progress made during the period of hospitalization and the condition on discharge."<sup>31</sup> This stands in marked contrast to the nineteenth century practice in which the clinical notes recorded only what the patient said about his problem and what the doctor did to treat it.<sup>32</sup> The manner in which this information is collected and organized within the record reflects its primary purpose and use. The contents are generally "loosely" organized and problem oriented -- focussing on the patient's actual ailments.<sup>33</sup> If nothing out of the ordinary takes place, little or nothing is recorded.<sup>34</sup>

In addition to the personal data and the ward chart, which has replaced the traditional doctors' order and nurses' report books and which contains the details of the various clinical activities, the patient file is usually complemented by a variety of supporting documents. These items,



such as test results, x-rays, or legal consents, serve to round out the medical record. Indeed, there is a general recognition that within the medical record proper, there are actually three classes of documents, termed primary, secondary, and transitory. The primary documents comprise those containing the pertinent medical data, based on summaries and reports, as well as test findings, prepared during the course of the period of hospitalization. Secondary documents include notes and reports that may be of vital medical importance at the time and which may have lasting legal significance but which are not required for the future care of the patient. Transitory documents are items, such as diet reports, graphic charts indicating temperature and blood pressure, and checklists, which are of no future value once the patient is discharged.<sup>35</sup>

Although in most instances these files are carefully maintained today, proper medical record keeping was one of the weakest aspects of hospital operation until well into this century. By 1914 only the better organized hospitals had medical record departments.<sup>36</sup> Attempts to standardize procedures and ensure the rapid updating of clinical records were actually frustrated by individual doctors. They argued that the compulsory completion of patient files was redundant as they maintained their own office records. Hospital administrators eventually prevailed.<sup>37</sup> The problem was not, however, solved either completely or uniformly. Medical documentation continued to be left incomplete, particularly for older records or those of patients who had been hospitalized for extended periods of time.<sup>38</sup> By the mid-1960s in the United States, the most common deficiency revealed during accreditation review was "failure to keep adequate medical records."<sup>39</sup> It should be noted that the issue of

"completion" continues to be a matter of some debate. Doctors argue that a record is complete when all the information required for the treatment of the patient is included, whereas administrators desire additional summaries and signatures before the record is closed -- inclusions that really add nothing new to the record.<sup>40</sup>

Most recently, as has been the experience in many other areas of record keeping, the movement toward automation has revealed continual shortcomings in medical records. Hansen has reported that in all too many instances the traditional medical record has not been well suited to automation or conversion to problem oriented form because "it is often poorly structured, does not use standard terminology, is often fraught with omissions and outright error, and is, most of all, usually illegible."<sup>41</sup> Modern medical records, patient files in particular, are generally accorded proper maintenance and management as they are considered a reflection of the level of care administered in the hospital.<sup>42</sup> Yet, the above noted facts are useful to bear in mind, particularly for those who may be involved in appraising such records and encounter evidence of gaps and other shortcomings.

Today the majority of patient files continues to be maintained in textual form, but a number of institutions are moving toward the use of machine readable and updatable patient records, where the entire file is stored on disk or tape. Already many hospitals have installed computerized systems which allow chart information to be recorded and amended on-line. The current file can be displayed on a monitor or printed into hard copy as required. Statistical summaries can also be prepared from the information held in the data banks.<sup>43</sup> For example, the 600 bed

Deaconsville Hospital in Evansville, Indiana, has adopted a totally automated medical records keeping system, utilizing 90 terminals throughout the institution.<sup>44</sup> In addition, many hospitals have adopted microform -- either alone or in a COM mode -- as a cost-efficient method of retaining large numbers of files. The record can be read on a special reader or reconstituted in paper form as requirements dictate.<sup>45</sup> Whether used for storage or daily reference, modern automation techniques have been revolutionizing the handling of medical records. As is the case with administrative uses of new technology, this situation, as Virginia Stewart and others have warned, demands a new level of expertise on the part of the archivist.<sup>46</sup>

The trend toward automation is also influencing the traditional relationship between medical and administrative records. As will be seen in greater detail in the next chapter, while the two types of records are still strictly divided, the information contained in the medical record is now used for a variety of administrative tasks. At the Greater Niagara General Hospital, Niagara Falls, Ontario, a newly implemented patient registration system was designed for the expressed purpose of streamlining the retrieval of medical records and creating a database to be used as a general information source throughout the hospital.<sup>47</sup> As hospitals become more completely automated, the distinction between administrative and medical records may well become blurred. In the future, all hospital information may be contained in a single database, with different applications being used to generate the pertinent information as required. In this situation, the administrative-medical division would be between the different applications used to retrieve the

records, not the records themselves. At the present time, the division remains, indeed it is constantly reinforced due to concerns of improper access, but it would be a mistake for the archivist interested in hospital archives not to be aware of the potential for what would amount to a dramatic change in the very nature of hospital record keeping.

As indicated previously, medical records, or, more specifically, patient files, should be the best maintained documents in the hospital due to the general realization of the implications -- medical and legal -- of errors or omissions. While some hospitals continue to have records stored in each of the various health services departments, most now have a medical records department or library which centralizes the storage and maintenance of these files as they come off the wards in the wake of the patient's discharge.<sup>48</sup> Here they are kept in current or inactive status depending on the frequency of the individual's use of the hospital. If readmission takes place, the file is reactivated and remains on the ward until the individual is again discharged. As will be seen, the frequency of readmission, combined with the applicable regulations and the type of institution in question, determines the overall retention period in the medical records department. In effect, the medical records department carries out a standard records management function applied to the specific needs of the patient files, with the department itself acting as the records centre.

Other items that complete the medical record comprise a variety of non-textual media. X-rays are perhaps the first such documents to come to mind. While the results are usually noted on the patient file, the films themselves are stored in a separate library within the radiology

department when not in actual use by the treating physician. Hospitals are also making increasing use of both still photographs and videotapes of clinical or autopsy procedures or findings in the belief that a picture is indeed worth a thousand words.<sup>49</sup> In similar fashion, one still encounters the work of the skilled medical illustrators whose sketches and paintings were used to depict all manner of clinical phenomena.<sup>50</sup> Sketches or paintings by the patients themselves can also be included as part of the record, particularly where, as is the case with psychiatric patients, these drawings reflect on the illness or treatment methods involved.<sup>51</sup>

From the foregoing discussion of the general nature of the records encountered in a hospital, one can begin to comprehend the types of documents that could be destined for an archives. While their contents are different, in terms of the various media involved and their basic organization, the medical records are not drastically different from those on the administrative side of the institution. Both are clearly produced as part of the regular functioning of the hospital. In this light, the medical records can also be considered within the framework of the traditional archival definitions of both records and archives cited above. While certainly only a small portion of the total documentary output would be destined for permanent retention, both types have a place in the institutional archives. Taken together, they provide a complete overview of both the structure and functions of the hospital.

In any analysis of hospital archives, it is imperative that the true nature of the records be recognized. Nancy Peace recently commented that "research into the content, organization and use of different types of records will provide the hard information that archivists need to fully

understand the nature of their task and the means by which to best accomplish it."<sup>52</sup> The hospital is certainly no exception. The archivist must first become familiar with its operational structure. Then, an understanding of the current administrative-medical record dichotomy becomes the fundamental prerequisite for any informed discussion. While at some point both types of records should be destined for the archives, they lead completely separate existences throughout their active and semi-active phases. The archivist faced with the task of implementing an archival programme must be fully cognizant of this fact. It would be a grave error to ignore medical or patient records, just as it would be naïve to consider lumping them in with the rest of the hospital's records -- either in theory or in practice. The complexity of hospital records cannot be escaped and should not be denied.

## Notes for Chapter One

<sup>1</sup> Stanley Raffel, Matters of Fact: A sociological inquiry (London: Routledge & Kegan Paul, 1979), p. 77.

<sup>2</sup> Francis X. Blouin Jr., "An Agenda for the Appraisal of Business Records," in Archival Choices: Managing the Historical Record in an Age of Abundance, ed. Nancy E. Peace (Toronto: D. C. Heath, 1984), pp. 72-73.

<sup>3</sup> Betty Lowry, "M.I.S. Project -- overview and framework," Dimensions in Health Service (hereafter DIHS) 60 (March 1983): 45.

<sup>4</sup> Kingston General Hospital (hereafter KGH), "Report on Archives and Records Management at Kingston General Hospital," prepared by Ron MacLeod (May 1980), p. 1. The information on the number of beds is taken from Canadian Hospital Association (hereafter CHA), Canadian Hospital Directory 32 (September 1984): 74.

<sup>5</sup> Bonnie Upton, "St. Joseph's Hospital gears up for the future," DIHS 60 (March 1983): 25.

<sup>6</sup> Charles Newman makes the point that medical records are like those of any other institution, both in general format and in that they have their own peculiarities. See his "Medical Records," Archives: Journal of the British Records Association (hereafter Archives) 4 (Lady Day 1959): 1.

<sup>7</sup> T. R. Schellenberg, Modern Archives: Principles and Techniques (Chicago: The University Press, 1956), p. 16.

<sup>8</sup> Treasury Board of Canada (hereafter TB), "Chapter 460: Records Management," Administrative Policy Manual, p. 5.

<sup>9</sup> Pauline Sears and Patricia Allderidge, "Medical Records Conference," Journal of the Society of Archivists (hereafter JSA) 5 (October 1977): 554.

<sup>10</sup> Mary Devlin and Marguerite Fallucco, "The Archives of the American Medical Association," IL 63 (April 1981): 337.

<sup>11</sup> Terry Cook, "Commentary on 'The Challenge of Automated Access: Regional Prototypes'," paper presented at the Archives, Automation and Access Conference, Victoria, B. C., March 1, 1985.

<sup>12</sup> Robert G. Ballentine, "Records and Archives of the Professions," American Archivist (hereafter AA) 29 (April 1966): 191.

<sup>13</sup> KGH, Accounting Service, Records Retention Schedule, n.d.

<sup>14</sup> See, for example, Ira R. Berlin, "The Northwestern Memorial Hospital Archives," IL 63 (April 1981): 333-34; and Ron MacLeod, "Waiting for the archivist: techniques for novices," DIHS 59 (December 1982): 30.

<sup>15</sup> See Berlin, "Northwestern Memorial," p. 334; and Barbara Craig and Gordon Dodds, "The Picture of Health," Archivaria 10 (Summer 1980): 191-223.

<sup>16</sup> See Gertrude L. Annan, "Archives in a Medical Library," BMLA 46 (July 1958): 317-18.

<sup>17</sup> Jack P. Kowitt and B. J. Rudow, "Computer Generated Microfiche Saves Space and Time at Mt. Sinai Hospital," Journal of Micrographics (hereafter JM) 8 (January 1975): 104.

<sup>18</sup> Robert B. Fireworker, "Computerized Health Care Systems," Journal of Systems Management (hereafter JSM) 27 (August 1976): 30.

<sup>19</sup> Most Canadian hospitals are using computers in one way or another, either for patient records or for administrative uses. Of the various provinces, Manitoba is considered the most progressive, particularly with regard to administrative automation. On the latter point, see Burroughs Canada, "Industry Marketing: Health Care Services," insert to DIHS 60 (March 1983): 3.



<sup>20</sup> See Melvyn Bernstein, "Laboratory Medicine: The Genesis For a Hospital-Based Clinical Computer System," reprint from Computers in Health Care (September-October 1982): 1, 5.

<sup>21</sup> Schellenberg, Modern Archives, p. 16.

<sup>22</sup> Christopher Hives, who recently completed his M.A.S. thesis on the subject of business archives, has indicated that during his extensive research he did not see any reference to hospitals. The only exception found in the course of this thesis on hospital records concerned the archives of St. Luke's Hospital in Kansas City, which was discussed in Douglas A. Bakken, "Starting a Business Archives and Keeping it Healthy," MAC: Newsletter of the Midwest Archives Conference 11 (January 1984): 27.

<sup>23</sup> This was almost exclusively the emphasis of the three articles which appeared in DIHS in the latter part of 1982.

<sup>24</sup> Janice P. Dickin McGinnis, "Records of Tuberculosis in Calgary," Archivaria 10 (Summer 1980): 182.

<sup>25</sup> James V. Hansen, "Progress in Health Care Systems," JSM 26 (April 1975): 14.

<sup>26</sup> Ibid.

<sup>27</sup> See Alice M. Donahoe, "Putting Automation into Hospital Record-Keeping," Records Management Quarterly (hereafter RMQ) 5 (July 1971): 14; and Barbara Ravesies, "Medical Records Key To St. Jude Outpatient Care," Medical Record News (hereafter MRN) 41 (December 1970): 27.

<sup>28</sup> William J. Curran; Eugene M. Laska; Honora Kaplan; and Rheta Bank, "Protection of Privacy and Confidentiality," Science 182 (23 November 1973): 797.

<sup>29</sup> Raffel, Matters of Fact, p. 3.

<sup>30</sup> American Hospital Association (hereafter AHA), Medical Record Departments in Hospitals: Guide to Organization (Chicago: A.H.A., 1972), p. 55.

<sup>31</sup> Gilbert Sharpe and Glenn Sawyer, Doctors and the Law (Toronto: Butterworths, 1978), p. 122.

<sup>32</sup> Newman, "Medical Records," p. 3.

<sup>33</sup> Herman Schuchman; Leila M. Foster; and Sandra G. Nye, Confidentiality of Health Records: The meeting of Law, Ethics, and Clinical Issues (New York: Gardner Press, 1982), p. 56.

<sup>34</sup> Raffel, Matters of Fact, pp. 67-68.

<sup>35</sup> British Columbia, "Hospital Act," B.C. Reg. 389/73, Consolidated Regulations, July 31, 1984, pp. 4-5.

<sup>36</sup> Agnew, Canadian Hospitals, p. 146.

<sup>37</sup> Ibid., pp. 5, 33-36.

<sup>38</sup> James F. Gill and Thornton W. Mitchell, "Ohio -- Disposition of Medical Records in State Mental Hospitals," AA 26 (July 1963): 372.

<sup>39</sup> Edwin P. Hoyt, Condition Critical: Our Hospital Crisis (New York: Holt, Rinehart and Winston, 1966), p. 21.

<sup>40</sup> On this point see Raffel, Matters of Fact, pp. 104-09.

<sup>41</sup> Hansen, "Health Care Systems," p. 20. This sentiment has been echoed in the British experience. See Bernard Benjamin, Medical Records (London: William Heineman Medical Books, 1977), p. 181.

<sup>42</sup> Emmanuel Hayt, Medicolegal Aspects of Hospital Records. 2nd ed. (Berwyn, Illinois: Physicians' Record Company, 1977), p. 9.

<sup>43</sup> Donahoe, "Automation," p. 16. For further information on the impact

of computerized medical records systems see Henry P. Lundsgaarde; Pamela J. Fischer; and David J. Steele, Human Problems in Computerized Medicine (Lawrence: University of Kansas, 1981), p. 1-7.

<sup>44</sup> Fireworker, "Computerized Health Care," p. 32.

<sup>45</sup> See, for example, Kowitt and Rudow, "Computer Generated Microfiche," pp.103-07; and Glen E. Roundy, "Microfiche: An Answer To A Medical Records Paper Problem," JM 14 (September 1981): 23-28.

<sup>46</sup> Virginia R. Stewart, "Problems of Confidentiality in the Administration of Personal Case Records," AA 37 (July 1974): 397.

<sup>47</sup> Sue Turnbull, "Greater Niagara General automates registration," DIHS 60 (March 1983): 16.

<sup>48</sup> Ibid.

<sup>49</sup> On the use of both still photographs and videotapes, see Berlin, "Northwestern Memorial," p. 334; Ravesies, "Medical Records Key," p. 27; and Martin O'Malley, Doctors (Toronto: Macmillan, 1983), p. 22.

<sup>50</sup> "Archive of Medical Visual Resources," BMLA 57 (July 1969): 293.

<sup>51</sup> Such painting and drawings are included in the archives of London's Bethlem Royal and Maudsley Hospitals. See Janet Foster and Julia Sheppard, British Archives: A Guide to Archive Resources in the United Kingdom (London: MacMillan Publishers, 1982), pp.25-26. Similar items were discovered by the author in the files of Dr. Clifford Scott who, coincidentally, worked at the Bethlem Royal and Maudsley Hospitals from 1946 to 1954. The latter files are to be found in MG 31, J 20 at the Public Archives in Ottawa.

<sup>52</sup> Nancy E. Peace, "Deciding What to Save: Fifty Years of Theory and Practice," in Archival Choices, pp. 15-16.

## Chapter Two

## INSTITUTIONAL USES OF HOSPITAL ARCHIVES

The justification of any archives -- large or small, public or private -- rests primarily on the perceived utility to the sponsoring agency of the services provided and the records contained therein. This "utility" can take a number of forms, ranging from direct monetary benefit to cultural value. In this so-called "era of restraint" it is unfortunate but true that few archives outside of those maintained by governments can be justified solely on cultural grounds.<sup>1</sup> Rather more pragmatic arguments must be advanced to support the preservation of archives by private institutions such as hospitals. Although these arguments will obviously emphasize the value of historical information, this must be placed in the context of archives contributing directly to the administration and operation of the institution, not simply as a cultural benefit. While this will fly in the face of those who defend the traditional, scholarly view of archives, it reflects the reality of the hospital situation. The archives must be perceived by the management of the hospital as an asset worthy of support.

In 1979, the noted British archivist Felix Hull recounted his experience in trying to persuade employers that he had something to offer:

I remember being asked in 1948 how I could justify my appointment at Reading to a City Council which had never had an archivist, did not know if it wanted one and in any case did not like spending money -- and that from the Chairman of the Council. Inevitably we explored every possible area open to us and sought to find new fields of service, sometimes to the alarm of those nurtured in a wholly

traditional fashion.<sup>2</sup>

Archives in an institutional setting need to be "marketed," by identifying those services which are wanted and then providing them, even if this leads to less common fields of archival endeavour. As Cynthia Swank noted in a recent issue of Archivaria, this is particularly true in the private sector:

Anyone entering such a corporate job is a pioneer, creating a new function that has not been defined adequately by either employer or university. One must be a teamplayer as well as a salesman. This job exists to serve the institution, and it is up to historians and archivists to prove their value. Mumbling about historical heritage does not work.<sup>3</sup>

Unless the archives contributes directly to the hospital it will be, in the words of Philip Mooney, "open to serious question and possible extinction."<sup>4</sup>

Hospital administrators are professionally trained in the management of their institutions and they will be quick to judge the merits of any proposals put before them. A small but growing number are interested in archives and they will respond to properly conceived arguments in favour of their implementation.<sup>5</sup> The majority, however, will in all likelihood require a great deal of convincing. Simplistic claims of historical value will not be enough. The various uses of hospital archives must be articulated in a cogent fashion.<sup>6</sup> Administrators must be persuaded that archives will exist primarily to serve their interests. Once in place, this perceived self interest may well result in an allocation of space and money to allow the archives to carry out its assigned functions.<sup>7</sup> As a

step in this direction, archives should be evaluated in terms of their potential utility to the hospital in specific areas of operation.

The primary value of both administrative and medical records for current purposes should be self-evident. A hospital cannot function, either as a formal institution or in treating its patients, without them. Once the immediate value has passed, however, most cease to be of any real use to either the institution or the research community. Yet there are certain hospital records that retain important evidential and informational values. Evidential value resides in the items documenting the organization and functioning of the hospital, whereas informational value encompasses records revealing specific details about particular people, places and subjects within the institution.<sup>8</sup> It is this relatively small proportion of total record production which administrators require to ensure the smooth operation of the hospital and which medical personnel use to conduct continuing clinical research and education. These records constitute the potential archives of a hospital.

Despite the real importance of archivally-preserved records, one often encounters a vastly different perception of what archives are and how they can be of value to hospitals. It is unfortunate that this mistaken view is supported by some of the current medical library literature which seems to focus almost exclusively on memorabilia as archives.<sup>9</sup> Most hospitals have some collection of old papers and artifacts. This can amount to little more than the residue of an old anniversary display. In other cases, it can be the result of some form of rudimentary records management or, more probably, the efforts of one or more interested and well meaning but archivally-naïve individuals. Often simply an adjunct to

a museum or reference library, these collections usually comprise a scattering of old records, reports, awards, special event programmes, and photographs of staff and facilities. In addition, one normally encounters the ubiquitous scrapbooks of clippings and pamphlets, as well as a vast array of memorabilia, often suffering from what have been politely termed "eccentric and erratic collection techniques."<sup>10</sup> The St. Paul's Archives collection, for example, includes various uniforms and items of clothing, a 1917 metal hypodermic syringe, a wooden floor tile from the original nurses' residence, and even an early heart lung machine, all in addition to records.<sup>11</sup> While, as Gertrude Annan correctly notes, "we can have only gratitude for the foresight of the history conscious individuals who in this way saved valuable minutiae,"<sup>12</sup> this is not the material on which archives should be based nor the form in which it can be of significant use to the hospital.

It is this often disorganized assortment of old records and papers, along with artifacts and items of ephemera, that is usually considered the "archives" by the hospital staff. This lack of comprehension is by no means limited to hospitals. Similar perceptions exist with respect to business archives. Douglas Bakken quotes one official who firmly believed that the archives' function was to retain "a little bit of everything concerning the company that no one else wants to keep."<sup>13</sup> The value of this type of collection for the administration and operation of the institution is seen as minimal, and this conclusion is not without justification. Overcoming this lack of respect for historical records as an institutional asset has been termed the principal point on which future development of such archives depends.<sup>14</sup>

Such is definitely the case as far as hospitals are concerned, as education on the value of archives is of primary importance. Administrators, and staff members generally, must be persuaded that, as emphasized by Ron MacLeod, archives should never be:

three dimensional scrapbooks hastily assembled from willing donors and left dormant once the enthusiasm dies. A successful archives should be an integral part of hospital administration, a useable resource nurtured by regular additions controlled by the person assigned the professional responsibility to identify, preserve and make available the hospital's archival resources on an on-going and efficient basis.<sup>15</sup>

While the items collected on an ad hoc basis may have some real archival significance, unless an archivist becomes actively involved in either planning or operating the repository, the true nature and utility of a systematic archival programme will be lost on most administrators.

As part of this educative process, the artificial barrier between current and historical hospital records must be removed.<sup>16</sup> Emphasis should be placed on the record continuum, and the role of the archivist in dealing with the complex documentation within the hospital. From the point of creation through to final deposit in the archives, he or she can contribute to the identification and effective use of these records. This will enable the archivist to escape what Hugh Taylor has called the "historical shunt" and re-enter the mainstream of information management within the hospital.<sup>17</sup> If the archives exists only at the end of the record process it will appear to have a more limited application for hospital administration and operation,<sup>18</sup> a not unreasonable conclusion. Yet,



of economic restraint, this can have dire consequences, as graphically depicted by Gordon Dodds:

the archivist is prey to many predators who lurk nearby and never more so when, in jurisdictions where operational records are created, an archives is regarded as a dumping ground severed from records administration. Then the archives becomes dispensible because its justification is at worst mere corporate whim, at best a vague regulation.<sup>19</sup>

As part of this "selling" process, the archivist should push for the integration of the archives with the other functional departments of the hospital. This, along with the recognition of the value of combining older records with current information systems,<sup>20</sup> will enable the archives to become an effective administrative tool within the hospital.

Turning first to what one can term "conventional" archives, exclusive of medical records, one finds an extensive literature exemplifying the vital role they can play in the operation of any organization, and a hospital is certainly no exception.<sup>21</sup> While clearly not all of the profit oriented justifications of business archives are equally applicable to hospitals, there is still widespread benefit to be derived from their proper preservation. Archivally retained records are of importance for a variety of administrative, public relations, financial, personnel, legal and research functions within the hospital.<sup>22</sup>

In the opinion of George David Smith, institutional archives represent something of a "hard sell." Administrators must be convinced that the potential benefits outweigh the costs of establishing and maintaining an archives.<sup>23</sup> A partial answer to this problem undoubtedly lies in the

mechanism of records management, by which an element of control is exerted over the often amorphous mass of records proliferating in the hospital. Ideally as part of an all-inclusive records management programme in which the ephemera is discarded, an archives guarantees the preservation of essential inactive records in a central location, rather than maintaining them at greater cost and with far less efficiency in the various departments and clinics all over the hospital.<sup>24</sup> In this way, the archives will function as the records center of the hospital, rather than as some long forgotten storage room. As well, the archivist should be in a position to advise hospital officials on the most effective methods of organizing current records, thus ensuring archival involvement with the records at or even before their creation.

While some historically-oriented archival purists may baulk at the idea of a joint archival-records management programme, this is often the reality of archival endeavour outside the haven of direct government funding. As well, as Allan Ridge correctly observed in 1975, "where one has a combined records and archives service one can achieve the most satisfactory results."<sup>25</sup> The historical value of archives is not to be ignored, it should in fact be emphasized, but it cannot be held as the sole rationale for their existence. Initially at least, cost savings and efficiency speak louder to the hard nosed and hard pressed administrator than do cultural concerns. At the same time, the latter benefits from archives should not be hidden or slipped in behind the backs of those paying the bills. The key is a properly conceived, well balanced approach to those in a position to support the archives.

In 1958, writing for her colleagues in the Medical Library

Association, Gertrude Annan concluded that, while archives had an important role to play in providing source material for medical history, "most medical institutions ... do not have the vast stores of papers needing the attention of experts in 'Office Records Management'."<sup>26</sup> How times change. Dealing with the current volume of records is now seen as "a critical hospital management decision" -- one all too often postponed.<sup>27</sup> It is this modern "paper explosion," the very term used to describe the crisis that befell Chicago's Cook County Hospital, that has given rise to the establishment of archives in a number of hospitals.<sup>28</sup>

When coupled with records management, the benefits of space and equipment saving accruing to the archives can be substantial. Furthermore, in addition to ensuring the preservation of valuable records, such a programme reduces the intangible costs of time wasted searching for that one important piece of paper amid hundreds of dusty old files, a problem which plagues hospital staff members just as often as it does those from other institutions.<sup>29</sup> One cannot locate or make use of inactive records unless they are under some form of systematic control. An archival programme provides that control. If there is no formal records management, a prudent inventory of all current and inactive records is the first step in determining which items merit retention to meet the long term requirements of the hospital.

