## INTRODUCTION TO THE FIRST EDITION

FEW professional activities have come under such close scrutiny as general medical practice in recent years. Information has been needed on which plans for community health care could be based and already a considerable store of information has been gathered.

It has been found that the value of statistical data on general practice depends in part on the extent to which material from one source can be compared with that from another. It has happened that extensive individual studies have been undertaken using definitions which differed to a degree which made realistic comparison impossible, and this diminished the value of each study.

The need for information on the circumstances under which health care is provided continues, and many more studies will be undertaken. It is in the hope that areas of comparability may be increased that the College is offering a glossary of terms and definitions which may be used in future studies. No implication of compulsion should be read into this production, for should a study require a special definition or set of definitions to be used this will, of course, be done. Where, however, the study does not demand that, it is as easy for the observer to use one set of definitions as another, and far more valuable if the same set is used by his colleagues in other studies.

The list of subjects to which an attempt has been made to give a precise form is by no means exhaustive. Some omissions are deliberate for it has been impossible to make a good enough definition. Others are accidental and in time this basic list may be extended. As with a classification of morbidity, the list will not receive universal agreement on points of detail, but we believe that a series of generally accepted definitions—to be used at the discretion of the research worker—will be a helpful contribution to research in general practice.

The rapid expansion of the teaching of family medicine in the United States, Canada and the United Kingdom has brought to the scene a large number of academic general-practice units. A proper part of any such unit activity is, of course, research. It is hoped that around each of these units, interested family doctors will join in co-operative research efforts, in a way that is now clearly recognised as interesting and beneficial in Great Britain.

There is already widespread interest in the work done by the Research Unit of the Royal College of General Practitioners, especially in the E-book, its successor, the Diagnostic Index, and summary card analysis. *The Handbook for Research in General Practice* was published for the College by Drs T. S. Eimerl and A. J. Laidlaw in 1969.

## INTRODUCTION TO THE SECOND EDITION

General practice is in a period of rapid change not only in this country but particularly in the other countries of the English speaking world. Nowadays there is a freer and more rapid communication between these countries than ever before and as medical care systems develop much common ground can be expected.

In this second edition a small amount of new matter about the United Kingdom has been added. The main change lies in the inclusion of definitions and descriptions which relate to general medical practice in Australia, Canada, New Zealand, and the United States of America.

It is hoped that widespread acquaintance with each others' terminologies will make international comparisons easier for us all.

## SOME PRACTICE DEFINITIONS

### 1. General practitioner

A doctor in direct contact with patients who has continuing responsibility for providing them with or arranging for their medical care. This term can be interpreted as covering the whole range of medicine, surgery and the specialties. Usually, he is the doctor of the first instance, except where accident services exist.

The practitioner may be a principal in full or part-time practice or he may be employed as an assistant or locum tenens. An assistant is normally involved in the routine work of practice while a trainee or a registrar in general practice is one for whom the principal carries a teaching responsibility. In Australia there may be interns in general practice, young graduates in their first two postgraduate years seconded from a hospital to a training practice for three months.

A *locum tenens* is a practitioner employed for shorter periods as for example during sickness of the principal.

In North America a family physician can be defined in the same way. He can be defined, as a doctor who sees both sexes and all age ranges of patients, and who recognises the nuclear family as a true biological entity and, therefore, as susceptible to medical management *per se*.

*Family medicine* can be defined in the same way.

### 2. General practice

General practice i.e., the work of a general practitioner is either:

(a) Singlehanded.

(b) *In group practice*—where the provision of services is shared between not less than three professional colleagues, with paramedical support.

In North America group practices may either be composed purely of family physicians, or be multi-specialty in which family medicine may or may not be represented.

In New Zealand, financial help can be obtained for building group-practice premises for not less than three doctors in cities or two doctors in country areas. Even though there may be no more than two doctors, the ' group ' description is more applicable than ' partnership '.

(c) *In partnership practice* there will be a sharing of income in agreed proportions.

(d) *In health-centre practice* the doctor may share accommodation and resources provided by the local health authority or in Australia the municipal health authority.

(e) In the context of the Royal College of General Practitioners:

(i) *A study practice* is a practice serving as a laboratory or workshop in relation to the research centre with attached graduate and secretarial staff.

