An analysis of fat folders

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SUMMARY. A review of patients with fat folders showed that a high proportion of them had evidence of organic disease and were frequent attenders. Many of them had also changed their allegiance between doctors and there was often evidence of past or present marital disharmony. A high percentage were on psychotropic medication.

Introduction

THERE have been articles about frequent attenders in general practice (Wamoscher, 1966; Semmence, 1969; Courtenay *et al.*, 1974; McArdle *et al.*, 1974) but there has been little research into the patient with a fat folder of medical records. The two may not be synonymous, and Franklin (1971), a psychiatrist, suggested that patients with a thick folder of notes have a specific syndrome which has the following characteristics: a thick file of notes; failure to gain full and lasting benefit from any treatment; and the arousal of frustration and resentment in doctors. He postulated that the disorder had two interacting components, "one being an underlying chronic but unrecognized psychiatric illness, the other, a massive hypochrondriacal superstructure".

Buckmaster (1973) found 89 patients (34 males and 55 females) out of a list of 2,100 with notes measuring two centimetres or more in thickness. He noted that 49 patients had almost wholly organic illness and 33 had a mainly psychiatric or emotional problem and little organic disease. The remaining 24 patients had about an equal amount of organic disease and emotional disease.

As part of an exercise in reviewing and improving the records of all the patients who had registered on my personal list since I became a partner in 1977, I took the opportunity to examine the features of those patients who had excessively large records.

As well as examining Franklin's postulate and syndrome, I expected that certain of my own impressions could be confirmed or refuted, namely that the thick files were lacking in major organic illness and that many belonged to patients who had either registered from other local general practitioners and/or were divorced.

Aim

To prove or disprove the null hypothesis that patients with fat folders did not have special characteristics.

Methods

The study was undertaken during April to June 1980 in an urban five-doctor group practice of 12,850 patients. My own personal list numbered 1,111. All work in the study was done by me. During the preceding three years, all the records of the patients on my personal list had been systematically pruned of contents which were considered valueless, for example blank continuation cards (FP7/8) and prescription forms (FP10), duplicate letters, hospital letters that had been superseded by later correspondence, and laboratory data which could be transcribed on the patients' record cards. All the continuation cards and hospital letters had been placed in chronological order and, where appropriate, summary cards (FP9A/B) and repeat prescription cards had been added. For the purposes of the study I applied this systematic pruning also to the records of those patients who were regularly seen by me but were registered with one of my partners.

After pruning, I weighed the notes. All those weighing 100 g or more were defined as 'fat folders'. (I decided that weighing rather than measuring the record envelope would be simpler and more accurate). These methods produced a total of 57 fat folders—51 from patients registered with me and six from patients registered with one of my partners. I recorded the age and sex of the patients, the weight of the pruned record envelopes, the marital status of the female patients as far as was known and whether the patient had transferred from another doctor within the town.

For each of my female patients with fat folders, I found a control from the age-sex register. The controls were picked by choosing those patients nearest in age and sex to the fat-folder patient.

Table 1. Weight of medical record envelope and registration of patient, author's list. (Percentages in brackets.)

Weight (g)	Registered with and seeing own doctor since moving to practice area	Changed from another practice	Total personal list	Registered with partner
0-99	1,011 *(96.9)*	49 *(72.1)*	1,060 *(95.4)*	83 *(93.3)*
100+	32 *(3.1)*	19 *(27.9)*	51 *(4.6)*	6 *(6.7)*
Total	1,043 *(100)*	68 *(100)*	1,111 *(100)*	89 *(100)*

Table 2. Weight of medical record envelope by marital status* (female patients aged 20 years or more), personal list. (Percentages in brackets.)

Weight of folder (g)	Married	Single	Divorced	Total
0-99	275 *(66.6)*	86 *(20.8)*	52 *(12.6)*	413 *(100)*
100+	31 *(60.8)*	7 *(13.7)*	13 *(25.5)*	51 *(100)*

*Definitions: married = first marriage or widow, single = never married, divorced = separated, divorced or remarried.

A detailed note was kept of the timespan of each set of notes. I did this by finding the earliest date recorded on either the hospital letters, the continuation cards (FP7/8) or the FPC stamp on the envelopes (FP5/6). The completeness of the notes was leniently defined: notes were regarded as incomplete only if they started more than five years after the date of birth.

In the case of fat folders and their controls, further information was recorded: evidence of current psychotropic medication and the average number of consultations with a general practitioner per year recorded during the 24 months from 1 January 1978. A frequent attender was defined as a patient who had seen a general practitioner on average more than 10 times a year. I also examined the characteristics of patients with thick notes. Using a classification prepared by Buckmaster (1973), I divided them into the following groups.

1. Those with a long illness or recurrences or combinations of illnesses with almost wholly organic context.
2. As above but also with a small proportion of distinct emotional or psychiatric illness.
3. Those with equal proportions of organic and emotional illness.
4. Those with mainly emotional or psychiatric illness, but with some organic illness.
5. Those with almost wholly emotional or psychiatric illness.

Results

Forty-five (4 per cent) of my own female patients and six (0.5 per cent) of my male patients had fat folders. The folders of these female patients were larger than those of the male patients and, not surprisingly, the size of the folder was related to the age of the patient.

Since so few male patients had fat folders, it was not possible to come to any conclusions about them but, among these six patients, there was a heavy bias towards emotional or psychiatric illness.

