Tranxene*
CLOPAZEPATE DIPOTASSIUM

Anxiolytic-sedative
For management of anxiety

CONTRAINDICATIONS:
Tranxene is contraindicated in patients with myasthenia gravis and with known hypersensitivity to the drug.

PRECAUTIONS: Use in the elderly. Elderly and debilitated patients, or those with organic brain syndrome, have been found to be prone to CNS depression after even low doses of benzodiazepines. Therefore, medication should be initiated in these patients with very low initial doses, and increments should be made gradually, depending on response of the patient, in order to avoid oversedation or neurological impairment.

Dependence liability. Tranxene should not be administered to individuals prone to drug abuse. Caution should be observed in patients who are considered to have potential for psychological dependence. Withdrawal symptoms similar to those occurring with this category of drugs have been observed after abrupt discontinuation of clorazepate. Insomnia, nervousness, irritability, muscle aches, diarrhea, tremor, and memory impairment were reported after abrupt withdrawal of large doses of Tranxene taken for prolonged periods.

Use in mental and emotional disorders. Benzodiazepines, such as Tranxene, are not recommended in the treatment of psychotic or severely depressed patients. It should be recognized that suicidal tendencies may be present, and that protective measures may be necessary. Since excitement and other paradoxical reactions may result from the use of the drug in psychotic patients, it should not be used in such patients suspected of having psychotic tendencies. Patients on Tranxene for prolonged periods should have blood counts and liver function tests periodically. The usual precautions in treating patients with impaired renal or hepatic function should also be observed.

Potentiation of drug effects. If Tranxene is to be combined with other drugs acting on the central nervous system, careful consideration should be given to the pharmacology of the agents to be employed. Animal experience indicates that Tranxene prolongs the sleeping time after intraperitoneal or subcutaneous pentobarbital, increases the inhibitory effects of chlorpromazine, but does not exhibit monoamine oxidase inhibition. Clinical studies have shown increased sedation with concurrent use of benzodiazepines. Combined use of the benzodiazepines may be potentiated by barbiturates, narcotics, phenothiazines, monoamine oxidase inhibitors, or other antidepressants.

Narrow angle glaucoma. Tranxene should be given with caution, if at all, to patients with acute narrow angle glaucoma.

WARNINGS: Tranxene is not recommended for use in depressive neuroses or in psychotic reactions. Because of the lack of sufficient clinical experience, Tranxene is not recommended for use in patients less than 18 years of age. Since Tranxene has a central nervous system depressant effect, patients should be advised against the simultaneous use of other CNS-depressant drugs and cautioned that the effects of alcohol may be increased. Patients on Tranxene should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating hazardous machinery including motor vehicles.

Use in pregnancy. Safety of use in pregnancy has not been established. Therefore, Tranxene is not recommended for use during pregnancy or lactation. The use of any drug in pregnancy, lactation, or in women of childbearing age requires that the potential benefit of the drug be weighed against its possible hazard to mother and child.

ADVERSE REACTIONS: The one side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genito-urinary complaints, irritability, dysarthria, depression, slurred speech, and hypotension. Abnormal hepatic and renal function tests and fall in hematocrit have been reported.

ADMINISTRATION: Orally. The usual daily dose is 7.5 mg t.i.d. or q.i.d. The dose should be adjusted gradually within the range of 15 to 60 mg daily in accordance with the response of the patient. In elderly or debilitated patients, the starting dose is 3.75 mg once or twice daily.

AVAILABILITY: Three dosage strengths, 3.75 mg, 7.5 mg (most frequently used), and 15 mg.

*T.M.

The BJS System: Recording and Retrieving Data for Family Medicine

MICHAEL BRENNAN, MD and LINDA SPANO, MHSc

SUMMARY
A new system of classification, registration and retrieval of patient data involving the use of an edge punched card, is described. The integration of physical, social and psychological data with necessary demographic information is an essential component of this system, which provides for simple and rapid retrievability. Retrieval of this information provides many opportunities for research and modification of patient care.

