LETTERS

Deafness after Otitis Media

Sir,
In their report (February *Journal*, p. 92) Barritt and Darbyshire correctly emphasize the importance of checking hearing six weeks after an episode of acute middle ear infection. The results also included the statements that a history of allergy was common (49 per cent) among the children with otitis media and that a positive history of allergy was assumed when atopy was present either in the child or in the immediate family. The terms 'allergy' and 'atopy' are often used in an imprecise manner and the authors do not give any specific definitions of these terms. Was a family history of atopy based on clinical impression or skin testing of individuals?

Schutte and colleagues in a general practice survey claimed that children with serious otitis media had a significantly higher incidence of atopy than a control group but their definition of atopy was defined as 'entry in the general practice record of one or more of the following terms—asthma, eczema, hay fever and wheeze', and there were no confirmatory tests to indicate that these patients were truly atopic.[1]

Before accepting that there may be a link between otitis media and atopy a more precise description of terms is required. The relationship between otitis media and associated respiratory conditions may be due to impairment of host defence mechanisms in response to virus infections and the use of the term atopy when referring to children with asthma and wheezy bronchitis may just serve to confuse the issue.

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Reference

1. Schutte PK, Beales DL, Dalton R. Secretory otitis media—a retrospective general practice survey. *J. Laryngol. & Otol.* 1981; **95:** 17-22.

Maintaining Standards

Sir,
On reading your recent series of articles in the *Journal* on the College diploma examination, I felt it would be an appropriate time to resurrect a discussion about the usefulness of the examination and whether it should continue in its present form or at all.

Currently all those aspiring to be members of the College have to pass this examination. This has not always been the case and a large number, although I believe now a minority of members and fellows, have never had to subject themselves to this test. In the past, membership could be purchased for a modest sum on the recommendation of one's colleagues who happened to be College members themselves.

The examination was introduced to establish a basic standard of knowledge and ability amongst members of the College. It was agreed at that time that this test should only apply compulsorily to those doctors who were not at that time members but who wished to join. Those members who wished to test themselves could also sit the examination without fear of losing their membership and many chose to do this.

But does the current system of testing *guarantee* in any way a basic standard for all members and fellows of the College? For those who have not sat the examination it patently does not. For those who have sat the examination, I feel it is ludicrous to suggest that one successful attempt at such a 'basic' examination guarantees a lifetime of 'basic' practice skills. Surely, if an examination is to achieve the ideal of ensuring that all College members are good general practitioners then the examination has to be continuous and has to apply to all members. Alternatively the examination could be abandoned altogether.

By introducing some form of continuing assessments, the College would give a lead to other Colleges who at the moment do not test the members beyond entrance examination. How many consultant physicians and surgeons would pass their respective College examinations if tested again? I am not suggesting, however, that every few years every member or fellow of the College goes through the full MCQ MEQ traditional essay and oral which new members currently have to pass. Indeed, it has been suggested that some of the older members might have difficulty with this type of examination because of the long hours of concentration involved (although no quarter is currently given to those older general practitioners who wish to join the College). Nor would I suggest that 'failure' of an assessment should automatically result in expulsion from the College. I have no doubt, however, that some form of assessment acceptable to most could be agreed upon and performed at an informal local level.

Proponents of the examination have put forward many reasons for its continuation. The most frequently voiced is that it is a good test of knowledge at the end of training, approaching it in much the same way as one might running a marathon or mountain climbing. Others claim that the existence of the current examination entry system puts our College on a par with other Royal Colleges and gives general practice prestige. All this in spite of the examination being much easier than other College examinations. My own concern, however, is more with maintaining standards than inflating egos. Attempts in this direction recently pay only lip service to this goal and some form of compulsory rather than voluntary review of our general practice abilities should become an integral part of College membership.

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The College and Health Service Cuts

Sir,
I read with dismay the news that the College had refused to join other Medical Royal Colleges in protesting against Health Service cuts.

I appreciate that this has been done because the College does not feel that general practitioners have been hit. This I feel displays a very narrow and insular outlook from the College. Very few people doubt that, in real terms, there has been a decrease in funding of the NHS over the last few years and, as the letter from the other Colleges states, there is great fear that the future funding may not be sufficient to maintain even the present standard of care. Consequently the cuts will be, and in some cases already are, biting into patient care. At the moment this appears to be more obvious in the hospital sector. However, are general practitioners not concerned with increased waiting lists for physiotherapy, delayed opening of geriatric and psycho-geriatric day hospitals, ward closures that have set back holiday relief admissions and the marked reduction in ambulance services that has been observed recently?

Anything that affects patients and their well being must by right affect general practitioners.

Whilst it may be necessary to reappraise the allocation of funds to the various specialities from the Health Service budget, there can be no justification in actually decreasing the funding of this budget.

