Middle Articles

GENERAL PRACTICE OBSERVED

A New Record System for General Practice

Report from Research Committee of Scottish Council of Royal College of General Practitioners

Recorder: E. V. KUENSSBERG, M.B., CH.B., F.R.C.G.P.

Brit. med. J., 1968, 2, 420-423

In his review of the National Health Service, Dr. Stephen (now Lord) Taylor (1954) stated that "the present record card and envelope (E.C. 5-6-7-8) is a satisfactory system providing for the recording by the general practitioner in the National Health Service." This may have been true in 1954, but without doubt the N.H.S. pocket type of record with its continuation card no longer fulfils the functions of an adequate recording system.

Records are required for (1) the clinical situation, (2) the need of the doctor, (3) the need of the patient's next doctor, and (4) the legal implications. In general practice the *clinical* situation has undergone a subtle change since Lord Taylor's report. General practitioners will be more often required to record the actual measurements and biological values than in the past, when the diagnosis or complaint was only of passing interest, the therapeutic substances available being of a far lesser specificity. In addition, drug histories may often be of greater importance in assessment of clinical situations, possibly on occasions more so than notes on detailed clinical examination.

Any record system can be made to work by an individual doctor, but it stands or falls as a national system on whether or not it induces the generality of practitioners to keep adequate clinical records: this the present E.C. 5-6-7-8 does not do, as exemplified by a survey (1964) of 2,000 records received from N.H.S. doctors, of which 43% had either a blank E.C. 7-8 (continuation card) or none at all, though over half of these envelopes contained specialists' or hospital/laboratory communications; 37% had E.C. 7-8s with some information on them; while 20% had nothing whatever inside their envelope.

Problems

The Research Committee of the Scottish Council of the Royal College of General Practitioners investigated the administrative, technical, and professional problems.

Administrative and Technical

The N.H.S. record is the only docket indicating to the doctor that he is being paid for the patient; therefore careful transmission of medical records from one family doctor to another is essential. The English and Scottish envelopes cannot easily be filed together, being of different dimensions and layout.

On an average each N.H.S. doctor carries out six to seven services per patient per year. For the twice-weekly attender and the very sick patient the figure is much higher. It is unlikely that the quality of the present N.H.S. record will stand

up to such frequent handling during the lifetime of a patient. Already, after 20 years of recording, at least 30% of those records are patched up and showing signs of serious wear and tear.

Professional

The professional difficulties are less tangible. They stem partly from the fact that most general practitioners have to develop their own method of record-keeping. Teaching during their undergraduate and preregistration period is centred entirely on the hospital needs.

On extracting the material from the envelope there is no obvious spotting of the last entry or last letter. Each one has to be looked for, however systematic or tidily the continuation cards and letters have been filed away. At best, both groups of material require to be inspected and possibly turned over. At worst, a hectic sorting of the total content is necessary on each occasion. The "treasury tag system" so ingeniously advocated by Marsh and Simons (1967) is most certainly an improvement in restoring some usefulness to the N.H.S. record, but, like all compromises, it has its problems. The narrow side of the envelope is open, which means that the deep pocket leads to impaling of records and/or introduction of records or letters becoming tiresome or destructive to the record envelope. If

Fig. 1

reference is made to content of the record, everything has to be pulled out and later replaced.

The size of the N.H.S. records raises a most important question: Scottish (5 by 8 in.; 12.5 by 20 cm.), English (5 by 7 in.; 12.5 by 17.5 cm.), or the hospital folder size (12½ by 11½ in.; Tunbridge, 1965). If it were possible to expect 20,000 general practitioners and all the executive councils to equip themselves with new filing equipment there is little doubt that the hospital folder size would be the correct one for use in the consulting-room, while the present size is ideal for home visiting. Even permitting the argument that the average medical record envelope will get bulkier and that each general practitioner will require at least 5% increase of his filing system each year, it still makes the cost (£2 million) of a complete changeover to a new size uneconomic, particularly as it seems that for many of us mechanical handling of records could be 10 years or less away. This does not take into consideration the major cost that efficiency problems such an alteration to a quarto format would entail—that is, the greater space in the general practitioners' premises to house this large format record system.

After consideration of these difficulties the Research Committee of the Scottish Council of the Royal College of General Practitioners set up a special Working Party to develop a field trial to: "test the possibility of a patient's record in the N.H.S. which would facilitate (1) easier record keeping and filing without disturbing the filing systems owned by N.H.S. doctors; and (2) induce better record keeping and use of records for morbidity studies." For this purpose the Working Party adopted a modified version of the "K-wallet" (Fig. 1).

