PRACTICE OBSERVED

Medical Records

II: A4 folders — a step into the present

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I can recall quite clearly the incidents that triggered my conviction that major reform was needed in the conventional system of recording in general practice using medical record envelopes. It was in 1967 when I saw in rapid succession three patients with complex histories, bulging envelopes, and difficult current problems: all were long-time residents in the district, all thought that I should know something about them, and with all of them I felt embarrassed and inefficient as I tried to disentangle jumbled sheets of hospital letters and reports and wads of continuation cards.

First steps

Talking to partners and colleagues, academics, and medical politicians, I soon found that I was far from alone in thinking that the medical record envelopes (introduced in 1920) no longer provided an effective system for the greatly changed conditions of general practice in the 1970s. Agreement that the system was less than ideal was one thing; agreement on how it might be changed quite another. The pessimists argued that you couldn't change a system now used by 23 000 practitioners; the optimists claimed that the computer would shortly solve all the problems; and the realists warned that no change would be made until hard evidence for its need (as opposed to the simple "gut reaction" of some) could be shown.

This was the spur for three years' work leading to an MD thesis on the general practitioner's use of medical records and a couple of published papers. These provided the necessary spin-off for political action. It was fascinating to initiate and watch the progress of the democratic process from a motion proposed at and passed by the Local Medical Committee, to agreement by the Scottish General Medical Services Committee, followed by debate in the General Medical Services Committee (UK) and finally the Conference of Local Medical Committees who agreed that as a matter of policy the future medical record should be of a size to contain unfolded paper of A4 size and should be made available to those doctors who wish to use it.

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Inevitably a working party was set up and after protracted deliberations produced two reports: prescribing a nationally accepted design for folders and insert sheets that are now available to volunteer practices in Scotland (but not in England and Wales), thus giving a form for a new record which matches more nearly the needs of general practice at the end of the twentieth century.

IMPROVEMENT

In our practice we were convinced in theory (and this conviction has now been sustained by practice) that record folders would be easier to use, more adaptable, and more efficient than medical record envelopes. Our aim was to improve patient care and doctor job satisfaction by improving record keeping. It is easier in a folder than in an envelope to separate different categories of information—such as summary, family history, continuation notes, immunisation state, repeat prescribing, etc. In a folder correspondence can be filed flat and in chronological order, where it can be consulted rapidly in book fashion rather than retrieved by pulling out, unfolding, and often scrambling among unsorted documents. This feature is important for a secondary reason—it encourages the review of record contents and the relegation of obsolete material to the wastepaper basket, a "weight-watcher" exercise which should become a reflex discipline if we are to avoid becoming engulfed in paper.

RECORDS IN THE PRACTICE

How did all this affect our practice? Mainly by giving us the excitement (and also the hard work) of taking an early part in an evolutionary process that continues today. We are a partnership of six doctors, with about 11 500 patients, working in a long-established Edinburgh suburb that is still growing. The practice was started by my grandfather, and when this work on records began my father was still the senior partner and we were practising from adapted premises attached to his house. In 1971 we moved, along with two other local practices, into a group practice medical centre (fig 1). This is one floor, privately leased, of a speculatively built office block just a quarter of a mile from our former surgery.

The first A4 records we used were Wantage folders—we were one of the practices recruited to help in the scheme pioneered by J S L. Loudon and his partners,¹ and we had 50 folders which were used to

The bottom right quadrant of the summary sheet is used for the "family portrait". This is the diagrammatic recording of family structure and history that I have described elsewhere² and which has been modified and adapted by Zander and his colleagues³ at St Thomas's. The top right quadrant is used for recording the patient's occupation, and the bottom left quadrant for cross-referenced family data.

Pruning a record requires the ability to skim material at some speed. It is surprising how many hospital letters and reports either are no longer relevant (now likely to be so in the future) or have been superseded by later ones. It is also remarkable how little of value can be extracted from old continuation cards, remarkable that is until one realises that their main use has been, quite properly, that of aide-memoirs whose usefulness is in the sheer of things, bound to be ephemeral. It is sometimes hard to bring oneself to destroy the handiwork and communications of others, but it must be done in the interests of efficient recording, which demands relevance and brevity.

