The family index in practice

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A GRANT FROM THE RESEARCH FOUNDATION BOARD has made it possible to bring the family index up to date by using the smaller hole variety of the Copeland-Chatterson punched cards (figure 1).

The basic principles of recording family relationships were drawn up by Kuennsberg in 1964, and, I suggested using card indexing instead of the ledger, and devised a code of initials to make it simpler to describe these relationships. [1]

Family Card, House Card and Life Card (1970).

Figure 1 shows three cards, which each consist of an edge-punched portion and an upper and lower central portion. The upper, and lower right portion of the central part is identical in all three cards, and is for recording the identity of the patient and his family. The layout is improved to make the relevant edge-punched details more easily scanned when the cards are stacked in the drawers in daily use.

The edge-punched part is clipped for the following:

1. Patient's date of birth
2. Patient's date of acceptance by the doctor
3. Patient's relationship (if any) to the key relation, including sex
4. Social status, and degree of health/fullness of living (Life Card)
5. Date of removal from the list
6. "Z" if dead

There is also a special hole to be clipped of any special cards which need to be made out for relatives affecting the health of a patient, but who are not themselves on the list; these are clipped at "K", and their own doctor's name is written in if possible.

Such cards should be kept separately.

Method

A starting date was chosen for introducing the index. The medical records of the practice had already been prepared, and it was known that the records in the files tallied with their counterparts in the executive council offices on that day.

To help to scan them, new envelopes (EC 5, 6), always ungussetted, were made out for each dirty one in use. Owing to limited funds at this stage, the index was introduced for the patients of only one of the three partners. A Life Card was then made out for each patient.

Each Life Card was then matched with a Family and House Card, which were made out in sufficient detail to identify the patient and family.

The House Card was then reversed on the Family Card and Life Card, and all three were clipped; for acceptance date, for date of birth of key relation as appropriate, for sex, relationship etc.

The Life Card was then returned to its place, and finally the other two were clipped for date of birth of the patient, before filing the Family Cards in chronological order, and the House Cards in family order, that is, in alphabetical order of key relations.

Fuller details were made out on the bottom-left-hand centres of the cards as they became clearer in use.

Date of acceptance (after the starting date) was taken as the date when the doctor signed and sent the medical card to the executive council, and a careful check was made of the EC 7B,

8B and of other signs of 'ratification' as they came through; this process could well be speedy in a computer age.

Date of removal on the other hand was taken as the date on the sheet of names from the executive council stating that they had been removed. When these sheets arrived, the respective Life Cards were taken out and checked against the details on the medical record envelopes before being sent off. The Family and House Cards were then also removed, matched for

