Medical records — the need for reform

ONE of the fascinating aspects of the development of general practice as a discipline is the way in which certain topics predominate at certain times and it is interesting to try to understand the reasons behind each development.

Recently medical records have emerged as a topic of central concern in general practice, because there are three main forces all pressing in the same direction at once: standards of care, teaching, and research.

Standards of care

During the last few years it has become clear that the ability of a general practitioner to look after a patient depends more and more on the standard of organization of his or her medical records. In the past, when most general practitioners were single-handed and there were few partnerships and fewer rotas, patients usually saw the same doctor whenever they went to the surgery. The doctors knew their patients as individuals, their notes took the form mainly of *aides mémoires* and often merely of recording the medication. They certainly did not perceive the need of writing records for colleagues. The conditions with which they were dealing were often acute and sometimes severe infections. Before 1950 there was relatively little preventive medicine, apart from immunization, and therefore little research was based on general practitioner records.

However, there followed a number of developments which all challenged the modern general practitioner to write with an eye to his colleagues and the future, rather than just for himself. First of all, the great majority of general practitioners do not now practise alone and can expect their notes to be seen certainly by partners, if not by trainees or other colleagues. Secondly, patients are more mobile and many move many times in the course of their lives.

The rubella status of girls, the timing of tetanus and polio immunizations as well as cervical smears, all require information to be readily available to doctors not just now, but in the future. The emerging evidence on the importance of life-style means that patterns of behaviour, especially smoking habits, are becoming important in determining diagnostic probabilities (McKeown, 1976; Lalonde, 1975) and these trends are continuing.

Finally, the major change in clinical practice from acute to chronic physical and emotional illness in general practice in itself demands documentation: the progression of long-term conditions such as asthma, epilepsy, hypertension, rheumatoid, chronic anxiety state, and depression must be carefully recorded so that the doctor can look back quickly through his or her records and compare signs and behaviour today with those of a year or five years ago in order to find out whether there has been progress or deterioration. Once medicine became as concerned with chronic illness as with acute, long-term medical records became mandatory. The exact details of whether such records should now be kept in terms of flow charts, coloured cards, summary sheets or problem lists is still a matter for debate. What is no longer under discussion is the need for some systematic approach.

Teaching

The introduction of a teaching role for general practitioners came late in medical history: it is only in the last 15 years that vocational trainees have been entering general practices on a large scale and starting to work with existing general practitioner records. The cry of concern, the frustration and fury, the anger and attack these young doctors are making on existing records has in itself been a potent reason for reform. The trainees are asking how personal doctors can teach personal care when their trainers' records do not show personal or preventive care. Examination of medical records from all over the British Isles make sad and sombre reading: standards generally vary from being poor to a professional disgrace. Against such a background, Professor Metcalfe's call today for patients to keep their own medical records might act as a potent spur to practitioners to produce *some* professional system of record keeping.

With such pressure coming from trainees and with a growing number of practitioners ready for record reform, it is understandable that the postgraduate medical organizations, under the leadership of the Joint Committee on Postgraduate Training for General Practice, are turning their attention to the trainer's records. The JCPTGP in its booklet *The Criteria for the Selection of Trainers in General Practice* (1976) appropriately pinpoints the importance of records, to which it refers three times in nine pages. It points out that appointment committees have an opportunity to test competence "in a variety of ways which may include . . . e) looking at clinical records and record systems." Under Criterion 7 it states: "A practice suitable for teaching should have

individual clinical records which are well kept, tidy, and complete in essentials, so that the trainee has every opportunity to learn good record keeping himself, following his trainer's example." Finally: "Visits will also provide the appointments committee with its only opportunity to make an examination of randomly drawn case notes which belong to the patients of the applicant."

It is now routine in some regions and a growing practice in others for visiting teams when assessing would-be trainers to examine a random selection of medical records in the training practice and to look first-hand at the standards with which trainees would have to work. Some regions have begun to draw up criteria of satisfactory standards and a regional trainers' day at Torbay spent half a day discussing grade 1 (hospital letters attached in chronological order), grade 2 (general practitioner continuation cards, attached in chronological order), and grade 3 (hospital letters and continuation sheets both attached in chronological order), as well as additional grades involving the introduction of summary sheets, drug sheets, and other systematic record cards.

Training practices are on the move. Up and down the country a blitz is beginning on redundant information and superfluous paper, as recommended by Wilson today (p.421). Whilst it may well take a year or two for these standards to become the norm, the JCPTGP can be pleased that the stimulus of its regional visits has been a powerful factor in encouraging trainers to review the quality of their medical records.

Research

Although for many practitioners research in general practice still seems a rare and esoteric activity, as this *Journal* has previously shown vocational trainees have fewer inhibitions. Trainee projects are common in many schemes. Basic systems, however, are needed such as an age/sex register and often a diagnostic register. Trainees carrying out clinical studies are often hampered by the poor quality of the medical records themselves. When records become organized, so the potential for clinical research at last becomes possible.

As a start, more and more general practitioners are becoming interested in clinical review and in surveying the progress of their patients with various conditions, and we publish today four articles by authors who have carried out such reviews (Wilks, p.390; Lloyd Jones, p.396; Goucke, p.401; van der Does, p.405). Thus research, like teaching, leads back to better service, and practices which have facilities for the one are likely to be able to carry out the other, thereby being able to care better for their patients in the future.

The future

It is interesting that the intensity of the debate on the size of the medical records, and the rights and wrongs of conversion to A4, seems to be dying away. Whilst there is clearly room for experiment, the focus of attention in general practice now seems to be on what kind of information should be kept and how it should be arranged, rather than what size the paper should be on which it is recorded.

The recent rapid developments in computerization and the move towards microcomputers make it at least possible that A4 records may be bypassed in the years ahead. Meanwhile, whatever the mechanisms and whatever the size of the folder, it is quite clear that multiple experiments in the ways of arranging general practitioner's records are now required so that the maximum amount of useful information can most easily be retrieved by the general practitioner, his or her partners, and other colleagues. We publish today four further articles showing the use to which careful recording can be put (Gadsby, p.410; Heward and Clayton, p.412; Dajda and Austin, p.417; Williamson, p.422).

Teaching needs, research needs, and above all day-to-day service needs, have all focused attention on the urgent need to reform the medical records in British general practice.

Computers in Primary Care

A compatible computer system could (and should) be in widespread use in general practice in five years' time, and be adopted by virtually all practices in ten years
RCGP (1980)

IT has been obvious for many years that computers are coming, coming in society in general, and coming with increasing frequency to medicine in particular.

Reports have been appearing, such as the British Medical Association's (1969) *Computers in Medicine,* and the issues that need to be clarified have gradually emerged. Nevertheless, it is probably true to say that most general practitioners do not foresee computers in their own practices in the immediate future, and many are not yet seriously contemplating them within their own professional lifetime.

This *Journal* publishes today, as *Occasional Paper 13, Computers in Primary Care,* the report of the Working Party of the Royal College of General Practitioners which has been chaired by Dr Clifford Kay, Chairman of the College's Research Division. Far from accepting the gentle introduction of computers into general practice on a lengthy time scale, this report challenges the profession sharply with this statement: