

# LETTERS TO THE EDITOR

## OBSTETRICS AND GYNAECOLOGY FOR GENERAL PRACTICE

Sir,  
Council has approved the report of the Working Party on education for obstetrics and gynaecology (see pages 72-79). This discussion document has been sent to Faculty Boards for consideration, but I should like also to bring it to the notice of all members, who are welcome to send me their opinion, as individuals, by 30 April 1981.

JOHN HASLER

*Honorary Secretary of Council*

14 Princes Gate  
London SW7 1PU.

## PATIENT RECORDS

Sir,  
The response (November *Journal*, p. 699) to Professor Metcalfe's (1980) "Why not let patients keep their own medical records?" was predictable and would perhaps have been more constructive had the work on patient-held records been summarized. This includes collaborative care of hypertensives using a shared record (Ezedum and Kerr, 1977), the use of a home record card for permanently housebound patients (Stuart, 1972), as well as American and Australian experience (all of which is obtainable through the excellent College library).

The most impressive scheme has come from the obstetricians and midwives at St Mary's Maternity Hospital in Plymouth (Murray and Topley, 1974). Out of 10,000 case records carried by patients throughout their pregnancies only two were lost. The scheme was found to save time, money and space and, more importantly, provided a continuous record immediately available to those sharing in care, including the patient. The aim was to extend this to gynaecological patients.

We have just begun patient-held records for pregnant women in the practice and hope to extend it if it proves a success—why not?

JOHN ROBSON

South Poplar Health Centre  
260 Poplar High Street  
London E14.

## References

- Metcalfe, D. H. H. (1980). Why not let patients keep their own records? *Journal of the Royal College of General Practitioners*, **30**, 420.
- Ezedum, S. & Kerr, D. N. S. (1977). Collaborative care of hypertensive patients using a shared record. *British Medical Journal*, **2**, 1402-1403.
- Stuart, J. M. (1972). The use of a home record card for permanently housebound patients. *Journal of the Royal College of General Practitioners*, **22**, 63-64.
- Murray, F. A. & Topley, L. (1975). Patients as record holders. *Health and Social Services Journal*, **84**, 1675.

## THE 'S' CARD AND THE CENSUS

Sir,  
Morbidity data collection based on the 'S' card was first promoted by the Records and Statistical Unit (later the Research Unit) of the College (1966, 1972, 1973).

In the Birchfield practice we have been collecting data in this way since 1966, and we have now computerized these data. This temporal record of morbidity enables the practice to relate episodes of illness, preventive procedures and health education to individuals and groups of patients by age and sex, ethnic group and social class. We have now added a space dimension to the morbidity record to relate some environmental characteristics to morbidity.

We did this by using columns 52 to 59 on the 'S' card to enter the 1971 Census enumeration district (ED) and postal code. Changes of address with change of ED and postal code were entered on the 'S' card before the data were computerized, so that we could relate changes of address to morbidity. The 1971 census data make possible the linking of census environmental data for small areas of approximately 200 households to the morbidity record. Because EDs are not the same from census to census, it seems to us that, for long-term studies, postal codes should be recorded, and these are to be used for the 1981 census. Postal codes do not change with time. Each ED is considered to be relatively homogeneous.

Our purpose in writing this letter is to suggest a way to link environmental data and morbidity data in general practice in England and Wales, and to identify some problems for those who

attempt to utilize the ED in this way.

EDs were not obtainable in a logical alphabetical listed form. Individual addresses had to be identified from maps which were difficult to read without a magnifier, and in our practice area within a radius of two miles from the practice centre there were 344 separate EDs. Fortunately, the Post Office supply books of postal codes for the area and the practice research clerks were able to write the appropriate ED code on the addresses in the postal code book, as they were determined from the map.

This study is part of a project on environmental aspects of health promotion and health care funded by the Department of the Environment through the Inner City Partnership Programme (Contract DGR/462/133).

L. A. PIKE

C. D. BEAUMONT

*Lecturer in the Management Centre,  
University of Aston*

Birchfield Medical Centre  
95 Birchfield Road  
Handsworth  
Birmingham B19 1LH.

## References

- Records and Statistics Unit of the College of General Practitioners. (1966). *Journal of the College of General Practitioners*, **11**, 34-40.
- Research Unit of the Royal College of General Practitioners. (1972). *Journal of the Royal College of General Practitioners*, **22**, 377-381.
- Research Unit of the Royal College of General Practitioners and the Department of Engineering Production, University of Birmingham. (1973). *Journal of the Royal College of General Practitioners*, **23**, 413-427.

