design. Without their help this work would not have been possible.

FOOTNOTE

Since this work was begun a national scheme for the central recording of congenital abnormalities has been introduced. It is interesting to note that the incidence of abnormalities in our small series corresponds with that revealed by this scheme (Ministry of Health, 1964). Thus the figure of 24 per 1,000 total births (live and still) for the country as a whole approximates to ours of seven in 308 births, neither of which is unexpectedly higher than the value of 15 per 1,000 derived by Lamy and Frezal (1961) from several surveys of ' major ' abnormalities detected soon after birth.

During 1964 the County Medical Officer of Health for Shropshire was notified of 129 congenital abnormalities occurring in 95 children out of a total of 6,021 born (O'Brien, 1965).

Thus congenital abnormalities can no longer be regarded as rare curiosities devoid of practical significance. They must rather be sought out meticulously as common, in many cases amenable to treatment and in all worthy of note.

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A SYSTEM OF RECORDING INFORMATION IN GENERAL PRACTICE

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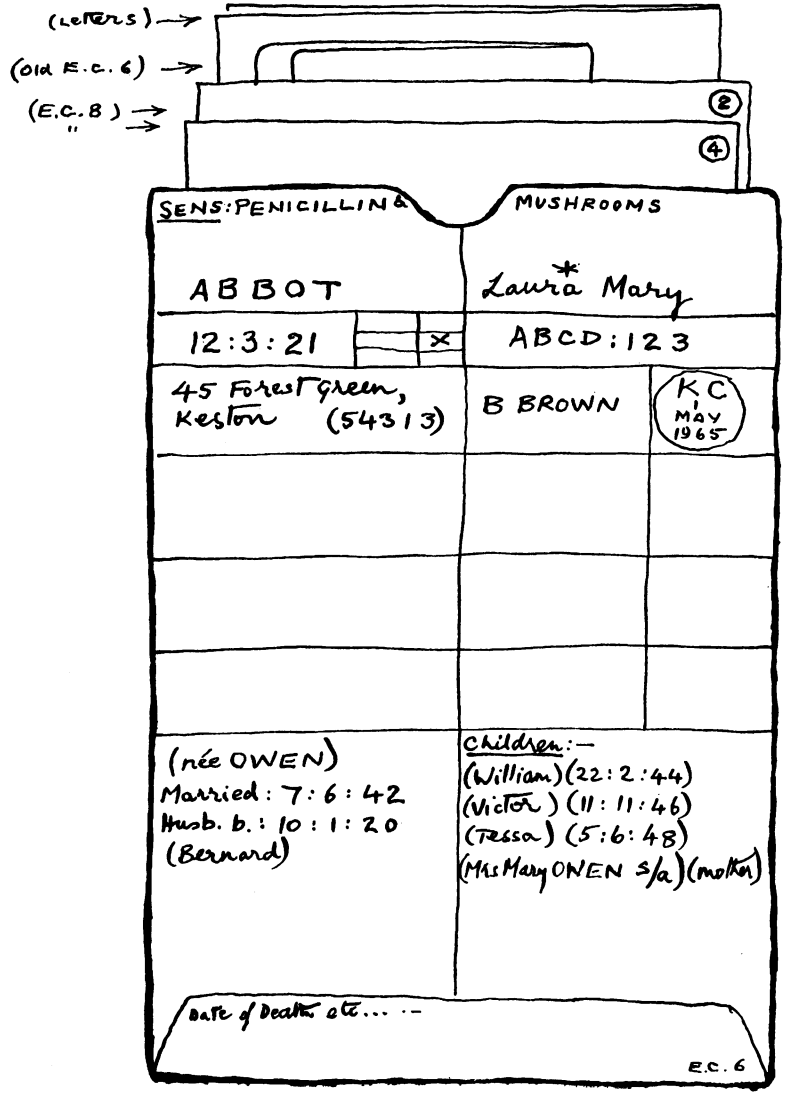
WHEN A PATIENT IS REFERRED to a consultant, the general practitioner often summarizes the relevant past history and treatment; this paper describes certain conventions and in this paper in order to simplify this process only National Health Service cards and folders are mentioned but the principles may suit any list.

Letters

All letters concerning a patient were kept together in the folder (E.C.5, 6). Each letter was filed so that the information was outermost (if folded) and the date facing the front of the folder; if folding was necessary the letter was folded once, or at most, twice with all edges dressed in line, so

that the ' pack ' of letters could easily be straightened up after referring to it. The letters were arranged in chronological order from the front back, so that the most recent letter was at the back of the folder. All the main creases were put to the right (see diagram), even if the date of a double-folded letter had to be up-side-down.

All sheets were independent of each other to make full use of their natural stiffness and to avoid any smaller ones getting dog-eared or hidden between sheets. Staples were removed, and glued surfaces separated or



renewed by transcribing on to a clean sheet, although this happened rarely.

Each sheet was dated, if necessary by rewriting it in the top right-hand corner. No sheets were ever cut to size as it was found that a cut edge was more difficult to straighten up with the other letters, and the fold often reduced the stiffness of a cut letter that was intended to be filed flat. The flimsy nature of many official letters was found to be somewhat offset by the fact that they had to be folded twice as a rule.

