

## SOME OTHER IDEAS ON RECORDING OF CLINICAL FACTS

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**I**N THE past issues of this *Journal*, methods of record-keeping, indexing and making available the material so recorded has been described and discussed. The principle outlined has always been the same: the recording of disease or symptoms and signs in general practice being a continuous process, requires some sort of system to summarize the total or selected morbidity at a given moment of time. This morbidity must preferably be related against the background information of the population at risk. In other words, if we wish to know how many patients with cervical carcinoma there are in the practice, we need to know this figure against the number of married women, of the various age groups. If we want to know the number of new cervical cancer cases in our own practice as rate per 1,000 per year, it is essential also to know when in point of time the cancer was diagnosed, apart from the population figures mentioned earlier.

Over the past years, the College has developed a method which will make access to such figures relatively easy in those practices where this system has been adopted. The principle being that with the help of visible index books the new cases of morbidity seen each day are recorded by name, age and sex on an index slip for each respective disease. Thus all cases of tonsillitis appear on one sheet of paper, indexed by the disease, Tonsillitis. One could of course index morbidity by using each patient as the denominator, recording against each all the morbidity incurred. This is in fact what a summary card (*see* College Summary Card) of the patient does. It is not perhaps sufficiently recognized that this sort of recording without any elaborate aids would yield a rich crop of interesting information, particularly as summary cards lend themselves quite readily to mechanical sorting, and thus to speedy analysis.

A further method has been described when the indexing denominator is the family or household, with the obvious advantages if one is interested in the familial pattern of morbidity. This method, does not lose any of the information, and by mechanical sorting or even hand sorting, disease categories, etc., can be extracted as well.

For all these systems of recording it is important or perhaps preferable to know the total number of patients at risk, the population group observed and its age/sex pattern, so that any morbidity figures become meaningful. This is provided *par excellence*, in the British National Health Service where each general practitioner has an official list of patients which remains relatively static. Thus an age/sex register of such a N.H.S. practice is the only necessary prerequisite to allow the evaluation of morbidity recording, by whatever system. ('W', 'E', 'F', Book, or summary card).

It is therefore not surprising that doctors in other countries where the United Kingdom type of health service is not practiced are exploring other forms of recording. The research committee of council of the College is to be congratulated on seeking to widen the horizon of our own experience by inviting an exponent on recording from a completely different point of view, to address a very successful Research Conference, organized on the 23/24 May, at the College. Dr Walter Döhrn, from Düsseldorf, Germany, explained his system (its outline has appeared as a German paperback), which has become the backbone for the International Society for General Practice and its working party on "statistics, methodology and documentation".

Dr Döhrn's method is based on the principle that symptoms and signs can be represented by graphs or lines, and also by code numbers and association of such numbers to indicate parts of the anatomy and treatment. The latter part of his technique is perhaps a bit difficult for us to understand: we are beginning to find that either the international classification of disease or the College classification with its code numbers is extremely helpful. It also seems to be unrealistic to attempt to devise a complicated numerical system when it can be envisaged that computer handling of medical data and facts is just around the corner, and such preparing for machine handling should certainly not be the concern of the doctor. Where Dr Döhrn's contribution is particularly interesting and applicable is when he reminds us that the temperature chart, along with the pulse recordings and blood pressure recordings makes the quickest and simplest way of assessing a patient's progress by giving us this visual graphic picture of the patient's state, past and present.

Similarly, such a visual demonstration of a patient's progress can be extended to include linear recordings of symptoms or symptom groups, or laboratory findings translated into graphs. The extension of this recording might be particularly useful when it comes to drug trials or therapeutic assessment in related types of illnesses, or even in the same clinical entities, and antenatal and obstetric records could be so adapted most profitably. A sufficient number of such graphs superimposed on each other and related to method of treatment would show quickly results or failure of such treatment in a given number of cases.

From the diagram it is clear that if one takes the symptoms and signs, it is quite simple to indicate time on the downward axis of a case sheet and by downward lines on the case notes. Thus one can present the length of time a symptom or sign has lasted without having to describe it in words. This can be adjusted to different scales to make allowance for the irrelevant or otherwise history of illness, and to compress the time of convalescence so that not too many miles of paper are required, and yet give a visual summary of the case.

