MEDICAL PRACTICE

*General Practice Observed***The clinical record in British general practice**

I G TAIT

Part I—A practical scheme for reform*British Medical Journal*, 1977, **2**, 683-688

The poor standard of our records in general practice impairs the quality of our clinical care at all times, and exposes our patients to risks that grow increasingly serious as medical care becomes more complex.^{1 2} It is hard to forgive the complacency with which we appear to tolerate present standards. Furthermore, the effect of bad records is not confined to patient care. Our new responsibilities in medical education, research, and developing methods of self-assessment are all made infinitely more difficult. It lies within our own power to correct their worst faults, and I suggest a practical way to do this.

Function of the clinical record in general practice

Any attempt to improve our records must start by recognising the functions we wish them to perform. These are: (1) to inform the doctor about his last consultation with the patient; (2) the storage and easy recall of background information needed in patient care²; (3) communication with other doctors or professionals also caring for the patient³; (4) an aid to research, education, and audit of clinical practice⁴; and (5) provision of medicolegal information.

The first of these is the only function achieved by our present records, and then only imperfectly. Why are they so bad? There are two major problems: Firstly, the absence of a place to record important background information separate from day-to-day notes, and, secondly, that letters have to be folded to be stored in the record envelopes.² But there are also other faults—for instance, we lack a suitable diagnostic system for use in general

practice that will allow expression of psychological and social problems as well as physical, and of unexplained symptoms as well as established pathological diagnoses.^{5 6} Further, we need a better system for documenting day-to-day clinical episodes and the long-term management of disease.

An adequate record system for general practice should provide the following: (1) a separate space for recording relevant background information; (2) a diagnostic terminology that can give equal weight to physical, psychological, or social problems; (3) A method of recording day-to-day notes that allows the intentions and actions of the doctor to be communicated effectively and their quality to be assessed; (4) Flow sheets for recording the long-term management of defined conditions; and (5) a form of record that allows letters and reports to be filed flat.^{2 7}

In addition, any improved system of record keeping should be able to be introduced progressively into general practice as the opportunity presents itself for individual doctors or practices. When used concurrently with existing records it should do nothing to increase the difficulties of those doctors who continue to use the present medical record envelopes.

Our record system has been designed to satisfy these requirements and conditions.

References

- ¹ Walford, P A, *College of General Practitioners Research Newsletter*, No 7, 1955, **2**, 53.
- ² Cormack, J J C, *Journal of the Royal College of General Practitioners*, 1970, **20**, 333.
- ³ Acheson, H W K, *Update*, 1973, **5**, 891.
- ⁴ Stevens, J L, *Journal of the Royal College of General Practitioners*, 1977, **27**, 455.
- ⁵ Mackenzie, J, *Report of the Interdepartmental Committee on Medical Records*, Appendix 1, London, HMSO, 1920.
- ⁶ Crombie, D L, *Lancet*, 1963, **1**, 1205.
- ⁷ Loudon, I S L, *Update*, February 1975, p 259.

(Accepted 26 July 1977)

Aldeburgh, Suffolk

I G TAIT, FRCP, DCH, general practitioner and associate regional adviser, East Anglia