ner happens to be available for each episode of illness. No one doctor will be charged with the responsibility for providing continuing primary care for a vulnerable individual and collective responsibility can so easily become the collusion of anonymity.

As general practitioners we are under threat from many quarters. The taxpayer would prefer to employ more ancillary staff at a quarter of our salaries to do 90% of our work, nurses and pharmacists feel they already do much of our job themselves, and hospitals are encroaching into general practice in every possible way with paediatric, geriatric, psychiatric, handicap, asthma and diabetic community teams. The general practitioner's unique role is to provide continuity of care in the context of family medicine. If we abdicate from that we have only ourselves to blame if others eventually decide that general practitioners have nothing extra to offer the care of the sick in the community apart from doing the night calls (where there is no deputizing service).

After reading the letters in the March *Journal,* I then turned to the original papers in the same issue. My eye was caught by the summary of the article by Roland and colleagues (March *Journal,* p.102). It stated: 'Patients registered with practices operating personal lists received much better continuity of care than those registered with practices operating combined lists. Patients...regarded continuity of care as important, especially if they were registered with practices operating personal lists'.

I suggest that combined list practices have little advantage for patient care over personal lists and it is only doctors who benefit from them.

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Sir,

I was surprised that Dr Elliott-Binns (Letters, March *Journal,* p.134) listed so many disadvantages of the personal list system. In practices with partners of different ages the methods of treatment of different conditions, for example hypertension, are often totally different; with Dr Elliott-Binns system of pooling patients the younger practitioners may not be familiar with the side-effects of methyldopa and similarly the elder practitioner may not be familiar with the side-effects of calcium antagonists.

Dr Elliott-Binns also suggests that personal lists decrease the doctor's awareness of his partners' ways of working but he forgets that in most partnerships night visits, evening visits and weekend work is usually discussed by the visiting doctor and it is without doubt better for the patient that the duty doctor has a specific doctor to inform about a patient's progress. This will lead to the discussing of patients which Dr Elliott-Binns fears would not happen with a personal list system. The beauty of the personal list system is that chronic problems and chronic patients do not get passed from one doctor to another, but doctors are made responsible for the proper treatment of their patients. With a personal list system it soon becomes apparent if a doctor has a weakness, as other partners are constantly picking up that problem at night or at weekends. This leads to a superb peer review system, and a stimulus for the doctor to brush up his weak subjects.

Dr Elliott-Binns makes the point that patients are unable to sample or choose their doctors, but on the other hand it is well-known that many patients will 'hunt' the general practitioner who will give them the treatment they perceive they need. It may be better for the patient to be told to take aspirin for a sore throat rather than to make appointments with each doctor in the practice on separate days until he is prescribed the penicillin he perceives he needs. If the patient can only turn to one doctor he will always get the same drugs and the same treatment and will learn to respect and understand that doctor's working methods.

Finally, I would agree with Dr Elliott-Binns' comment that sometimes one particular doctor is busier than the others. This does tend to equal out over the year, and the advantage is that the busy doctor cannot shirk his own patients. If they are his patients he has to see them. It is all too easy in a busy partnership for each doctor to invent excuses not to see any 'extras'.

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Medical record folder for the Lloyd George envelope

In January 1965 I took over a practice from a single-handed practitioner and was immediately faced with the task of keeping clinical records to satisfy my needs. I felt that a summary card was needed and I plagiarized the idea of a folder from the Birmingham practice where I had previously been an assistant. The redevelopment of Aston had caused the NHS list of Dr Roger Morgan to have a high turnover and I adopted his solution to the problem of summarizing clinical information about large numbers of new patients. This solution had some features in common with the record folder proposed by Drs Floyd and White (January *Journal,* p.19). I shall call Dr Morgan's design the 'Aston' folder and Dr Floyd's design the 'Croydon' folder.

The folder acts as a cover for the contents of each medical record envelope (FP5/FP6). The material and dimensions are critically important; the most suitable material is index board which resists wear and tear at the fold for much longer than cheaper, softer papers. At the same time the surface is not too highly glazed to be written on conveniently. I use a card of the same height as the Croydon folder (177 mm) as this is the height of the English forms FP7 and FP8. NHS stationery is not standardized and there is considerable variation between different print orders by the DHSS. Present continuation cards do not fit envelopes FP5 and FP6 which are 2 or 3 mm shorter and, because of the thickness of the cards, the internal dimension loses a further 2 mm or so. Both the folder and FPs 7 and 8 therefore project some 5 mm, with resultant wear on the top edges. The Aston folder is a few millimetres wider than the Croydon folder which allows it to enclose the whole contents of the envelope and to slip easily in and out of the envelope for each consultation. I have found in a short trial of treasury tags that there was excessive wear on records and that mounting pages on tags caused avoidable extra work for both ancillary staff and doctors.

I am also concerned that the Croydon folder carries so much sensitive and confidential information on its outside pages.

Dr Floyd uses the second page of the record card to create a dated biography. While this has points in its favour, it is very wasteful of space for the majority of patients. It may show clusters of life events but it may be just as relevant to show clusters of organ or regional events. In 1964, Dr Morgan devised a graphic way of overcoming the list presentation by printing an outline anatomical figure on page two of the Aston folder. This figure enables clinical events from fractures to fugue-like states to be entered in relation to regions, by side and by site, and enables the many scars on some abdomens to be clearly identified. The addition of a simple detail here and there will easily distinguish internal events. This minimal structure allows great flexibility of recording and has been readily adapted to patients' needs over long periods.

