導師研習營

病歷寫作

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- PGY之訓練寫作與六大核心能力學習相關
- 教師對於PGY之病歷寫作，有責任給予完善之指導

病歷書寫的目的

1. 互相溝通（Patient care）
2. 醫療品質（Medical knowledge and professionalism）
3. 醫療糾紛（Interpersonal and communi-cation skill）
4. 調查研究（Practice based learning and improvement）
5. 健保及評鑑之資料（System based practice）

病歷有幾個特性

1. 個人隱私
2. 真實性
3. 詳實
4. 日曆排序
5. 合乎邏輯
6. 重點化

基本資料

- 姓名.....相同者不少
- 性別：male, female / man, woman
- 出生年月日.....注意陽曆及陰曆紀錄，西元/民國
- 身份證號碼(或passport號碼，或Visa號碼)
- 戶籍所在地
- 現在住址
- 職業及職位

（現在多是電腦資料帶入）

- 了解病人的身分、職業、工作內容、以及生活關係、嗜好等（Social, Economical Status）
  - ✓了解生病的背景環境
  - ✓一定要記錄

主訴

- 簡明扼要
- 包括主要症狀及期間或Onset (開始）之時間
- 時間因素重要

Chief Complaint
主訴

- 病患最主要的症狀或徵兆

- 以片語表示，並說明發生時間及頻率
  - “Shortness of breath”
  - “Cough with copious yellow sputum for 3 days”
  - “Chest pain that started the night before admission”

症狀盡量”量化”

- 頻度(frequency)以及嚴重度（severity)。
- 知其重要性，也是之後評估疾病之發展(assessment)上重要之依據。

Chief Complaint

- 使用病人自己的用語或字句，避免專用術語
  - Hematemesis and melena for 2 days (X)
  →Vomited blood and passed dark stools for 2 days
  - Dyspnea since last night (X)
  →Shortness of breath since last night
- If admitted for certain treatment or procedure, state the treatment/procedure and the problem
  - For radioiodine ablation therapy (X)
  → To receive radioiodine ablation therapy for thyroid cancer

History of Present Illness (HPI)
現在病史

- 以chief complaint為中心，再包括相關症狀
- 詳細描寫導致病患入院的事件
- 依照時間順序，有系統的整合陳述
  - 以住院的當時為時間定點
    - "Experienced chest pain 3 days prior to admission"
    - "Nausea started 1 week before admission, then vomited twice the day before admission."
- 邏輯引導進入你的入院診斷
  - >80% of patients' diagnoses can be made by history alone

Content of HPI

- 病人的背景描述
- 產生現在病狀前的健康狀況
- 主要症狀的描述
- 相關症狀或狀況的描述
- 現在病症的演變
- 入院前的其他治療或在其他院所知發現及處置

➢ 依照時間順序，有系統的整合陳述

HPI – Example from NEJM

- A 56 year old man was admitted to the hospital because of cough and rash.
- The patient had been well until 9 days earlier, when light-headedness, chills, and extreme fatigue developed. The next day, a rash, which he described as red and pimply, developed over his chest and axillae; it gradually improved but did not resolve. Five days before admission, he developed a cough which was associated with sharp substernal chest pain on inspiration, which improved with lying down. There was no rhinorrhea or sore throat. His physician saw him the next day and prescribed him Azithromycin. However, the cough persisted, worsened, and remained nonproductive. On the day of admission, the patient returned to the doctor's office.

HPI

- 第一段著重於症狀和自然病程的描寫
- 是問診及檢查後，經過整理及邏輯思考後的寫作
- Past medical/surgical history, personal and social history若和本次疾病相關，應列於本段
  - Suspect cardiac chest pain → include tobacco use
  - Suspect sexually transmitted disease → include sexual history

HPI第一段

- Begin with patient's background information
  - Demographics (age, race, sex)
  - 相關或影響現在病情的過去疾病及手術
  - Include where patient came from (home, nursing home, other hospital) and where he presented at (OPD, ER)
  - CC: Chest pain x1 day
  - HPI: The patient is a 67 year old Taiwanese man who is a smoker with DM2 x20y and Stage III CKD who was brought from home to the ER by his son for chest pain that started one day before admission.

