Why we need better records

Before we can expect most general practitioners to devote time and perhaps money to the task of improving their records we have to convince them that it is necessary. The quiet assumption that what was good enough in 1960 is good enough in 1980 still prevails among us, and many would-be reformers have given up in the face of the sceptical indifference of partners who hold that view. Perhaps a few facts will convince such sceptics that clinical care in general practice is very different from what it was 20 years ago and calls therefore for a new and more appropriate response from us in relation to the kind of records we keep. The changes that have created the present crisis for our records are the result of changes both in the organisation of general practice and in the nature of our clinical work.

It is sometimes claimed that a good general practitioner knows all his patients and doesn't need records. In 1956 I did a locum for a single-handed country doctor. It was my first experience of general practice. When I arrived he was in a hurry to leave, and I suggested I could find the facts I needed about patients in the notes. "I don't keep notes," he replied, "but if you think you need them, they are in the cellar." During the next two weeks it became clear that he was a conscientious and competent doctor. I even began to believe that perhaps he could do without notes, but I certainly couldn't. The point is, of course, that the importance of proper records increases in direct relation to the number of different people who help care for patients. In practice today there is a large element of shared care. Group practices, rota systems, shared lists, trainees, and the extended team are all features of practice today that demand that a doctor who takes over from another doctor the responsibility for the care of a patient has available to him any essential information he needs to provide safe and efficient care.

There have also been great changes in the nature of clinical medicine that now make it almost impossible to do without adequate records. Over the past 20 years we have lived through a revolution in treatment: there have been more changes in the investigation and treatment of patients than in any previous period in the history of medicine. The range of technical investigations and the complexity of modern drug treatment regimens make it impossible for doctors to have accurate knowledge about their patients' current medical care unless there is an efficient record system to help. For most general practitioners this does not exist. Furthermore, the investigation and treatment of patients is now shared between general practitioners and hospital colleagues to a greater degree, and this requires recognition and appropriate records to support and indeed to encourage such shared care. Doctors now entering general practice are trained in modern hospital medicine and are keen to develop relationships with their hospital colleagues. The idea of shared care for hypertension, diabetes, rheumatic diseases, and malignant disease is now accepted, but the reality requires a continuous sharing of information between the practice and the hospital. This can only be achieved with the help of good records. In this respect hospital records are far from perfect; those in general practice are too often useless.

One final point must be raised about the need to do something positive about our records at this moment. We in general practice have loudly insisted that since ours is a branch of medicine with its own special knowledge and skills, no preparation for it can be complete without a proper inservice training. Our claims have been recognised, and starting next year all doctors seeking to become principals in general practice will need to do a year as a trainee in a teaching practice. What kind of training in record keeping will they get? It is surely inconceivable that we should allow new generations of general practitioners to learn nothing better than our present habits. At the end of his extensive personal study of general practice in Britain in 1954 Stephen Taylor wrote: "One has reached the conclusion that the key to good general practice is the keeping of good clinical records." If that was true in 1954 how much more is it true in 1981? Good record keeping can be taught only by example.

Function of the clinical record in general practice

If we are to decide how to improve our records a necessary first step is understanding clearly the functions that they must perform. When almost any group of general practitioners discuss this subject they come up with similar answers. Let us make it simple: first and foremost we need an adequate record to supply us with information for use during our consultations, and it must do this quickly and reliably. Secondly, our notes must allow us to share information with colleagues who help to care for our patients. Thirdly, we are also beginning to see how valuable our records can be for our own education based on audit of our own clinical performance. Finally, the research we should be achieving in general practice depends absolutely on the quality of our records. We may summarise these functions with a mnemonic:

I—information for the consultation;
C—communication with colleagues;
E—education and audit;
R—research.

Records are of course also needed for medicolegal purposes, but if records are kept that fulfil the functions listed above they will be adequate for legal purposes, which arise only rarely and nearly always unexpectedly.

For everyday purposes the vital function of the record is to provide information for the doctor to use during his consultation. If the record is designed and maintained to do this successfully the other functions will mostly be fulfilled. Let us look then in greater detail at the range of information that the record should supply for the doctor when he sees his patient. Again we may use a mnemonic:

P—past history: personal, medical, and family;
A—active problems: physical, psychological, and social;
R—relevant reports: relating to active problems;
T—treatment: drugs and current dosage;
S—sensitivities.