(ii) *A satellite practice* is a practice equipped for data collection and research studies with attached secretarial staff.

### 3. Partnerships and group practices

Partnerships and group practices vary in size, composition and in the extent of joint care of patients between partners. The pattern of a practice should be described in enough detail to make this clear.

### 4. Staff

The medically qualified partners may be supported by ancillary staff of varying kinds. Nurses or practice sisters are employed by practitioners or attached to practices by health authorities.

In Australia, some services are provided by State or Commonwealth Departments, health visitors are similarly attached in many places, and the principle is being extended to include medical social workers, psychiatric social workers and other trained staff. A few British practices employ practice administrators.

The practitioner is also assisted by receptionists and secretaries. These do not necessarily have special nursing training, though formal courses of instruction of ' practice aides ' with elements of secretarial and nursing training have been introduced in Canada and the United Kingdom.

In North America, to the *staff detail* should be added business manager, controller, bookkeeper or variations, since the financial management of a large American practice is onerous, extensive and complicated. Much research in the near future in America will relate health management to cost and, to this extent, the deployment and involvement of such staff in research projects may well be important.

### 5. Type of practice

The practice may be described as *Urban, Semi-rural or Rural.* An urban practice may be sub-classified as *industrial or residential.* Also, the practice may be carried out from a single centre or from more than one. As well as using these terms, mention the size of community served, or in which the practice is carried on. In Australia the terms ' metropolitan ' and ' country ' are used to describe ' urban ' and ' rural ' practices.

Traditionally practice was carried out from *surgeries.* More often nowadays group practices work from a *practice centre* or a *consulting centre.* Where local authority clinics are held on the same premises it is a *health centre.* There may be central premises with branch premises elsewhere. Medical records are customarily not held at branch centres.

In North America the *doctor's office* may accommodate one or more than one practitioner. It may be situated in a *medical building* also housing paramedical services.

### 6. Patient

A patient is a person who seeks professional advice or treatment from a doctor; or who may be invited to accept presymptomatic investigation or ' preventive therapy ' by a doctor, because the doctor accepts professional responsibility for him.

*A patient may be*:

*Private*, paying the doctor wholly for his services (in Scandinavia, patients pay part fees directly, while receiving state medical services).

*Registered*, participating in an organised health care service, e.g. National Health Service, Pensioner Medical Service, Veterans' Administration, Scandinavian Medical Care Service. The patient remains the continuing responsibility of the doctor on whose list he is, as the doctor of first contact as in the British NHS.

*Insurance*, participating in a voluntary insurance scheme, e.g. the British United Provident Association or Blue Cross.

In North America, registered patients may be prepaid patients as in the Kaiser Permanente Foundation, Hospital Insurance Plan, of New York, and other prepaid group practice schemes. In America and Canada, in addition to private insurance schemes, such as Blue Cross/Blue Shield, there are State or Federal insurance schemes, such as Medicaid for the poor, and Medicare for the aged. These, in fact, represent another category, best defined as *Medicare/Medicaid.*

A *visitor*, receiving care temporarily while away from home. In NHS practice temporary residents are those living in the areas for less than three months.

A further category would be Indians cared for under the auspices of the United States Public Health Services, often in contract with local doctors; as also would be servicemen and their families. In Canada services are organised on a provincial basis.

*Age groups*

When classifying patients by age groups, the analysis will depend on the subject under investigation. If there are no specific contra-indications, the analysis shown below is recommended:

0–1, 2–4, 5–14, 15–44, 45–65, 65 plus.

In some studies broad age-bands will conceal certain trends, therefore; narrower bands are appropriate.

0–4, 5–9, 10–14, 15–19, 20–24, etc.

When classifying patients by *social class*, the short form of the *Registrar General's Classification* (in Britain) should be used. This is derived from a statement of the occupation of the patient which should be recorded in full on the medical records. A husband's occupation covers his wife and children.

It should be kept up to date on the primary records.

I. Professional and higher administrative occupations in finance and commerce.
II. Intermediate occupations; teachers, employers in industry and retail trades.
III. Skilled occupations, subclasses: (a) Mineworkers
(b) Transport workers
(c) Clerical workers
(d) Armed forces
(e) Others
IV. Partly skilled occupations, subclasses: (a) agricultural workers
(b) others
V. Unskilled

For a more precise classification, the *Registrar General's Classification* of socio-economic groups can be used (Census 1951, England and Wales, Classification of Occupations, Her Majesty's Stationery Office).