HPI第一段

- LQQOPERA Analysis of symptoms
  - Location 位置及牽扯部位
  - Quality 性質
  - Quantity or severity 定量，嚴重度
  - Onset
  - Precipitation factors 觸發事件
  - Exacerbating factors 加重因子
  - Relieving factors 緩和因子
  - Associated symptoms 並存症狀

1. Location (位置):

局部性 (localized)、瀰漫性 (diffuse)
移位性 (migratory)、放射性 (radiating)、等等

2. Quality (性質)

刺痛 (pins and needle)、銳利 (sharp)、
頓痛 (dull or achy) 、壓迫性 (pressure-like)、等等

3. Quantity or severity (定量，嚴重度)

持續性 (persistent) 、間歇性 (intermittent)、
6 out of 10 in intensity

4. Onset (起病狀態)

超急性 (abrupt)、突然 (sudden onset)
緩慢性 (insidious)、漸進性 (progressive)

HPI: Description of Main Symptom

- The patient is a 67 year old Taiwanese man who is a smoker with DM2 x20y and Stage III CKD who was brought from home to the ER by his son for chest pain that started one day before presentation.
- Patient was climbing a flight of stairs one day before admission when he experienced the pain (PRECIPITATING FACTOR and ONSET). Pain was located in left anterior chest and radiated to his left arm (LOCATION), and was described as dull and pressure-like (QUALITY). The intensity of pain was 6 out of 10 (SEVERITY). Patient experienced nausea with the chest pain, but did not report vomiting or shortness of breath (ASSOCIATED SYMPTOMS). Pain improved with rest (RELIEVING FACTOR); however, pain returned to the same intensity with minimal exertion (EXACERBATING FACTOR).

Content of HPI

- Pertinent negatives
  - 病人否認的相關症狀或狀況，其不存在可排除某些鑑別診斷

"Patient's chest pain was not relieved by nitroglycerin and rest. EKG did not reveal any abnormality"

→ (cardiac ischemia is less likely)

"For several days before his loss of consciousness, the patient had not been taking his DM medications"

→ (hypoglycemia is less likely)

（應該要有，但PGY常缺少）

  - Avoid using "Patient denied…."; instead say "Patient did not have…." or "Patient reports no…"

Information從何而來呢？

- 小baby→父母或其照顧者
- 大　人→自己最清楚（？）
- 老　人→很多事忘了，子女、配偶或許更清楚
- 緊急時→送的人（鄰居、朋友、警員）不一定很熟悉
- 家屬
- 轉診摘要
- 舊病歷

Past Medical/Surgical History
過去病史

- **All ongoing medical problems**
  - **Include more detailed information for certain diseases**
    - DM2 (on insulin since 10/2001, A1C 7.9 on 11/21/2009)
    - Stage III CKD (baseline Cr 2.0)
- **Include major past interventions and dates of procedures**
    - Right knee OA s/p TKR (10/23/2008)
    - 3v CAD s/p PCI for LAD (3/5/2005)

（PGY常常寫不完全）

過去病史

- 高血壓為例
  - ✓年數
  - ✓最高多少mmHg
  - ✓用何種藥物？doses
  - ✓目前狀況
  - ✓有無合併症
  - ✓小心一些藥有不同之含量
    - Tenormin 50mg/100mg
    - Inderal 10mg/40mg

Current Medications

- Drug Allergies: 描述對於藥物過敏，及其嚴重程度，例如是否過敏到呼吸衰竭或休克的程度
  - PCN → developed rash
  - PCN → anaphylactic shock requiring intubation
- Current medications:
  - Prescribed medications (name, dose, frequency of use)
  - 必須詢問病人自己購買的藥物 (include nutritional supplements and herbal medications)

身體診查(Physical Examination)

- Basic：身高、體重 、 BP、 TPR 、Pain score
- 望聞問切（全身均應仔細檢查）
- Inspection、palpation、percussion、auscultation
- 有些Negative finding and Positive finding一樣重要
- 可繪圖者更清楚
- Digital exam.
- Neurological exam.

