MEDICAL RECORDS

Sir,
I feel compelled to reply to Professor D. Metcalfe's question "Why not let patients keep their own records?" (July *Journal,* p. 420).

He states that about 10 per cent of records cannot be found when patients attend and that patients can be relied upon to look after their records at home, citing the obstetric co-operation card as his example.

The majority of people are healthy most of the time and are unlikely to treasure their medical records as a mother treasures her unborn baby. One only has to note how frequently medical cards are missing when changing doctors and an FP1 has to be completed to suggest that more than 10 per cent of records would disappear.

Most pregnant women have some pride in their condition whilst many people are ashamed of their medical history. The temptation to 'lose' records pertaining to psychiatric illness, alcoholism, marital disharmony, venereal disease, termination of pregnancy, and dealings with the legal and insurance professions would be overwhelming. The certain knowledge that this would happen in some cases would serve to devalue all records.

Professor Metcalfe's suggestion that the records would be available in emergencies ignores the fact that records would not be available at any time when the patient was not present. How, therefore, do we write accurate referral letters and deal with the endless stream of enquiries about patients from third parties, and how do we cope with the telephone consultation? Notes would be available neither for research nor for educational purposes.

Another suggestion is that expensive secretarial time would be saved by the absence of filing and that the space saved could be filled by a computer. Would a data processor be less expensive, even supposing that a hard-pressed practitioner committee granted reimbursement of salary? Of course, if computers take over entirely then the whole suggestion becomes irrelevant.

Professor Metcalfe's belief is that record sharing symbolizes sharing health responsibility, but doctors are not the only professionals with files concerning clients. I do not expect to be handed my file by my solicitor or bank manager! However, I do not consider our relationship to be an adult/child one in form.

These are the relationships of professional to client and I would prefer to have this relationship with my patients.

It is more flexible than the doctor/patient relationship wherein role playing by both parties within that relationship only conceals the important points in many consultations.

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Sir,
I was interested to read Professor Metcalfe's article in the "Why Not?" series in the July issue of the *Journal* (p. 420).

I think he presents very well the theoretical reasons for allowing patients to have their notes. However, it behoves us to be practical and he fails to look at the practicalities of implementing his idea.

First, he quotes the co-operation patients give with their maternity co-operation cards. This is a highly motivated group of people and it might be more relevant to look at what happens when we hand patients repeat prescription cards. In this instance, the age range of those who handle the information we give them is much larger. I am sure anybody who surveys what happens will find that patients often fail to bring their cards even when they want a repeat prescription; they lose their cards fairly frequently and these have to be replaced; they forget to bring them when they come to see us; they can't find them when we go to see them. If this happens with repeat prescription cards I am afraid it is going to happen with notes, so I do not think our patients will look after their notes very well.

Secondly, what is going to happen to all the information that keeps arriving at our surgeries which we normally file in their notes, such as letters and reports of investigations and x-rays? This creates a logistics problem of filing—where to file them and when to put them into the patient's notes.

Then, of course, every envelope which is given to the patient really must be thoroughly vetted. Patients are going to read their notes thoroughly and although we might quite happily ignore such remarks as "The patient has a pain in the neck and is a pain in the neck", which doubtless Professor Metcalfe has seen in notes as I have done, our patients are hardly likely to take kindly to them. I am afraid that reviewing their notes is going to generate a tremendous amount of work.

Then we come to the problem of researching in the notes. Recently we have done a study which made it necessary for us to review the notes of all our patients on 'Lanoxin'. If these had been dispersed around our practice area they would have been reasonably difficult to get hold of. As it was, all we had to do was to extract them from the filing rack.

I see no immediate easy solution to these problems other than continuing in the way we do at present, which is to have our notes on the premises.

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Sir,
The impression has been formed that recent issues of the College *Journal* do not seem to contain many clinical contributions relevant to everyday general practice. It seems to me that there is a surfeit of writing about non-clinical matters—for example, registers of various kinds, audit, appointments systems, and computers.

Referring to the July *Journal* (p. 420), I would like to take issue with Professor D. H. Metcalfe concerning his suggestion that patients should have their own medical records. Is he really being serious? What would happen if records were lost or fell into the wrong hands, or were used in complaints procedures? It does not bear thinking about! In my experience only 60 per cent of patients take care of their record cards which relate to basic clinical information and treatment. It is far more important to get patients to co-operate with advice and treatment given to them by their personal physicians by the use of straightforward language and simple systems, which I will be pleased to amplify if any of your readers are interested.