Summarising and pruning take time (we have calculated that the average is about six minutes per folder, within a wide variation), but there is little doubt that it is time well spent because it leads to much more satisfactory information retrieval and consequently much more satisfactory patient care.

Conclusion

Now that we have our records in A4 folders and the majority at least of those in regular use are summarised and pruned, doctors and staff alike are convinced that there has been a major improvement. Quality of care is noticeably different to measure, but experience with folders has confirmed for us the statement by the 1976 Conference of Local Medical Committees that "... the A4 type of record folder is an important method of record keeping with significant benefits in patient care."

We were fortunate in being able to overcome the problems of finding the extra space required, but for practices for which space is a problem I suggest converting, say, 25% of the records which

cause the greatest difficulties—that is, those of patients with complex or chronic problems—and thus solve perhaps 90% of the main record problems. Our gradual conversion convinced us that it is quite possible to combine the two systems (medical record envelopes and A4 folders), and this may well be a case where half a loaf is better than none. If we had to start again we would still proceed much as we did. Computer recording (at least of patients' day-to-day records) still appears to be some way off; if and when it does come we think that we are nearer to having data in a form that could be easily transferred to computer file than would be the case if we still used medical record envelopes.

The benefits of the system lie largely in summarising and pruning. The one special feature which we developed of "family portraits" is especially helpful in an area of high population mobility because it enables one to build up clearer pictures of the family background of patients who are new and at the same time to have a fuller grasp of the structures of families who have stayed with us through three generations in the same practice. With A4 folders our practice is undoubtedly pleasanter and almost certainly more efficient. The frustrations and the embarrassments of the bulging fat envelopes are now for us things of the past, and whatever the future may bring we feel that our present records, though of course by no means perfect, match more nearly the needs of today.

References

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Managing Sex Problems in Practice

Diagnosing sex problems in general practice

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Most of us are prepared to live with whatever sexual problems we may have. We are concerned here only with patients who are sufficiently distressed to want to talk about them. The doctor should be ready to help patients express themselves. They can see at once if he is showing professional concern, rather than trying to gratify himself by talking sex with them. It is only too easy, however, to respond clumsily to the patient's hints for help, and perhaps to ridicule rather than help.

Let the patient talk

For example, a patient at a postnatal examination may inquire anxiously about the episiotomy scar, "Is it all right?" It would

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be natural to reply "Yes, it's fine," but it might be better to ask if he feels right to her. She may then reply that it hurts or feels different, and with a little encouragement that her sexual feelings have gone. The doctor might then reply that this is only to be expected after an episiotomy, but she could possibly feel that her problem was being rejected. If instead the doctor makes an encouraging grunt, she might go on to say that all her feeling had gone since the baby was born. The doctor could then reassure her that every couple needs time to adjust their feelings at this stage. He might be rather pleased at being one jump ahead of her, but it might be the wrong jump. If instead of reassurance he grunts encouragingly again, she could have something quite different in mind. "Nothing's been the same since the delivery. I thought I was doing fine, but suddenly they started doing things to me, and used the forceps." Perhaps she feels unreasonable anger at the obstetrician who "cheated" her of an important moment in her life and left her with a painful perineum. At this moment she does not want her general practitioner to be incisive and reassuring like the gynaecologist,

FIG 1—Ladywell Medical Centre. The centre occupies the ground floor of the office block and has a separate entrance from the rear of the building. It can accommodate 12 principals and nurses, health visitors, and secretarial staff.

house the contents of some of the most notorious of our "fat envelopes." As time passed we acquired small samples of other designs of folders which we tested out for the working party. Eventually we recovered from the Scottish Home and Health Department a supply of folders and insert sheets sufficient to convert all our records, and the task was carried out over about four years.