Personal & Social History

- 目的在於使醫師可正確地想像病患的生活起居，以找出可能病因
  - **Occupation: Exposures?**
  - **Substance use: Include amount use and duration (alcohol, tobacco, illicit drugs)**
    - Alcohol: 2 cans of beer every night for past 10 years
    - Tobacco: 1ppd x20 years, quit 2y ago.
  - **Travel history**
  - **Current living situation**

Laboratory Test Results

- Include old lab results for comparison
  - Any abnormal lab values on admission should be compared to previous values if possible
    - Cr 1.0 (6/23/2009) → Cr 2.0 (10/30/2009)
  - Others including: A1C, Hemoglobin, chemistry, etc.

現在常用copy及paste整組放入，而缺少邏輯思考與整理

R.O.S(Review of System)

1. 系統化，一般由頭開始，問到腳
2. 有症狀或問題時，立即思索與本病(現在病史)之關聯性，如有應放入現病史

Hypertensive encephalopathy

50歲男性，B.p. 150/86 mmHg

↓

Otorrhea，L't for years

↓

照會ENT→Otiltis media

↓

Emergent operation

Review of Systems

- 病人求診時較不會遺漏和主訴相關的症狀，但對於其他系統器官或變化卻未必會主動告知醫師。

- 依問卷方式，針對每一個器官系統，詢問病人有無相關症狀 (Yes or No)
  - 讓處置更完整

- 若標示 positive (+) 要詳加說明
  - 症狀出現的部位，時間，性質及強度

- 本意是如此，但是電腦代勞後，直接帶入，反而錯誤更多。

Impression / Assessment

- Impression/Assessment (臆斷) = Tentative diagnosis:
  - 臆斷而非最後診斷

- 依據住院當時所記載，做出的臨床診斷
  - Use evidence from history, physical exam, laboratory and radiological data to support your tentative diagnosis

- 以最可能和主訴相關之診斷寫在第一位，其他有關之診斷依其重要性列後面
  - First problem should be the one that led to the current hospitalization
  - Then list the other problems in order of urgency

Impression / Assessment

- Differential diagnosis (鑑別診斷): alternative diagnosis for the observed problem
  - 列舉不能排除，不能忽略，或可能會很快致命的疾病
  - Try to include at least 2 or 3 differential diagnoses for the major problems

- Rule out ___: diagnosis that needs to be excluded

Rule out (R/O)

- R/O 的意思是排除。因此前提必須是有一個相對的診斷，然後在列出其他需排除之可能性疾病或診斷
- R/O的誤用:
  - Fever, R/O pneumonia: 意思應該是，病人發燒，肺炎是最有可能的診斷。但讀起來像是排除肺炎
- 應該寫為:
  - Fever, likely pneumonia, R/O URI
  - Dyspnea, suspect decompensated CHF, R/O COPD exacerbation

Impression / Assessment

- 2 ways of organizing Assessment and Plan

Impression:

1).....

2).....

Plan

1).....

2).....

OR

A/P:

1).....

1)

2)

2).....

1)

2)

- **For patient with multiple issues, would advise placing the specific plans under each individual problem**

Assessment and Plan

CC: Shortness of Breath

A/P: 1) Shortness of breath likely due to decompensated CHF given recent weight gain and worsening lower extremity edema, poor medication adherence, crackles on lung exam, and elevated BNP. Other differential diagnoses include COPD exacerbation and anemia. Anemia is unlikely the cause because patient had recent lab indicating normal hemoglobin level.

- Furosemide 40mg IV bid, adjust dose according to daily I/O.
- Serial cardiac enzyme and EKG to evaluate for possible ACS as cause for decompensation.
- Echocardiogram to evaluate cardiac function.
- Limit fluid intake to 1L/day.