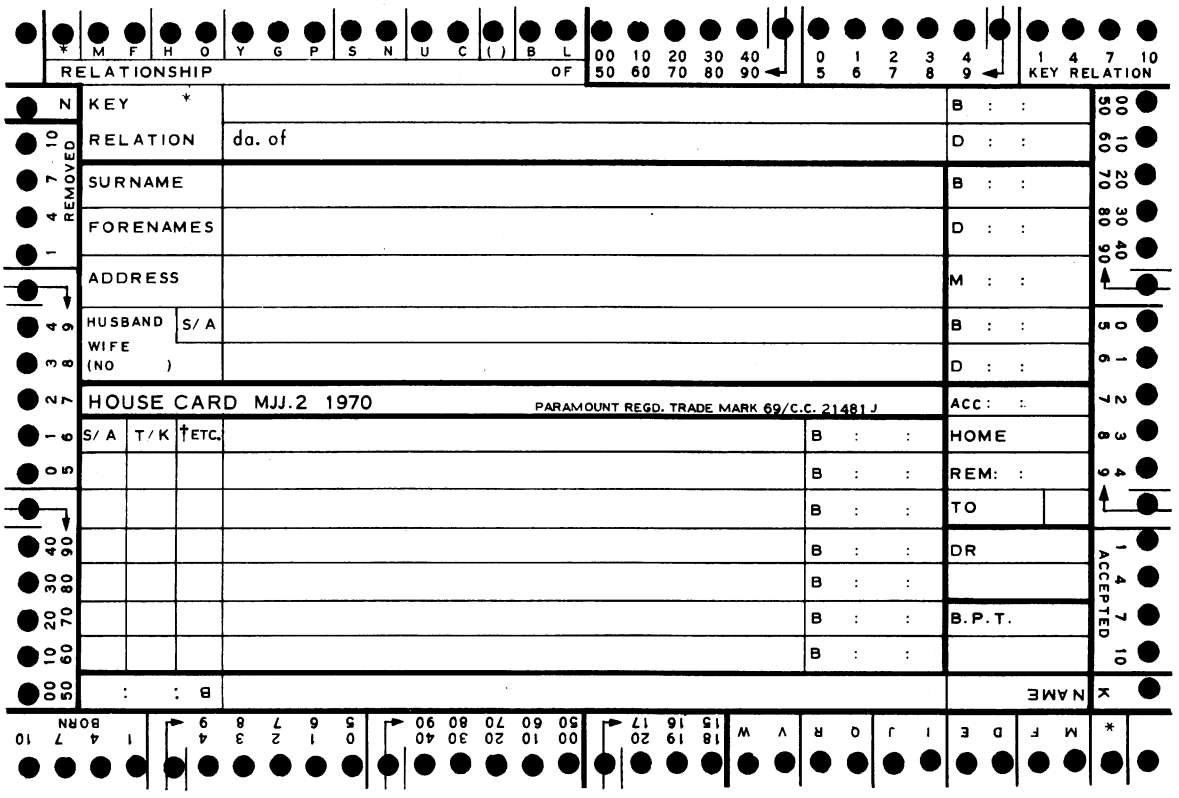

Figure 1a

position, and clipped for date of removal. All three were then filed in the Past-Patient Index in the same sort of order as in the current index. The Past-Patient Index has the cards which have been removed in any one year grouped together. So much useful material is retained with so little extra effort that the College Research and Statistical Unit's age-sex cards cannot compete.

Because the space on the card is limited, and because each college project can have different emphases on the facts required, no attempt has been made to number the compartments for translating on to 80-column IBM cards. When the time comes this can easily be done from a *pro forma* made out for the project in hand, and on to the special stationery required by each project.

Using the code of initials

By definition, each married woman on the list is made a key relation and the relationship between the key relation and any of her household is described by means of three letters. MHL represents her husband and MOB or FOB represents her son or daughter. In practice the majority of relatives of the married women on the list who are also at the same address fall into these two categories. But the card has contingency initials to describe any other relationship, and a convention for using brackets round the centre initial to distinguish a step-son M(O)L from a son-in-law MOL is being developed. The purpose of including them at such an early stage

in the development of the index is to make the cards useful in other fields of research such as genealogy and historical research into the medical history of one particular family of interest. There is therefore spare capacity for fifteenth, sixteenth or seventeenth century people to have cards made out for them, and by so establishing a precedence of position for the clips concerned this can be taken back further even to the "0, 1, 2," stage.

Discussion

A simple code is needed to describe relationships, and one suggestion is that described in 1964 [1] and in use without an alternative being published since. There is also a need to standardize the conventions in use for filling up the various forms which state the identity of individuals. It would help if a conventional layout emerged so that, for instance, the surname in block capitals came first, followed by the 'forenames' not in block capitals, and then the former

