THE ART OF RECORD KEEPING IN GENERAL PRACTICE*

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Records. Why keep them? I have no doubt that some will say that they have no time to keep records—they are too busy; the answer to that is that if doctors keep good records they are not nearly so busy. They have the facts about their patients in front of them in black and white instead of in some inaccessible area of their brains. The patients get out of their surgeries in half the time; they are cured in half the number of attendances and the doctor has twice as much free time.

I have sat in on surgeries of doctors who keep no records and claim that they can remember all they need to remember. I have listened to them frittering away valuable minutes pumping their patients to try to find out what they were being treated for—information that the doctor should have had in front of him. I have listened appalled while they argued with the patient about what treatment he was having. And at the end of it all they still claimed that they could remember all that they needed to remember. The time frittered away in this futile performance was ten times more than I would have spent on making notes.

I believe that good record keeping is the most efficient labour saving device yet invented for the general practitioner. It is even more important than a good secretary, and in my view a good secretary is worth her weight in gold. I realize that what suits one man will not suit the next and I do not suggest that the system that I will describe is the only one or even the best one.

The first thing to decide is for whom are you keeping records; is it for yourself or is it for some after-coming practitioner who may see the patient in five years' time? I used to keep notes with this altruistic idea that somebody else might want to read them in years to come and the result was that the notes were much too long: nobody

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ever did read them of course. The most the after-coming practitioner will want to know is the diagnosis and perhaps the treatment: he is extremely lucky if he gets that now. Therefore keep records for yourself; ignore the after-coming practitioner but if you keep them in the way I recommend he will come out of it very much better than he does now.

Firstly, then, instead of writing your notes continuously down the page, when you come to the end of one illness and start another, leave a gap of two blank lines between the illnesses. Your notes will then be blocks of writing separated from each othei by empty spaces, each block being a disease.

At some stage, if fortune is with you, you may make a diagnosis. Celebrate this happy event by writing it in capitals and putting a box round it. It will then stand out as the one legible word in the block of writing. If you fail to achieve a diagnosis, do not despair; this simply proves your integrity. Write the main symptom in capitals and box it round. Your notes will then consist of a series of blocks of writings: in each block there will be one word which stands out, being in capitals—the diagnosis.

Keep an inch or so on the right of the page for treatment. Don't get your medicines mixed up with the rest of the notes. Then, if a patient asks for the pink pills he had three years ago, it is a very simple matter to run up the right hand margin and find them.

Whereas in most cases your treatment will do neither good nor harm, it may sometimes happen that it is effective. As the patient will probably get this same disease again in three or four years time, make a note of the good effect of this drug and draw an arrow from the drug in the right hand margin to its effect in the body of your notes. With about equal frequency your treatment may have harmful effects: you may produce an agranulocytosis, or he may get an intolerably irritating drug rash, or you may prostrate him with abdominal pain and vomiting. Record this in the same way by means of an arrow.

Never write notes on the back of the medical record envelope. The top half of this is invaluable for past history and the bottom for family history. I interpret past history in the broadest sense and anything useful goes in there; if the patient is a nurse for instance. Other things that go on the back are the Rhesus factor, sensitivities, heavy smoking or drinking, or any other disability that the patient may labour under, such as a drunken husband or having a doctor in the family. However, restrict your past history to the minimum. Once you have more than about six entries the value of the thing starts to deteriorate. And enter these things in capitals.

At the bottom of the medical record envelope write the family

history, if any, starting at the bottom and working upwards. I have never seen anyone record family history, yet it really is most helpful. I do not usually take a formal family history, but throughout the years the patients drop an awful lot of casual information about their relatives, who live outside the practice. I always jot this down on the bottom of the medical record envelope while they are talking. In after years you can acquire a reputation for almost supernatural omniscience by enquiring after the diabetes of their mother whom you have never met.

If the back of the medical record envelope is already covered with writing you can use the Summary Card of the College of General Practitioners*. In addition to spaces for everything we have already mentioned, it has a place for inoculations. I must say I have found this a most useful card and all young children in my practice now have one of these in their records, on which their inoculations are entered simply by stamping the date in the appropriate space.* Another labour saving card that you can get from the same source is a chart for use by women with menstrual irregularities.

