THE PRACTICE INDEX

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Keeping good records is one matter. Being able to use these records for retrospective research is quite another.

Many people keep a postcard in their top drawer on which they jot down the names of all the people they see with their pet disease. The snag about this is that it takes three or four years to get enough cases to be of any use for a survey and by that time one has lost interest in that disease and got interested in something else.

It was to get over this difficulty that the Practice Index was invented.[1] Instead of only keeping a list of people with the disease that interests us today, we keep lists of people with *all* diseases, so that we can instantly turn up the records of all patients with any disease we wish who have been seen during the current year or during the previous years for as far back as Indexes have been kept. This of course is only worth while if the standard of recording has been high.

The Practice Index bears a superficial resemblance to the "E" book, used by the Records Unit (p. 220) consisting as it does of a Twinlock visible index loose-leaf notebook, with one page per disease. But there is a fundamental difference between the two. The Practice Index is solely a means of locating the records in which the desired information will be found, whereas the "E" book is itself the source of information (Morbidity Statistics) and must therefore contain all the data that are going to be required (plate IV).

Since the Practice Index is no more than an index, the operation of using it can be cut down to the mere recording of a name on a page, once in each episode of illness. There is no need for the date of birth or the sex or the registration number (except under special conditions)—these things should be obtainable from the records together with the clinical data. Nor is there any particular need for everybody to stick to the same classification.

Classification

The problem of classification is so intimately bound up with the use of the Practice Index that it deserves more than passing mention.

The following points are relevant:

(1) Perhaps half the cases in general practice are either not diagnosable in the strict sense or do not need diagnosis beyond symptomatic level inasmuch as that experience shows that they will get better within a reasonable time, long before we should get the results of a full scale investigation if such were to be put in train. Nevertheless they are the stuff of which general practice is made and the classification has got to be capable of categorizing this mass of incompletely diagnosed material as well as providing precision where precision is possible.

(2) There is a point beyond which, if the precision of a clasification is increased, the accuracy of any results based on it is reduced. Dr John Todd has made this point very clearly in an article entitled " Precision in Diagnosis ".[2] For example, there may be a handful of practitioners in this country who, if faced with a patient with a painful shoulder, can say with enviable certainty that the patient is suffering from subdeltoid bursitis, supraspinatus tendinitis, periarthritis, or any of the other labels that consultants are wont to apply to these cases; nevertheless the majority can seldom, in many cases, go much further than a dignosis of a painful shoulder. If therefore there is a category for painful shoulder the entries in it will be nearly one hundred per cent accurate; but if instead, there are categories for the more exotic diagnoses mentioned above, the entries in them will be of very limited value.

(3) Nebulous concepts like fibrositis are best avoided. Uncertainty exists concerning the cause of many of the pains labelled fibrositis which occur in the arm and chest and elsewhere, and in informed circles there is even doubt as to whether there is such an entity as fibrositis. These pains of doubtful origin are therefore classified under their site of occurrence.

(4) It is sometimes argued that one must stick to the W.H.O. classification or some modification of it in order to be able to compare figures with other workers. But is this true? If A has 50 hypertensives in his practice and B has 500 in an otherwise identical practice, A's figures are only comparable to B's if A and B use the same definition of hypertension. If A has 5 gastric ulcers and B has 50, all that it may mean is that B diagnoses them on their symptoms alone while A insists on radiological proof. What matters is not that A and B should use the same classification but that they should use the same *definitions*.

Method of Use

The method of using the index is simplicity itself. When a diagnosis is made on a patient, that patient's name is entered on the

appropriate disease page. Only one entry needs to be made in the course of each illness. At the end of a year therefore that page will contain the names of all the patients diagnosed during the year as having that disease. If it is desired to carry out a survey of some sort on that disease it is easy to get out the records of all the affected patients and go through them. A fresh book is used for each year and the old ones are carefully retained.

