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

who had could be defined as having 'moderate' hypertension on repeat testing, which presumably the practice thought to be still worth treating.

Out of the group with less than three blood pressure measurements, how many had life-threatening complications of hypertension (for example hypertensive heart failure) and how many had unequivocal evidence of end-organ damage making further measurements unnecessary? Again, these figures must have been readily available, yet we are not given them.

That many of the people could be reclassified as having 'moderate' hypertension is not surprising, bearing in mind that the Gaussian distribution of blood pressure makes 'severe' hypertension much less common than 'moderate' hypertension.

Although the data may suggest that some people are treated needlessly for hypertension, the suggested figure is not a measure of this but a measure of the variance of opinion between a small number of doctors, none of whom is 'correct' because we do not yet have the results of the relevant clinical trials.

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Care of the Long-term Neurologically Handicapped

Sir,

As a member of the South West Thames Board of the Chartered Society of Physiotherapy, I write to express the concern of the Board for the future welfare of the long-term neurologically handicapped in the community.

It is the present policy of this government to encourage the transfer of the handicapped from institutional care to that of the community. Whilst this is an admirable aim, the provision of adequate care in the community for certain sections of the handicapped is sadly lacking.

The care in the community of those suffering the results of multiple sclerosis, Parkinson's disease, stroke, spina bifida, motor neurone disease, cerebral palsy and so on produces a demand on the resources of chartered physiotherapists which we are unable to meet. Lack of both manpower and finance leaves us unable to provide the standard of care and rehabilitation which is required and for which we are trained.

The quality and quantity of care are not only benefits to the patient who is seeking to maintain independence, but are an essential support to families who remain ultimately responsible for the day to day care of these patients.

The purpose of this letter is not only to express our concern but to request the help of the members of the College to indicate ways of increasing our resources, and therefore to enable us to provide the standard of care which is in demand.

We are fully aware that most sources of financial help are fully stretched at this time, but the scope of the problem is such that we feel that we must explore all possible ways of increasing the volume of care we are able to provide.

All known areas of aid are being fully used and there is cooperation between chartered physiotherapists employed within the NHS and those in private practice where this is possible.

On the principle that 'two heads are better than one', we would be most grateful for your suggestions on any new and *positive* avenues of aid which we could explore.

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Register of Interests

Sir,

The report of the Council meeting on 3 December 1983 (February *Journal,* p.109) includes mention of the debate about the creation of a Register of Interests of Council members, presumably to identify possible bias. Whilst this would attract Council members whose view of democracy demands that only those who have no 'interest' in a subject may be trusted to debate, it has serious practical disadvantages.

For example: all general practitioners may have some bias about general practice; all CND members may have a bias about radiology, including nuclear magnetic resonance because of its alliterative connection; all who have opted out of 'out-of-hours' cover may have a bias about deputizing arrangements; all prescribers may have a bias about prescribing; all junior partners may have a bias about senior partners.

Indeed, all who have ever expressed a view about a subject may have a bias about it. *Reductio ad absurdum?*

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Undergraduate Learning in General Practice

Sir,

We were interested to read this paper by Professor I. M. Richardson (November *Journal,* p. 728). Feedback from students about what they have learned during their undergraduate attachments is an important aspect of the evaluation process and course tutors find it useful in planning their teaching.[1] In Bristol, students have completed structured questionnaires to identify any apparent learning deficiencies of the undergraduate attachments in general practice.[2] Questionnaires have also been used to study how the experience of these attachments alters students' approach to patient management.[3]

As well as the methods used in Bristol and Aberdeen, techniques to assess general practice teaching have been developed in other medical schools. It might be appropriate for the College to review what is now available and to consider whether any methodologies should be adopted on a more widespread basis. For example, findings from one, or a selection of these methods applied to groups of students in several medical schools could provide interesting comparisons. Teaching arrangements for general practice, the number of years and the time devoted to this teaching differ between medical schools.[4] The findings from such comparisons could help to identify any need for Professor Richardson's suggestion that general practice should be given the same extended clinical teaching as hospital-based specialities.

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References

1 Philipp R. Student evaluation: its worth for course tutors. *Medical Education* 1980; **14:** 199-201.
2 Philipp R, Hughes AO. Aspects of general practice studied by University of Bristol students. *The Bristol Medico-Chirurgical Journal* 1983; 120-122.
3 Philipp R. Assessment of undergraduate general practice teaching. *Medical Education;* in press.
4 Murray TS, Barber JH. Undergraduate teaching of general practice in the UK. *Update* 1978; **16:** 39-47.