istrars (vocational trainees) should learn the basic principles of quality assurance during their formal training.[6,7] Another important obstacle lies in the lack of collaboration between care providers in the practice team or local setting. This study underlines the crucial importance of teamwork and good collaboration for quality assurance in general practice, as suggested and found in other studies on quality assurance methods, such as the north of England study on standards and performance in general practice[8,9] and the studies on peer group review performed in the Netherlands.[10,11]

To guarantee representativeness in the present study, potential participants were approached in a random and systematic manner. This seems to have worked well. The use of experienced general practitioner interviewers probably contributed to a good response rate (only 20% refused) and also to the general practitioner respondents feeling free to express their opinions in the interview. It could be expected that the results provide a much more valid picture of the views, concerns and needs of general practitioners than is usually gained through postal questionnaires. Validity was improved by giving the doctors the opportunity to react spontaneously to open questions and by following up their answers in order to explore further their feelings and views. Specific quality assurance activities were explained to the general practitioners to guarantee a good understanding of the questionnaires and to promote reliable results.

In conclusion, this study provides a representative picture of the attitudes, experiences and requirements of general practitioners with respect to quality assurance and medical audit in a country that has had specific quality assurance policies and programmes in general practice for between eight and 10 years. General practitioners in the Netherlands were generally found to be positive towards quality assurance and were aware of many of the proposed activities. They did not, however, have specific experience of carrying out most of the activities and were therefore in need of support in this process. The implementation of quality assurance systems in general practices can be compared to the implementation of clinical guidelines: a well-designed strategy, with a combination of different interventions, will be necessary to be effective.[12,13]

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Patient-held medical records in Lesotho

THE capital cost of medical records and their storage systems is considerable, the space they take up is immense, and the amount of staff time used in filing and retrieving them is huge. These factors can only be justified if they can always be found when needed and the contents are accessible and accurate. Patient seen in hospital accident and emergency departments, on house calls (especially out of hours), and even in hospital outpatient departments, have a high likelihood of being seen without access to their medical record. Furthermore, the larger the health care facility, the more vulnerable such records are to unauthorized inspection and to breaches of confidentiality. All of these features of conventional medical records make the idea of patients keeping their own records worthy of careful consideration.

The objections to such an idea are mostly founded on the belief that patients would lose their records, and to a lesser extent on doctors' reluctance to have patients reading what they have written about them, despite the fact that the information, if valid, belongs to the patient and, if invalid, would be subject to correction by that patient. This study refutes these objections.

Patient-held records have been in use for 20 years in Lesotho, a largely rural third world country. Seven hundred people were interviewed, of whom half had more than one hour's walk to reach a health care facility. Of these, 89% preferred to keep their record themselves, and 83% felt that the information in it was theirs and that unauthorized people were less likely to read it if it was patient-held than if it was kept in the health care facility. Interestingly, while 32% of the sample worried about unauthorized people reading their record at home, 41% said that they would allow others, of their choice, to read it.

Forty one per cent of nurse clinicians and 36% of doctors estimated that people failed to bring their record more than 20% of the time. In fact, only 29% of people remembered ever having attended without their record.

More than 80% of the doctors and nurses in this survey felt that patient-held records prevented unnecessary repetition and prevented mistakes. In total 85% of nurses and 51% of doctors felt that if patients hold their own records they have increased responsibility for their own care, and 59% of nurses and 36% of doctors thought that patient-held records improved compliance.

If poverty stricken people in a developing country can keep, value and use their own records, generating in their carers respect for patient responsibility, should we not be prepared to learn from this work as a way of reducing the costs — financial, human and structural — of a paternalistic system?

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Source: Henbest RJ, Germond T, Fehrsen GS. 'I keep my health book with me': a national survey of 20 years' experience of patient-retained medical records in Lesotho. *S Afr Fam Pract* 1995; **16:** 80-94.

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