CONVERSION

The reform of our records needed two processes: converting from medical record envelopes to folders, and summarising and pruning the records converted. The conversion was carried out by my secretarial and receptionist staff, initially in spare moments, but when the main exercise began to get into full swing we employed an experienced part-time receptionist to work steadily through the records until the task was complete. The conversion was done in two stages: constructing the files by fixing the insert sheets in the agreed order, and then transferring material from the old medical record envelope to the new file.

The convention we have adopted for the insert sheets is as follows:—the summary sheet is pasted inside the front cover of the folder (fig 2);

- the clinical notes sheet faces the summary sheet, being mounted on the front edge of the first spine (fig 3);
- the immunisation and screening investigations sheet is mounted immediately behind the clinical notes sheet;
- the x-ray and pathology investigations sheet is mounted on the rear edge of the second spine facing the front cover.

The material in the old medical record envelope is dealt with by heading up the insert sheets with the patient's name, address, and date of birth and also writing these details along with the National Health Service number, telephone number (if any), and date of registration on the front cover of the folder. The continuation cards are put inside the pocket on the inside of the front cover (under the summary sheet in our system) and hospital letters and reports put in chronological order, with the most recent letter on the top, and faced to the front edge of the second spine. Finally x-ray and pathology reports are mounted on the appropriate sheet.

By timing this exercise over a sample of folders we estimated that this part of the job took on average four and a half minutes per folder. It is impossible to compute the cost, falling as it did into the staff salary element of practice expenses, with the usual 70% reimbursement.

Second step

In this practice the doctors summarise and prune the records. It is a continuous process and the responsibility devolves on the partner who usually looks after the patient (not necessarily the one on whose list the

FIG 2—Summary sheet.

FIG 3—Clinical note sheet.

patient is registered). The summary of the patient's past medical history—that is, episodes which the doctor considers should be recorded for the use of his colleagues and successors—is entered in the top left quadrant of the summary sheet (fig 2). The patient's blood group, if known, is written above the title of the sheet and drug hypersensitivities (in red ink) below the title.

but to share her disappointment, accept her anger against men, and let her feelings return. I find that a sensitive medical student or trainee observing an interview can point out to me where I have missed such opportunities.

Patients in our waiting room may appear to be casually reading magazines, but some of them are rehearsing what they are going to say to us. There is usually one respectable problem like backache, and perhaps several other distressing thoughts in the back of their minds, which they may not quite have faced properly.

One such patient came to me with backache on a day that I was preoccupied and definitely off form. I kept asking him questions and not even listening to his answers, and I went through a ritual examination and dismissed him with a prescription. I told him to return if he was no better (and patients will tolerate a lot from a doctor if he does so), and when he came back I realised he needed my full attention. We soon got away from the backache itself on to insomnia and irritability, trouble with his eldest son, and a missed promotion at work. This was embarrassing for him because his wife's father was in the same business. I encouraged him to talk of how this affected his home life, and he suddenly told me how he had failed sexually on two or three recent occasions. He had obviously not rehearsed this, but he was relieved when I accepted it along with the rest. We added it up together as a rather bad patch in his life, with the sexual part very important to him, but we got it in perspective in a general theme of temporary failure.

This is a fairly typical general practice case to those of us who see our work in this way, but it illustrates several points. It is important to be receptive and tune in to what the patient is trying to say. Doctor and patient can usefully shuffle the various ideas that arise into some sort of focus that is acceptable to both of them—in this case "failure." This superficial diagnosis is a matter of mutual choice, but it is very valuable. Also, since sharing a problem is the beginning of facing it and changing things, perhaps diagnosis and treatment overlap however the case may be handled subsequently. In emotional and sexual matters as soon as the patient enters the surgery the processes of diagnosis and treatment have already begun, whether we intend it or not.