Method

With financial assistance from the Scottish Home and Health Department and a grant from the Nuffield Provincial Hospital Trust, a study of the feasibility of the wallet was mounted in 1965. Two practices in England and six in Scotland began using these records in December 1965. A parallel study was started in 1966-7 in Northern Ireland, but this has not been included here.

The eight practices were selected from volunteers to represent single-handed urban and country general practices with and without secretarial help, and partnerships in various locations with degrees of secretarial help. Some practices were asked to switch over completely to the new wallets, others only partially, to discover how the wallet and envelope worked side by side. In one practice only a very gradual introduction of the wallet was planned in order to assess the handling difficulties between the predominantly old system and the new wallet if used simultaneously.

While six Scottish practices took part, one of them filed as in England, and the total number of records used thus during the experiment were divided reasonably evenly between the English and Scottish filing systems, as the English practices were large partnerships (see Table).

Description of Proposed Wallet N.H.S. Record

In contrast to the envelope type of N.H.S. record E.C. 5-6, the wallet consists of three sections folding on each other. The overall dimensions of the folded wallet are 7½ by 5 in. (19 by 12.5 cm.). This is ½ in. (1.3 cm.) longer than the present English record and ½ in. shorter than the present Scottish one. The alteration of ½ in. to bring the English and the Scottish record to an identical size does not seem too much of a mutual sacrifice. The English filing systems, as provided commercially in drawers, can accommodate this additional ½ in., while the Scottish filing drawers would be more loose-fitting. Open-shelf filing would not be affected.

First Section

When filed laterally the outside of section 1 (see Fig. 2) would face to the front (or right), the surname and Christian name and date of birth being visible on the top line. This aspect of section 1 is ruled, as the present Scottish envelope, suitable for lateral filing. A special part of this section is set out for the civil state, with a date column for entry when married, widowed, separated, divorced. It also contains the usual space for date and cause of death.

Fig. 2

The inside of section 1 contains the short fold, 1½ in. (3.5 cm.) wide, under which the continuation card E.C. 7-8 (of new dimensions, 4½ by 7 in.; 12 by 18 cm.) is slipped. The left-hand top corner is marked for colour coding, which results in the colours showing on the top left lateral edge of the record if filed horizontally (Scottish) or the right side of the top edge if filed vertically (English).

Second or "Middle" Section

Along the top 5-in. (12.5 cm.) dimension of the outside of section 2 (see Fig. 2) are shown the name and address, date of birth, and N.H.S. number, according to the English layout. The space below is divided equally downwards, the right half being given over to dated entries for occupation, the left to immunization and vaccination dates, sensitivities, and special drugs such as steroids. These last two entries, along with Rh and blood group, conform to the recommendation of the special committees on hospital record standardization—"that these require to be shown on the outside of the case folder" (Walker, 1967). By this arrangement of having the name and address in two position—that is, section 1 and section 2—the wallet can be filed upright or lengthwise as required.

Inside section 2, at the lower 5-in. (12.5-cm.) edge, there is a flap 1½ in. (3.8 cm.) wide, which helps to retain letters, etc., in place.

It may be desirable to reverse the order on the outside of these sections for records originating in England, and of section 1

Fig. 3

for those originating in Scotland, giving the maximum address space, as presumably the majority of records will not require to cross the border and will therefore be filed in their present customary position.

Third Section

The outside of section 3 is devoted to a summary section (see Fig. 3) and a section on family history, number of children, sisters, and brothers. On the inside of the long lower edge there is a 1½ in. (3.8 cm.) flap into which letters are tucked, similar to that in section 2 (see Fig. 2).

The space, 7½ by 10 in. (19 by 25 cm.), provided in sections 2 and 3 for letters will allow the natural retention of the latest letter on top without any further clipping or punching. This should encourage the doctor or his secretary to assess the advantage of retaining this letter as against the previous one and possibly lead to a more economic use of record storage space by selective retention of letters.

Section 3 is folded on to section 2, covering the letters, now folded once, and presenting to the doctor the summary face of the record along with the continuation card in section 1. This makes the usual working portion readily visible, with all relevant information.

Finally, section 1 is folded over the summary card side of section 3 and is ready for filing in either the lateral or the vertical position.

