Had we not carried this out, two of the 97 vaccinated women would not have benefited from the programme. RA 27/3 vaccine has the advantage of producing a more rapid immune response,[8 11] so that reliable results may be obtained as soon as eight weeks after vaccination. Retesting too soon after vaccination can be misleading.[1 2]

Our comprehensive programme is not feasible as a routine procedure. We describe elsewhere[11] the considerable amount of extra work and expense, and suggest a simpler programme, spread over a longer period of time, where neither an age-sex register nor much extra work is required.

We are convinced that rubella screening is a vital aspect of preventive medicine. It needs to be continued for at least two more decades, and general practice is the best setting for it.

Conclusions

Forty-six per cent of all women at risk (totalling 1926) in two group practices were screened for immunity to rubella. The single radial haemolysis technique showed 12% to be seronegative. Ninety-one per cent of the women were vaccinated with RA 27/3 vaccine. Seroconversion was ascertained by repeat blood tests. A simplified version of this screening programme could be used in general practice as a routine procedure.

We thank the partners and staff of both practices for their co-operation. Sisters Barbara Beadle and Helen Elliott in particular made major contributions to the study. Dr D R Gamble, Public Health Laboratory, Epsom, gave invaluable guidance. Helpful advice was given by Smith, Kline & French Laboratories. Data analysis was performed by Miss J A Bertram at the Wellcome Foundation. Financial assistance was received from: Searle Laboratories, Smith Kline & French Laboratories, Syntex Pharmaceuticals, Wellcome Scientific Services Division, and Wyeth Laboratories.

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Report of a Joint Working Party on Radiological Services for General Practitioners

The Royal College of General Practitioners and the Royal College of Radiologists have published this report in the September issue of the *Journal of the Royal College of General Practitioners* pp 528-30. The following information has been taken from a press release.

Direct access to radiological services is essential to general practitioners, and they should have a similar right of access to consultants for their patients.

Clinical priorities should determine the use of services if resources are short. Priority should normally be given to hospital inpatients, but if constraints have to be applied they should fall equally on referrals from general practice and from hospital outpatient departments, subject to the radiologist's decision on medical priority.

X-ray facilities should be provided in properly staffed departments. The working party was not generally in favour of the further provision of x-ray equipment in health centres or other small units, except where geographical considerations determine otherwise. More complex examinations require adequate supervision and should be restricted to departments where there is a radiologist. The specialist radiologists assume clinical responsibility for patients while in x-ray departments.

When possible, general practitioners should be able to visit x-ray departments to view the films of their patients. In the interests of reducing radiation exposure as well as economy films should be transferred with the patient when the patient moves to the care of another hospital.

There is a need for better education of medical students and trainee general practitioners in the use of radiological services.

Correction

Diabetes mellitus: I: Diagnosis and initial management

An error occurred in this article by Dr John Jarrett *et al.* (5 September, p 648). The last sentence on page 649 should have read "... a fasting plasma glucose concentration above 7·8 mmol·l (140 mg/100 ml), or a whole blood glucose concentration greater than 7 mmol·l (126 mg/100 ml)."

Conference Report

Psychological problems in general practice: Oxford conference on a "grey area"

RICHARD SMITH

A great many unhappy, disturbed, anxious, fed-up, and depressed people walk into general practitioners' surgeries hoping for some help. All of the 200 delegates to the Mental Health Foundation Conference on psychiatric disorders in general practice were agreed on that, but they were not able to agree on much more. They disagreed on the size of the problem; how to recognise, define, treat, and study the patients' problems; and how to organise treatment and preventive services.

Pertinently, in a conference bedevilled by generalities, platitudes, jargon, uncritical statement, and "broad strategic discussions," the confusion and disagreement were best illustrated by discussions about a particular patient. Dr Anthony Clare of the Institute of Psychiatry and Karl Sabagh, director of the MSD Foundation, showed a video recording that the Foundation had made of a 10-minute consultation between a general practitioner and a woman who said she was depressed. After watching the recording the conference delegates (about 60 general practitioners; 36 psychiatrists; 12 psychologists; 12 social workers; and others) were asked to write down how they would describe the woman's problem, what they would do for her, and what they thought of the general practitioner's performance.