Listen closely

The two patients described so far saw their problems as personal failures rather than in terms of the marital relationship. One needs to listen similarly for sexual problems in anxious adolescents, aging or all patients on drug treatment of various kinds, and especially people undergoing mutilating surgery. Inhibited homosexuals may also need a doctor who can hear what they are trying to say and help them to accept their feelings. The girl who is frightened of vaginal examination may not be very frightened of men in general, but have most of her fears in her vagina. She can be greatly helped by mutual examination and re-education about her vagina, preferably from a skilled woman doctor, rather than by talking about relationships in general. Many people have sexual problems that are reflected in all their relationships, including those with their doctor. We may know their family over many years, and may be seen by the patient as caring and controlling them like a parent, and at the same time the confidential intimacy and physical contact may have sexual associations. Since many people have problems sorting out their sexual feelings, the general practitioner may become an important person here. (For example, some people see sexual partners as either good and boring or exciting and dangerous.) The fact that the general practitioner is definitely not the lover or parent actually increases the tension, since involvement is limited and safe. So those who go through life endlessly repeating the same mistakes in choosing a partner and hoping for a magic solution may present the same problem to the general practitioner, often with physical touch to match. If doctor and patient are the same sex, similar powerful feelings

may be aroused with the doctor as a rival or a model. The young woman doctor irritated at being called "nurse" may miss the fact that some women envy her success and have strange fantasies about her private life reflecting their own problems.

Physical problems may have a sexual side

One might regard this sexualisation of the doctor-patient relationship as a threat or an opportunity, but in any case it helps to diagnose what is happening. For example, in 100 consecutive cases of cystitis I found five patients with troublesome recurrent attacks who fitted the pattern of a strong woman, despondent men as weak or dirty, yet afraid of the magic powerful lover she sought in vain. The general feeling was "men are no good and that goes for you too." I can recall several elderly homosexual men over the years with severe asthma, who responded better to warmth and friendship than drugs. One young homosexual man actually lost his asthma completely when given time and encouragement to talk of his anger and fear of women, and his sexual desires completely inhibited by guilt. He lacked any intimacy in real life, and we both felt happier sharing his feelings for me and others, rather than dealing with asthma.

The women with chronic pelvic symptoms or disease may have all manner of sexual problems. It may be easier to think of physical and sexual problems as reflecting each other, rather than to look for a sequence of cause and effect. "Men hurt me" is usually true both physically and emotionally and needs a doctor prepared to look at both.

Watch for the traps

It is not uncommon to find a barrier of anger, fear, and guilt, with symptoms shifting from one to the other, which can people off from close relationships. They may either be inhibited from actual sex or promiscuous and not enjoying it. The doctor can easily get caught up in this, and be trapped and manipulated by the patient's bad feelings.

For example:

Anger: Men are all the same, they only want one thing. Fear: Then they abandon you, give you venereal disease, make you pregnant.

Guilt: It's my fault I suppose, I'm no use to anyone except as a slave.

Anger again: So they take advantage of me... etc. After listening to this a few times the doctor may feel he is one of a long line of men—lovers, priests, and doctors perhaps—who have been "deduced" and manipulated by her. He may try to refer her to a psychiatrist, which will activate the same mechanism in a different form: "I'm not going to let any shrink blow my mind; I thought you were really going to help me yourself, but I know I'm an unworshipping patient; doctors always send me away in one way or another."

There are many such traps for doctors, and I am sure that the best way to learn how to cope with them is to discuss them with colleagues in a suitable group. Otherwise, it is easy to get out of touch with reality when the patient's problem activates the doctor's own problems.

OF THE APOPLEXY.

The apoplexy is a sudden loss of sense and motion, wherein the patient is to all appearance dead; the heart and lungs however fill continue to move. Though this defile proves often fatal, yet it may sometimes be removed by proper treatment. It is chiefly attended by a great faintness, who life is rich and plentiful diet, and indulgence in strong liquors. People in the decline of life are most liable to the apoplexy. It prevails most in winter, especially in rainy seasons, and very low flates of the barometer. (Buchen's Domestic Medicine, 1786.)