Medical records and public policy: the discursive (re)construction of the patient in Europe

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‘...I think perhaps there can be a way of telling the surface story so that the background claim is made. One wants a specificity as to precisely the way in which the world is anarchic. If one could get that right, the telling it the way it is, which is what Elmore Leonard does, it would have this kind of resonance to it. That's what I’d like to do. But you don't get there just by talking about it and I don't feel equipped at the moment.’

Introduction

The origins of this paper lie in the cross-national study of health policy. A couple of years ago, I finished a comparative study of health politics in Europe (Freeman 2000) with some relief, but also with a some residual frustration. The book does what that kind of book might be expected to do: it talks about the specificity and salience of health politics; it describes different kinds of health systems and then compares them, one with another; it assesses recent reform, considers the changing relationship between the medical profession and the state and analyses new initiatives in public health.

The sources of frustration, predictably (and probably rightly), were several. A chapter on patients - the users of health care - had been by far the most difficult to write; I felt, and still feel, that I hadn't quite 'got it', or even really come very close. I sensed, too, that various projects for system-wide reform of health care in different countries had been exhausted. The set-piece naval engagements of the 'crisis' period - roughly 1985-1995 - had been won and lost, and just as often avoided. Critical issues had slipped below the surface; the interesting things were going on in a different, submarine world. More generally, having spent a long time studying health policy in European countries, I couldn't answer the common sense questions about health care which my peers and others evidently expected me to be able to: 'What's it like in (say) Andorra? What happens when you go to the doctor there?' That is to say that, for all the systemic differences I knew about in the arrangements for the finance, delivery and regulation of health care in different countries, what difference did any of them make?

What I've been looking for, to be brief, is a bit more verstehen. I wanted to enter the different assumptive worlds of health policy actors in different countries, to capture the meanings which shape and frame what they (think they) do. I wanted to begin to write what might be described as a phenomenology of the health care state. This, of course, entailed working with a different purpose and a different methodology.


2For a fuller statement of this position, see Freeman (1999a). I have taken inspiration from recent developments in comparative studies of welfare which privilege a qualitative, micro-level sociology and, in so doing, pay a new attention to biographical and subjective experience (Bolderson and Mabbett 1997, Chamberlayne, Cooper, Freeman and Rustin 1999, Chamberlayne and Rustin 1999,
Meaning must inhere in local, system-specific vocabularies, but also in non-verbal cues such as in dress, in architecture, in technology: not just in the words but in the typeface in which they are set. I take it as axiomatic that these things are signs, which is to say that they have meaning as well as function, that they are expressive as well as performative. I take it as axiomatic, too, that they refer to and reinforce each other: they are mutually constitutive: they work as a 'language' or system. This is why I use the term discourse to describe what it is I want to represent.

Methodologically speaking, I take discourse to be neither a dependent nor an independent variable: it's not my intention here to explain it, or to explain anything by it. I want simply to define or delineate it: it is in itself an account of 'what it's really like' or, perhaps more accurately, 'what's really going on'. This is also why the paper is comparative. There are two logics at play in any comparative research design. One is that of experimentation and the control of variables, of hypothesis testing and explanation. The other, which is mine here, is that of exploration and description, of illustration and definition. Comparison makes it possible to identify a phenomenon by seeing it repeated in a different context, or to understand what it is by learning about what it is not.  

A discourse cannot be captured as a whole. I focus here on an artefact, the medical record. It is meant as a probe, a critical indicator, an entry-point into a whole world of behaviours, assumptions and practices. The point is that the detail is somehow constitutive of regime: it embraces both macro and micro and is a vital way of connecting the two.  

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3A model in medical sociology is Philip Strong's account of conducting research in the US as well as the UK in order to understand The Ceremonial Order of the Clinic (Strong 1988; Strong 1979). Cross-national comparison was done in response to the problem of 'how to notice significant absences, how to discover what might have been there but instead was systematically excluded?' (1988, p 235).

4A rich and powerful social science has been built on similar foundations. Benjamin's (1999) study of the Parisian arcades is perhaps the seminal work in the field of cultural studies; Ritzer (1996) takes McDonald's and du Gay et al (1997) the Sony Walkman as paradigms or essences of wide-ranging and multidimensional social processes. Comparable examples in political science include Torpey's recent (2000) account of the passport, and Wildavsky's classic (1964, 1986) use of budgets: 'Public policymaking is epitomized through the budget... When a process involves power, authority, culture, consensus, and conflict, it captures a great deal of national political life' (Wildavsky 1986, p 2). Titmuss, similarly, used blood donation to explore different worlds of welfare (Titmuss 1970). A classic statement among studies of technology and society is Winner (1980): his example of the tomato harvester is 'not merely the symbol of a social order that rewards some while punishing others; it is in a true sense an embodiment of that order... The issues that divide or unite people in society are settled not only in the institutions and practices of politics proper, but also, and less obviously, in tangible arrangements of steel and concrete, wires and transistors, nuts and bolts' (Winner 1980, pp 127-128). In addition, I have learned much from various statements of Actor-Network Theory, and specifically from Steve Woolgar's account of 'Configuring the user' in the course of microcomputer usability trials (Woolgar 1991). In social theory more broadly, of course, the inspiration is Foucault. But forget the hospital and the prison; remember his use of the table in a discussion with Maoists: '(L)ook a bit more closely at the meaning of the spatial arrangement of the court, the arrangement of the people who are part of or before a court, the very least that can be said is that this implies an ideology. What is this arrangement? A table, and behind this table, which distances them from the two litigants, the 'third party', that is, the judges. Their position indicates, firstly that they are neutral with respect to each litigant, and secondly this implies that their decision is not already arrived at in
perhaps especially a certain kind of complex, public sector organisation, will acknowledge that they
seem to be held together - if at all - 'with glue and bits of string'. What I'm interested in are those bits
of string.