While some will argue that hospitals cannot afford archives, in light of the conditions under which they operate most cannot afford not to. After all, as Harold Anderson rather smugly noted, the records destined for the archives cost nothing extra to acquire!<sup>30</sup> Such remarks aside, it is true that the establishment and maintenance of an archives require certain

funds which may be seen, initially at least, to counterbalance the financial benefits associated with records management. It is in response to these concerns that one must identify the real contributions that archives can make to hospitals -- contributions which, while sometimes intangible, are of significant benefit to the institution. It is these benefits which enhance the archival function beyond that of strict records management. The information contained in the archives should be seen as one of the most valuable resources of the hospital and not just as an overhead cost.<sup>31</sup>

In 1978, responding to T. H. B. Symons's Report on Canadian Studies, the Association of Canadian Archivists noted that the preservation of the records of the sponsoring body was transforming cultural agencies into functional archives.<sup>32</sup> Institutional archives were beginning to evolve from museums into information centers. In terms of the day-to-day operation of a hospital, the archives should function not simply as a passive historical collection, but rather as a central, organized, historically based information resource -- a vital link in the comprehensive hospital information system.<sup>33</sup> As such, the archives can serve the administration in several ways.

One of the most immediate and important areas is the field of policy formulation. Archives preserve the best picture of the structure and function of any institution. According to David Bearman of the Smithsonian Institution, this, in turn, can and should be turned into power for the archives as it supplies information to staff members.<sup>34</sup> The archives can then become "a key decision resource" for the hospital.<sup>35</sup>

In order to identify precedents before developing or implementing

-new policy, or to discover the historical basis of current practices, members of a governing body or the director may wish to peruse original reports or the minutes of meetings that occurred years earlier. More commonly, decision makers will commission others to prepare research summaries to assist them in their deliberations. Such information must be supplied quickly and in a usable form.<sup>36</sup> Without a proper archives, the preparation of this type of report could be extremely difficult, if not impossible, and the finished product less than desirable. In the Federal Government, the value of historical information to provide the background for decision making is widely recognized.<sup>37</sup> Such use of archives is not limited to government or business. There is a place for archives in hospital policy development as well, although this is not yet generally recognized.

Speaking before England's Society for the Social History of Medicine in 1970, Thomas McKeown charged that the direction of medicine, in both general care and research, "is seriously prejudiced because of the lack of the perspective which historical investigation could and should provide."<sup>38</sup> He argued that many of the contemporary problems facing hospitals in particular, problems for which policy revisions were long overdue, could not be properly solved without recourse to this historical perspective.<sup>39</sup> In similar fashion, Parks Canada historian Tom Brown contends that the current problems facing the Canadian mental health system stem in large measure from the fact that today's policies are formulated by those unfamiliar with historical developments and trends -- trends which show that in our handling of the mentally ill, history is, in fact, beginning to repeat itself.<sup>40</sup> It is the archives that can and will

supply the data required to provide this perspective.

In the spring of 1983, Betty Lowry, Director of the Management Information Systems (M.I.S.) Project of the Canadian Hospital Association, indicated that under current circumstances most of the nation's hospitals were being forced to make important, long-range policy and fiscal decisions without adequate background information on their possible impact or their relevance to community needs. One of the main tasks of her project was to seek ways of improving the "timeliness and comparability" of the information collected and utilized within health institutions. She concluded that "at all levels, there is a need for information which will assist the planning and allocation of resources required to meet community needs."<sup>41</sup> While the primary emphasis of the M.I.S. Project was for improving current information, implicit in her discussion was the need for comparison with past trends. In his or her guise as an "information scientist," the archivist can assist in the identification of current data that is needed for policy formulation.

While one cannot take this justification to an extreme, as many decisions are undoubtedly made without such reflection or assistance, a number of those institutions which have archives make valuable use of them in this regard. This is particularly the case where those making the decisions have spent relatively little time in their present position or with the institution.<sup>42</sup> In Great Britain, the National Health Service decreed that where possible the inactive records of hospitals should be kept in the institution as new administrators would need to refer to them in order to carry out their jobs.<sup>43</sup> At Kingston General Hospital, the assistance of management policy formulation and decision making is

emphasized as one of the archives' primary functions. It is also used for orientation programmes for those newly appointed to the governing board as well as new staff members.<sup>44</sup> The value of archives for management familiarization and education, in association with policy development, has been acknowledged in the business world. That a similar trend is developing in hospitals should come as no surprise.

Hospital archives are useful for various promotional activities. This is one area in which archives have had a "traditional" function in hospitals, although seldom used to full potential. Certain archival holdings, particularly photographs and records such as charters and admission registers, are eminently suited to use in historical displays.<sup>45</sup> These can be used in conjunction with the celebration of anniversaries, or other special events such as the opening of a new hospital wing.<sup>46</sup>

In similar fashion, the publication of an institutional history, usually associated with some milestone, would be all but impossible without an archives. The calibre of the final product is often a direct reflection of the richness and availability of the sources.<sup>47</sup> Such a project may serve to provide the impetus for the creation of an archives in the first place, although it should never be the sole rationale for the repository, nor should the collection be organized to conform to the writing of the history.<sup>48</sup> Whether designed as a fund raising activity or as part of a publicity campaign, a history of a hospital can be of value to both the institution and the wider community, historical and otherwise.

The importance of such projects in maintaining a high level of public awareness and, ipso facto, both moral and financial support is no small consideration for today's hospital. As hospital utilization patterns

change, institutions become increasingly dependent on the public for both funding and, more importantly, patient patronage.<sup>49</sup> Thus a display, history, or similar project which appears to have only some vague historical merit may prove to have a far more significant impact in the long run due to the positive image it projects and the goodwill it engenders. Thus the archives has related application as a resource for public relations.

The significance of a proper public relations function in hospitals has only recently been fully realized. It is now seen as a necessary part of the projection of the hospital into the community in order to attract both patients and funding.<sup>50</sup> Borrowing and modifying the marketing techniques of business and industry, hospitals are thus responding to today's economic strictures with a more coordinated approach to public relations and related activities.<sup>51</sup>

In conjunction with this development, the importance of archives has not been lost on hospitals. In business the link between the two functions is generally recognized.<sup>52</sup> Several hospitals have followed these examples. Indeed, a number have developed archives for that express purpose. Chicago's Michael Reese Hospital created and continues to make effective use of its archives as a resource within its public relations department.<sup>53</sup> Kingston General Hospital's director of public relations uses the archives for research on reaction to policies and events, as well as the preparation of speeches and news releases.<sup>54</sup> In an extreme public relations move, the archives of the Cook County Hospital has served as the basis of a survival operation. In response to threats to close the hospital, collections have been used by staff and other interested parties to show



the importance and longstanding contribution of the institution to the community. So far, these efforts have apparently met with success.<sup>55</sup>

The above arguments notwithstanding, the archives should always be more than just a public relations tool. Several authorities have cautioned that assigning the archives to a specific department like public relations may narrow both the clientele attracted and the services rendered.<sup>56</sup> In his discussion of the Michael Reese Hospital Archives, David Burns admitted that limitations on general use within the hospital and shortcomings in certain subject areas were attributable to its position as just a branch of the public relations department.<sup>57</sup> While public relations is an important area for an archives and a role which can lead to its creation, the scope of the repository should never be limited to this task. It is just one of many functions in which it can benefit the hospital.

Like most large organizations, hospitals produce a variety of financial documents, many of which must be retained for the continued operation of the institution or to meet various regulations. Once financial records have ceased to be of current use, those earmarked for long-term preservation can be more economically stored and more efficiently retrieved from a central repository. At Kingston General Hospital, a small number of the general accounting records are slated for a fifty year retention period. These comprise the journal vouchers and related reports, annual financial statements, general ledger reports, posting summaries, and trial balances. They are used for statistical comparison as well as for the review of specific subjects.<sup>58</sup> After the expiration of the fifty year period, it is likely that these records will be retained for strictly historical purposes, although at this point the scheduling procedure does

not include archival uses. Thus, in addition to complying with statutory and other regulations, archival financial records can be of use for comparisons with current audits and research into long-term budgetary trends.

Hospital archives, like those of any other large institution, also have a role to play in personnel matters. Hospitals normally employ a sizeable number of people. The Vancouver General Hospital, one of the country's largest, has a regular staff of over 4,500. This number is regularly augmented by 400 or more medical and nursing students.<sup>59</sup> Each individual has a file recording details of his or her applications and actual work history. Once a person leaves the hospital the file is no longer of active interest for the personnel department, but it requires retention in case of subsequent contact. Matters like reapplications, pension and insurance claims, appeals of dismissal and the like could all arise at some point in the future -- in some cases many years in the future. It is therefore in the best interests of the hospital to retain these personnel files. The archives, fulfilling its function as a records center, is the obvious place for them to be stored.<sup>60</sup> Beyond a certain limit, these files should be scheduled for disposal, although a portion of these personnel records may be retained for their research potential, either for future personnel planning, or for various types of historical investigation.<sup>61</sup>

In similar fashion, hospital archives have relevance for legal matters, although at this point the discussion does not include medical records. Documents pertaining to the establishment of the institution and subsequent expansion should be kept permanently. These include certificates of incorporation, charters, constitutions and by-laws, and

deeds and easements.<sup>62</sup> The latter two can be of particular value where the management of property is concerned. Other records which may have legal significance include various accreditation reports and licenses, and the documents required by the health authorities overseeing hospital operations, although not all are worthy of permanent preservation.

In the business world, there has developed a difference of opinion as to how much other material should be saved for legal purposes. A number of authorities have echoed corporate lawyers' sentiments that the retention of records may increase the amount of litigation launched against the company. As Francis Blouin put it, "fear of litigation is, to some extent, an inducement to save, but, to a greater extent, it is an incentive to destroy records."<sup>63</sup> This concern has more recently been applied to the hospital, where it has been noted that "pressure from archivists on the subject of legal obligations could ... be counter productive."<sup>64</sup>

Despite this, Douglas Bakken has countered that as far as business archives are concerned, the experience of the past forty years has simply not borne out these fears.<sup>65</sup> In the hospital field, litigation over non-medical issues is far less common than in business. More importantly, while businesses might have the luxury of destroying records to prevent legal action, publicly funded hospitals have no such choice, even with respect to administrative records. While the preservation of archives may incur some risks, these are outweighed by the benefits, not just in the legal realm, but for the administration of the institution as a whole.<sup>66</sup>

In all its functions, the archives acts as the central repository for

those administrative records that have been identified as possessing long term value. In the case of an emergency or disaster, some of these records would prove to be invaluable. As such, they fall under the general category of "vital" or "essential" records. Essential administrative records include the minimum legal, financial, and managerial documents that would be required by the staff if called upon to re-establish the hospital.<sup>67</sup> Clearly not all archival records would be needed, just as there are many essential records that would still be in active use. However, the archives could be called upon to make a significant contribution. As discussed earlier in this chapter, ideally the archivist should be involved in the entire life cycle of the records as they exist in the hospital. He or she will then possess an intimate knowledge of the structure of the institution and an understanding of how these records relate to its regular functioning. By virtue of this insight, the archivist is the staff member best suited to identify the vital documentation and develop the essential records plan for the hospital. In case of emergency, the archivist would have one of the most important functions to perform.

The "other hospital archives," composed primarily of patient files, is also of vital importance for the effective operation of the hospital. These files are initially retained to meet the various clinical, research, teaching, statutory and regulatory, and legal defence requirements of the hospital.<sup>68</sup> The clinical aspect, the provision of background information in case of readmission, is normally handled by the medical records department and is therefore outside the responsibility of the archives. This is particularly the case in those hospitals which, due to the nature of the disease involved, keep their records in what amounts to active status

for the patient's entire lifetime.<sup>69</sup>

It is nonetheless true that records destined for the archives may retain some long term clinical importance. For example, when previously accepted medical procedures have been found to have negative results, it may be only through archival records that former patients can be identified. Such is the case with the recent concern about irradiation treatments of the head and neck area, used between the 1930s and 1960s to reduce enlarged thymus glands in children. This procedure is now associated with an increased incidence of thyroid tumors. These patients' records, or at least those that have survived beyond the legally required retention periods, are now the only source for identifying these cases.<sup>70</sup>

Once the overriding clinical requirement has passed, the latter two reasons cited above come to the fore as far as archives are concerned, as they can have significant -- and long-term -- legal implications. Provincial regulations, insurance plans, and accreditation procedures all bear on the contents, handling, and, of particular interest to archivists, retention periods of the records. While the actual archival retention periods will be discussed in chapter five, each province requires patient files to be kept for between six and ten years (depending on the province) after the date of death or last discharge.<sup>71</sup>

Today, in light of the rather dramatic increase in all types of medico-legal problems, including litigation by former patients, the retention of these records and associated documentation is a matter of paramount concern. In case of medical negligence action, the medical record can act as direct evidence or it can simply assist in refreshing memories.<sup>72</sup> In either instance, it has a vital role to play. While there

are those who advise that administrative records be destroyed to avoid such legal headaches, woe be to any hospital director or doctor who follows such a policy for patient records. In addition, with the recent enunciation of the "discovery principle," which dictates that the statute of limitations with respect to claims for damages from malpractice and related causes does not begin to run its course until the patient discovers the abnormality, a retention period of six to ten years is no longer considered adequate. In British Columbia, legislation gives a potential plaintiff a ten year cutoff point, beyond which no action can be launched. In Quebec, in contrast, it now appears that a patient may have up to thirty years before losing legal recourse for damages.<sup>73</sup>

In light of such developments, many hospitals are now preparing to keep their patient records much longer. Those responsible are recognizing that, as enunciated in 1979 by the Coroner of Ontario, "there is really no safe period for the destruction of records."<sup>74</sup> While this should not be taken to imply that for legal reasons all records need be kept forever, it does illustrate that no matter how long the ultimate retention period, it goes well beyond that required by the clinical purposes normally associated with medical records department storage. For legal considerations alone, archival retention of inactive patient records may well be necessitated.

Inactive or archival medical records are also used extensively for the research and professional education carried out in the hospital, particularly, but by no means exclusively, in teaching hospitals associated with medical schools.<sup>75</sup> Whether used simply to check facts, or to re-examine past trends, these records play an important role in the

improvement of medical science and service. While admittedly this function is of secondary importance to most practicing physicians and administrators,<sup>76</sup> it can make a contribution to the institution. There is a strong belief that the quality of the medical care increases in hospitals where clinical research is carried out.<sup>77</sup>

Research on a particular ailment, focussing on the cause, progression, and treatment employed, often necessitates the use of many files over an extended time span in order to obtain sufficient data. As Nancy Spingarn has observed, "medical researchers can unravel nature's secrets only by studying patient histories."<sup>78</sup> Summaries are not always sufficient. This is of particular significance for studies of communicable disease. Research in archives may be necessitated for illnesses which, while not common today, could re-emerge with serious consequences. Similar investigation is often required for diseases which manifest themselves in successive generations.<sup>79</sup> The ability to link new information with the contents of archival records is important to this type of investigation.<sup>80</sup> Such research is not always restricted to the traditional patient record. The New York Hospital-Cornell Medical Center Archives reports that its collection of clinical photographs has proven to be of great interest to medical personnel engaged in research.<sup>81</sup>

The retention of inactive patient records in an archives thus serves the hospital by providing the raw material for continuing research by physicians and study by students. A 1960 survey of records use in Illinois reported that, for both purposes, few files were used beyond fifteen years after discharge.<sup>82</sup> This is not surprising, although it does not mean that older records are never requested. Files describing certain afflictions

may be of value for much longer, particularly for those interested in carrying out specific historically-oriented medical research. At Vancouver's Shaughnessy Hospital, for example, a recent oncology research project made use of over twenty years worth of patient files.<sup>83</sup> As well, as argued by Virginia Stewart, "this projection of past research needs disregards current trends, especially those stimulated by computer capabilities for analysis of vast amounts of raw data."<sup>84</sup> While the issues pertaining to sampling of patient records will be addressed in chapter five, it remains evident that the archives, rather than the medical records department, is the repository best equipped to preserve and service these records.

Medical records are also of use as the basis for statistical data, from which reports are compiled for the administration, medical staff, and external agencies.<sup>85</sup> Indeed, at Shaughnessy, virtually all statistical information used by both the administration and government bodies comes directly from the medical records department.<sup>86</sup> It is necessary for those running a hospital to have accurate information on such variables as the length of stay, types of services rendered for different illnesses, drugs administered, and so forth. This is often of particular significance when changes over time can be illustrated with the use of an extended series of files. Future expansion of facilities or a re-allocation of funds may depend on what this type of study reveals about the shifting patterns of disease.<sup>87</sup> Management use of this information in planning has long been neglected by both staff members and researchers.<sup>88</sup> Yet, in his discussion of marketing strategies in hospitals, Richard Ireland considers a historical audit of hospital records, intended to reveal utilization



patterns, one of the first steps to be carried out prior to any shift in policy.<sup>89</sup>

Today most hospital medical record departments provide such statistical information on a regular basis, simply adding the details of new patient files to automated data bases, either on-line or with regular batch updates. This aggregate data supplies the information needed for all planning and review activities. Initially, then, it is difficult to see where archives would fit in to such a programme. Once the required information has been extracted, the original record would appear to have little further use. While true to an extent, such an assertion presupposes that at the time the information was gathered and transcribed all future requirements had been taken into consideration. This may not prove to be the case. It is to the advantage of all concerned to have continued access to original records. In his examination of hospital financial administration, for example, Robert Broyles contends that a statistically viable sample of medical records should be kept in order to meet any future administrative requirements.<sup>90</sup> Careful selection practices, discussed more fully in chapter five, are being developed to meet similar needs in other institutions. These procedures are required to ensure the utility to the hospital of such samples.

In general, the archives of a hospital guarantees a permanent record for internal reference and also assists in increasing awareness of the hospital's role.<sup>91</sup> The key element involved in assuring this contribution is planning. As will be seen in greater detail in chapter four, the archives should be established with specific goals and objectives, and those overseeing it should remember that like all other departments it will be

productive in direct relation to the amount of support it receives.<sup>92</sup> It should, as emphasized by Harold Moulds, be built "on an understanding of the organization's functional arrangement and management information needs."<sup>93</sup> In all cases, the potential users must be identified. They represent what Uri Haller has called the archivist's "wild card" -- the archivist must take what he or she has to offer and mold it to their needs.<sup>94</sup>

In addition, it is imperative that the value of an archives be impressed upon the denizens of the hospital world. Success in such institutions, writes Deborah Gardner, is "contingent upon providing utilitarian value to an inhouse clientele unfamiliar with the notion of using the past to make current decisions and plans for the future."<sup>96</sup> Some hospital administrators do appreciate the value of archives, but they are still very much in the minority. If the archives is properly conceived, administrators and members of the medical staff will find occasions when a visit will be both desirable and necessary as it represents an important, centralized reference source. Without the archives, the hospital will operate less efficiently.

## Notes for Chapter Two

<sup>1</sup> See Association of Canadian Archivists (hereafter ACA), "The Symons Report and Canadian Archives," Archivaria 11 (Winter 1980-81): 9; and Consultative Group on Canadian Archives, Canadian Archives: Report to the Social Sciences and Humanities Research Council of Canada, Ian Wilson, Chairman (Ottawa: SSHRCC, 1980), pp. 58-59.

<sup>2</sup> Felix Hull, "The archivist and society," JSA 6 (April 1979): 128.

<sup>3</sup> Cynthia G. Swank, "Archivists' Lib: A Response to 'Whose Handmaiden?'" Archivaria 18 (Summer 1984): 16.

<sup>4</sup> Philip F. Mooney, "Commentary I," [On business archives] AA 45 (Summer 1982): 292.

<sup>5</sup> See, for example, the series of three articles in the October, November, and December 1982 issues of DIHS. These were intended to generate greater interest on the part of hospital administrators in the field of archives and records management. This can be interpreted as an indication of awareness among at least a minority of hospital officials.

<sup>6</sup> George David Smith, "Dusting Off the Cobwebs: Turning the Business Archives into a Managerial Tool," AA 45 (Summer 1982): 288.

<sup>7</sup> Mooney, "Commentary I," p. 291.

<sup>8</sup> Schellenberg, Modern Archives, pp. 140, 148.

<sup>9</sup> See, for example, G. S. Terence Cavanagh, "Rare Books, Archives, and the History of Medicine," in Handbook of Medical Library Practice, 3rd ed., ed. Gertrude L. Annan and Jacqueline W. Felter (Chicago: Medical Library Association, 1970), p. 280.

<sup>10</sup> Dickin McGinnis, "Records of Tuberculosis," p. 174.

<sup>11</sup> St. Paul's Hospital, Archives Steering Committee, Minutes, October 12, 1983.

- <sup>12</sup> Annan, "Medical Library," p. 317.
- <sup>13</sup> Douglas A. Bakken, "Corporate Archives Today," AA 45 (Summer 1982): 280.
- <sup>14</sup> Smith, "Dusting Off the Cobwebs," p. 287.
- <sup>15</sup> MacLeod, "Waiting for the archivist," p. 28.
- <sup>16</sup> Sears and Allderidge, "Medical Records Conference," p. 555.
- <sup>17</sup> See Hugh A. Taylor, "Information Ecology and the Archives of the 1980s," Archivaria 18 (Summer 1984): 30-34.
- <sup>18</sup> Gordon Dodds, "Back to Square One: Records Management Revisited," Archivaria 2 (Summer 1976): 91.
- <sup>19</sup> Ibid., pp. 89-90.
- <sup>20</sup> Harold P. Anderson, "Business Archives: A Corporate Asset," AA 45 (Summer 1982): 264.
- <sup>21</sup> See, for example, the summer 1982 issue of AA which was entirely devoted to the topic of business archives.
- <sup>22</sup> Harold Moulds, "Hospital archives: necessity or frill?" DIHS 59 (October 1982): 38.
- <sup>23</sup> Smith, "Dusting Off the Cobwebs," p. 287.
- <sup>24</sup> Moulds, "Hospital archives," pp. 39-40.
- <sup>25</sup> Allan D. Ridge, "Records Mangement: The Archival Perspective," RMQ 9 (January 1975): 14.
- <sup>26</sup> Annan, "Medical Library," p. 313.

- <sup>27</sup> MacLeod, "Waiting for the archivist," p. 28.
- <sup>28</sup> Terrence S. Norwood, "The Cook County Hospital Archives," IL 63 (April 1981): 338.
- <sup>29</sup> MacLeod, "Waiting for the archivist," p. 29.
- <sup>30</sup> Anderson, "Corporate Asset," p. 265.
- <sup>31</sup> See Thomas H. Berliner and Cloene Bork, "The role of information in public sector policy making," Optimum 8 (1977): 56.
- <sup>32</sup> ACA, "Symons Report," p. 9.
- <sup>33</sup> See Anderson, "Corporate Asset," p. 264.
- <sup>34</sup> David Bearman, "'Who About What,' or 'From Whence, Why, and How': Establishing Intellectual Control Standards to Provide for Access to Archival Materials," paper presented at the Archives, Automation and Access Conference, Victoria, B.C., March 1, 1985.
- <sup>35</sup> Robert Levy, cited in Bakken, "Corporate Archives Today," p. 279.
- <sup>36</sup> Berliner and Bork, "The role of information," p. 56.
- <sup>37</sup> See the examples given in Don Page, "Whose Handmaiden?: The Archivist and the Institutional Historian," Archivaria 17 (Winter 1983-84): 166, 171-72.
- <sup>38</sup> Thomas McKeown, "A Sociological Approach to the History of Medicine," Medical History 14 (1970): 342.
- <sup>39</sup> Ibid., pp. 350-51.
- <sup>40</sup> Tom Brown, "'Architecture as Therapy'," Archivaria 10 (summer 1980): 101.
- <sup>41</sup> See Lowry, "M.I.S. Project," pp. 40-43.

<sup>42</sup> Smith, "Dusting Off the Cobwebs," p. 289.

<sup>43</sup> John Dodd, "The Archives of Hospital Contributory Schemes," Archives 1 (Lady Day 1949): 38.

<sup>44</sup> Sylvia M. Burkinshaw, "A look at Kingston General Hospital's archives," DIHS 59 (November 1982): 20-21.

<sup>45</sup> A good example of this type of display was presented at the Public Archives in Ottawa, June 4 - July 8, 1980. It was jointly sponsored by the Royal College of Physicians and Surgeons of Canada and the Hannah Institute for the History of Medicine, with the assistance of the P.A.C., and it included items depicting the development of hospitals. See Canadian Medical Archives: A selection of archival material relating to the history of medicine in Canada (Ottawa: June 1980); and "Canadian Medical Archives," The Archivist 7 (July-August 1980): 6-8.

<sup>46</sup> See, for example, A. P. Farr, "Are your historical records worth a centennial project?" Office Administration 12 (December 1966): 11-12, 37-38; and Ralph P. Engle, "Medical Archives," Bulletin of the American Society for Information Science 4 (October 1977): 23.

<sup>47</sup> See comments in Keith Thomas, "Some Contributions to Medical History," Archives 6 (Michealmas 1963): 98.

<sup>48</sup> The original Kingston General Hospital archives collection was brought together by Margaret Angus as she was researching and writing her anniversary history of the hospital. She organized the material to meet her specific needs, rather than along traditional archival lines. As a result, the collection has proven difficult to integrate with more recent accessions. It was finally decided to leave the original material as it was and treat it as a closed accession. KGH, "Report on Archives," p. 4; and Interview with Shirley Spragge, Archivist, Queen's University Archives, Kingston, Ontario, July 20, 1984.

<sup>49</sup> Robin E. MacStravic, "Should Hospitals Market?" and Richard D. O'Hallaron, Jeffrey Staples, and Paul Chiampa, "Marketing Your Hospital,"

both in Marketing in Nonprofit Organizations, ed. Patrick J. Montana (New York: AMACOM, 1978), p. 252; 115, 122.

<sup>50</sup> Lee F. Block and M. Elliott Taylor, "Bridging the Public Relations Gap Between Hospital Provider and Consumer," in Marketing in Nonprofit Organizations, pp. 244-45.

<sup>51</sup> See examples: Bakken, "Starting a Business Archives," p. 27, which discusses the public relations activities at St. Luke's Hospital in Kansas City; and Douglass J. Seaver, "Hospital Revises Role, Reaches Out to Cultivate and Capture Markets," Hospitals: Journal of the American Hospital Association 51 (June 1977): 59-63.

