Christian Heath

Preserving the consultation: medical record cards and professional conduct[1]

Abstract Professional medical practice in public institutions involves the systematic documentation of information concerning the transactions of organizational members and their clientele. In general practice (primary health care) as in other forms of medical work, record cards are maintained in which the details of patients' illness and its management are documented. These medical biographies provide the profession with a significant resource in their day-to-day dealings with their clients; the records inform decisions and generally play a crucial role in the organization of the consultations. To enable professional conduct to rely upon the records, a community of practices provides for the systematic documentation and comprehension of information. It is these practices which form the concern of the following brief essay.

Introduction

As Weber pointed out in his classic theory of bureaucracy, files and documents are an essential aspect of modern organization, both in the public sector and the 'advanced institutions of capitalism'. The modern medical organization is no exception; both time and money are devoted to documenting information concerning the duties and responsibilities of bureaucratic personnel. An example of such documents is medical record cards. As even the most cursory visit to a medical organization reveals, a great deal of energy is directed to recording aspects of the medical biography of patients. The concern of this brief essay is to examine some sociological features of records in medical life.

Over the past couple of decades there has been a growing sociological interest in files and documents as a feature of organizational activities. Studies both in the USA and the UK have revealed a rich collection of observations concerning the role of paper work as a feature of bureaucratic duty. For example, consider the studies collected in Wheeler (1970) or the pioneering work by Bittner and Garfinkel (1967). More recently in the UK there have been a number of studies explicitly examining the role of files and documents in medical settings, including Macintyre (1978), Raffel (1979) and Rees (1981). There are, of course,

Sociology of Health and Illness Vol. 4 No. 1 1982
 0141-9889/82/0401-0056 $1.50/1

important theoretic and analytic differences between the aforementioned studies.[2] However, for the purposes at hand, it is more significant to note that, in contrast to more traditional sociological concerns, in which documentary information is employed as a source of data for statistical analysis,[3] these studies have in diverse ways examined the relationships between files and documents and organizational activities. Within this vein the present study explores how general practitioners produce and understand the contents of medical record cards.

The medical record

Medical record cards consist in large part of descriptions of consultations;[4] each and every consultation warrants a description, a single entry in the records. The records are stored and made available to the doctor whenever he consults with a patient. If the patient moves to a different region and registers with a new general practitioner processes are set in motion to transfer the records to the new location. It is only the death of the patient which makes his records irrelevant and even then they are kept for a short time in case any contingencies arise to which the records might be of assistance. The importance of the descriptions lie, not just in the fact that they constitute a record, but because they are resources in the organization of professional conduct.

The following are examples of entries found in medical record cards.

28/9/75	c.	Vomited X 2 in night Maxolon 10 b.d. (300m)
9/1/74	v.	Pain now appears to be allright Chest X.R. Cert 1/52
12/1/76	c.	Died 12.30 a.m.
25/1/77	c.	'Sore throat' 'slight cough' Apsin 125 mg.
3/12/76	c.	Dog bite Rf --- Tetanus Toxoid 0.5 ml.
22/4/76	c.	Cold Flu also Rheumatism Cert 1/52 Paracetemol

At first glance the entries in a record seem brief, almost crude and we may wonder why so much trouble is devoted to their upkeep. Certainly, for social scientists and members of the medical profession who attempt to use the records for research purposes, many difficulties arise, not least the 'inconsistency of information' and the 'lack of detail'.[5] Furthermore, the contents are relatively impermeable to change. Even where

specific attempts are made to improve the quality of the descriptions in the records, such as providing larger folders, specific information sheets and summary pages, it is found the contents remain the same.

The difficulties encountered when using medical records, however, are largely found when they are addressed for purposes for which they were not intended. In actual consultations, during the course of day-to-day medical work, the contents of the records are frequently employed with no difficulty and generate little complaint. Reading and writing the descriptions found in the records is an integral part of conducting professional consultative activity; the descriptions are necessary for both the assessment and management of illness. Taylor (1954) went so far as to say:

> One has reached the conclusion that the key to good general practice is the keeping of good clinical records. Time and again one has seen a quick glance through a well-kept record card provide either the diagnosis or an essential point in treatment.

The following are a few examples of how the medical record cards are used by a doctor in consultation:[6]

Before beginning a discussion with a patient concerning the reason for a patient's visit, the doctor needs to discover whether the patient is visiting the doctor for the first time with a particular complaint or whether the patient has been asked to return to the doctor following a previous consultation. If the patient is returning, the doctor is expected to know why. By reading the records the doctor is able to discern whether the patient is returning and if so why. This allows him to design the topic-initiating utterance with respect to the particular characteristics of the patient.