The patient record

The argument here is that explicating the nature and function of its information flows serves as a way
of describing a system itself. For to become a patient is to enter a specialised set of communications:
symptoms are reported, diagnoses given, referrals made, prescriptions issued. The fact of these
various communications taking place, as well as the detail of their form and content, is ordinarily
recorded in some way. The doctor-patient encounter itself, meanwhile, is predicated on a further set
of elaborate administrative communications: these have to do with the initial registration of patient
entitlement, and with subsequent doctor payment. The production, recording and exchange of
information, that is to say, is an intrinsic aspect of what might be thought of as patienthood, or the
condition of being a patient, as well as of the practice of medicine and the management of health care.

Across countries, meanwhile, these relations of information are being transformed by two closely
related processes: computerisation alters the mode of information (cf Poster 1990), and
managerialisation its functional logic; both impact on its material content. What is being remade in the
process of computerisation is its predicate, that is the clinical encounter between doctor and patient.

Since Parsons's treatment of the sick role, patient identity has been a staple of medical sociology,
being explored through work on the doctor-patient relationship, on 'lay' knowledge and, more recently,
on participation. A much smaller body of writing attends to the administrative rather than clinical or
political aspects of patienthood - the ways in which being a patient is defined in administrative terms
as well as in the process of treatment or in the representation of interests - and most of it is generated
from an ethnomethodological or social constructionist perspective. The pioneer is Garfinkel (1974 ): in
postulating 'good' organisational reasons for 'bad' clinic records he notes that 'the crux of the
phenomenon lies.. in the ties between records and the social system that services and is serviced by
these records' (p 114). Drawing a distinction between an 'actuarial record' and a 'record of a
therapeutic contract' between clinic and patient, he explains that 'The various items of the clinic folders
are tokens... gathered together not to describe a relationship between clinical personnel and the
patient, but to permit a clinic member to formulate a relationship between patient and clinic as a
normal course of clinic affairs when and if the question of normalizing should arise as a matter of
some clinic member's practical concern' (p 123). Macintyre shows that information recorded in a
maternity clinic is a social construction of those assembling data and that, to some extent, 'the
advance, that it will be made after an aural investigation of the two parties, on the basis of a certain
conception of truth and a certain number of ideas concerning what is just and unjust, and thirdly that
they have the authority to enforce their decision. This is ultimately the meaning of this simple
arrangement' (Foucault 1980, p 8).
patient... is what the records say she is' (Macintyre 1978, p 607, emphasis in original). Heath (1982) shows how the record works to preserve the general practice consultation, while Berg (1996), in a hospital setting, claims that the record is 'a fundamental, constitutive element of medical practice' (Berg 1996, p 499). Moreover, it is not neutral but transformative, mediating the relations that act and work through it: it is 'one of the ways power differences are materially constituted' (Berg 1996, p 512). For Berg and Bowker (1997) similarly, because the record is 'a distributing and collecting device: work tasks begin and end there' (p 519), it can be argued that the record effectively produces both the patient and the clinic. '(T)he act of recording... enacts the organization' (Berg and Bowker 1997, p 524). The medical encounter is governed, it can be said, both in its process and terms on which it is undertaken, by the information required to produce it.5

Research method

My empirical research has consisted in studies of the nature of medical and related record-keeping in England and France. I took the patient record to include all information stored in such a way (on paper, in electronic format; in health care settings, in local, regional or national administrative centres) that it can be retrieved and/or exchanged by health care personnel (professional, paraprofessional and administrative staff), as well as by patients themselves. The point was to capture the ensemble of documented information, at once legal, medical and financial, through which patienthood is constructed.

My research interest lay not in the detail of any given patient's medical history but in what might be described as the informational architecture of the record. What is at issue here and in what follows is the nature of the information required of, by and about the user of health care, as well as the nature and implications of technological innovation. I was concerned to establish types and patterns, 'standard operating procedures' in health care practice and administration. These were gleaned, first, from interviews and site visits (the strategy may be best described as one of interrogative observation: 'show me what you do'). My sense of the organisational and political framing of the subject was derived from government and other administrative regulations, guidelines and policy statements.

