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:

"We believe that a compatible computer system could (and should) be in widespread use in general practice in five years, and adopted by virtually all practices in 10 years" (Chapter 3).

This report begins by discussing the desirable attributes of a general practice record (information) system; it lays down the aims and hence the standards that must be provided if computers are to contribute substantially to raising the quality of general practitioner care. This befits a report written primarily by general practitioners for general practitioners.

There is an invaluable short glossary of computing terms on page 6, which lists in just a few pages those words and phrases that have become generally accepted in computer language, thus making it possible for practising clinicians to understand the principles involved. Micro and minicomputers are defined, with the helpful statement that the distinction between them is vanishing rapidly and that it is probably true that in a few years' time the performance specification associated with a minicomputer will be available for present day costs of a microcomputer.

Among the difficulties associated with the acceptance of computers has been the problem of confidentiality of medical records, a topic of great interest to personal doctors and one which has attracted attention in this *Journal* in the past *(Journal of the Royal College of General Practitioners,* 1978). This Working Party makes the firm statement that the confidentiality remains the responsibility of the doctors, with the added advantage of greater security provided by the computer, and goes on in a later section (page 30): "The working party is satisfied that the confidentiality of patient data can be achieved in a computerized system at a higher level than that currently available on manual records."

A second important historical difficulty in attitudes has been associated with the idea of linking general practice information with large centralized machines in some big, bureaucratic empire.

Here again the Working Party concludes: "The recent availability of low-cost micro or minicomputers leads us to favour *practice-based* machines at present" (our italics). Here is a revolutionary breakthrough which can be regarded as a further example of miniaturization in general practice (Pereira Gray, 1978), which will enable the benefits of the new technology to be spread rapidly and widely whilst retaining for the patient personal control by independent principals.

Later sections of the report give examples of use and emphasize the value of early incorporation of appointment systems and home visiting lists. Recent developments such as the GPO Prestel system are described, and possible applications for supplying important morbidity statistics and operational data to service authorities are foreseen, as well as interesting possibilities of links between practices, between different branches of the health service, and between other professionals.

In a final, but important, short section on political and economic problems the report discusses some of the arrangements which may be necessary to help general practitioners who own their own practices and equipment to introduce such machines in the short-term future. The conclusion is that it is important that co-operative action should be taken by the Royal College of General Practitioners, the British Medical Association, the Department of Health and Social Security, and the Working Party and is optimistic that this will be possible. The report concludes with the statement: "The situation is changing fast. The earlier a united profession begins discussions and negotiations with the Department of Health and Social Security the less likely are we to be overtaken by events."

Computers in Primary Care appears at an appropriate time, and the Council of the College, especially the members of the Working Party led by Dr Clifford Kay, can be congratulated on producing this useful and thought-provoking booklet which deserves to be widely read.

Computers in Primary Care, Occasional Paper 13, is available now from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £3.00 including postage.

References

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Section 63 Activities

SECTION 63 of the National Health Service Act (1968) gives Parliamentary authority for financial support for "such instruction as appears to him [i.e., the Minister of Health] conducive to the efficient carrying out of that activity" (i.e., services provided by general practitioners). A Parliamentary authority has been delegated to regional postgraduate deans and the regional education committees who have on the whole been liberal in their interpretation of the meaning of the Act.

The significance of Section 63 has been greatly underestimated by those writing the history of recent educational developments in general practice, but it has been one of the more important reforms in the last 15 years because it has provided important real resources at a time when they were badly needed.