<sup>52</sup> Deborah S. Gardner, "Commentary II," [On business archives] AA 45 (Summer 1982): 294.

<sup>53</sup> David D. Burns, "Michael Reese Hospital: Archives and Public Affairs," IL 63 (April 1981): 335-36.

<sup>54</sup> Burkinshaw, "Kingston General Hospital's archives," p. 21.

<sup>55</sup> Norwood, "Cook County Hospital," p. 339.

<sup>56</sup> Gardner, "Commentary II," p. 295.

<sup>57</sup> Burns, "Archives and Public Affairs," p. 336.

<sup>58</sup> KGH, Accounting Service, Schedule. The records earmarked for the fifty year retention period represent only five of the 113 series listed in the schedule. The uses to which these documents are put are noted in Burkinshaw, "Kingston General Hospital's archives," p. 21.

<sup>59</sup> CHA, Canadian Hospital Directory, p. 28. The actual figures for VGH are 4,550 regular staff and 435 students.

<sup>60</sup> For details of personnel department use of archives, see Burkinshaw, "Kingston General Hospital's archives," p. 21.

- 61 Dickin McGinnis, "Record of Tuberculosis," p. 182.
- 62 Kenneth R. Wagner, "Developing a Records Retention Schedule For a Medical Clinic," Medical Group Management 20 (March-April 1973): 17.
- 63 Blouin, "Appraisal of Business Records," p. 69.
- 64 Sears and Ailderidge, "Medical Records conference," p. 554.
- 65 Bakken, "Corporate Archives Today," p. 285.
- 66 Anne Van Camp, "Access Policies for Corporate Archives," AA 45 (Summer 1982): 298.
- 67 For further details on the contents and importance of essential records, both in general and for specific institutions, see Emergency Planning Canada, Guide to the Preservation of Essential Records, rev. ed. (Ottawa: 1984); and Supply and Services Canada, Essential Records for Industry, 2nd ed. (Ottawa: 1973).
- 68 Lorne E. Rozovsky, "Medical records as evidence," DIHS 55 (July 1978): 16.
- 69 Ravesies, "Medical Records Key," p. 27. In this instance, most of the patients whose records are kept on a permanently active status are children suffering from leukemia and other "catastrophic" diseases.
- 70 Schuchman et al, Confidentiality of Health Records, pp. 57-58.
- 71 See Lorne E. Rozovsky, Canadian Hospital Law, 2nd ed. (Ottawa: CHA, 1979), p. 97.
- 72 Ellen I. Picard, Legal Liability of Doctors and Hospitals in Canada (Toronto: Carswell, 1978), p. 278.
- 73 Milan Korcok, "When the lawyer is called in your best friend is a good set of records," Canadian Medical Association Journal (hereafter CMAJ) 116 (March 19, 1977): 689.



<sup>74</sup> T. David Marshall, The Physician and Canadian Law, 2nd ed. (Toronto: Carswell, 1979), p. 7.

<sup>75</sup> AHA, Medical Records Departments, pp. 57, 111.

<sup>76</sup> Hansen, "Health Care Systems," p. 14.

<sup>77</sup> Jacques Genest, "Clinical Research in Canada," CMAJ 86 (14 April 1962): 680.

<sup>78</sup> Natalie Davis Spingarn, Confidentiality: Report of the Conference on Confidentiality of Health Records, Key Biscayne, Florida, November 6-9, 1974 (Washington, D.C.: American Psychiatric Association, 1975), p. 1.

<sup>79</sup> N. J. M. Kerling, "Hospital Records," JSA 5 (April 1975): 182; and AHA, Hospital Medical Records: Guidelines for Their Use and the Release of Medical Information (Chicago: AHA, 1972), p. 40.

<sup>80</sup> Joseph Steinberg, "Social Research Use of Archival Records: Procedural Solutions to Privacy Problems," in Solutions to Ethical and Legal Problems in Social Research, ed. Robert F. Boruch and Joe S. Cecil (New York: Academic Press, 1983), p. 249.

<sup>81</sup> Engle, "Medical Archives," p. 23.

<sup>82</sup> Illinois Association of Medical Record Librarians (hereafter IAMRL), "Retaining records: how long?" MRN 34 (February 1963): 10.

<sup>83</sup> Mary Webster, "Health Records Management in the Hospital Environment," paper presented at the monthly dinner meeting of the Vancouver chapter, Association of Records Managers and Administrators (ARMA), Vancouver, B.C., May 28, 1985.

<sup>84</sup> Stewart, "Problems of Confidentiality," p. 389.

<sup>85</sup> AHA, Medical Record Departments, p. 67; and Lowry, "M.I.S. Project," pp. 42-43.

- 86 Webster, "Health Records Administration."
- 87 Newman, "Medical Records," p. 1.
- 88 Hansen, "Health Care Systems," p. 14.
- 89 Richard C. Ireland, "Using Marketing Strategies to Put Hospitals on Target," in Marketing in Nonprofit Organizations, pp. 125, 131.
- 90 Robert W. Broyles, The Management of Working Capital in Hospitals (Rockville, Maryland: Aspen Systems Corporation, 1981), p. 402.
- 91 Burkinshaw, "Kingston General Hospital's archives," p. 21.
- 92 Bakken, "Corporate Archives Today," pp. 281, 85.
- 93 Moulds, "Hospital archives," p. 40.
- 94 Uri Haller, "Commentary on 'National Information Systems and Access'," paper presented at the Archives, Automation and Access Conference, Victoria, B.C., March 1, 1985.
- 95 Gardner, "Commentary II," p. 295.

## Chapter Three

## HOSPITAL ARCHIVES AND EXTERNAL RESEARCH

While the primary function of a hospital archives is to serve the needs of the institution, the additional value for the wider community should not be underestimated. In fact, any discussion of the uses of the records would be incomplete without an examination of their importance for research carried out by historians and similar investigators, academic and otherwise, working outside the hospital itself. Yet, as Nancy Peace has cautioned, "the goals of economy and bureaucratic efficiency are not necessarily in harmony with the needs of research."<sup>1</sup> It is, therefore, necessary to draw attention to these other applications of hospital archives lest they be overlooked in the rush to streamline the records management function within the institution.

As the same archival records can be used simultaneously by administrators for planning and social scientists for research, any such internal-external division is rather artificial. However, as is the case with archives in any setting, there is a point at which the records undergo a transition from their non-current administrative use to that of a distinctly historical or cultural nature. While many institutional projects will continue to require access to these holdings, the value for research benefitting society at large becomes their prime raison d'être.

Of the types of external research that can be conducted using hospital archives, history -- particularly the history of medicine -- immediately comes to mind. Having made significant strides in the past decade and a

half,<sup>2</sup> this field of study has much yet to add to our understanding of the science of medicine, its institutions and practitioners, and their impact on Canadian society. Given the importance of the hospital as one of the central components of the health care system, various investigations can be undertaken in its archives. Such research can illuminate the direct contribution of the hospital itself, or how it has influenced other aspects of medical practice. When combined with other sources, particularly the private manuscripts of individual doctors, hospital archives provide a wealth of information of value to historians.<sup>3</sup> The relative youth of Canadian hospitals means that trends revealed by a historical examination of the past often reflect -- and help one understand -- current conditions and practices.

The value of old patient files and supporting medical record documentation for the history of medicine is immense, in their own right and as a complement to other records. British archivist Charles Newman contends that after their clinical use, medical records are preserved for a number of reasons, "of which historical research is usually not the most deliberate, but often the most enduring and far reaching."<sup>4</sup> He also believes that while many people do not realize it, the main reason for keeping case notes is for historical, not scientific research.<sup>5</sup> While the latter assertion could be debated, one cannot refute the overall importance of medical records. These documents provide the historian with insights not normally available to the social scientist and, as the information is collected on a regular basis, they facilitate the investigation of questions spanning long periods.<sup>6</sup> While there are obvious restrictions based on the need to preserve confidentiality, on which more will be said in Chapter

Six, medical records are the primary sources for the historian of medicine.

When combined with the techniques of quantification, the contents of medical files can be used for various statistical analyses. Detailed profiles of various groups or types of patients can be produced. The standardized nature of most of these records readily permits such computer based research. Individual files can also be used for a case study, or simply as an illustration of past medical trends.

By providing insight into who patients were, how they were treated, and, often, what became of them, medical records can redress the traditional imbalance that once prompted historian F. B. Smith to comment that "patients loom small in medical history."<sup>7</sup> Such records also reflect the attitudes prevalent in a given era and can therefore illustrate the common but often ignored gaps between the accepted medical theories of the textbooks and the actual practices carried out in the wards and surgical theatres. The development of various investigative procedures and technological innovations are revealed in the pages of medical records.<sup>8</sup> Such files may also constitute the only significant sources for the early history of medical specialties such as psychiatry, and obstetrics and gynecology.<sup>9</sup>

In addition to medical files, hospital administrative documents, which American social historian Charles Rosenberg has termed the "previously unfashionable institutional records,"<sup>10</sup> have also come into their own as important historical sources. In 1981, in the introduction to his edited collection of essays on Canadian medical history, S. E. D. Shortt, recently retired professor of medical history at Queen's University, observed that hospital administrative records could be used to reveal a

great deal about such subjects as the development of hospital financing, support services, accreditation systems, links with medical and nursing schools, and the emergence of specialized institutions, as well as the evolution of the hospital as part of the community and its role in health care.<sup>11</sup> Correspondence, minutes, and policy documents are just some of the records that could be used to investigate these issues.

Hospital archives are, of course, admirably suited to studies focussing on the institution itself, the most common being the formal institutional history. While a number, as mentioned in the previous chapter, are commissioned by the hospital in recognition of some milestone, many are prepared as more detailed external research projects. Traditional examples of this genre have not been without shortcomings. Too many authors have been guilty of producing turgid accounts "heavily weighted towards descriptions of physical plant expansions or the contributions of former matrons, superintendents, or physicians."<sup>12</sup> Fortunately this is changing, in part because historians are making increasing use of medical records to complement the administrative documents that have been the traditional sources of hospital histories. These patient files inject a sense of life into what could otherwise be dull institutional history. The work of Dickin McGinnis on the Baker Memorial Sanatorium outside Calgary, facilitated in part by access to a virtually complete series of ten thousand patient files, is an excellent example of what can be achieved by a judicious use of the contents of medical records in combination with annual reports, correspondence, and other administrative material.<sup>13</sup>

Beyond the strict institutional histories, research on the role and

influence of hospitals can have significant results for wider areas of enquiry. Although a great deal of work on the role of hospitals has been produced in other countries, a recent evaluation of Canadian hospital historiography indicates that much remains to be done. Specific areas requiring further research include the degree to which early institutions made positive contributions to health care; the role and contributions of the members of the "hospital subculture" -- nurses, attendants, and stewards -- who interpreted and implemented the physicians' orders; and the patient perspective on hospitalization.<sup>14</sup> All three can be assisted by, and are probably all but impossible to discover without, recourse to the archives of the hospital.

Such work can make effective use of all documents encountered in the hospital, but perhaps most important are the medical files. These provide information not just on the patients, but also about the staff members who produced them and the institution itself.<sup>15</sup> As they represent the operational records of the hospital they can illustrate a great deal about how it functions.

In addition to these traditional sources, other types of archival records permit research on the impact of medicine through the auspices of the hospital. Brown's insightful investigation of the Toronto Asylum is a case in point. On the basis of a careful examination of the plans and diagrams of the institution, complemented by photographs, reports, and correspondence, he was able to show how the building's architecture actually counteracted the therapeutic environment it was intended to create.<sup>16</sup> Similar research has been carried out with the records of England's famed Bethlem ("Bedlam") Hospital.<sup>17</sup> Such work enhances

today's understanding of past theories on the nature and treatments of diseases such as mental illness -- theories which often colour current perceptions. This type of research would be extremely difficult to carry out without the retention of and access to archivally preserved hospital records.

Photographs, used alone or in conjunction with other records, are being increasingly sought as primary research material. In "The Picture of Health," a photographic essay covering the period 1885-1935, Barbara Craig and Gordon Dodds used materials drawn from both government and institutional collections to "evoke visually the growth and sophistication of hospital health services."<sup>18</sup> Photographs were also used in a display held at the Public Archives of Canada in the summer of 1980. Jointly sponsored by the Royal College of Physicians and Surgeons of Canada and the Hannah Institute, this exhibition included a series of photographs depicting the evolution of hospitals in Canada.<sup>19</sup>

Related to photographic sources, x-rays are also of value for specific types of historical research. The films are often used to complement investigations of illnesses or injuries, such as the evolution of wound treatment during the Great War.<sup>20</sup> In other instances, the research may focus on the development of the x-ray technology itself.<sup>21</sup> In either case, researchers will desire access to the original films, or at least accurate copies. While the preservation of x-rays may appear to present special problems for the archives, they can be treated in much the same fashion as the other photographic holdings.

In recent years oral history has gained popularity with the research community and this trend has not gone unnoticed in either the medical



history field or the hospital itself. Oral history projects have been set up as part of a number of heritage programmes.<sup>22</sup> Indeed, one of the first tasks of the newly hired archivist of Cleveland's University Hospital was to establish an internal oral history programme.<sup>23</sup> As a result, both tapes and transcripts are included in hospital archives. These record interviews with various individuals who have been associated with the hospital, usually, but not exclusively, in senior positions. They are therefore of value to the researcher interested in additional personal information on the development of the hospital and those who worked in it.

Research on hospital operations is also being carried out using a variety of other records, including diet plans, menus, and drug and stock inventories. These sources enable historians to understand and, in large measure reconstruct, the day-to-day functioning of a hospital, whether twenty years ago or two hundred or more.<sup>24</sup>

The history of medicine encompasses much more than simply the growth of institutions, and hospital archives can assist in these other areas as well. As but one example, research based on these records enhances an understanding of the evolution of medicine as a profession. Professionalization has become an important topic in many fields, and medicine is certainly no exception.<sup>25</sup> As the hospital became the locus of medical activity, the development of the profession was increasingly intertwined with that of the institution. Research such as that carried out by Colin Howell on the professionalization of doctors in nineteenth century Halifax reveals how doctors strengthened their position in society. Based partly on the medical registers and minute books of the local hospitals, Howell's work provides evidence of the way in which doctors supported the

incorporation of scientific medical advances into new hospitals in order to add weight to their demands for self-regulation.<sup>26</sup>

Before looking at the other sub-disciplines of history which can benefit from access to hospital archives, the actual use of such sources should be examined. While obviously of value, the extent to which they are used may influence those considering their preservation. In the case of business history, Francis Blouin reports that between 1977 and 1981 only seven percent of the works appearing in Business History used what were considered "traditional corporate archives." This was seen as evidence in part of a move away from the use of individual business archives.<sup>27</sup> In contrast, an informal survey of recent work in Canadian medical history, drawing on both published collections of essays and the fledgling Canadian Bulletin of Medical History reveals that over 28 percent of the articles made use of hospital records (although not all were located in established hospital archives), even though the majority of works did not pertain directly to hospitals. A healthy 73 percent made use of archival records of one kind or another. The details of this survey are found in Appendix D. While this is not a definitive investigation of archival use, it is indicative that despite the lack of easily accessible records and the few formal hospital archives, these materials are being sought after and used.

Hospital archives are not limited in their usefulness to the history of medicine. The records are a rich source for investigation in a number of other areas. For the field most closely related, social history, hospital archives provide a wealth of information. Concerns about health and disease are an important part of the social development of any community.

It has been said that "priests see men [and women] at their best, lawyers at their worst, but doctors see them as they are."<sup>28</sup> More recently, sociologists Gerald Turner and Joseph Mapa observed that "the experience of being hospitalized adds another dimension to the experience of being ill."<sup>29</sup> Evidence drawn from medical records can tell a great deal about the lives of those who worked within the walls of the institution and those who were committed to its care. For example, reflecting on the records encountered in the archives of the London Asylum in Ontario, Wendy Mitchinson found that the files helped personalize the women on whom the doctors operated.<sup>30</sup>

Demographic research based on hospital records also provide insight on conditions of life and death in the past.<sup>31</sup> Admission registers, which usually recorded such facts as age, sex, diagnosis, and eventual disposition (death or release) can be used to identify the patterns of illness which existed in the community.<sup>32</sup> Studies of hospital records have challenged a number of basic assumptions about mortality during the eighteenth and nineteenth centuries. Utilizing the records of England's York County Hospital, E. M. Sigsworth discovered that the poor reputation of early hospitals may have been undeserved. While the eventual fate of many of the patients remains unclear, as they could have been released just prior to their "imminent demise," he concluded that contrary to popular belief they did not "normally" die in hospital.<sup>33</sup>

Recent research based on Canadian hospital records has produced some remarkable findings about conditions of life in the past. University of British Columbia historian Peter Ward's investigation of the relationship between infant birth weight and nutrition is a case in point.

Drawing on information contained in the patient registers of Montreal's University Lying-in Hospital, later renamed the Montreal Maternity Hospital, Ward discovered a consistent decline in the birth weight of babies born between 1851 and 1905. As birth weight is closely associated with the health and nutritional status of the mother, these statistics have enabled Ward to theorize that the quality of diet declined in this period, with malnutrition becoming particularly prevalent among the poorer classes after 1880.<sup>34</sup> In England, similar research into nutrition and its relation to age-specific height has been carried out using series of hospital and military medical records.<sup>35</sup>

In addition to specific medical details, information on various occupations and professions, general living conditions, occupational hazards, and other hidden details of past societies can be derived from hospital records.<sup>36</sup> Administrative records such as the admission and discharge registers or mortality lists, as well as the actual case notes, paint a picture of the times that existed decades if not centuries earlier. Records of poorhouse infirmaries and charitable hospitals in particular, represent what Joan Sherwood has termed "a roll-call of the victims of indigence and its complications: ignorance, undernourishment and immorality." Such records, she continues, "enable the historian to limn out a few outlines in the grey, amorphous fog which has engulfed most of the poor in the past."<sup>37</sup> From sources such as these, one can paint a portrait of life at the lower end of society -- a picture often difficult to sketch from traditional archival records. Hospital archives thus reveal more than just how the patients were cared for.

Other branches of history make productive use of hospital records. A

relatively new field, urban history, has been enriched by recourse to these sources. Access to the archives of Trinity Hospital, Salisbury, England, containing land deeds and other records dating from the 1300s, has enabled scholars to trace the evolution of the early city. As specific streets and properties are described in this lengthy series of records, it has been possible to document growth over several centuries.<sup>38</sup> While collections of this vintage are not to be found in North American hospital archives, the records that do exist are equally valuable. Due to its size and orientation, the hospital has always had a marked effect on its surrounding community, influencing, among other things, the social, economic, political, and physical environment.<sup>39</sup> Decisions on redevelopment, including expansion or relocation, or a reorientation of services can have a significant impact on the rest of the city or town.<sup>40</sup> These events are normally well documented in hospital records, in the form of correspondence, minutes, and planning reports.

Due to its central role, the hospital often reflects local, regional, or national trends of interest to economic historians, as well as economists themselves. Statistics on hospital financing and use can indicate a variety of things about the economic situation at a given point in time. In two years, during the height of the Depression, outpatient consultations at the Vancouver General Hospital increased from around fifteen thousand to some forty-four thousand. This prompted the author of a short history of the institution to conclude that the outpatient department was "a pretty accurate barometer of the community's economic condition."<sup>41</sup>

As various series of hospital administrative records have been preserved largely intact, they can provide the basis for studies of

economic shifts over time. Admission registers listing the professions of those admitted to charitable hospitals or the scales of fees charged are useful, as are the account books which itemize stock purchases and the menus listing the type and amount of food served. Earl J. Hamilton's innovative study of the price revolution of the seventeenth and eighteenth centuries in Spain was based largely on records located in hospital archives.<sup>42</sup> By applying quantification methods to these records, economic historians are arriving at fascinating and significant conclusions about the past. In France, investigation of hospital diet records, specifically account books and menus, has revealed changes in food prices and diet composition over a period of some one hundred years. From this, the general cost of living pattern has been extrapolated.<sup>43</sup> North American scholars are beginning to follow the lead of their European counterparts in using hospital records for this type of research.<sup>44</sup>

Other types of historical research can benefit from access to hospital archives. Given the predominance of churches and holy orders in the provision of hospital services, particularly in the institution's early years, the records preserve information of value for religious history. In similar fashion, given the close relationship between medical practice and prevailing "scientific" beliefs, the archives of hospitals provide material for those investigating intellectual history.<sup>45</sup> Students of art and architecture will find the blueprints and photographs of hospital buildings to be valuable sources for their studies.

Hospital archives have also been touted as an often overlooked source for the growing numbers of genealogists.<sup>46</sup> While detailed patient files will probably not be released for this purpose, at least not for many years

after closure, compiled lists of patient names, particularly from obstetric cases, are greatly in demand. So too are the older admission and discharge registers which often provide information on the patients' age, occupation, next of kin, and address. These sources can furnish the ardent genealogist with a variety of pertinent details about his or her forebears.

Outside of the historical profession, various other social science investigators can benefit from access to hospital records.<sup>47</sup> Some, like economists and sociologists, will make use of the material in ways similar to those previously described for economic and social history. The patterns derived from an examination of the past can be applied to both the present and the future. Urban and regional planners and public administrators will also find that information preserved in the archives can inform their studies on the role of hospitals within the community and the health care system generally.

The political scientist can similarly make effective use of hospital records. Particularly in the realm of health insurance and funding, hospitals have been associated with a number of political issues which have had significant and long term ramifications for the country.<sup>48</sup> Whether used as part of a specific investigation on the impact of insurance schemes, or the more general reaction to government policies on education, health, or social services, hospital administrative records provide the reports and correspondence to support such research. Lawyers and law students also make research use of hospital records, both medical and administrative. The records of Royal Columbian Hospital, located at the City of Vancouver Archives, have been used by researchers from the Faculty of Law at the University of British Columbia to investigate a

precedent setting legal case involving the hospital which took place during the 1920s.<sup>49</sup> Other disciplines, such as geography, engineering and psychology, can benefit from the use of hospital records.

External research based on hospital archives is also not restricted to the social science community. Investigations of a scientific nature are routinely undertaken utilizing medical records. These projects are often identical to those carried out by staff members but in this case are conducted by individuals not affiliated with the institution. Such people include physicians in private practice, government officials, medical school professors, and graduate students. This work may be associated with the publication of a book or simply related to the treatment of patients. N. J. M. Kerling, archivist of the Royal Hospital of Saint Bartholomew, England, has noted that such research is particularly useful for doctors and nurses who are planning to travel to underdeveloped countries to practice. In these areas current conditions often resemble those encountered in the west in the last century, when ailments such as tuberculosis and pneumonia, which are now rare, were then prevalent. A study of old patient charts and pathology reports may serve to familiarize the practitioner with the aetiology of such cases before they are encountered first hand.<sup>50</sup>

The information contained in hospital archival records has important applications outside the institution itself, whether in original form or as aggregated data. Public health and welfare personnel often require clinical or sociological data for demographic analyses. Various government bodies, occupational health organizations, and social services agencies similarly make use of the statistics compiled from hospital



records. This information is often required for planning at the provincial or national level.<sup>51</sup> While current records are automatically placed on the data banks, recourse to older original documentation is often necessitated by the desire for comparison or review, as discussed in the previous chapter.

There are thus a wide variety of valid research applications that can be undertaken in hospital archives. As Sherwood concluded in the 1980 issue of *Archivaria*, "the utility of hospital archives is limited only by the ingenuity, diligence, time and good luck of the researcher."<sup>52</sup>

With the growth of research in medical history and related fields, and the parallel scramble for new source material, hospital administrators will increasingly be faced with requests for access to their records. In 1980 the Wilson Report noted that archives have traditionally not kept pace with the new directions in historical research, and the same can definitely be said for hospitals.<sup>53</sup> While admittedly it is most likely that the documents are still located in the hospital, they must, in the words of Herbert Finch, an archivist at Cornell University, "be collected and presented to the world of scholarship in a usable form."<sup>54</sup> Even requests for statistical data will be more easily dealt with if the hospital has an in-house capability to handle such analyses.<sup>55</sup> The ability of the hospital to meet these demands is important if the institution is to encourage interest without upsetting its daily operations.<sup>56</sup>

It is necessary for those responsible for the establishment and maintenance of hospital archives to realize the extent and significance of external research, as well as its benefits for the institution itself. A hospital does not exist in a vacuum. Interest in the hospital is increasing

at various levels as people realize that, as Margaret Angus observed in the preface to her history of Kingston General Hospital, the hospital "represents a common ground on which the patient, the community, and the professional groups meet."<sup>57</sup> The value of this public concern and awareness, noted earlier with respect to formal public relations, should not be discounted. As well, the use of hospital archives by scholars enhances the status and reputation of the institution. By providing material and assisting in the dissemination of the information contained therein in a responsible and professional manner, the archives can perform an important public service.<sup>58</sup> Such benefits, tangible or otherwise, are important in maintaining the hospital's image as a participant in the community.

Based on both this and the preceding chapter, it should be apparent that the preservation of hospital archives is indeed justified. The most immediate purpose for the identification and retention of the records required by the staff is to maintain the institution and its services. Beyond this, the benefits to both internal and external research -- of various types -- are also of great significance. The social and cultural rationale for the preservation of hospital archives is not the easiest to put across to administrators, nor should it be viewed as the sole purpose of the repository. It remains, however, a component of the archives function that merits interest and support -- and one which may well have the most long lasting and far reaching impact.

## Notes For Chapter Three

<sup>1</sup> Peace, "Deciding What to Save," p. 9.

<sup>2</sup> As late as 1970, medical history in Canada was not sufficiently developed to merit any specific comment in an assessment of Canadian historiography. Indeed, social history as a whole received only passing reference. See Carl Berger, The Writing of Canadian History: Aspects of English-Canadian Historical Writing, 1900 to 1970 (Toronto: Oxford University Press, 1976), pp. 263-64. By 1984, however, medical history had achieved new found status with a greatly increased number of both professional and amateur practitioners, conferences, and journals. It has been said that a new era for the field is about to unfold. See the introduction to Roland, ed. Health, Disease and Medicine, pp. 11-12.

<sup>3</sup> See John B. Blake, "Medical Records and History," AA 27 (April 1964): 229-35.

<sup>4</sup> Newman, "Medical Records," p. 1.

<sup>5</sup> Ibid., p. 4.

<sup>6</sup> Raffel, Matters of Fact, pp. 6-7.

<sup>7</sup> F. B. Smith, The People's Health, 1830-1910 (London: Croom Helm, 1979), p. 9.

<sup>8</sup> British Records Association (hereafter BRA), "Preservation of Medical Records," The Lancet (February 13, 1960): 379.

<sup>9</sup> See Richard A. Hunter, "Some Notes on the Importance of Manuscript Records for Psychiatric History," Archives 4 (Lady Day 1959): 9; and Audrey Eccles, "Notes and News -- Medical Records," JSA 5 (October 1976): 400.

<sup>10</sup> Charles Rosenberg, "And Heal the Sick: The Hospital and The Patient in The 19th Century America," Journal of Social History (hereafter JSH) 10 (Summer 1977): 428.

<sup>11</sup> S. E. D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada," in Medicine in Canadian Society: Historical Perspectives, ed. S. E. D. Shortt (Montreal: McGill-Queen's University Press, 1981), pp. 8-9. This list of possible research areas was echoed in Berlin, "Northwestern Memorial," p. 334.

<sup>12</sup> Shortt, "Historiographical Lament," p. 4.

<sup>13</sup> Janice P. Dickin McGinnis, "The White Plague in Calgary: Sanatorium Care in Southern Alberta," Alberta History 28 (Autumn 1980): 1-15. The account of her experiences with the records themselves is found in "Records of Tuberculosis," pp. 173-88.

<sup>14</sup> Shortt, "Historiographical Lament," p. 10.

<sup>15</sup> Raffel, Matters of Fact, p. 82.

<sup>16</sup> Brown, "'Architecture as Therapy'," pp. 99-123.

<sup>17</sup> Hunter, "Psychiatric History," pp. 10-11.

<sup>18</sup> Craig and Dodds, "Picture of Health," p. 192.

<sup>19</sup> Canadian Medical Archives, pp. 19-21.

<sup>20</sup> See, for example, Robin G. Keirstead, "The Canadian Military Medical Experience During The Great War, 1914-1918 (M.A. Thesis, Queen's University, December 1982), p. 97.

<sup>21</sup> See, for example, Peter Robertson, "The All-Penetrating 'X,'" Archivaria 10 (Summer 1980): 258-60.

<sup>22</sup> See, for example, L. S. McClung, "Oral History for Archives of the American Society for Microbiology," American Society for Microbiology News 35 (April 1969): 24-26; and Manfred J. Wasserman, "Manuscripts and Oral History: Common Interests and Problems in the History of Medicine," BMLA 58 (April 1970): 173-76. A recent oral history project initiated by the Hannah Institute has recorded a series of interviews with senior staff

members of the Medical Faculty of the University of Toronto. The tapes and transcripts were transferred to the Public Archives last summer. The latter are to be found in MG 28, I 406.

<sup>23</sup> Herbert Finch, "New York Medical Archives in Upstate Area," New York State Journal of Medicine 71 (June 15, 1971): 1555.

<sup>24</sup> See comments in Thomas, "Contributions to Medical History," p. 98.

<sup>25</sup> Prompted in part by the growth of sociological research into the development of the various professions, particularly but not exclusively in the United States, the 1970s and early 80s have witnessed the publication of a number of works on the evolution of medicine and the emergence of a strong, independent profession. Influential American books include Eliot Friedson, Profession of Medicine: A Study of the Sociology of Applied Knowledge (1970) and William Rothstein, American Physicians in the Nineteenth Century: From Sects to Science (1972). An example of a more recent Canadian effort is R. D. Gidney and W. J. P. Millar, "The Origins of Organized Medicine in Ontario, 1850-1869," in Roland, ed. Health, Disease and Medicine, pp. 65-95.

<sup>26</sup> Colin D. Howell, "Elite Doctors and the Development of Scientific Medicine: The Halifax Medical Establishment and 19th Century Medical Professionalism," in Roland, ed. Health, Disease and Medicine, pp. 105-22.

<sup>27</sup> Blouin, "Appraisal of Business Records," p. 71.

<sup>28</sup> Quoted in Newman, "Medical Records," p. 8.

<sup>29</sup> Turner and Mapa, Humanizing Hospital Care, p. 79.

<sup>30</sup> Wendy Mitchinson, "Gynecological Operations on the Insane," Archivaria 10 (Summer 1980): 140. On the general utility of case files for social history see G. J. Parr, "Case Records as Sources for Social History," Archivaria 4 (Summer 1977): 122-36.

<sup>31</sup> See, for example, the discussion in Chad Gaffield, "Theory and Method in Canadian Historical Demography," Archivaria 14 (Summer 1982):

127-29.

<sup>32</sup> Gabriel Désert, "Une source historique trop oubliée: les archives hospitalières," Gazette des Archives (hereafter GA) 94 (1976): 152.

<sup>33</sup> Sigsworth, "Gateways to Death?" pp. 97-110.

<sup>34</sup> W. Peter Ward and Patricia C. Ward, "Infant Birth Weight and Nutrition in Industrializing Montreal," American Historical Review 89 (April 1984): 324-45.

<sup>35</sup> J. M. Winter, "The Preparation of an Archive of Medical Disablement Records of Pensioners of the First World War," c. 1983 (Typewritten), p. 8.

<sup>36</sup> Kerling, "Hospital Records," pp. 182-83.

<sup>37</sup> Joan Sherwood, "The Archives of the Inclusa," Archivaria 10 (Summer 1980): 69.

<sup>38</sup> William Smith, "A Medieval Archive from Trinity Hospital, Salisbury," Archives 16 (April 1983): 41-42.

<sup>39</sup> Elisabeth Wittman, "The Historical Records and Archives of the University of Illinois at the Medical Center," JL 63 (April 1981): 342.

<sup>40</sup> Burns, "Archives and Public Affairs," p. 336.

<sup>41</sup> Vancouver General Hospital, After The Wild Wind (Vancouver: VGH, 1966), p. 32.

<sup>42</sup> Cited in Sherwood, "Archives of the Inclusa," p. 71.

<sup>43</sup> See chart in Désert, "Les archives hospitalières," p. 157.

<sup>44</sup> See S. E. D. Shortt, "The New Social History of Medicine: Some Implications for Research," Archivaria 10 (Summer 1980): 9 and Gerald N. Grob, "The Social History of Medicine and Disease in America: Problems and Possibilities," JSH 10 (Summer 1977): 391.

<sup>45</sup> See comments in Estelle Brodman, "Preface to the First Edition," in Archives Procedures Manual, 2nd rev. ed., p. ii. Washington University School of Medicine Library. St. Louis: WUSML, 1978.

<sup>46</sup> Berlin, "Northwestern Memorial," p. 334; and Burns, "Archives and Public Affairs," p. 336.

<sup>47</sup> In addition to the various branches of history, some of the disciplines most likely to benefit by access to medical or hospital archives include public administration, political science, geography, psychology, sociology, anthropology, architecture, engineering, and economics. There are probably many others. This list is drawn from Margaret Dunn, "The Medical Archives Inventory Project," in Science, Technology, and Canadian History, ed. Richard A. Jarrell and Norman R. Ball (Waterloo: Wilfred Laurier University Press, 1980), p. 205; and Philip D. Jordan, "The Challenge of Medical Records," AA 23 (April 1960): 146.

<sup>48</sup> See Carswell, Lion's Gate Hospital, pp. 100-01.

<sup>49</sup> Interview with Sue Baptie, City Archivist, City of Vancouver Archives, Vancouver, B.C., March 5, 1985.

<sup>50</sup> Kerling, "Hospital Records," p. 182.

<sup>51</sup> "Social Research and Privileged Data," Valparaiso University Law Review 4 (Spring 1970): 372.

<sup>52</sup> Sherwood, "Archives of the Inclusa," p. 72.

<sup>53</sup> Consultative Group on Canadian Archives, Canadian Archives, p. 105.

<sup>54</sup> Finch, "New York Medical Archives," p. 1553.

<sup>55</sup> Steinberg, "Social Research Use," p. 255.

<sup>56</sup> The need for an awareness of these potential demands is emphasized in Mitchinson, "Gynecological Operations," p. 129.

<sup>57</sup> Margaret Angus, Kingston General Hospital: A Social and Institutional History (London: McGill-Queens University Press, 1973), "Preface."

<sup>58</sup> Gardner, "Commentary II," p. 295.



## Chapter Four

## ESTABLISHING HOSPITAL ARCHIVES

While it is fine to speculate on the divergent uses to which hospital archives might be put, it is another matter to decide how and where the repository should be established, to say nothing of how it should be funded. Depending on the specific needs of the institution and the perceived value of the archival services, various options are available. While external uses should be borne in mind, few hospitals can be expected to develop programmes which go much beyond their internal requirements.<sup>1</sup> However, all archives should be based on a proper conception of the advantages to be realized from a formal archival and records management programme. Unfortunately, many of those responsible for hospital archives are evidently unaware of this important relationship. As a result, their repositories are not efficiently meeting the real archival needs of the institution.

Perhaps the most basic requirement in setting up a hospital archives is formal recognition from the administration. Without entrenching the archives within the organization and clearly defining its mandate, future development will be at best haphazard and many of the potential benefits will be missed. The archives, like other hospital departments, will only be productive to the extent that it receives support.<sup>2</sup> Barbara Craig recently lamented the fact that most hospital archives "survive on sufferance" and that very few have "an official de jure existence within the hospital's administrative structure."<sup>3</sup> It is vital that the status of the archives be officially entrenched in the by-laws or equivalent governing regulations of

the hospital.<sup>4</sup> As part of the legitimizing process, a mandate should be formulated, detailing the objectives and responsibilities of the archives. As well, some form of Archives Committee should be set up to advise the administration on archival matters and assist in planning and carrying out specific programmes. For an example of a draft hospital archives mandate see Appendix E.

As emphasized by MacLeod and others, it is particularly important that this mandate "establish the archival function as independent from any particular incumbent."<sup>5</sup> Too often, particularly in hospitals it seems, archives exist on an unofficial basis because some employee is interested in history. Even where more formal recognition exists, the dependence of the archives on one or two individuals is a dangerous precedent to set. At the Kingston General Hospital, for example, a recent change in senior administrative personnel, coupled with the retirement of the archives' most stalwart defender, led to questioning of the maintenance and, at one point, the very survival, of a valuable collection.<sup>6</sup> The enthusiasm of individuals is important in fostering initial interest in archives, but this alone cannot support it for long. Professionally trained archivists should be incorporated into the regular staff of the hospital.

Once the mandate is set out, a more precise policy and set of operating guidelines or regulations is required. The specific contents of a hospital's archival policy will depend on the needs and resources -- to say nothing of management commitment -- of the particular institution. However, like other branches of the hospital, it should reflect thoughtful planning.<sup>7</sup> In all cases, several questions should be addressed before any action is taken. These relate to the apparent level of interest, anticipated

use (type, source, and volume), records to be included (and excluded), nature and location of currently held archival material, type of external acquisitions (if any), services to be provided, availability of facilities, level of administrative support (moral and financial), relationship to other departments, and so forth.<sup>8</sup> In addition, the position of the archives within the hospital hierarchy should be considered. In the business world, archives have traditionally existed "in a variety of locations in the organizational chart."<sup>9</sup> The strength of the archival function will be determined by the degree of autonomy and the ability of the archivist to report to senior officials. As Gardner has warned, without such access and status, "the archivist and the archives will be viewed as peripheral to the ongoing concerns of the organization, and thus neither indispensable nor justifiable by any criteria."<sup>10</sup> Burying the archives within a specific department is not in the hospital's best interests. Consideration of these and related matters before any actual acquisition or processing begins, will help in the development of a solid foundation on which all subsequent activity will be based. Either as part of the general policy or as a detailed set of regulations, having these concerns formally addressed will help put the archives on a stable footing.

As part of the policy formulation process, it may prove necessary to ensure that hospital personnel involved with the archives are familiarized with archival procedures as well as the types and values of the material involved. As we have seen, the general impression of what constitutes archives may fall short of the mark. More than one observer of hospital archives has commented on the need for advice and assistance from those trained in archival matters.<sup>11</sup> This lack of understanding, as Craig has

observed, is not limited to hospitals apathetic or antagonistic toward the development of archives:

Even in the rare instances where strong management commitment has led to financial and administrative support for archives, too often this interest is devoted to antiquarian material. The old photograph or artifact, the yellowing scrapbooks of newspaper clippings, the hospital genealogies in the form of staff and student lists -- these are sent to the archives while the unique, substantive, institutional records, often repetitive and usually voluminous, are ignored as too common, too problematical or too lacking in *curiosa* value. Such quixotic archives arrangements are a danger to scholarship.<sup>12</sup>

Such collections, one must add, are also of little value to the hospital itself.

The development of sound and effective archival policy within a hospital depends to a great extent on what Francis Blouin has called a "coalition of interests."<sup>13</sup> All those potentially involved in the archival operation, be they administrators and department heads or members of the hospital auxiliary historical society, should be involved in the discussions. In this way general agreement on the nature of the archives and its various services can be achieved before work commences. After the archives is formally established, it is also important that this support be maintained. The efficiency of subsequent archival service will influence the degree of cooperation from the rest of the hospital community.<sup>14</sup>

One of the primary policy decisions involves the question of what hospital records should be destined for the archives. Although initially appearing rather straightforward, this can be exceedingly complex. In theory, the archives should encompass all records; in practice, the status

of the medical records merits special consideration. While clinical photographs and other supporting documentation may find their way to the archives, patient files may not. Due to their medical importance, the desire to maintain confidentiality (of which more will be said later), and the common misconceptions of what archives actually are, these records are often treated as a completely separate entity. The inactive administrative records may go to the archives, but the old medical records stay in the medical records department. Thus most hospitals have the potential for, or in fact have already established, what amount to two separate archives -- one relating to the foundation and development of the institution itself and the other comprising all the information on patient treatment.

At Vancouver's St. Paul's Hospital, for example, all patient files are maintained in the extensive medical records department. As it is a teaching hospital involved in clinical research, all of the files are now earmarked for permanent retention in either textual or microfilm format. The records are virtually complete back to the 1930s.<sup>15</sup> The St. Paul's Archives, on the other hand, is currently in what may best be termed an embryonic phase of development, but the emphasis is clearly on only the old administrative records of the hospital, personal papers, and a large assortment of artifacts and memorabilia. There is no evidence that patient files will be included within the mandate of the archives.<sup>16</sup> In similar fashion, all the records held in the archives of Chicago's Northwestern Memorial Hospital are non-clinical. Any patient files discovered during the processing of historical material are immediately returned to the medical records department, apparently regardless of their

age.<sup>17</sup> This is the most common practice in hospital archives. Indeed, of the 131 non-government hospitals listed in the recently published Directory of Medical Archives in Ontario, only two indicated the presence of what can be considered formal patient files, although a further twelve held the older and less detailed admission and discharge registers.<sup>18</sup>

Of those hospitals that do contain patient files, most are by no means systematic in their acquisition. The extensive archives of Kingston General include little more than one small box containing examples spanning the period 1927-55. The rest of the patient files, both current and inactive, have remained in the medical records department.<sup>19</sup> In contrast, the archives at the New York Hospital-Cornell Medical Center has extensive records concerning patients dating from 1791 through to 1932. Since then, representative samples of inactive patient files have been regularly transferred to the archives.<sup>20</sup> This arrangement, while appealing to archivists and researchers, is admittedly uncharacteristic. Nonetheless, it does indicate that the combination of both types of records in a single hospital repository is possible.

Given the obvious division between hospital administrative and medical records, policy should address their relationship as regards the archives. It is of vital importance that a precise determination of the timing of transfer of patient records be made. The current practice of separating the two types of records needs to be re-examined.

From a practical point of view, once the various clinical and related uses of the medical records have passed there is no reason why they cannot be transferred from the medical records department to the archives. Authorities rightly decry the decentralization of medical

records which are needed for patient treatment.<sup>21</sup> However, by their own admission, beyond a certain period (15 to 25 years) these records normally cease to have any regular clinical treatment value. Clearly at this point they no longer fit into what Terry Eastwood has termed "the ambience of current medical/patient records administration."<sup>22</sup> Whether retained for administrative reference, or for social science and historically oriented medical research, these records are better suited for inclusion in the archives, rather than the medical records department. At this point the archivist, by virtue of his or her training and outlook, is best prepared to care for these records and also assist other staff members in retrieving desired information. In all cases, however, the archives and medical records staff members should continue to maintain close ties.<sup>23</sup>

Hospitals intending to establish an archives also face a number of alternatives with regard to size and scope. All of the considerations enunciated above will influence actual requirements. Each hospital should be governed by its own situation, although the experiences of other institutions can be instructive.

Once policy matters have been decided, the next consideration is normally the physical facilities needed by the archives. While there are space savings to be realized from records management, these are normally cumulative, drawing on the small savings in a number of offices and storage rooms. For an archives to best serve the hospital, it is desirable to centralize the entire operation, thereby maximizing efficiency and lowering overall costs. Sufficient space is needed for both current or anticipated holdings and future expansion. Work areas and research facilities will also be required. The space allocated should conform as

closely as possible to the minimum acceptable environmental standards. Often, hospitals find that combining the records center and archives minimizes the total space committed to the archives function without disturbing operations. From a practical archival standpoint this could well be the best arrangement, although the permanent archives should be separated from the other records stored therein.

Some hospital archives are quite large. The Northwestern Memorial Hospital Archives comprises some 3800 cubic feet of records.<sup>24</sup> The New York Hospital-Cornell Medical Center Archives takes up most of the 25th floor of the complex, occupying some 5600 square feet. Included are an office, reference and processing rooms, and a storage area, the latter containing 2700 square feet of stacks, or approximately one linear mile of shelving.<sup>25</sup> Admittedly, these are extremely large hospitals, and archival operations of this magnitude are rare. Most institutions operate with far less space, particularly where the archives is combined with another facility. Whatever the size of the operation, however, the physical space requirements need to be considered before archival activity commences.

All decisions on the scope of hospital archives are ultimately dependent on the financial resources available. While an examination of financial and economic matters may initially seem out of place, it is actually central to the establishment of archives, in hospitals and elsewhere. Indeed, as Thomas Flanagan asserted in the Summer 1979 issue of *Archivaria*, "archives are economic institutions because they use scarce resources -- land, capital, labour, and raw materials -- to achieve human objectives."<sup>26</sup> These are all resources which can be used elsewhere in the institution. Their use for archives must be justified.



Although records management can lead to some savings in this regard, it would be a mistake to conclude that the establishment and maintenance of a properly functioning archives will not lead to some additional costs. Facilities, supplies, and personnel must be provided. If a full scale operation is envisioned, as it should be, these can require a rather sizeable investment, particularly if properly trained staff is hired. While this will pay long term dividends, the immediate and annual costs must nonetheless be addressed. Given the current financial situation of most hospitals, with budgets strained to meet existing operating requirements,<sup>27</sup> the source and type of funding is no small factor to be considered as part of the policy towards the archives.

Even under ideal economic circumstances it is often difficult to persuade administrators to allocate money for archives. Part of this undoubtedly stems from the fact that while archives incur real costs, their benefit to the institution is very often impossible to define adequately in monetary terms. This is not a new problem for archives nor, in fact, a situation new to the hospital. Commenting on the public relations experience in hospitals, Lee Block and Elliott Taylor illustrate the conundrum which also faces the archivist:

We must dispel the lingering suspicion that dollars spent on public relations are questionable expenditures by demonstrating that the function can indeed directly serve the patient's interest. It has been said that one of the reasons public relations in hospitals has been slow to receive acceptance is because it deals with intangibles, that it cannot provide quantifiable results to the administrator who is required to be strictly accountable for every hospital function. Perhaps those same circumstances may account for the fact that while we are now seeing a growing acceptance of the *idea* of public

relations in hospitals, we have yet to see it even begin to approach any realization of its full potential.<sup>28</sup>

Clearly this sentiment is equally applicable to archives in hospitals, including the final comment about not realizing its full potential. While some of the benefits of archives, particularly those associated with records management, may be expressed in terms of financial savings on office space or filing cabinets, most cannot. How, for example, does one place a dollar value on the immediate availability of needed information? Arguably, one can quantify staff time wasted retrieving poorly filed items. However, it is impossible to make such calculations if the records are irretrievably lost because there is no archives. Once records are gone, no amount of time or money is likely to restore them exactly as they were.

Most hospital archives exist on what may be termed "shoestring" budgets. At St. Paul's, for example, the administration provides only the physical facilities. Most of the work is carried out by volunteers and supplies are purchased from monies provided by the Nurses's Alumni and Medical Staff funds. Future expenses are expected to be met through fund raising activities.<sup>29</sup> Many other hospitals follow similar patterns, although some lack even the very basic staff funds on which the St. Paul's Archives largely depends. While these arrangements may be suitable for the maintenance of small archives of museum or antiquarian character, they do not permit the attainment of proper archival services and benefits. For one thing, the body most likely to reap such benefits -- the hospital -- shoulders little or none of the cost.

Some institutional archives, including those in hospitals, depend on

various public or private grants for their operation, if not their very existence. Most of these grants, like those administered by the Social Sciences and Humanities Research Council of Canada, are funded by the various levels of government. They, like a number of other heritage conservation grants, are usually intended for a specific purpose and are seldom renewable beyond a set term. Dickin McGinnis' work in the records of the Baker Sanitorium in Calgary was financed in this way under the Canada Council Explorations Programme.<sup>30</sup>

While useful for particular, limited projects, such grants cannot be seen as the sole basis for archival existence. Indeed, when used as such they can amount to a waste of money as the short term benefits that may accrue from the project are left behind to gather dust once the grant expires. Worse, such grants often become, in the words of H. G. Jones, "a crutch for the lethargic and crafty."<sup>31</sup> It is unfortunate that in this way many grants have actually hurt the cause of archives, undermining, as they do, the responsibility of the sponsor to support the archives.<sup>32</sup> As Frank Burke has cautioned, "we must realize that we cannot sustain progress by taking handouts for narrow, specific purposes. Financial planning begins at home."<sup>33</sup>

Despite the shortcomings, grant money can play a role in financing the establishment of hospital archives, but not in the manner described above. "Seed" grants to help set up an archives, but which are forthcoming on the stipulation that the institution take over the operation once it is firmly established, are a useful source. The hospital administration will be required to commit itself to the archives, but it will not have to start paying the bills immediately.

Rather than condemning archives to dependence on such uncertain sources of funding, it is a virtual necessity that the hospital administration shoulder most, if not all, of the financial burden of operating its repository. In this way, the archives will be more able to become an integral part of, and contribute to, the operation of the hospital. If the administration is paying the bills it is more likely to take an active interest in, support, and, perhaps most importantly, make effective use of, its archives. This relationship between the institutional archives and its "employer" has generally been recognized within the archival community. In its 1980 report, the Consultative Group on Canadian Archives stated categorically that "all archives must depend for their continuing core funding on their parent body."<sup>34</sup> The hospital is no exception.

Such a situation, however, presupposes that money is available within the hospital. Arguably it is, but actually getting it for the archives is an extremely difficult task. Indeed, for the foreseeable future, the central challenge in establishing proper hospital archives may well be locating the necessary funds. The annual budgets of most large hospitals run into the tens of millions of dollars, and yet little, if any, is available for such "peripheral matters" as archives. The annual budget for St. Paul's is just over \$71,000,000 and yet, as noted above, its archives is supported by donations and staff funds. The Vancouver General Hospital is spending more than twice that amount -- \$169,000,000 -- during the 1984-85 fiscal year.<sup>35</sup> Despite this, VGH has no formal archives and the small number of records transferred to the City Archives are dealt with at the latter's expense.<sup>36</sup>

Not surprisingly, given the financial strictures under which these

institutions operate, there is very little money available for the traditional historical research archives. Hospitals which are laying off nurses are not likely to turn around and hire an archivist whose sole responsibility is to arrange and describe records for the few researchers who may wish to write a history of the institution. Approaches to administrators in support of such archival operations seldom yield positive results. Even when proponents present sound arguments emphasizing the various administrative, operational, and even financial benefits associated with archives, the crux of the matter of establishing the repository returns to issues of dollars and cents. It is therefore necessary to examine the various sources of money that may be available.

In Canada, hospital funding is virtually dominated by government. Ottawa pays the major portion of all hospital bills through the transfer of income tax points and direct cash contributions to the provinces. With the passage of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act in 1977, the responsibility for actually administering the system of health and hospital services shifted from the federal government to the provinces and territories.<sup>37</sup> Thus it is the provincial government that has direct control of hospital funding. While specific hospitals may have various opinions as to the relative value of archives, the provincial government is the central body which could be lobbied in support of sponsoring hospital archives. Changes to existing laws or regulations could be undertaken in support of hospital archives. Tax credit schemes have been suggested as a means of rewarding businesses that establish and maintain corporate archives. While hospitals do not pay the equivalent of tax, some financial incentive,

perhaps as a direct grant to defray administrative costs, could be instituted. The recent legislation passed in Québec, by which every publicly funded institution -- explicitly including hospitals -- must make provision for the archival retention of records is an example of what could be accomplished.<sup>38</sup> In a single step the retention and effective use of hospital archives would be much closer to a realization.

Certainly a legal obligation to establish and maintain hospital archives, complete with a specific mechanism for funding, is the ideal approach to take in ensuring the retention of the permanently valuable records. However, if this type of legislation is not backed with some financial arrangement, either in the form of permission to use part of the regular budget or as a separate fund, it will not automatically lead to the preservation of hospital archives. At present, the financial details of the Québec act remain unclear, and it may well be some time before the real implications of the legislation are apparent for hospital archives.