I have taken two case studies: preliminary research (Freeman 1999b) had established that France and England,6 while holding some major background variables constant (such as the extent of public

5In a parallel field (child and family psychiatric social work) Prince shows how 'Records actually occupied a 'hot seat' in the power relations between social workers, their managers and consultants, and functioned not only as an index of power but also as a bearer of meanings, codes, resources and emotions' (Prince 1996, p 180).
6Differences in the administration of the NHS in Scotland, Wales and Northern Ireland mean that some of the terms and procedures considered here differ across the territory of the UK. Whitehall statements apply in the first instance to England (sometimes England and Wales) alone, though it is
finance of health care and its concomitant state regulation), were likely to generate the most revealing analytic contrasts. The focus throughout is on ambulatory care in local practice, the principal point of contact between the patient and the health care system.

The paper proceeds as follows. I begin by describing health systems in France and England respectively (old habits die hard), and then try to construct what I call the *status quo ante* of medical record-keeping. This is a heuristic device, a reconstruction, an archaeology, a representation of a social practice visible now only in traces. In order to understand how things have changed, I needed to work out what they were like before.⁷ I go on to describe the development of policy in both countries, and offer an interpretation of it as an exercise in state-building. I pay particular attention to the ways information policy is being used to govern the medical encounter, and to changes in the conditions of patienthood which that entails. I conclude with a discussion of information policy as the attempt to construct a ‘national language for health care’.

*Health care and health policy in France and England*⁸

Health care in France is funded by a universal but limited system of compulsory insurance. This is provided by a system of occupation- and area-based funds; 80% of the population is covered by the *Caisse nationale d'assurance maladie des travailleurs salariés* (CNAMTS, usually CNAM), which is divided into regional and local units. CNAM is a self-governing ‘technostructure’ (Pomey and Poullier 1997), controlled by unions and employers; it regulates the health insurance system. At government level, the health portfolio tends to change with each change of administration, and is currently subordinated to the Ministry of Employment and Solidarity.

Insurance contributions are paid by employers and employees. Hospital bills are settled directly between insurance fund and provider, the majority of which are in the public sector. In ambulatory care, payments are made as reimbursements of fees, and cover approximately 70% of the cost to the patient. Patients are free to choose and change a doctor as they wish, though most stay with one they know. Referral from one doctor to another is frequent but not normal; patients may also seek a second opinion for the same complaint. Doctors in ambulatory care are self-employed, and may be

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normal for equivalents to be produced in the other countries, too. Differences between countries may or may not be reinforced by devolution.

⁷At the same time, too, of course, I was committing a different kind of simplification: I was trying to formulate what might be standard experience in what is self-evidently a varied, complex domain. According to country and context, there are often important exceptions to the patterns I describe, notably for children and in maternity care, for some older people and for some low-income groups.

⁸The literature on health care and health policy in different countries is now vast. The fullest and most recent (though they are already becoming outdated) chapter-length accounts of whole systems are those in Raffel (1997). For comparison and context, see Freeman (2000).
either generalists or specialists; most (approximately two-thirds, with some variation according to
gender and specialty) are in solo practice.9

In the UK, health care is delivered through a public system, the National Health Service (NHS), and is
funded predominantly out of general taxation. In England, health policy is the ministerial responsibility
of the Department of Health (DoH), while the operation of the service is managed by the NHS
Executive. Local administration is the responsibility of Health Authorities. Hospital and community
services are provided by independent public agencies (Trusts). Importantly, a clear distinction is
made between care provided in hospitals by specialists and in local practice by generalists (general
practitioners, or GPs).10 GPs are independent contractors to the NHS, and most work in group
practices.11

All UK residents have the right to register with a GP. They pay no charges for consultations; charges
for prescriptions are paid to the pharmacist when and where they are submitted. Except in
emergencies, access to specialist and hospital care is by GP referral only.

Record-keeping in local practice: the status quo ante

Information is collected and used in different ways at different times as a patient interacts with an
office-based doctor. Five stages can be defined: registration, reception, recording the consultation
itself, referral and billing and remuneration.

The French patient registers with a sickness insurance fund, normally a statutory caisse primaire, and
is issued with a carte d’assuré social, which is typically a small fold-over document carried in a wallet.
It carries an ID number which is used for a variety of other official purposes, including employment and
taxation. The British patient registers with a doctor; in the majority of cases, in effect, this means with
a group practice. A practice accepts a patient onto a doctor’s list (the basis of the payment of GPs by
capitation) and in turn registers that patient with the local health authority.12 The health authority then
issues a small yellow registration card, the National Health Service Medical Card to the patient. The
card contains an NHS number.