Two decades of experience of this system have shown the following advantages:

— The contents of the medical record envelope are easily arranged and easily retained in proper order without the use of tags.

— The contents are easily slipped in and out of the medical record envelope by the 'shoe-horn' effect of the card folder. When it gets a bit tight it is the signal to edit the letters again rather than make out a gussetted medical record envelope.

— The synopsis of previous events and adverse drug reactions is immediately available opposite the latest clinical notes. Sensitive information is always entered on page 3 and in ordinary use is always covered by other notes. An arrow or asterisk on page 2 will alert clinical users to entries on page 3.

— The simplicity of the structure has been invaluable in adapting the system to the needs of patients and staff for 21 years.

— The Aston folder has been demonstrated to trainers' courses in Wessex since 1978. It has been freely adapted by neighbouring practitioners, and many others have made favourable comments when my synoptic record has followed patients moving round the county.

I would like to hope that these innovations in record keeping will stimulate the Council of the College to press the General Medical Services Committee to keep up demands on the DHSS for simple improvements in our record system before further deterioration takes place.

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Inspection of vocational training schemes

Sir,

Doubts have recently been expressed about the validity of the inspection of vocational training schemes by visitors from the Joint Committee on Postgraduate Training for General Practice (JCPTGP).[1] The author described a visit to his large vocational training scheme which was accomplished in six hours. Visits to other schemes may have been done equally quickly, but this was not our experience; a visit to the East Cumbria Vocational Training Scheme, performed in 1980, was done thoroughly and took three and a half days to complete.

At the time of the inspection the scheme had eight training practices, in Carlisle, east Cumbria and southern Scotland and the hospital posts were based in the four hospitals in the Carlisle area, representing a wide variety of experience in specialties of direct relevance to general practice.

The details of the visit were worked out well in advance and considerable time was taken to arrange and coordinate with all the members of the team and other persons concerned with the visit. The visitors had a working dinner with the regional adviser and the scheme organizers and they visited each of the practices, talking to the trainers and, somewhat more briefly, to the non-training partners. The premises, facilities and records were inspected. The visitors also attended the half-day release seminars, during which they had ample time to discuss with the trainees their feelings about the course in particular and vocational training in general. On the evening of the same day the team went to a trainers' workshop, when discussion with the trainers also took place. The hospital consultants involved in the scheme were not neglected and after a dinner hosted by the chairman of the then Cumbria Area Health Authority the consultants were given ample time to discuss their feelings about the scheme and air their grievances (which were, mercifully, few!). On the afternoon of the last day the visitors met with the scheme organizers to give them their preliminary report, their full and final report being received via the regional advisers and the Regional Education Committee for General Practice some weeks later.

We felt the visit was not only an inspection of the quality of training provided by the scheme but also contained educational elements which arose from the conversations that the visit engendered. The scheme organizers and all those involved with the scheme saw the final report in full and had ample time to discuss this. Indeed, nobody had any major criticism of the visit or its findings. Whether the most recent visit, which took only six hours, reflects more the attitude of the course organizers or is a reflection of the changed attitudes of the JCPTGP is not clear. Certainly, we did not feel that our visit had been skimped, and probably thereby felt justified in accepting the report of the team without dissent.

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Reference

1. Bahrami J. JCPTGP: from the other side of the fence. *Br Med J* 1986; **292:** 29-32.

What happens to surgical patients when their admissions are postponed?

Sir,

One consequence of the reduction of the number of acute beds in National Health Service hospitals and the increase in the size of waiting lists is the considerable pressure on available beds. Inevitably, when booked admissions are postponed because of shortage of beds, some patients will suffer hardship. I carried out a study at Ealing Hospital in London to assess the nature of this hardship for surgical patients and I report my findings here to draw the attention of general practitioners to this problem.

At the beginning of this study 580 patients were on the hospital's waiting list for general surgery. If an admission was cancelled every endeavour was made to give the patient priority when a bed was available, and a standard letter was sent to him explaining the reason for the cancellation, and stating that he would be sent for again soon.

Each patient placed on the waiting list was asked to complete a questionnaire detailing the nature of the inconvenience caused each time his admission was cancelled. When the patient was finally admitted the completed questionnaire was collected for analysis. The inconvenience caused to the patients was divided into medical, social and financial. Medical inconvenience was deemed to have occurred if the patient had symptoms from his condition, and would have obtained relief had the admission taken place; an example of this is continuing pain from a duodenal ulcer. Social inconvenience was one which caused disruption in the lifestyle of the patient or of his relatives and friends; for example, if the patient's spouse took time off work to look after the children and the admission was postponed. The financial loss which occurred had to be shown to be due directly to the postponement of the admission. For patients in employment the total number of days taken off work was also recorded, as well as the reason for not returning to work as soon as it was clear that admission would not take place. The study was conducted for 12 months from February 1983 and during this period there were 556 admissions from the waiting list.

There were 171 cancellations involving 125 patients whose ages ranged from 16 to 86 years (mean 47.4 years). Thirty-one patients had their admissions cancelled on two occasions, and 11 on three occasions or more. No patients died while they were