

and DROs) that are available to help with occupational health problems;

7. give advice (or to describe where advice may be obtained) about suitable occupations for patients with particular disabilities—for example, epilepsy, diabetes, back pain and visual defects;

8. demonstrate an awareness of current legislation relating to employment protection, health and safety at work, sickness certification and pay;

9. assess a patient's fitness for a particular employment and give appropriate advice.

These objectives apply throughout medical education but may require different emphasis at each stage.

The medical student wants to understand the facts of medicine and the skills of diagnosis and management; he is interested—'What is going on?' The vocational trainee, in contrast, is driven to ask, 'What should I do?' Finally, the established practitioner in continuing medical education begins by asking, 'Have I established appropriate standards of care, and am I meeting them?'

So, during basic medical education, it is necessary for all students to learn about the importance of occupational factors in health care. If the desired attitudes are not acquired during this phase of medical education, subsequent teaching and learning will be more difficult.

In vocational training the major learning environment is the training practice, which should provide a model to help the young general practitioner to prepare and develop appropriate standards for his practice in the future.

When, finally, the general practitioner is established in his own practice, his motivation to learn derives from his own performance review. His continuing education will more easily achieve its maximum potential if the framework from the earlier years is satisfactory.

As the scope of curricula of both trainees and medical students increases, it is unrealistic to add to a trainee course a module on occupational health. For the most

part, the objectives can be accomplished by educational methods already familiar in vocational training and continuing medical education for general practice. What is required by both teachers and pupils is an acceptance of the importance of occupation in considering the patient and the illness. The following methods may be found useful:

1. Case discussions about patients in whom occupation has had a significant bearing on diagnosis or management.

2. Analysis of case records at random to explore the effect of occupation on health and *vice versa*.

3. Small group discussions with appropriate resources, including video.

4. Audit of medical records to review information about occupation.

5. Discussions with full- or part-time occupational physicians and other occupational health professionals.

6. Visits to places of work where there are occupational health services and discussions with representatives of employers and employees: review of the range of work of the occupational health nurse and physician and its interface with general practice.

In the past 20 years general practice teaching has paid increasing attention to the part played by the family in the course and management of illness. Comparable attention should be given to the patient's occupation.

KEVIN BROWN (Chairman)

JOHN HORDER (Secretary)

ROY ARCHIBALD

PETER CONSTABLE

ANTHONY HAINES

MARSHALL MARINKER

ADRIAN SEMMENCE

Working party of members from The Royal College of General Practitioners, the Faculty of Occupational Medicine of the Royal College of Physicians and the Civil Service Medical Advisory Service.

Record requirements

'The best memory is a record made at the time'

Sir William Gull

THE limitations of doctors in the field of communication were documented with painful clarity by Charles Fletcher in the 1972 Rock Carling Monograph *Communication in medicine*,¹ which should be required reading for every medical student and trainee. Good communication, a *sine qua non* if optimal standards of care are to be achieved, is heavily reliant on well organized records. These have been the subject of much interest in the past decade with the appearance of problem-orientated medical records (POMR)^{2,3} and an increasing recognition of the contribution of good com-

munication to patient care. POMR offered the most carefully designed system available. The emergence of the computer at first promoted interest in records, but has lately tended to overshadow them. One hears the comment, 'We're not bothering about records, we're buying a computer', which is tantamount to running a Jaguar on two-star petrol. After all, the staple diet of computers is good records—we all know the tart dictum, 'Garbage in, garbage out'. However, the primary reason for keeping high quality records is to improve patient care—directly during the consultation, and indirectly through the development of improved means of prevention, teaching, audit and research. A record

system must ensure complete cover of all pertinent information, provide easy access to important material therein and express its message clearly and quickly.

General practice records have been criticized for their inadequacies in the past.^{4,5} In a study (unpublished)⁶ of 400 records reaching our practice six years ago, it was found that one file in four had data missing which was valuable or essential to patient care, including history of open heart surgery, rheumatic fever, hepatitis, asthma, depression, deep vein thrombosis, renal failure, ankylosing spondylitis, hysterectomy, caesarian section and abortion. In addition to this, progress notes are often amorphous and fail to highlight important information, the reliability of diagnoses is often uncertain and records lack coherence in chronic disorders, such as when blood pressure readings are scattered throughout the file. For a branch of the profession dedicated to the constant improvement of standards, this makes dismal reading. It also explains why training practices are under pressure to raise standards of recording and, particularly, to ensure that file contents are in chronological order, records of each patient contact are legible and each file contains a summary card.

To achieve these standards, the doctor needs a file of all the relevant facts, providing rapid and reliable access to information through indexing and the structuring of progress notes. The records should also be integrated so that they express their message clearly, especially when dealing with chronic disease. Formal updating must be built into the system, which should also identify 'at risk' patients for regular review. Finally, the system should be transferable to any practice. A4 files have been widely canvassed for use in general practice, but Tait⁷ and Maycock⁸ have shown that an adequate system can be developed using the FPC record envelope.

Only the problem-orientated record system^{2,9} meets the above requirements, subject to certain modifications: the numbering of problems is unnecessary, as is the use of the SOAP acronym; the highlighting of important data by underlining, boxing or colour tagging is all that is required, while formal plans are necessary only for a minority of chronic disorders. Finally, registers should be used for 'at risk' groups of patients, those whose quality of life is likely to be impaired because of chronic disease, handicap, old age or obesity. The use of registers enables them to be carefully monitored by the primary care team.

In one respect, however, patients are likely to be worse off with the problem-orientated system since important (and sometimes sensitive) information on the patient is more easily accessible. This increases the risk of a breach of confidentiality especially in the day-to-day handling of files in practice premises. Strong precautions, therefore, are required to ensure that reference to the files is kept to a minimum and restricted to authorized personnel only. The growth of computerized data bases and the development of interactive computers is likely to threaten confidentiality further.

The highest standards of security must be developed to protect such information; not only must this be done but it must be seen to be done, or the public will be unwilling to discuss sensitive issues affecting health with their doctors—a most undesirable outcome. The proposed provisions of the Police and Criminal Evidence Bill would have posed just such a threat but this seems to have been removed by the deletion of clause 10. Continuing vigilance, however, is essential whichever political party is in power.

The development and maintenance of this record system is a major task and there are those who would question its value. Yet no professional activity can be properly planned, organized, administered, maintained and reviewed without proper records. It is time to stop regarding records simply as an *aide-memoire* for current clinical care and to recognize them as a dynamic tool. In clinical care they are an aid to rational thought and better decision making. Without good records, there is less likelihood of an optimal standard of treatment, the risk of inappropriate therapy is increased, and reporting to others (sometimes long after the event) is difficult. Good records are the building bricks of epidemiology and the foundation of better preventive care. Audit and research are essential tools for improving standards and they too depend on careful recording. In teaching, a good record system is vital to the development of clinical discipline and well organized files makes the process of teaching itself much easier. Finally, there is a greater need for complete and accurate records with the introduction of computers.

Good records will not ensure good patient care, but bad records will conceal standards of care, however good, and increase the risk of inappropriate treatment in an age of increasing litigation. The maintenance of high standards in record keeping presents a challenge which family doctors must be prepared to meet.

A. J. TULLOCH

General Practitioner, Bicester

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