In neither system is the card presented at reception. In France, the principal function of the card and
number is in serving as the basis of an application for reimbursement from the insurer. The British

91991 figures, from Pomey and Poullier (1997).
11In 1994, 60% of GPs worked in group practices of four or more, and only 10% on their own (Hatcher 1997).
12In England and Wales, the NHS Central Register holds basic personal details (but no clinical information) of all patients registered with a GP.
patient is unlikely ever to show her card, or to know or use the number it carries. In both countries, the clerking and filing functions carried out by receptionists mean that medical records are stored close by, often within sight of the reception desk but in such a way as to prohibit unauthorised (patient) access to them. In this way, while the receptionist mediates between patient and doctor, she also acts as a barrier between the person (in front of the desk) and the patient (emergent in the document) behind it.13

The record of the nature and outcome of the consultation, the medical record, known in France as the dossier de suivi medical (usually simply the dossier) and in the NHS colloquially as the 'notes', is kept in paper form in cardboard envelopes or folders. In England, this envelope (file GP 111, slightly larger than A5, portrait) is known as the 'Lloyd George'.14 It contains brief written records of consultations as well as lab results, referral letters and responses to them; it tends to be thicker than its French counterpart, and appears to be viewed more clearly as a sine qua non of medical practice. Records are transferred when a patient registers with a new practice, for example as a result of a change of residence. Both doctors and support staff express great concern that notes should not be lost, mislaid or misfiled. In France, the record may transferred on referral, but not if a patient simply chooses to consult a new doctor.

At the end of a consultation, the French physician gives her patient a note of treatment or care, the feuille de soins, which is at once an itemised bill and a form on which to claim reimbursement. It is a four-part, fold-out document, containing a minimum of information to be completed by the patient. The patient pays doctor, writing a cheque (usually) as the doctor completes the feuille. The reimbursement payment to the patient is then made by cheque or bank transfer within a few weeks.

What is striking here (to English eyes) is the way in which the health care domain in France is circumscribed or perhaps even defined by matters of finance. The 'system' is one of payment for health care, not of the provision of health care, and this system is 'owned' by labour unions - by virtue of their government of the funds - rather than by the state. Registration appears to confer status and

13This is a critical act of alienation of the person from the self-as-patient. What happens next, of course, is that the alienated person then encounters the self-as-patient in the doctor's office: by means of the record, the doctor (re-)presents the patient to the person. The construction of the patient-in-the-record is in some sense negotiated between the doctor and the person, though it can never be said that this negotiation is conducted on equal terms.

14The letter and accompanying guidance sent by the Executive to Health Authorities and primary care providers following the change in legislation permitting GPs to keep electronic records refers formally to 'the existing Lloyd George envelope (FP5, FP6, FP111)' (NHS Executive 2000, xv). In reaching a pay settlement with panel doctors in 1912, Lloyd George [expl] introduced a requirement for them to keep records (Honigsbaum 1979, p 94). At that time, they took the different, unwieldy format of day sheets, six feet square. They were in two sections, neither of which was retained by the doctor: one was used by the insurance committee for calculating a doctor's pay, while the other was intended to provide statistics for preventive medicine.
entitlement: the carte is a record of the immatriculation of the assuré. In the NHS, it is the doctor and the local practice which appears central: patienthood is governed professionally rather than administratively. The organisation of health care appears both more whole and more paternalistic. Though few patients will be aware of it, the name of the author of public health care, Lloyd George, lingers on in the terminology of the record. The French patient, meanwhile, enters a partial, segmented world; in France, the patient herself appears to do much of the work of integrating the system. Her consultation ends with a symbolic exchange of papers, while the English patient may or may not be given a prescription.

Policy change

In France, CNAMTS's difficulties with processing claims data had been recognised as long ago as the early 1970s. The SESAM project\(^1\) originated in 1980, based on the use of microprocessor cards to hold and capture data. Pilots began in six sites across the country in 1986; in 1989, other major insurers catering to self-employed professionals (CANAM) and farmers (CCMSA) joined the scheme, and a more extensive pilot got underway in Boulogne. In the hospital sector, also in 1989 and following the earlier introduction of prospective budgeting in 1984, public providers were given a new degree of organisational autonomy in the collection and processing of systems data. Predictably, this made for different patterns of activity in different agencies, though it was largely restricted to administrative matters.

By the early 1990s, it was clear that data capture on the part of the health and medical professional was to become the effective point of entry to a networked health information system. In February 1993 a Groupement d'Intérêt Public (GIP)\(^2\) was formed to develop the Carte de Professionnel de Santé (CPS), which made possible the secure exchange of information between health care professionals. At the same time, the GIE SESAM-Vitale\(^3\) was formed by the three insurers and given operational responsibility for the development of the patient-based card system. New cards were piloted in 1994 and the electronic transfer of medical claims forms (Feuilles de Soins Electroniques, or FSEs) was introduced the following year.