*Social class classification.*

It is difficult to apply the British classification in the United States and Canada. Most sociologists in America allocate people on the I to V scale on the basis of income, educational achievements and housing standards and since this information is gathered from the United States census, it can be related to geographical boundaries.

In terms of life style, perhaps the most useful classification for America would be annual family earnings over £15,000—upper class; those between £7,000 and £15,000—middle class; and those below £7,000—working class. The value of any classification of this kind however, is limited. In Australia classification of patients by social class is uncommon. Occupation is normally used, but there is no generally accepted short-list.

## 7. Consultation

A consultation is an occasion on which a patient receives professional advice or help or treatment from his doctor. Usually this will be a *direct consultation* where doctor and patient meet; the consultation may be *indirect* when conducted by telephone or a third party requests a prescription on the patient's behalf.

Practitioners may set aside special times for *long consultations* where it can be anticipated that a problem requires prolonged history-taking or examination. These are usually longer than half an hour and may be longer still where the problem is psychiatric.

On a *domiciliary or specialist consultation*, the doctor is accompanied by a specialist in the patient's home. Where the specialist attends alone, the occasion is a *specialist visit* (see below)

Consultation in America and Canada means a doctor-to-doctor consultation about a patient. These may be informal, often called, for instance, ' corridor consultations ' where a peer colleague is used, or by arrangement. Either the specialist will come to the physician's office to see a patient, or the physician may (in the U.S.A.) accompany his patient to the specialist's office. In Canada, the physician may arrange a consultation at hospital or in the specialist's office, exchanging information by letter and verbally.

## 8. Attendances and visits

Direct consultation may be grouped as *consulting room attendances* where the patient attends the practitioner's consulting room or branch premises, and *visits* where the practitioner sees the patient in some other place.

Where not stated, a visit is assumed to be a home visit (house call, home call). Visits may also be made to accident sites, factories, or hospital). When recording the number of visits it is important to distinguish between first visits and follow-up visits made subsequently. These may be classified as ' new calls ' and ' return visits '. Home visiting is tending to diminish in the United Kingdom. In New Zealand a ' visit ' may be an ' attendance '.

In the New Zealand social security system the following definitions are used for payment, and therefore for classification:

C. Consultation at surgery

E. When an attendance extends beyond half an hour

H. Visit to a private hospital
N. Night service, 20·00 hours to 08·00 hours
S. Sunday or public holidays
T. Telephone conversation
V. Domiciliary visit

The common phrase in America for normal doctor-patient contact is a *visit*. To this extent, when the patient attends the doctor's office, it is a visit and when the doctor attends the patient's house, it is a house call (it could be a hospital call or a site call). Similarly, it is important to distinguish between ' new visits ' and ' return checks '.

## 9. Appointment systems

Where an appointment system is in operation it may be:

(a) Complete—where no patients other than emergencies are seen except by appointment.

(b) Partial—where appointments are made for certain consultation sessions only, including special clinics held within the practice.

A description of the system should be given where it does not conform to these definitions.

## 10. Calls out of hours

These are requests for the practitioner's services during the following times:

(a) From 12.00 hours (noon) until 08.00 hours the next day on the practitioner's ' half-day '.

(b) From 20.00 hours until 08.00 hours on a normal day.

(c) From 12.00 hours on Saturday until 08.00 hours on Monday, at a weekend.

These have been alternatively defined as:

(a) From 19.00 hours until 08.00 hours next day.

(b) From 13.00 hours on Saturday until 08.00 hours on Monday, at a weekend. (Second Report of Joint Discussions with Ministry of Health, *British Medical Journal*, 16 October, 1965).

Or less precisely:

' Calls requested after the normal time for receiving such requests '. The definition chosen should be clearly specified.

## 11. Night calls

Night calls are requests for the practitioner's services made between the hours of 20.00 and 08.00 and resulting in a consultation during these hours. It may be convenient to subdivide these into 20.00 hours until midnight and 12 midnight till 08.00 hours. In parts of Canada calls received between 18.00 and 08.00 hours are listed as night calls.

