The diagnostic index and the family record card

These combined now in recording morbidity

MERVYN GOODMAN, M.R.C.S., L.R.C.P., D.Obst.R.C.O.G., M.R.C.G.P.
Netherley, Liverpool

THE value of the diagnostic index ('E' Book)[1] in recording morbidity in general practice is proven. It enables data to be recorded in a simple manner so that crude information can be retrieved by hand or complex information by using a computer. It has the added advantage of being reasonably adaptable to individual research projects.

In compiling statistical data the value of the resulting information will depend on reducing the errors in recording to a minimum. It should be done in a way which does not disrupt the organization of the filing system used for the clinical records. In a practice of more than one doctor, and where the index is kept by the practice secretary, this is an important consideration. It is necessary to ensure that each episode of morbidity is recorded, at the same time avoiding duplicate entries in the same recording period. To overcome this hazard the family record card (FRC)[2] was introduced into this practice as an intermediate stage.

The FRC is a research tool in its own right, virtually being a composite 'S.4' personal record card[3] capable of recording the data for up to eight people in the same family. Because it can be used on its own for statistical analysis the notation of the columns differs from that on the diagnostic index pages. As the columns in both are titled, as well as numbered, this difficulty can be overcome.

In this practice the medical record cards are filed in families, each having its own A.4 size folder. The executive council medical record cards (EC's 5 and 6) are kept in the folder together with the FRC. When a family registers an FRC is completed and this is changed at the beginning of each recording period (the recording periods are April—September and October—March). Kuenssberg's system of using a different colour of ink for different periods is used.

During the consultation the doctor writes his notes in the usual manner on the medical record card, and, at the end of the consultation, refers to the FRC to ascertain whether or not the disease has been entered on it. If it has, and no further action is taken, the card is replaced in the folder. If this particular episode of morbidity has not been recorded, or if it is a chronic disease which has not been entered during this recording period, he writes the date of the consultation, the type and the diagnosis, leaving the space in the diagnostic code column blank. The family record card is then left out for the secretary to complete.

It is an added advantage to have three tier 'beanstalk' file self standing near the desk. In the top tray the FRC's are placed for the secretary to complete, in the middle one the family folder from which the cards have been removed and in the bottom tray the family folders from which the cards have not been removed which can be returned to the filing cabinet straight away. At the end of each consultation or visiting session the secretary goes through the cards which have been left out and completes the card by coding the diagnosis, entering the code number in the appropriate place. Immediately after this she makes a corresponding entry in the index book and the family record card is then returned to the folder.

In this practice a study is being made into patterns of morbidity and, in addition

to the usual data, the type of accommodation of the patient is recorded. Other information such as pathological and radiological investigations and referal admissions to hospital are also recorded in the diagnostic index using columns 32–40. It is at this stage that there is some difficulty in correlation FRC with the diagnostic index itself. To overcome this, the number of the appropriate column in the index is entered in column 77–80 (titled 1st and 2nd referal). For example, if column 33 in the index indicates direct access radiological investigation and if the patient is referred for a barium meal or a chest x-ray then the number 33 is inserted in one of the columns 78–80. Similarly, a patient admitted to hospital would have 38 inserted in one of the columns. This indicates to the secretary that this information is to be recorded as a stroke in the column bearing the number in the index.

If the diagnosis cannot be made during the early stage of an illness only the date of the episode is recorded. This reminds the doctor that the episode has to be coded before the diagnostic index is sent to the computer at the end of the recording period. At least one month should be allowed between the end of the recording period in the despatch of the index to the computer. During this period the FRC's which have been removed from the folders, are scrutinized by both the secretary and the doctor to ensure there are no blanks in the diagnosis. Where these do occur the clinical records are consulted and the card completed wherever possible. In many instances it may be necessary to add further data to the index. A patient sent for a chest x-ray may be found to have a neoplasm and is referred to outpatients or a patient referred to outpatients may be admitted to hospital. If this additional information is inserted on the FRC without advising the secretary it may fail to be transferred. A proforma (figure 1) has been designed and duplicated and this is clipped to the FRC obviating this difficulty. The proforma can also be used to indicate a change of diagnosis when this occurs.

ADDITION TO "E" BOOK

Name ....

Date of birth ....

Disease code ....

Date of entry ....

Additional entries to be made—

Box

Box

Change of diagnosis—

From ....

To..

Figure 1

The recording of morbidity by any method is not simple and when necessary, if the secretary is on holiday or off ill, this burden cannot be left to the receptionist or to a 'locum' student from a commercial college. During these periods the FRC is filled in as usual but it is then returned straight-away to the folder. It can then be completed by the secretary on her return at any time before the index sheets are sent to the computer

in a transfer ledger. This relieves the doctor of clerical works at times when he may be busy.

The use of the FRC confers other benefits. At each consultation it presents the doctor with a summary of the recent medical history of the whole family at a glance. The doctor can correlate an enuretic child with a mother suffering from an anxiety state or an impetiginous child with a brother who has an abcess. It also enables research studies to be undertaken at a later date, when possibly the patient has left the practice, without having to refer to the clinical notes. Finally it makes the use of the index much easier in a multi-doctor practice.

Summary

A method is described using a combination of the family record card and the diagnostic index to facilitate the recording of morbidity in general practice.

Acknowledgements

This method forms part of a research project into morbidity supported by a grant from the United Liverpool Hospitals and the Liverpool Regional Hospital Board. I am grateful to Drs R. J. F. H. Pinsent and D. L. Crombie for their help and advice.

REFERENCES

1. *Journal of the College of General Practitioners.* 1963. **6,** 219.
2. *Journal of the Royal College of General Practitioners.* 1970. **19,** 172.
3. *Journal of the College of General Practitioners.* 1966. **11,** 34.

Expressions of morbidity in general practice. D. C. Morrell. *British Medical Journal*, 1971, **2,** 454.

This study in a three-man practice "was designed to supplement the usual measurement of consultation rates and observed prevalence rates with measurements of the time devoted to the management of different diseases, the disability they produce, the diagnostic activity they provoke, and the extent to which the management of illness may be delegated to paramedical workers".

As a result of the study the work of the general practitioner was seen as concerned with two contrasting groups of diseases, (1) short-lived acute episodic illness, such as infection and trauma where consultation was largely initiated by the patient, and (2) diseases where a relatively small number of patients consulted with high frequency, many of these consultations being initiated by the doctor; diseases in this latter category being chronic respiratory and circulatory complaints, diseases of the locomotor system and mental illness.

Mental illness and diseases of the circulatory system appeared to provide most demand by the doctor for paramedical assistance.