KEEPING RECORDS IN GENERAL PRACTICE

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We are all aware of the awkward questions asked by cross-examining counsel about some clinical point long forgotten and buried in the notes; of the patient who loses or swallows all his tablets in such circumstances that only reference to the doctor's records will reveal how many and what they were; of the importance of clinical notes in compensation or fatal cases; but however important these are they are only a minority. What of the vast majority?

Good records help to make good practice. In family doctoring, as we know it, it is impossible to keep the same type of medical record as in hospital, but the gist of the history and complaint, the results of any necessary clinical examination and the treatment initiated can be recorded. At subsequent consultations progress can only be estimated by a study of the previous notes. Some have better memories than others, but there are few who can dispense with writing altogether. In any case there is a duty to pass on to any future medical adviser the patient's medical history. What is written varies according to the doctor's methods and interests. Only common and well recognized abbreviations and hieroglyphics should be used, as these must be intelligible for future readers. Continuity of treatment is important in single episodes, and in cases of chronic illness may be necessary during the life of the patient. To a family doctor treating a new patient the previous history may be of prime importance. Meticulous notes at the bedside or in the consulting room convince the patient of the adviser's interest, and do much to improve the doctor-patient relationship. The opportunity for research in general practice becomes more and more recognized, and, with it, the necessity for better records. Impressions are of little or no use. Finally there is a greater awareness of the importance of co-operation between the different sections of the National Health Service—the public health, consultant, and general-practitioner services. It is increasingly apparent that the importance of the family doctor lies in the vast amount of experience which passes through his hands. He, alone, sees the patient,

the family, and the community. Without records this experience is lost.

No doubt all will differ on the actual mechanics of record keeping. Since the inception of the original " panel " system, record envelopes and continuation cards have been provided, with minor modifications only. These are open to criticism. The material of the newer envelopes is poor and wears badly. Originally, these were reinforced with a gauze material which added strength, but often the strands of gauze came adrift, and being pushed down inside made it impossible to replace the continuation cards without irritation and waste of time. The recent gussetted envelopes are of poor material, and although necessary for a small number of patients they take up a great deal of room in the filing drawers. If full of continuation cards and various reports it is difficult to sort out the information required. The size of the ordinary envelopes varies a little, some being slightly bigger than the average so that the continuation card disappears inside. The card cannot then be grasped at the thumb cut-out at the top, again causing an irritating waste of time.

No matter what method is used the records occupy a great deal of space—a serious problem when the consulting room is of limited size. For a list under the limit allowed a single practitioner, the writer uses 27 standard drawers, as follows:

19 main storage, (10 female, 9 male)
2 patients attending surgery (1 female, 1 male)
1 patients being visited
2 retained cards of deceased patients (1 female, 1 male)
2 midwifery records
1 specialty—in which the writer is a clinical assistant.

The drawers of the standard cabinets seem slightly too narrow. As a result the envelopes soon wear at the edges because they are rubbed when being taken out. In each drawer there is a sliding stop to retain the envelopes at the front, particularly if it is only partially filled. The runners upon which this stop works wear two holes in the base of the envelopes. If the advertised number of records is stored in the drawer they will be found to be too tightly packed for comfortable use. It should be possible to flick the cards over. Only then can they be easily found, taken out, and returned. Overfilling causes rubbing which soon renders the notes in the back of the envelopes unreadable.

Even with care general repairs are needed. The envelopes are printed flat, and then folded, so that there is a join down the front centre and a flap turned up at the bottom and glued to the front. The join bursts open and the flap comes adrift. A large roll of cellotape—one inch wide and on a dispenser—will be found invaluable for the necessary first aid. Perhaps the clerical staff of executive

councils might be encouraged to do these repairs before sending out dilapidated envelopes, though they sometimes make out a new one and enclose the torn record. It is suggested that the reverse side of the envelope should be used only for specific information of importance. As a patient's first record is usually issued soon after birth, it would be possible to print the back for special items, for example, similar to those on the reverse side of the College Summary Card.

Continuation cards should be stored in chronological order, the one in use being at the front of the envelope. Nothing is more irritating than having to search through the others or the hospital letters to find the most recent. The summary card is placed at the back being only used at infrequent intervals. Such simple rules save time in a busy practice.

Letters from hospital form a problem, especially in cases of chronic illness and long hospital follow-up. They should be stapled together in episodes and in order of their dates; though the glue pen may have advantages over the stapling machine. It saves time to summarize the contents in one pithy sentence at the foot of the letter, or to ring round or underline important points in red ink. This will often obviate the necessity of reading carefully through a whole batch of letters to form a full clinical picture. Even with the new gussetted envelopes it may be found preferable to store large batches of hospital letters in special folders, for example a " Seven part " Closefast Folder taking paper of foolscap size (A Rapidfile Product). Stationery used by hospitals should be of standard size, for example, a sheet which, when folded in half, would fit into the envelope. The more the letters have to be folded the thicker the result. Even the thickness of the paper makes an appreciable difference as the years pass. One general hospital in this area has co-operated in this way with the size of letters and reports. Standardization of stationery might lead to economy in cost as well as in space.

