Some simple improvements in record-keeping in general practice

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SUMMARY. A method of keeping records in general practice is described which can be easily used on National Health Service forms. The method consists of two tiers i.e. of emphasising diagnoses made by boxing them and by organising the layout of other data.

Introduction

It has been said, and with a modicum of truth, that general practitioners' records are so bad that they would be dangerous, but for the fact that the general practitioner seldom uses them. He relies on his memory instead. If this is true it seems a pity that he should spend his time writing down much that is not going to be of use to him and even less to others. This is especially so because with the same expenditure of time and energy it is possible to produce records which would greatly increase efficiency. Nothing slows down successful treatment more than failure to make a diagnosis and nothing speeds the diagnostic process more than good records.

Functions of records

What exactly do we want our records to do? We want them to fulfil two main functions which unfortunately are mutually contradictory, because one calls for extreme brevity and the other for detail.

First we want a record that will give us, at a glance, a condensed version of the whole of the patient's past medical history in order to give us a backcloth against which to view the patient's present complaint; and in the second place we want a record in detail of the illness that we are currently treating, and the process of diagnosis is often spread over several consultations. However, if such detail is recorded for every illness that the patient gets, then any hope of being able to get a rapid appreciation of the patient's past medical history by reading through the records is lost. Records of a patient who has been in a practice for 20 years sometimes number 20–30 pages.

Is it possible to reconcile these two opposing needs?

Recording in detail

The aim should be to build each consultation on the shoulders of the previous one, ideally without having to recapitulate what has already been dealt with in previous sessions. So what is written at the first consultation has to be enough to produce adequate needs at subsequent consultations. How much to write down is a personal decision. In single-handed practice, no more than is necessary to jog the memory may be enough. But in partnership much more is needed.

If reasonably detailed records are kept on a patient for 20 or 30 years a small book will be formed which no one will ever have time to read and in particular no one can gain a rapid review of the patient's past history.

Two-tier system

Figure 1 illustrates the two-tier system. First, there are four illnesses recorded on this page, which is a minor triumph. Rarely can one look at a record card and say without a moment's hesitation how many illnesses were recorded on it. We can go further. We can say exactly what the four illnesses are and we can do that in four seconds flat, one second per illness, because in each case the diagnosis has been highlighted. This is a second triumph; faced with a page of

