A medical record folder for the Lloyd George envelope

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SUMMARY. A summary card in the form of a four page folder is described for use in the standard medical record envelope. It holds the current continuation card, has space for basic patient data, a problem list and a simple biography and provides an aid to regular screening and other preventive measures.

Introduction

THE current medical record envelopes (Lloyd George envelopes) have been in existence since the First World War and in spite of many criticisms, there are points in their favour. Their size makes them easy to handle and they occupy minimal storage space. They can be carried in an overcoat pocket on home visits and they discourage copious note-taking. Other more expensive or bulky systems have been proposed and researched, such as A4 systems[1] and computer records.[2] In the present impecunious state of the National Health Service the likelihood of their implementation throughout the country is small. It seems reasonable to assume that the present medical record envelopes are here to stay and every effort should be made to improve them.

The Joint Committee on Postgraduate Training for General Practice (JCPTGP) requires training practices to organize their patients' medical records. Continuation cards (FP7/8) and hospital letters should be punched and mounted on treasury tags in chronological order. By 1986 every training practice should be starting to create summary problem lists where they do not already exist and, if appropriate, an easily discernible drug summary card for each medical record envelope. The JCPTGP are also requesting that records should be legible.

In general practice it is rare to find doctors' notes which allow information to be readily extracted. Two systems for improving the extraction of information have been described — the Aldeburgh system[3] and the Crediton system[4] — both using the standard medical record envelope. The first uses five specially printed cards and the second uses four overprinted cards supplied by family practitioner committees (two FP8s, one FP8A and one FP9A).

It was decided to devise a single summary card, with easily recognized areas, on which certain basic details of the patient's medical, personal and family history could be entered. This would enable anyone seeing a patient for the first time to gain a working knowledge of the patient in about half a minute. Different formats for the summary card were evaluated and finally a four-page folder was selected.

Description of the folder

The summary card measures 22.7 × 17.7 cm and folds in half to form a four-page folder which fits into the standard medical record envelope. A photocopying technique was used to print onto white card, thus avoiding the expense of printing and allowing changes in the format of the card to be made easily.

The first page of the summary card is used for basic data about the patient (Figure 1). The order of the items on this page follows the order of a questionnaire given to new patients. This allows easy transfer of the information on the questionnaire to the card by clerical staff. At the same time the medical record envelope is sorted and its contents secured with treasury tags. The patient's name, place and date of birth and ethnic origin are entered on this page of the summary card. The address is omitted as patients often move house without leaving the practice. The personal history of the patient including drinking and smoking habits are entered and there is a column for problems. These problems include major illness, important events (for example, 'parents divorced when patient aged nine years'), chronic illness and current situations (for example, 'husband has multiple sclerosis'). The section of the card entitled family history offers a check-list of illnesses present in the patient's family and provides space for any familial disease not listed. School leaving age, further education and occupations are also entered on this page.

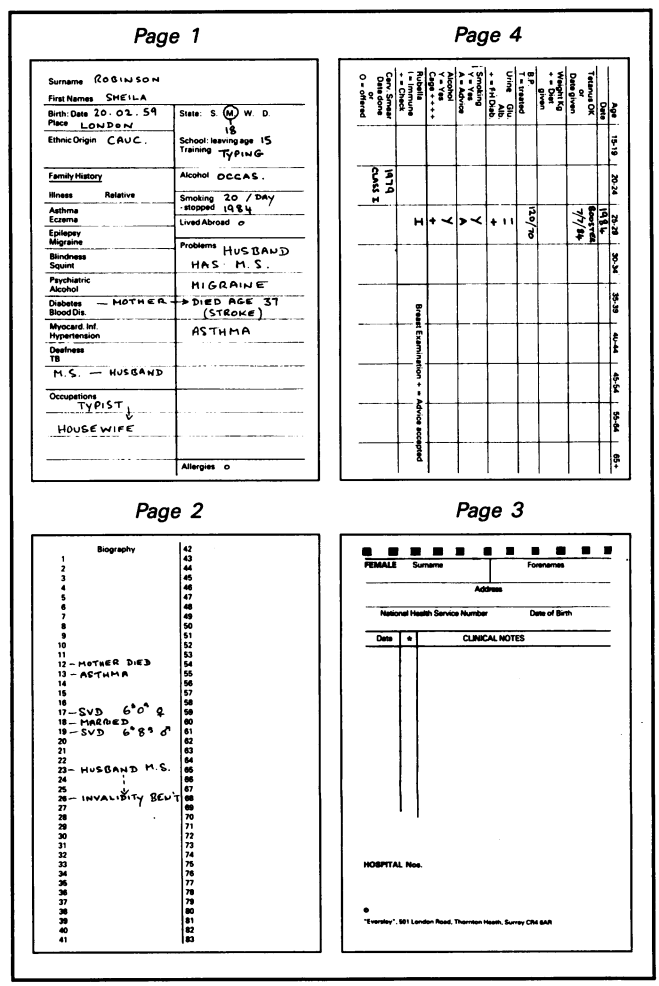

Figure 1. *Example of use of the summary card. Pages 1 and 4 form the outside of the folder and pages 2 and 3 the inside.*