In the later part of the decade, policy development both intensified and became frustrated by mismanagement and technical failure. Showing some impatience with achievement thus far, and in the context of more general concern at the relationship between France's social security system and its economic performance, the government included the modernisation of health service information in

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\(^1\)Système Électronique de Saisie de l'Assurance Maladie
\(^2\)The GIP is a public-private sector partnership formed in order to develop a public interest project. In this instance, see <http://www.gip-cps.fr/>.
\(^3\)Groupement d'Intérêt Economique: <http://www.sesam-vitale.fr>
a package of administrative reforms, the *Plan Juppé*, which was agreed in 1995 and implemented in a subsequent ministerial regulation in April, 1996.\(^\text{18}\) In the interests of ‘clinical management of health spending’,\(^\text{19}\) health care professionals were obliged to be able to deliver claims to insurers electronically by the end of 1998, with fee sanctions to be applied for continued use of paper forms from the beginning of 2000. Patients were to be issued with the *Carte SESAM-Vitale* by the end of 1999, with a provision that ultimately this would also carry medical information. The legal status of electronic claims forms (FSEs) was established. The information programme as a whole was to be supported by a FF 1bn fund raised from the doctors in the 1996 fee negotiations.\(^\text{20}\) A networked system of computer-based health service information appeared to have been imposed more or less by fiat.

In October, 1996, however, a review committee chaired by Charles Rozmaryn, then general manager of France Télécom, pointed to the considerable technical difficulties inherent in the programme, and criticised its management at the same time. It recommended that a strategic policy unit be created, which should be directly answerable to the minister: the *Conseil Supérieur des Systèmes d'Information de Santé* (CSSIS) was formed for a three-year term in January, 1997. The CSSIS was quick to emphasise two central concerns for policy: the SESAM-Vitale project and the construction of an integrated health information network, the *Réseau Santé Social* (RSS).\(^\text{21}\) Its position was reinforced by a technical report submitted to the minister in December 1997, the *Rapport Pantin* (CSSIS 1997). At the same time, however, a further critical report by a former health minister, Jean de Kervasdoué, declared that the chances of the SESAM-Vitale system working reliably remained remote. The government now announced that technical cooperation was to be supported by a new *Mission pour l’Informatisation du Système de Santé* located in the ministry itself (Secrétaire d’Etat a la Santé 1997).

In 1998, the broader public interest was expressed in the format ion of a parliamentary committee (*Mission d’Information*) to monitor the development of information policy in the health system. The CSSIS issued reports for years 1997, 1998 and 1999, as well as an intermediate report on the medical record at the end of 1998. Its final report, for 1999, represented a summary of its work and something of a strategic statement.\(^\text{22}\)

The formation of an NHS/DHSS Steering Group on Health Service Information (the Körner committee) in 1980 is taken to mark the beginning of a formal interest in information gathering in the NHS. Responding to the report of a Royal Commission (1979), it established a national system of data


\(^{19}\) *la maîtrise médicalisée des dépenses de soins*.

\(^{20}\) FORMMEL: Le Fond d’Organisation et de Modernisation de la Médecine Libérale.

\(^{21}\) The contract to develop the RSS was awarded to the private telecoms giant CEGETEL in February, 1997.

\(^{22}\) This was the document proffered by respondents as the key document in the field.
collection in a series of six reports produced between 1982 and 1984. The service-based demand for information then increased rapidly in the mid-1980s, following the introduction of general management at unit level and above as recommended by the Griffiths report of 1983. In 1984, a report on the administration of Family Practitioner Committees by management consultants Arthur Andersen paid particular attention to the prospective benefits of the use of computers (Strickland-Hodge, Allan and Livesey 1988), and in 1988 the NHS Executive launched a Hospital Information Support Systems Initiative (HISSI), which piloted the use of integrated computer systems in acute care. A DoH/NHS R&D programme to develop an electronic patient record, also for use in hospitals, was introduced in 1993-94 and ran until 1997. Meanwhile, the Executive’s Information Management Group (IMG) published first a discussion document and then a new Information Management and Technology Strategy in 1992, recognising that the introduction of what was known as an ‘internal market’ in the NHS required a new intensity of data collection and processing. This envisaged a system of common classification and coding to enable the capture of clinical data, the introduction of a new NHS number for patients, as well as a dedicated network of administrative registers (Keen 1994a and 1994b).

Over the next few years, increased information flows brought some concern for efficiency and confidentiality. A number of independent audit investigations of different aspects of information policy were undertaken, some arguing for better management of information in the health service; some scrutinising and criticising various misconceived attempts to do so. Hospital information management systems and medical records were the subject of Audit Commission reports in 1995 (Audit Commission 1995a, 1995b): though casenotes were described as often ‘fat and disorganised’ (1995b, paragraph 8) there was some wariness about promoting alternatives to the paper record. NHS Executive Efficiency Scrutinies in 1996 were principally concerned with minimising ‘bureaucracy’, and pointed to the advantages of computer links between general practice and hospitals and health authorities (NHS Executive 1996a, 1996b). In 1997, the Audit Commission again put the case for improving efficiency in the collection and processing of management information, now in Community Trusts (Audit Commission 1997). Meanwhile, there was criticism of the management and implementation of HISSI from both the National Audit Office and the House of Commons Public Accounts Committee in 1996 (NAO 1996a). The NAO also reported that the disposal by the then South and West Regional Health Authority of its information technology agency SWift meant that it was effectively undersold (NAO 1996b) and later condemned the conflict of interest inherent in the

