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.

R. M. MILNE

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Dechmont
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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.

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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

commitment as a general practitioner regardless of how I am paid: for instance, ear syringing, which earns one a grateful patient, and night visits for which it is demeaning to have to get a form signed every time. We are gradually moving towards an item-of-service system of payment which can only encourage doctors to encourage patients to be ill in contrast to the capitation system we now have which encourages doctors to educate their patients towards good health and healthy attitudes.

Item-of-service payments should be restricted to those procedures which could be referred out of the practice but which the doctor prefers to do himself for extra payment, or else to enable him to recoup the cost of expensive equipment. Appendix B of the report is purely arbitrary and could be expanded or contracted at will—it is guided by no identifiable principle despite the verbiage in Chapter 7.

A more selective use of the item-of-service payment would then improve practice and lead to all possible work being done by the primary care team: it would increase job satisfaction, as the report says, but not at the expense of endless form filling.

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Reference

General Medical Services Committee (1979). Report of New Charter Working Group. London: British Medical Association.

Sir,

As a new member of the College I would like to comment on the proposals for a new general practitioner's charter (GMSC, 1979).

First, on the positive side, I welcome: 1. the reduction of list size, 2. the aim of increasing emphasis on health education, and 3. the emphasis on both undergraduate and postgraduate training in general practice. As a student in a large inner city teaching hospital I was taught that general practice is learnt in the accident and emergency department because "nobody bothers to go to general practitioners here as they are so awful"—hardly a recipe for generating enthusiasm in a student!

Despite this I have chosen to work in an inner city area and am fortunate to be working in a health centre where there is a good team atmosphere and where we do our best to cope with the awful problems that surround us.

Which brings me to the negative side of this charter—what we need in inner Liverpool is time—time to sort out the real problems behind Mrs Smith's 'depression'—whether it's because her husband is beating her or because he is drinking to cope with his fears of imminent unemployment. Time to deal with Mrs Jones who at 84, and with a colostomy, is too old to go out to her lavatory in the backyard in the middle of the night.

Payments for such ESR procedures as ear syringing, pregnancy testing, and injections will mean more forms and less time. Any doctor worth his or her salt should be doing these when necessary anyway: if not—what is medical education all about?

I am in favour of a salaried service because I would like a reasonable income to allow me to do my job properly. I did not go into medicine to make money by doing millions of cervical smears—I do them because I believe they are of value in detecting cancer of the cervix.

Time and good medical practice *cannot* be bought.

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COMPULSORY REMOVAL

Sir,

I am conducting research into the operation of Section 47 of the National Assistance Act, which provides for the compulsory removal of people, usually elderly people, in need of proper care and attention.

General practitioners are often very much involved in this type of compulsory removal, as they are usually the co-signatories of the application for removal in the more commonly used 1951 Amendment of the Section 47 powers, which allow for the minimum removal of people on the application by a community physician and another registered medical practitioner.

I should be most grateful if general practitioners who have experienced difficulty with the Act, or have views on ways in which it should be further amended, could write to me. It would help me considerably in the preparation of my final report.

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SELECTING TRAINERS

Sir,

I have been interested to read the correspondence between Dr J. C. Oakley (February *Journal,* p.117) and Drs P. Handfield Jones and J. Hasler (March *Journal,* p.186) about trainer selection. Drs Handfield Jones and Hasler feel that they have justified the acquisition of the MRCGP examination as an essential requisite in selection of trainers, but I think the following points ought to be answered as the Oxford Region is at variance with the majority of other regions in stipulating the criterion.

1. The prospective trainer, knowing the requirements, is likely to apply only if he thinks there is a good chance of being accepted. I wonder what percentage of prospective trainers were turned down before the MRCGP examination became compulsory, and how many after?
2. What evidence is there that trainers with the MRCGP are better than those without? If Dr Hasler is justified in making it compulsory, does this mean that Oxford is the best area in which to be trained?
3. Does the trainer with the MRCGP give the trainee confidence in his trainer's ability? If so, is there not a danger of the trainee being trained for the examination rather than for general practice? It is arguably not the same thing.
4. By insisting on the MRCGP examination as a criterion the Oxford area has begun to turn the selection of prospective trainers into a black or white decision and are not in a position to accept a trainer whatever other qualifications or merits he may have.
5. The inclusion of a trainee in the practice will make demands on all those in a partnership, whether they have the MRCGP or not, if the practice is a cohesive unit.

Does this mean that eventually partnerships with 'non-MRCGP' partners will be excluded from becoming a training practice? This could happen in two ways: first, if the selection committee deem the practice to be unsuitable; and secondly, if non-MRCGP members of the practice refuse to have anything to do with the trainee. Of course if this were to happen for either reason the examination for some would become divisive rather than unifying as it was intended to be.

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