Conclusion

The general conclusion must be that for men the higher rates of consultation in social classes IV-V are strongly related to greater need. Men in these classes experience more chronic illnesses that require more consultations; they also suffer from more conditions that are urgent or life threatening. Their higher consulting rates result only a little from help seeking for trivial symptoms, though this group of patients may either experience more conditions that are functionally incapacitating but not serious or take such conditions more seriously. Manual workers may seek relief more readily for symptoms that threaten the capacity to work or make it painful. On the other hand, different groups may have a different perception of the importance of particular symptoms. More research is required.

For married women the picture is more confused, even when attendance at clinics and fertility related consultations are excluded. Categorising women by their husband's social class produces smaller class differentials for them than for their husbands. Nevertheless, the small difference between social classes for conditions categorised as "urgent," the equal number of consultations per episode (even though the chronic conditions which require repeated consultations and long term care are socially differentiated for women, as they are for men), and the declining consultation rates with age (even though these same chronic conditions must become more prevalent) suggest that consulting patterns may not match need. Referral to specialist care, in relation to presumed need, seems to be biased in favour of social classes I-II. Consultations for preventive care (as for men) and gynaecological conditions (for illnesses and malfunctions, as well as for "not sick" care) show deficits in social classes IV-V. Perhaps more for women than for men, the results of this quantitative analysis suggest that the more important and interesting questions concern the qualitatively different use that social classes may make of primary care.

I thank the panel of general practitioners who participated in the categorising of diagnoses; Professor W W Holland, Dr D L Crombie,

and Dr P M Lambert for helpful comments; and Andrea Francis for clerical help.

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Instant age-sex register

JOHN HENDERSON

Abstract

An age-sex register for use in general practice was obtained directly from the family practitioner committee computer by direct transfer of data to a microcomputer.

Introduction

A desire to obtain an age-sex register for use in my practice and two years of experience with microcomputers led me to consider trying to obtain the registration details of all my patients

Hilary Cottage, Fairford, Gloucestershire GL7 4HT
JOHN HENDERSON, MRCGP, MRCP, general practitioner

directly from the family practitioner committee computer. A traditional age-sex register is usually in the form of a card index. It is set up by clerical staff in the surgery or family practitioner committee who work through the medical records or registration cards and enter the data manually onto preprinted cards. This is slow. My family practitioner committee had already computerised all these data and were able to print a complete list of patients, either on paper as a list or directly onto cards for filing. To obtain maximum benefit from the register and use the fast search capabilities of the computer the data would still need to be typed into the surgery computer. As this laborious task had already been done at the family practitioner committee I intended to avoid repeating it. Most computer systems in surgeries have as their database an age-sex register which requires several months of typing to install. I asked the family practitioner committee if they could supply a tape or floppy disk containing the data. The many different disk formats made this more difficult than a direct transfer of data from the family practitioner committee minicomputer to my own microcomputer.

Method

I have a Tandy TR850 Model 1 microcomputer with 48K of memory, expansion interface, two floppy disk drives, and printer. A microcomputer system smaller than this is unlikely to have the capacity for useful communication with a minicomputer such as the DEC PDP-11 used by the family practitioner committee. In theory any two computers may send information to one another by means of an RS232 interface. To communicate, both computers also need to run appropriate programs that control the sending, receiving, and writing of data to the disk. The family practitioner committee provided a program to select patients registered with the three partners and sort them into sexes. I have an inexpensive communications program which may be obtained commercially to receive and store the data.

The data obtained should be in a format that may be directly used. I selected the following fields of data: surname, forenames, National Health Service number, date of birth, sex, date added to list, address (2 lines), postcode, whether on the dispensing list. I can add other items to a total of 40 when required. The fields are not of fixed length but cannot exceed 255 characters. To my surprise I found that there are three sexes: male, female, and indeterminate. There were seven indeterminates in our population of 6000 patients. They were all patients whose names gave no clue as to their sex. We easily corrected the family practitioner committee records but in areas where there is a large population of immigrants with unusual names this might be difficult. The average size of the data record for each patient was 95 characters. The family practitioner committee developed a program which was sent to me in a format accessible by my computer using another commercially available program for data management.