Dr. Brennan is an associate professor of family medicine at the University of Western Ontario. Ms. Spano, a former family practice nurse, is currently studying medicine at McMaster University.

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THE BJS SYSTEM of recording and retrieving of medical data for family practice was developed as part of the ongoing process of searching for a practical method of record-keeping in our discipline. We have attempted to maintain the key elements of brevity, simplicity, and low cost which always characterize good medical records. In addition to these elements the medical record should, as Treat1 suggests:

1. Allow rapid and accurate patient identification.
2. Facilitate recording and retrieval of data.
4. Permit rapid horizontal scanning.
5. Allow for meaningful review and audit by displaying data in a systematic manner and encouraging the recording of clinical reasoning.

We reviewed and modified other recording and classification systems2-13 for incorporation, where appropriate, into the BJS method.

The BJS system is named with its developers' initials (Brennan, Jackson, Spano) and combines registration of the practice population, indexing of chronic problems affecting each patient and ready retrievability of important demographic and health data. It employs an edge-punched index registration card specially designed for family practice. Early pilot projects demonstrated the need for improving the data-collection system in our practice — we needed record-keeping which is more 'process' than episode-oriented, more 'problem' than disease-oriented and more 'person' than problem-oriented.

The system consists of four major and integrated components as shown below.

Intake and Data Base
Two of the primary distinguishing differences between family practice and other disciplines are the long-term and continuous doctor/patient relationships and the physician's availability for the widest range of health problems presented by his patients.14

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CAN. FAM. PHYSICIAN 22:1064 SEPTEMBER, 1976
These differences dictate the contract established by patient and physician. In the past this contract has usually been informal and implicit; we recommend that a more formal and clearly explicit approach be taken from the initial contact and reinforced throughout the life of the relationship. Toward this end we have developed an intake format sheet (Fig. 1) and a set of guidelines for intake history and physical assessment (Fig. 2). These forms are printed on each side of a single sheet which is placed in the record folder. Years of trial and error with numerous printed forms have convinced us that up to this time no single assessment form or health questionnaire has been developed which can serve better than an individually taken history, and a physical examination appropriate for that patient's age, sex and health status. For that reason we use the guidelines to provide the structure from which we write or dictate the intake history and physical assessment for our primary data base. The intake format sheet is completed by the practice nurse, who ensures that the intake process is adequately negotiated. While our sheet is designed for this teaching service, it can be adapted to private practice.

The patients' data are obtained from two major sources: the patient and/or his family through appropriate interviews and physical examination, and retrieval of past records from all or any available sources of previous care. We use a standard record release form for this purpose. In this way a comprehensive body of data is compiled which serves not only to illustrate past health history but obviates the necessity to repeat previously conducted investigations which may be expensive, unnecessary and/or dangerous. Retrieval of past data also clarifies gaps in the patient's memory and/or perceptions.

The Progress Notes
During and following the intake assessment a list of problems is compiled which may be temporary, long-term or both. Temporary problems are assigned a specific number in the progress notes until they either resolve or become classifiable as long-term. In the latter situation, the problem(s) are listed on the major problem list, referred to below.

Our method of writing progress notes is to use a three column sheet. In column 1 go the date, diagnosis, and

<table>
<thead>
<tr>
<th>Previous source(s) of care:</th>
<th>Data Rec'd</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y  N</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
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<tr>
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<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

The Intake Format Completed on_______Date BJS Completed______

Y = Yes  N = No  N/A = Not applicable

Fig. 1. Intake Format

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Origin contact:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Data Rec'd</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Hospitalizations:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td></td>
<td></td>
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<tr>
<td>5</td>
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<td>7</td>
<td></td>
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<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An Intake Format Completed on_______Date BJS Completed______