Australians refer to these as calls out of hours, and night calls as those which get the doctor out of bed.

## 12. Clinic sessions

Clinic sessions are occasions when patients of similar type, or suffering from the same condition, are grouped together for supervision, examination, treatment, discussion or advice. Clinic sessions may be held at the practice with or without local authority help, either medical or ancillary. Their nature and times should be indicated to patients. Appointments may or may not be required.

The type of clinic should be specified, e.g. *obstetric clinics* which include antenatal and postnatal care, *child health clinics* which include attendance by children as well as babies, *special clinics* for obesity, geriatrics, diabetes and other conditions.

This use of the word ' clinic ' does not apply in Australia; ' special sessions ' are held. In North America the term *clinic* refers to the charitably operated parts of the hospital where patients are seen usually by junior doctors in a multi-speciality clinic, for less than it would cost them to see specialists in their private offices. In American *family medicine*, a special session would be a *prenatal session*, or a *child health session*, etc. In Australia the term ' clinic ' is reserved for group-practice buildings.

## 13. Services given

(a) These include preventive services and all relevant immunisations and vaccinations, well-baby, child and adult examinations (check-ups) except those initiated or required by an outside body, employer or insurance company.

Systematic presymptomatic screening, urinalysis mass radiography, taking cervical smears for laboratory interpretation, audiometry, and systematic tonometry are included. Sessions where premarital guidance or help to parents is given, where help is given in understanding and use of social services are also counted, as is health education in its broad sense.

Counselling, where indicated in the management of mental illness and social disability, is classified here.

In North America this is described as *health maintenance* or *well-person care*, and defined in precisely the same way.

(b) *Diagnostic services* are provided by the doctor himself, or by others at his request. The range of diagnostic investigations undertaken by the doctor himself, or assistants working with him should be precisely specified.

(c) *Therapeutic services* make diagnosis a prerequisite. Therapeutic service or activity may involve instruction, prescription, dispensing, referral, admission or administration either singly or in combination. Counselling and the doctor's own therapeutic value are included.

(d) *Maternity services* comprise the diagnosis of pregnancy, antenatal care, delivery, postnatal care, including a final follow-up examination. If baby-feeding care and supervision is included this should be specified.

(e) *Administrative services* follow from the doctor's responsible position in the community; examples are witnessing of signatures and attestation about character. Certain administrative services, often concerned with documentation, are essential to efficient operating of the practice. Life insurance examinations and those preceding employment may be undertaken. Simple private medical certification should be grouped with clinical activities since professional judgment is involved.

Administrative duties also fall to the doctor from his position in the practice. The affairs of groups of doctors require co-ordination at partnership level and in committees at other levels in the structure of organised health services.

(f) *Other services* not included in the above, arising from the doctor's special interests, for example: Volunteer Forces, Medical Officer to a Boys' Club, Red Cross or St John Ambulance.

## 14. Referral

Referral is made when resources outside any one doctor's ability, whether in or outside the practice, are used on the patient's behalf. Patients are referred to professional colleagues who may work in hospitals or elsewhere. Patients may also be referred to a service. Sources of medical advice to whom reference can be made include:

(a) A practitioner colleague,

(b) A hospital consultant or specialist,

(c) The medical director of an investigation centre providing such services as mass miniature radiography, radiology or pathology.

Australian consultants and specialists are usually in private practice or if attached to a hospital they may have the right of private practice.

Sources of help may be situated at and patients sent to:

(i) *General or special hospitals* as an inpatient (admission) or an outpatient.

In Australia, hospitals may be public (large metropolitan and teaching hospitals) or private. These vary from those with a few beds in a converted building to larger edifices with several hundred beds.

(USA) *Academic health centres* as an inpatient or outpatient, *local hospitals*, profit or non-profit, as an inpatient or outpatient.

(ii) *General-practitioner hospitals* (cottage hospitals).

(USA) *Community hospitals* as an inpatient. *Specialists' offices.*

(iii) *Investigation centres*, e.g. mass miniature radiography, if separate from hospital outpatient department.

(USA) *Investigation centres* as defined. Also *multiphasic screening units.*

(iv) *Local health authority services*, e.g. health visitor, school health service.