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23 For detail and discussion, see Mason and Morrison (1985).
24 For comment on the organisational change required, see Laughlin (1991).
25 The new NHS number was in widespread use in England and Wales by mid-1997 (NHS Executive 1997). While NHS patients had always been accorded a number on registration, this had existed in 22 different formats; it was now replaced by an unambiguous and unique 10-digit identifier. The purpose of this was to make data computer-compatible, to improve its accuracy and to make for easier access to it, as well as to enable linkage between records kept at different sites.
26 ‘Hospitals should approach any alternatives to paper records with caution. Unless the existing system of medical records is sound and alternatives are considered carefully before implementation, they can cause as many problems as they solve’ (Audit Commission 1995b, 36).
Director of the NHS Centre for Coding and Classification being also the owner of the company which held the license and distribution rights to the codes it purchased (NAO 1998).

The Executive issued guidelines concerning the confidentiality of patient-related information in 1996 (NHS Executive 1996c); a major review, requested by the Chief Medical Officer and undertaken by Dame Fiona Caldicott, reported at the end of 1997 (DoH 1997a). Its recommendations included the appointment of ‘guardians’ in each health service organisation, who were to be responsible for safeguarding confidentiality, as well as the extensive use of guidance and protocols related to the handling of information. For the sake of confidentiality, too, it supported the replacement of other identifiers by the new NHS number, as for example on GP Item of Service claims.

The incoming Labour administration issued a white paper in December 1997 (DoH 1997b), followed within the year by a new information strategy statement, *Information for Health* (NHS Executive 1998a). It took up the theme of modernisation developed in the white paper, and described new initiatives including a National Electronic Library for Health and NHS Direct, a telephone and internet-based advice service for patients. It set out plans for the continuing development of the electronic patient record as well as for an electronic health record, and held out the prospect of a patient-held summary record using smart card technology.27 Its emphasis lay on the integration of health service information, for which an appropriate infrastructure, including software and network systems (by now known as NHSnet), were to continue to be enhanced. In recognition of some of the failings of policy making in this area (above), the Executive’s IMG was disbanded and replaced by a new Information Policy Unit; one of its functions to oversee the work of a new National Health Service Information Authority formed in April 1999. Subsequent Health Service Circulars gave guidance on the use of records in hospitals, general practice, and health authorities and trusts respectively (HSC 1998/153, 1998/217, 1999/053). From 1 October 2000, GP terms of service were amended to remove the obligation on general practitioners to keep paper records, and to permit them to rely solely on electronic forms (NHS Executive 2000).

Clearly, there are common denominators operating in this field across countries. The most powerful of them, perhaps, is that computerisation is designed to improve the management of health care, whether by professionals or by administrators. The irony, of course, is that in both countries

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27 The Electronic Patient Record (EPR) is understood as the record of periodic care provided mainly by one institution, usually an acute hospital. The Electronic Health Record (EHR) is held in primary care: it holds summaries of EPRs and is conceived as a log of patient health and health care ‘from cradle to grave’; under certain circumstances, it may also incorporate material from social care (NHS Executive 1998a, 2.9ff). The DoH website is now more specific about the Personal Health Record (PHR): ‘The purpose of such a record is to enable the individual to maintain their own information for their personal reference or for their use in any interactions with the NHS (NHS Direct, GP, hospital etc) if they so desire. It is a personal record, held, maintained and accessed by the individual. There will be some structured elements to the record as well as free-text for general notes. It is not any type of electronic record that is used operationally by healthcare professionals in the delivery of care and treatment’ (DoH 2001 e version, 3.3.7).
information technology initiatives have themselves been subject to strong and sustained criticism for poor management. It is arguable that this testifies as much as anything to the inherent complexity of the issue and its extraordinary rate of change. In this context, policy statements serve as critical acts of sense-making, as attempts to provide coherence and fixity in a fluid and contested environment. That is to say that the more significant common denominator may be the erosion of common sense. Medical records are no longer an element of everyday practical wisdom: what was formerly common sense - part of the local knowledge of the practitioner - has become government strategy.

*Building the information state: context, culture and control*

The deployment of information technology in the health sector is part of a more general reformation of the public sector widely referred to as the 'reinvention of government' (Osborne and Gaebler 1993). For all that, it amounts just as much to an exercise in traditional state-building. It is driven by changes in the political environment; it is a cultural project as much as (because it is a) political one, and it is dependent on the establishment of new mechanisms of control. This is the metaphor that drives the remainder of this paper.

Health systems are embedded in the political, social and economic systems which surround them, on which they draw and which they in turn support (cf Moran 1995). It is this embeddedness which explains the emergence and development of health care information policy. This is important, because it serves in both countries as a prime justification of policy change. Modernisation, especially of government, was a strong theme of the Blair administration returned in 1997. It was the key term of the NHS white paper (DoH 1997b), and was developed at length in a further white paper published a little over a year later, called simply *Modernising Government* (Cabinet Office 1999). What it means for health services to 'modernise', apparently, is that they should work as efficiently as business systems, employing comparable administrative and managerial tools, and prove as capable as other services of satisfying customer or user preferences. *Information for Health* cites advances in personal banking (NHS Executive 1998a, 2.48); *Building the Information Core*, which updates the 1998 strategy, refers to holiday booking (DoH 2001, 3.3).