In most provinces such a situation is not likely to exist for some time, if ever. Other methods must be tried. Supporters of archives can petition the administration to earmark part of the hospital's global budget for the retention and preservation of its records. Under the global budgeting system, hospitals which have established "a level of approved experience" are assigned a sum of money for use in implementing various projects or programmes. Although guidelines are given along with the money, the hospital administration can modify the specific programmes provided the budget is not overspent. As long as the programmes funded in this way can be justified, the hospital has the freedom to allocate a portion of its budget as it sees fit.<sup>39</sup>

This is the route currently being investigated at the Kingston General Hospital which, for the 1984-85 fiscal year, has an operating budget of \$68,000,000, with an additional \$9,435,000 earmarked for education.<sup>40</sup> As Sylvia Burkinshaw noted in late 1982, the success of this bid for more secure funding for the archives from the global budget hinges on "potential users [being] supportive of giving it sufficiently high priority in the overall hospital rating of all the departments."<sup>41</sup> The only way such a situation is likely to arise today is if the archives provides a full range of functions. If not, it will never be supported to the extent that its funding takes priority over that of other departments. While some hospitals support small, traditional archives, the total funding does little more than cover basic expenses and it does not make a direct contribution to the operation of the hospital. In this situation, it probably cannot be considered money well spent.

As to the formal establishment of the archives within the hospital, available resources and projected requirements will dictate its nature. The most complex arrangement is the hospital equivalent of "total archives" with all administrative and inactive patient records, as well as related collections of personal papers, regardless of media, consolidated in one large repository under one set of personnel. The addition of the latter collections is in keeping with the general belief, enunciated by the Association of Canadian Archivists in their 1978 response to the Symons Report on Canadian Studies, that "where possible, the functional records of an organization should be augmented by the private records of the individuals associated with that organization."<sup>42</sup> In the case of a hospital, the personal papers of former medical staff members and

administrators are obvious examples. In some instances, the papers of particular patients might also be considered for inclusion if they relate exclusively to their experiences when hospitalized. These collections, some of which might otherwise be split up or irretrievably lost, are invaluable for the presentation of a true picture of hospital life and practice.

If set up in this fashion, such a facility would constitute one of the most important resource centers for reference and research within the institution and it would be well suited to serving the various administrative and operational requirements of the hospital. With the addition of private papers and other acquisitions related to the hospital and local medicine in general, this type of archives would also meet the needs of a wide range of external users.

While this arrangement might be ideal as far as archival and research interests are concerned, it is questionable whether more than a few hospitals would be willing to undertake such a project. In most cases, the reality of hospital archives dictates something less. Realistically, the best one can and should hope for in most hospitals would be a well-rounded archival programme designed to meet the specific requirements of the administration. Few hospitals are in a position to concern themselves specifically with providing much more than the minimum for external research. This is not to say that the situation described above should not be borne in mind as an ideal to be worked toward. In the meantime, access to that which is preserved for internal reference would still be a great boon to scholarship. It is unlikely, if the archives is provided with proper facilities, that external researchers will



present a real burden.<sup>43</sup>

It is not necessary for every hospital to have a full archival programme incorporating materials other than institutional records. If a few strategically located hospitals preserve this type of collection, of specific value to external researchers, the rest can concentrate on retaining smaller archives intended primarily for internal use. This would avoid unnecessary duplication of collections of private papers and other records not central to the operational and administrative needs of the institutions. The need for cooperation and coordination in this regard is apparent, and it could be incorporated into the existing framework of government regulation of the health care field, perhaps linked specifically to funding arrangements for designated hospitals.

Both administrative and medical records should be included in the archives, although the extent to which the latter are retained may well depend on how many other institutions of similar size and type (such as acute, chronic, or extended care) have preserved this type of collection. All hospitals need some type of archives to meet their internal administrative and operational requirements. However, not all require large collections of medical records for research. These records are normally disease or illness specific, not institution specific. Here again, some form of coordination, to be discussed later in both this and a subsequent chapter, would be required. The retention of some of these records is a necessity, but the repetition of several such collections, especially in a small geographical area, is not.

Unfortunately, despite the apparent logic of the arguments advanced above, the most common archival arrangement in Canadian hospitals

continues to be based on a strict division between medical and administrative records. This is primarily the result of considerations of efficiency and confidentiality. Hospital administrators are apparently more comfortable with all medical records centralized in a single department under what they perceive to be proper care, no matter what their age. That an archives can provide a similar level of care and service is not always recognized. In many hospitals where archives have a low priority, this division reflects the belief that patient files are vastly more important than some assortment of old records and papers. If the archives is only a passive repository for items deemed by someone to have "historical value," rather than part of an efficient records and information management programme, such a conclusion is entirely appropriate.

If separated from the inactive medical records, a hospital archives can still take a number of forms. In a large hospital with an effective records management programme, the volume of administrative records and associated work is more than sufficient to devote extensive space and funding to the archives, as well as hiring properly trained staff, including an archivist, either as a full time employee or on a long term contract.<sup>44</sup> If this is not the case, the use of a consultant, particularly one hired to establish the archives, may suffice. One must be careful, however, to check the credentials of those presenting themselves as consultants. The profession is still sufficiently undeveloped that almost anyone with some type of historical or library background can "sell" themselves as freelance archival and information management consultants. Advice may also be solicited from existing archival repositories in the vicinity of the hospital.<sup>45</sup> It is important to remember that any arrangement which falls

short of establishing a full service repository with a professional archivist on staff is less than ideal and one which will not yield the maximum results for the hospital.

Despite this fact, the majority of Canadian hospitals, or at least those that have archives, have opted for arrangements less complete than those described above. A number have archives operated by the members of voluntary organizations. As noted previously, the St. Paul's Archives functions mainly through volunteer interest. Perhaps surprisingly, the archives of Toronto's large and prestigious Hospital for Sick Children, which comprises records dating from its foundation in 1875, is in a similar situation. Organized by the Hospital Women's Auxiliary, it is staffed by four volunteers.<sup>46</sup> In both cases, these volunteers are servicing what are essentially antiquarian collections.

Some hospitals have set up small archives as part of other departments, such as public relations or administrative services. This common practice was recommended as one alternative by Moulds in Dimensions in Health Service.<sup>47</sup> As noted earlier, this type of arrangement can severely limit the scope and effectiveness of the archives. In other institutions, the archives is seen as appropriate to locate with, if not actually function as part of, the museum.<sup>48</sup> Normally this indicates that the records and other items contained therein are intended for display purposes only and that the archives is completely divorced from the actual operation of the hospital.

In a large number of cases, the library is seen as the most appropriate home for the archives, unless the volume of records involved necessitates otherwise.<sup>49</sup> Such an arrangement is, initially at least, perhaps not all

that surprising when the archives is seen an information reference source -- what better location than the library which serves the entire institution. This opinion is supported by contemporary medical library literature which emphasizes that "archival materials form an important part of the library's collection."<sup>50</sup> In some cases the purely historical holdings of the archives are grouped with the library's special collections.<sup>51</sup> While useful in preserving the research component of archives, this practice does not facilitate effective records management nor does it always assist hospital administrators in the ways a formal archives can. As well, having the archives function as "a creature of the library," as Barbara Craig once put it, does not permit easy and unimpeded access to senior management and sources of continued funding.<sup>52</sup> An archives that starts out in a library may eventually develop as a separate repository in its own right, but until then it will exist as but one part of a larger department. Under such circumstances it will not be able to provide the complete range of services that would be forthcoming from an independent body designed specifically to meet the records and information management needs of the hospital.

Some hospital "archival operations" are decentralized to the point where very little, if anything, is held by a central repository. Instead, lists of the important records that are located in the various branches and departments are compiled and used for reference.<sup>53</sup> While admittedly the records are identified, such an arrangement does not represent an archival function in the true sense. The benefit to either the hospital administration or the research community is all but negated by difficulty in locating, retrieving, and then using the records, as well as ensuring

their preservation.

Under certain circumstances, external resources may merit consideration with regard to the location of the archives, although once again any such arrangement will diminish the potential benefits to be realized from a proper internal archives. If a hospital cannot afford or lacks sufficient space and expertise to establish its own archives, the services of a nearby repository may be canvassed, for either temporary or permanent deposit of some of its records. This should not, however, absolve the hospital from its responsibility to establish or maintain its archives. Nor should such a decision be made without careful consideration of the effect it will have on both the nature and utility of the records earmarked for retention. Offsite storage, particularly that which is located some distance from the hospital, militates against the regular use of the records for administrative and operational needs.

The Public Archives of Canada or the various provincial archives could be contacted about such an arrangement, although not all are conveniently located as far as many hospitals are concerned.<sup>54</sup> Regional or local repositories, such as university or municipal archives, are often better suited to hospital requirements. The City of Vancouver Archives holds records from two local hospitals, Royal Columbian and Vancouver General. In the case of the latter, certain record series are transferred on a regular basis.<sup>55</sup> Calgary General Hospital has deposited some records at the Glenbow Archives and, as has been mentioned, Kingston General makes use of the facilities at Queen's University. In the latter instance, the transfer is viewed as a temporary expedient, as it is hoped that funds will become available for the development of a larger internal archives.<sup>56</sup> The

advantages of such an arrangement for both the hospital and external researchers are obvious, particularly in terms of proper facilities and staff.

However, the use of external facilities presupposes that the repository in question wants or has room for the records of the hospital. This may not be the case, particularly as acceptance of hospital records places a heavy burden on the external archives to continue caring for and storing the large volume of records produced. As well, those records containing restricted material can present administrative problems regarding access when located away from the creating agency. The expenses incurred by the host repository can also be considerable. Some type of cost sharing arrangement may have to be devised, requiring the hospital to cover at least a portion of the total amount, before a transfer would be permitted. In Vancouver, the City Archivist has indicated that she would be more than willing to transfer the Royal Columbian Hospital collection to either the provincial archives or back to the hospital itself, as long as she was assured that the records would be properly cared for.<sup>57</sup>

Indeed, there is a small but growing belief that archivists have a responsibility to refuse such requests if, in their opinion, the institutions involved are capable of caring for their own records. Following in the wake of the Wilson Report, which called for existing repositories to foster the development of institutional archives, archivists such as Kent Haworth, recently appointed to the University of Toronto, have considered it their professional duty in such instances to prod the institutions to care for their own records.<sup>58</sup>

Another potential complication is the matter of proximity. The

Queen's University archives is situated just across the street from KGH, but many hospitals are far less fortunate. A suitable repository may not exist within a radius of several hundred miles. This fact alone could have a rather dramatic influence on the nature and volume of the material transferred. Records used by the hospital for research and reference on a regular basis would undoubtedly be retained in the hospital. In addition, while administrators might agree to internal movement of inactive patient files it is less likely that they would accept their transfer out of direct hospital custody. This means that the records sent to the external repository would have little value to the hospital itself. Such is the case with most of the Vancouver General records now located at the City Archives. City Archivist Sue Baptie estimates that in the past decade less than a dozen separate reference requests have been forthcoming from the hospital, almost half of which were carried out by her staff.<sup>59</sup> In such instances, these collections cease to have real value to the hospital. While they are useful for external research, the records that are needed by the institution remain within the hospital, in effect creating a further divided archives.

Another factor worthy of consideration relates to the general belief that the inactive and historical records of a hospital should always remain with the institution itself. In the late 1940s, the British Hospital Association advocated that such material be retained in the hospital of origin rather than being put in a museum or similar institution.<sup>60</sup> More recently, Canada's archival profession reaffirmed its belief that in all cases the body creating the records should maintain custody.<sup>61</sup> As noted above, if these records are not retained in the hospital they will be of far

less use to the administration. In addition, they may be lost or at the very least scattered throughout a number of locations. The archives of the Toronto General Hospital is a case in point. Records are located in the Hospital itself, as well as at the University of Toronto, the Metro City Library, and the Archives of Ontario.<sup>62</sup> Such fragmentation hurts the institution and all those who may desire or, indeed, require access to the archives. While initially appearing to be an excellent alternative to an in-house operation, the external deposit of hospital archives is a matter for serious evaluation.

Another option, involving external resources to a limited degree, is the cooperation of two or more hospitals in the establishment of some form of regional hospital archives. Coordination of effort and the development of networks is not new to the archival community nor to the health care community. The current approach to this cooperation in the archival sphere is based on institutional type, such as church or university archives.<sup>63</sup> Such a practice could, circumstances permitting, be readily adapted to suit hospital needs. Particularly in urban centres, where several institutions operate in close proximity, the benefits are clear. Whether developed in one of the member hospitals or in a convenient central location, the cost and space savings could be considerable. A well-established archives in one hospital could attract other institutions which cannot maintain their own records but which would be willing to share costs in return for use of some of the facilities.<sup>64</sup> If no single hospital could afford a proper archives, the combined resources of several institutions could more easily provide both a properly trained archivist and the requisite facilities.



Such an arrangement would be beneficial for both administrative and medical records. The former would be preserved separately for each of the participating hospitals in order to permit rapid reference and retrieval. As for the latter, the repository could function as a centralized research facility for all types of medical record based investigation. Given that one large set of files could be preserved for this purpose, this would avoid the duplication resulting from each hospital preserving its own set of research files. Today many hospitals are involved in regional medical planning and networking in order to coordinate programs and avoid duplication of services.<sup>65</sup> This type of existing umbrella organization could provide the format for hospital archival cooperation.

It is obvious that, once established, hospital archives vary remarkably. In too many instances, the potential benefits deriving from a formal archives are not achieved nor, one suspects, really understood. Yet each of these archives reflects perceived needs, balanced against the limitations of space and dollars. While it is easy to be critical of these efforts, in most instances they represent a serious attempt -- ill informed though it may be -- to address archival issues and requirements. This, in itself, is significant. Once the interest is shown, progress can more easily be made towards the realization of an effective archival operation. The archival profession must become involved and assist hospitals in formulating specific policy for their archives. This is necessary in order to ensure that the existing archival effort is not wasted and that further effort is fostered.

Before any archival activity commences in a hospital, careful planning and preparation is required. The goals of the archives must be

defined in terms of specific requirements, and its permanent status within the institution must be assured. As well, in order for the archives to contribute to the hospital, it must receive continued support -- both moral and financial. If the archives is placed within the administrative framework of the hospital and if its operating policy reflects an understanding of its potential, it will function as an integral part of the hospital information system.

## Notes for Chapter Four

<sup>1</sup> See Colin Smith, "The Corporate Piper Calls the Archival Tune," Archivaria 18 (Summer 1984): 16.

<sup>2</sup> Bakken, "Corporate Archives Today," p. 285.

<sup>3</sup> Craig, Review of Directory, p. 106.

<sup>4</sup> On this point see Jerome O'Brien, "Archives and the Law: A Brief Look at the Canadian Scene," Archivaria 18 (Summer 1984): 41. For guidelines on how such by-laws could be implemented see the discussion of medical records and Medical Records Committees in Lorne E. Rozovsky and W. McKay Dunlop, Canadian Manual of Hospital By-Laws (Toronto: CHA, 1975), pp. 38-39, 44.

<sup>5</sup> MacLeod, "Waiting for the archivist," p. 25; see also Dunn, "Medical Archives Inventory Project," p. 203.

<sup>6</sup> After the retirement of Sylvia Burkinshaw and the arrival of new senior officials, the future of the KGH archives was questioned as part of a cost cutting programme. Interviews with Shirley Spragge; and Paul Banfield, Summer Records Survey Project Manager, Kingston General Hospital, Kingston, Ontario; both July 20, 1984. Indications now are that the archives will be preserved and may actually be expanded.

<sup>7</sup> Bakken, "Corporate Archives Today," p. 281.

<sup>8</sup> Martha Teach Gnudi, "Building a Medical History Collection," BMLA 63 (January 1975): 42.

<sup>9</sup> Bakken, "Corporate Archives Today," p. 284.

<sup>10</sup> Gardner, "Commentary II," p. 295.

<sup>11</sup> See Sears and Ailderidge, "Medical Records Conference," p. 554; and Dickin McGinnis, "Records of Tuberculosis," p. 188.

- <sup>12</sup> Craig, Review of Directory, pp. 106-07.
- <sup>13</sup> Blouin, "Appraisal of Business Records," p. 75.
- <sup>14</sup> See a similar sentiment expressed with regard to medical records departments in Donohoe, "Automation," p. 15.
- <sup>15</sup> Interview with Miriam Hunter, Director of Medical Records, St. Paul's Hospital, Vancouver, October 25, 1983.
- <sup>16</sup> Archives Steering Committee, Minutes, October 12, December 9, 1983.
- <sup>17</sup> Berlin, "Northwestern Memorial," p. 333.
- <sup>18</sup> Dunn and Baldwin, Directory of Medical Archives, pp. 93-119. In this particular instance, it should be noted that the low response about the presence of medical records may reflect the types of questions asked during the survey. Following the traditional archival approach to hospitals, it appears to have emphasized the identification of administrative records. Indeed, 42 of the 122 hospital responses were presented in the "Master Series List" format evidently used as part of the survey. As shown in Appendix B, this format focusses on administrative records.
- <sup>19</sup> Queen's University Archives, Kingston General Hospital Records, Finding Aid, September 1979, p. 28. See also Burkinshaw, "Kingston General Hospital's archives," p. 21.
- <sup>20</sup> Engle, "Medical Archives," p. 23.
- <sup>21</sup> Jean-Guy Fréchette, Access to Medical Record Information: The Legal Aspect, 2nd ed., trans. Jacqueline E. Kouri (Sherbrooke: Association québécoise des archivistes médicales, 1979), p. 66.
- <sup>22</sup> Terry Eastwood, to the author, April, 1984.

<sup>23</sup> In Quebec, archivists and medical records personnel have traditionally had closer ties than has been the experience in the rest of Canada. Indeed, in the fall of 1969, l'association des archivistes médicales de la province de Québec became an institutional member of l'association des archivistes de Québec [AAQ]. See Madeleine Berthault, "La nouvelle législation protège les patients des hopitaux," Archives [AAQ] 69.2 (juillet-décembre 1969): 11.

<sup>24</sup> Berlin, "Northwestern Memorial," p. 334.

<sup>25</sup> Engle, "Medical Archives," p. 23.

<sup>26</sup> Thomas Flanagan, "Archives: An Economic and Political View," Archivaria 8 (Summer 1979): 91.

<sup>27</sup> See, for example, Holly Horwood, "Hospitals stalled," Vancouver Province (hereafter Province), April 12, 1985, p. 3. This article appeared under the front page headline: "Restraint Clobbers Hospitals: VGH Hopes Dashed." In 1974 Harvey Agnew warned that rising costs were approaching the point where "the hospital system as we have known it is severely threatened." Recent experiences appear to be proving him correct. See Agnew, Canadian Hospitals, p. 173. See also footnote 35.

<sup>28</sup> Block and Taylor, "Public Relations Gap," pp. 249-50.

<sup>29</sup> Archives Steering Committee, Minutes, October 12, 1983.

<sup>30</sup> Dickin McGinnis, "Records of Tuberculosis," p. 176.

<sup>31</sup> H. G. Jones, "The Pink Elephant Revisited," AA 43 (Fall 1980): 480-81.

<sup>32</sup> See Ibid., p. 481.

<sup>33</sup> Frank G. Burke, "Archival Cooperation," AA 46 (Summer 1983): 304.

<sup>34</sup> Consultative Group on Canadian Archives, Canadian Archives, p. 62.

<sup>35</sup> CHA, Canadian Hospital Directory, pp. 27-28. These figures can be somewhat misleading, especially as St. Paul's is now anticipating a \$3.2 million deficit due to its annual increase falling behind the inflation rate; see John Doyle, "St. Paul's is ailing over budget shortfall," Vancouver West Ender, May 23, 1985, p. 1. In similar fashion, Vancouver General has had its budget cut to \$136 million, which is over \$40 million less than anticipated operating costs; see "VGH to abandon use of 200 beds in summer," Vancouver Sun (hereafter Sun), May 14, 1985, p. 38.

<sup>36</sup> Interview with Sue Baptie, March 5, 1985.

<sup>37</sup> Broyles, Working Capital in Hospitals, pp. 34, 42 ff.

<sup>38</sup> Jacques Grimard, "SAPHIR: Foundation for a Network of Public and Private Archival Services," paper presented at the Archives, Automation and Access Conference, Victoria, B. C., March 2, 1985.

<sup>39</sup> For a discussion of global budgetting in hospitals see Broyles, Working Capital in Hospitals, pp. 289-90.

<sup>40</sup> CHA, Canadian Hospital Directory, p. 74.

<sup>41</sup> Burkinshaw, "Kingston General Hospital's archives," p. 21.

<sup>42</sup> ACA, "Symons Report," p. 8.

<sup>43</sup> An emotional and, at times, acrimonious, debate has developed with respect to the function of institutional archives. Some see the archives as a branch of the organization with an obligation to meet its needs first and foremost. Others argue that institutional archivists have a professional responsibility to provide archival services to the public as a whole, no matter who is paying the bills. On the general debate see Anthony L. Rees, "Masters in Our Own House?" Archivaria 16 (Summer 1983): 53-59; Brian S. Osborne, "Masters in Our Own House: A Commentary," Archivaria 16 (Summer 1983): 60-61; and Smith, "Corporate Piper," p. 16.

<sup>44</sup> On the use of part time or contract archivists for hospital and

medical archives see MacLeod, "Waiting for the archivist," p. 31; and, as an example, "Special Collection Documents History of Psychoanalysis," BMLA 60 (July 1972): 502. The use of short term contracts is particularly advised for the preparation of inventories. On this point see Kingston General Hospital, "Report on Archives," pp. 4-5.

<sup>45</sup> See Alan D. Ridge, "Arranging the Archives of the School of Nursing of the Montreal General Hospital," JSA 3 (October 1968): 404. In this instance, the McGill University Archives was approached to assist Montreal General. In Quebec, where provincial legislation requires hospitals to preserve their own archives, the Archives Nationales also provides assistance when requested. Noted in Grimard, "SAPHIR."

<sup>46</sup> Toronto Area Archivists Group, Guide to Archives in the Toronto Area (Toronto: TAAG, June 1975), p. 37.

<sup>47</sup> Moulds, "Hospital archives," p. 40.

<sup>48</sup> See, for example, the brief discussion of records in Sandi Morton, "Alberta Mental Hospital of Ponoka Museum Collection," Museum Quarterly (Spring 1983): 35-36.

<sup>49</sup> See Annan, "Medical Library," p. 313; and Bakken, "Starting a Business Archives," p. 27. In the latter article, the archival programme within the library of St. Luke's Hospital, Kansas City, is briefly discussed.

<sup>50</sup> Lucretia W. McClure, "Reference Services: Policies and Practices," in Handbook of Medical Library Practice, 4th ed., ed. Louise Darling (Chicago: Medical Library Association, 1982), p. 161.

<sup>51</sup> See, for example, Sandra L. Chaff, "Archives and Special Collections on Woman in Medicine at the Medical College of Pennsylvania," BMLA 66 (January 1978): 55-56; and Wittman, "University of Illinois," p. 340.

<sup>52</sup> Barbara Craig, Review of Archives Procedures Manual, Washington University School of Medicine Library, Archivaria 3 (Winter 1976-77): 136.

<sup>53</sup> "Francis A. Countway Library of Medicine," AA 28 (October 1965):

605.

<sup>54</sup> See, for example, Provincial Archives of British Columbia, Royal Jubilee Hospital Papers, Add. MSS. 313, Finding Aid, n.d. The PABC hold various records and papers relating to a number of other hospitals.

<sup>55</sup> Interview with Sue Baptie, March 5, 1985.

<sup>56</sup> Burkinshaw, "Kingston General Hospital's archives," p. 21.

<sup>57</sup> Interview with Sue Baptie, March 5, 1985.

<sup>58</sup> See the sentiment expressed in Kent Haworth, "Welfare for Archives and the Will of Archivists," Archivaria 13 (Winter 1981-82): 124-26.

<sup>59</sup> Interview with Sue Baptie, March 5, 1985. The City Archivist estimates that in this period four requests were handled by her staff and another five by personnel from VGH.

<sup>60</sup> Dodd, "Hospital Contributory Schemes," p. 38.

<sup>61</sup> ACA, "Symons Report," p. 9.

<sup>62</sup> Dunn and Baldwin, Directory of Medical Archives, p. 116.

<sup>63</sup> F. Gerald Ham, "Archival Choices: Managing the Historical Record in an Age of Abundance," in Archival Choices, p. 136.

<sup>64</sup> Cavanagh, "Rare Books, Archives," p. 280.

<sup>65</sup> Agnew, Canadian Hospitals, pp. 97, 255.



## Chapter Five

## THE APPRAISAL OF HOSPITAL RECORDS

One of the most intellectually demanding archival functions deals with the appraisal of records to identify which are of permanent value. This, combined with the subsequent preservation of the records, is central to the success of any archival operation. All hospital records are not of equal value, to either the institution or the research community. It is for this reason that they require evaluation to determine which should be destroyed as soon as their current uses have passed, which should be retained in the records center (and for how long), and which should be destined for the archives. Arriving at these decisions is never an easy task, although it is one with which the archivist is best prepared to deal.

The retention of records, as recently retired Dominion Archivist Wilfred Smith once observed, is determined by use, and all records should be destroyed when they are no longer useful to anyone.<sup>1</sup> However, before such irrevocable action is taken, it is vital that all potential uses of the records be considered. Appraisal procedures and criteria are thus required as part of archives policy within the hospital. Those responsible for carrying out this appraisal need proper training, to say nothing of administrative support. If some form of records management is in place, or is to be implemented, archival records should be earmarked for permanent retention as part of the scheduling process. Regular transfer of these inactive records to the archives would then be facilitated.

Most records management programmes focus on streamlining current

and semi-active records handling. Less emphasis is placed on the permanent preservation of records with long-term value. In records management, the identification of the types of records existing in the institution is one of the first priorities. This is normally facilitated by a survey of existing holdings within the departments. Interviewing staff members producing or using the records helps determine which are necessary for administrative purposes. This information is used to prepare retention and disposition schedules. Schedules indicate: the total length of time each record should be kept, according to its value to the hospital; how long it should be kept active in the appropriate department and then in inactive or dormant storage in the records center; and, finally, its ultimate disposition, be it destruction, or transfer to the hospital's archives for permanent retention.<sup>2</sup>

When applied to the mass of administrative records produced by any modern institution, records management has been shown to reduce drastically the total volume while at the same time identifying and ensuring the preservation of those of value. Echoing numerous other archival authorities in his 1982 article "Hospital archives: necessity or frill?," Harold Moulds concluded that "only a small percentage of records (two to five percent of the overall total) will be identified as being of permanent value and be slated for transfer to the custody and control of the hospital's archives."<sup>3</sup>

If no formal records management programme exists, individual departments can be contacted in order to solicit material for transfer to the archives. In extreme cases, reliance may have to be placed on donations from the various branches of the hospital. Both situations

should be avoided, but in the absence of systematic acquisition, the archives might be forced to become something akin to what Annan has called the hospital's "waste basket" in order to ensure important items are not lost.<sup>4</sup> Unfortunately, such a practice leaves too much to chance and does not effectively meet the real needs of the institution or the research community.