(USA) *City, county or state services* as defined without the appointed medical officer.

(v) *Industrial health services*—works medical officer, or in the United Kingdom the medical officer appointed under the Factory Acts.

(USA) *Occupational health services* as defined, without the appointed medical officer.

(vi) *Voluntary organisations*, Women's Voluntary Service, St. John's, Rotary old people's or pensioners' welfare groups.

(USA) *Voluntary organisations* without definition.

(vii) *Other* (religious bodies, for instance).

(USA) *Other* as defined.

A. Admissions to hospital may be *direct.*

(i) when the practitioner contacts the hospital, the choice is the doctor's.

(ii) bed bureau, when choice of hospital is not under general practitioner's control.

or *indirect*, when a patient is admitted from the waiting list, when self-referred or referred by the police or accident services in an emergency, without the intervention of the general practitioner.

may be under the care of the family physician, as in Australia or North America where most doctors have admitting rights or may be under a specialist, such as a surgeon in an acute abdominal situation, on referral from the family physician. Each should be specified.

from a specialist to whom a referral was made, as an ambulatory care patient by the family physician. There is no American equivalent of a bed bureau or admissions agency. The *indirect* ones are as described.

B. *Investigations*, which are not necessarily limited to those required to establish or confirm a diagnosis, may be undertaken:

(i) in the doctor's own premises, or group-practice centre. Where material is collected by the practitioner for examination elsewhere, this should be specified.

(ii) in a hospital where the practitioner has direct access (these may be pathology, radiology, or other).

(iii) by the practitioner at such special centres as family-doctor diagnostic centres.

In North America usage of the situation where material is collected by the practitioner for examination elsewhere other than a hospital as in (ii), should be a separate number, since many specimens are sent to commercial laboratories (ii) then becomes (iii), and (iii) can be deleted.

C. *Health authority clinics* for various purposes, may overlap with clinics operated in the practice, but as defined here, mean work done in health authority premises on behalf of the local health authority (antenatal, school, or babies).

In North America, *local authority clinics* are called public health clinics. In Australia, they may be organised on a state or Commonwealth basis.

D. *Industrial health service* may include, for this purpose, references under the Factories Act.

In North America for *industrial* read *occupational.*

E. *Voluntary organisations* may include organisations such as Alcoholics Anonymous or the Multiple Sclerosis Society.

F. *Other bodies* will include the remainder and others not conveniently classified, for example, the probation service.

## 15. Analysis and presentation of material

In order that comparisons may be made between different practices certain definitions may be helpful.

*Age-sex* structure should be taken from the practice age-sex register at the mid-point of the period of a study. The total number of people is the:

*Practice population.* Some problems may arise when not all members of a group practice are taking part in a study. If partners normally only attend their own patients then the problem is relatively simple, but if the patients are attended by partners more or less at random, it can be extremely difficult to define the population at risk. Probably the simplest way of doing this is to divide the total population of the practice by the number of partners and multiply by those taking part in the study.

During a survey period, the number of patients, by age and sex, entering and leaving the practice should be noted.

(U.S.A.) Definition of a *practice population* in America is complicated by the fact that patients are not permanently registered with the practitioner except in prepaid systems, and there is no restriction on the patient entering the medical care system elsewhere, either by direct self-referral to a specialist, or to an outpatient clinic, or to an emergency room.

For medical legal reasons, doctors maintain on their shelves huge numbers of records of patients for whom they are probably no longer at risk, a fact which they have no way of ascertaining. The practice population could be described as those people for whom the doctor holds records showing that they have attended the office within the last year. Hopefully, those who have done so, but now left the area, will be balanced by the healthy people who still regard the doctor as their route into care, but have not attended for over a year.

Before any research should be undertaken, therefore, the records should be ' screened ' in this way.

The freedom of entry of the patient into the medical care system at various points makes morbidity analysis difficult, except in closed communities or where only one doctor or one group of doctors looks after a whole township. Even there, it is surprising how many people from the catchment area may use other centres as well.

In Canada, there is increasing experience of ways of calculating populations for whom the practitioner is at risk. These may result in figures, as accurate, or more accurate than those from the United Kingdom. The almost universal enrolment in medical plans ensures that patients attend their practitioner first. The stability of the doctor-patient relationship in some Provinces may be greater than is usually believed.