The lines are numbered to match the numbered explanation on the top of the sheet which will, of course, not require to be predetermined or standardized but can be entered to suit and allow for the contingencies of each particular group of illness. The right-hand side of the chart contains the lines indicating the treatments and their duration. Its effect, if any, will of course become apparent from the lines indicating the duration of symptoms, and special conventions can naturally be designed or added to indicate residual pathology. Such case notes as illustrated can be continued by sticking new sheets on to the basic record and either rolling or folding them up, so that the last few days are clearly visible. The devoted originators of this system assure us that it is a practical procedure.

There is no difficulty in taking these case notes to a patient's bedside and completing the continuation or termination of each line, or starting a new one as one goes along, either during the consulting hour or at the patient's home. The linear and visual presentation of medical records has many attractive features, most of all the scope it gives to each practitioner to record the type of illnesses in which he may be particularly interested. For instance, to record the varying pyrexias which appear as epidemics off and on throughout our general practice experience, would soon give the epidemiologically-minded a tremendous chance to discover if similar

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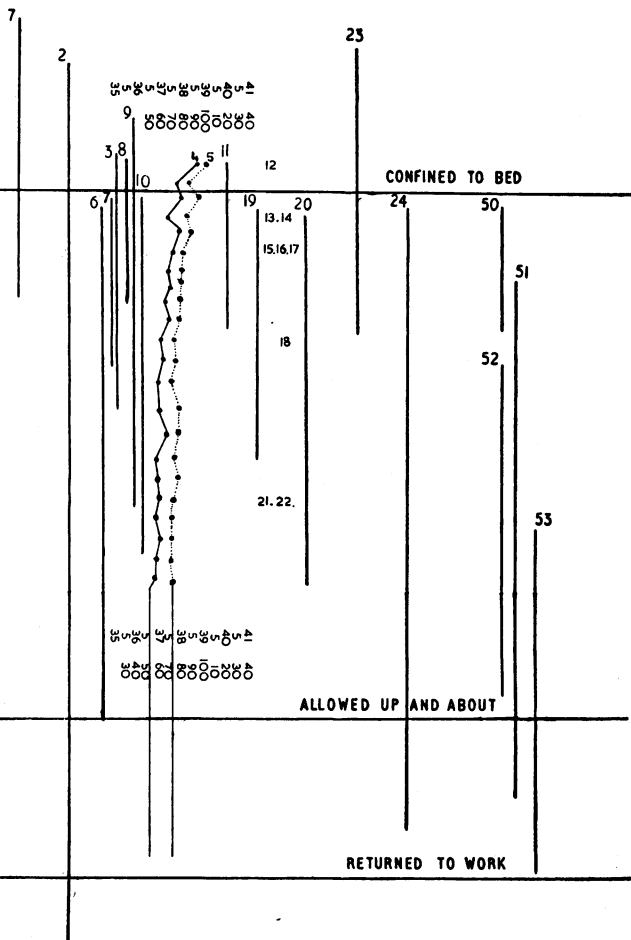


Figure 1

Key to Figure 1.

1. Recurring severe headaches, mainly in the morning
2. Deterioration of vision
3. Injection of conjunctiva
4. Temperature
5. Pulse

6. Weight
  7. Jaundice (icterus)
  8. Oedema of sacrum and ankle
  9. Loss of appetite
  10. Loose stools
  11. Vomiting
  19. Serum bilirubin raised above normal
  - 13—18 and 21—22. Various laboratory reports and results of different investigations
  20. Proteinuria
  23. Catarrhal cough
  24. Extra fluid intake
  - 50—54. Various forms of treatment, detailed on back of form
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patterns of signs and symptoms are discernible. Its main use, however, must surely lie in the field of therapeutic trials.

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#### Peptic Ulcer. A Profile. J. FRY. *Brit. med. J.* 1964. 2, 809.

Two hundred and sixty-five persons were diagnosed as having peptic ulcers over a ten-year period in a practice of over 6,000 patients. Follow-up studies showed that there was a tendency for disability to reach a peak six to eight years from the time of initial diagnosis and then for the disease gradually to burn itself out.

Forty-three patients, all with severe symptoms, were treated surgically and the final assessment showed that these did better than those treated medically. However, 15 of the 41 patients who had a partial gastrectomy developed anaemia (usually iron-deficient) five to ten years later. Records showed an increased tendency for some diseases to be associated with duodenal ulcer, notably pulmonary tuberculosis, neurosis, coronary heart disease and chronic bronchitis.