Medical records in general practice

ONE of the unique features of the British National Health Service is the fact that every patient registered has a single medical record which is transferred from doctor to doctor, in theory, throughout life. In practice the system works reasonably well apart from unfortunate delays when patients move across health service boundaries. Most general practitioners hold medical records for most of their patients, which go back for many years.

The two principal causes for concern about this system have been the ethical problem of making notes on paper which is the property of the Secretary of State and the difficulty about safeguarding patients' confidences. There is a third problem about determining the optimum size of the paper. Another more recent challenge has been the introduction of computerization which raises new questions about the long-term use of paper records in their present form.

Whilst a small number of doctors actively concerned with ethics have emphasized the ethical dangers (Jones and Richards, 1978) and a larger group, but still relatively small in number, have identified the considerable advantages of A4 records *(Journal of the Royal College of General Practitioners,* 1973; Tait and Stevens, 1973) the vast majority of British general practitioners have soldiered on using a conventional records system designed in 1921 and keeping notes in a style which has changed little since then.

An analysis of medical records received for new patients entering a practice shows that the records and the notes can be classified into a small number of groups: first, there are those which are even today totally disorganized, with continuation sheets mixed higgledy-piggledy within the envelope and hospital letters and investigations folded separately, making it impossible for any clinician to find a particular letter quickly or even to see a general trend.

The second group is when some simple system of organization has been introduced by, for example, either stapling the continuation cards in chronological order or linking them by treasury tags. Similarly a growing number of practices have been organizing hospital letters and investigations, usually by stapling or clipping them with the most recent letter or investigation on the top.

However, the third and most important category of general practice records are those in which there has been some attempt to organize the information to enable the clinician to extract key information quickly. There are many ways of doing this and these include problem orientated records, summary cards, or summary problem sheets, separate cards for family charts, prescribing cards, and contraceptive cards (Froggatt, 1977).

Although there have been signs of more experiments and innovations in the last few years than at any time in the past, nevertheless it remains true, as Dawes (1972) has shown, that most basic information in most records in general practice is not organized and even key information like age, marital, and social class status is often not recorded.

Occasional Paper 5

It is against this background we publish today *Occasional Paper Number 5, Medical Records in General Practice,* written by Zander, Beresford and Thomas, from the St Thomas's Hospital Medical School, London. This document is timely because it appears from a general-practice teaching unit which is renowned for its interest in clinical work and for the heavy service commitment carried by its academic staff.

This paper consists of a series of essays outlining a variety of different ways of organizing the general practitioner's medical record. One part of it, the system for recording family histories, was published in the September 1977 issue of this *Journal* (p.518) and has already attracted widespread comment. We republish it today because of its considerable importance for family doctors and because the original article has already inspired a growing number of practices to incorporate a system of recording family history in their records.

Of even greater importance is the report on summary problem sheets and problem analysis which are outlined in the early chapters of this report. The theme has always been to record what is essential, what is important, what has long-term significance, and what is likely actually to be used in everyday general practice. Although the original records at St Thomas's are maintained on A4 folders, perhaps the greatest importance of this system of record keeping is that much of it would be equally applicable on conventional NHS records.

It is particularly encouraging that throughout the document the authors emphasize that they concentrated on what was practical and did not use special or expensive resources which would not usually be available in the average British general practice.

Medical records are the Achilles heel of general practice and reveal the current state of disorganization bordering in some cases on chaos. What is most needed is some simple, practical system which lays out general principles and which can be started immediately. The Department of General Practice at St Thomas's can be congratulated on providing such a system. However, it is unlikely to be the final answer and what is urgently needed now is a continuing debate among clinicians in general practice on the pros and cons of the various

systems. *Medical Records in General Practice* should initiate that debate and is available now from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £2·75, including postage.

References

Dawes, K. S. (1972). *British Medical Journal,* **3**, 219-223.

Froggatt, C. (1977). *Journal of the Royal College of General Practitioners,* **27**, 107-109.

Jones, R. V. H. & Richards, J. (1978). *Journal of the Royal College of General Practitioners,* **28**, 137-140.

Journal of the Royal College of General Practitioners (1973). Editorial, **23**, 301-302.

Tait, I. & Stevens, J. (1973). *Journal of the Royal College of General Practitioners,* **23**, 311-315.

Referral letters from general practitioners: outpatient analysis

In this survey I analysed 75 consecutive new referrals from general practitioners to the outpatient department for content of the referring letter. While there were significant discrepancies in terms of both symptoms and signs between the letter and the clinic assessment, the major failure of the referring note was in the area of drug treatment. Documentation of drugs administered was unsatisfactory in half the cases.

Reference

Ismail, W. A. (1977). *Journal of the Irish Colleges of Physicians and Surgeons,* **7**, 65-66.

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