Comparisons of rates between practitioners working in different systems of practice can be based on total numbers of people seen, by age and sex or on the total number of items of service rendered.

*The calculation of rates*

A rate can be defined as the number of times a specified event occurs (numerator) divided by the number of people or things at risk of having that event occurring to them (denominator), in a unit of time.

In algebraic terms:

$$R = \frac{a}{a + b} \quad \text{or} \quad P = \frac{a}{\text{Population}}$$

It is usual to express a rate in terms of ' per cent ' or ' per 1,000 '. Thus, a death rate is often expressed per 1,000 and is calculated as follows:

$$\text{Death rate per 1,000 population} = \frac{\text{Deaths} \times 1{,}000}{\text{Population}}$$

A rate is normally limited in time and maybe per year, per month and so on, and is expressed as an annual or monthly rate respectively. The time relationship is essential. Some rates of particular use in general practice are given below:

*Consultation rate* There are two of these in general use. It is most important to specify which is being used.

(a) *Consultations per patient* in the practice population i.e. *number of consultations* (A patient is counted at each practice population consultation).

(b) *Consultations per patient* attending during the period of the survey. i.e. *number of consultations* (as in (a) above)

Number of patients consulting (counting each patient who consults as one, however many times he may do so.)

*Patient consulting rate.* The number of patients who consult during the survey (counting each patient once only) divided by the practice population. This is usually expressed as a percentage.

*Episode of illness rate.* An episode of illness may be hard—indeed impossible to define; for example, it is difficult to know when an episode of peptic ulcer in an individual patient starts and ends. This difficulty can be circumvented for all conditions, or at least the most difficult, by counting each single diagnosis as an episode however often throughout the survey that the patient may consult for it. Thus, if a patient with a peptic ulcer consults his doctor on one or more occasions during a survey for his condition, it is counted as a single episode, however far apart in time the consultations may be. For conditions such as injuries it is, of course, simple to differentiate one episode from another.

Episodes of illness are normally recorded by diagnosis and may be measured as episodes per patient in practice population, episodes per patient attending or number of consultations per episode.

*Late call rates.* Late call rates (or rates of calls out of hours) may be tabulated in several ways. For example:

(a) per 100 patients on the list
(b) per 100 patients attending
(c) per 100 consultations
(d) per 100 episodes

It is important to relate these to a stated period of time i.e. per month or per year.

*Hospital and other referral rates.* It is important to distinguish the different purposes for which a patient may be referred, e.g. for outpatient consultation, inpatient treatment, physiotherapy. As with late calls, referrals may be tabulated in several different ways.

(USA) *Hospital and other referral rates.* Most hospital referrals are for admission, either under the family doctor, or under a specialist. Only poor patients are referred to the outpatient department.

*Attendances-visit ratio.* This is usually calculated as the number of consulting-room attendances per home visit. It may apply to the whole practice or to individual diagnoses.

The rates and ratios given above by no means exhaust the possible combinations of the various factors measured. For example, one may wish to calculate the number of late calls per 100 visits or the number of referrals for outpatient consultation per patient in a restricted age or sex group. It is important to describe clearly and concisely every measure used so there is no possibility of misunderstanding.

*Incidence and prevalence.* It is important to understand the distinction between incidence and prevalence. An annual incidence rate is the number of *new* cases of a

condition per 100 at risk during a year. On the other hand, prevalence is the number of cases of a condition which exist either during a period or at a point in time.

In the diagram, time is indicated on the horizontal scale. The vertical lines YX Y2 indicate arbitary points in time at which a census is taken. Horizontal lines represent case histories related to these points in time.

' A ' indicates an episode beginning before the survey period and ending before the first arbitrary point of time.

' B ' represents a chronic disease beginning before the study period and continuing through it. It will be recorded at both points and in routine records maintained between them.

' C ' is an illness for which the first consultation is made after the survey starts, but, as in ' B ', continues past both points.

' D ' concerns yet another illness, the onset of which occurs between the two arbitrary points.

' E ' represents an illness beginning and ending before the first point.

' F ' an illness which occurs in the year reviewed, but is too late for the second point.

