

ner happens to be available for each episode of illness. No one doctor will be charged with the responsibility for providing continuing primary care for a vulnerable individual and collective responsibility can so easily become the collusion of anonymity.

As general practitioners we are under threat from many quarters. The taxpayer would prefer to employ more ancillary staff at a quarter of our salaries to do 90% of our work, nurses and pharmacists feel they already do much of our job themselves, and hospitals are encroaching into general practice in every possible way with paediatric, geriatric, psychiatric, handicap, asthma and diabetic community teams. The general practitioner's unique role is to provide continuity of care in the context of family medicine. If we abdicate from that we have only ourselves to blame if others eventually decide that general practitioners have nothing extra to offer the care of the sick in the community apart from doing the night calls (where there is no deputizing service).

After reading the letters in the *March Journal*, I then turned to the original papers in the same issue. My eye was caught by the summary of the article by Roland and colleagues (*March Journal*, p.102). It stated: 'Patients registered with practices operating personal lists received much better continuity of care than those registered with practices operating combined lists. Patients...regarded continuity of care as important, especially if they were registered with practices operating personal lists'.

I suggest that combined list practices have little advantage for patient care over personal lists and it is only doctors who benefit from them.

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Sir,

I was surprised that Dr Elliott-Binns (*Letters, March Journal*, p.134) listed so many disadvantages of the personal list system. In practices with partners of different ages the methods of treatment of different conditions, for example hypertension, are often totally different; with Dr Elliott-Binns system of pooling patients the younger practitioners may not be familiar with the side-effects of methyl dopa and similarly the elder practitioner may not be familiar with the side-effects of calcium antagonists.

Dr Elliott-Binns also suggests that personal lists decrease the doctor's awareness

of his partners' ways of working but he forgets that in most partnerships night visits, evening visits and weekend work is usually discussed by the visiting doctor and it is without doubt better for the patient that the duty doctor has a specific doctor to inform about a patient's progress. This will lead to the discussing of patients which Dr Elliott-Binns fears would not happen with a personal list system. The beauty of the personal list system is that chronic problems and chronic patients do not get passed from one doctor to another, but doctors are made responsible for the proper treatment of their patients. With a personal list system it soon becomes apparent if a doctor has a weakness, as other partners are constantly picking up that problem at night or at weekends. This leads to a superb peer review system, and a stimulus for the doctor to brush up his weak subjects.

Dr Elliott-Binns makes the point that patients are unable to sample or choose their doctors, but on the other hand it is well-known that many patients will 'hunt' the general practitioner who will give them the treatment they perceive they need. It may be better for the patient to be told to take aspirin for a sore throat rather than to make appointments with each doctor in the practice on separate days until he is prescribed the penicillin he perceives he needs. If the patient can only turn to one doctor he will always get the same drugs and the same treatment and will learn to respect and understand that doctor's working methods.

Finally, I would agree with Dr Elliott-Binns' comment that sometimes one particular doctor is busier than the others. This does tend to equal out over the year, and the advantage is that the busy doctor cannot shirk his own patients. If they are his patients he has to see them. It is all too easy in a busy partnership for each doctor to invent excuses not to see any 'extras'.

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### Medical record folder for the Lloyd George envelope

In January 1965 I took over a practice from a single-handed practitioner and was immediately faced with the task of keeping clinical records to satisfy my needs. I felt that a summary card was needed and I plagiarized the idea of a folder from the Birmingham practice where I had

previously been an assistant. The redevelopment of Aston had caused the NHS list of Dr Roger Morgan to have a high turnover and I adopted his solution to the problem of summarizing clinical information about large numbers of new patients. This solution had some features in common with the record folder proposed by Drs Floyd and White (*January Journal*, p.19). I shall call Dr Morgan's design the 'Aston' folder and Dr Floyd's design the 'Croydon' folder.

The folder acts as a cover for the contents of each medical record envelope (FP5/FP6). The material and dimensions are critically important; the most suitable material is index board which resists wear and tear at the fold for much longer than cheaper, softer papers. At the same time the surface is not too highly glazed to be written on conveniently. I use a card of the same height as the Croydon folder (177 mm) as this is the height of the English forms FP7 and FP8. NHS stationery is not standardized and there is considerable variation between different print orders by the DHSS. Present continuation cards do not fit envelopes FP5 and FP6 which are 2 or 3 mm shorter and, because of the thickness of the cards, the internal dimension loses a further 2 mm or so. Both the folder and FPs 7 and 8 therefore project some 5 mm, with resultant wear on the top edges. The Aston folder is a few millimetres wider than the Croydon folder which allows it to enclose the whole contents of the envelope and to slip easily in and out of the envelope for each consultation. I have found in a short trial of treasury tags that there was excessive wear on records and that mounting pages on tags caused avoidable extra work for both ancillary staff and doctors.

I am also concerned that the Croydon folder carries so much sensitive and confidential information on its outside pages.

Dr Floyd uses the second page of the record card to create a dated biography. While this has points in its favour, it is very wasteful of space for the majority of patients. It may show clusters of life events but it may be just as relevant to show clusters of organ or regional events. In 1964, Dr Morgan devised a graphic way of overcoming the list presentation by printing an outline anatomical figure on page two of the Aston folder. This figure enables clinical events from fractures to fugue-like states to be entered in relation to regions, by side and by site, and enables the many scars on some abdomens to be clearly identified. The addition of a simple detail here and there will easily distinguish internal events. This minimal structure allows great flexibility of recording and has been readily adapted to patients' needs over long periods.