Y = Yes  N = No  N/A = Not applicable

<table>
<thead>
<tr>
<th>Explain teaching aspect/viewing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developemental milestones</td>
</tr>
<tr>
<td>Immunization status assessed</td>
</tr>
<tr>
<td>Rubella immune</td>
</tr>
<tr>
<td>History &amp; physical done</td>
</tr>
<tr>
<td>Vision</td>
</tr>
<tr>
<td>Hearing</td>
</tr>
<tr>
<td>Height</td>
</tr>
<tr>
<td>Weight</td>
</tr>
<tr>
<td>Blood pressure</td>
</tr>
<tr>
<td>Birth control status</td>
</tr>
<tr>
<td>PV</td>
</tr>
<tr>
<td>Pap</td>
</tr>
<tr>
<td>GC swabs</td>
</tr>
<tr>
<td>Urine</td>
</tr>
<tr>
<td>Hemoglobin</td>
</tr>
<tr>
<td>VDRL</td>
</tr>
<tr>
<td>Tine test</td>
</tr>
<tr>
<td>Chest X-ray</td>
</tr>
<tr>
<td>ECG</td>
</tr>
<tr>
<td>Blood sugar</td>
</tr>
<tr>
<td>Diet</td>
</tr>
</tbody>
</table>

Comments:

This Intake Format Completed on_______Date BJS Completed______

Y = Yes  N = No  N/A = Not applicable
fee. Columns 2 and 3 record the visit using the problem oriented approach and the SOAP format (Subjective findings, Objective findings, Assessment, Plan of management).

Problem Listing and Classification

The major or long-term problem list is attached to the front of the chart folder. It records the date, problem number, date of onset, problem label and the date resolved. We define a chronic health problem as "any disturbance of, or threat to, health homeostasis which is identified as a problem by the health professional and/or the patient, and which continues, or is likely to continue for a period of not less than three months."15

Items such as previous major surgical procedures and long-term treatments and medications are also listed here, under the headings of problem number, date of onset, long term medication or treatment, date stopped.

The development of the International Classification of Health Problems in Primary Care (ICHPPC) has been a significant advance in the organization of our nomenclature. In the BJS system we base our classification (and correlate it) with the ICHPPC but use the BJS item numbers on the problem list and in the progress notes.

For temporary problems in the progress notes we insert the letter A in front of the appropriate number to indicate that the problem is acute, or short-term. In this way we are able to link problems and follow their progress through the record. If a temporary problem progresses to chronicity, we drop the A in the progress note, list that problem on the major problem list and note the BJS card in the appropriate place.

In developing the card we had to define broadly a number of terms which, though commonly used, are vaguely and variously interpreted. These definitions are available in the BJS book.15

The BJS Card

The essential unit of the system proposed is the BJS card, a specially printed McBee Keysort card which carries a profile of each active patient in the practice (Fig. 3). Register cards double as a practice index. In addition to the standard information which identifies the patient by name.

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**Fig. 2. Guidelines for Intake History & Physical Examination**

Name ___________________________ DOB _______ DOE _______

**SUBJECTIVE:**

Presenting complaints: all symptoms, conditions, subjective complaints with duration, treatments and response to treatment.

Past history: significant childhood diseases, hospitalizations, surgery, trauma, etc.

Family history: position in sibship; family health including parents' health status or causes of death; familial disease trends, especially history of epilepsy, mental illness or retardation, diabetes, cardiovascular or respiratory disease, malignancy, atopy; developmental data (family of origin).

Social history: occupation, marital status, home situation, relatives, friends and significant relationships, self-image, sexual activity, degree of satisfaction, number of children, financial situation, social development, education, recreation.

Risk factors: alcohol, tobacco, drugs, obesity, immunizations, occupational hazards.