Two options were available. The first was to communicate by telephone using a modem. A modem converts data signals into a form transmissible by ordinary telephone lines and records them at the other end. The speed of data transmission varies and is expressed as the "baud rate." The usual range is from 300 to 9600. At a rate of 300 baud the details of one patient would take three seconds to transmit. This would mean a five hour telephone call for 6000 patients using a standard British Telecom modem. This would be expensive, and particularly so if errors occurred and the call had to be repeated. At a rate of 9600 baud records for about 10 patients could be sent a second, but the cost of a more complex pair of modems was not justified. The alternative was to take my computer to the family practitioner committee for a direct link. Microcomputers are extremely portable and as we expected practical problems this second option was taken.

The project was initially beset with technical troubles. My RS232 interface, though new and unused, was faulty and this resulted in total failure at the first attempt. The second attempt proved that communication was possible, but only at slower rates of data transfer than I had hoped for. We found that occasional characters of information were "dropped" and lost at baud rates of more than 2400. The final attempt was completely successful and in three hours the complete age-sex register was written to disk. Most of this time was spent checking the files after transfer to avoid the need for another attempt.

Confidentiality

Although the information held at the family practitioner committee is not clinical, those of us who use computers have a responsibility to ensure the security of the data. My access to the family practitioner committee computer came about through personal contacts with the administrator and his staff. I do not expect freedom of access to be given to all general practitioners and their staff without close supervision. Once the disks containing data are held in the surgery then security is less of a problem. It requires more skill to extract information from disks held in the office than to read the registration details written on the front of a medical record envelope. Disks should not be sent by post, and direct telephone access to our own computers by outside agencies should never be permitted except under direct control.

Discussion

The future use of the age-sex register will depend on keeping it up to date. The results of other studies (see summary data by Fraser and Clayton)¹ showed that as the years pass the register

gradually becomes less accurate. With the daily births, deaths, and new registrations of patients, it can never be completely accurate without exceptional and foolproof administrative procedures in the surgery. I do not intend to divert any of my staff to this constant chore. At intervals (as often or as little as required) a relatively short telephone call directed to the family practitioner committee using a modem will produce a data file containing new or deleted patient registrations.

One disappointment has been the number of errors found in the patient details: wrong addresses, incorrectly spelt addresses, and patients not on the dispensing list who should be and vice versa. Spending some time on the correcting of these should improve the accuracy of records both for us at the surgery and for the family practitioner committee. Since a correct address is an essential ingredient of repeat prescriptions printed by computer this work will have to be done.

I understand that the patient data was transcribed for the family practitioner committee by a typing bureau and not by the staff. I feel sure that local knowledge would have led to more correct spelling of village names.

I thank the family practitioner committee at Gloucester for their enthusiasm and help, Rob McKenzie from the Exeter Health Computing Project who wrote the software for the family practitioner committee, and Dr Guy Knights who helped me with the whole project.

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ONE HUNDRED YEARS AGO Cruelty to children—Either greater publicity is given to these pitiable cases, owing, perhaps, to a healthy growth of opinion among the poorer classes, or they are greatly on the increase. We note two cases recently reported in the daily journals, testifying to extraordinary cruelty and callousness on the part of women, who, perhaps from the nature of things, seem to excel men in, so to speak, torturing helpless children. In one case a woman was charged with ill-treating her nephew, aged seven years. Persistent cruelty to this poor boy had been noticed by a woman living in the same house, who very properly applied the police of what was going on. The child was taken to the workhouse, and according to the testimony of the medical officer, Mr Ashford, weighed only twenty-four pounds, and was in a condition produced by protracted cruelty and starvation. In another case, a woman was charged with deliberately burning the fingers of one of her little daughters, aged 8 years, by pushing her hand on to the bars of the fire-grate while the fire was burning, because the child had been guilty of some petty offence in helping her mother. The Ashford case weighed only twenty-four pounds, and was in a condition produced by protracted cruelty and starvation. In another case, a woman was charged with deliberately burning the fingers of one of her little daughters, aged 8 years, by pushing her hand on to the bars of the fire-grate while the fire was burning, because the child had been guilty of some petty offence in helping her mother. The Ashford case weighed only twenty-four pounds, and was in a condition produced by protracted cruelty and starvation. 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