Notes

The cards E.C.7 and 8 were arranged in date order where possible, and numbered in the top right-hand corner of each side, so that the earliest card was (1)/(2).

They were then arranged in sequence, the odd numbers always being used for the name-side, and the even numbers for the reverse side (even if this did not tally strictly with the date order of past notes). Waste space on blank or half-used sheets was removed and all the information on the rest of the sheet transcribed chronologically on to a fuller one.

Other details

Old E.C.6 folders were folded lengthwise with the front outermost, and placed between the packs of letters and notes as a watershed, to help in removing and replacing either pack, as it was usually found necessary to do this separately. Vaccination records and maternity record cards were filed between the packs in the same way.

Scottish folders and continuation cards were cut down to size.

The folder (E.C.5, 6)

An arrangement was made with the Kent and Canterbury Executive Council and any defective or outdated folders were replaced by new clean ones.

The information was then recorded as shown in the diagram: SURNAME, christian names in full with an asterisk against the one commonly used by the patient, date of birth, N.H.S. number, address, phone number (or if none, details for giving messages), and the doctor's name and council stamp.

The bottom half of the folder was reserved for the essential family history.

Sensitivity was noted in capitals above the surname, at the very top of the front.

The surname and initials, but with the main christian name in full, were repeated at the top of the back of the folder.

Below the name on the back was built up the full family and social history as it became apparent while the patient was on the list, but not necessarily written down at the time of the interviews.

The bottom half of the back of the folder was kept for essential details of past history, with dates of operations and when chronic illnesses were first noted.

The system in action

The records were completed as far as possible up to 1 May 1965, and then that was taken as the starting date for the arrangement with Maidstone for renewing any folders as the need arose, but most of the conventions had already been tried out for the past three years on the old folders.

When a patient came on the list, a continuation card (E.C.7, 8) was made out, giving the name in full with usual christian name marked, the address, and the date of birth. A note was made of the date of this meeting with any relevant medical notes for that occasion, and the medical card sent off the same day if possible. This ' new patient card ' was kept in a box with others, until its folder arrived from the council. In the meantime its place was marked in the main file of folders by a pink card (an old immunization record card) with the name and date of acceptance on the list written along the top.

It was not until the folder had arrived that fuller details of family and job were asked for, although much of this was told without prompting at an earlier meeting. It was also found best to record any such details immediately after the interview, because the opportunity for asking for such personal details a second time often did not arise until much later. As soon as a folder was received, it was sorted, the new patient card and any letters were put in it, and then it was filed in the place of its pink card in the cabinet.

When a folder was removed for use, a plain pink marker was put in its place temporarily.

The folders were kept in alphabetical order, females in one group, males in the other, with clear markers for each initial letter as usual. When a patient was known to have died, the folder was removed from the main filing cabinet, and replaced by a pink marker, labelled with the name and date of death; the folder was put in the box behind the new patient cards; and when it was sent for by the council, it was replaced there by the pink marker from the cabinet until all further correspondence had arrived from the hospital or home. But when a patient was known to have left the district, the folder was not moved from the cabinet until asked for, but a note made on the continuation sheet as to the date and place of removal. Temporary resident and emergency notes were dealt with in the same box as the new patient notes.

When the executive council sent for a folder, the letters and notes were flipped through to remove anything personal or no longer relevant, and a brief summary was written at the end of the last note, not repeating past or family history already on the folder, but giving a thumbnail sketch of the sources of stress and character; this was then signed and dated the day of sending to the council. Where possible the backs and fronts of folders were completed by reference to the folders of the members of the same family before sending them off. Any information that was needed for further study was transcribed, on to the Family Card[1] which had also served as the age/sex register of the practice.

Diaries

As a check for future reference, especially concerning contact with

patients who were a source of stress, an appointments book was kept, not only for booking attendance in advance, but also for recording those who came without appointment (and those who missed their appointment, although this was rare without phoning), and next to either of these a note was made of any patients or relatives seen at the same time as the 'real' patient, especially if that patient was not present: a wife coming on his behalf for example. After the last patient, a line was drawn and the visits for the day written in after they had been done, if possible in the order of doing them, and with a note of who was also seen at the house at the same time. Finally a note was made of those who had rung up for a prescription, or who had written asking for one; whenever possible the person writing or phoning on a patient's behalf was noted in brackets after the patient's name—this applied to appointments, visits and requests for advice or prescriptions.[2]

Hospital admissions

One of the local hospitals already notifies the general practitioner when any patient is admitted off the waiting list, and another is actively considering it. As soon as a patient was known to have gone to hospital, the name was put down as a visit in the same way as usual, and written in the diary (appointments book) after being seen; if they had already been discharged this was noted in the same way as a missed or cancelled appointment; all hospital visits were marked in the diary with an " H ".

Summary

A system of recording and abstracting information quickly is described, which makes full use of conventional material already found in N.H.S. records. No previous knowledge of the system is required for another doctor to take over where the last one left off. It is flexible enough to make use of any size of rectangular sheet up to foolscap size. It is chronological and dovetails in with an age/sex and personal history register that has already been described. It is designed to help summarize the state of affairs when referring the patient for another opinion, but can be used for any line of prospective or retrospective research in general practice.

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