It is of course necessary to define the extent of the information the general practitioner requires his records to provide. He needs enough but not too much. None of us wants to record information that we are not going to use. In the language of problem-orientated records, what we have to do is to define a minimum data base for general practice. It is convenient to think of this data base as falling under the headings described above.

Past history must include significant events in the medical, personal, and family history. Significant in this sense means that the fact or event in question has potential or actual importance for the medical care of patients in general practice. For instance, thyroidectomy, the death of a spouse, or a strong family history of ischaemic heart disease are all potentially significant. I am not here primarily concerned with how these facts are collected and recorded, but a questionnaire that can be completed by the patient and a summary card of important events are aids that many doctors have found effective.

Active problems—The notes should remind the doctor of the active problems needing his attention. These may be physical, psychological, or social and will also vary in other ways—for example, they may be established diagnoses or vague symptoms, or perhaps unexplained abnormal findings of which the patient is unaware. A way has to be found to express these problems so that they are easily accessible to any doctor using the notes. The use of a problem list is advocated by some, others use problem statements written in red or highlighted in some other way in the continuation notes. Whatever method is used, problems should be expressed at the doctor's honest level of understanding and should not suggest a certainty that he does not feel.

Relevant report—At the same time as being aware of the

active problems the doctor must have all the reports and the latest information relating to those problems with which he has to concern himself in the consultation. This information may be contained in reports from hospital or elsewhere or may be in notes written by colleagues. The structure of the record should be such that hospital or laboratory reports can be filed in a way that makes them easy to find and review. Secondly, a standard format for recording consultations in the continuation notes helps other doctors to extract information (the SOAP system of recording used in problem-orientated records is an example). It is surely time that we defined for ourselves and taught our trainees a suitable method for recording clinical episodes in our continuation notes. By all means we should have flexibility, but to have no system at all often makes those notes useless to anyone else. A good continuation note should allow other doctors to share all important information gained and all diagnostic and treatment plans formulated by the doctor who writes it.

Treatment—The complexity and potential dangers of drug treatment in general practice today are formidable. We should know with absolute confidence at any given time what drugs our patients are taking and in what dosage. In how many cases is this true? Too often we have to try to extract the information from the patient or his empty bottles—a humiliating and thoroughly unreliable performance. In the long-term management of patients today it is likely that drug regimens will change frequently and the dosage of drugs alter. The only way to record these changes is by using a flow sheet that allows the doctor or his ancillary staff to know what drugs the patient should be taking and in what dosage. A record system that cannot do this is simply unsafe.

Sensitivities—Year by year, as more drugs are used, the problem of sensitivities and the complications of drug treatment becomes more important. General practitioners are well aware of the problem, and a variety of methods have been advocated for marking the record in some way so as to alert the doctor to the existence of a drug sensitivity. Once again we lack an agreed system that will not only inform us of known sensitivities but also indicate the degree of risk. Furthermore, it should be possible by referring to a patient's record to be assured that he has no sensitivities—it is not enough to know that none has been recorded.

The way ahead

Discussions about improving our records too often end in disagreement about the detailed design. Record reformers quite naturally become enthralled by their particular solutions, but disagreement over details inhibits our efforts to effect change. It would be better to agree on the basic functions of the record and on what information those records should supply for us. Any record that succeeds in satisfying those criteria should then be acceptable. In this article I have tried to define the information we need using the mnemonic PARTS. Thus we should ask of any record system that a doctor examining the record is able to extract this information quickly and reliably. If this can be done the record might be said to pass the PARTS test. We should aim to make all our records do this. Just how this is achieved may reasonably be left to each doctor or practice; there is a real place for flexibility over detail, so long as essential functions are fulfilled. At the same time we must keep in mind that we have a uniform record for general practice which is used by all doctors for all patients. Such a record has great advantages in a health care system such as ours. Our aim must be to agree over the basic design of our records, the method of their use, the standards that we should set for ourselves, and how we propose to maintain those standards.

Meanwhile there are many good ideas that may help doctors to improve their records now. In the articles that follow in this series on records some of these ideas will be described by the general practitioners who use them and know them. The authors will be candid in describing the difficulties, the costs, and the extra work, but all will express a conviction that it was worth all the trouble. Those who follow these pioneers—for they are still pioneers—can learn from their failures as well as their successes.

Clinical curio

An oral antiprostaglandin agent, mefenamic acid, twice produced complete and prolonged relief of the symptoms of acute urinary retention in a patient. Mefenamic acid was more effective than parenteral pethidine and thus antiprostaglandin agents may be useful for treating acute urinary retention, provided that the obstruction is relieved as soon as possible.

