Records and prevention for the beginner

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THE importance of preventive care[1] and good records[2] in contemporary general practice is reflected in the aims of vocational training schemes.[3] New principals, fresh from their trainee year, may encounter frustration in these areas because their new partners do not share the same priorities. The aim of this study was to determine how much improvement to clinical records and preventive care a principal could reasonably carry out during his first year in practice.

Method

The study period of 12 months started on 1 March 1981. The author's first month in practice (February 1981) was excluded as a settling-in period.

The practice comprises three full-time principals, a practice sister (part-time) and secretarial staff who work from private premises in an urban area in north Kent and serve a combined list of 7,000 patients. However, the partners are working towards a system of personal lists and only patients on the author's list were included in the study, although he saw many of his partners' patients over the year. During the study year the author's list grew from 1,800 to 1,980 patients.

Clinical notes were put in chronological order and the patient's history was summarized on one side of an FP7A form. Repeat prescriptions were written on an FP7B form.[4] Contraceptive advice was noted on a specially designed card.

For a short diagnostic index, separate pages of a loose-leaf file were headed with 18 of the major chronic conditions—for example, diabetes, hypertension. The patient's name was written on the appropriate sheet when a diagnosis had been entered on the FP7A summary card mentioned above.

A rubber stamp was made for printing a six-item list in the margin of the reverse side of the summary card: blood pressure, smoking, weight, dietary roughage, rubella status, cervical smear.[5] Details were recorded on the same sheet, together with the date: blood pressure and weight were measured and advice was given on smoking and dietary roughage. Female patients in the age range 20–64 years were referred to the practice sister for a cervical smear if they had not had one in the previous five years. Girls aged 10–14 years who had not received rubella immunization were referred to the practice sister, and young women (14–35 years of age) whose rubella immunity was in doubt were referred for laboratory tests.

The number of patients seen, their age, sex and details of preventive measures were recorded separately at the end of each consultation (excluding the weekly antenatal and child health clinics).

The total number of patients in each at-risk group on the author's list were obtained from an age–sex register which was constructed during the study year.

Results

During the study year, 2,542 out of a total of 5,165 consultations were with patients on the author's list. Over half of these (1,469) were repeat consultations. The 2,748 preventive measures performed on the author's patients averaged 7.6 per surgery, 1.1 per consultation with the author's patients and 0.5 for all consultations. Table 1 shows that well over 90 per cent of the at-risk patients seen (and about 50 per cent of the at-risk patients on the author's list) received preventive care. Clinical notes were summarized at a rate of 29.4 each week. Of the 328 entries in the diagnostic register, 84 per cent were made in the first six months, suggesting that the majority of important diagnoses were entered during the study year.

Discussion

This study demonstrates that a new principal can implement, with minimal assistance, what he has learned about prevention and record-keeping during vocational training.

How much extra work did it involve? The preventive work was assimilated into the normal surgery booking of seven to eight consultations per hour. This was possible because about half the author's consultations were his partners' patients, for whom no preventive care was attempted. The recording improvements took two or three hours extra each week, time that was approximately halved when secretarial assistance was available.

How much extra did it cost? Apart from the doctor's and secretary's time, the only expenditure was on the rubber stamp and treasury tags.

The author's partners agreed to the project since it did not involve them in extra work, the cost was minimal and there was no change in the running of the surgery.

Although there are few recent studies with which to compare the figures, after only one year the data for blood pressure, smoking and cervical cytology compared favourably with Fleming and Lawrence's survey.[6]

An important 'spin-off' was the boost given to the doctor–patient relationship.[7] The patients often com-

Table 1. Preventive care of at-risk patients.

Preventive measure	At-risk patients	Number of at-risk patients: Seen	Number of at-risk patients: On author's list	Number of preventive measures performed	Percentage of at-risk patients receiving preventive care: Seen	Percentage of at-risk patients receiving preventive care: On author's list
Blood pressure	Males and females aged 20–64 years	603	1,070	596	*98.8*	*55.7*
Smoking				601	*99.6*	*56.2*
Weight				580	*96.1*	*54.2*
Dietary roughage				591	*98.0*	*55.2*
Rubella status	Females 10 year olds—1st pregnancy (or 35 year olds)	132	—	128	*98.0*	—
Cervical smear	Female 20–64 year olds	292	542	252	*93.7*	*6.5*
Totals		1,027	1,612	2,748	—	—

mented that it was a long time since a doctor had checked their blood pressure. Through these anticipatory procedures, both patient and doctor appreciated prevention.[8]

References

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