Practicability in Handling

All eight practices were inspected after they had used the wallet record for 18 months to two years. In one of the practices the wallet was handled only by the doctors, as no secretarial help was available. In the other practices the various secretarial personnel were very enthusiastic about the new N.H.S. wallet. One of the expected advantages of the wallet—having the last hospital letter in front facing the doctor (see Fig. 2)—was that it encourages the practitioner to resist the squirrel instinct and destroy superfluous letters—for example, it could be recorded on the previous letter that “the V.V. operation by So-and-So’s method had been found successful at the six-month follow-up,” or it could be entered in the summary section that “the Colles’s fracture had healed satisfactorily without any functional deficit.”

This slimming of N.H.S. patients’ records is an art which has as yet not been successfully tackled by most general practitioners.

There are some other basic requirements which emerge clearly from this experiment. (a) Names and addresses should be written with felt pens by executive councils on issuing the records. It would ease filing. (b) More space could be gained by a redesigned E.C. 7-8 (continuation card). Its present colour is probably helpful to differentiate letters, though with the

wallet in use this would be less significant. (c) Uniformity of size of N.H.S. record throughout the U.K. is even more than ever desirable in view of the far greater mobility of the population. (d) Some gusseted envelopes will always be required in addition to the wallet.

To arrive at the evaluation the Recorder visited all the volunteer practices and counted certain incomplete or complete entries, counted damaged records, and enumerated and inspected bulky ones. The Table gives some results of this investigation.

Summary of Advantages

The wallet record, by ease of opening, presents the continuation card and the last hospital or laboratory report for ready perusal. It offers systematized information on civil status and preventive medical data and long-term therapy. Its format when filed is such as can be accommodated in the filing systems at present available to general practitioners, and it is believed that this is a more realistic way to improve the present N.H.S. record system than by going over to a completely new format, however desirable theoretically.

For nearly two years 12,100 wallet records by the Scottish method of filing and 10,700 by the English system have been under trial. This has shown that the wallet is interchangeable between Scotland and England simply by changing its filing method.

The wallet has proved its sturdiness in experimental use over two years in various types of practices with various staffing. The wallet has proved to be a practical proposition when used alongside and among the present National Health Service record envelopes.

The introduction of the new standard hospital stationery will greatly enhance the value of the wallet record, though this will not prove the expected boon if international sizes A-5/6 are the basis of this standard.

The wallet could be used with considerable benefit in conjunction with a plastic transparent sleeve.

Summary and Recommendations

The practicability and effectiveness of the wallet record has been demonstrated in eight diverse practices. It is interchangeable with the Scottish and English N.H.S. Records (E.C. 5-6).

It is recommended that it be a permissive alternative to the present E.C. 5-6 along with the appropriate E.C. 7-8 available through executive councils, and that all new records issued after a certain date be of the wallet type. This would make for a gradual introduction of a better N.H.S. record without causing any dislocation or sudden need to increase filing or storage capacity.

The present gusset type of record envelope should be continued, but possibly the new size suitable for both Scotland and England should be adopted and also have a printing

Results of Investigation

Practice	No. of Partners	No. of Partners Using Wallet at Beginning of Trial	Assistant	Type of Practice		Surgery		Secretary Employed	Total No. of Wallets Used	Type of Filing		Improved Recording	Stood Wear and Tear	Used Side by Side with Present N.H.S. Record	Additional Filing Space Needed	Support for this Method after Two Years
				Semi-rural	Urban	Converted House	Purpose Built			Lateral	Upright					
A	2	2	1	+			+	+	3,500	1 S	1 S	+	+	+	1/3	++
B	5	3			+	+		+	3,000			+	+	+	1/3	+++
C	3	1			+	+			400	1 S		+	+	+	1/5	+++
D	3	3			+	+		+	4,700		1 D	+	+	+	1/3	+++
E	3	3		+		+		+	3,000		1 S	+	+	+	1/5	+++
F	3	1			+	+		+	3,000	1 D		+	+	+	1/5	+++
G	1	3		+			+	+	5,000	1 S		+	+	+	1/5	+++
H	7	7			+		+	+	200	1 D		+	+	+	1/5	+++
Total	27	23	1	3	5	5	3	7	22,800	12,100	10,700	8	8	8	1	

D = Drawers. S = Shelving.

arrangement similar to the wallet on its outside face 1 and 2 to make it interchangeable between Scotland and England.

The following took part in this experiment, and the special pain-taking work done by them in connexion with it is gratefully acknowledged: Dr. B. L. Alexander, Manchester; Dr. D. E. Fraser, Bucksburn; Dr. W. W. Fulton, Glasgow; Dr. D. W. W. Hendry, Cupar, Fife; Dr. M. Hogg, Dundee; Dr. J. McGlone, Glasgow; Dr. F. Smith, Morecambe; and the recorder's partners.

