CLINICAL RECORDS IN GENERAL PRACTICE

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A recent survey of general practice in South Africa[1] has brought to light the fact that in most of the practices visited, the keeping of clinical notes leaves much to be desired. Although the practices examined were not selected as a true random sample, there is no reason to suppose that the findings are not representative of general practice in this country as a whole. Of 11 city practices, 2 were found to have no facilities of any kind for general clinical records. One of these only keeps notes pertaining to antenatal consultations.

Of 9 practices in larger towns, 5 were found to be devoid of any record system, while in the small country towns the situation is even more hapless, with 7 out of the 10 practices visited being unable to produce clinical notes of any kind, not even records of antenatal attendances. Not a single practice was found where an attempt is made at keeping notes about work done outside the consulting rooms. All house visits, constituting about one-fifth of the work of the average GP, go completely unrecorded from a clinical point of view. There can, therefore, be no doubt that the matter requires urgent attention.

It is surprising how often the doctors who are guilty of neglect in this respect, excuse themselves on the grounds of being too busy to find the time to make notes about their work. Nevertheless, it was frequently pathetic to witness the desperate and time-consuming attempts of some of these doctors to discover even the most elementary facts about an old and respected patient without causing ill-feeling. Taylor[2] found the same in England and remarks: 'In the long run good notes speed up work rather than slow it down, for there is no need to take histories over and over again.'

The admittance of the importance of good clinical notes, is, however, only the first step. A record system which is practical as well as adequate must then be devised. In this paper an attempt will be made to describe such a suggested record system. Country-wide uniformity is not essential. In spite of attempts in this respect by the British National Health Service and the Nederlands Huisartsen Genootschap, it is found in practice that notes made by one doctor are seldom of much use to another. The short notes of general practice are usually too personal a matter to be of such general use. A short extract of the main facts on a record card in the form of a letter is far more practical when a patient changes doctors. My own experience with Railway Sick Fund cards sent to me even by meticulous RMOs, bears this out.

The problems of clinical notes in general practice may be classified under 3 headings:

1. Notes about consultations at the rooms;
2. Notes about house visits or other activities taking place outside the consulting rooms; and
3. The filing of specialist reports, laboratory reports and X-rays, etc.

1. NOTES ABOUT CONSULTATIONS AT THE ROOMS

Size and Type of Card Used

The traditional 4 × 6 in. card as advocated by the NHS or the Nederlands Huisartsen Genootschap as well as certain South African Benefit Societies, is to be condemned outright. The only possible advantage of this particular format is the saving of space when filing such cards. As it is to be expected that any reasonably organized general practice should have sufficient space available to accommodate larger filing cards, this advantage does not negate all the obvious objections to such a size.

One of the main disadvantages of these small cards is the cramming of notes, resulting in an illegible shambles. Another drawback, namely the impossibility of filing specialist reports, will be discussed later.

Folio-size cards are strongly to be recommended. Such cards allow sufficient space to make the cramming of the notes unnecessary, thereby making it possible to extract findings of previous individual consultations. A small space left between notes of successive consultations will also tend to facilitate subsequent perusal.

It is essential to use a separate card for every individual rather than haphazardly pooling the notes pertaining to one family on a single card. Such a confused mixture of notes precludes the chronological following of the progress of any one patient. With regard to the material to be used for these cards, it is less easy to be didactic. Ordinary foolscap writing paper is cheap and reasonably satisfactory, but it suffers from the disadvantage that it is not durable and any letters stapled to it tend to tear loose with repeated handling. In contrast to the ledgers of specialists, each card in a general practice is used regularly over many years and must, therefore, be of a material which will be able to withstand a reasonable amount of abuse. After careful consideration the Nederlands Huisartsen Genootschap has decided to print their 'working card' on special light green, durable cardboard.[3] The colour as well as the material was chosen after extensive experiments in actual practice.

Each card should have a heading which allows space for standard data in connection with the patient. Although the cards of a family will be kept in a file, it is still advisable to have sufficient data on individual cards to allow transfer to other ledgers, for instance, in the case of a daughter marrying, or to enable identification of a card which is accidentally misplaced.