The entries in the medical records stand as the 'factual' version of a patient's medical biography.[7] So on occasions in which the doctor wishes to discover 'what actually happened' in the past, the doctor turns to the medical records to gather the information. Patients cannot be expected to remember (or even have available) the exact and relevant details concerning their previous consultation with doctors. The medical records, however, are both exact and relevant.

The contents of the medical records can serve on occasions as a source of hints or confirmations. For example, a doctor may be puzzled as to the diagnosis of a complaint which he is investigating; a quick glance at the medical records may provide a hint as to the correct diagnosis. Or, on the other hand, a doctor may have a number of hypotheses concerning the diagnosis of a particular complaint and he may glance at the medical records to confirm one or the other. During a consultation the records may be employed to generate solutions where problems emerge.

In everyday professional practice the medical record cards are repeatedly used for these and many other purposes. The doctors rely upon the records; they expect them to contain certain sorts of information and to be adequate for the uses to which they are so frequently put. If for any reason the records fail to live up to their expectations, it may occasion complaint, even bitterness. At the health centre in which the study was conducted it was trainee general practitioners who often became the objects of such complaint. Their mistake, perhaps a result of their eagerness to please, was that they occasionally wrote too much, that they failed to recognize the economics of description. Learning to become a general practitioner involves learning to write adequate and suitable descriptions in the records.

Records are a bureaucratic phenomenon; they consist of the descriptions written by many doctors. Doctors need and employ their own descriptions and the descriptions of their colleagues. Since records follow patients, doctors regularly use descriptions produced by doctors with whom they are unfamiliar and personally unacquainted. This causes no difficulties, save perhaps the problem of deciphering a colleague's writing. The descriptions in the records are such that any doctor (at least any general practitioner) is able to retrieve the information required concerning past consultations. Thus, this process of description and retrieval necessarily requires a set of communal practices, practices which the descriptions are written are isomorphic with the ways in practices employed and followed by the doctors themselves.[8]

Describing and recognizing a description of a consultation are social actions like any other.[9] They require a methodology, a code of practice, which provides for how they are produced and understood. The ways in which the descriptions are written are isomophic with the ways in which they are read. The descriptions are written by and intelligible to a collection of persons. They are products of social actions, produced through an orientation to some set of practices by some category of persons, namely doctors. The aim of this essay is to illustrate these practices. It will focus on both general and local features of the descriptive process, and in this way it can be considered ethnographic.

The mapping of category items

Returning to the data, the actual entries in the records, we can begin to discern particular items which occur or are retrievable in a single entry.

29/2/75	c.	'feeling tired' depressed. Librium (30) (5 m.g.)

The first couple of items '29/2/75. c.' concern the occurrence of the consultation. The first is the date on which the consultation took place, the second refers to the location of the consultations ('c' stands for the consulting room and 'v.' refers to a visit to the patient's home'). Next we encounter 'feeling tired' and 'depressed'. Both items describe the complaint of the patient. The first item refers to the patient's version of his complaint; for doctors the 'subjective' version. The second refers to the doctor's assessment of the patient's complaint – 'depressed', the 'objective' version,[10] sometimes involving a diagnosis. Finally, the entry contains an item which refers to the management of the patient's complaint, in this one, details concerning a prescription – 'Librium (30) (5 m.g.)'. Other management items may include details concerning referrals and certificates.

We therefore confront classes of items in an entry in the records, the occasion of the consultation, the patient's complaint and the management of the patient. Within these classes there are categories of items, for example, the patient's version of his complaint and the doctor's assessment (crudely, symptoms and the diagnosis). The information which these classes and their constituent categories entail can regularly be found in an entry, a description of a consultation. This is not to say that each item of each category is specifically recorded, though it often is, rather it is to suggest that such information is retrievable in the description (if the relevant phenomena occurred in the consultation). I will return to this issue.

An aspect in producing and comprehending the contents of the medical records is the writer or reader's assumption that the entries are mapped in regular ways. There is a geography to the records. Entries not only follow one another in serial, sometimes sequential order, but are also internally ordered. As in the example above, the three classes follow on from each other, as do their component categories. Mapping the category items in this way allows the reader to understand the intended sense of the particular items and the entry as a whole.