Table 1 shows that whereas only 3 per cent of the patients who had registered with me on first moving into the area had fat folders, almost 7 per cent of those who had transferred their allegiance from another partner had fat folders; of those who had transferred, for whatever reason, from another practice in the town, 28 per cent had fat folders.

Table 2 shows a higher divorce rate among women with fat folders; 26 per cent of those aged 20 or over and who had fat folders were divorced, but only 13 per cent of those without fat folders were divorced. For the age group 30–69 years, the imbalance persisted, with 42 (18 per cent) of women with normal folders and 12 (35 per cent) of those with fat folders being divorced. Despite a somewhat lax definition of the completeness of the notes, it was surprising to find that 30 per cent of the 45 records were incomplete, a proportion which rose to 50 per cent for those patients in the 30–69 years age group.

Table 3 shows the different characteristics of the fat-folder patients and controls. The controls had a lower rate of divorce and few had changed doctors within the town. The fat-folder patients were more frequent attenders and more of them were taking psychotropic medication.

Using Buckmaster's classification (Buckmaster, 1973), about half the fat-folder patients were recorded as suffering, either wholly or mainly, from organic illness (Table 4). This confirms Buckmaster's conclusions. However, using this classification was difficult. For instance, the nine patients classified in Group 3 had had a number of referrals to hospital but there was no recorded evidence of specific organic or psychiatric diagnoses. Six of the nine were thought to be suffering from rheumatological or orthopaedic problems and five had transferred their allegiance from another doctor. Evidence of mental or family disharmony or psychosexual problems was also present in six of the nine patients.

Discussion

A significant benefit of the study was the reorganization of the records. The perusal and pruning of the medical record envelopes provided a clearer picture of the past history of my patients and a greater insight into record-keeping and its usefulness. The disorder of the vast majority of notes was not unexpected, but must make it

Table 3. Characteristics of patients with fat folders and of controls, females only. (Percentages in brackets.)

	Controls	Fat folders
Aged 20–39 years	18 *(35.3)*	18 *(35.3)*
Marital status		
Single	12 *(23.6)*	7 *(13.7)*
Divorced	6 *(11.8)*	13 *(25.5)*
Changed doctor	2 *(3.9)*	17 *(33.3)*
Seeing one partner but registered with another	6 *(11.8)*	6 *(11.8)*
Frequent attenders	8 *(15.7)*	28 *(54.9)*
On psychotropic medication	5 *(9.8)*	24 *(47.1)*

Table 4. Illness classification* of patients with fat folders and of controls, females only. (Percentages in brackets.)

	Controls	Fat folders
Group 1	43 *(84.3)*	16 *(31.4)*
Group 2	6 *(11.7)*	9 *(17.6)*
Group 3	1 *(2.0)*	15 *(29.4)*
Group 4	0	8 *(15.7)*
Group 5	1 *(2.0)*	3 *(5.9)*
Total	51 *(100)*	51 *(100)*

*Source for classification: Buckmaster (1973).

difficult for general practitioners to be familiar with much of the past medical history of their patients, a problem which is compounded if either the patient or doctor is new to a practice. Interestingly, after pruning, I found that none of the notes had outgrown its gussetted envelope and most fitted easily into their traditional Lloyd George envelopes.

It is important to note that there are a multitude of factors influencing the size of any records. For example, the timespan covered by the notes, the consultation rate of the patient, the amount of notes and letters kept by the general practitioner, the number of referrals to hospital, the frequency of letters from the hospital and the length of the letters. However, the high proportion of notes that were found to be incomplete was unexpected. Presumably, in a large number of cases the records failed to pass from one general practitioner to another as a result of poor response to FP22s.

Like Buckmaster (1973), I noted the proponderance of organic disease in the fat folders. However, the inadequacy of our traditional diagnostic classification based on organic disease was exemplified in Group 3, a difficulty which in turn leads to misdirected and, therefore, unsuccessful treatment. One example of this problem was a patient in this group who had abdominal pain and dyspepsia unrelieved by cholecystectomy. The surgeon had indicated in his letters that he was reluctant to operate as there was little objective evidence of gall bladder disorder. However, persisting symptoms had pushed him into operation.

The patients in Group 3 seemed to fit Franklin's guidelines for a 'thick-file case' (Franklin, 1971). They often had persisting symptoms, despite referral to more than one consultant. Resentment or frustration on the part of the doctor was perhaps reflected by the multiple referrals among this group and by failures in the doctor–patient relationship, given that five of the nine patients had changed their doctor.

The most striking finding in my own group of patients was the high number who had changed their allegiance between one doctor and another. It could be argued that these patients also fit into Franklin's syndrome, that is there was a failure to gain lasting benefit from treatment, and anger and frustration in the doctors themselves. While it must be correct that patients can change their doctor when the doctor–patient relationship becomes soured, the fact that many of these patients pose difficult management problems may well partly explain why other general practitioners are reluctant to accept them on their lists.

My research also showed that many patients with fat folders had evidence of other significant factors—current use of psychotropic medication, evidence of marital disharmony and frequent attendance at the surgery.

Conclusions

Certain common features have been demonstrated in this and other studies of frequent attenders, and it would seem profitable to explore this group of patients in greater depth, using the fat folder as a signal pointing to the need for careful study of the history and the characteristics of the patient concerned.

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