## IMMUNIZATION RECORDS

Sir,  
We were interested in Dr Gadsby's paper on the records of immunization in a general practice (*July Journal*, p. 410). We were not surprised by his findings that 23 of the 186 children had completed a course of primary immunizations of which the general practitioner was unaware. He does not say whether or not he also encountered difficulties in matching the general practice record with the health authority's record for the same child in other respects which, in a recent study, we found to be a serious problem (Rawson *et al.*, 1980).

In this study we compared the replies

received in answer to requests which were sent to both the specialist in community medicine for child health (SCM) and the child's general practitioner (GP) for the immunization records of children included in the National Childhood Encephalopathy Study. Both the SCM and GP supplied records for 690 of these children and there was agreement that 85 (12 per cent) had received no immunizations of any kind. In the cases of another 102 children (15 per cent) the records disagreed on whether or not the child was immunized, with one record providing details while the other (often the GP record) stated "no record of immunization." The records of the remaining 503 children (73 per cent) agreed that the child had been previously immunized, but by no means all agreed on what had been given or when.

Out of a total of 1,271 immunization procedures in which either diphtheria/tetanus/pertussis or diphtheria/tetanus vaccine had been given, there was disagreement concerning which of the two types had been given for 104 (eight per cent) of the procedures. This figure was halved after extensive further enquiries to try to reconcile the differences, although several entirely new discrepancies then appeared. Many discrepancies concerned the date on which immunization had been given. The SCM and GP disagreed on the date of 214 (14 per cent) of the 1,493 occasions on which the 503 children were immunized. Further enquiries resolved less than half of these differences.

Recent concern about the use of pertussis vaccine and possible serious adverse reactions underlines the need for accurate records of immunization if adequate surveillance of the use, effectiveness and safety of vaccines is to be achieved. Our study has shown that much greater care and attention are required in compiling records of immunizations if they are to be sufficiently reliable for these purposes, as well as for the clinical and legal reasons to which Dr Gadsby directs attention.

N. S. B. RAWSON  
Medical Statistician

R. ALDERSLADE  
Lecturer in Community Medicine

D. L. MILLER  
Professor of Community Medicine  
Middlesex Hospital Medical School  
Horace Joules Hall  
Central Middlesex Hospital  
London NW10 7NS.

Reference

Rawson, N. S. B., Alderslade, R. & Miller, D. L. (1980). Discrepancies in immunization records. *Community Medicine*, 2, 202-208.

THE COST OF PRESCRIBING

Sir,  
I congratulate J. C. Murdoch on his paper on "The epidemiology of prescribing in an urban general practice" (October *Journal*, 1980). In it he states "The desired outcome of audit of our prescribing should be increased quality of care for the individual patient, not primarily therapeutic purity or saving of resources." I think the aim should be the attainment of all these outcomes but that attempts should also be made to measure the cost of prescribing, especially now in the financial climate of recession, inflation and cash limits.

I analysed all the prescriptions in our three-man rural non-dispensing practice for the month of October 1977 with regard to age, sex, drug, morbidity, ingredient cost and whether a repeat or consultation prescription. The demography of the two villages which we serve was known and therefore the incidence and prevalence of the prescribing could be estimated as well as its cost.

I found that in October 1977, 2,848 items of prescriptions costing £5,039.57 for a population of 6,496 were prescribed to 1,492 patients. The expenditure on drugs was concentrated as expected where the greatest total of prescriptions fell, namely in the age groups over 60 years; there was little difference in relative costs in items prescribed when the patient consulted the doctor or was given a repeat prescription.

However, for true comparisons, populations should be standardized to unit costs; the figure shows the total ingredient cost per 100 members of the

population in each five-year age group. The costs rise sharply after 75 years of age due to the fact—demonstrated by Murdoch in his paper and confirmed in my study—that as age increases so the proportion of the population receiving prescriptions rises to almost 70 per cent over the age of 80 and 100 per cent over the age of 95. The older patients are, the more they are likely to have prescriptions, and the more expensive their age group drug bill per person becomes.

Whether the drug is appropriate, effective, still required, and the cheapest to give the required therapeutic effect, is important to the patient and to the purchaser of the drug (largely the tax payer on behalf of the patient). The general practitioner is responsible for prescribing 80 per cent of the National Drug Bill (*Merrison Report*, 1975), and the retired population consume it for their increasing morbidity; general practitioner prescribing is open-ended. Attempts to contain the rising drug bill should bear these points in mind. It surely behoves us to include the cost of prescribing in our therapeutic considerations, since there are implications for our patients, the tax payer and the pharmaceutical industry.

B. J. STEVENSON

Haymeads, Brighton Road  
Sway, Lymington  
Hampshire SO4 0EB.

Reference

*Report of the Committee of Enquiry into the Regulation of the Medical Profession*. (1975). Merrison Report, London: HMSO.

Distribution of ingredient cost of prescribing in the practice for the month of October 1977 expressed as unit costs per 100 population in five-year age groups.