A 60-year-old biochemist had his first attack of severe colicky lower abdominal pain at midnight on a Saturday in October 1974. He was unable to pass urine, despite the feeling of a full bladder. He took the only analgesic available to him, mefenamic acid 500 mg, by mouth. The pain subsided, and he slept fitfully until 7 am, still unable to micturate. At 8 am he drove to the home of his family doctor who arranged hospital admission for acute urinary retention due to benign prostatic hyperplasia. The pain returned at 8.30 am and continued, with frequent severe exacerbations until catheterisation three hours later. Seven days later the catheter was removed. Within four hours he was again in severe pain, which lasted for 3½ hours until he received intramuscular pethidine 100 mg. This relieved the pain for only 45 minutes. A repeat catheterisation was necessary, after which he recovered uneventfully. He was discharged on no treatment four days later.

He remained symptom free until last May when about 2 pm he had a second attack of acute urinary retention. Again he took mefenamic acid 500 mg by mouth. Within 50 minutes he was free of pain and was able to drive four miles to his doctor's home. After the diagnosis was confirmed he drove 10 miles to hospital. He remained free of pain until the retention was relieved by catheter at 6.30 pm, more than four hours after the onset of symptoms. The following morning he underwent a successful prostatectomy, and he has since remained well.

Drugs that inhibit prostaglandin synthetase may well act directly on the bladder wall. Prostaglandin F_2 alpha and prostaglandin E_2 by their actions on specific prostaglandin receptors[1] have been shown to increase the tone and the contractility of the bladder. The detrusor muscle produces prostaglandins, which increase the tone and spontaneous activity of isolated muscle strips.[2] The prolonged analgesia in this patient may have been due to the antiprostaglandin activity of mefenamic acid inhibiting or reversing bladder muscle spasm. If so, mefenamic acid may be useful for treating acute urinary retention, provided that the obstruction is quickly relieved. Reports of similar results with mefenamic acid or other antiprostaglandin agents would be welcome, as there are no other effective oral drugs for the symptomatic treatment of acute urinary retention due to prostatic hyperplasia.—T C G SMITH, general practitioner, Girvan, Ayrshire.

[1] Khanna OP, Barbieri EJ, McMichael R. Effects of prostaglandins on vesicourethral smooth muscle of rabbit. *Urology* 1976;12:674–81.
[2] Bultitude MI, *et al.* Clinical and experimental studies on the action of prostaglandins and their synthesis inhibitors on detrusor muscle in vitro and in vivo. *Br J Urol* 1976;48:631–7.

We will be pleased to consider for publication other interesting clinical observations made in general practice.—ED, *BMJ*.

Pitfalls in Practice

Situation vacant

I: Hiring a receptionist

JOHN OLDROYD

This article is based on an audiovisual presentation made for vocational trainees in general practice by the MSD Foundation. Further information about the tape-slide programmes on which this series is based is available from the MSD Foundation, Tavistock House, Tavistock Square, London WC1.

Employing practice staff is difficult and needs careful thought. This story illustrates many of the mistakes that may be made.

"Brian, you will have to get a receptionist." Thus spoke Barbara Bumble, wife of Dr Brian Bumble, respected general practitioner in the town of Deerford, Mudhamptonshire. Barbara was deserting her fort as her husband's telephone slave, having been invited to become president of Mudhamptonshire Goat Fanciers' Society.

This order by his wife didn't entirely displease Dr Bumble. He had realised after talking to his colleagues at the Deerford Postgraduate Centre that by not having a receptionist he wasn't quite keeping up his image as a member of the Royal College of General Practitioners. After all, he could get 70% of the money back from the family practitioner committee and the remainder was a tax expense, but he hadn't been able to think of a way of breaking the news to Barbara that she was to be made redundant.

Agreement having been reached at home, Dr Bumble inserted an advert in the next weekly edition of the Mudhamptonshire *Reporter*:

> Wanted for doctor's surgery in Deerford Parva, Receptionist. Hours and salary by arrangement. Apply Box 24, *Reporter* Office, 4 Deerford Gate, Mudhampton.

Two days after its publication, Dr Bumble received a reply in the surgery letter-box.

Rose Cottage
70 Cemetery Road
Deerford

Dear Dr Bumble,
I saw your advertisement in this week's *Reporter* and thought you would like to know that I can manage it. I am at home most mornings if you want to call and let me know.
Yours faithfully,
P Prattler (Mrs)
P Prattler (Mrs)

PS: I know it was your surgery since Mrs Wheelwright that works at the Health Centre has told me that they haven't any jobs there.