Later in the day a recording was shown of the woman being interviewed a year after the original consultation. The woman had been pleased with her two short consultations with the general practitioner: she was now feeling much stronger and better able to cope; and she thought that the doctor had helped her. Some of the conference delegates, however, had not been impressed by the doctor's consultation: and proportionately twice as many psychiatrists as general practitioners thought that he had performed badly. There were wide differences, too, in the way that the doctors described the problem; and a sixth of the general practitioners and psychiatrists attached a formal psychiatric label to the woman, although the interview of a year later seemed to confirm that this was quite inappropriate.

One of the most interesting points to emerge from this practical act in a weekend of theory was that each of the various professional groups tended to suggest that this woman would benefit from the treatment that they could offer: family therapists would have given her family therapy; counsellors would have counselled her; marriage guidance workers would have guided her marriage; psychiatrists would have offered her a long interview; and general practitioners would have offered a series of shorter consultations. Yet the woman after being given a few simple insights by her general practitioner had solved her own problems with her own resources.

What should be the priorities of those who offer and organise treatment services, Dr Clare asked. What was the natural course of patients' psychological problems? What were the forces that people used to deal with their own problems? How many of these patients really stood to benefit from expensive and intensive treatments? These were questions raised also by others; Dr John Fry, a general practitioner, pointed out that there was no good evidence that one form of managing these patients was better than another. He called, too, for longitudinal studies of the natural course of these disorders. Dr Jack Ingham of the Medical Research Council epidemiological research unit in Edinburgh suggested that before hordes of enthusiasts were financed and unleashed on those many patients seen in general practice with psychological problems better evidence was needed of who was likely to benefit and who would recover regardless of treatment.

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Back to theory

The theory of the meeting fleshed out the issues raised by the videos. The prevalence of any problem in a population depends critically on how that problem is defined. For some 30 years epidemiologists have been playing the game of trying to put a prevalence figure on psychiatric problems in patients in general practice; they have used a bewildering variety of standard interviews and questionnaires and have employed many different definitions of what is a psychological problem. Consequently, they have come up with wide variations in prevalence—from about 3% to 65%. Standardisation of techniques and increasing consensus on definitions have meant, as Dr Ingham explained, that these figures have come closer together. Most would now agree that about 10-20% of the people in Western communities have psychological problems.

But is this figure worth having? A much more crucial task for epidemiologists is to "sort out this grey area" and decide how many of these problems are overcome by individuals themselves, how many present to general practitioners, how many need treatment, and how many benefit from treatment.

Epidemiological confusion exists alongside diagnostic confusion: while epidemiologists have played with their numbers nosologists have tinkered with their classifications. The latest chimera to appear is "triaxial diagnosis" in which "a statement (rather than a diagnosis) is made" about the patient's problem in biological, psychological, and social terms. But while the nosologists fiddle, general practice burns: individual general practitioners recognise widely differing incidences of psychological problems in their patients. Some see virtually no patients whose problem they diagnose as psychological while others think that half of their patients have problems that are primarily psychological. Professor David Goldberg from Manchester has studied the factors that influence how many psychiatric diagnoses a general practitioner makes. Attitudes, personality, and interview techniques have all proved to be important, and by an intensive three-week training using videos of consultations Professor Goldberg has been able to increase the ability of some general practitioners to recognise psychological problems.

Unfortunately, he has not shown either that this improvement is maintained over years or that it has any effect on eventual outcome.

Many of the general practitioners and other therapists at the conference were not too much worried by this epidemiological, nosological, and diagnostic confusion because they were primarily interested in management. And, as Dr Clare said, in this "grey area" diagnosis and management do not seem to be much related: doctors treat without diagnosing. And for those primarily interested in management a wide range of therapeutic wares were displayed at the conference.