The *incidence* of episodes represented on the diagram, during the 12 months represented on the scale, must include all episodes beginning within this period. Conditions ' C ', ' D ', ' E ' and ' F ' would all be included. Condition ' D ', however, is the only one to begin during the period between census points. *Incidence* represents the number of cases which begin during the stated period during which observation is made.

*Prevalence*, however, is a measure of circumstances prevailing during the chosen time period whatever this may be. It may be examined in two ways, as ' period prevalence ' and ' point prevalence '.

If the *period prevalence* per annum is to be calculated all these illnesses are to be included since they all occurred during the year under review. If it were desired to calculate the period prevalence for the three months between the two points, perhaps in order to demonstrate some seasonally occurring phenomenon, episodes ' B ' and ' C ' and ' D ' would be included.

*Point prevalence* rates are denoted by the intersection of the lines and those representing episodes. They denote the situation at a point in time and thus are 'censuses '. At the first census episodes ' B ' and ' C ' would be included. At the second census, episode ' D ' would be included also. It is essential to realise that, if the point prevalence is measured at different points of time, the number of cases prevalent at these times may be very different.

For the same reason that it is difficult to delineate episodes of illness, it is often difficult to decide when a case is a new one, for strictly a further episode of illness of a patient who has attended before for the same condition is not a new case.

Most general-practice surveys of disease relate to a period prevalence, the period usually being a year or a month.

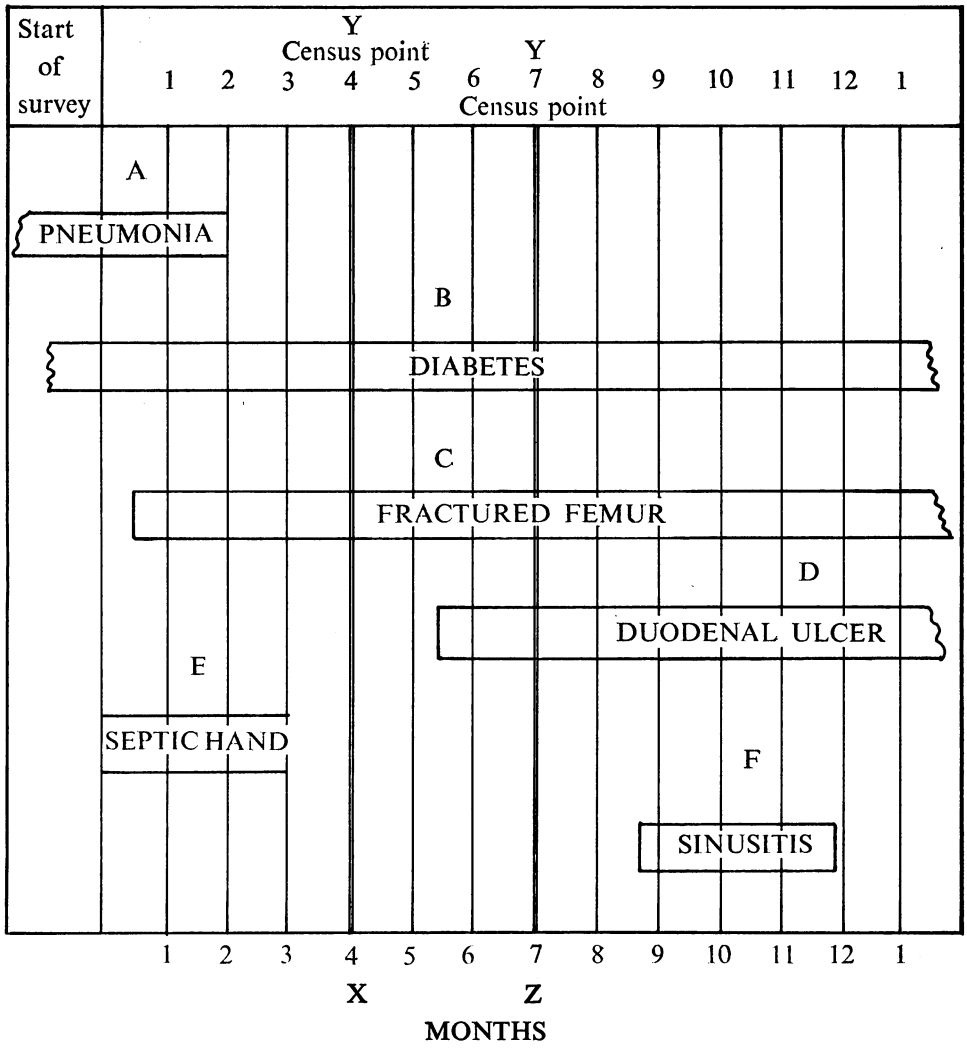


Diagram 1.—Incidence and Prevalence.