At a time when the Health Service is under threat, to voluntarily divide the weight of medical protest seems a foolhardy move. It will make the protest seem less serious, and will inevitably isolate the College even further from its own members, other general practitioners and the representative bodies of all other specialities.

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Discarding Patients' Records

Sir,
Michael Jolles' letter (April *Journal*, p. 244) has highlighted an important problem: the use of medical records in general practice. The underlying problem is an 'information explosion' with general practitioners writing and receiving increasing amounts of data about patients.

There is more written about each consultation both for medico-legal reasons and also to improve accuracy of records; an entry now of a significant illness is usually at least four lines long to allow SOAP notation. More than ten years ago it was rare to see more than one line per illness used on FP7/FP8 cards. There is increasing use of other cards in the records; lists or flowcharts for past history, immunizations, cervical cytology, contraception or other problem or system-oriented notations.

Other agencies, including hospitals, are increasing their output of letters to general practitioners. Whereas for a routine operation nowadays three separate forms are sent as well as the outpatient and histology reports, it is rare to find more than one letter detailing an operation more than ten years ago.

Currently, medical records occupy a manageable volume of about 1.5 m^3 per doctor. However, a substantial proportion of this has accrued within the last few years; if doctors were indiscriminately to store all such information presented to them then medical records could be expected to increase threefold over the next three decades.

Aside from the obvious problem of storage space is a less noticeable but more important matter; speed of access to information. That more records will impede information finding is not surmise but mathematical certainty. Of an unsorted record, as its size increases access time increases not in direct proportion, but as its square power. Only if the record is sorted chronologically and the date of the information required is known does the access time increase in simple proportion to the record size.

It is important to note that medical records are already showing signs of engorgement. Apart from the bulk of some envelopes, information within them is being irretrievably lost. I have been dismayed to find that some contain FP7/8 cards or letters which do not relate to that patient. Usually the misfiling, having occurred in another practice many years ago, cannot be corrected. More common is the finding of a large gap in the history once the record is sorted. Such defects cannot be seen without a summary and chronological order. Another rare but important matter is that records may contain information of past serious, significant disease about which the patient and general practitioner have forgotten.

Clearly, current medical records are, to misuse the current jargon, 'write only memory'; information is easily stored but not necessarily easily retrieved. For example, I have recently sorted a medical records envelope in which a previous doctor had arranged all the hospital letters in order of size. While this certainly reduced the bulk of the letters, it reduced their use even more, such that understanding of the patient's past history was impossible.

Many general practitioners have realized that they need to do something about their records. No doctor wants to use up time on tedious paper work, removing anything from the envelope goes against the hoarding instinct of our profession, yet if record size is to be kept within reasonable limits then something has got to go. The only authoritative guidelines come, lamentably, not from the profession itself, but from the defence societies who recommend that records less than ten years old be retained and matters concerning serious psychiatric or obstetric illness be retained intact indefinitely. Outside this lies a huge area of medical records where the general practitioner must balance the risks of the intentional loss of information after summary against unintended loss within the unpruned records in the patient's envelope (or someone else's), or at the bottom of a gussetted envelope.

As this problem increases it will be interesting to see what consensus occurs, if any, amongst the profession. I look forward to a time when I shall know exactly what I should keep and what may be safely summarized. For the present I suggest that the measure of a good medical record is not the total information which is put into it but the amount which can be consistently got out.

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Hypertension in General Practice

Sir,
Having read Dr Patterson's paper (February *Journal*, p. 97) I feel I must express doubts about its relevance to the problem as experienced by other practitioners. The author implied that hypertension is being overtreated in general practice but I fear his data do not support this hypothesis.

One immediately has doubts about how representative are the diagnostic criteria and prescribing policies of the single small group of doctors studied. Furthermore, out of the sample of patients identified as being hypertensive, only just over 70 per cent were unequivocally under treatment for hypertension. In this group presumably some patients were being treated with hypotensive drugs for other reasons than hypertension alone (for example angina and heart failure) and would still have received them even if their doctor did not consider their blood pressure worth treating. We are not given these figures but presumably they must have been available to the author. These two factors may therefore be artefacts increasing the sample size.

The author then introduces us to his definition of hypertension requiring treatment (diastolic pressure greater than 110 mmHg on three occasions), that is only those people with 'severe' hypertension. The author cites the lack of evidence of the value of treatment in 'moderate' hypertension, which is a perfectly valid reason but is at variance with common practice. Would he really not treat a man of 40 with persistent diastolic pressure of 108 mmHg?

He then goes on to show that only a few (12 per cent) of the practice's 'hypertensives' fulfil his criteria for treatment. There were two reasons for this—firstly, because some patients did not have three blood pressure recordings prior to diagnosis and secondly, because a large proportion of those