THE 'L' BOOK

Records and Research Advisory Service

THE way in which research records are kept in general practice is determined by the requirements of special studies, but if continuing recording is undertaken the interests of the doctor can influence his choice of method. It is the problem of the Records and Statistics Unit to provide a number of practical alternative methods and to offer the doctor a choice. The Unit must also ensure that data collected by observers using any one method may be accurately compared with that gathered by the other alternatives.

In the 'E' Book Diagnostic Index the denominator is diagnosis. In the 'S' Card method of recording the denominator is the individual whose morbidity experience is summarized, and where data are accumulated in relation to an age-sex register the need to identify groups and individuals in the practice population becomes the governing factor. The observer can thus choose the method of recording best suited to his interests and can at the same time achieve comparability of his data with those of others provided appropriate facilities for mechanical data-handling are available to him.

The measurement of work-load, with the simultaneous collection of material for statistical analysis, is not covered by these alternatives, and it is with this as denominator that the 'L' Book has been designed from the ledger used by Dr H. N. Levitt. The modifications introduced by the Records and Statistics Unit enable data cumulatively stored on ledger sheets to be transferred to punch cards or magnetic tape without difficulty, while at the same time the doctor, or his staff, can keep a record of items of service rendered, together with such qualities relating to these items as he may choose.

The 'L' Book is a loose-leaf ledger with sheets of foolscap size designed to lie on the desk of the doctor, or secretary, with the long axis horizontal. On each page are horizontal columns enabling data to be recorded on 25 consecutive items of service. The completion of the ledger can be the responsibility of the practice secretary or receptionist who would keep it as the practice daybook, one of the subsidiary purposes which it can usefully serve. The doctor, however, is required to code certain items of information, including the diagnosis, before the receptionist can complete her entry. The

Dr. Code

1	2	3	4	5	6	7

ROYAL COLLEGE OF GENERAL PRACTITIONERS RECORDS AND STATISTICS UNIT

L.I.Copyright (1966)

"L" BOOK

SHEET No.

8	9	10

Item No.	Date			Surname of Patient				Forename		Date of Birth			Sex	MS	SS	Occupation	Diag. Code			Att.		A	B	C	D	E	F	G	H	I	J	K	L	M	N	Remarks
11-12	13-14	15-16	17-18	19	20	21		22		23-24	25-26	27-28	29	30	31		32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	
1																																				
2																																				
3																																				
4																																				
5																																				
6																																				
7																																				
8																																				
9																																				
10																																				
11																																				
12																																				
13																																				
14																																				
15																																				
16																																				
17																																				
18																																				
19																																				
20																																				
21																																				
22																																				
23																																				
24																																				
25																																				

diagnosis is coded according to the Classification of Diseases introduced by the College, and further items selected, perhaps by the doctor himself, are coded according to rubrics agreed with the Records and Statistics Unit.

The recording procedure is similar to that employed in both Diagnostic Index and Summary Card Recording. The Code Number identifying the doctor is the first entry to be recorded, on the outside of the ledger, and at the top left-hand corner of each sheet (Boxes 1–7). In a partnership practice a separate ledger can be kept for each doctor, and in National Health Service practice the identifying code can be the seven digit number found on the prescription pads of all practitioners. This entry must be made on each ledger page so that photocopies of single pages can be correctly identified. The serial number of the ledger sheet will be entered at the top right-hand corner of the page (Boxes 8–10) and the ledger is then ready for use.

The sequence of items of service is kept in the first vertical column of the page (Boxes 11–12), where the number of the item is printed up to a total of 25, and as each patient attends, the secretary completes the horizontal column appropriately. The date is first inserted (Boxes 13–18) followed by particulars which enable the patient to be identified. This is essential where data are to be linked to an individual patient by mechanical means. The first three letters of the patient's surname are entered (Boxes 19, 20, 21) and the first letter of the first forename follows (Box 22). To these four characters are added the full date of the patient's birth expressed in the conventional way (Boxes 23–28). In Britain this will be day–month–year; in some other countries month and day will be reversed.

The sex of the patient may not be evident from the name, so this is recorded (Box 29, M=male, F=female), as is the patient's marital status (Box 30, S=single, M=married, D=divorced, W=widowed, O=other). The social status of the patient is recorded in terms of the Registrar General's socio-economic classification (Box 31). This is derived either by the secretary or the doctor from a full freehand entry of the nature of the patient's occupation in the adjacent column.