Consider how we understand the entry in our example. 'Depressed' achieves its factual status as an assessment of the patient's complaint because it follows 'feeling tired' and precedes the category item for the management of the complaint (i.e. Librium (30) (5 m.g.). Were we to introduce an item following 'depressed' such as 'paranoid' and perhaps omit 'feeling tired', then 'depressed' would be understood as referring to the patient's version of his complaint. Actual items, such as 'depressed', 'paranoid', 'flu' and the like can be employed in various categories in various descriptions on a range of occasions. They do not have a fixed and determinate sense.[11] Rather their sense is generated in part through the ways in which they are mapped on the medical records and

organized with respect to the constituent items of the entry. Doctors produce their descriptions to enable them to be read in the ways intended. The geography of items is an essential feature of the production and recognition of the description.

In describing a consultation in the medical records and reading an entry doctors attend to a strict economy of items. The descriptions are brief, but more importantly, they avoid repetition and overlap. An adequate description of a consultation relies upon a stringent collection of items, gathered with an eye to a strict theme – a theme which can only be discovered if you read the collection of items as a 'whole'. The economy is achieved not through the mere mechanical use of a set of classes and their constituent categories, but rather as a result of the doctor's practical reasoning and sensitivity to the understandings of his colleagues. In describing a consultation the doctor gathers a collection of items with consideration as to how they will be understood. The doctor relies upon his colleagues reading into the descriptions what happened in the consultation; he triggers certain references and interpretations. The adequacy of a description of a consultation relies upon what is both recorded and retrievable in the description. Considering how it will be understood, a doctor can economize and manipulate the categories of items. To use H. L. A. Hart's (1958) term the doctor may 'defease' a particular category item assuming it will be inferred from other items in the description as a 'whole'.

Interclass defeasibility

The following examples may serve to elaborate the defeasibility of category items and the inferential work of a reader.

10/2/73	c.	Tonsillitis. Apsin (30) (250 m.g.)
14/3/74	c.	'fed up'.
13/2/73	c.	feeling sick. Depressed. Valium (15) (5 m.g.)

In the first example it may be observed that the doctor has not recorded any items which fall within the category the patient's presentation. Within the class 'patient's complaint' we find only the doctor's assessment of the complaint. However, any doctor on reading such an entry in the records could infer the relevant information concerning the patient's presentation. The doctor could warrantably assume that the patient had a sore throat and infected tonsils, given the assessment tonsillitis provided. Hence, though there are no details recorded by the

doctor who wrote the description concerning the symptoms of the patient, such information is retrievable by any doctor perusing the entry. It is therefore unnecessary for the doctor who wrote the entry to include a category item for the patient's presentation. He may defease the relevance, considering what any doctor could read into the actual description.

The second example is slightly different. The item recorded and its inverted commas allow us to understand that it is a summary of the patient's presentation of the complaint. The absence of a category item concerning either an assessment or a form of management would allow any doctor to infer that, given the normal inquiries, no serious evidence could be found to warrant an assessment or a particular treatment. Such an item, standing alone, would very likely lead doctors to assume that the patient's problem was trivial; it failed to warrant medical intervention. In other words, by absenting particular category items the doctor allows the reader to infer what he thought about the case. Again, the description of the item and the absence of other possible category items is carefully designed with consideration of what can be inferred.

In the final example we find an item recorded for both categories in the class the patient's complaint. Given what has been suggested concerning the inferential work of the reader one might wonder why the doctor bothered to record 'feeling sick'. However, the kinds of information a reader could infer from 'depressed', as an assessment of the patient's complaint, such as tired, moody, perhaps even tearful, would not include 'feeling sick'. Hence, by attending to the inferential work he might expect from a reader, the doctor describing the consultation would have to include 'feeling sick' if he wished it to be known.

In describing a consultation therefore a doctor is attentive to how his colleagues will read the description, the sorts of inference they will draw and the kinds of understanding they will generate. Doctors attribute to each other particular forms of knowledge concerning the meaning and sense of items in an entry. They expect the reader to be able to infer various characteristics and make the correct associations between the reported items. Without assuming that the reader has this knowledge and understanding, it would be pointless to describe the consultation in the way that it is.