（寫的方式可以有所不同）

Plan

- **Be specific about each plan**

  - **Specific medication, dosage, route, and duration**
    - "Continue IV hydrocortisone 100mg q8h for 2 days after surgery, then taper to oral cortisone at 25mg daily"

  - **Specify indication for lab tests and diagnostic tests**
    - "Abdominal ultrasound to check for ascites"

醫囑

- 告訴醫療團隊（主要是護士）應作的以及應避免的事
- 診斷／及注意事項
- Diet
- TPR
- BW,BP
- Intake & output
- 病人之活動activity
- Absolute bed rest?

- Avoid xxx
- Allergy
- PRN order(必要時才給）
- 長期order
  臨時order(stat)
- 必需告知主治醫師之狀況
- Please inform the Physician if……..

- 每家醫院電腦系統不太一樣，如果是套餐式的點出，PGY的記憶會較差，將來真正應用時會出問題。

1. Medical order 一定要簽名／護士要check
2. Stat order只有一次，必有時間紀錄
3. PRN order 是告知護理人員，在某一狀況下才給之order
   - B.T＞38.5˚c時？diarrheas超過5次時….
   - 一天可以幾次，或隔幾個小時以上才可以再給均要註明
4. 重要事項並記入progress Note上

每日必需紀錄Progress Note

- 住院病人應至少每日診察一次
  - 每日至少紀錄一次
- 理論上每日會有一些變化
  - ✓ 檢查檢驗/及結果
  - ✓ 診斷之變化
  - ✓ 病情之變化
  - ✓ 診療方式之反應，效果及改變

每天紀錄（Progress Note)

- 要評估病情有無好轉？惡化？Assessment
  不只是Dx還包括進展
- 三天沒有進步，表示病情不樂觀，考慮更換治療方式
- 七天沒有進步，表示危急、緊張。要小心謹慎，更多次探訪病情，並多與家屬溝通，寫好紀錄。

記錄不光只是記錄，還包含了邏輯思考之訓練及經驗之累積

早上一上班，即要看病人一次，並作下記錄

- 下班前應再審視病人一次
- 中間記錄檢查結果/症狀之變化
  - 主治醫師迴診之結果及意見
  - 意外事故或病情特殊變化
  - 特殊之診療事項
- 危急時應經常記錄

以上比較容易被PGY輕忽，他們只注意每天寫一次，但對於突發事件會沒有記載

Progress Note

- SOAP format
  - Subjective, Objective, Assessment, Plan
- 務必記錄：病情的評估、病因與致病機轉、安排特殊檢查的原因、檢查結果、改變藥物的原因、治療的效果、會診的建議與結果、併發症
- 也就是要加強對問題的詳細描述、判斷與處理

Progress Note - SOAP format

- **Events:** Significant events in the past 24 hours
  - Transfused 2u PRBC for anemia.
- **Subjective:** Patient's complaints and changes in symptoms (in their own words)
- **Objective:** Physical exams and new diagnostic results
- **Assessment and Plan:** List each problem, then write assessment and plan under each problem

Progress Note – A/P

- Assessment: 務必常更動修改，並作補強
- Admitted for upper GI bleeding
  - Upper endoscopy found a duodenal ulcer
  - Patient is a long term NSAID user.
- A/P: 1) UGI bleed due to NSAID induced duodenal ulcer: Patient's hemoglobin level has been stable for the past 3 days and has no signs of rebleeding.

  - Stop IV omeprazole and switch to oral esomeprazole 40mg once daily
  - Educate patient to avoid NSAID use

POMR＋SOAP傳統寫法

- 缺點
  1. S/O可能會重複
     有些S/O不在problem內
     有些問題沒有 S/O
  2. 太強調記錄格式，病人資料被分割，不一定會有整體概念
  3. 臨床思路無法連貫
  4. 太浪費時間

- **Modified POMR**

  S:

  O:

  #1:

  A:

  P:

  #2:

  A:

  P:

  #3:

  A:

  P:

今天作CT檢查為例

- 最好今天借片子，看看有什麼變化
- 畫出來....(確實知道變化所在)

  可能的病有哪些?又是哪一個最可能?
- 請教專家意見、請教主治醫師
- 再核對報告

  這些都記入病歷中

（PGY常常會將整份報告copy入progression note內，而不加篩檢重點）

住院迴診記錄

- 由住院醫師書寫
- 跟隨VS 迴診，隨時提出問題。
- VS隨時會教導難得之經驗或案例。
- 考驗自己聽與記錄之能力
- 敘述現象，結論及理由之訓練。
- 是否正確？獲得確認。

