the patient asked for a repeat prescription the item(s) required were copied out by a member of the office staff on to a prescription form, which they also headed and dated. Issue of the prescription was entered on the RPRC in ruled columns: (1) date; (2) ::A/V column, to show that the prescription was issued without consultation at surgery attendance at a home visit; (3) code letter(s) of items prescribed. The record and prescription form was then left for the doctor to check and sign. This system works, saves the doctor time, has good safety features, and costs almost nothing to set up. Many of our original cards have been in use for up to 10 years. Minor disadvantages of the original RPRCs are that it takes a couple of minutes to prepare each card, and that after a time the tags may bend or tear off, making the card difficult to recognise at a glance. To overcome these minor difficulties we are now using a professionally printed RPRC on yellow card (fig 2). The design of this card[3] basically follows our original layout, but incorporates some features described by Southgate[4] and Tait.[5]

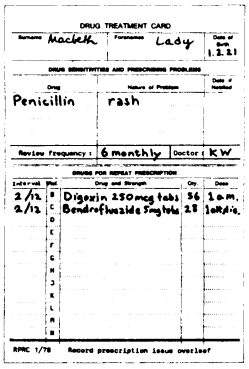

FIG 2—The front of the yellow repeat prescription record card.

CONTRACEPTIVE SERVICES RECORD CARD (CSRC)

This card, which is, I think, the third most useful innovation introduced to our record keeping system, can probably only be justified on purely clinical grounds if problem-oriented medical records (POMR) are kept. From the point of view of administration, however, a separate card is a convenient way to keep a clear record of dates of claim forms FP1001 (an especially useful feature in a training practice as trainee assistants don't have the same incentive as principals to keep checking on this date). Several types of structured cards are now available from manufacturers of oral contraceptives, and initially I designed a similar highly structured card overprinted on a pink summary card FP9A.[6] In many cases the rigid structuring of the clinical record on this card proved inconvenient after a couple of years, so since 1976 we have used a pink summary card left plain on the front for clinical details (except that we obliterate MALE printed in the top left-hand corner with C for Contraception). We overprint the back of the cards using a simple hand duplicator (Emgee large memo stamp) which costs a few pounds from office equipment suppliers. The back of the CSRC has four sections (fig 3). The first two are spaces for entering the dates of FP1001 claim forms and dates and results of cervical smears. The third section is used to write out the current prescription in full, and the fourth has spaces to record the dates of issue of these prescriptions. These last two sections are used in exactly the same way as the RPRC and are laid out as a continuation to that card, although in practice few patients will have both in their notes in use at one time.

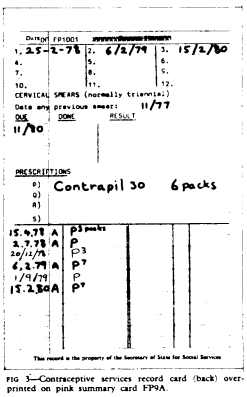

FIG 3—Contraceptive services record card (back) overprinted on pink summary card FP9A.

Improvements needing the doctor's effort

PROBLEM HEADINGS

The second group of improvements we have made require some extra effort by the doctor to achieve results. The two schemes in this group could usefully be applied in any practice, but are particularly helpful in a group, especially a training or teaching practice. So far we have put the clinical record cards in order and removed surplus data from these cards, but it is often still difficult to get a picture of the past history quickly. Even if your partners have perfect handwriting or your records are typed there is a lot of dead wood to get through. Various solutions to this problem have been described, but the method I have found to work in our practice is to give each consultation, or series of consultations, a margin heading. Diagnostic headings may be used, but because of the nature of general practice diagnoses are often very tentative at the initial consultation, so we use problem headings. Not only are these more honest, but an open problem heading is less liable to prejudice a subsequent consultation than a closed diagnostic heading that may be incorrect. The problem heading is written in the left-hand margin in block letters and is boxed—for example, DYSURIA , or where everything is cut, dried, and proved UTI . Using this type of problem heading takes away much of the potential usefulness of a summary card, though we sometimes use these cards when there are multiple problems, or for recording family or social data that might not appear in the main notes. When we feel a summary would be helpful we use the reverse of the vaccination record card FP7 8A.