In the data at hand it is general practitioners who are describing consultations for other general practitioners. In describing a consultation a general practitioner cannot assume that the future reader will be someone with whom he is familiar. Records follow patients, and any general practitioner may be faced with the task of deciphering the contents of the records. In describing a consultation, therefore, a general practitioner is attributing a form of knowledge and understanding to a

category of persons in society, namely 'general practitioners'. The descriptions in the records therefore are, to use an expression, coined by Sacks (1971), 'recipient designed'; where the recipient is taken to be a member of a category of persons. In this way we can begin to see how the descriptions produced for medical records have similar interactional characteristics to descriptions produced in other settings and through other mediums such as conversational interaction.

The description as a 'whole'

Defeasibility of category items may not only occur within a particular class but also across classes.

14/4/73	c.	'badly bruised'.	cert. 1/4. Brook Centre.
12/6/74	c.	'can't get up'.	Librium (30) (10 m.g.) r/f A.A.
2/11/72	c.	'tired and weepy'.	r/f G.C.

In the first example there is no explicit item referring to the doctor's assessment of the patient's problem. The quotation marks encapturing 'badly bruised' indicates that it is a quote from the patient rather than an assessment by the doctor.[12] However, hints as to the doctor's ideas concerning the patient may be inferred from an item he includes in the patient management class, namely 'Brook Centre'. The Brook Centre is a temporary shelter for women who have been battered by their husbands. The reference to Brook Centre provides a rich source of information for a reader assessing the doctor's thoughts on the patient's problem.[13] Very delicately, it also allows the doctor to avoid committing himself to claiming that the woman is being battered by her husband. The doctor provides information concerning an assessment of the patient's complaint without explicitly saying it.

The second example has no recorded item in the doctor's assessment category. However, finding Librium in the patient management class could provide the reader with the ability to infer that the doctor considered the patient to be depressed. A category item from one class is dropped because it is available in a category from another. The presence of 'Librium' also reveals that the doctor is treating the patient's complaint (for example, 'can't get up') seriously. Compare this to the instance mentioned earlier which recorded 'fed up' with no additional item. 'r/f A.A.' gives a new light to the entry on a whole. It signifies the doctor has recommended the patient to Alcoholics Anonymous.

Finally, the last example has similar elements to the one above. 'Tired and weepy' as a patient's symptoms might initially lead one to believe that the doctor considered the problem relatively unimportant, especially since there is no assessment, nor any prescribed treatment. The key to the entry however lies in 'r/f G.C.'. It is a referral to G.C. (a psychiatric social worker). This would allow a reader to understand that the doctor who wrote the entry considered the case serious enough for referral, and after making enquiries had deliberately avoided assessing or treating the patient.[14] In this way symptoms perhaps considered trivial alone are accorded a status they might not otherwise have.

The sense of an item in an entry therefore is related to the other items with which it occurs. The surrounding items to a component such as 'badly bruised' give the component its particular flavour in that context. Items are located and part of a framework of components each of which contributes to the overall sense of an entry and its component items. The sense of a particular item is thus contextual; it does not have a fixed and determinate meaning insensitive to time and space; rather, it is meaningful in context.

The contents of the records are employed for various purposes across many occasions. In reading the records the doctor will review the specific information which is relevant to his practical purposes on that particular occasion. The doctor elaborates the descriptions with some set of relevancies; relevancies which spring from the activity in which he is engaged. It is with respect to such occasional relevancies that the doctor will interpret the contents of the records. An entry and its component items therefore are rendered meaningful not only in terms of each other but also the occasional relevancies of the reader.[15]

A consultation is described, not by listing or checking off items, but rather by producing a coherent picture of the consultation as a whole. Category items are recorded with respect to each other. The components of an entry are collected with consideration to the impression they provide of the actual consultation. The doctor is concerned with providing an adequate and economic description. The description is not so much a precis of what happened but a sketch of some significant aspects of the consultation. The sketch is drawn through a few, short, sharp movements rather than detailed exposition. The consultation is drawn by interrelating the components in such a way as to achieve the intended pattern. A feature of both the descriptions of a consultation and the interpretation of an entry in the records is the doctor's reliance upon the contribution of items to the sense of the whole and vice versa. This process is not unlike the relationship of parts of the Gestalt contexture described by Gurwitsch (1964, p. 134).

> Between the parts or constituents of a Gestalt contexture there prevails the particular relationship of Gestalt coherence defined as the determining and conditioning of the constituents upon each other. In thoroughgoing reciprocity the constituents add to, and derive from one another, the functional significance which gives each one its qualification in a concrete case.