In the hospital records management continuum, it is with decisions on final disposition that the archivist's role is of paramount importance.<sup>5</sup> As Gerald Ham has cautioned, without an archival perspective, administrators may achieve "management efficiency [but only] at the expense of losing the historical records; with it they preserve the record and greatly reduce storage and processing costs."<sup>6</sup> The careful appraisal of hospital records is central to the successful implementation of any type of archival records management programme. Such an important task should be left to those with specific training -- archivists.

In appraisal, the archivist deals with the secondary values of records.<sup>7</sup> As records age, their administrative value to the hospital diminishes. Beyond a certain point, most non-current records cease to have any real significance to the daily operation of the hospital. To cite one example, in the realm of finance the complex auditing work of 1984 does not, as Tom Nesmith of the Public Archives of Canada recently pointed out, require reference to budgets and other records from 1884 or even 1954.<sup>8</sup> A relatively small number of records, however, (perhaps two to five percent of the total) do retain both informational and evidential value. These are the records that have crossed the threshold from administrative to historical or cultural significance. It is the recognition

of this transition that sets the archivist apart from the records manager, just as it sets the hospital archives apart from dormant records storage.

It is important that hospital administrators and records management personnel are made fully aware of this shift. Such is the case at Kingston General Hospital, where, as one of its objectives, a records management survey carried out in the summer of 1984 was intended "to make available and to secure preservation for study and analysis of the records of an early upper-Canadian [sic] hospital and the development of a regional system of health care research projects."<sup>9</sup> Unfortunately in many hospitals such a recognition of the long term value of records is not present.

In the opinion of former Dominion Archivist W. Kaye Lamb, despite the hopes of Sir Hilary Jenkinson and his disciples, it is not realistic to expect or trust administrators to make appraisal decisions with such far reaching implications. While these individuals are the best equipped to evaluate their own requirements, they are frequently rather poor judges of value outside their own sphere. Archivists, on the other hand, take the long term view, investigating all the potential uses of the records.<sup>10</sup> Echoing these views, Lamb's successor, Wilfred Smith, has argued that in virtually all circumstances the archivist should be responsible for the selection of records for permanent retention.<sup>11</sup> While recognizing the objections likely to be forthcoming from administrators on the one hand, and historians on the other, both men nonetheless concluded that the archivist was the person for the task.

The hospital is no exception to this rule. Admittedly archivists do not normally have the medical knowledge and expertise of regular staff

members. Yet, by virtue of their training and experience, they bring a unique archival perspective to an evaluation of hospital documentation, based on an understanding of the form and function of records and how they reflect the institution's structure and operations. This perspective is gained in large measure from the training that the archivist brings to his or her job. The need for appraisal to be carried out in a systematic and responsible manner is one of the strongest arguments in favour of hospitals hiring professionally qualified archivists, rather than depending on volunteers, clerks, or administrators.

An understanding of the specific hospital setting, as well as medical history and terminology, is required, but this is within the professional scope of the archivist. As well, Schellenberg has indicated that the use of subject specialists to assist the archivist is an advisable practice.<sup>12</sup> This would probably be required in the hospital, given the technical nature of many of the records. The hospital is also well suited to a "team approach" to appraisal.<sup>13</sup> All those having a vested interest in the retention or disposal of hospital records should take an active part in the appraisal deliberations. However, the final decision should always rest with the archivist.<sup>14</sup> Drawing on available technical expertise, he or she can best identify and evaluate the evidential and informational needs of administrators and researchers.

With archival assistance, hospitals would be well served by developing a clear policy statement identifying the types of records which are of long term value and are therefore to be included in the archives. Unfortunately, such guidelines seldom exist. Due to the high cost and other problems associated with retaining the ever-increasing number of

old records, many hospitals are discarding them with distressing frequency. This has continued unabated to the point where today we are fortunate that any extensive collections are extant.<sup>15</sup> After trying unsuccessfully to keep everything, some hospital administrators are now destroying everything. Often such drastic steps are taken without any real appreciation of the administrative or historical requirements of the institution or society generally.

In far too many instances, the only records retained after a relatively short period are a few that some staff member has considered "interesting" or "historical." These seldom serve the needs of either administrators or researchers. Hospital administrators, like the directors of many other institutions, need to be reminded that, "knowing what to choose for inclusion ... [represents one of] the keys to the success of ... archives."<sup>16</sup>

Interest in the formulation of policies for the appraisal and retention of hospital records is not new. During the Second World War, for example, the National Archives in Washington undertook a survey of government medical records in order to obtain data for post-war planning. Prompted primarily by the vast increase in records generated by the war and the expansion of the armed forces, this survey, the results of which were apparently not reported publicly, was designed to determine "what types or groups of records are essential to future medical research and accordingly what should be preserved."<sup>17</sup>

More recent attempts to deal with hospital records retention have not always met with widespread success. Throughout the 1960s Britain's Ministry of Health issued a series of guidelines for the retention and

destruction of both administrative and medical records. These regulations followed the general five and twenty five year review recommendations of the 1954 Report of the Committee on Departmental Records (The Grigg Report).<sup>18</sup> Hospitals were advised to keep all records produced prior to the 1858 Medical Act; to assess the value of those generated between that date and the 1911 National Insurance Act before deciding on destruction; and to retain more recent records for twenty years. The British Records Association advised a similar procedure for hospitals not under direct government regulation.<sup>19</sup>

The reaction to these regulations was by no means uniformly positive. Patricia Barnes of the Public Record Office argued that the system of review recommended by the Grigg Report was largely ineffective in hospitals because "it presupposed an orderly system of record keeping and a rigorous supervision of records administration which did not exist."<sup>20</sup> At a 1977 conference on medical records, it was suggested that as far as hospitals were concerned, the Grigg Report needed updating and, although it recognized the need for special treatment of "particular instance papers" containing information on individuals, a clearer distinction between medical and administrative records was required.<sup>21</sup> Kerling, a vocal critic of the Ministry of Health regulations, also astutely questioned who on the staff of most hospitals has the appropriate knowledge and training to evaluate the records. She was likewise concerned that if such procedures were followed to the letter, most of the records produced between 1858 and the last twenty years might very well be lost.<sup>22</sup>

Since then, British regulations have undergone revision to bring them more into line with the reality of hospital practice. There is now a

positive duty on the part of hospitals to retain important records. In cases where authority is questioned, destruction requests are reviewed. Of greater significance, these regulations acknowledge that institutions may wish to retain certain records beyond their prescribed retention period. As a result, it is noted that hospitals "which for special reasons consider it desirable and practicable not to destroy any or certain of their clinical records should treat such records as designated for permanent preservation."<sup>23</sup> The problem of who carries out such appraisal nonetheless remains.

Across the Channel, the French have adopted a more conservative approach to the preservation of hospital records. The retention periods for administrative records range between two and twenty years, while those for medical records span ten to seventy years. A sample of the latter are normally earmarked for permanent retention, as are the admission and discharge registers.<sup>24</sup> However, as in Britain, experience has shown that some of the regulations are too rigid, while others are too flexible.<sup>25</sup> In both countries, problems have resulted from attempts to establish and enforce one detailed set of rules for all of the nation's hospitals. Given the wide diversity in size and orientation of these institutions, it is not surprising that many of the policies proved unworkable.

In Canada, each province regulates the retention of medical records. In British Columbia, for example, the minimum retention period for the three types of documents comprising the medical record are currently set out as follows: primary records are to be kept for ten years after the last date of discharge; secondary documents are to be retained for six years after the date of the service to which the document applies; and transitory



materials can be destroyed the day after the final completion of the medical record by the attending physician.<sup>26</sup> These specific periods notwithstanding, B.C. Hospital Act Regulations recognize that these records may be of use for much longer, concluding that hospital officials "may determine that certain medical record documents have continuing value for research, historical or other purposes." In such instances, the senior administrator, "may direct that such documents be retained for a further period specified by him after which he may authorize their destruction."<sup>27</sup>

Although permitting longer retention periods, such statutes do not provide further guidelines or recommendations, particularly as to how the appraisal is to be conducted or by whom. In Ontario, as Craig has recently indicated, the Public Hospital Act and associated regulations in effect define permanent as fifty years.<sup>28</sup> Thus the onus remains on the individual hospital administrator to identify these records and then determine the actual retention period that meets the institution's requirements. His or her ability to assess all the potential uses of these records must be questioned.

While government regulations and legal concerns affect the minimum retention periods for most medical records, the majority of Canadian hospitals are more independent than their English or French counterparts as far as administrative records are concerned. Retention schedules can therefore be tailored to meet the needs of individual institutions. The only exception is Quebec where recent legislation has required all publicly funded institutions to make specific provision for preservation of archives.

As for the specific criteria on which appraisal decisions should be based, to a certain extent this depends on the nature of the archival operation within the hospital. Archivists have traditionally grappled with the complex problem of devising objective standards for appraisal.<sup>29</sup> An element of subjectivity seems destined to remain. As an example, in dealing with the question of historical research value, the problems inherent in trying to predict or respond to changing trends are legion.<sup>30</sup>

As hospital administrative records are similar to those of other organizations, they lend themselves to the appraisal methods normally associated with archival records management. The selection criteria followed by the staff of Chicago's Northwestern Memorial Hospital Archives is one example of how broad guidelines can be delineated. In order to merit accessioning, materials must possess the following minimum "internal characteristics:"

they must have permanent historical, legal, or operational value; they must document the creation and organization of N.M.H. and its predecessors; they must document or provide evidence of the hospital's activities and their consequences; they must record activities or actions that have ceased; and they must answer questions which pertain to the hospital's operation.<sup>31</sup>

When properly applied by trained personnel, such guidelines help determine which administrative records are to be retained for both internal reference and external research. While this particular collection excludes patient files, it is evident from the terminology used that the selection criteria could also be applied to inactive medical records. This reflects the fact that beyond a certain point the administrative-medical division

serves no real purpose.

However, medical records do present some special problems for both appraisal and retention. A surprising number of hospitals have no firm policy on how these records are to be handled. Most often only generalized periods of use are enunciated. Although unique because of their contents, medical records, particularly the patient files, are not unlike other types of sensitive case files encountered by archivists. Thus they are able to advise on the short and long term retention of these records.

The American Hospital Association advises that retention decisions should be guided primarily by the needs of the individual institution, modified by existing laws and potential litigation. It goes on to observe that, generally speaking, after twenty five years hospitals seldom require medical records for clinical, scientific or research purposes.<sup>32</sup> The use of a register in the medical records departments of individual hospitals to monitor the actual demand for inactive records is recommended.<sup>33</sup> An Illinois study, dating from the 1960s, found that of all inactive medical records retrieved during a six month test period, only 7.5 percent were more than fifteen years old.<sup>34</sup> A similar investigation conducted into retention needs in medical clinics concluded that medical documentation could be destroyed after ten to fifteen years in inactive storage.<sup>35</sup> In 1978, a report by the Ontario Council of Health concluded that after only three years the number of requests for retrieval becomes insignificant in many hospitals and it therefore recommended that the mandatory retention period be reduced in the name of economy. The report did, however, acknowledge that such legislation should be permissive in nature, allowing some hospitals to keep records longer.<sup>36</sup>

While such findings are useful guides as to potential retention requirements, they are based primarily on current administrative concerns, and not on an assessment of all potential uses of the records -- most notably as an archival resource for research. Indeed, in the American Archivist of July 1974, Virginia Stewart took issue with the findings of some of the agencies cited above and concluded that they disregarded current research trends and the potential future use of such records.<sup>37</sup> Those hospitals which follow the minimum retention guidelines often destroy or weed their medical records without serious consideration of the implications of such actions.

In Britain, despite the age of many of its hospitals, surveys have indicated that the majority of records, particularly those of a clinical nature, rarely extend back before the turn of this century.<sup>38</sup> In a classic example of a near disaster, had the Royal College of Physicians of London not intervened in 1957, the inactive patient files of King's College Hospital would have been lost. The records earmarked for destruction spanned the period from the founding of the hospital in 1839 through to 1937, in keeping with the specific requirement to retain only those produced within the last twenty years.<sup>39</sup> This is a clear indication of the dangers inherent in generalized administrative instructions. One can imagine the wealth of information for both medical and historical research that is to be found in what amounts to a virtually complete series of records.

Even if patient records are not destroyed, unwitting damage can still be done to a collection. Such was the fate of some Calgary General Hospital records, now on deposit at the Glenbow Archives. Much of what

was culled by medical personnel and transferred to Glenbow has proven to be of little value. The only patient records remaining from the early years of the hospital are a few which were considered "interesting cases." The rest, going back only to 1940, were stripped for microfilming before being transferred. While a few valuable documents remain, many more were removed during this process. The condition of this material is less the result of concerns of confidentiality than it is of a lack of understanding of archival requirements and general neglect.<sup>40</sup> As Dickin McGinnis has correctly observed: "Institutions do not destroy their history in this manner through any sort of perversity. They simply do not think anyone would be interested."<sup>41</sup> To this one is tempted to add that far too many do not even realize that there is anything to be interested about.

Despite the long term retention requirements brought about by the ever-increasing legal concerns, some hospitals have found it impossible to undertake indefinite or permanent preservation of all original medical records, even where there is a high medical research demand. The primary pitfall is usually one of space. With the increasing use of automation, concern with the volume of records may become a thing of the past. At the present time, however, space limitations are central to the issue of the archival retention of these records. As well, even with automation, it is likely that increased costs and problems of access will, in Peace's words, "prevent archivists from divesting themselves of their selection responsibilities."<sup>42</sup>

Microfilm has proved to be a valuable tool in alleviating the space problem in a number of institutions. A pioneering project undertaken at the Colorado State Hospital serves as an example of what has been

accomplished. Patient records spanning the period 1879 to 1959 were filmed as part of an automated access system, with the result that 155 five-drawer filing cabinets were emptied.<sup>43</sup> Throughout the 1960s and 70s, microfilm was adopted in many large hospitals, and it continues to be used as the primary long term storage medium for patient records. A number of hospitals have set up in-house microfilming operations for this express purpose. Others have contracted out the microfilming of medical records, although this practice should be investigated to see if there are legal constraints on the removal of records and their subsequent value as evidence.<sup>44</sup>

However, micro-reproduction is not the panacea it was thought to be. While useful for storage, it may not assist in the retrieval of information.<sup>45</sup> It has also often proved uneconomical when used simply as a space saving expedient.<sup>46</sup> Unless the contents of the medical files are of special significance or, more commonly, if they have a high research and reference value, microfilming may not be the best response to record handling problems.<sup>47</sup> While microfilming can be justified in most major research or teaching hospitals, it is not always cost-effective for smaller hospitals, particularly those involved in what amounts to custodial care. As well, in some instances the originals may still have to be kept in order to satisfy legal requirements, so there is no space saving benefit to be realized.<sup>48</sup> There is thus a clear need for prior deliberation and planning before any microfilming takes place. Specifically, it must be determined that microfilm is in fact the best way of addressing the medical record storage and retrieval problem.<sup>49</sup>

Even when microfilming is used, the volume of medical records can

still be overwhelming. Hospitals like St. Paul's, which maintain only ten years worth of records in paper form, are virtually swamped.<sup>50</sup> If the records are to be retained for only relatively short periods, other methods, such as temporary (and less expensive) off-site storage, should be investigated. As well, unless their permanent archival preservation is justified on research grounds, at least some will eventually have to be destroyed. For a number of reasons, therefore, many authorities have come to agree with James Gill and Thornton Mitchell who, as early as 1963, asserted that "the wholesale appraisal of ... medical records as 'permanent' must be reevaluated."<sup>51</sup> The determination of what is to be destroyed should be made advisedly, on the basis of sound archival principles, and not simply as a way to reduce volume and save space.

In dealing with the problems associated with space shortages and related costs, to say nothing of the need to separate the wheat from the chaff as far as medical documentation is concerned, a number of hospitals have found the solution to rest with a modified records management programme, with scheduling tailored to meet the special requirements of these records. This was the basic approach used by the Colorado State Hospital for the microfilming project cited above. In this way, all the various uses of the records could be assessed. When retained for strictly research purposes not all are required. Indeed, if there is a similar research collection in a neighbouring hospital very few would need to be kept.<sup>52</sup>

In Illinois, for example, as part of the scheduling process it was determined that unless they contained unique findings, patient records could be destroyed twenty five years after the date of death or last

discharge. Once again, indicating that the long term research value of the records was underestimated, only those identified as having "special value" were to be retained indefinitely. Any institution having microfilm of records not required for current use was instructed to deposit it with the State Archives which would then handle all subsequent research requests. Many hospitals deemed it expedient to send many of their other records there as well.<sup>53</sup>

Special attention was paid to x-ray material. Unless legal action was pending or anticipated, all x-ray film with normal findings was to be kept for a maximum of five years and then sold for its silver content or destroyed. At the time this policy was initially formulated a decision had been withheld on the retention period for x-ray film with abnormal findings, but in a similar situation Ohio officials decided it should be kept sixteen years.<sup>54</sup>

Although much of this pioneering work in medical records management was carried out in the 1960s, it appears that the guidelines remain in force today with little modification. In the case of the Ohio project, appraisal of the patient records focussed on three values. The first was the administrative or clinical use of the records in case of further correspondence or readmission. It was determined that the limit was five years, after which time the information was believed to be of marginal value. The second consideration was legal requirements which, as has been seen, are precisely laid down by the various provincial or state regulations. The final criterion was research value, in this case primarily medical.<sup>55</sup>

It appears that research value, particularly for other than medical



purposes, has not always received high priority. The destruction of all x-ray film is one example. Some of the programmes instituted in the United States have led to rather drastic reductions in the numbers of patient files as well. If appraisal is carried out with a proper recognition of research potential, the reduction of volume is not a cause for concern. In Ohio, however, destruction decisions were made in the belief that since a series of records lacked uniform terminology and completion methods it was useless for research!<sup>56</sup>

Hospitals have several choices when faced with large series of medical records deemed not worthy of microfilming. Weeding of files is one option although, as noted in the case of Calgary General, if not done carefully it can ruin an otherwise useful reference set of records. Proper weeding, designed to reduce bulk while at the same time preserving the valuable records, is worthy of consideration.<sup>57</sup> Weeding can be done within a series by removing a set number of files, or within files by removing certain unnecessary documents. In the case of medical files, the removal of less valuable individual items may be advisable. However, this can be extremely time consuming and should only be considered if the items to be removed are easily identifiable and will make a demonstrable difference in the total volume of records. When weeding is implemented, it is useful to retain typical or prototype examples of what was removed so that the complete operational contents of the files can be reconstructed for research purposes.<sup>58</sup>

In cases where a hospital has deemed it necessary to destroy most of its inactive patient records, the retention of only those containing special or unique findings, a common practice in many institutions, should be

reviewed. While obviously important in the eyes of those who selected them, one cannot help but question their real utility for either medical or historical research. Too often they represent little more than the source of an interesting footnote. What would prove to be more useful to all concerned would be a sampling of the records destined for the shredder. Indeed, Susan Rosenfeld Falb, an archivist working for the U.S. Federal Bureau of Investigation, recently commented that whereas the tendency once was to keep the atypical, today the focus is on keeping the typical.<sup>59</sup> The exact nature of the sampling method to be employed would obviously depend to a large degree on the intended use of the records,<sup>60</sup> but it is clear that hospitals should not undertake such a project without the advice or assistance of an archivist. Sampling, as Hull emphasized in his 1981 RAMP Study, should always be considered an "archival activity."<sup>61</sup>

The goal of sampling is the reduction of records volume while at the same time preserving general informational content in a useable form. This is based on the assumption that most large series of standardized records, patient files being a very good example, will be required for research based on aggregate data. As Schellenberg noted in his National Archives bulletin on appraisal, singly most such files have limited research value. It is only when used in large numbers that they are important.<sup>62</sup> Ham has concluded, perhaps optimistically, that "with a valid sample in hand, the archivist can replace 400 cubic feet of records with a reel or two of tape."<sup>63</sup>

As early as 1954, the Grigg Report concluded that within the British government, only those particular instance papers that could be reduced to a statistical sample should be kept.<sup>64</sup> Four years later, the British

Records Association reported that in dealing with the masses of patient files already in existence, hospitals and other repositories would be forced to resort to some form of sampling.<sup>65</sup> Today sampling has become very much a necessity for hospitals desiring to preserve some records for research but not willing or able to invest in large scale microfilming projects.

In the archival field, there are four generally accepted types of samples: example or specimen; purposive or qualitative; systematic; and random.<sup>66</sup> Of these, probably the best approach with hospital medical records is actually a combination of two -- a statistically valid random sample and a purposive sample of historically significant files. This method is currently being applied to the millions of FBI case files in Washington,<sup>67</sup> although there remains some doubt as to the complete effectiveness of statistical sampling of archives. In the hospital setting, such a sample would provide the raw material for both social science and medical research based on aggregate data. As well, the retention of some particularly significant files would provide researchers with specific evidence. While there is some concern that the retention of a purposive sample will ruin the accuracy of the random sample,<sup>68</sup> this could be overcome by the intellectual separation of the two sets of records.

Another option for hospitals is a combination of a random sample and the preservation of standardized forms from the files scheduled for destruction. This approach was used with some success by a British team dealing with the military medical files of Great War pensioners.<sup>69</sup> In the case of patient records, the most common standardized form is the summary sheet. Completed after the termination of treatment, it normally

condenses the contents of each file into a single page, listing only the reasons for admission, pertinent physical findings, test results, therapy notes, progress during hospitalization (including complications), and final diagnosis.<sup>70</sup> In the Ohio project cited earlier, while most of the actual files were destroyed, all the summaries were retained.<sup>71</sup> The same practice is currently recommended by Britain's National Health Service.<sup>72</sup> Alone, summaries do not always provide enough information for all research applications. However, if they were retained in conjunction with a random sample of the entire collection, sufficient material would be preserved for most types of research.

Sampling is only suitable to series of records in which the information is essentially homogeneous in nature.<sup>73</sup> Medical files fall into this category, but they do vary according to illness. Sampling could be carried out by type of illness rather than across the institution's records as a whole. This would, however, profit the institution only if the records are already arranged in this way. If not, the difficulty in identifying and separating them would outweigh the benefits. Here, a random sample of all the records would still preserve some files of each illness. A caution in such cases would be to ensure that the sample is large enough to provide an accurate portrayal of the entire collection of medical records. As J. M. Winter has warned, if the sample is too small it can provide misleading information.<sup>74</sup>

Sampling and weeding are two of the options open to hospitals considering the retention of some files for research purposes but which have decided not to make extensive use of microfilm. When properly applied, these techniques drastically reduce the volume of original records

without harming the research potential of the collection. The destruction of any set of records is a serious, irreversible step to take, but with archival assistance hospital administrators can carry out such procedures with confidence that the long term research value of the records has not been damaged.

In dealing with the complex challenges of preserving valuable hospital records, it is apparent that the archivist has an important role to play. From the formal appraisal of all the records, through to the determination of how sampling should be carried out, he or she brings to the job special skills not normally available within the hospital. In all these endeavours the archivist faces two different challenges -- the narrower and most immediate one of documenting the history and operation of the hospital, and the wider one of documenting a part of society.<sup>75</sup> Whatever the exact approach taken in response to the problems of the selection and preservation of hospital records, certain risks exist. Not all records can or should be retained. Building on a careful analysis of the needs of both the institution and the research community, the archivist can make the appraisal decisions required to preserve valuable records while at the same time reducing the total volume of documents to a manageable size.

## Notes for Chapter Five

- <sup>1</sup> Wilfred I. Smith, "Archival Selection: A Canadian View," JSA 3 (October 1967): 276.
- <sup>2</sup> TB, "Records Management," p. 18.
- <sup>3</sup> Moulds, "Hospital archives," p. 39.
- <sup>4</sup> Annan, "Medical Library," p. 314.
- <sup>5</sup> Ridge, "Records Management," p. 12.
- <sup>6</sup> Ham, "Archival Choices," p. 141.
- <sup>7</sup> T. R. Schellenberg, The Appraisal of Modern Public Records, Bulletin No. 8 of the U.S. National Archives (Washington, 1956), p. 6.
- <sup>8</sup> Tom Nesmith, letter to the author, June 26, 1984.
- <sup>9</sup> KGH Memorandum, from Richard Binhammer, Executive Assistant to the Hospital Director, to all Department Heads, May 16, 1984. This memo informed the departments that the records survey was to take place.
- <sup>10</sup> W. Kaye Lamb, "The Fine Art of Destruction," in Essays in Memory of Sir Hilary Jenkinson, ed. A. E. J. Hollaender (Chichester, Sussex: Moore and Tillyer, 1962), pp. 51-54.
- <sup>11</sup> Smith, "Archival Selection," p. 276.
- <sup>12</sup> Schellenberg, Appraisal, p. 27.
- <sup>13</sup> Burke, "Archival Cooperation," p. 300.
- <sup>14</sup> See Peace, "Deciding What to Save," pp. 11, 13.
- <sup>15</sup> See E. M. Dance, Review of Catalogue of an Exhibition of Medical

Records in the Library of the Royal College of Physicians of London, intro. L. M. Payne, Archives 4 (Michaelmas 1959): 114.

