letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk.

Medical Records and their Recorders

Editor – Your editorial (*Clin Med*, July/August 2003 pp 301–2) and the article by Mann and Williams[1] are timely. To a bacteriologist who many times had to analyse series of patients' notes the varieties or even absence of structure was an unnecessary burden. But who does the recording also matters. Over 50 years ago as a house physician puzzling over a patient, I referred to his notes from an admission twenty years earlier. They were beautifully and intelligently written. Their student author was Janet Vaughan, by then a distinguished haematologist.

As you say, chronic patients' records are particularly difficult. In the Rheumatic Unit at the Canadian Red Cross Memorial Hospital, Taplow, children with Still's disease remained in hospital for many months. Generally this would have meant an unwieldy mass of notes which, even if legible, needed weary searching for whatever nuggets they might contain. At Taplow the notes, rigidly controlled by Eric Bywaters, the unit director, consisted of semi-formalised information on a series of charts sellotaped into a long horizontal scroll. The senior registrar's job was to impose the Bywaters doctrine onto the daily practice of a series of house physicians. But finding data and following a patient's course was quick and easy.

More recently, when involved in an intensive surveillance of hospital-acquired infection,[2] I hoped that computerisation of notes would help. It did, but not much since every hospital had a different system. As Mann and Williams suggest, there is still a long way to go. Developing good systems is difficult but whether records are computerised or not, the following quotation[3] (from memory) applies,

'Easy reading's curst hard writing' –
Editors *Journal of General Microbiology*

'Easy writing's curst hard reading' –
Richard Brinsley Sheridan

References

1 Mann R, Williams J. Standards in medical record-keeping. *Clin Med* 2003; 3:329–32.
2 Glynn AA, Ward Valerie, Wilson J, Charlett A et al. Hospital-Acquired Infection: Surveillance Policies and Practice. London, Public Health Laboratory Service,1997 pp7 and 71.
3 Quotation printed on the cover of the Journal of General Microbiology for many years.

PROFESSOR ALAN GLYNN
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Editor – Belated congratulations to the authors of the paper on standards in medical record keeping (*Clin Med*, July/August 2003 pp 329–32) for highlighting a professional issue of fundamental importance.

After this, the fiction will no longer be a sustainable one that composing a clinic letter or a discharge summary is a mindless chore, and that neither of these two activities makes a contribution towards continuing professional development.

OMP JOLOBE
Retired Geriatrician

Investigating older people

Editor – Deciding when, whether and how far to investigate older people is becoming increasingly complex in the face of wide armamentarium of investigations available to modern day clinicians. In geriatric practice, we face this dilemma often. In this respect, the article by BJ Adler and DJ Stott (*Clin Med*, September/October 2003 pp 418–22) on how far to investigate to older people is helpful and thought provoking.

We have two concerns. Firstly, we question the usefulness of an algorithm in dealing with this complex problem.

Secondly, the algorithm appears to suggest that in patients not competent to consent to investigations, the clinical responsibility is transferred from the medical team to the next of kin. We agree that next of kin should be consulted and their views taken into account. However, we do not believe in withholding necessary investigations solely on the basis of disagreement with the next of kin. In such cases, the option of obtaining an independent second medical opinion may be useful.

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In response

We thank Drs Sivakumar and Tong for their interest in our article.

The algorithm that we provide is intended to emphasise key principles that may affect decision-making for investigation of older patients. We hope that it will reinforce the importance of careful selection of investigations in older patients with multiple pathology, the necessity of determining competency of patients to give consent for investigation, and the importance of discussing plans for investigation with next of kin or guardian if a patient is not competent to give consent. Neither in the algorithm nor in the text of the article do we suggest that clinical responsibility should be 'transferred' from the medical team to the next of kin. It is however imperative that their views be sought and taken into account in making any decision