It may also be suggested that a description of a consultation and an understanding of an entry are produced through a sense of the relationship between the actual consultation and its representation. In describing the significant aspects of a consultation, the doctor attends to how the picture he is sketching stands for the real events as he encountered them. In the course of actually producing a description, the description is meaningful inasmuch as the doctor can relate it to the 'actual consultation'. Of course, his idea of the actual consultation at that specific moment is received through its relevance to the description.

In a similar way a reader, on encountering an entry in the records, does not only rely upon his sense of the interrelationship of items and occasional relevancies for generating the meaning of the entry, he also treats the entry as 'standing on behalf of' an actual consultation. In understanding an entry in the records, a doctor elaborates aspects of an actual consultation to make sense of the entry. The entry is seen as a 'representation' of a consultation; it provides the resources for the elaboration of the consultation itself. Simultaneously, a sense of the actual consultation features in the comprehension of its 'representation' in the records. Descriptions are understood as, and elaborated through, a sense of some underlying referent and vice versa. This process of understanding is discussed by Garfinkel (1967, p. 78) as the documentary method of interpretation:

> The method consists of treating an actual appearance as 'the document of', as 'pointing to', as 'standing on behalf of' a pre-supposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of 'what is known' about the underlying pattern. Each is used to elaborate the other.

Redocumenting an illness

The description of a consultation may not only be produced with consideration to overall impressions it gives but it may also be sensitive to the description(s) of preceding consultations.[16]

26/11/70	c.	conjunctivitis Albacid 10%

3/12/70	c.	eye now appears virtually normal Neospurin
10/6/74	c.	schizo cert. 4/52
6/7/74	c.	cert. 4/52
2/8/74	c.	cert. 4/52
12/4/75	c.	'weepy', tired depression. Valium 10 m.g. (30) cert. 1/52
19/4/75	c.	valium (10 m.g.) (30) cert. 1/52

Above there are three collections of examples, each collection gathering entries from a particular region in a patient's medical records. Given what has been said, consider the difficulty for a doctor confronting an entry such as the following.

3/1/71	c.	eye now appears virtually normal Neospurin

The entry contains an assessment of the progress of the patient's complaint, not an assessment of what the trouble is. Not knowing the original problem with the eye the doctor might find it difficult to comprehend what was going on. The treatment Neospurin provides some hints, but would leave the field open to blepharitis, styes and corneal ulcers, as well as conjunctivitis.

Descriptions such as 'eye now appears virtually normal. Neospurin', 'cert. 4/52', or 'valium 10 m.g. cert 1/52' might initially be thought inadequate. Category items can be found to be relevant, for example, the treatment indicates that an assessment was made, but the details are not included in the entry. The absence of particular category items in an entry serves to instruct the doctor to look elsewhere for the objects. On confronting such entries the reader would look to the prior entry(ies) to discern their relationship with each other. In the examples above the reader would turn to 'conjunctivitis. Albacid 10%', 'schizo cert. 4/52'. By turning back and considering former descriptions the doctor can find just the information he needs. Thus the machinery which provides for the occasional relevance of items, provides for their coherence and thereby instructs doctors as to where the relevant information may be discovered.

Illnesses often take a number of consultations, each consultation dealing with the development of the same problem. An example is the conjunctivitis in the first couple of entries above. Accordingly, in describing a consultation it is important for a doctor to provide the reader with the impression of the course of the illness and its related

consultations. It is also considered unnecessary to repeat the information which recurs in each subsequent consultation, for example, the diagnosis.

In describing a subsequent consultation the doctor designs the entry in consideration of the previous entry(ies) dealing with the particular complaint. It is by reviewing what is contained in the previous entry that the doctor can appropriately design the description of a subsequent consultation. The doctor can assess, with consideration of the typical recorded and retrievable items, the additional information which is required for the subsequent consultations. As in the first example, changes in the state of the complaint may be recorded, as will treatment details. Describing a subsequent consultation involves the careful balance of accuracy and detail, whilst simultaneously providing the reader with the necessity to turn back and elaborate the relevant previous entry(ies).

Doctors redocument illnesses. In a subsequent consultation they use the relevant entry(ies) in various ways to organize their consultation with the patient. Even generating the topic is dependent upon their appropriate reading of the records.[17] During the consultation the doctor produces the description of this consultation and, in so doing, redocuments the particular illness. The way in which the descriptions for a number of interrelated consultations are built provides the reader with the resources through which he can infer the sequential relationship between the consultations. A reader of the records, confronting interrelated descriptions, elaborates the whole course of a particular illness, its beginnings, its development and its outcome (if it is complete). A proper understanding of the descriptions and the illness can only be achieved by elaborating all the relevant descriptions. In other words, the descriptions are considered adequate, inasmuch as they are written and read as a 'whole'; a 'whole' which consists of a sequence of entries in the records.

