COMPUTERS IN PRIMARY CARE

Sir,
I have read and attempted to digest the stimulating view of future general practice contained in *Computers in Primary Care, Occasional Paper 13* (RCGP, 1980). While a great deal of thought has been given to the exciting and sometimes exotic possibilities arising from the use of this medium in general practice, I find that scant attention has been paid to one important and basic principle, and no attention at all to a vital practical problem, namely, that of conversion to the new system.

The principle is the primary purpose of a medical record as kept in general practice at present. This is surely to provide a day-to-day record of the doctor's findings, diagnosis, treatment, and any other relevant details which may be required at any time. This is not only for use during the course of an illness but also for reference at any time in the future. Is it envisaged that as much or even more detail than at present will be fed into the computer after each consultation, which will result in even more indigestible material appearing on print-outs, though at least it would be legible? Or are details to be kept on manual records and only significant findings transferred to the computer? If this latter course is adopted, would retrospective research, for example, be possible? And will a computer print-out be acceptable as evidence in court or for purposes of medical defence? These seem to me to be fundamental questions which require clear answers before considering the undoubted advantages of the system for use in education, research, and the provision of information at present not readily available.

The practical problem of transferring the existing records onto the computer is immense. The first requirement for this is an updating and summarizing of the existing records, a very daunting task as anyone who has transferred from the 'Lloyd George' envelope to an A4 system will be only too well aware. This work can be done adequately only by the doctor himself and is both tedious and time consuming. The subsequent feeding into the computer can be delegated to the staff but again this will occupy at least some time. Finally, the continuing input of data into the computer will depend almost entirely on the doctor and will require considerable discipline, application and, again, time. It cannot be emphasized too strongly that a computer will provide only information which has been fed into it. This process must take time and must largely involve the doctor.

In chapter 2 it is stated that the adoption of improved records such as the A4 type has been "an achievement reserved for obsessional and fanatical exponents of the art and science of general practice". Is this not likely to be the fate of computers in general practice unless we devote a great deal more thought to the problems I have outlined above while there is time?

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Reference

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MRCGP EXAMINATION

Sir,
A successful candidate in the MRCGP examination told me that he was completely astonished that he was not asked one single question on geriatrics, either in the written or the oral sections of the examination.

This is quite disgraceful and brings considerable discredit to the College. I would point out that under the recent Review Body Awards, the standard capitation fee for persons aged 75 and over has been increased from £5.20 to £6.65 a year, no less than £2.50 more than for patients under 65.

I can modestly claim to have acquired some knowledge of geriatrics 'from both sides of the counter'. I worked for a considerable period as a clinical assistant in a large unit, with special responsibility for long-stay and terminal patients. Not long afterwards, having experienced the misfortune of having had a hip replacement which became infected, I attended an excellent day centre for rehabilitation.

Those general practitioners who undertake the care of the elderly should have the ability and knowledge to merit the additional remuneration, and it is clearly the responsibility of the College to co-operate in achieving this objective, both in courses of instruction and in the examination for membership.

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PATIENT PARTICIPATION

Sir,
Dr B. L. E. C. Reedy is of course right in saying there is nothing new in patients participating (June *Journal,* p.376). The phrase 'patient participation' has, however, moved on in its meaning.

In fact I am very surprised that someone of Dr Reedy's calibre should not have realized this from material published in this *Journal* (Paine, 1974; Wilson, 1975; Dakin and Milligan, 1980). However, we all have blind spots, which is why it sometimes helps if patients point them out.

The essence of present-day patient participation is that patients can make such a *positive contribution* to primary care—not only to the way a practice is run (ideas, reactions, suggestions, criticisms), but also to the well-being and care of fellow patients (community care, lobbying for better local facilities such as chiropody, fund-raising, and so on). All that successful patient participation needs are doctors who are prepared regularly and systematically to tap this precious well, and patients who are willing to share their gifts and energies.

This kind of participation *is* new; it's high time it ceased to be a novelty.

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Paine, T. F. (1974). Patient's association in general practice. *Journal of the Royal College of General Practitioners,* **24**, 351.

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WHY NOT?

Sir,
I read, with no small degree of incredulity, two of the articles in the July *Journal* (p.421, p.422): "Why not sort out our records?" and "Why not use local maps in general practice?".

I wait with eager anticipation for the next stimulating and thought-provoking articles in this series. Such titles that spring to mind are "Why not employ a receptionist?" or "Why not install a telephone?".

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