Functional enquiry (FE)

1. Allergies, current medications
2. General (patient's perception of own health state, energy, weight)
3. Systems, as appropriate, positive, or significant negative
4. Conception control (males & females)

**All females of childbearing age:**

<table>
<thead>
<tr>
<th>GP A</th>
<th>LMP</th>
<th>LNMP</th>
</tr>
</thead>
</table>

**Menstrual Formula:**

<table>
<thead>
<tr>
<th>Laboratory</th>
<th>cycle</th>
<th>duration</th>
<th>amount</th>
<th>problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>menarche</td>
<td>cycle</td>
<td>duration</td>
<td>amount</td>
<td>problems</td>
</tr>
<tr>
<td>days</td>
<td>days</td>
<td>(pads or tampons)</td>
<td>(pain, spotting)</td>
<td></td>
</tr>
</tbody>
</table>

G (gravidity) number of pregnancies (multiple gestation counted as one pregnancy)

P (parity) state of having given birth to an infant, ALIVE or DEAD, weighing 500 g or more (when weight unknown, estimated gestational age > 20 weeks from start of LMP)

LMP – last menstrual period AB – abortion (spontaneous or induced)

LNMP – last normal menstrual period BC – birth control

**OBJECTIVE:**


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**Abbreviations**

PV – Per Vaginum (pelvic examination)

neg. GP – negative for glucose & protein

NAD – no abnormality detected

VA – visual acuity

PERLA – pupils equal and reactive to light & accommodation

EOMs – extra-ocular movements

TM – tympanic membrane

IPPA – inspection, palpation, percussion, auscultation

DTRs – deep tendon reflexes

ROM – range of motion

1/7 = one day; 1/52 = one week; 1/12 = one month

1/24 = one hour; 1/60 = one minute

↑ = Increased; ↓ = Decreased

**ASSESSMENT:** Use BJS numerical labels; LIST ALL PROBLEMS, acute and chronic. List medications which are, or are likely to be, long term (e.g. dig., insulin).

**PLAN (MANAGEMENT):** Date of next visit. All medications (doses, amounts). All investigations, referrals, therapeutic approaches. Reminder of further plans (e.g. 2 hr. PC, BS if glycosuria next visit).
address, health insurance number etc., specific features of demographic or medical significance are indicated by an edge-punch. Information available for review and retrieval includes:

1. Date of birth
2. Sex
3. Marital status
4. Living situation
5. Religion
6. Social position – Blishen scale
7. Risk factors – e.g. smoking, alcohol or drug abuse
8. Chronic and recurrent symptoms – without evidence of, or relationship to, organic disease
9. Significant history
10. Chronic organic problems
11. Psychosocial problems
12. Longterm medications
13. Birth control
14. Primary immunization
15. Disability status – a four point scale is used
16. Significant family history

A few blanks allow the practitioner to record items of special interest. Some common organic problems have been identified separately from the general system under which they fall e.g. No. 71 – Hypertension (see Fig. 3).

Although information carried by the BJS profile card may be analyzed by computer, active patient information is immediately accessible. When a physician wants to identify all patients of his practice for whom a given common factor exists, he simply inserts a metal needle through the appropriate punch hole for a batch of cards. All those which have been edge punched at that particular hole will then fall out of the batch. It is a simple further step to investigate which patients of that sub-group are comparable on other parameters registered. If a problem list is maintained, the coding can be done by a well-trained office nurse and/or receptionist who consults with the physician when necessary.

Implementation of the BJS System can be a gradual process initiated by the receptionist who prepares the cards for patients as they present for service. It remains then for the physician to complete the profile by any method he chooses.

Subcodes

The card includes a number of subcodes which further define the database. These are listed in Fig. 4. If, for example, the physician wishes to review all of his patients who have, or have had, neoplastic disease, he may ‘needle’ hole number 83 which will allow all cards notched at this hole to fall out of the pack. Of these, he may further review which of the neoplasms are benign or malignant as indicated by the adjacent boxes numbered 1 and 2 (see Fig. 3). In order to obtain this information he must, of course, hand sort these particular cards. In addition to identifying patients with neoplastic disease he can further identify the body system affected by that disease if the N (for neoplasm) in the MICIDAN subcode has been penciled in adjacent to the identified body system which is also noted.

