MEDICAL RECORDS

Sir,

The article by Dr A. Elliott and colleagues on A4 folders (February *Journal,* p.85) is not helpful to the cause of the A4 campaigners: by its own admission it is entirely subjective and therefore offers no proof that clinical practice, patient care, research, or administrative efficiency are made easier by conversion to that system. The only objective evidence is that an A4 folder occupies more than twice as much space as the traditional medical record envelope. The authors' questions about improved care of patients really begged the answers they obtained. Where is the evidence that A4 files are more helpful during surgery consultations, or make one better informed about the patient's medical history, or make one record more useful information in better handwriting with better use of time to reach better informed and objective decisions? Who are they trying to convince—themselves?

It has just taken me 18 months to convert 3,300 records to A4. Initially I employed two girls for a week to write the name, address, date of birth on the A4, and insert the old envelope inside it. I did the sorting of the contents of the medical envelope and the filing of the relevant material in chronological order myself. I challenge the assertion in Table 2 that conversion is expensive. Seventy per cent of the girls' wages was reimbursed; the remaining expense was my time. Going through the medical record envelopes and sorting them out without changing to A4 folders would itself have made the information more comprehensive and systematically ordered, and made me better informed about the medical histories. It is going through the record, not the size of the folder in which the information is stored, that makes one better informed.

As for retrieval and storage—our folders are filed laterally on open shelves and my secretary tells me that it takes her longer to get them out and replace them than it did with the old medical record envelopes.

Certainly A4 folders look better: the patients in the waiting room can see the banks of files and are impressed by the size of our practice, which may make them more tolerant if they have to wait to be seen! During the conversion I have learned a great deal about many patients, most of which I find that my partner, who has been there for 30 years, knew anyway! Repeat prescriptions are just as easy on a purpose-designed card inside the traditional medical record envelope. The A4 is good for laboratory reports which can be easily reviewed on their separate sheet. More space for clinical notes means that I write more, but I do not know that more means better: some of the succinct comments found on old records 30 years ago contain a diagnosis in one line, which is probably all that matters. I have a sneaking feeling that new record systems, computers, secretaries, tape recorders, and typists have made us all too long-winded.

It is really very difficult to provide objective evidence that A4 folders are better but—and here I am subjective like the authors of the article—having made the conversion, I would not like to return to using the little brown bags, stuffed with cardboard and paper. I believe modern general practice deserves something that looks good and makes the user feel better, even if their value still remains unproven.

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Sir,

The publication of *Occasional Paper 5* by Zander and colleagues (1978) on Medical Records prompts me to write about records in general practice.

The NHS patient's FP 7/EC 7 medical record card has survived in its present form since 1920. From attempts made by several colleagues and by us we gather that a change to A4 records will not be possible for some years to come owing to "overburdened FPC staff, lack of funds" and so on. Therefore, any ideas about the standardization of record keeping and the best use of records by primary health care teams throughout the country would be helpful to many, if not all, general practitioners practising in the NHS.

Several practitioners have evolved their own individual systems of symbols, colour coding, edge marking, card clipping and starring of notes to make their records more effective; the different 'record techniques' used by various practitioners would be of great interest. If standardized across the country these techniques would enable all practitioners to use their patients' records to the best effect.

CATHERINE M. MOLLOY

Reference

Zander, L. I., Beresford, S. A. A. & Thomas, P. (1978). *Medical Records in General Practice. Occasional Paper 5.* London: *Journal of the Royal College of General Practitioners.*

LABORATORY: A MANUAL FOR THE MEDICAL PRACTITIONER

Sir,

In order to remove any misunderstanding that might result from the review of *Laboratory: A Manual for the Medical Practitioner* (February *Journal,* 1979, p. 121), I would like to make it clear that *Laboratory* is *not* confined to clinical chemistry only. The *Manual* includes a wide range of microbiological, haematological, and histological investigations that may be requested by medical practitioners, as well as clinical chemistry. In this respect the comparison with Zilva and Pannall's (1975) excellent book on clinical chemistry is misleading.

As we state clearly on pages IX and X, the *Manual* does not set out to be a textbook in the conventional sense, but to be a work wherein doctors may find rapidly information regarding the relevance and interpretation of laboratory investigations. Readers are recommended to refer to specialized works when information is required in greater detail.

H. W. K. ACHESON
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Reference

Zilva, J. F. & Pannall, P. R. (1975). *Clinical Chemistry in Diagnosis and Treatment.* 2nd edition. London: Lloyd-Luke.

NEW CHARTER

Sir,

Dr H. M. S. Noble's letter (March *Journal,* p.187), coinciding with the publication of the report (GMSC, 1979) of the new charter working group, opens an important debate which the College cannot afford to ignore.

Dr Noble advocates fees for extra services and Appendix B of the new charter report gives a long list of items which the working group thinks should attract fees. I am worried that these recommendations, if accepted in their entirety, are going to produce a vast proliferation of forms and a great increase in non-productive bureaucratic work both in our practices and in the family practitioner committees. I question whether the complete package will improve practice.

Many of these items involve work that I consider a routine part of my