It is suggested that the following data should be included: name, address, date of birth, phone number, Sick Fund number and name of nearest relative. As the address, telephone number and Sick Fund numbers are subject to variation, these can be in pencil to obviate untidy alterations.

Each family should receive a code number to prevent confusion between families with the same name and initial. It is then requested that these reference numbers be quoted by specialists and laboratories to prevent incorrect filing of incoming reports.

The Actual Notes

It is impractical and unnecessary to make any suggestions about the nature of the actual notes. Each doctor will gradually evolve his own system of abbreviations and these are seldom of any use to another practitioner. All that may be suggested is that the notes should, where possible, reflect the following particulars: (1) date, (2) main complaints, findings, etc., (3) diagnosis and (4) the prescribed treatment.

The use of a date stamp instead of hand-written dates results in greater ease when individual consultations have to be traced. Such stamped dates are also easier to count for statistical purposes. In my own practice, my nurse notes any services which she renders, and for this purpose she uses a different coloured ink on her inking pad and all her entries are, therefore, easily seen.

Items 2 and 3 need no further elucidation, except to mention the useful suggestion of Waldorf[4] to draw a 'box' round the diagnoses to facilitate the subsequent skimming of the notes. The need to write down the actual prescription must, however, be stressed. It so often happens that a patient requests a repeat of some particularly efficacious medicine while the poor doctor has to search his memory as to the exact nature of the prescription, often to no avail. A host of other aids are possible, e.g. underlining the date when the consultation results in referral to a specialist, etc. When a card is full (and preferably only one side is used) the new card is stapled to the front of the previous one. The history will, therefore, follow chronologically from the rear to the front. This means that the card in actual use will be at the top and easily accessible.

The Filing of Cards

It is advisable to keep the cards of a family in one file. This prevents confusion and at the same time ensures the ability to treat the family as a unit. Often consultations with different members of a family are interdependent as in the case of impetigo in more than one child. Sometimes one member of a family is asked to obtain a repeat prescription for another member during his own consultation. When the relative's card is immediately available, valuable time can be saved. The nature of the files in which the individual cards are kept, presents a few problems. Files provided with clamps which retain the loose cards are expensive and occupy too much space in the filing cabinet. The simplest form of fold-over cover is the most suitable, provided that they are filed with the open side to the top, otherwise the cards will fall out and accumulate at the bottom of the drawer. However, with the open side at the top, the number of leaves presenting are doubled and this will complicate the finding of any particular file. This objection can be avoided by cutting the rear page of the fold-over file about half an inch shorter than the front page. Thus only the longer front leaf will present in a closely-packed filing drawer. A filing cover with three leaves, where the third folds back to protect the contained cards, is another way of ensuring that cards will not be lost. This type of cover makes it impossible to attach riders to the file, as they will render it impossible to open the cover. The same objection holds for files with clamps which are then filed wi h the open end down. Only paste-on stickers can be used in these cases and this prevents them from being easily changed.

The cover can be printed so that it will present, after having been correctly completed, all relevant data about the family as a unit. Dr. H. P. Botha[5] also uses the cover for recording information pertaining to preventive medicine, for instance, vaccination histories, allergic tendencies, etc.

My experience with cards which are printed with an abundance of squares to be completed is that most busy practitioners will sooner or later fail to fill in all the expected data.

The incorrect filing of a folder, resulting in frustration and waste of valuable time, may be partially prevented by attaching stickers or riders to the top (that is the presenting open ends) of the folders in such a way that each letter of the alphabet will form a line of stickers. The edges of the folders need not be printed with the alphabet to facilitate this. A ruler can be made which can be held next to the folder as a template, in order to locate the exact required position of the rider. A misplaced card will stick out and be easily visible because its rider will be out of line. Admittedly this still does not prevent the misplacing of cards of the same letter of the alphabet, but such mistakes are more easily rectified.