Letters from consultants are not necessarily of such prime importance that they must be preserved for all time in the patients' notes. If your extract the sense from the letters and make an entry in your notes often the letters may be placed in the waste-paper basket. Most consultant's letters can be summarized in one line. This will save you much time in ferreting through old letters at a later date. Treat pathology reports and x-ray reports in the same way, keeping only those letters and reports that you cannot summarize or that you may need in defending yourself in a court of law, or that might be useful to a later doctor.

I would like to end by introducing you to a couple of refinements more suitable, you may think, for the obsessional than the common man. The first is the stapling machine. Why waste minutes every surgery searching through the record envelope for the current record card? Fix them premanently in chronological order with a staple, but there is a right and a wrong way of doing this. Don't staple through the corner in the way that letters are stapled; staple them down the left side. You can then go on adding to them and they will always open like a book.

Lastly, the rubber-stamped diagram. It is much quicker to indicate with shading on a diagram the site of a pain than to describe the same pain in writing. As, however, you cannot conveniently carry around a rubber stamp in your bag, a better plan is to use the

*Supplies of both these cards be can obtained from the College of General Practitioners, 41 Cadogan Gardens, London, S.W.3, price 12/6 a hundred.

rubber stamp to print tear-off diagrams on adhesive paper. Admirable for the purpose are the perforated rolls of adhesive paper obtainable from any stationer.

It is hardly necessary to say that to keep records of minor illness in the surgery and not to keep records of major illness seen in the home, is quite irrational. And apart from that, to visit a patient without having the old notes there to help you, is to enter the fray with one hand tied behind your back. You *must* take your records with you and they must be written up at the time. This in itself saves time because you don't have to make out a visiting list. You just arrange the cards in the order you want to visit. If you make yourself a box to carry the cards and include in it a card index divided into days you avoid also having to use a visiting book.

That is the end of what I want to say on records. Now a word on the Practice Index which was first described by T. S. Eimerl. If you keep reasonable records, you will sooner or later wake up to the fact that you must have in your filing cabinets a vast amount of valuable material that it would be most interesting to analyse. If it is not indexed you cannot do anything about it. For instance, over ten years you probably treat quite a lot of people with coronary thrombosis, and you might be interested to see if you get as good results with the simple means at your disposal as the hospitals do with all their gadgets. But if you have no index giving the names of all your coronary patients you cannot do it. It is this deficiency that the Practice Index is intended to remedy. It enables you to put your finger on all the patients in your practice who have had coronaries or any other disease you like to name. It is a combination between a card index and a loose-leafed notebook. You have a separate page for every common disease and after using it for a day or two you ought to be able to find the right page within 5 seconds. When you make a diagnosis you enter that patient's name on the page reserved for that disease and put some sort of tick in the notes to show that you have done so. It adds perhaps 3 minutes to the day's work. One of these books lasts for a year.

If you are interested in doing a bit of modest research, particularly retrospective research, then I would say that this book or some equivalent is almost a must. I think you will be impressed by its extreme simplicity. But remember that it is primarily an index to your records and not a gadget for producing ready made statistics. If you have an urge to produce statistics, use the Index to find your way about the records and produce the statistics from the records.

Of course you have got to use some sort of classification: I do not find the *International Classification* entirely suited to general practice. It contains many rare diseases but when it comes to the things that

are common in my practice, like undiagnosed abdominal pain, headaches or undiagnosed coughs, they are not there. The *College Classification* which is based on it suffers from the same defects. I have therefore been driven to modifying the *College Classification* by adding these common things to it and subtracting the rare ones. The result may not look quite so scientific but it is more realistic.

"... As a part of the book-keeping commonly falls to the lot of the assistant it is desirable that he should write a tolerably good hand. Legibility is the first requirement; neatness the second. No man likes to see his books of account disfigured with blots or daubs of ink. Hence I may note that no candidate for an assistantship in England need expect that his application will be entertained if the letter seeking the appointment is slovenly in its style or badly written; such a letter would at once prove the incompetency of the applicant for the post he proposes to fill. Frequently such letters are sent on to me by principals, with remarks upon the 'horrid scrawl', and an expression of surprise that gentlemen who 'cannot write decently' should seek engagements where some part of the book-keeping will devolve upon them. The vulgar, brainless affectation of writing illegibly is now confined to purse-proud ignoramuses, who thus seek to cover the deficiences of their education, or to fops and fools whose writing can never be of any consequence to anybody except themselves; such men are a nuisance to their friends, and their communications usually go direct to the waste paper basket, for no man of business would trouble himself to decipher them."

Langley, J. Baxter, *Via Medica.* Third Ed. London 1869. p. 99.