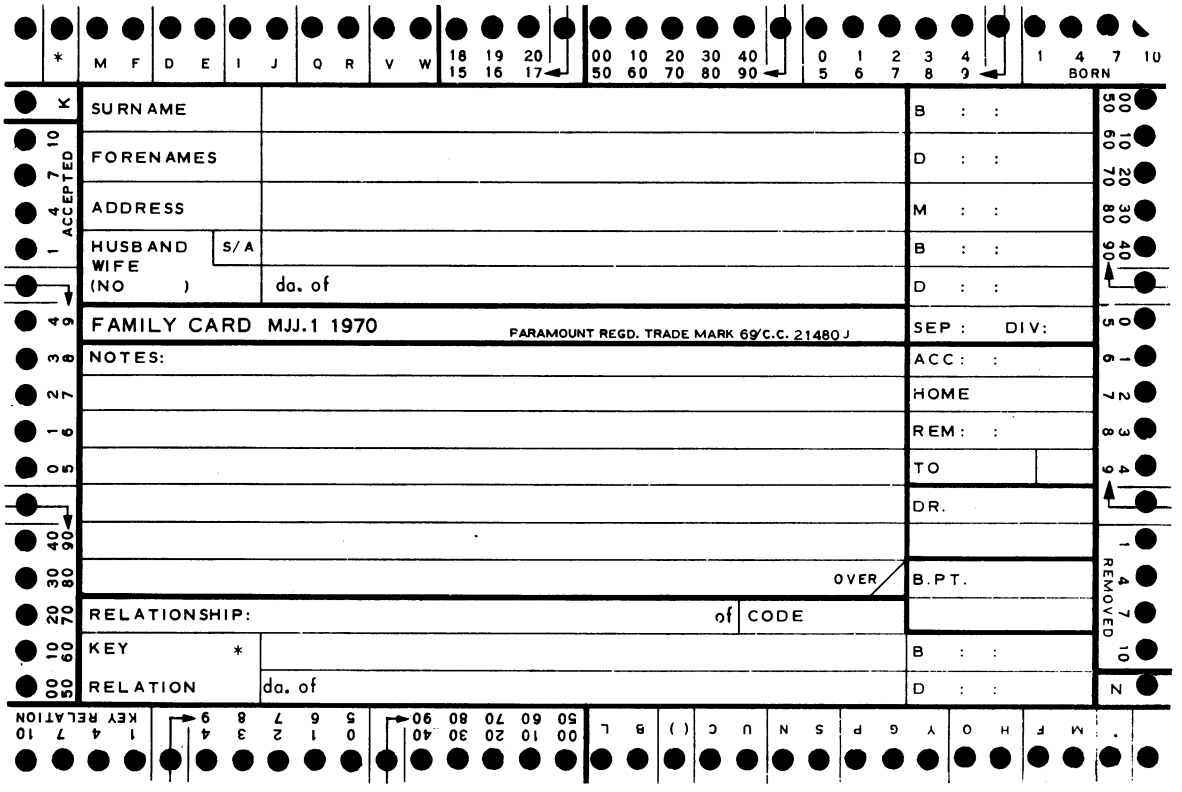

Figure 1b.

surname again in block capitals but prefaced by 'nee' or 'fly' (formerly) as known. It would be useful in age-sex registers which use cards rather than ledgers if the layout was defined in principle, so that, for instance, the surname came near the top and was written legibly enough to be read at speed when scanning through the index, and if the date of birth was likely to be found somewhere in the top right-hand corner in each system. Organizations such as the Ministry of Health and Social Security and the Royal College of General Practitioners sometimes state that a certain card or form, or convention in filling up the form, or in filing the forms, is 'their' form or convention and is the one to use. Surely these must be constantly reviewed and revized in the light of papers published in the field. It is important that each form in use should have some means of identification of its source and vintage.

The advantage of using edge-punching is that any cards that are not clipped correctly or are not filed correctly are seen at once. Unlike the 1–5 per cent error in the work of trained

punchcard operators, a doctor who compiles his own Cope-Chat index on cards he knows how to use can achieve 100 per cent accuracy however tired he is.

The other advantage of Cope-Chat cards used in this way is that a continuous and instant impression can be gained of the distribution of the cards and this can be more useful than dry statistics.

Summary and conclusions

A card index has been described in a previous article and is applied here to a practice list in its present form for the first time.