Earlier it was mentioned that a description of a consultation was coherent inasmuch as it is treated as a whole; as a set of interrelated items each giving sense to the other and vice versa. In the earlier examples the framework of interpretation was the single description, the single consultation. In the case at hand, we discover a much broader interpretive framework, a sequence of consultations. The consultations are described, and the descriptions are only understood, with consideration to each other. Each item of entry contributes to the overall picture; the whole constitutes a varied collection of items and a number of entries. Each item and each entry contributes to the sense of the whole, just as the sense of the whole contributes to the meaning of the individual items and individual entries. The consultations and the illness are understood in this way; the descriptions are designed to elicit such an understanding.

Illness careers as common sense constructs

The idea that a collection of descriptions in the records are treated as representing a sequence of consultations and the development of a particular illness is not unrelated to the concept of career in sociological analysis. Following the pioneering work of Hughes (1956), the concept of career has permeated many sociological studies in the fields of occupations, medicine and deviance. For example, the classic studies of Becker (1963), Goffman (1961) and Strauss et al. (1964) all in various ways feature the concept of career. In its most simplistic sense the concept of career may be characterized as referring to the ways in which particular categories of persons (jazz musicians, mental patients, psychiatric staff, etc.) develop temporary shared understanding, engage in patterns of behaviour and encounter similar significant stages during the course of time. Much interest has been devoted to unearthing the sociological aspects of careers, for example, what constitutes a significant stage in the course of some career.

In medical sociology one focus of interest has been with the concept of illness career. Study has been devoted to discovering the behavioural pattern and significant stages of persons with particular forms of trouble, for example, cancer or polio. In examining the contents of records or analysing consultations, we find that doctors and patients also employ the concept of career in organizing their actions and making sense of the world. For example, consider the case of conjunctivitis in the entry above. The subsequent description in the records, approximately a week later, is meaningful inasmuch as it can be brought under the auspices of the typical career of conjunctivitis. After a week the patient returns for a check up and the eye is virtually clear. Doctors and patients associate particular patterns with particular illnesses; they assume particular illnesses follow particular paths or careers. Such devices allow doctors to discover related entries in the records: they allow him to discover a sequence of consultations concerning the same complaint.

To give another example, consider the instance concerned with depression:

12/4/75	c.	'weepy', tired. depression. Valium 10 m.g. (30) cert. 1/52
19/4/75	c.	Valium (10 m.g.) (30) cert. 1/52

Doctors would treat the two entries, the consultations to which they refer, as related. They would assume that the second consultation was dealing with the same illness as the first. They would understand that

the second consultation is a next stage in the course of the patient's illness. A doctor would also assume that further consultations about this particular complaint might take place. Were a doctor to interview the patient, say within a week of the last consultation, he would understand that the patient was returning about the depression and would design the consultation accordingly.

Change one number, say '19/4/75' to 19/4/76. No longer would a doctor on confronting the two entries consider the consultations concerned the same illness, even if the two entries remained in close juxtaposition. It is likely that a reader would consider that either the dates were incorrect or the doctor had failed to record the relevant details in the second instance. Separated by a year, no doctor confronting the two entries would consider them as part of the same trouble.[18] Furthermore, if the complaint had occurred a year later then it would have been presented in the records as a separate illness episode, with an assessment in the first entry and additional information in the subsequent entries.

The doctor's ability to bring the example under the auspices of a career of depression includes not only a conception of the temporal relevancies between particular stages of the illness, but also an idea of what those stages consist of. A crucial stage, both for the doctor and patient, is the first consultation concerning the particular complaint involving the assessment and proposed management. Subsequent stages involve checking the progress of the complaint and evaluating how it is reacting to treatment. Particular stages at specific temporal junctures involve different sorts of activities for those concerned with the illness. The depression and its associated career projects a set of expectations both for the doctor and the patient; expectations which, if fulfilled, are accomplished with respect to the concept itself. In assessing a complaint in a particular way, depression, tonsillitis, conjunctivitis or whatever, a doctor and a patient employ the associated illness career to organize their actions and activities. For example, the timing of the next consultation and what it involves can be organized in terms of the typical pattern associated with the particular complaint. The illness and its career is a device for organizing actions and activities and making sense of what occurs. In the same way, a doctor, reading the report of the illness in the records, can render the descriptions meaningful by bringing them under the auspices of the typical pattern and course associated with the illness. Thus the concept of career is a device employed by societal members for organizing their actions and activities and making sense of the world. It is an actor's concept fully attuned to the practicalities of everyday life.