The same idea of modernisation underpins a degree of national myth-making and image management by which reforms are framed. The Department of Health is now arguing that the NHS ‘must embrace multi-channel communications and ensure that the strength of a revitalised NHS brand is recognised

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28 The French term is *informatisation.*

29 This second analogy is intriguing, and is repeated in other documents. It appears to derive from a remark made by a DoH official to the House of Lords Select Committee on Science and Technology: 'If you can book a holiday anywhere in the world then it is about time that you can book an outpatient's appointment before you leave the GP's surgery' (House of Lords 1996, 4.96). It is worth asking quite why going to hospital is like going on holiday.
not only nationally but also internationally' (DoH 2001, 4.3). There is something of this, too, in the French Ministry’s claim that one of principal benefits of computerised health information is to guarantee ‘la pérennité du système français d’assurance maladie’ (MES 2001). And the means by which this is to be achieved are the clinically appropriate control of health spending and the modernisation of sickness insurance.

The modernisation of health care is also a cultural project in more general sense. ‘The purpose of the new information strategy is to put in place over the next seven years the people, the resources, the culture and the processes necessary to ensure that NHS clinicians and managers have the information needed to support the core purpose of the NHS, in caring for individuals and improving public health’ (NHS Executive 1998a, 1.24). The first of the five ‘work areas’ of the Executive’s Information Policy Unit is introduced as follows: ‘The main challenge facing the implementation of Information for Health is one of cultural change’. In France, the CSSIS (1999, p 26) comments more negatively, but to the same effect: ‘...on doit insister sur les idées suivantes: - le culture médicale française (sic) n’a pas accordé au dossier de santé la place centrale qu’il mérite...’

While cultural change may appear to be a project which is as diffuse as it is diverse, it is predicated here on central control. Across countries in Europe, the increasing significance of public health care, in terms of public spending, employment and welfare entitlement, has been barely matched by the administrative capacity of government to regulate it effectively (Freeman 2000, chapter 2). What was for along time accepted to be an arena of ‘private government’ has only recently come to be challenged by thoroughgoing reform (Freeman 2000, ch 5). Here, in respect of health care information, the evolution of policy in both Britain and France has become increasingly subject to ministerial direction, and both countries have established dedicated agencies for its coordination at the highest level (though this sense of control may be stronger in the NHS than it is in France, simply as a result of its greater degree of organisational integration [Freeman 2000, chs 3 and 4]). This makes for the prospect of governments establishing greater authority in the electronic or virtual health system than in its empirical counterpart. Indeed, previous incarnations of the health care state may come to look like dated versions of early operating systems.

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30The NHSIA’s current ‘programmes of work’, similarly, include the nhs.uk programme, which was established in April 2000 to provide ‘a high quality NHS corporate web site which will provide a strongly branded gateway, known as “nhs.uk”’ <http://www.nhs.uk/>.

31<http://www.doh.gov.uk/nhsexeci/contacts/ccc.htm>. Perhaps even more revealing is an early reference to the ‘philosophy’ of the electronic patient record: ‘In the short term, the EPR can contribute by demonstrating the use of clinical information captured by information systems to improve quality and increase efficiency. In the longer term, when the EPR philosophy is nationally accepted, the clinical information provided will be important for the longer term needs assessment and outcome studies’ [emphasis added] (EPR Programme 1994-97 proceedings: Towards an Electronic Patient Record ’96; http://www.nhsia.nhs.uk/general/epr2.htm; 27 August 1999).
Policy change entails changed ways of thinking and acting. What are the defining terms of these new patterns of thought? What kinds of activity do they make possible, and what kinds do they exclude? What are the ends to which new forms of control are being exercised?

**Governing the medical encounter: the record in the network**

Information policy in health care has two principal elements: the computerisation of the medical record, and the construction of electronic communications systems or networks, known as intranets (NHSnet and the French RSS). These networks serve two functions: they facilitate the exchange of information between health care agencies, staff and administrators, and they also redefine the boundaries of the health system, demarcating it as a specific domain of authorised expertise. Because new flows of communication raise new questions about confidentiality, much work has to be done to ensure that networks are secure. The reduction of the system’s internal differentiation depends on increased its differentiation or separation from its environment. Intranets are at once the canals and railways of the new health care state as well as its re-equipped navies and customs officers. As the CSSIS (1999, p 41) puts it, ‘...le RSS est un lieu sécurisée de communication entre professionels de santé, un territoire réservé d'échange’. As in the industrial era, defence and communications are the public goods provided by government to support a changing economy.32

Networks offer the prospect of the integration of health systems, a long-standing goal of government since its entry into the field. Network-based communication is intended to overcome divisions between specialist and generalist, between community-based and hospital-based provision, between payer and provider, and between health care and social care. NHS documents continue to reiterate an original ambition to provide health care ‘from cradle to grave’, the archaic phrase alternating with its contemporary equivalent, ‘seamless care’. Crucially, however, integration depends on standardisation: successful communication is dependent on a common language. Network-based communication in health care requires the common coding and classification of professional activity, as well as a standard representation of the patient (the permanent patient identifier). Both therapeutic codes and patient numbers are embedded in - carried by - the electronic medical record.