COLOUR TAGGING

Colour tagging the outside of the record envelope, using the Royal College of General Practitioners' scheme, acts as a shorthand summary

to important conditions. I have extended this scheme a little in our practice. Of course, one could tag for anything, but if tagging is restricted to conditions or problems one would *always* want to know as background to any consultation, it is a very useful procedure. Our extra colour tag is grey, marked N for neoplasm, CH for chronic chest disease, and H(MI) or H(RHD) for ischaemic and rheumatic heart disease respectively. For other rare but important conditions we write the full problem by a plain grey tag—for example, ONE KIDNEY.

Some things tried and abandoned or modified

A4 RECORDS

Finally there are the projects on which we have embarked but have either abandoned completely or continued on a very limited basis. The fact that we have curtailed these projects does not mean I think the ideas are bad. In our own practice we have decided that the return from these projects does not justify the work or money needed to introduce them.

When we modernised our office five years ago we put in shelving to hold A4 records, and early last year we received our first supply from the Department of Health and Social Security. Initially we rapidly converted a small alphabetical section and then our most frequent regular attenders. This took a few weeks. Then we stopped to assess the value of A4 records. After just over a year's assessment my view is that A4 records have only limited advantages over the old record envelope. The A4 is physically about three times the size of an FP5. A great deal has been made of the difficulties this may cause in filing, but it also takes a lot more desk space when in use; because it is fat at one edge it does not stack easily, it is cumbersome on home visits, and it certainly does not lend itself to being written on on one's knee. I am sure the flimsy sheets of the A4 records are not going to stand up to the daily use and abuse in the same way that the faithful Insurance Commission-Executive Council-Family Practitioner Committee cards have come through the past decades. Proponents of the A4 record like to quote the advantages over bulging unmanageable FP6 envelopes, and this I agree with, but with the amount of work we have put into our record envelopes I estimate that only 1-2% should benefit from conversion to A4.

MECHANICAL DATA HANDLING

At the time we embarked on our trial of A4 records I looked into the possibility of reproducing basic patient data—that is, name, address, birth date, NHS and local hospital numbers, and general practitioner's name—by mechanical means. Plastic card or metal foil label-making machines that cost over £2000 seemed to be too highly priced for a small, two-man practice, so I started a pilot project using a Scriptomatic hand addressing machine. This method certainly saves a little time when making up new A4 record folders, and is useful for lab request forms as well as prescription heading, but these are rather marginal benefits for the investment of over £100 per doctor that would be required to use the system for all patients. I still use the system on a limited basis with our small number of regular attenders with A4 files.

NEW PATIENT QUESTIONNAIRE

The use of these questionnaires has been well described recently by Zander *et al*[11] and Tait.[5] I have run trial projects with different designs, but they have never gone beyond the pilot stage as I find that with the larger questionnaires a certain degree of obsession is needed to extract the data obtained, and they have a cost disincentive. The smaller questionnaires seem rather pointless in our practice where we like to see at least one member of each new family registering.

I hope this account of our experiences may be useful to others when considering possible changes in record keeping. Certainly I think a well-groomed and tended FP6 record is a neat, convenient asset in patient care.

My thanks to my partner, Mr R H C Kok, for his co-operation, advice, and patient sufferance of my record-keeping experiments.

References

1 Kuennsberg EV. Recording of morbidity in families. *J R Coll Gen Pract* 1964;7:410-22.
2 Cormack JIC. Family portraits, a method of recording family history. *J R Coll Gen Pract* 1975;25:520-6.
3 Zander LI, Beresford SAA, Thomas P. Medical records in general practice. *J R Coll Gen Pract*, Occasional paper 5, 1978:16-21.
4 Stevenson JSK. Appointment systems in general practice. How patients use them. *Br Med J* 1967;ii:827-9.
5 Stevenson JSK. Repeat prescription cards. *Br Med J* 1967;ii:312.
6 Walker K. Repeat prescription recording in general practice. *J R Coll Gen Pract* 1971;21:748-51.
7 Walker K. Repeat prescriptions. One system—step by step. *General Practitioner* 1979 June 22:38-9.
8 Southgate K. The problem of repeat prescriptions. *Update* 1974;9:55-64.
9 Tait IG. The clinical record at British general practice. II. The Aldeburgh record system. *Br Med J* 1977;ii:684-8.
10 Walker K. Organising a contraception service. *Update* 1976;12:438-9.
11 Zander LI, Beresford SAA, Thomas P. Medical records in general practice. *J R Coll Gen Pract*, Occasional paper 5, 1978 24-9.