The concept of career is employed within a sociological programme which treats the perspective of the actor, his meanings, definitions and

the like as a crucial concern in empirical analysis. Investigations as to the nature of careers, be they of an illness or a marijuana smoker, are concerned with discovering the (social) characteristics of the particular careers for some category of persons. Such investigations, starting with the best of intentions, often result in a stipulative exercise, the sociologist specifies the nature of the career – the shared understandings of the actors, and the stages through which persons pass, etc.

The concept of career therefore plays an important theoretical role in such investigations; it gathers together a disparate collection of instances and locates some common elements. However, as I have attempted to show, the concept is also an actor's concept employed in particular situations to organize and make sense of objects, actions and activities. The meaning of the concept is located by, and achieved in, the context of its use. It cannot be assumed to have a stable meaning through time and space. The stipulated characteristics of the concept are bound to run contrary to its particular sense in a particular context, such that the claim of 'coming to terms with the perspective of the actor' is rather dubious. Such investigations run roughshod over the delicate ways in which actors employ such concepts on actual occasions and furthermore, encounter the difficulty of warranting their particular version in competition with the interpretations of the actors.

As Bittner (1974, p. 70) suggests in discussing the concept of organization:

> The point at which the use of commonsense concepts becomes a transgression is where such concepts are expected to do the analytical work of theoretical concepts. When the actor is treated as a permanent auxiliary to the enterprise of sociological enquiry at the same time that he is the object of the enquiry, there arise ambiguities that defy clarification.

Summary

Medical record cards, like other forms of documents and files in modern organizations, constitute an anonymous and bureaucratic collection of details concerning the private lives of individuals in society. They consist of reports concerning the transactions between organizational officials and their clients. The reports are written and read in the actual interviews between personnel and their clients, in this case doctors and patients. Personnel use the reports in organizing various aspects of their interviews with a client. In the case of doctors and patients the very diagnosis and prognosis of a patient's complaint is, in various ways, produced through the use of the descriptions contained in the records.

Doctors, like personnel in other bureaucratic organizations, rely upon

the contents of their records. Without them they would be unable to conduct their professional consultative activities. The very ways in which their practical tasks are organized, from starting a topic to assessing a complaint, depend upon the availability of the descriptions in the records. If these descriptions were, as is sometimes suggested, inconsistent, irrelevant or ambiguous, they would be useless for the practical issues for which they are addressed. The descriptions have to be relevant; they have to be reliable; they have to contain particular types of information and they have to be comprehensive. Otherwise they may as well be shredded.

If the medical record cards are to be a useful and reliable source of information then there has to be a community of practices which provides for the factual and comprehensive nature of the entries. These practices include: classes and categories of items, a serial and sequential geography, the defeasibility of items, and orientation to the inferential work of the reader, a presumption of knowledge concerning medical matters and consultative activities; and, underlying all these aspects, the presupposition that these practices are common within the community of the profession.

Written descriptions, as found for example in medical record cards, can, like any other form of descriptive activity, be treated as a social action and thereby be subject to sociological investigations. Such descriptions fall under the auspices of the discipline inasmuch as the descriptions are the products of some set of practices and involve an orientation to the behaviour of others. Hence, what initially appears as a private and individual act, or one which generates anonymous and bureaucratic information, turns out to be an eminently social affair.

Revised version
received: January 1981
Accepted: March 1981

Department of Sociology
University of Surrey

Notes

1. I wish to express my gratitude to Pfizer Ltd and, more latterly, the (British) Social Science Research Council (grant no. HR/5148) who provided the funds for this research. I should also like to mention my very great debt to the late Emeritus Professor P. S. Byrne who provided every assistance to this research. On the academic side, I should like to thank Dr D. R. Watson of the University of Manchester for his extensive comments on an earlier draft of this work. The author is responsible for what remains.

The study was conducted at an urban, general practice, health centre. Data for the study were gathered over a two-year period through observation, interview, audio and audio-visual recordings. Approximately four thousand consul-

tations were observed, many of which were recorded. The author also had free access to the notes and documents in the health centre. A full report of the various works conducted during this period may be found in Heath, C. C. (1978). Clearly the project has a very great debt to all those personnel of the health centre who so freely gave their co-operation.