A moment's reflection will show that mistaken diagnoses in the index are self-correcting. If a patient is diagnosed today as having thyrotoxicosis and is entered as such in the index and if next week the diagnosis is changed to anxiety state, one simply enters the new diagnosis in the index without bothering to correct the old. The fact that there is now in the index a case of thyrotoxicosis which ought not to be there is of no importance because if figures on thyrotoxicosis are required, the index is used to find the records and the fact that this particular case was incorrectly diagnosed becomes immediately apparent on looking at his records. If a case is mistakenly entered twice for the same illness it does not matter. Whether a recurring illness like asthma is entered once or many times makes no difference, although it is desirable to be systematic.

The book used for this work is the Twinlock H.R.12 which can be ordered through most large stationers together with a dozen index sheets to fit and about 300 feint-ruled sheets. One also needs a few strips of $\frac{3}{4}$ in. Kuturown, a transparent indexing material for attaching to the indexing sheets.

If one plans to go in for this work seriously there are certain desiderata:

(*a*) As for nearly all research in general practice an Age/Sex register is almost an essential.[3]

(*b*) The records of deceased patients must be retained. (The executive council will send them back, if requested to do so, after they have been formally returned at the patient's death.)

(*c*) One must retain the records of the patients who leave the practice. This is the most difficult part and has been got over in various ways, the most popular of which is to keep the old records but to send on to the after-coming practitioner a summary of the patient's history in the old M.R.E.

(*d*) A simple marriage register should be kept for women, indicating change of surname.

Obviously one must keep reasonably good records to make it worth while. A simple tidy method of record keeping used by the author was described in the *Journal* of May, 1962.[4]

The Future

The original object of the Practice Index was to enable the general practitioner to do a little modest research in his own practice, which adds enormously to the interest of the work and has great educational

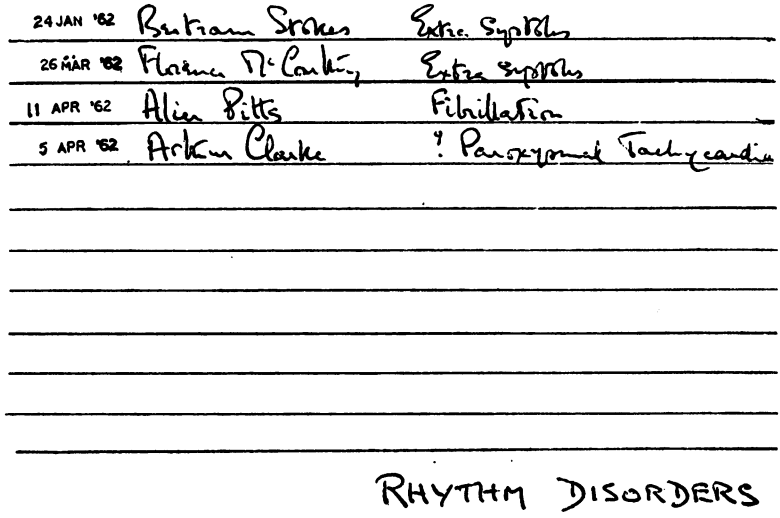
value. This is still the primary objective but now that there are quite a number of general practitioners using this method a new possibility has opened up—the possibility of working together to solve problems which the single-handed practitioner, by reason of small numbers of cases, could not by himself tackle. A start has already been made on this and four projects have been carried out at the request of various people, consultants and others.

It is not impossible that in the years to come, this group of workers (The Retrospective Survey Group) will be in a position to provide a unique service in supplying information that could be obtained in no other way.

The Practice Index Classification

The classification is divided into 8 parts. Each part occupies a full length section in the twinlock book.

Most categories are complete in themselves and need only the names of the patients to be written on the page, but some (including all those marked " other ") are multiple diagnosis categories and require the addition, after the patient's name, of the full diagnosis. These are marked with a star (★). This device gives the advantages of an infinitely detailed classification without its disadvantages. See sample page below:



Many workers will expand certain sections (psychological and obstetric) and contract others.

