general practice can be grateful to the authors for the tremendous amount of work which they have done.

Classification of Diseases, Problems and Procedures 1984, Occasional Paper 26, is available from the Publications Sales Office, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £4.75 including postage; payment should be made with order.

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Quasijudicial use of medical records

It is likely that both doctor and patient presume that clinical notes will be used only as an adjunct to the care of that patient. Nevertheless, the content of the medical record may subsequently be disclosed to an outside agency and used in assessing the patient's standing as an insurance risk, as an adoptive parent, as a prospective employee, or for some other purpose.

Is the medical record a reliable (or even ethical) source of information for these other agencies? Much of what is written in general practice records reflects the attitudes of the general practitioner and the course of the particular consultation, rather than the presence or degree of serious disease. Furthermore, what is put into, and retained, in the medical record envelope may be arbitrary and yet have serious consequences. This is a particular danger in the hazy area between the normal and the diseased wherein lie so many of the problems presented to general practitioners. For example, one doctor might reserve the word 'depression' for serious and protracted affective disturbance, whereas another doctor might apply it freely to anyone who complains of being 'run down'. One doctor might intimate in the clinical notes that there is a drink problem, while another might think this but not write it down, and a third doctor might not even think of the possibility. Then, the distinction between asthma and bronchitis is difficult to determine in children, and the diagnosis can cost the child a job 10 years later.

If there has to be summarization of medical records for quasijudicial use, the fairest way of doing this would be to involve the doctor who made the original record. Unfortunately, this is becoming impracticable with fewer single-handed practices and with the increased movement of populations.

Doctors and lawyers are rightly concerned that consent for medical procedures should be both proper and properly obtained. Certain criteria must be met in the consent to an operation under general anaesthesia: the patient must understand the nature of, and the reasons for, the surgery; the consent must be freely given; the patient must be free to refuse the operation; it will be understood that the surgeon, in performing the procedure, will be acting in the Hippocratic tradition—exercising his skill in the service of the patient. The type of consent required for the disclosure of the contents of the medical record is quite different: it cannot be 'informed' consent unless the patient knows both the content of the record and the significance of what is written—and neither criterion is possible with present day medical records; consent is given under duress, since refusal might disallow the goal to the patient.

The ethos of medical disclosure is seldom explained and probably not often understood. Most patients believe that doctors always act in their interests; they are unaware that in preparing a medical report the doctor is acting for another agency. Although legally acceptable, the present consent for disclosure of a medical record is ethically inadequate. If patients were aware of the possible risk to their future when information is used for purposes other than their personal medical care they would, understandably, choose to withhold information.

For their part, doctors are not immune from the effects of the records they make. If the doctor's first duty is to care for his patient, the decision about what to record must be dictated by a consideration of the benefits or dangers for the patient relative to that information.

Much is being done to foster better, more detailed medical records. At the same time, doctors should be aware of the use and abuse of medical records and be considering radical changes in the present practice of information disclosure.

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