Cards supplied by the local authority for recording immunization and vaccination procedure should be the same size as the continuation card. In this area these are 8 in. x 5 in., and consequently must be filed separately. At the time of each injection two cards have to be found if a record is kept in addition to the one for the medical officer's department.

Branch surgeries are a difficulty if patients attend the branch and main surgery at will. Records may be made temporarily and later transferred to the cards at the main surgery. This is expensive in time, and there is the added disadvantage of not having the patients' records to hand at the consultation. The writer therefore carries to the branch surgery the envelopes of patients known to be attending. For this purpose two leatherette filing boxes—8 in. x 5 in.—are

used, and they are returned to the main surgery at the conclusion of each session. They are therefore available, if required, at either surgery, and the cards remain in the boxes until the end of the current episode, when they are returned to the main drawers. In this way the boxes do not get overfilled. This has been found far preferable to carrying continuation cards only, a method previously tried.

A fourth leatherette box—8 in x 5 in.—at the main surgery contains current midwifery records. A separate weekly antenatal session is held, and this separate filing arrangement makes it easy to find the cards and also to note any failure to attend.

The register of visits is written monthly in a book ruled with a space for the name and address and 31 columns—one for each day of the month. Recently, the diagnosis and year of birth have been added after the patient's name. One standard drawer is kept for patients being visited. No daily lists are written out, but the cards needed for each day's visiting are carried on the round. The area covered by this practice is cut into equal parts by a main road, and the amount of visiting is about equal on either side. For this reason two leather wallets are used, each with two pockets holding about twelve record envelopes. These are sorted into the order in which visiting will take place—one pocket for the journey out and one for the return. Each wallet serves for one side of the main road. Of course it is sometimes necessary, because of an emergency or urgent call, to depart from the desired order, but this happens less frequently than might be expected. At each visit the record is taken from the front of the pocket. It is difficult to miss anyone, necessary points maybe ascertained and notes made at the bedside, the card being afterwards returned to the back of the pocket.

A system saves time. Industry spends large sums on planning and expert advice. Time and labour saved amply repay the expense. Planning is needed in surgeries and in organizing the work. Without an appointments system, and particularly if the practitioner finds the records at the time of the consultation, the filing cabinets must be placed so that there is a minimum of " jumping up and down ". This is not always easy as most surgeries are rooms modified to serve a purpose for which they were not originally intended. In planned health centres, offices and record rooms would be provided. In such circumstances it might well be found that a type of folder, similar to those in use in hospital, would be far preferable to the present envelopes, which are now inadequate for their purpose. Such folders are easier to use. There is no need to take out and replace the notes, letters, and reports, which may be glued in permanently. The usual visible method of filing folders in suspension racks is far easier to use than the closed drawers. The main criticism of

the folder would be the difficulty in sending it by post when a patient leaves the area. With sufficient clerical help, however, a clinical summary could be compiled, existing and growing parallel with the main records. The summary could follow the patient and the folder be retained unless specially requested. Perhaps the future will bring the possibility of photostatic copies if the records are shown to be worthwhile. Public health departments already have this means of copying.

In conclusion, adequate records are essential, help to make good practice, improve the doctor-patient relationship, and open up a vast field of experience otherwise unknown, but much thought is needed concerning the mechanics of record keeping and the materials provided. This will bring improvements and pay dividends. Without any great scheme of re-organization, time may be saved by very simple rules when these are invariably and systematically followed.

". . . The ' ledger ' is the book containing the entries of the number of visits made and medicine sent, or operations performed for each patient, with the charges against each. Whilst the ' visiting list ' is a memorandum of the visits intended and made each day; the ' day-book ' is a register of the medicine prescribed and sent, as well as of all other appliances, and of the visits to be charged; and the ' ledger ' is the book in which the items are set forth with the charges to be made. The accounts in the ' ledger ' are therefore made up from the day-book, and the operation is called ' posting '. The name of the party owing the account being written across the top of the page, the date at which the attendance commenced is entered in the first column, and opposite to it the ' visit ' or ' mixture ', or operation charged. In many cases subsequent dates and several other items may be entered upon the same line with the items which are charged opposite the first date in the line. In some establishments the total of the charges is run out at once and entered in the money columns; in others this is left to the principal when the accounts are made out, for the reason that a different scale of charges may be made as between the richer and poorer patients. In a well ordered establishment the ' posting ' will be done frequently and at regular intervals; in a large practice it should be done daily, so that if any patient wish to pay an account for recent attendance the bill can be made out without delay. Very generally the principal himself assists in the ' posting '; in some cases the surgeon's wife keeps the ' ledger ', in others the junior assistant is expected to lend his aid."

Langley, J. Baxter, *Via Medica*. Third Ed. London 1869. p. 100.