PRACTICE INDEX CLASSIFICATION

I. Infections. Neoplasms. Metabolism. Blood. Psychological

Infections	Chickenpox
	Measles
	Mumps
	Rubella
	Whooping cough
	Herpes zoster
	Gastro-enteritis
	Infective hepatitis
	Worms
	Tuberculosis
	★Other infections
Neoplasms	★Malignant
	★Benign
Metabolism	Diabetes
	Gout
	Obesity
	★Other metabolic
Endocrine	★Thyroid
	★Other endocrine
Blood Diseases	★
Psychological	★Psychoses
	★Neuroses
	★Other psychological

II. Central Nervous System. Eyes. Ears

CNS	Vascular lesion
	Concussion
	Epilepsy
	Migraine
	Vertigo
	★Other Central Nervous System
Eyes	Conjunctivitis
	Blepharitis
	Iritis
	Styes
	Meibomian cysts
	" Sticky eyes " in babies
	Foreign bodies in eye
	Injuries to eye
	★Other eyes

Ears

Otitis media — No discharge
Otitis media — With discharge
Otitis externa — (Eczema)
Otitis externa — (Boil)
Chronic otitis media
Eustachian obstruction
Wax
★Other ears

III. Circulatory

Circulatory

Coronary disease
★Rhythm disorders
Heart failure
Rheumatic fever and chorea
★Other heart
Faints — blackouts — drop attacks
Hypertension
Peripheral vascular disease
Varicose veins and complications
Phlebitis
Piles
Chilblains and frostbite
★Other circulatory

IV. Respiratory. Digestive

Respiratory

Pharyngitis
Coryza
Tonsillitis
★Large tonsils and other atypical throats
Sinusitis and antritis
Laryngitis and tracheitis
"Influenza"
Pneumonia and pneumonitis
Adult — bronchitis, acute
Adult — bronchitis, recurrent
Adult — bronchitis, chronic
Child — wheezy — asthma — bronchitis
Hay fever
Asthma (adult)
"Catarrh"
Epistaxis
Cough — undiagnosed
★Other respiratory

Digestive

Ulcer, gastric or duodenal
Indigestion
Hernia
Appendicitis
Abdominal pain — undiagnosed
★Mouth — teeth — tongue
Fissure in ano
★Other digestive

V. Genito-urinary

Urinary	Cystitis
	Pyelitis
	★Nephritis — acute — chronic — nephrosis
	Prostate
	Hydrocele
	Orchitis and epidydimitis
	Enuresis
	★Other urinary
Menstrual	Dysmenorrhoea
	Amenorrhoca
	Menorrhagia
	Irregular menstruation
Gynaecological	Discharge
	Prolapse
	★Other gynaecological
Pregnancy	Miscarriage
	Toxaemia
	★Other complications of pregnancy
Labour	★Complications of
Puerperium	★Complications of
Breast	★Excluding neoplasms and pregnancy complications

VI. Skins

Skins	★Infections — boils — abscesses — whitlows
	Infected lacerations
	Impetigo
	Warts and verrucas
	Eczema — adult
	Eczema — child
	Dermatitis
	Psoriasis
	★Diseases of scalp
	Acne
	Tinea
	Pityriasis rosae
	Papular urticaria
	★Allergic skins including stings and insect bites
	Rashes of doubtful origin
	★Other skins

VII. Organs of Movement

Arthritis	Rheumatoid arthritis
	Osteoarthritis

Back	Backache, probably disc Backache, probably not disc Sciatica, probably disc Sciatica, probably not disc Pain in sacroiliac joint
Joints, Tendons	Non-traumatic synovitis of joint Tenosynovitis
Injuries	Sprains including traumatic effusions Lacerations, bruises, etc. Burns and scalds ★Fractures ★Other orthopaedic

VIII. Special referred Pains and Miscellaneous

Pains	★Headache (subdivided according to site) Neck pain Shoulder pain Arm pain Chest pain. Front — infraclavicular pectoral submammary central Back — trapezius rhomboid subscapular ★Other chest pain
Miscellaneous	Acroparaesthesia ★Diseases confined to infancy ★Congenital malformations ★Unclassifiable including P.U.O.

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