Oddity remembered: no verdict

In 1855 Dr Robert Stirling, recently appointed assistant to Dr Watson of Burnopfield, failed to turn up for his Thursday morning surgery. Dr Watson seems to have assumed that he had gone home to see his parents in Scotland and did nothing about it. Two days later Dr Stirling's mother appeared and said she had dreamed that her son had been murdered. Search parties were sent out and his body was found covered with leaves hidden under some bushes with one gunshot wound and marks of battering with a heavy instrument about his head and neck. His silver watch had been stolen and the contents of his medical bag scattered round about. The police thought that the murderers had mistaken him for a tenant farmer who was due to pay his rent at nearby Gibside Hall on the day in question and would be carrying the money in a bag. After extensive inquiries two men were arrested but subsequently acquitted for lack of evidence largely on the insistence of a single stubborn juryman. The lack of evidence was thought to be due in part to the loyalty of a close-knit village community and in part to fear of what might happen to anyone giving evidence against the men. The name of the lane in which the murder was committed was changed to Stirling Lane, which it is to this day, and there the matter rested.

My grandfather heard the story when he extended his Whickham practice to Burnopfield in the 1870s, and I was told it as a boy and later read it up in the local history books. When I came into the practice and discussed it with the general practitioner in what was once Dr Watson's practice he told me a sequel. One of his patients, a spinster, left him an old silver watch in her will. He thought it a surprising possession for a poor working-class woman, opened it up, and found on the inside of the lid the initials RS. This must surely be Dr Stirling's watch. He made discreet inquiries and learned from an old man whose family had lived in the village for generations that the old woman was a descendant of one of the acquitted men. The watch had evidently been handed down from generation to generation, and the dying woman with no children to leave it to had willed it to Dr Stirling's medical descendant. He thought it his duty to try to trace the Stirling family and return the watch to them. This was not easy, but after a lot of work and considerable difficulty he got the address of one of them and sent him the watch. He did not expect a reward but a letter of thanks would have given him enormous pleasure. He never got one.—ANDREW SMITH, general practitioner, Newcastle upon Tyne.

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

Sex Problems in Practice

What can a general practitioner do?

MICHAEL COURTENAY

Every general practitioner will inevitably be presented with sex problems, but most GPs in practice at the beginning of the 'eighties will have had no special training—or, indeed, any undergraduate training—in managing them. Yet GPs are increasingly thought by their patients to be experts on sex problems.

Just as with most other medical problems, some simple sex problems can be managed in general practice, but more difficult ones will need referral to a specialist. One snag with this system is that the specialist resources in Britain for dealing with sex problems are still inadequate to meet the demand: several clinics set up in recent years have closed after being overwhelmed with referrals. Specialists cannot blame GPs for not doing their share of the work, however, as it is those same specialists who have failed to ensure that undergraduates receive a good education in the subject. Most undergraduate curriculums do nothing more than acknowledge that sex problems exist and that they might properly be considered a medical responsibility.

There are strong arguments, however, for making sex problems a postgraduate subject: firstly, some years of sexual experience are an advantage to any professional who is going to treat patients; and, secondly, adequate training in any of the methods available is likely to be time consuming. A course in managing sex problems should last at least six months and preferably considerably longer.

The recent legislation making vocational training for general practice compulsory opens up new possibilities for adequate training in sex problems for the future GP. The training might perhaps be given in association with training in obstetrics and gynaecology and psychiatry; this would have the added advantage of ensuring that future psychiatrists and gynaecologists are trained in managing sex problems.

Dispelling myths

Some problems should lie within the competence of any GP. The first category is sexual myths; these can normally be dispelled by education. The myths result from lack of information or inaccurate information. Much of the knowledge we now have about human sexual functioning has been gained only during the past 25 years, so that it was simply not available to doctors training in the mid 'fifties. Only those doctors with a special interest have learnt about the subject; most do not consider it a medical subject at all and certainly not one of crucial importance. This seems a curious view when we consider that many people may think that losing sexual function was worse than losing an eye or a limb.

We must remember not only the suffering that results from sexual dysfunction, but also that a good sexual relationship is a most important part of a good marriage, which in its turn is important in rearing children. So sexual problems may damage the health of more than one generation.

Most of us agree that removing the fig-leaf from modern medical practice is long overdue, but what will we discover when we do so? Perhaps the best way to approach this is for me to offer a check list of the sort of sexual questions that any GP might be asked by his patients.