- 16 Anderson, "Corporate Asset," p. 265.
- 17 "The National Archives," AA 7 (April 1944): 140.
- 18 Great Britain, Report of the Committee on Departmental Records, Cmd. 9163, Sir James Grigg, chairman (London: HMSO, July 1954), p. 30.
- 19 Kerling, "Hospital Records," p. 181; and BRA, "Preservation of Medical records," p. 379.
- 20 Cited in Sears and Allderidge, "Medical Records Conference," p. 554.
- 21 Sears and Allderidge, "Medical Records Conference," p. 555.
- 22 Kerling, "Hospital Records," p. 181.
- 23 Benjamin, Medical Records, pp. 185-87.
- 24 J. Roubert, "Les archives médicales en France," Archivaria 10 (Summer 1980): 25-56; and Florence Greffe, "La réglementation des archives hospitalières en Angleterre et en France," GA 108(1980): 50-51.
- 25 Greffe, "Archives hospitalières," pp. 49-51.
- 26 BC, "Hospital Act," p. 4. For the definition of these three categories, refer to Chapter One, p. 23.
- 27 Ibid.
- 28 Craig, Review of Directory, p. 106.
- 29 See discussion in Peace, "Deciding What to Save," p. 3; and Schellenberg, Appraisal, p. 44.
- 30 See, for example, Blake, "Medical records and History," p. 234; and,

for a general view on the problem, F. Gerald Ham, "The Archival Edge," AA 38 (January 1975): 8.

<sup>31</sup> Berlin, "Northwestern Memorial," p. 333.

<sup>32</sup> AHA, Medical Record Departments, pp. 62-63.

<sup>33</sup> AHA, Hospital Medical Records, p. 35.

<sup>34</sup> IAMRL, "Retaining records," p. 10. Of those required for medical research, only approximately 3% were over fifteen years old. For administrative needs, as many as 15% were that age or older.

<sup>35</sup> Wagner, "Record Retention Schedule," p. 16.

<sup>36</sup> Ontario Council of Health (hereafter OCH), Report of the Task Force on Medical Record Keeping (Toronto: OCH, 1978), p. 17.

<sup>37</sup> Stewart, "Problems of Confidentiality," p. 389.

<sup>38</sup> BRA, Catalogue of an Exhibition of Medical Records in the Library of the Royal College of Physicians of London, 25th November - 12th December, 1958, intro. L. M. Payne (London: BRA, 1958), p. 6. There are a few notable exceptions, such as the Radcliffe Infirmary, Oxford, which has medical case records for the period 1796-1830.

<sup>39</sup> Ibid.

<sup>40</sup> Dickin McGinnis, "Records of Tuberculosis," p. 176.

<sup>41</sup> Ibid., p. 188.

<sup>42</sup> Peace, "Deciding What to Save," p. 4.

<sup>43</sup> Dolores C. Renze, "Colorado State Hospital Records Program: An Experiment in Instant Retrieval," AA 28 (October 1965): 586.

<sup>44</sup> AHA, Medical Record Departments, p. 64.



<sup>45</sup> See Kowitt and Rudow, "Computer Generated Microfiche," p. 103; and Roundy, "Microfiche," p. 23.

<sup>46</sup> Great Britain, Committee on Departmental Records, p. 64. Gerald Ham has noted that some general record series are so voluminous that wholesale reproduction on microfilm is virtually impossible, see "Archival Edge," p. 12.

<sup>47</sup> Virginia Lake, "Pioneering in the Control of Medical-Clinical Case Records," AA 24 (July 1961): 303.

<sup>48</sup> Rozovsky, Canadian Hospital Law, p. 98. See also reference to hospital records in Kenneth L. Chasse, "The Legal Issues Concerning the Admissibility in Court of Computer Printouts and Microfilm," Archivaria 18 (Summer 1984): 173, 188-89.

<sup>49</sup> TB, "Chapter 445: Micrographics," Administrative Policy Manual, pp. 5-6.

<sup>50</sup> St. Paul's Hospital, which has an extremely efficient medical records system, is nonetheless forced to resort to using poor storage facilities due to the number of records existing in this mid-size hospital. Two rooms serve as the overflow area for the department. They are typical basement storage areas, complete with overhead water pipes, widely fluctuating temperatures, dust, and excessive crowding. It was hoped that better facilities would be obtained as part of the hospital's capital building project. However, due to provincial budget cuts, further construction is now on hold. The Director of Medical Records has been trying to have the period that the original files are kept before microfilming reduced from ten to seven years. As of the fall of 1983 she was unsuccessful in persuading the administration. Interview with Miriam Hunter, October 25, 1983.

<sup>51</sup> Gill and Mitchell, "Disposition of Medical Records," p. 378. This sentiment is in direct opposition to the view of the Coroner of Ontario cited in Chapter Two.

<sup>52</sup> See discussion in Ham, "Archival Choices," p. 137. The matter of avoiding duplication of research material is also examined in Chapter Four.

<sup>53</sup> Lake, "Control of Medical-Clinical Case Records," pp. 305-06.

<sup>54</sup> Ibid., p. 305; and Gill and Mitchell, "Disposition of Medical Records," p. 375.

<sup>55</sup> See Gill and Mitchell, "Disposition of Medical Records," pp. 376-77.

<sup>56</sup> Ibid., p. 377.

<sup>57</sup> Gertrude L. Annan, "Medical Archives: Resource For Historians," AB Bookman's Weekly 53 (February 18, 1974): 648.

<sup>58</sup> Peace, "Deciding What to Save," p. 12.

<sup>59</sup> Susan Rosenfeld Falb, "Automation, Appraisal, and the Social Scientist," paper presented at the Archives, Automation and Access Conference, Victoria, B.C., March 1, 1985.

<sup>60</sup> Schellenberg, Appraisal, pp. 41-42.

<sup>61</sup> Felix Hull, The Use of Sampling Techniques in the Retention of Records: A RAMP Study with Guidelines (Paris: UNESCO, 1981), p. 44.

<sup>62</sup> Schellenberg, Appraisal, p. 28.

<sup>63</sup> Ham, "Archival Choices," p. 143.

<sup>64</sup> Cited in Peace, "Deciding what to Save," p. 8.

<sup>65</sup> BRA, "Preservation of Medical Records," p. 379.

<sup>66</sup> Hull, Sampling Techniques, pp. 10-16, 49-54.

<sup>67</sup> Ibid., p. 28; and Falb, "Social Scientist."

<sup>68</sup> Hull, Sampling Techniques, p. 40.

<sup>69</sup> Winter, "Medical Disablement Records," pp. 4-5.

<sup>70</sup> OCH, Medical Record Keeping, p. 12.

<sup>71</sup> Gill and Mitchell, "Disposition of Medical Records," p. 374.

<sup>72</sup> Benjamin, Medical Records, p. 185.

<sup>73</sup> Hull, Sampling Techniques, p. 27.

<sup>74</sup> Winter, "Medical Disablement Records," p. 2.

<sup>75</sup> Peace, "Deciding What to Save," p. 9.

## Chapter Six

## ACCESS TO HOSPITAL ARCHIVES

While the determination of what merits preservation as part of the hospital's archives is obviously one of the most important matters of consideration, after the material is earmarked for retention and placed in a suitable storage facility the next major concern is one of access. Reflecting on her experience at the London (Ontario) Asylum, Mitchinson concluded that "hospital records are notoriously inaccessible, partly because of the inadequate archival arrangements of most institutions, but mostly because of the belief in the confidentiality of those records."<sup>1</sup> Indeed, maintaining the confidentiality of sensitive documents while at the same time facilitating research is currently one of the greatest challenges faced by the archival profession. In the hospital, this concern is central to the existence and use of an archives. If sensitive records cannot be adequately protected the entire rationale for archival retention is called into question. Settling these concerns may well be an important prerequisite to the establishment of the repository. As a result, archivists must convince administrators, researchers, and, indeed, patients, of their ability to protect the confidentiality of hospital records while ensuring they are made available for research purposes.

The American Hospital Association has stated that under all circumstances it is essential for hospitals to have a well-defined policy on the use and release of information from their records.<sup>2</sup> This constitutes advice that institutions disregard at their peril for it is only

with the benefit and backing of such policy that requests for access to potentially sensitive information can be permitted. On the issue of access to archival records, the matter should not be left to the discretion of the archivist. Decisions on granting access should never be made without the direct approval and support of the hospital administration.<sup>3</sup> Rather, a policy should be arrived at by the administration, with the advice of the archivist, and then formalized in a series of regulations or guidelines. Normally this can be accomplished by addressing the access question as part of the rules governing the overall operation of the archives. Those hospitals that operate without a clear statement on archival access are doing so at great risk, to both the institution and their patients.

Concern for the confidentiality of hospital archives most often focusses attention on medical and patient files, almost to the total exclusion of administrative records. It is easy to dismiss the latter as not normally requiring heavy restrictions. Such is not the case. In business, certain administrative documents are considered confidential if their disclosure could prove harmful to the corporation or a customer. The records of the board of directors and executive committees, which often contain details of major policy decisions, are but two examples.<sup>4</sup>

In the hospital, similar records are often extremely sensitive. They can reveal the basis of decisions affecting health care for specific individuals or for the community as a whole. Today, with funding limited, health authorities are making controversial decisions to phase out certain services in favour of others. The revelation of the details of these deliberations as reflected in the records, even several years after the fact, may have serious repercussions. Thus the minutes of many hospital

administrative bodies and departments are often routinely restricted for a set period lest unauthorized disclosure adversely affect individual staff members or the public image and operation of the hospital. Such is the case of the minutes and other related records of Royal Columbian Hospital which are on deposit at the City of Vancouver Archives.<sup>5</sup>

The hospital also produces a large number of records which, while technically administrative in nature, nonetheless contain information relating to the practice of medicine in the institution. These can also be extremely sensitive. As mentioned in Chapter One, most hospitals have an elaborate infrastructure of special committees which review or investigate various aspects of its operation. Clinical appraisal, infection control, patient care, and utilization committees are but a few of the bodies that routinely generate sensitive records, ranging from minutes and correspondence to formal reports.<sup>6</sup> As John Dinse recently commented in the pages of the legal journal For The Defense, "merely a recitation of such [committee] titles gives an idea of the potential information available if not protected."<sup>7</sup> Some of these bodies, such as the abortion review committees now established in many Canadian hospitals, deal with sensitive and controversial matters on a regular basis.

Other confidential material produced by administrative bodies deal with staff members rather than patients. Peer review committees are a good example. Reporting in the New York Times, Joel Brinkley observed that "the medical community has always insisted that peer review can succeed only if the work is kept confidential."<sup>8</sup> In keeping with the profession's desire for self-regulation, dissemination of this information is tightly controlled. Hospitals restrict the minutes and reports of such

bodies from outside investigators and also unauthorized staff members, while at the same time retaining them for official reference.

In Britain, hospital administrative records are covered by the provisions of the 1958 Public Records Act and are not available for public inspection until they are fifty years old. In addition, those earmarked for permanent preservation may be subjected to special conditions or restrictions beyond fifty years if, in the opinion of the Lord Chancellor at the Public Record Office, the contents merit continued controlled access.<sup>9</sup>

Despite the specific contents of hospital administrative records, when it comes to the implementation of restrictions they can once again be treated in similar fashion to business records. In the special business archives issue of the American Archivist, Anne Van Camp, archivist of the Chase Manhattan Corporation, outlined an access policy for administrative records that could easily be modified for use in hospitals. She suggested that three types of records be designated according to their sensitivity: open records, immediately made available to all users; restricted records, closed to the public but open to staff for business needs; and closed records, closed to all but the staff of the archives and the office of origin for a specified period of time.<sup>10</sup> The specific time periods and conditions of use would still have to be determined, in a manner similar to that to be discussed for medical records, but such an approach would ensure that the hospital retained control over its sensitive administrative records while at the same time preserving them for internal use now and for research in the future. Such a policy should, however, be developed in keeping with the necessary concern for public accountability. Beyond a certain period, the onus should be placed on the hospital to demonstrate why

administrative records cannot be used for research purposes.

Despite the sensitive nature of certain hospital administrative records, it remains true that the greatest concern over confidentiality focusses on medical or patient records. While inactive medical records may be maintained separately from the archives proper, the archivist may still be involved in decisions on access, particularly in response to external research requests. Hence, it is worthwhile to examine the issues involved in some detail.

In terms of actual ownership of medical records, current legal opinion is that the physical record is the property of the hospital while the information contained therein remains the property of the patient.<sup>11</sup> Yet, as Jeremiah Gutman has cautioned, "it advances our understanding little to talk about who owns the record." Rather, he contends that the focus should be on the rights and obligations of the various parties concerned.<sup>12</sup> Although in English Common Law there is no absolute right to privacy, there exists an implied contract between a hospital and its patients to maintain the confidentiality of the individual's records.<sup>13</sup> In addition, there is a general recognition in the health care field that it is imperative for the patient to be able to speak openly to the physician, free from concerns over what will happen to the information divulged, in order to ensure the best treatment.<sup>14</sup>

As such, the dissemination of the contents of a patient file to a third party, for whatever purpose, is an extremely sensitive issue. This applies to both current files in the medical records department and inactive records deposited in the archives. While there is a natural tendency to think of requests for access to archives as being solely for research,



archives staff should be prepared to expect third party requests from such sources as insurance companies, lawyers, and other official bodies. In these cases, reference to the formalized terms of access will be necessitated. Where such a policy does not yet exist, advice from the hospital's attorney should be solicited.

Despite the concerns of privacy, there remains a desire to carry out research that will be of benefit to a wider community. This is explicitly recognized by Emmanuel Hayt in his definition of a medical record:

A medical record is the compilation of the pertinent facts of the patient's life history, his illness, and treatment. In a larger sense the medical record is a compilation of scientific data derived from many sources, coordinated into a document, and available for various uses, personal and impersonal, to serve the patient, the physician, the institution in which the patient was treated, the science of medicine, and society as a whole.<sup>15</sup>

Similar views are held in Canada about confidential government case records and their importance for future historical research.<sup>16</sup> With regard to hospital patient records, however, most legislation and regulations concentrate on medical research use, with little or no reference to related social science research. Fortunately, as Jean-Guy Fréchette has speculated, "it would seem reasonable to assert that one who studies within a discipline related to the health sciences should be included [within the scope of access regulations]."<sup>17</sup>

In his 1960 discussion of medical records, Philip Jordan cautioned that while extremely valuable for research, "all such sources must be laid against the yardstick of both medical and historical ethics, and every one

must be guarded against improper and prying use."<sup>18</sup> Twenty years later, the editors of the "Archives and Medicine" issue of Archivaria echoed this sentiment with the observation that while the patient record "is a first class archival record ... such matters of privacy are always to be balanced against the archivist's anxiety to discover documentation that can be used and the historian's natural wish to put it to use."<sup>19</sup>

The hospital has an obligation to protect its patients, as well as a desire to protect its reputation, by ensuring that these considerations are borne in mind when archival retention and use of medical and patient records -- purposes other than for which they were originally produced -- are discussed. The archivist can provide advice and expertise to hospital administrators facing this issue. To achieve this end, however, it is clear that archivists, individually and as a profession, must be fully cognizant of their responsibility and must likewise overcome any reluctance to deal with this sensitive and complicated problem. As Virginia Stewart has noted, "the archivist must recognize that in assuming custody over case records he becomes responsible for administering materials in which two social values -- the public's 'right to know' and the individual's personal privacy -- come into potential conflict."<sup>20</sup>

As for the actual practice in handling archival medical records, in Britain, generally speaking, no patient file is made available as part of the public record (most hospitals operate under the National Health Service) until one hundred years after the date of last entry, which normally coincides with the cessation of treatment, due to either the death or the discharge of the individual.<sup>21</sup> There appears to be a degree of variation between counties, however, with some records being closed for only fifty

years.<sup>22</sup> In addition, exceptions are routinely made by archivists for the bona fide researcher "on production of evidence of his standing and competence." In such instances no patient names may be revealed and researchers are required to agree in writing to observe all the relevant regulations prior to being given access to the records.<sup>23</sup>

Based on the belief that, subject to safeguards, the information contained in patient records can be made available without the individual's consent, the British Medical Research Council has developed specific guidelines for the use of this material for research. The suggested safeguards include:

- (1) All such information should be confidential and communicated only to medical research workers engaged in investigations in the interests of the health of the community and only if ... such communication will not harm the patient ....
- (2) access by non-medically qualified research staff should be allowed only when they are working with a medically qualified worker who can take responsibility for confidentiality ....
- (3) If the personal collaboration of the patient is needed, he or she should have the right of refusal. [and]
- (4) The results of research should never be presented in such a way that an individual patient can be identified.<sup>24</sup>

All of these regulations are subject to the overriding stipulation that "no harm or distress will come for the individual and his family, and that the doctor-patient relationship will in no way be impaired."<sup>25</sup>

The Medical Research Council also provides rules for the custody of research records which are of particular interest for the hospital archivist. Included are suggestions that all those handling data should be

under a written obligation to maintain confidentiality, that physical security be maintained, that identifying data be separated from the main body of the records or "scrambled" within computers, that generalized statistical data be used unless the nature of the research warrants access to the original records, that material be reviewed periodically and destroyed if and when all research value has passed, and that researchers be subjected to the same restrictions as apply in clinical practice, where the use of the information is conditional on maintaining the patient's interests.<sup>26</sup> While there may be questions as to the feasibility or, indeed, desirability of implementing all of these guidelines, they remain indicative of some of the steps available for the protection of privacy while at the same time permitting research.

In Canada, a variety of similar procedures exist, although, given the lack of a single governing body, the approach to the problem is less systematic. Each province, and to an extent each hospital, can develop its own response to requests for access to sensitive archival administrative and medical records. In the case of the latter, however, provincial regulations and recommendations have to be considered.

In Ontario, government hospital patient files, most notably those from psychiatric institutions, are closed "permanently." However, researchers can be granted access with the permission of the Deputy Minister of Health. The staff of the Archives of Ontario is attempting to have this practice amended, with a view to establishing a one hundred year closure after which time the material would be opened.<sup>27</sup> As for the records of other hospitals deposited at the Archives, by the terms of the donor agreement the responsibility for the maintenance of confidentiality

continues to rest with the individual hospital. Access to these records is permitted only on the basis of a written authorization from a pre-designated official. This permission must also specify whether the researcher is allowed perusal, transcription, or copying of the records.<sup>28</sup> Similar, though less elaborate, procedures exist at the Provincial Archives of British Columbia and the City of Vancouver Archives for the donating hospital to control access to sensitive material.<sup>29</sup>

Some hospitals, rather than transferring sensitive records, have formulated specific regulations governing access to the restricted materials in their archives. At Kingston General, access to patient records compiled within the last fifty years is limited to authorized members of the medical records department or officials specifically authorized under the Public Hospitals Act of Ontario. Those patient files over fifty years of age, as well as restricted administrative records, are accesible under the following conditions:

- a) The guiding factor in allowing access will be the intent of use of records by the researcher, which must be set out in a letter to the Hospital Archivist.
- b) Records may only be used in the aggregate. Individual names may not be published.
- c) The agreement of the Hospital Archivist is required before any information derived from the records is published.
- d) If any research requests pertaining to access arise which require discussion, the Hospital Archivist will refer the request to the Access Control Committee [composed of the Professor of the History of Medicine and the Hospital Archivist or a designated alternate] for a final decision.<sup>30</sup>

In addition, each researcher is required to sign an agreement to abide by

the regulations cited above. Anne MacDermaid, Queen's University Archivist and, on the basis of a dollar a year honorarium, Kingston General Hospital Archivist, admits that where matters of confidentiality are concerned, a conservative approach to granting research access is often the best policy.<sup>31</sup> Similar procedures exist at a number of other institutions which preserve confidential case files.<sup>32</sup>

At the Public Archives of Canada, access to confidential documents from federal institutions is governed by the terms of the Privacy Act. Medical records are recognized as one of the most sensitive types of historical documents held in the Federal Archives Division. A portion of the Act, paragraph 8(2)(j), is specifically designed to permit medical and social science research in files containing personal information, while at the same time making researchers formally accountable for the protection of individual privacy. Under its terms, personal information may be disclosed for research or statistical purposes provided that the head of the government institution, in this case the Dominion Archivist,:

(a) is satisfied that the purpose for which the information is disclosed cannot reasonably be accomplished unless the information is provided in a form that would identify the individual to whom it relates, and

(b) obtains from the person or body a written undertaking that no subsequent disclosure of the information will be made in a form that could reasonably be expected to identify the individual to whom it relates.<sup>33</sup>

A Review Committee has been formed to advise the Dominion Archivist when such requests are received. In practice, the methods of handling the

material varies with the exact nature of the research. In the case of Great War military medical files, a number of which are essentially hospital records, the researcher is provided with selected photocopies which have had the identifying personal data blotted out. Where the type of project requires use of a much larger number of files, the researcher is evidently given access to the unexpurgated records.

The Manuscript Division is currently in the process of responding to the growing number of access related issues. A committee has recently been formed to review access policies in the Division. Due to the fact that acquisitions of both institutional and personal papers, including medical records and other similarly sensitive material, are originating outside the government, there is a greater difficulty in defining procedures to deal with the maintenance of confidentiality. The donor represents another party to be considered in the deliberations. Nonetheless, there are indications that a more active stance on the part of archivists will be forthcoming in order to ensure that this valuable material is preserved and not abused.<sup>34</sup>

The types of safeguards noted above have, unfortunately, not been completely successful in preventing invasion of privacy and breaches of confidentiality. Indeed, it has been asserted that:

Historically, personal health records have been protected very little. Although health professionals may have tried to guard some sensitive material ... more records have been more readily accessible to more people than many other sorts of records. It is usually far easier to get hold of sensitive health records, for example, than sensitive business records.<sup>35</sup>

Even where rules exist, they have not always succeeded in protecting individuals. As Irvine Loudon commented in an early 1984 issue of the British Medical Journal, "codes concerning medical confidentiality are often much less clear than is generally supposed, to the confusion of those who try to impose rules strictly."<sup>36</sup>

The shortcomings of existing procedures have been illustrated by a number of disturbing incidents which have occurred in recent years. One, which made headlines in British Columbia in 1977, resulted from a sociology research project investigating the effects of a government hospital closure on patients being treated for alcohol abuse. Summer students given access to patient files began to contact ex-patients for interviews.<sup>37</sup> The situation was further complicated when it was revealed that the students had been permitted access to the files through a "misunderstanding" and that the hospital staff had not inquired as to how the research was to be conducted.<sup>38</sup> A public outcry ensued.<sup>39</sup> In response, the Health Minister intervened and promised to institute new controls to stop this type of abuse, while at the same time permitting proper research.<sup>40</sup> This did not satisfy all parties, a number of whom refused to countenance the research use of files containing patient identification.<sup>41</sup>

This British Columbia example highlights the fact, as enunciated in a 1970 issue of the Valparaiso University Law Review, that "presently, the burden of safeguarding the research subject's confidential disclosures belongs to the researcher himself as imposed upon him by his own sense of integrity and ethical standards."<sup>42</sup> Most often the violation of privacy rests not in the use of the data, but in the failure to protect it from



unauthorized dissemination.<sup>43</sup> There is a clear message here for those involved with hospital archives. Dependence on scholarly integrity is not always sufficient. Both the hospital and the archivist have a direct responsibility to ensure that improper use or disclosure of the contents of sensitive archival records does not happen. Those charged with the preservation of these materials must undertake a more careful evaluation and control of research.

Traditionally, the protection of confidentiality of case files has taken one of two less than effective forms, either the imposition of a relatively short closure period or the refusal to transfer records to an archival repository.<sup>44</sup> Neither of these methods achieves the desired balance between the conflicting interests of research and privacy. Today, rather than opting for the extremes of permanent closure or destruction -- a definite temptation in view of the potential for abuse -- hospitals would be better served by developing precise policy with regard to access to, and use of, the material contained in the archives. This policy should focus on determining the exact purpose of the access request, the nature of the information requested, and the identity and qualifications of the requestor.<sup>45</sup> These details should be known and verified before any decision on granting access is made.

It is clear that if these records are to be used for research, and well they should be, every effort must be made to ensure that patient identities are not revealed. Stewart correctly contends that "public acceptance of the use of case records for purposes other than the provision of services to patients and clients is conditional on the maintenance of individual privacy."<sup>46</sup> Likewise, it is generally acknowledged that the written

consent of a patient is not required only when the medical record is used as an impersonal document.<sup>47</sup> In Ontario, responding to a recommendation of the Report of the Commission of Inquiry into The Confidentiality of Health Information (Krever Report) that identifiable health information be disclosed under certain circumstances to qualified researchers without the patient's consent, the College of Physicians and Surgeons opposed such disclosure to anyone other than qualified medical personnel. In similar fashion, health records associations asserted their belief that researchers should only be permitted to abstract nonidentifiable patient information.<sup>48</sup> Anonymity at all phases of research is one of the most basic means of ensuring privacy but very often it is not possible to remove identifying data from files before granting access.<sup>49</sup> When the records are computerized this may become more feasible, but here too one runs the risk of unauthorized or inadvertent data linkages revealing individual identities.<sup>50</sup> Depending on the nature of the project, some researchers will require access to archival documents which retain individual patient identification. It is here that hospital archives require firm policy, backed by the potential for legal action if necessary, to protect the rights of the patients whose files are used in this way.

In an attempt to safeguard these rights, as well as protecting the interests of the hospital, specific restrictions beyond the preliminary screening are often imposed and enforced in the belief that, as Stewart phrased it, "enforcement of appropriate standards cannot end with the granting of research access." Further, she contends that this is particularly true when the archivist has "doubts about researcher sophistication in handling sensitive material."<sup>51</sup> While archivists as a

group try to avoid being placed in a position of discriminating among researchers, and there are those who shy away from any notion of "archivist as censor," there remains the professional responsibility to both the hospital and its patients to ensure confidentiality is maintained. Hospitals should insist upon certain prerequisites prior to granting access to material in the archives. Particularly if there is concern over improper handling of patient records, access may have to be denied. While hospitals are funded by the government, and therefore bound (morally, if not legally) by the dictates of public accountability as far as most of their records are concerned, this should not interfere with patient privacy. The hospital's first concern is to the sanctity of its contract with its patients and so it should be discriminating. Only when the archivist is convinced that confidentiality will be maintained, should research access be granted.

In addition to preliminary screening of any would-be researcher and his or her proposal, medical or otherwise, there are a number of other control mechanisms currently employed in various archives to minimize the risk of violating confidentiality. These include one or more of the following: the signing of a formal agreement not to reveal the identity of any of the individuals appearing in the files (prepared in consultation with the hospital's attorneys to ensure it is legally binding); pre-publication review of manuscripts to ensure no reference is made to individuals; review of research notes, on either a regular or an impromptu basis; and the concealing of patient identification prior to granting research access, by either obliteration or coding.<sup>52</sup> The Krever Report has recommended that patients be given a statutory right to damages in cases of unauthorized and unjustifiable disclosure of health information.<sup>53</sup> While

some of these procedures are neither practical nor desirable in all circumstances, they nonetheless indicate the types of measures that may be employed to protect the information contained in archives from unauthorized or improper disclosure.

