

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

Whilst it may be necessary to re-appraise 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<sup>3</sup> 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 gusseted 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