At one end of the range were psychotropic drugs. These are unfashionable at the moment among the "forward-thinking" groups represented at the conference, and Professor Peter Parish fought a rearguard action in saying that they were powerful removers of symptoms and that "they were not prescribed any more inappropriately than any other group of drugs." Whether this was because most drugs were prescribed inappropriately he did not elaborate, but he was worried about "medical imperialism"—doctors going out looking for patients and playing at politics in the name of prevention.

Other speakers discussed counselling, team approaches, community psychiatry, alternative medicine, and support groups. All sounded marvellous but few have been proved to be of benefit in vigorous, well-controlled trials. Curiously, however, prevention was almost ignored. The Mental Health Foundation had paid for the publication of the Royal College of General Practitioners' report on prevention of psychiatric disorder in general practice and every delegate was given a copy, but there was little detailed discussion of its proposals. The implicit thinking seemed to be that when description, diagnosis, organisation, and management were so inadequate to think about prevention was premature.

All in all, a general practitioner who had given up his weekend to attend this conference would not have come away richly rewarded. As he sat in his surgery on the next Monday morning facing his first patient of the day with a "psychological problem" little would be changed from the previous Friday.

Medical Records

A framework for establishing a record system

L I ZANDER

The inadequacies of our record keeping are well recognised.[1 2] If general practice is to expand and develop into activities such as monitoring chronic disease, prevention, and audit, an adequate information system will be essential. This concluding contribution to the series on medical records attempts to provide a framework for those wishing to improve their records.

Function of records

SERVICE

Consulting patient—Records must allow optimal care.

Non-consulting patient—Information on the characteristics of the practice population such as age and sex structure, morbidity patterns, etc, is essential if the practitioner is to initiate care for all his patients.

MEDICAL CARE PLANNING

Information about clinical and administrative aspects of the practice is necessary to provide optimal care and to make the best use of resources.

SELF LEARNING AND AUDIT

A regular review of clinical records will improve clinical care. Internal audit is generally considered more acceptable and effective than imposed audit, and the presence of vocational trainees may provide a stimulus.

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Record design

When designing a clinical record the following criteria should be borne in mind.

Ease and speed of recording is essential if the records are to be completed.

Important items of data should be made to "stand out" by underlining or boxing-in, use of capitals, or placing special items in separate columns.

Information must be easily retrievable so records should be well organised, with letters filed in chronological order.

Data of which the doctor is unaware should be so placed that they will be brought to his attention.

A good record should not just record care that has been provided but should stimulate the doctor to undertake new inquiries or procedures. A problem-oriented format and flow charts for monitoring chronic diseases could be helpful.

Introducing, maintaining, and using better records

Before changing records the implications should be discussed with medical, paramedical, clerical, and reception staff, and the part that each can play in the procedure should be carefully considered.

Unless carefully maintained records will become inaccurate and unreliable. Clerical staff can check recording.

Great efforts are often made to establish age/sex and morbidity registers only to find that they are rarely used. How they will be used should be considered before they are produced.

DATA IN THE SYSTEM

The following data should be included: (*i*) information necessary for clinical care; (*ii*) information for establishing a data base, including relevant family and social history; (*iii*) specific "at-risk" factors—for

example, smoking, alcohol consumption, obesity, etc; (*iv*) information for administrative and legal purposes.

Data will usually be obtained during consultations but other methods such as patient self-administered questionnaires should also be considered.[3 4] If information is obtained by the clerical staff the need to maintain confidentiality should be considered.

A mechanism should be devised to remove unnecessary items regularly.

Record content

The NHS envelope is unlikely to be replaced. Portability is its principal advantage, and many have shown that its size is no handicap to good recording.[5] The advantage of the A4 folder is increased space for clinical recording and letters. Replacing the paper record altogether by computer is, I believe, not worth considering at present.

The record design should ensure adequate entry of relevant information and easy extraction of important data. The possibility of all members of the team making entries should be considered.