Secretariat for London Local Medical Committees, Tavistock House North, London WC1H 9HT
JOHN OLDROYD, MB, FRCGP, secretary

Dr Bumble's reaction was not one of undisguised pleasure. He recalled Prudence Prattler as a patient of his for many years. Granted, it was not the lady herself who had needed much of his time, but he had met her frequently over the years in his consultations with her recently deceased husband, Percy—consultations at which Mrs Prattler had made her approval or disapproval of his advice eminently clear. He had to reconsider, however, when he collected the replies from the *Reporter* office a week later. A 16-year-old pregnant school-leaver and the town's best-known alcoholic were no competition for Mrs Prattler, and Dr Bumble took time off from his rounds the following day to visit the applicant at Rose Cottage. Mrs Prattler greeted him at the door.

PRATTLER Oh, hello, doctor. I've been expecting you. It's about the job I suppose. Come in and have a cup of tea.
BUMBLE Well, er yes—thank you, Mrs Prattler. Getting on all right since you lost your husband? Not too lonely?
PRATTLER Well, yes. It's the loneliness that gets you, doctor. Still, we have to be grateful for the times we had. But that's why I fancied the job—so I could get out and meet people. Mind you, the money will be useful, too.
BUMBLE Yes, I can see that it would be. . . .
PRATTLER (interrupting) Don't stand up, doctor. Sit in the settee over there while I brew the tea. The kettle is boiling.

Dr Bumble was lost. With a sense of foreboding he realised that any decision on whether Mrs Prattler became his receptionist would not be made by him.

PRATTLER Two lumps of sugar? You'll have to watch your figure, doctor. Now, what hours did you have in mind?
BUMBLE Well, there's during the surgeries, of course, which you know are 9.00 to 10.30 every morning and 5.00 to 6.30 in the evening, I'm afraid.
PRATTLER Oh, don't worry about late evenings, doctor. You haven't a surgery on Wednesday and Saturday, and those are the only two nights I like to get out to the church wives and the sewing circle.
BUMBLE But besides that you'll have to be in the surgery to answer the telephone in the afternoon. When we finish in the morning we can put it through to the house, but there's no one there in the afternoon now since. . . .
PRATTLER Oh, I know all about that doctor. Mrs Waterworth, who cleans for your wife, was telling me about her going into Mudhampton regular now. I was at the church Beetle Drive the other Saturday night.

Bumble, who knew that he was rapidly losing grip on the situation, felt he must be more efficient.

BUMBLE So you'd be able to manage that then. But we would have to think about your money. . . . I haven't worked out how many hours you'll be working, but I suppose we should think of hourly rates, as sometimes surgery will go on longer than 6.30 and you may not be able to get away. I thought perhaps about. . . .

Bumble was groping at this stage, as he wasn't quite clear what to offer. His best thought was the advice he had received from an

acquaintance at the Huntsman's Arms, where he regularly called on his way home from evening surgery. He was aware that this fellow was manager of the American Tractor concern on the industrial estate employing a good proportion of Deerford's more eligible young graduates of the county secretarial college. £1·50 an hour was the figure pronounced in the Saddle Bar as being the least you could expect for anything decent.

BUMBLE £1·45 an hour.

Bumble believed he had been very shrewd. Prudence was preening herself because she had found out from a friend at the job centre that £1·20 was the going rate.

PRATTLER Oh, yes. Oh, that's quite acceptable, doctor. I am sure you will be giving increases like other clerks get each year as well.

Bumble, who hadn't thought of this, agreed and decided that he had better get off benefits and talk about duties. He knew about the telephone but was a bit vague about other duties. He had always kept his records in the surgery next to his desk.

BUMBLE Now, as to what you will have to do: there'll be the telephone to answer and dealing with the patients and their cards, of course.
PRATTLER Oh, I'll soon get into the way of it, don't you worry. I know a lot about that side of it from when I helped at the casualty at the hospital when Percy was away in the 8th Army in the war.
BUMBLE You know about this sort of thing then? I didn't know you were a nurse.
PRATTLER Well, not really a nurse, doctor. I just helped sister run things. Well, that seems to be sorted out. I am sure we know one another well enough to trust and understand ourselves. When would you like me to start?

Prudence Prattler started the following morning. The seeds of disaster had been sown: he had already made some mistakes.