Questions any GP should be able to answer

QUESTIONS ABOUT NORMAL PHYSIOLOGY

(1) Is there a difference between clitoral and vaginal orgasm?
(2) Is there a female counterpart to male erection?
(3) Do women take longer to achieve orgasm than men?
(4) Are women capable of multiple orgasm?
(5) What part does the uterus play in orgasm?
(6) What effect has the menopause on a woman's sexual life?
(7) Is the size of the penis related to a woman's sexual response?
(8) Do men become sexually excited more rapidly than women?
(9) Do men have voluntary control in delaying ejaculation?
(10) Can men have an ejaculation in the absence of an erection?
(11) Can men have an orgasm in the absence of an ejaculation?
(12) What effect has aging on erection and ejaculation?

QUESTIONS ABOUT COMMON PATHOLOGICAL PROBLEMS

(13) What effect has mastectomy on a woman's sexual feelings?
(14) Can a paraplegic man still enjoy a sexual life?
(15) What sexual problems are produced by severe arthritis?
(16) What effects has childbirth on a woman's sexual function?
(17) What effects has diabetes on a man's sexual function?
(18) What effects has multiple sclerosis on sexual function?
(19) What effects has a hysterectomy on sexual function?
(20) What effects has prostatectomy on sexual function?
(21) When is it safe for a man to resume sexual intercourse after a myocardial infarct?

QUESTIONS ABOUT IATROGENIC CONTRIBUTIONS TO SEXUAL DIFFICULTIES

(22) Can treating hypertension affect sexual function?
(23) Can treating malignant disease affect sexual function?
(24) Can treating severe asthma affect sexual function?
(25) Can treating peptic ulcers affect sexual function?
(26) Can treating Parkinsonism affect sexual function?
(27) Can treating anxiety states affect sexual function?

"Answers" are given later in the article.

If a GP possesses this small amount of information it may then transform his appreciation of his patients' sexual problems. Also, the GP will have some base from which to proceed in dealing with the problems he will encounter most often, and he will be more likely to become aware of his patients' needs. Clearly, however, the "answers" to the questions posed (even if there was general agreement on them) would not qualify the GP for anything more than a commonsense approach to sexual problems. But even this would be a major advance for many GPs.

London SW18
MICHAEL COURTENAY, MB, MRCGP, general practitioner

Problems in management

A "commonsense" approach is not quite as easy as it sounds, however, because, not only is common sense rare, but many GPs experience great personal difficulties in applying themselves to sexual problems. To most people sex is a private matter (though perhaps the next generation will consider it less so) and also a very emotive one with religious and philosophical overtones. The strong emotions stem from those vital and consciously forgotten years before he or she even went to school. Thus many professionals with strong views (though these vary greatly from person to person) but often with little actual experience are in the unfortunate position of having to tackle other people's problems. More unfortunately still, the doctor may be tempted to treat problems in patients that he or she has not been able to resolve in himself or herself. To achieve a more balanced and helpful attitude in handling sexual problems the doctor will need further training. Even then only when he has established a professional attitude will he be able to develop the necessary skills for treating more difficult problems.

This leads to the dilemma of wanting to encourage GPs to tackle the simpler problems of sexual medicine but being anxious that some may be tempted to tackle difficult problems that are really beyond them. In this series we want to walk this tightrope: encouraging what can be safely encouraged and indicating where the GP can refer patients and where he can acquire further training. We will also consider the special problems of the disabled, and, finally, following the dictum that even if you cannot do any good do not do any harm, we will consider the dire effects that some treatments may have on sexual function.

"Answers"

(1) No essential difference. It is thought that the "orgasmic platform" at the outer third of the vagina is structurally associated with the clitoris through the labia minora, so that the penis stroking the orgasmic platform will produce clitoral sensation. This may not be true in every woman. Orgasm through direct stimulation of the clitoris may be subjectively different from orgasm through intravaginal stimulation, but subjective considerations are difficult to quantify.

(2) Yes. The formation of the vaginal transudate and the erection of the orgasmic platform.

(3) Not necessarily. Early experience of sexual intercourse in some women may be associated with relative slowness.

(4) Yes, though the importance of this is subjective.

(5) It contracts, but this is only experienced in certain circumstances. Subjectively the effect seems uncertain.

(6) It may enhance it (for instance, if the woman has been afraid of further conception) or it may decrease pleasure (for instance, if the woman mourns her lost fertility).