Commonly occurring problems have also been included by numbered subcodes e.g. Box No. 1 in column 66 (Endocrine and Metabolic) indicates diabetes mellitus.

The subcodes for Psychosocial Problems are adapted from McWhinney’s Taxonomy, and are elaborated in the book which fully describes the system.

Reverse Side of Card

The reverse side of the register card has been printed with the headings date, complaint(s), problem(s), label(s), management and place of service, to facilitate its use as a summary of each service rendered to the patient. This can be completed by the receptionist,
from the clinician’s record, at the time of billing. It serves several purposes but is primarily a method of rapidly reviewing the episodes and process of the patient’s care.

This visit list is optional. In some instances, frequent attendance may dictate that new profile cards be started for a small group of patients whose cards are filled before their scheduled retirement. Early retirement of cards poses no particular problem. Such cards may be back-filed in a container for retired cards and reviewed at the physician’s leisure.

A simple, brief code for recording episodic visits is proposed in the BJS book. Information about why patients change their physicians may be of particular value to some family physicians. This information, where available, may be entered on the back of the card, allowing the physician to examine practice attrition against demographic, psychosocial, organic and other data. In addition, causes of death for later analysis of mortality data in his practice may be recorded here.

**Updating and Replacement**

If the BJS card is routinely presented with the patient’s chart at each visit, updating is simple. Adding data simply means a new notch; deletions of data are possible with repair tabs.

A ‘retirement schedule’ of cards offers the clinician two advantages.

---

**Fig. 4 Reference for Abbreviations and Sub Codes**

<table>
<thead>
<tr>
<th>Date of Birth (30-38)</th>
<th>Tens</th>
<th>Units</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.</td>
<td>1</td>
<td>30.</td>
<td>1</td>
</tr>
<tr>
<td>35.</td>
<td>2</td>
<td>31.</td>
<td>2</td>
</tr>
<tr>
<td>36.</td>
<td>4</td>
<td>32.</td>
<td>4</td>
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<tr>
<td>37.</td>
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<td>33.</td>
<td>7</td>
</tr>
<tr>
<td>38.</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Code last two digits of date of birth. Select appropriate number (0, 2, 3, 4, 7) or two numbers whose sum is equivalent to that required.

<table>
<thead>
<tr>
<th>Date</th>
<th>Tens</th>
<th>Units</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1934</td>
<td>1+2</td>
<td>4</td>
<td>30, 31, 36</td>
</tr>
<tr>
<td>1906</td>
<td>0</td>
<td>4+2</td>
<td>30, 30, 32</td>
</tr>
<tr>
<td>1972</td>
<td>7</td>
<td>2</td>
<td>37, 31</td>
</tr>
<tr>
<td>1940</td>
<td>4</td>
<td>36</td>
<td>35, 36, 31, 33</td>
</tr>
</tbody>
</table>

39. Other than Canada

1. 2. 3. Ad lib
4. 5.

40. Disability

1. slight (some limitation of
2. (usual activity for
3. age-sex)
4. severe limitation
5. non-physical disability

41. Primary Immunization

1. First DPT & P
2. Second DPT & P
3. Third DPT & P
M Measles-Rubells (+ mumps)
B Booster DPT & P

42. Birth Control

1 Intrauterine device
O Other effective method

Psychosocial Problems (59-63)

For each problem (59-63 inclusive)

Check any which apply to problem situation

L – Loss M – Maladjustment
LA – Lack I – Isolation
C – Conflict F – Failure
CH – Change