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COMPUTERS IN PRIMARY CARE

Sir,
Dr H. Mackay is quite right in believing that the task of changing over from the current 'Lloyd George' envelope to any other system is daunting (October *Journal,* p. 635). He is not quite right in believing that this can be done adequately only by the doctor, because for the Exeter system a team of paramedical workers has been assembled who, to the best of my knowledge, has carried out the task to everyone's satisfaction.

Our own contribution to the thinking on this point is our insistence that a system should be devised which will allow doctors to change from their current records to a computer system gradually and at their own pace, so that the whole exercise can be spread over as many years as the doctor might wish. The system we envisage would be compatible with both computer and manual records, and I believe that this might well be an acceptable solution to what is, admittedly, a major problem.

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Sir,

May I congratulate Dr Clifford Kay and his Working Party on their report *Computers in Primary Care* (RCGP, 1980). After so much discussion, correspondence, and debate, it is a most significant step, and no mean achievement, to set down so many practical details and recommendations.

However, I fear that the report may go the same way as so many before it, and fade away in a haze of the usual talks, discussions, committee minutes, and referrals up and down the bureaucratic scale. It will be a case of yesterday's problems being planned for implementation tomorrow, mañana!

I believe that if the College is to take a lead in this field, it must very soon set up a small team dedicated to initiating a handful of pilot trials and to assisting practices to become computerized. If two or three enthusiastic doctors, with a programmer, a systems analyst, and a technician, were to be available to help interested practices to install and run their own computers, on however modest a scale, then the ball would be set rolling. It can only be through such practical experience that ideas, attitudes, and opinions will be generated which will form the 'data-base' for the evolution of computers in primary care.

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Reference

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WHY NOT SCREEN FOR HYPERTENSION?

Sir,

I think we are all agreed that hypertension can be treated with advantage and that only about half the cases in the population have been detected and are receiving treatment. The question is not 'why' but 'how', since we are obviously under an obligation to find these cases and treat them.

I find routine blood pressure estimations very tiring and boring, and though they might lengthen my patients' lives they will surely shorten mine. I feel that these patients cannot be screened in the current framework of general practice, and that we should make use of the tactics of public health for this purpose, such as those used to screen for pulmonary tuberculosis.

Fortunately the apparatus required is cheap and readily available. In my surgery I use a digital blood pressure measuring unit called a U Check Super made by the Brethuen Corporation of Japan and costing about £70. It gives an accurate reading of blood pressure and pulse rate with very little trouble. One nurse could run four or five of these machines in parallel. One would therefore require a hall with screens and couches for about five patients. The patients would lie down and the nurse apply the cuff and pump up the machine, leaving it to take an automatic reading while she went on to the next patient. By the time she returned to the first patient the machine would have automatically taken the blood pressure and pulse rate which the nurse would write down before asking a new patient to take his place and starting the process all over again.

Patients who gave a high reading should have their estimation repeated until its significance was determined. Patients giving consistently high figures, e.g. above 160/95, would be referred to their general practitioners for further investigation and treatment. Compared with my own measurements with a sphygmomanometer, this machine gives readings which are a little high; however, they seem very consistent, so it may be my own which are low.

This seems to me to be an extremely worthwhile and practical approach to the problem, and I would like to hear from other general practitioners who might wish to adopt it so that we can take some concerted action.

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THE DIVISION IN BRITISH MEDICINE

Sir,

In the course of challenging the fairness of your review of what now appears to be only the first instalment of his book (Honigsbaum, 1979), Mr F. Honigsbaum (August *Journal,* p. 501) attributes to me a preference ("would rather be recognized as the most versatile of medical social workers than the least of medical men") which was in fact not mine—though I would not be ashamed of it. It was quoted by me in 1965 from the correspondence columns of the *British Medical Journal* the year before. In any case, although the College may move in mysterious ways it is hardly likely to appoint its Dean of Studies on the strength of this or that expressed sentiment—even if it was aware of it.

The particular dichotomy referred to by Mr Honigsbaum came about largely through previous comparative neglect, and is rapidly becoming meaningless as general practitioners appreciate the importance of being competent both as body technicians and as counsellors in order to discharge their responsibilities effectively.

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Reference

Honigsbaum, F. (1979). *The Division in British Medicine.* London: Kegan Page.

CLINICAL MEDICAL OFFICERS

Sir,

From the wide-ranging discussions which have taken place regarding the future of clinical medical officers engaged in child health, there would appear to be considerable agreement that their training should be such as to make them eligible to move into general practice or to seek to specialize in paediatrics by engaging in further training. As the three-year vocational training programme for general practice can include up to 18 months' paediatric experience (and also includes one year in general practice) the Joint Paediatric Committee of the Royal Colleges of Physicians and the British Paediatric Association, and the Royal College of General Practitioners consider that appropriate training programmes for these clinical medical officers can be encompassed