Mistakes he made

(1) Dr Bumble lacked preparation because he failed to assess his needs.
(2) The advert was unsuitable because it was not specific.
(3) It was probably unwise to appoint a patient of the practice as his receptionist.
(4) He should have waited longer for replies or indeed made inquiries from other sources such as the secretarial college, other medical staff training agencies, and the job centre.
(5) Where should the interview have been carried out? Certainly not in an armchair on the applicant's home ground.
(6) What should the content of the interview have been? (*a*) Delineation of hours, salary, holidays, sickness entitlement, and need for confidentiality. (*b*) Statement of duties in some detail. These clearly may extend in this practice beyond simple reception to record keeping, keeping petty cash, and undertaking minor secretarial duties. (*c*) Assessing the personality and suitability of the applicant. (*d*) Assessing the applicant's experience in some detail. (*e*) Understanding the needs and expectations of both parties.
(7) Accurate information of pay scales should have been obtained from the sources Mrs Prattler used and from local colleagues, the secretarial college, and published figures of the Whitley Scale Guild of Medical Secretaries, which is available from local medical committee secretaries or from publications such as *General Practitioner*.
(8) Dr Bumble should have emphasised that Mrs Prattler was hired for a trial period. Before starting, full and adequate instructions should have been given about how to deal with telephone messages, especially the degree of responsibility Mrs Prattler should or should not have, and whether she should deal with these on her own.
(9) The conversation suggests that no contract of employment was going to be signed. Within 13 weeks of the start of employment the employer is required to give the employee a written statement. Forms are available from stationers with appropriate headings. This statement should spell out:
(*a*) the parties;
(*b*) the starting date of employment;
(*c*) the nature of the job and its duties;
(*d*) whether previous employment counts as continuous employment;
(*e*) rate of pay and intervals at which it is to be paid;
(*f*) terms and conditions relating to hours of work;
(*g*) entitlement to holidays and holiday pay;
(*h*) arrangements in case of sickness and for retirement;
(*i*) length of notice to be given on either side;
(*j*) job title.

(*Employment Protection Act 1978; Section 1*)

In the next article I will show how Dr Bumble got into difficulties and how he could have avoided them.

Clinical Curio

A patient of mine who used to drink rather a lot crashed into the back of a car at a traffic light and was charged with driving under the influence of alcohol. Could the symptoms he had recently consulted me about have caused the accident, his solicitor asked. I had tentatively diagnosed petit mal and said that it was possible but I thought that alcohol was a more likely cause.

My patient, Mr A, had been driving home for lunch after his usual drinks in a pub when it happened. A policeman who saw the accident questioned him, got a stream of abuse, and arrested him. The police surgeon examined him and pronounced him unfit to drive because of drink. Mr A, a successful professional man, asked for a second opinion and sent for his previous general practitioner, an old friend, who smelt his breath, accepted the police surgeon's verdict, and said that there was nothing he could do. Neither doctor took a blood sample, which was not unusual years ago when this happened.

I agreed to give evidence about Mr A's petit mal at the hearing, though I did not think it would help him much. On the morning of the trial Mr A, his solicitor, a well-known barrister, and I met at the county court. Mr A was his usual charming self and did not smell of alcohol. I had noted before that he never did in the morning. The barrister glanced into the courtroom, remarked that the jury did not look very bright, then led Mr A into a rehearsal of his case. Half way through he seemed to ignore a question, which was repeated. He still did not answer but stared blankly ahead for a further few seconds, seemed to half come-to, said several aggressive words, then became his normal self. The barrister looked quizzically at me. No doubt about it. Petit mal with postepileptic automatism. Was this what had caused the accident? Had we misjudged him? The barrister got an adjournment until the next day for further evidence. The barmaid from the pub was sure that Mr A had drunk no more than his usual midday drink: one whisky and a pint of beer. A distinguished neurologist saw him that evening, agreed that petit mal could have been responsible, and would say so in court next day. The barrister cross-examined the police surgeon on the details of his examination, the neurologist made it seem obvious that petit mal explained the accident, and the jury came in with a verdict of "not guilty." Mr A was fined a nominal sum and lost his licence on the grounds of ill health (to be restored when petit mal was shown to be stabilised), and I was not called.

Just as well, I thought, because I ought to have advised Mr A not to drive even on a tentative diagnosis. The diagnosis had been clinched only when I saw him having an attack in the barrister's room.—ANDREW SMITH, general practitioner, Newcastle upon Tyne.

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