Instead of using the alphabet as a filing index, each folder can be given a number. These numbers are noted in an alphabetical book against the name of the particular family. Families soon tend to remember their numbers, thus making frequent reference to the book unnecessary. Riders can still be used as explained above, to form lines in blocks of 50, or any suitable number.

For an average-sized general practice, 2 steel cabinets each with 4 drawers will be found ample to accommodate all the folders, provided 'dead' folders are removed regularly when patients change their doctor, or move to a different town.

2. NOTES OF ACTIVITIES TAKING PLACE OUTSIDE THE CONSULTING ROOMS

The problem of recording work done outside the consulting room presents considerable difficulty. I have only seen one practice where an attempt is made to keep regular notes of findings during house visits. This was in England, in a country village near London. The particular practice in question still retained the old custom of having the consulting rooms attached to the doctor's house. This made it possible to take cards along on visits, even if the calls were received after hours.

Even this doctor had to admit that his good habit sometimes breaks down when calls are received while he is on his rounds and he is, therefore, unable to return home to collect the particular card. In this country where it is becoming a rarity, even in rural areas, to find a practice with the consulting rooms attached to the house, the above system of having the card available at every, or most house calls, is obviously impractical. Only the cards of patients who placed calls during or before a consulting hour can be taken along on the rounds, but all calls received while the doctor is busy on his rounds, or after hours, will have to be attended to, without having the card at hand. The only practical solution is to make notes

in a pocket book and to rewrite these on the proper cards at some later stage. The great danger of this method is that the rewriting tends to be postponed until exact details of the findings are no longer clearly remembered. A receptionist can be taught to rewrite the notes, but this presupposes legible and accurate original notes. In such a case it would be best to write down only the bare essentials in a set form, for instance name, diagnosis, treatment and whether it was a night call, a hospital visit, or an ordinary house call. One doctor uses specially printed loose-leaf books for this purpose. However, one must face the fact that it requires constant self-discipline for the busy and often harrassed GP to keep such records consistently. This is borne out by the stated observation that no practice in this country seen for the purpose of the above-mentioned thesis had any notes available about house or hospital visits.

3. THE FILING OF SPECIALIST REPORTS

The filing of specialist and laboratory reports, and any other correspondence relating to particular patients is the third requirement of a successful record system. In this respect it can be stated summarily that no method other than the stapling of the reports to the actual history cards will give satisfactory results. However carefully or correctly reports are filed in a separate cabinet or box, they will not be constantly referred to, if extra effort is necessary to locate them during consultation.

Only when it is absolutely unavoidable will the doctor allow himself the time and effort to look up an old report. *Immediate* and *automatic* availability is the only way to ensure constant reappraisal of old reports. For this reason foolscap-sized cards are essential. Reports can then be stapled to the back of each card to form a chronological record of previous referrals, X-ray reports, etc. This enables the doctor to glance back at the old reports while the consultation is in progress and will often bring to light interesting facts which would otherwise have remained undiscovered. As an example may be mentioned the discovery that a patient presenting with blood and mucus in the stools had a barium enema or a laboratory examination for the same complaint, 10 or more years ago. Even the most impressive clinical memory will fail to guarantee such knowledge unless the old reports are automatically available.

The habit of attaching the report to the cards in a folded condition is to be condemned, as this also tends to prevent easy and immediate referral to previous examinations. This is one of the many drawbacks of smaller-sized cards. Few specialists will make use of stationery larger than foolscap.

SUMMARY

An attempt has been made to present a workable record system for general practice. That a dire need for revision and vigorous propaganda does indeed exist is proved by the fact that lamentably few doctors keep adequate records. The record system as described, is a compilation of methods and ideas observed in many practices both in this country and overseas.

During visits to other practices it has always been important to note that most over-ambitious schemes tend to fall into neglect and that the simplest practical system is the only one which will survive the hustle and bustle of general practice. It is useless to be naïve about the ability of most busy doctors to practise the rigid self-discipline required to keep an intricate record system up-to-date. The separate filing and, for all practical purposes, consequent disregard of old specialist reports, is a good illustration of this point.

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