2. For example, one contrast is between those studies which fall within the 'interactionist' programme and those which fall within ethnomethodology. A discussion of these differences may be found in the article by Zimmerman and Weider in J. D. Douglas (1971).
3. Consider, for example, Durkheim's classic study of suicide rates. The source of the data in the study was the reports of various official agencies throughout Western Europe. For discussion of this issue and two very different analytic solutions see Douglas (1967) and Atkinson (1979).
4. The medical record cards in the practice under study were undergoing change during the work of this project. Originally the practice employed the standard envelope containing cards upon which were written the descriptions of consultations. The practice introduced an A4 sized folder which contained separate sheets including specific information sheets and summary pages. In both cases the descriptions were stored so as to enable the reader to encounter the most recent entry first and read backwards through the patient's medical history.

   It was believed that the change in format would improve the amount and quality of the information collected. It was hoped that the improved information would help primary health care and provide a more accurate collection of data for research. Sadly, though as I hope to show in the essay – not surprisingly, the format changed but the contents did not.
5. Clearly Bittner and Garfinkel's study (1967) discusses this issue. But it is also an issue which recurs not only in the sociological literature concerned with the use of documented information for quantitative research but also in the professional medical literature.
6. A detailed exposition of how the contents of medical record cards are used in the organization of professional consultative activity may be found in Heath (1978 and 1981).
7. See Zimmerman (1974) for an extensive discussion of the production and use of a factual version of a client's case in a public welfare agency.
8. I am drawing here, of course, on the writings within ethnomethodology, see, for example, Garfinkel (1956), Garfinkel and Sacks (1970) and Sacks (1963, 1966, 1972). A particular interest in this essay is to show how written descriptions, as in the medical records, reflect the procedures for describing or accounting found in other media of interaction such as natural conversation. The 'local' interest of this paper in medical record cards and general practice places it firmly within an ethnographic bag.
9. See Garfinkel (1956); Sacks (1963, 1966, 1972); Garfinkel and Sacks (1970).
10. Doctors and patients orientate to the subjective–objective contrast in investigating a complaint and making an assessment. The patient's symptoms are accorded the status of subject in contrast to the objective assessment of the doctor. In assessing or labelling illness, doctors orientate to, and encounter, meanings as a 'pre-existent cause of (their) action'. See Pollner's (1974) critique of Becker and labelling theory; see also Heath (1978).
11. Clearly items in an entry are indexical expressions. See Garfinkel (1967) and Garfinkel and Sacks (1970) for a discussion concerning the indexicality of expressions.

12. For a range of purposes, including: where there is an ambiguity as to whether an item will be read as a symptom or assessment; where the doctor wishes to cast scepticism over a particular object; or where he wants to emphasize the empirical basis of his finding, the doctor can employ inverted commas.
13. An interesting point raised by 'Brook Centre' turns on the relevance of local knowledge in reading and writing records. In other words, though the Brook Centre is known to the personnel of the health centre and locally, the doctor would not assume that a general practitioner in another area would know what it is. It perhaps further documents how the doctor who wrote this entry is avoiding a strong assessment of the patient's problem; this item is only relevant locally, so that if nothing comes of the referral, it wouldn't influence future readings by GPs in other areas; the item wouldn't be preserved.
14. The final instance in this example 'r./f. G.C.' is not dissimilar. In both cases one can see how the description is carefully selected with respect to how it will be read and the author's intention. In both cases the doctor provides enough information, but avoids commitment, allowing him to await the outcome of the referrals.
15. Consider the three examples given at the beginning of the essay and how each would influence the type of reading the doctor would conduct on the records. See Heath (1978 and 1981).
16. It is perhaps also feasible to suggest that a description may be produced with respect to possible future consultations and how they will be described. Consider, for example, waiting for the outcome of referrals mentioned earlier. I will not attempt to deal with this issue in any detail in this essay.
17. See Heath (1978 and 1981).
18. In fact depression and other psycho-social complaints are interesting in this respect. The more ambitious GP may well attempt to explore the underlying causes of the complaint. For example, in this way a different career would be involved, a career associated with 'marital breakdown' to enable the doctor to gather an array of otherwise unconnected phenomena under the same rubric. In the same way the descriptions remain organized in terms of the career or development of some trouble. In defining a trouble and invoking a career the doctor can retrospectively and prospectively bring an array of 'relevant' phenomena under its auspices.

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