(7) A small penis can stimulate the orgasmic platform perfectly adequately.

(8) There is a wide variation in the speed of response in both sexes, with much overlap.

(9) Yes, but it may be negligible in some men with premature ejaculation.

(10) Yes, but the pleasurable sensation is diminished.

(11) Yes, especially important to the aging man.

(12) It makes erection slower and delays ejaculation—sometimes indefinitely.

(13) It will alter her feelings about her body, and if she cannot adjust to the loss she may have difficulty in accepting herself as still being a desirable partner.

(14) Yes, although ejaculation will not be perceived. The orgasmic experience can be "transferred" to other parts of the body through mental processes.

(15) Stiff joints, especially hips, may make some coital positions painful or impossible.

(16) Variable: some women's libido increases enormously soon after childbirth. Other women lose libido for six weeks or so. Vaginal repair may cause dyspareunia.

(17) Neuropathy or vascular changes may cause erective failure, but about half of the diabetic men with sexual problems have them independently of their illness.

(18) Again variable, and associated with sacral nerve demyelination. Difficulties should be treated on the assumption they are not due to the disease.

(19) None physiologically. It may enhance it (see (6) above) or diminish it through psychological mechanisms.

(20) Some operations cause ejaculation into the bladder. Old-fashioned operations might damage the sacral nerves. In general there should be no change from structural changes.

(21) At about four weeks after the attack or when he can climb two flights of stairs without undue distress, or both. It is less stressful to have intercourse with an established partner than a new one. Nitrates have a beneficial effect on libido as well as suppressing angina.

(22) Methyldopa can produce impotence. Beta-blockers can produce Peyronie's disease (penile induration and fixed flexion). Spironolactone can decrease libido.

(23) Large doses of stilboestrol (more than 2 mg a day) can seriously interfere with male performance. There is no need for large doses. Cytotoxics can produce a neuropathy, but it is temporary.

(24) Corticotrophin and oral corticosteroids may decrease libido.

(25) Belladonna analogues can interfere with sexual function in men. Cimetidine may also inhibit it.

(26) L-dopa may interfere with male sexual function.

(27) Tranquillisers (and some antidepressants) can interfere with male sexual function.

This is the first in a series of articles on sex problems in practice.

Clinical Curio

I would like to report a coincidence that might or might not be important. In a practice of 17 000 patients we have had in the past 10 months seven new, florid cases of thyrotoxicosis. Five patients had thyroxine concentrations above 300 nmol/l (23·3 μg/100 ml). Five patients were women aged 18, 24, 31, 35, and 46, and two were men aged 35 and 50.

Statistically, seven new cases in 10 months is not particularly significant, apparently three per 10 000 in any 12 months being the norm. This assumes, however, that every case of thyrotoxicosis in our practice has come to light or has been diagnosed. Most of our seven patients had a particularly acute onset; indeed, one developed what a consultant described as a "raging thyrotoxicosis" over two or three weeks. Most of the patients traced their onset back to the spring and early summer. The mothers of two women had thyrotoxicosis, but in the other five there was no family history. One woman said that three weeks before the thyrotoxicosis began she had had an intensely sore throat. One thing that they all seemed to have in common was close contact with young children. But what is most interesting is that the two men who developed thyrotoxicosis lived next door to each other. In a community of 18 000 people this seems to be a remarkable coincidence.

If the pattern of these illnesses is exceptional then this assumes that there was some external factor. The only major medical event in the area earlier in the year was a widespread epidemic of hand, foot, and mouth disease—coxsackie A virus infection. The cases were generally very mild, and unless the children were examined carefully the few small blisters on hands and feet could easily be missed. Sometimes the stomatitis that we found on examination was not complained of at all. The disease seemed to be readily transmitted and many children were found to have it when they had been brought to the surgery for other reasons.

One of the two men with thyrotoxicosis had three children, all of whom had hand, foot, and mouth disease a few weeks before his symptoms developed. The two men saw each other infrequently but their children played with each other every day, and it is fair to assume that the children of both families were infected.

Two questions may therefore be asked. Does the experience of the practice amount to a small epidemic of thyrotoxicosis? If so, could there have been any connection between the thyrotoxicosis and a recognised epidemic of coxsackie A virus? The question is simply this—can coxsackie A either cause or predispose a person to thyrotoxicosis?—B N J DAILY, general practitioner, Burnham, Bucks.

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