**Other Health Professionals**

57. Physician
58. Non-physician
59. Other

**Chronic Organic Problems (66-89)**

66. Endocrine & Metabolic
1. Diabetes
2. Other disorders of glucose tolerance
3. Thyroid

68. Nervous System
1. Epileptiform
2. CVA

74. COPD – Chronic obstructive pulmonary disease

75. Digestive
1. Peptic ulcer
2. Hiatus hernia
3. Ulcerative colitis

80. Arthritis
1. Osteoarthritis
2. Rheumatoid arthritis

83. Neoplasm
1. Malignant
2. Benign

89. Therapeutic
1. Peptic ulcer surgery, including gastrectomy, vagotomy, pyloroplast,
2. Hiatus hernia repair

98. Major gynecological surgery
1. Hysterectomy
2. Oophorectomy
3. Laparotomy

99. Major Surgical Procedures
1. One
2. Two
3. Three
4. Four or more

100. Hospital Admissions
1. One
2. Two
3. Three
4. Four or more

Social Position (101-107)

Blishen Occupational Scale based on average education/income.

**ALPHA-CODE**

**FAMILY NAME (108-114)**

Code First Letter of Patient’s Last Name

<table>
<thead>
<tr>
<th>Code</th>
<th>a-1</th>
<th>b-2</th>
<th>c-3</th>
<th>d-4</th>
<th>e-5</th>
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<td>f-6</td>
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<td>j-9</td>
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40

CAN. FAM. PHYSICIAN 22:1072 SEPTEMBER, 1976
Firstly, the life of any register card, with frequent usage, seldom extends much beyond five years without becoming dog-eared and damaged. Secondly, regular replacement allows the practitioner to compare changes in the problems, both of individuals and of the practice, at specific intervals. Within each period, deletions are evident by repair tabs and the recorder has the option of dating additions, deletions or other data on the reverse of the profile card. We recommend that each card be retired after no more than three years of use to minimize wear, standardize review procedures and maximize efficient use.

Retired cards are filed separately and constitute a permanent summary of patients and their long term problems.

Uses of the BJS Card

The range of usefulness for medical records is expanded greatly with the addition of the BJS index card. Generally, its potential as a tool for monitoring preventive and regular care is of particular importance, since a description of the patient's visits and their outcome are immediately retrievable. More specifically the uses of the BJS system can be categorized under five areas.

Provision of preventive or regular medical care

1. Patients with common problems who would benefit from group discussion are readily identified, e.g. diabetic patients may be offered a planned review of diet by a nutritionist invited to the practice for this purpose at given intervals.
2. Patients with specific problems can be referred to new programs and new resource people as these become available, e.g. physicians can help their patients take advantage of changes in government benefits. In Canada patients over 65 years of age and on long-term medications now qualify for subsidy. Candidates for this benefit can be quickly identified, recalled and advised. New prescriptions can be issued if necessary.
3. Recall for patients with chronic problems who have not initiated follow-up contact.
4. Recall for patients who have failed to pursue preventive measures such as primary immunization.
5. Recall of high-risk, chronically ill patients for 'flu' immunization.
6. Identification of patients (during a routine visit) who have special risk situation, e.g. no birth control in sexually active patients.

7. Recall of patients who have not initiated visits to monitor therapies for continuing problems, e.g. pap smear for women with suspicious or abnormal histology of cervix.

Changing therapies

Therapeutic innovation can be applied to particular problems as new modalities become available, e.g. if a pharmacological agent is developed which arrests specific kinds of malignant growth, patients who would benefit can be readily selected from the register.

Research

Ready retrievability of patient data through the BJS card and if necessary from the records offers a wide range of research possibilities for the practicing physician. Some examples are:
1. The demographic makeup of his practice.
2. Prevalence of organic or non-organic problems.
3. Effectiveness and or side-effects of long term drug therapies.
4. Relationship of organic to non-organic problems.
5. Primary immunization rates in family practice.
6. Outcome of treatment of specific health problems.
7. Socioeconomic concomitants of health and illness.
8. Effectiveness of preventive measures.
10. Delivery and utilization of health services.