## 16. Miscellanea

(a) *Document indentification*

A colour code may be used to indicate some facts reported in medical notes. The code introduced by the Royal College of General Practitioners is:

| | |
|---|---|
| Scarlet | Sensitivities, drug idiosyncrasies and major allergies |
| Brown | Diabetes mellitus |
| Yellow | Epilepsy |
| Green | Tuberculosis, active, arrested or cured |
| Blue | Hypertension, any variety requiring hypotensive therapy |
| White | Long-term maintenance therapy, steroids, thyroid, vitamin B12 |
| Black | Attempted suicide. |

Colour tags of ' Sellotape ' or adhesive paper may be fixed to medical record envelopes or age-sex register card-index cards. Where necessary, combinations of the above colours may be used. Non-standard colours may be used by individuals for special purposes.

(b) *Age-sex register*

This is a card-index or loose-leaf ledger of the identities of the people on a medical practice list. The primary use of this is to provide a defined population against which rates of occurrence of phenomena in the practice may be calculated.

The register can also be used to monitor immunisation programmes, identify groups at special risk and for other purposes. Information about patients leaving the practice may be stored separately, with a note of the date of leaving. This enables the size and composition of the practice at a past date to be established.

(c) *Diagnostic index*

The diagnostic index is a ledger derived from the ' E ' Book in which illnesses recognised in a practice population are recorded by diagnosis, date, age and sex. The material can readily be converted to computer input. It is also a direct index to conventional medical-records systems. This has replaced the ' E ' book.

(d) *' F ' book*

This is a ledger method for recording diagnoses as above though not in such a readily convertible form.

(e) *Classification of diagnoses*

A classification exists of diagnoses based on the frequency of their occurrence in British general practice. It is directly relatable to the *International Classification of Diseases and Causes of Death.* The classification introduced in 1963 is being revised to increase its relevance to practices overseas.

(f) *' S ' cards*

Summary cards were introduced by the Royal College of General Practitioners for use with the primary medical record. These cards enable data on consecutive illnesses experienced by one individual to be recorded in a form capable of easy conversion to computer input. (*Journal of the Royal College of General Practitioners*, 1972).

(g) *' F ' cards*

This is a summary card derived from the above on which coded data on up to eight members of one family may be consolidated.

(h) *' W ' book*

A ledger method can be used for recording diagnoses without the constraints imposed by a classification of morbidity. This serves as an index to conventional medical records systems.

(i) *' F ' book*

This book is a ledger method for recording diseases of families providing information for clinical care and management, morbidity studies, particularly in regard to family relationships. Entire households are accommodated on one sheet.

(j) *' L ' ledger*

A ledger system has been designed to measure workload and clinical conditions encountered per unit time.

## 17. Research Unit of the Royal College of General Practitioners

More detailed help with the design, conduct and analysis of practice surveys can be obtained on request from the Research Unit of the Royal College of General Practitioners, c/o Birmingham Regional Hospital Board, Newlands House, 139 Hagley Road, Birmingham, B16 9PA.

Doctors planning studies are urged to approach the Unit in the earliest stage of their planning, since the value of the study usually depends on the way in which their material is collected. Statistical rescue operations on material collected in imperfectly defined terms are almost always impossible.

**Acknowledgements**

The first edition of the glossary was compiled by a working party of the Research Committee of Council. Those contributing were:

Drs M. A. Heasman, E. V. Kuenssberg, R. J. F. H. Pinsent, B. C. S. Slater, P. A. Walford and Mr S. A. Sklaroff.

The second edition incorporating new material was prepared by Dr R. J. F. H. Pinsent with help and advice from Drs W. A. Falk (Canada), D. H. H. Metcalfe (USA), Charles Bridges Webb (Australia), and J. N. Mein (New Zealand).

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