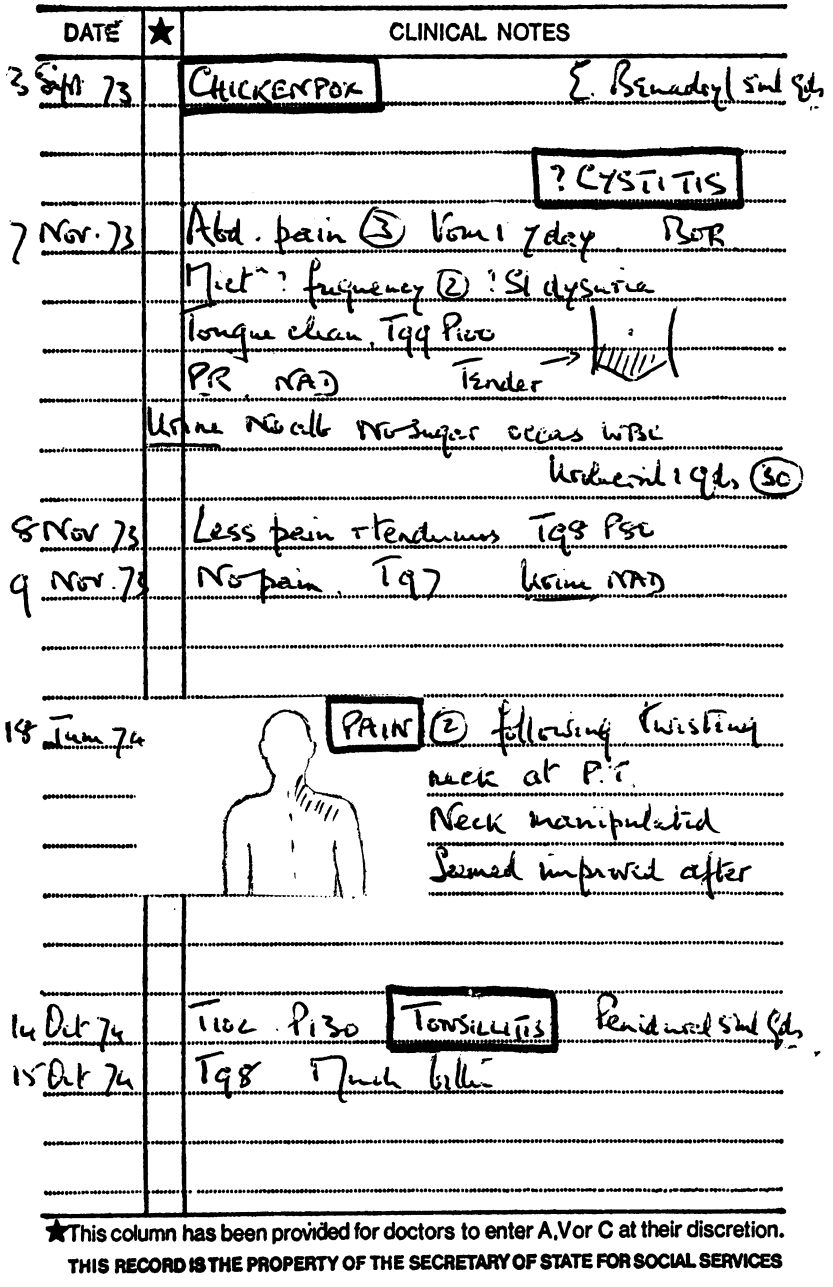

Figure 1
A N.H.S. continuation page showing two-tier recording.

writing after skimming from the top to the bottom of the page one knows what illnesses are recorded on it, having read only four words.

Thus one can read the record at two separate levels according to what is needed. If we want it we can have the detail, but if we don't we can ignore it and just look for the diagnoses.

Detail is needed in two main sets of circumstances, the chief being during the current illness until it is firmly diagnosed. Once that is done what matters is simply the diagnosis, and the

detail can be relegated. One may also need to look back for detail in the old records. This is because patients frequently get the same condition over and over again and one wants to see what treatment was given before, how it worked, and also how the condition resolved. Or sometimes later circumstances may challenge the original diagnosis and one may want to look back and see the data on which it was based.

Method

First the diagnosis, when made, is placed in capitals and a box put round it. This gives it a commanding position in the midst of a block of writing so that it stands out like a flag and immediately attracts attention. Then the block of writing to which it refers is separated from the blocks above and below by two blank lines between the end of one illness and the beginning of the next. If this is not done, the notes are a breathless jumble. One blank line is not enough to make a healthy gap between illness. Leaving this gap has another advantage; if the diagnosis cannot be made until after seeing the patient several times, when it is made there is room to put it at the top of the illness, in the gap, which is the best place for it.

The treatment is always in the right hand margin. For easy reference it is best to keep it well to the right because the patient, like Oliver Twist, is always coming for more.

The diagram can be printed on adhesive paper or a rubber stamp and such diagrams can save much time for many reasons. We can indicate the site of a pain far more accurately and quickly on a diagram than we can describe it in writing. Looking back at old records we can take in the content of these diagrams instantaneously and compare it with the present findings, whereas it takes time to translate lines of writing into a visual image. It is possible to print these diagrams by the dozen on adhesive addressing rolls, tearing them off as required.

Family history

Insufficient attention is paid to family history in general-practice records, partly probably because there is no convenient place to put it. The summary card of the Royal College of General Practitioners has a special place or one can put it at the bottom on the back of the medical record envelope.

Source-orientated records

One difficulty about records as commonly kept is that they are source-orientated, i.e. what the general practitioner writes is in one place, the x-ray and pathology reports in another, and the consultants' letters in a third. It is sometimes necessary to search all three. Apart from time lost, this adds greatly to the bulk of the records. Therefore it pays to enter in the records a brief summary of consultants' letters, x-ray reports and pathology and destroy them if at all possible. Thus all the information from all sources about one illness is under one heading in the notes.

Other ideas

There are a few simple devices which may appeal to some and not to others.

Time is wasted in searching for the most recent record card and can be saved by stapling them together in chronological order. They are best not stapled in the corner. By laying them face downwards on the table and stapled down the right hand side more cards can be added indefinitely and the whole record will open up like a book.

Reports on cervical smears are increasingly distending the record envelopes. They should be destroyed and the results entered in the notes, but as the patient (and the doctor) so often wants to know the date of the last one, retrieval of this information is speeded if the entry is made in green.

Likewise the Pill deserves special treatment. Entered in red it draws attention to the fact that the patient is on contraceptives and which one, and where repeated changes have been made it makes it easier to see what they have been.

Finally if the doctor customarily instructs his secretary to make an appointment for the patient to see a consultant by writing this instruction in the record, it is easily overlooked and the record filed away. If a marker that sticks out of the record is used then it should not be filed away without the secretary noticing it.

Research

It is often said that general practitioners' records are potentially a mine of invaluable research material. This is not true. One look at the records accompanying the new patients shows how little research value they could have. But records can easily become a basis for individual research, if the information is recorded systematically.

Of course, research calls for more than keeping good records and the Medical Recording Service Foundation tape No. 67: 13 deals with both record keeping and research and is a good starting point.

REFERENCE

Medical Recording Service Foundation (1974). *Record keeping and research.* Walford, P. A. Tape No. 67: 13, Chelmsford: M.R.S.F.

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