While hospitals need to arrive at a firm policy for granting access to the records reposing in their archives, there is a related question of the length of time that must pass before such access is granted. As Jean Tener has noted, "while the principle of public access is implicit in the system of specified closed periods of time before access, the immediate effect [of instituting time periods of closure] is denial of access."<sup>54</sup> In 1982, Grace Hyam reported to the Director of the Manuscript Division of the Public Archives that "a great deal of material which cannot be made public today because of considerations of personal privacy, is nevertheless important to the historical record and should be acquired and preserved so that researchers will be able to use it in the future."<sup>55</sup> This sentiment is equally applicable to the contents of hospital archives. While certain authorized hospital personnel will have immediate access to both medical and administrative records in order to carry out their jobs within the institution, decisions should be made on how to deal with the remainder of the staff, as well as external researchers, who may be interested in the records for projects of their own.<sup>56</sup>

The length of time that sensitive records are closed is directly related to the willingness of the repository to accept more stringent controls on access. The less stringent these controls, the longer the period of absolute closure required to protect the hospital and its patients. As indicated above, in practice sensitive files are closed for

anywhere between fifty and one hundred years, although access may be granted earlier under certain circumstances. Those dating from the latter part of the last century are now most often considered to be "in the public domain,"<sup>57</sup> much like the census results. More recent ones, again like the census returns, remain closed due to the more current and detailed nature of the information contained therein.

Some of the regulations applied to medical records are obviously designed to ensure that the people described therein are deceased before access is granted. The Privacy Act, for example, sets a limit of 110 years after the birth of the individual.<sup>58</sup> Other closure periods appear to be rather more arbitrary. Loudon has astutely questioned whether "if there is a limit, what principle is used to decide what it should be apart from an inevitable liking for round numbers?"<sup>59</sup> There is no easy answer. Those formulating access policies for hospital archives must consider all the possible uses -- and abuses -- of the records, as well as all the implications of the restrictions, before making a final decision.

There is also particular concern about access to computerized medical records.<sup>60</sup> In this realm the potential for abuse is great, but the problems of controlling access and preserving confidentiality are, conceptually at least, the same as far as the archivist is concerned.<sup>61</sup>

In all instances then, hospital archives should institute a firm policy for dealing with requests for access to confidential records, be they administrative minutes of committees or patient charts or x-rays. This policy should address such issues as who will be permitted access, when, and under what circumstances. As well, it is essential that whatever the details of the policy it should not be overly rigid. All rules should have

some inherent or discretionary flexibility to deal with special cases -- both positive and negative -- although as Loudon has cautioned, "one man's plea for flexibility and sensitivity may seem to another as immoral opportunism; and flexibility makes official bodies nervous."<sup>62</sup>

While the archivist should be the one to enforce the regulations, some type of Access Committee, possibly part of a larger Archives Committee, may be established to advise and assist the archivist and also communicate with the administration on such matters. This committee could be called in for consultation when sensitive or disputed situations arise. However, having regular hospital personnel sit in actual judgement of requests introduces a potential for prejudice. There is a fear that those making the final decision may have something to hide and therefore veto any research request. Perhaps this could best be avoided if a formal policy on access, once established by the administration in consultation with the archivist, is implemented by the latter operating at arm's length from the rest of the staff. Theoretically at least, this would allow the archivist to render an unbiased decision. The alternative, of having controversial requests decided upon by some third party outside the hospital would not sit well with the institution's directors. This could lead them to abandon the archives. In return for this special trust, the archivist should ensure that the material in the archives is protected and the administration advised to the best of his or her professional abilities.

In all circumstances, the hospital archivist and his or her superiors need to be aware of the potential risks that are a part of archival retention of records. Both should bear in mind Nancy Spingarn's sober warning: "Keeping the records is one thing. Keeping them confidential is

quite another."<sup>63</sup> Yet, despite such concern, it is possible to protect the confidentiality of hospital archives while at the same time permitting, and indeed encouraging, reference and research. The achievement of this balance is, along with establishing the archives in the first place, one of the major challenges facing archivists in hospitals today. The successful resolution of this problem will in large measure determine the extent to which medical records can be preserved and used in archives.

## Notes for Chapter Six

- <sup>1</sup> Mitchinson, "Gynecological Operations," p. 140.
- <sup>2</sup> AHA, Hospital Medical Records, p. 1.
- <sup>3</sup> Van Camp, "Access Policies," p. 296.
- <sup>4</sup> Ibid., p. 297.
- <sup>5</sup> Interview with Sue Baptie, March 5, 1985; and City of Vancouver Archives, Royal Columbian Hospital Collection, Add. MSS. 284, Preliminary Inventory and Finding Aid 24, n.d.
- <sup>6</sup> Rozovsky and Dunlop, Hospital By-Laws, pp. 44, 46.
- <sup>7</sup> John M. Dinse, "Access To Medical and Hospital Records," For The Defense 20 (December 1979): 278.
- <sup>8</sup> Joel Brinkley, "Proposed Rule Brings Battle On Access to Hospital Data," New York Times, 4 June 1984, p. A 17.
- <sup>9</sup> Benjamin, Medical Records, pp. 188-89.
- <sup>10</sup> Van Camp, "Access Policies," p. 297.
- <sup>11</sup> Picard, Legal Liability, p. 290; and Rozovsky, Canadian Hospital Law, p. 94.
- <sup>12</sup> Jeremiah Gutman, in Schuchman et al., Confidentiality of Health Records, p. 42.
- <sup>13</sup> See Lorne E. Rozovsky, "Patient communications are not secret," DIHS 54 (July 1977): 48-49; and Rozovsky, Canadian Hospital Law, pp. 95-96.



- <sup>14</sup> Benjamin, Medical Records, pp. 178-79.
- <sup>15</sup> Hayt, Medicolegal Aspects, p. 5.
- <sup>16</sup> See, for example, Peter Gillis, "The Case File: Problems of Acquisition and Access from the Federal Perspective," Archivaria 6 (Summer 1978): 39.
- <sup>17</sup> Fréchette, Access to Medical Record Information, p. 89.
- <sup>18</sup> Jordan, "Challenge of Medical Records," p. 143.
- <sup>19</sup> Dodds et al., "Archives and Medicine," p. 4.
- <sup>20</sup> Stewart, "Problems of Confidentiality," p. 389.
- <sup>21</sup> Benjamin, Medical Records, p. 189. For an example, see the entry for the Bethlem Royal and Maudsley Hospitals which indicates a 100 year closure for medical records and a 30 year closure for other public records, in Foster and Sheppard, British Archives, p. 25.
- <sup>22</sup> Irvine Loudon, "A question of confidence: How it strikes a historian," British Medical Journal (hereafter BMJ) 288 (14 January 1984): 126.
- <sup>23</sup> BRA, "Preservation of Medical records," pp. 379-80.
- <sup>24</sup> Cited in Benjamin, Medical Records, p. 183.
- <sup>25</sup> Ibid., pp. 183-84.
- <sup>26</sup> Ibid., p. 184.
- <sup>27</sup> Telephone Interview with Barbara Craig, Health Records Archivist, Archives of Ontario, Toronto, Ontario, July 19, 1984.
- <sup>28</sup> Archives of Ontario, Hospital Archives Donor Agreement, n.d.
- <sup>29</sup> See access terms noted in Provincial Archives of British Columbia,

Royal Columbian Hospital Papers; and City of Vancouver Archives, Royal Columbian Hospital Collection.

<sup>30</sup> KGH, Archives and Museum Committee, "Regulations for the Use of Hospital Archives," July 20, 1983, pp. 1-2.

<sup>31</sup> Telephone Interview with Anne MacDermaid, University Archivist, Queen's University Archives, Kingston, Ontario, July 11, 1984.

<sup>32</sup> See University of Illinois example cited in Stewart, "Problems of Confidentiality," p.396.

<sup>33</sup> Public Archives of Canada, "Guidelines for the Disclosure of Personal Information for Historical Research at the Public Archives of Canada," Ottawa, February 1984. (Typewritten), p. 13.

<sup>34</sup> Charles MacKinnon, Chief, Economic and Scientific Archives, letter to the author, December 11, 1984. Included was a copy of a discussion paper on the access question which was presented to the Manuscript Division planning session, 4-6 December 1984.

<sup>35</sup> Spingarn, Confidentiality, p. 31.

<sup>36</sup> Loudon, "How it strikes a historian," p. 125.

<sup>37</sup> "Researcher given access to patient files," Province, July 11, 1977, p. 1.

<sup>38</sup> Ros Oberlyn, "Breach of Confidentiality Claimed: Researcher given ex-patients' data," Sun, July 9, 1977, pp. 1-2.

<sup>39</sup> See, for example, the sentiments expressed in "Project Sloppy ...," [editorial] Sun, July 12, 1977, p.4.

<sup>40</sup> "Minister promises curbs on releasing confidential files," Sun, July 19, 1977, p. 17.

<sup>41</sup> "Private and confidential," [editorial] Sun, July 21, 1977, p. 4.

- <sup>42</sup> "Research and Privileged Data," p. 370.
- <sup>43</sup> Ibid., p. 377.
- <sup>44</sup> Jean Tener, "Accessibility and Archives," Archivaria 6 (Summer 1978): 29.
- <sup>45</sup> AHA, Hospital Medical Records, p. 21.
- <sup>46</sup> Stewart, "Problems of Confidentiality," p. 389.
- <sup>47</sup> AHA, Hospital Medical Records, p. 31.
- <sup>48</sup> J. D. Galloway, The Review of the Report on Confidentiality of Health Information (Toronto: Ontario Ministry of Health, 1981), pp. 77-78.
- <sup>49</sup> "Research and Privileged Data," pp. 375-76.
- <sup>50</sup> See Steinberg, "Social Research Use," pp. 251, 256.
- <sup>51</sup> Stewart, "Problems of Confidentiality," p. 391.
- <sup>52</sup> Ibid., pp. 391-92.
- <sup>53</sup> Galloway, Confidentiality of Health Information, p. 9. The amount advised by the Krever Report was the greater of either the actual damages or \$10,000.
- <sup>54</sup> Tener, "Accessibility and Archives," p. 19.
- <sup>55</sup> Manuscript Division memorandum, Grace Hyam to Robert Gordon, July 6, 1982, p. 3.
- <sup>56</sup> In Britain, there is a belief that if a doctor publishes a historical work which makes use of patient information he may be violating professional ethics. Thus, some argue that the doctor is placed at a disadvantage relative to lay historians. On this point see Stephen Lock, "A

question of confidence: An editor's view," BMJ 288 (14 January 1984): 123-25.

<sup>57</sup> Telephone Interview with Sheila Swanson, Librarian, Academy of Medicine, Toronto, Ontario, July 10, 1984.

<sup>58</sup> Public Archives of Canada, "Guidelines for the Disclosure of Personal Information," p. 3.

<sup>59</sup> Loudon, "How it strikes a historian," p. 126.

<sup>60</sup> See, for example, concerns about access and computers in Rozovsky, Canadian Hospital Law, pp. 98-99.

<sup>61</sup> Stewart, "Problems of Confidentiality," pp. 397-98.

<sup>62</sup> Loudon, "How it strikes a historian," p. 126.

<sup>63</sup> Spingarn, Confidentiality, p. 2.

## Conclusion

The preceding investigation has focussed on a number of broad issues relating to the current status and future development of hospital archives. Given the uncertain existence of most hospital archives and the apparent lack of interest and support from the archival community, this study was required to provide the background necessary for an informed discussion as well as ideas on how the repositories can be established and effectively used within Canada's hospitals.

The archival preservation of hospital records is important for both the institution itself and society generally. Without access to the information contained therein, those responsible for the operation of the hospital will find their jobs more difficult to perform effectively. In similar fashion, lacking the perspective provided by research based on the records of the past, the public will be far less able to understand and evaluate the influence the hospital has come to exert in their everyday lives. For both reasons, hospital archives should be viewed as a necessity.

Despite the complexity of hospital records, an awareness of their nature and their relationship to the operation of the institution is central to any understanding of the role of archives. Without this basic knowledge little progress will be achieved in either understanding or establishing an effective hospital archival programme. While hospital records, both administrative and medical, have certain standard characteristics, they need to be evaluated in the context of their specific institutional setting. Thus each hospital intending to establish an archives should first ensure that the full range of records are identified and that their importance to

the institution is understood. It is only with this knowledge that the archivist can set about establishing a repository that will achieve its full potential as a central information resource.

Today the fate of archives in most hospitals hinges on convincing those in authority that the preservation of the institution's important records is worthy of consideration and support. Such a goal is often difficult to achieve, particularly when the popular perception of what constitutes "archives" is often wide of the mark. Arguments in favour of the establishment of a repository need to be well-reasoned and well-articulated, with emphasis on its utility for the administration and operation of the hospital. Claims for cultural importance, while part of the overall rationale for archives, should not be made in isolation. Rather, existing or new hospital functions that would be assisted by recourse to the holdings of the archives should be identified.

Persuasive arguments in favour of the preservation of hospital archives should also be made via the benefits of records management. When combined with the scheduling and disposal functions associated with records management, a full-service archival operation ensures that records of long term value are identified and retained while the rest are earmarked for disposal at the earliest possible time after all their uses have been exhausted. Given the volume of records produced by the modern hospital, the savings of time and space will undoubtedly appeal to the hard pressed hospital administrator. With a proper archives, hospital staff will be able to locate, retrieve, and make effective use of their inactive records, something that cannot be achieved in most hospitals where old records are simply piled up in storage rooms with no effective physical or

intellectual control. To a large extent the continued establishment and development of hospital archives depends on the acceptance by administrators of the records management justification.

The external use of hospital archives for social science research is, perhaps not surprisingly, initially harder to justify to hospital administrators, but it can be far more significant in the long term. Particularly in the area of medical history and related fields, the promising research conducted over the past decade using hospital records bears witness to the importance of preserving these sources. The success of recent investigation, and the promising potential for future contributions, is perhaps the best single argument in favour of establishing hospital archives. As well, this research is the area on which public support for hospital archives can be focussed.

A corollary to the thesis that hospital records are worthy of archival preservation is that in most situations they should be retained by and within the institutions themselves. Perhaps surprisingly, once the initial decision is been made to save the records, there seems to be little disagreement on this point. The directors of external repositories, particularly the larger government archives, are becoming more hesitant about taking extensive collections of hospital records that consume valuable storage space and which also bring administrative problems relating to the protection of confidentiality. Hospital administrators themselves are equally hesitant about seeing sensitive files, particularly medical records, move out of their physical control. Thus, for a variety of reasons, the establishment of an in-house archival operation is, and will continue to be, the most practical situation.

In order for a hospital archives to fulfill all expectations, it must have a formal existence within the institution, complete with official recognition by (and direct staff access to) senior administrators, a specific, independent place in the hierarchy, and a clear mandate and policy. Lacking any one of these, the repository will not achieve its full potential. It is unfortunate that most of the existing hospital archives are not yet providing full service to their parent institutions. While a formal archives in each hospital is the ultimate goal, the cooperation of several institutions, either in joint planning or in the actual establishment of one central facility, is a step in the right direction. Indeed, if certain types of records, such as patient files, are pooled to make a larger research base such an arrangement may well be the most efficient.

Concern about the establishment of hospital archives leads to the specific matter of funding. It is in this area that the greatest obstacles to effective hospital archives programmes will continue to be encountered. Given the strained economic situation in which most hospitals are currently operating, it is at times questionable whether even the soundest arguments in favour of archives will have much effect. It is difficult not to harbour a certain pessimism about future development, at least in the short term. Archives have much to contribute to hospitals, but even where there is administrative support for the repository the difficulty in obtaining sufficient funds may retard or stifle development. A concerted effort of all concerned, inside the hospital and out, is required. Pressure must be brought to bear at all levels of hospital and government administration in support of hospital archives. Obtaining the money for hospital archives, related to the problem of justification, will



undoubtedly prove to be the greatest single challenge of the foreseeable future, but it is one that can be overcome.

Once a hospital archives is established the proper appraisal of records for transfer is central to the success of the repository. This is the task for which the archivist is professionally trained and it is here that his or her real importance to the hospital becomes apparent. Such work cannot be left to the regular hospital staff. While they should have input, the final decision must be left to the archivist. Hospitals that try to carry out archival operations without the help of a trained archivist do so at their records's peril. For their part, archivists have a clear responsibility to assist hospital personnel in identifying those records which are of permanent value.

In all aspects of hospital records keeping concern for the protection of patient privacy is central, and archival operations are certainly no exception. Archivists entrusted with the safekeeping of sensitive records have a difficult task balancing the right to privacy with the desire to facilitate research. Certain measures must be taken to ensure that the material is not abused, but at the same time the onus is on the archivist to make the records available in a useable form as soon and as efficiently as possible. The current tendency to protect privacy by destroying or permanently closing patient records must be challenged.

Hospital archives are thus an important but all too frequently neglected aspect of both institutional administration and archival consideration. Traditionally these valuable records have not received the recognition they deserve.<sup>1</sup> Fortunately this is changing, as much of the groundwork necessary for the subsequent development of hospital archives

has already been completed. The level of awareness of, and interest in, the subject is presently at its highest point and this can and should be used to advantage by all concerned.<sup>2</sup> It has recently been said that business archives are coming of age.<sup>3</sup> Given the similarity of their situations, it can now safely be said that hospital archives are not far behind. In most hospitals all that is required is the initiative of the senior administration to establish and then support the repository, combined with the willingness of the archivists to assist such endeavours.

Over the next few years interest in hospital archives will undoubtedly intensify within the archival community as more individuals become aware of the extent and value of the records awaiting attention. This will, in all likelihood, result in more detailed investigation of many of the issues that have been discussed in this study. These works, along with case studies illustrating specific hospital experiences with archives, will further enrich our understanding of hospital archives and will at the same time accelerate development.

Hospital archives represent a formidable challenge to the archival profession and it is important that its members become more actively involved in advising and assisting hospital personnel with their preservation. The hospital plays a central role in Canadian society and as archivists have a responsibility to document society their support of hospital archives should be a priority. The establishment of a formal archives in every hospital is perhaps the ultimate goal, but the realization of the importance of records and a genuine desire to preserve them is the first step to be encouraged. Once this is present, much can then be fostered. There is indeed a future for archives in Canada's hospitals.

Notes for Conclusion

<sup>1</sup> Engle, "Medical Archives," p. 23.

<sup>2</sup> The clearest evidence of the current interest in medical and hospital archives in Canada is the Summer 1980 issue of Archivaria and the series of articles that appeared in DIHS in the fall of 1982.

<sup>3</sup> Anderson, "Corporate Asset," p. 264.

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## APPENDIX A

## EXAMPLES OF HOSPITAL DEPARTMENTS

<u>HOTEL</u>	<u>DIAGNOSTIC &amp; THERAPEUTIC</u>	<u>NURSING</u>
Administration	Physiotherapy	Administration
Planning	Occupational Therapy	In-Service Education
Communications	Respiratory Therapy	Out-Patient Clinics
Public Relations	Pharmacy	Medical Wards
Finance	Social Services	-- General
Personnel	Radiology	-- Specialty
Housekeeping	Laboratories	Surgical Wards
Laundry	-- Histology	-- General
Maintenance	-- Autopsy	-- Specialty
Engineering	-- Cytopathology	Operating Rooms
Safety	-- Biochemistry	Recovery Rooms
Medical Records	-- Hematology	Intensive Care Unit
Chaplaincy	-- Microbiology	Day Surgery
	Blood Bank	
	CAT, Ultrasound, etc.	

Sources: Lowry, "M.I.S. Project," pp. 45-46.  
 MacLeod, "Waiting for the archivist," p. 30



## APPENDIX B

## MASTER SERIES LIST

BOARD OF GOVERNORS

minutes: full board  
 minutes: committees  
 correspondence  
 bylaws  
 incorporation records  
 deeds, leases, legal docs.  
 annual reports  
 fund raising  
 addresses and speeches  
 wills and bequests  
 reports to the board

MEDICAL ADVISORY BD.

minutes  
 correspondence  
 reports

HOSPITAL ADMINPRESIDENT/DIRECTOR

minutes  
 correspondence  
 memoranda from staff  
 memoranda to staff  
 departmental reports  
 administration manuals  
 annual reports  
 studies  
 accreditation files  
 university liaison  
 government liaison  
 contracts  
 speeches and papers  
 general files  
 insurance files

PUBLIC RELATIONS

correspondence  
 newsletters  
 inhouse publications  
 special events files  
 clippings and biog.  
 outside publications

FINANCE

correspondence  
 financial statements  
 budgets  
 salaries  
 studies and surveys  
 statistics  
 ledgers and journals

PERSONNEL

correspondence  
 job descriptions  
 staff lists  
 labour relations  
 appointments  
 manuals  
 general files

HOUSEKEEPING/ENGINEERING

correspondence  
 orders and invoices  
 inventories  
 general files

CHAPLAINCY

general files

NURSING DEPT.

correspondence  
 rules and regulations  
 staff lists  
 duty rosters  
 nursing information

SCHOOL OF NURSING

minutes of board  
 correspondence  
 teaching files  
 student records  
 studies and surveys  
 programs/invitations  
 student lists  
 staff lists

NURSING ALUMNI ASSN

minutes  
 correspondence  
 membership lists  
 publications  
 photos, scrapbooks

AUXILIARIES

minutes  
 correspondence  
 membership lists  
 financial statements  
 special projects  
 publications

PHOTOGRAPHS

corr. from other  
institutions  
admission records

MEDICAL DEPTS.  
minutes  
correspondence  
budgets  
research plans

MUSEUM OBJECTS  
artifacts  
paintings  
instruments,  
equipment  
badges and pins

Reproduced from: MacLeod, "Waiting for the archivist," p. 30.

This same "Master Series List" was included in the report prepared by Macleod for the Kingston General Hospital in 1980.

## APPENDIX C

SAMPLE CONTENTS OF TUBERCULOSIS PATIENT FILES  
FROM BAKER SANITORIUM, CALGARY

1. Name
2. Address on admittance
3. Birthplace
4. Date admitted
5. Date discharged
6. Time in Alberta
7. Time in Canada
8. Name of doctor making the referral
9. Address of above doctor
10. Religion
11. Closest friend or relative
12. Relationship of above
13. Address of above
14. Birthday
15. Age
16. Sex
17. Marital status
18. Occupation
19. Citizenship
20. Race
21. Father's name
22. Father's birthplace
23. Mother's maiden name
24. Mother's birthplace
25. Spouse's (maiden) name
26. Family health history
  1. parents
  2. siblings
  3. spouse
  4. children
  5. grandchildren
27. Past social and industrial history and habits
  1. type of work
  2. lifestyle
28. Past health and diseases
  1. disease

2. surgery
29. When last in good health
30. History of intimate exposure to infection
31. Date on which stopped work
32. Present illness
  1. Where diagnosed
  2. When diagnosed
  3. Earlier treatment, if any
33. Present symptoms
 

1. cough	10. palpitation
2. expectoration	11. dyspnoea
3. fever	12. nervousness
4. night sweats	13. insomnia
5. loss of weight	14. appetite
6. loss of strength	15. indigestion
7. haemoptysis	16. hoarseness
8. pain in chest	17. menstruation
9. flushing	18. micturition
	19. defecation
34. Character of onset
 

1. catarrhal	4. haemorrhagic
2. insidious	5. febrile
3. pleuritic	
35. Normal weight
36. Present weight
37. Height
38. Condition of the heart
39. Dental hygiene
40. Diagnosis on admission
41. Prognosis on admission
42. Work Tolerance Prognosis on admission
43. Diagnosis on discharge
44. Prognosis on discharge
45. Work Tolerance Prognosis on discharge
46. Disposal (Treatment, etc. after discharge)
47. Date of death
48. Cause of death
49. Experience in the sanatorium
  1. treatment

- 2. extent of illness
- 3. evidence of maladjustment
- 50. Evidence of successful follow-up
  - 1. out-patient treatment
  - 2. regular check-ups

Reproduced from: Dickin McGinnis, "Records of Tuberculosis," pp. 184-85.

## APPENDIX D

## SURVEY OF ARCHIVES USE IN MEDICAL HISTORY

<u>Volume See list</u>	<u>Number of Articles</u>	<u>Hospital Topics</u>	<u>Use of Archives</u>	<u>Use of Hospital Records</u>	<u>Used Onsite</u>
CBMH	16	2	8	2	0
Shortt	18	2	13	7	0
Roland	21	1	16	3	0
TOTAL	55	5 (9.1%)	37 (67.3%)	12 (21.8%)	0 (0%)
Arch 10	11	4	11	7	3
TOTAL	66	9 (13.6%)	48 (72.7%)	19 (28.8%)	3 (4.5%)
* * * * *					
L&N (US)	30	2 (6.7%)	16 (53.3%)	6 (20%)	5 (16.6%)

Sources: CBMH = Canadian Bulletin of Medical History, vol. 1 (1984).  
Shortt = SED Shortt, Medicine in Canadian Society (1981).  
Roland = CG Roland, Health, Disease and Medicine (1984).  
Arch 10 = Archivaria 10, "Archives and Medicine," (1980).  
L&N = JW Leavitt and RL Numbers, Sickness & Health in America (1978).

## APPENDIX E

### SAMPLE HOSPITAL ARCHIVES MANDATE

1. That the selection, preservation and control of archival records be under the authority of the chief administrative officer or his/her delegate.
2. That the archives be formally established to acquire, preserve and make available for use the permanent records of the hospital.
3. That the authority and terms of reference of the archives/archivist be defined by an administrative directive communicated to all hospital staff.
4. That such a directive should confer on the archivist the authority to:
  - \* inventory all hospital records;
  - \* prepare timetables for records disposition for management approval and monitor timetable implementation;
  - \* select certain records for permanent preservation in the archives; and
  - \* advise on all matters pertaining to the hospital's permanent records.
5. That the archives/archivist be provided with a budget commensurate with assigned archival responsibilities.
6. That the archives be provided with adequate quarters which meet accepted standards where archival records can be received, processed and preserved.

Reproduced from: MacLeod, "Waiting for the archivist," p. 29.