If data from different physicians are combined, this could provide a wealth of information on prevailing health status of larger population groups.

Continuing education for physicians and allied health professionals

The BJS card's potential for retrievability of data makes it a valuable tool for physicians who wish to examine particular aspects of their clinical experience.

Other Uses

A number of uses not initially envisioned as part of the purpose of establishing such a register have emerged:
1. Problem listing serves as a guide to those responsible for handling billing diagnoses. Patients attending for the routine supervision of a chronic problem, e.g. arthritis, become known to the receptionist through the BJS profile. She can then complete medical insurance billing cards with the appropriate problem label without the assistance of the physician.

2. Budget planning may be assisted by information available from the register. Social position, age/sex composition, stability and problem prevalence in the practice are examples of characteristics which affect patterns of use of primary care services. Thus, actuarial experience-rating is more readily applicable to particular practices.

3. The patient profile card provides a concise summary of the patient's status when record exchange becomes necessary. The profile card itself could be copied and forwarded as the essential ingredient of such communication.

4. Perhaps the most positive of these uses has been the increased attention of conditions highlighted through use of the card. Associations anticipated or revealed by the data can help determine the focus of his interaction with patients. A profile of his patients and practice stimulates the physician's interest in the care he provides.

Acknowledgements

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BJS cards and the necessary equipment, including a copy of the descriptive book, are available from Mrs. Claude Buffett, Administrator, Victoria Family Medical Centre, 520 Hamilton Road, London, Ontario NSZ 1S4. The cost of all the materials, including cards, is approximately five cents per patient.

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Behavioral Effects: agitation, restlessness, excitement, activation of psychotic symptoms and toxic confusional state. Anticholinergic effects: dryness, blurred vision, constipation, and genito-urinary disorders.

Central Nervous System Effects: drowsiness, insomnia, extrapyramidal symptoms. Cardiovascular Effects: dizziness, hypotension, tachycardia. Miscellaneous: fatigue, weight gain, increased sweating and other secretory effects, nausea, heartburn, rash and pruritus, paresthesia, edema, flushing, chills, tin-nitus, photophobia, decreased libido.

Dosage and Administration
An optimum dosage of Sinequan depends on the condition which is being treated and the response of the individual. Some patients respond promptly; others may not respond for 2 or 3 weeks. An initial dosage of 25 mg t.i.d. is recommended in most patients. This dosage should be increased as required by 25 mg increments at appropriate intervals until a therapeutic response is obtained. The usual optimum dosage range is 100-150 mg per day. In some patients, up to 300 mg per day may be required, but there is rarely any benefit to be obtained by increasing this dosage.

In elderly patients it is advisable to proceed more cautiously with dosage increments and to initiate treatment with a lower dosage. Once a satisfactory therapeutic response has been obtained, it is generally possible to reduce the dosage and maintain this effect.

For maintenance therapy in depressed patients, the total daily dosage, up to 150 mg, may be given on a once-a-day schedule. This dosage should be estimated as described above and should preferably be given at bedtime.

Oral Concentrate: SINEQUAN Oral Concentrate is available in 120 ml bottles with an accompanying dropper cap, containing 10 mg, 15 mg, 20 mg, and 25 mg. Each ml contains doxepin HCl equivalent to 10 mg doxepin. SINEQUAN Oral Concentrate should be diluted with water or suitable juices just prior to administration. Preparation and storage in bulk dilutions is not recommended.

Dosage Forms
SINEQUAN Capsules contain doxepin hydrochloride equivalent to 10, 25, 50 and 100 mg of doxepin in bottles of 100 and 500.

SINEQUAN Oral Concentrate is available in bottles of 120 ml. Each ml of SINEQUAN Oral Concentrate contains doxepin hydrochloride equivalent to 10 mg of doxepin.

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