The support from the Nuffield Provincial Hospital Trust through a grant to the Royal College of General Practitioners to study Practice Organization is gratefully acknowledged, as is the financial

aid from the Advisory Committee on Medical Research of the Scottish Home and Health Department.

REFERENCES

- Marsh, G. N., and Simons, M. E. (1967). *Brit. med. J.*, 1, 163.
 Taylor, S. (1954). *Good General Practice*, p. 150. London.
 Tunbridge, R. E. (1965). *Standardization of Hospital Medical Records*. H.M.S.O., London.
 Walker, L. (1967). *Hospital Medical Records in Scotland, Development and Standardization, Report of a Subcommittee of the Standing Medical Advisory Committee*, paras. 59, 91, 97, 98, Recommendation 8. H.M.S.O., Edinburgh.

AROUND EUROPE

Copenhagen Emergency Service

PAUL BACKER,* M.D.

Brit. med. J., 1968, 2, 423-424

The reason for establishing emergency services to relieve the general practitioner is that, as is the case of any other citizen in modern society, he has to have some time off—time for reading, time for postgraduate study, and time for leisure. If these conditions are not fulfilled it is inevitable that general practice will gradually wither away for lack of recruitment, no matter what else is done to keep it up.

Over 30 years ago, the general-practitioner organization in Copenhagen established an emergency service to cover evenings, night, Sundays, and Bank Holidays. The staff consists mainly of young hospital doctors, who are employed on a contract basis by the Copenhagen Medical Association. A small number of general practitioners also take part—usually at a time when they have just set up in practice.

Emergency services such as the Copenhagen scheme can be established only in towns of a certain size, which contain a sufficient number of interested young hospital doctors. Moreover, experience in the emergency service is considered to give both future consultants and future general practitioners some idea of the conditions and problems in general practice.

The extra earnings, which a young hospital doctor working in the emergency receives cannot be obtained by the general practitioner even if he visits his patients outside duty hours, as the latter receives only a fixed annual capitation fee. Hence most emergency calls outside working hours are made through the emergency service. Furthermore, this scheme provides the public with a simple, rapid system of effective emergency treatment administered by well-qualified doctors. Now it is natural for every patient to call the emergency service directly, when he develops an acute illness which is thought not to need his own doctor's special knowledge of the patient. Equally naturally the patient reports to his own doctor on the following day, while the doctor working in the emergency service leaves a report for the general practitioner in the patient's home. In special cases the service doctor reports by telephone to the general practitioner next day.

Financial Arrangements

General practitioners lose nothing financially by using the emergency service during their off-duty hours. Moreover, they gain nothing financially by not using the service—that is, attending to these visits themselves—and they do not pay for the upkeep of the service.

* General Practitioner. Copenhagen, Denmark.

Doctors working in the emergency service are paid by the Health Insurance Society for each visit. The fee depends on the service rendered and on the time of day it is rendered. The details of the service were fixed by agreement between the Copenhagen Medical Association and the private but State-approved Health Insurance Societies. In April 1966 the entire service was reorganized by the Copenhagen Medical Association in collaboration with the Copenhagen branch of the Health Insurance Societies. Under the old system each doctor working in the service had a fairly heavy work load, and hence they were tempted to engage, on their own initiative, assistants who were often recently qualified and who lacked the necessary experience for the work. There was little contact between the doctors and the head of the emergency service, and doctors had to use their own private telephones and cars for this work. This meant that as a result of parking problems and traffic delays patients often had to wait for a long time before they were seen by a doctor.

The principle behind the reorganization was to ensure that all the non-professional work was in non-professional hands. The aim was to create a system which would attract a large number of well-qualified doctors. This would also give the patients a rapid, efficient service, as well as saving the hospitals from unnecessary admissions. A further advantage was that it would increase the number of doctors interested in this type of work so that the individual work load could be diminished. Another aim of the reorganization was that the head of the service should be in constant touch with what was going on in all branches.

The Service Today

The Copenhagen Emergency Services covers an area with a population of about 800,000. Geographically this area is divided into nine districts during afternoons, evenings, Sundays, and Bank Holidays, and into four districts during the night. The service is in action from 4 p.m. on workdays, from noon on Saturdays, and all day on Sundays and Bank Holidays. The service closes at 8 a.m. on workdays, when the general practitioners start taking telephone calls again.

The duty periods are divided into five- or six-hour shifts, so that every fifth or sixth hour a change takes place in each district, new doctors as well as new cars taking over. Each doctor has an obligation to finish all the calls he has received during his duty period.

The call system and transport are operated by one particular taxi company and can be contacted only through them. A