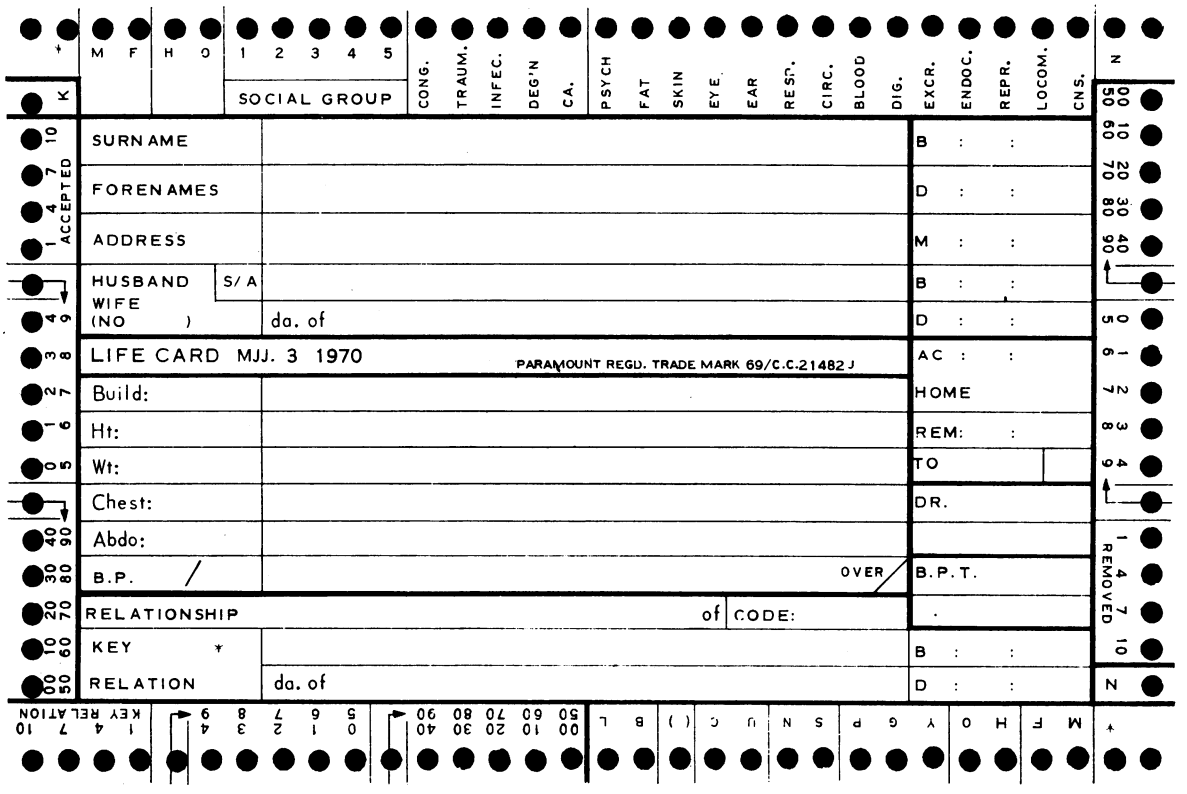

Figure 1c.

The family index is simple to compile, easy to maintain and accurate to use, and no more expensive (once it has been designed) than any other age-sex register of comparable usefulness.

The time has come for a review of age-sex registers. Any inquiry received by the College in this field should be met with a full description of systems in use, but no attempt should be made to favour one or other system unless the advantages of standardization have been published and proved to be overwhelming.

The tendency of bodies such as the Royal Colleges to adopt systems as their own before they have been exposed to the market forces in the field is unhealthy, for the system and the college concerned.

Any system or register or edition of a form is only the latest in a continuing series of attempts by general practitioners to help themselves to get to know the records of their patients as well as Pickles knew his Aysgarth ones, and any theoretical advantage in conformity must be off-set against the fact that a doctor will only maintain accurately a system he himself likes

to use for his own reasons as well as the wider ones of the project of the moment.

Ledgers (whether loose-leaf or not) are probably out of date.

Acknowledgements

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THERAPEUTIC TRIAL

A comparison of the erythromycin estolate and tetracycline in the treatment of respiratory tract infections

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PATIENTS WITH ACUTE EXACERBATIONS OF chronic bronchitis require effective antibiotic therapy for the prompt control of infection. As the range of available antibiotics increases, the selection of the most suitable one for a particular patient becomes more difficult.

Previous trials, in which efficacy of penicillin and tetracycline were compared, failed to demonstrate any significant difference between them (Medical Research Council 1966).

The commonest micro-organism to be encountered in the sputum of patients suffering from acute exacerbations of chronic bronchitis is *Haemophilus influenzae*, which is generally resistant to penicillin. Pneumococci have also been found in proportions varying from 9 to 22 per cent of cases, many of these becoming resistant to tetracycline during or after a course of treatment. (Percival, Armstrong and Turner 1969).

This trial was undertaken to study the effects of erythromycin estolate and tetracycline in the treatment of such cases, and to compare the efficacy of these antibiotics.

Material and Methods

Selection of patients. One hundred patients were initially admitted to the trial, over a period of 18 months. They comprised 72 men between the ages of 48 and 78, and 28 women between the ages of 55 and 85. All the patients were suffering acute exacerbations of chronic bronchitis, and in addition there were in most cases concomitant conditions such as anaemia, congestive cardiac failure, cerebral vascular disease, or senility.

Criteria for admission to the trial were the presence of clinical and radiological evidence of pneumonia, and of purulent sputum. The latter sign was taken as indicative of active

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