Page two of the summary card allows the patient's biography to be entered in chronological order (Figure 1). A series of numbers (1–83) in two columns enables entries of significant life events to be made alongside the patient's age at the time of the event. This appears to be more helpful than simple listing — as information about the patient is gathered over many consultations it can be entered by the appropriate age. An awareness of the major events in a patient's life adds another dimension to our understanding of the patient. The biography may show clusters of illness at the same time as major events in the patient's history. In addition a rapid glance at this page can prevent the doctor from asking the patient irrelevant questions.

Page three of the summary card has a hole in the middle of the card at the top so that continuation cards can be fixed, in order, by a treasury tag (Figure 1). All the continuation cards used in this practice are punched in this manner, enabling the cards to be placed either side up. With the folder open, the current continuation card is on the right and the biography is on the left. Page three provides space for hospital record numbers which are useful when trying to admit patients to hospital.

Page four of the summary card is designed to encourage the doctor to make periodic five-year checks on his patients (Figure 1). This page is divided into five-year age bands from 15 years to 65 years or over. These five-year checks are supported by a computer 'health check' which patients are invited to complete while waiting to see their doctor.[5] A print-out of the results can then be in front of the doctor during the consultation. He may then deal with that patient's particular needs and record the results of the health check in the appropriate boxes on page four of the summary card. The subjects covered by the computer check are tetanus booster, weight, blood pressure, urine and smoking. Drinking habits are assessed using the four questions of the CAGE questionnaire.[6] Women are asked additional questions about rubella status, contraception, cervical smears and breast examination.

Other cards may be included in the folder for specific purposes — for example, for contraceptive care, hypertension, diabetes or repeat prescriptions. Hospital letters, pathology reports and X-rays are treasury tagged and filed separately in the medical record envelope, as they are not needed at every consultation.

Discussion

It has been said that the key to good general practice is good record keeping. With consultations of only six mintues per patient a record system is needed which is both simple to operate and comprehensive. Patients are continually providing more information about themselves, but this is useless unless the information can be easily recorded and is readily available.

Basic information may be gathered using self-administered questionnaires and this data can be entered on the summary card by clerical staff. Although not a new technique, the collection of valuable information by computer may be unusual in general practice and it is a time-saving way of gaining information which is otherwise tedious to collect.

Patients' records must provide quick access to basic social and medical data. They should show at a glance the major events in the life of the patient and, ideally, should include a simple timetable on which to base continuing preventive care. An attempt to provide a record structure which meets these criteria has been described here.

The summary card is already providing valuable information during the consultation — particularly for doctors seeing the patient for the first time. However, systems of note-keeping are only as good as the care taken by those using them. It is suggested that the summary card described here makes general practice records more useful.

References

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Low back pain

Low back pain is one of the most common and difficult problems confronting the family physician. It is difficult both to diagnose and to treat; there are only a few defined back disorders for which there is a specific treatment. The majority of patients with chronic low back pain have no defined disease. Even if they have some non-specific vertebral or disc disease, there is often no direct relationship between the structural abnormality and the degree of chronic pain. In addition, the pain pattern is disproportionate to the degree of disease present.

Until the 1970s, physicians searched for some elusive disease, manipulated analgesics and other anti-inflammatory agents or labelled the pain 'functional' and in some way the patient's fault. This led to the psychosomatic approach to chronic pain, which assumed pain was a manifestation of some underlying psychiatric problem. If the psychiatric problems were found and resolved, the pain would lessen. The classic psychiatric approach to chronic back pain rarely resulted in improvement. Similarly, psychopharmacology seldom lessened the pain.

This methodology also led to what can be called the 'either/or' attitude. A patient with chronic back pain either had real organic disease or psychological pain. This implied the patient without disease was either crazy or lying. This approach only antagonized the patients — and aggravated the chronic pain. It also resulted in analgesic abuse.

Most patients with chronic back demonstrate excessive illness behaviour. The initial approach must be to rule out a treatable disease. Then the patient must accept that while activity may hurt, it will not harm. The patient and spouse must both understand that no further investigation or specific therapy will help. The family physician must teach patients to change their lifestyle through a programme of progressive activity. Realistic expectations must be set, with return to a normal lifestyle and work as the ultimate goals.

Source: Goldberg WD. A behavioral approach to managing chronic low back pain. *Can Fam Physician* 1985; **31:** 542-545.