Class 1 Professional occupations
Class 2 Intermediate occupations
Class 3 Skilled occupations, including mine-workers, transport workers, armed forces
Class 4 Partly skilled occupations, including agricultural workers
Class 5 Unskilled occupations, including building and dock labourers

Up to this point the secretary can complete the entry by reference only to the patient, or to the basic data recorded on the patient's medical record. The next entry must be made either by the doctor,

after the item of service is completed or copied by the secretary from a marginal note of the code number which he has made on the clinical records.

Where an envelope system is used, as in the National Health Service, the attention of the secretary can be drawn to the sheet or card on which the latest diagnostic code entry has been made by leaving the sheet projecting from the envelope. The doctor codes the diagnosis by reference to the 'glossy' classification on his desk and the secretary copies the three-digit rubric (Boxes 32–34).

It may be of value to know whether the attendance is a first, second or subsequent attendance for the condition under treatment and note of this is made in the next two columns (Boxes 35–36). This may be determined by the secretary from scrutiny of the notes or it, too, can be indicated for her by the doctor in the form of a marginal note. If the doctor uses cards of the type S.4A for his routine clinical notes he will find two columns adjacent to the date-space on the left of the card which can be used for this.

The data so far accumulated is basic to all methods of recording introduced up to the present and the data recorded in the remaining columns, which are identified only by upper case letters of the alphabet, is variable to suit the circumstances of the practice, of the particular study, or the interests of the doctor. Codes are constructed which enable alternatives to be recorded, either courses of action, treatment employed, symptoms presenting or other chosen qualities relating to the item of service. Where the number of alternatives is nine or less a single column can be used. Where the number of alternatives is more than this, two adjacent columns are committed.

The Boxes A—N (37—50) are used singly or in pairs. An observer might wish to record his disposal of cases as between eight different hospitals. Each would be given a code number from 1—8 and the code number entered. The digit '0' would be used if the patient were not referred. Supposing the observer wished to record his employment of one of a coded list of 20 pathological investigations two columns would be required. In either case a check-list of the codes to be used would be agreed in advance with the Records and Statistics Unit and kept on the recorder's desk for easy reference.

Though one standard ledger sheet will be introduced it will be possible to print different layouts for specific studies in which the use to which columns are to be put will be clearly and precisely defined. This would make for slightly greater ease of working, though it would only be justified where a sufficient number of sheets was to be used.

Within the practice running totals may be kept by the secretary,

and the activities of the practice examined in a number of ways without involving mechanical analysis. Consultations and visits may be separately identified, the time factor can be measured and information elicited of value both to the practitioner and others. Much more highly sophisticated analyses of data recorded can be undertaken by arrangement with the Records and Statistics Unit.

Completed ledgers for a given period may be sent to the records unit by arrangement, for analysis by punch-card or other means. After the contents of the ledger have been dealt with it will be returned to the practice where it will remain a source of information to which reference may be made and which will increase in value each year. Under certain circumstances photocopying of the ledger sheets might be desirable.

The Records and Statistics Unit wish to allow flexibility in the use of each of the methods which they introduce and new applications of the principles involved in the use of the ledger are sure to be found. No modification of the methods advised should, however, be introduced without direct consultation with the Records and Statistics Unit. To introduce variations without guidance might be to destroy the comparability between the data and that of others, or even to make mechanical analysis an impossibility.

The Records Unit will welcome discussion with those who wish to introduce 'L' Book recording into their practices. Further information may be obtained from the **honorary director, The Royal College of General Practitioners, Records and Statistics Unit, 146 Hagley Road, Birmingham 16.**

Appointment systems in general practice—how patients use them. J. K. S. STEVENSON, M.B., CH.B., D.OBST.R.C.O.G. *Brit. med. J.* 1967. **2**, 827.

This further paper by Dr Stevenson (See *Brit. med. J.* 1966. **2**, 515, abstracted *J. Coll. gen. Practit.* 1966, **12**, 318) is mainly concerned with how patients use appointments, and the data collected answers many of the questions asked by doctors contemplating their introduction. Time improved usage of appointments from 77 per cent in 1962 to 95 per cent in 1966 and also reduced the percentage of patients defaulting from their appointments from seven per cent in 1962 to three per cent in 1966. Everyone who wishes to be seen on a particular day is seen, although after examination if his demand for a consultation is thought to have been unreasonable this is pointed out. Surprisingly few patients, only two per cent, were prepared to wait a day or two to see the doctor of their choice.