PROBLEM LIST

There is general agreement about the value of having a problem list but not about what it should contain. I suggest the following classification.[2]

Conditions important for clinical assessment—Conditions liable to remission or recurrence—for example, peptic ulcer, multiple sclerosis; conditions liable to complications; malignancy; major operations; conditions patients are reluctant to mention—for example, venereal disease, attempted suicide, alcoholism.

Conditions requiring continuing medical care—Long-term management—for example, hypertension, pernicious anaemia; long-term follow-up—for example, renal insufficiency, after a gastrectomy.

Conditions affecting choice of drugs—For example, allergies and sensitivities, peptic ulcer, valvular heart disease.

Long-term severe handicaps—For example, blindness, phobic anxiety state.

Social factors—Abnormal family structure—for example, one parent family, family violence—for example, battered baby; long-standing disturbed relationships—for example, chronic marital disharmony; sociopathic behaviour—for example, chronic truancy, prison record, compulsive gambling; severe social handicap—for example, illiteracy, chronic unemployment.

Flow charts for monitoring chronic diseases may improve the care provided by encouraging the doctor to undertake certain agreed clinical actions.[6]

Hospital letters occupy much space and need continual pruning. Time will be saved if essential details are highlighted.

Although called family doctors, our knowledge of our patients' family and social history is often inadequate. The use of a family tree for recording has several advantages[7 8] as does the use of family folders.[9]

By including entries of the health visitor, district nurse, etc, the value of the record is greatly increased. This may be made easier but is not dependent on the use of A4 records.

Computers

The rapid developments in microprocessing has meant that using microcomputers in group practices is becoming feasible. Those contemplating their introduction should consider the following questions:

(1) What aspects of clinical care and practice management can be done more easily, completely, and economically by a microcomputer?

(2) What useful data can be obtained that are otherwise difficult to acquire?

(3) What will be the negative effect on other aspects of practice activity?

(4) What will be the likely demands on personnel and finance?

Personnel

The implementation of a record system concerns many individuals with differing needs and contributions to make.

As the main users of the system there should be general agreement between the members of the health care team about its design and utilisation.

Much effort is required to maintain the accuracy of records and their maximal use, and this may be better undertaken by a clerical worker than by a doctor. Individuals with no medical training can undertake the maintenance of the record system: processing all the records from the family practitioner committee; discarding unnecessary contents; drawing up the patient's summary problem list and family chart; maintaining an age and sex and associated morbidity register; reminding doctors of inaccuracies in their records; and extracting data necessary for clinical studies.[2]

Patients may contribute directly to data collection through self-administered questionnaires. Should patients have access to their own records?[10] We found that when patients were allowed to retain their "official" obstetric record throughout pregnancy the results were good.[11] The implications of such an approach to doctor-patient communication are worth considering.

Conclusion

The provision of medical care is being reappraised and evidence suggests a shift of emphasis towards primary care. General practice must show itself able to rise to the challenge. If, as in Lord Taylor's words, "a doctor's practice is only as good as his records"[12] we should ensure that this central aspect of our work receives the attention it deserves.

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ONE HUNDRED YEARS AGO Thomas Carlyle and Edinburgh University. The late Thomas Carlyle has shown the interest he felt in the university, of which he had been Lord Rector, by bequeathing to it the estate of Craigenputtock, in the county of Dumfries. The estate is about eight hundred acres in extent, and of the annual value of £300. Ten bursaries are to be founded, and are to be in custody of the Senatus Academicus; they are to be called the "John Welsh Bursaries." They are to be given to students the "worthiest" after competitive examination, five on the subject of classics, and five on mathematics. We could have wished that some of them had come to the medical faculty, but we trust they may help to give a thorough arts training to some who will afterwards enter the profession. The bequest is thoroughly Carlyle-like in its wording, and finishes thus "and so may a little trace of help to the young heroic soul struggling for what is highest, spring from this poor arrangement and bequest; may it run for ever if it can, as a thread of pure water from the Scottish rocks, trickling into its little basin by the thirsty wayside, for those who it veritably belongs to. Amen." (*British Medical Journal*, 1881.)