主治醫師、主任或教授迴診、記錄舉例：

- The correct diagnosis may be pancreatic cancer.There are 4 key points suggestive of pancreatic cancer.
- There are
  - (1)Weight loss 8 kg in one month
  - (2)Ca199.was abnormal(109)
  - (3)CT & abdominal sono.Showed mass at the pancreatic tail
  - (4)Amylase Cr.Clearance ratio：6%described by Dr. WWW/Dr.LLL
- Arrange ERCP tomorrow morning

一邊學習，一邊成長，印象深刻。

Weekly summary每週摘要

- 就一週來症狀變化，主要之檢查及結果略作敘述。
- 並對病情之變化作一評估（improved，或不變，或惡化）以決定治療方針（繼續、修正、改變、停止等）
- 通常在最後做簡述
  - ✓下週之診療事項
  - ✓可能之預後

導師要教的

- 不只是診斷，更重要的是理由。
- 不只是診斷，更重要的是處理的意見。
- 不只是給予治療，更重要的是其反應效果。
- 不只是知道而已，更重要的是記錄。

（邏輯思考與表達）

Discharge Summary

- 著重本次住院病史的摘要，診斷依據，住院期間所做的重要檢查與治療，及出院後的追蹤和治療計畫。

- Purpose – 讓其他醫療人員了解病人的治療反應，病情進展，已作適當的溝通和處理。

Discharge Summary

- Admitting diagnoses
- Discharge diagnoses (出院診斷)
- Procedures
- Consultations
- Key findings and test results
- Brief hospital course
- Condition at discharge
- Discharge destination
- Discharge medications (indicating new, changed, and discontinued)
- Follow-up appointments and management plan

Discharge Diagnoses
出院診斷

- 依與本次助院相關性依序列出
  - 主診斷 -- 引起本次入院最主要之疾病
  - 次診斷 -- 與主診斷相關
  - 併發症
  - 其他

Discharge Diagnoses

- **Make sure this is a diagnosis and NOT a symptom or sign**
  - **Be specific**
    - UGI bleeding → Duodenal ulcer bleeding
    - Urosepsis → Acute left pyelonephritis and bacteremia due to E. coli infection

Course and treatment

1. 是整理後之文章式的敘述
2. 主要的檢查(支持診斷)
3. 主要的治療(針對主要診斷及次要狀況)
4. 反應→結果要敘述
   - (1) improved
   - (2) the same
   - (3) downhill
   - (4) fatal
5. Op.要寫術式及病理
6. 有病理報告一定要寫
7. 有意外、問題、過敏也要敘述
8. 臨時出院時之狀況

（不是將progression note copy貼入）

Important Points

- 病歷書寫的主要目的是互相的溝通
  - 讓其他醫療人員了解病人的治療反應，病情進展，並作適當的溝通和處理。

- 病歷書寫是經過整理及邏輯思考後的寫作
  - 依照時間順序，有系統的整合陳述。

PGY病歷記錄常見的缺點

- 未及時記錄
- 不符合問題導向方式，常有遺漏
- 診斷、評估及治療計劃沒有一致性
- 複製以往病歷產生矛盾或完全不相關的記載
- 流水帳記法，言之無物
- 影像檢查之發現未記錄
- 定期摘要及換班交接記錄未落實
- 文字、文法、縮寫、日期、專有名詞之混亂使用

結論

- 寫好病歷是擔任醫師之基本要求，這是屬於醫療品質的一部份，而導師或臨床教師之指導，責無旁貸。
- PGY經由寫病歷時的思考，增加學習的機會，以充實未來行醫之能力。
- 修改PGY之病歷要有耐心
- 我們教了這麼多，PGY會照著做嗎？如果每天住院病人太多，照護之病床太多，他們仍然不會依我們的要求去做。

- 所以，重點在於合理的loading，不要讓他們負荷過重。

~謝 謝 聆 聽~