The patient record, that is to say, is as significant as a medium of communication as much as its object. Exchanges - between health care professionals, and between professionals and administrators - are conducted through the record as much as on or about it: 'Achieving integrated care is a key national policy objective. For professionals from different organisations to provide an integrated care service to their individual patients and clients, they require comprehensive and easily

32In the NHS, because the new PPI (permanent patient identifier) is specific to health care, this process of separation is perhaps more complete. In France, a more loosely coupled, embedded system, the CSSIS recommends that the standard social security and ID number be used (CSSIS 1998).
accessible person-based records as the basis for communication’ (NHS Executive 1998a, 2.28). The content of the record, meanwhile, in both countries, remains uncertain and contested. The NHS Executive (1998a, 2.9ff, 2.72) acknowledges that there is no agreement on the content of the EHR. For the French CSSIS, ‘Si le fait de placer le patient au centre des épisodes de soins est évident, il faut constater qu'il est aujourd'hui difficile d'obtenir un consensus sur le contenu du dossier informatisé et, par ce biais, des processus de soins’ (CSSIS 1999, p12). The record can be presented as the keystone of policy development - 'pierre angulaire des systèmes d'information' (CSSIS 1999, p4) - even while the nature of the information it carries is unclear. What is important about the record is not its content but the connections it makes.

Compare now the French project: ‘Ainsi le dossier de santé du patient, qui était une collection de dossiers par métiers - ou par professionnel - établis principalement à des fins de mémorisation, va évoluer vers un dossier partagé, donnant potentiellement accès à l'ensemble des données relatives au patient. Il devient à ce titre un outil de communication entre les différents intervenants qui apportent et coordonnent leurs compétences autour du patient’ (CSSIS 1998, 1). With repetition, it becomes clear that a second, equally subtle but perhaps even more significant manoeuvre is taking place here. The individual patient is being separated from the individual physician: the patient is being made accessible to multiple agents at multiple sites. For the replacement of the paper record by an electronic one integrates formerly separate documents kept by different staff working in different facilities: ‘Wherever a patient is treated, there is a record of that treatment. These are "organisational records" and at present they are, in the main, paper records. New technology gives us opportunities for making those records safer and available for other health professionals’ (DoH 2001, 4.4). The effect of this is to erode the individualised relationship between patient and physician which is perhaps the central construct of liberal medicine - whether la médecine libérale or its anglo-saxon equivalent.

Decreasing control of the record by the individual physician is mirrored in its increasing control by the organisation of which s/he is a part. That is to say that these processes of separation and standardisation make the medical encounter (which is what the record is a record of) more amenable to government. One of the principal justifications of the new information policy in both countries is the opportunity it creates for enhanced clinical governance, or medical audit [references: (CSSIS 1998, 2.2b), others]. For its real object - which is the subject of the record, too - is not the patient but the health care professional and what he or she does. The stated rationale for the new information

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33Cf also the health service circular HSC 1999/053 which, in referring to the Audit Commission’s 1995 report on Setting the Records Straight (Audit Commission 1995b) noted that ‘This [the Audit Commission’s Report] has given rise to a range of concerns e.g the question of “What constitutes an adequate medical record?”; an issue which will require further exhaustive consultation across the whole health sector.’

34A further indicator of this separation is the way in which the record is described. The CSSIS is explicit in preferring a vocabulary of health rather than medicine (CSSIS 1998, 1), while NHS nomenclature (Electronic Patient Record, Electronic Health Record, Patient Health Record) avoids, if it does not deny, explicit association of the record with the doctor.
strategy in the NHS is ‘supporting patient care’ (NHS Executive 1998a, 2); in France, the first of five reasons for computerising health care information is ‘Pour améliorer la prise en charge individuelle des patients’ (MES 2001). In both instances, the focus is apparently the patient, effectively the professional.

The patient is enrolled in this process by claims about the reduction of travel and delays in the NHS (NHS Executive 1998a, 5), and of administrative form-filling in France. The first stated objective of the SESAM-Vitale system is to simplify the reimbursement procedure for sickness insurance claims: ‘Avec les feuilles de soins électroniques (FSE), l’assuré n’a rien à remplir, ni à coller (vignettes), ni à poster, ni à affranchir: c’est une économie d’un milliard de francs par an pour les malades’ (MES 2001). Nevertheless, the fundamental logic of policy statements is that the patient will benefit because the professional will work better. To this extent, the electronic record serves as something of a promissory note.

The patient in the policy

NHS policy states quite clearly that ‘information will be person-based’ (NHS Executive 1998a, 1.30). In this it reflects changes in the industrial and commercial worlds, in which information technology has figured prominently in the redesign of even very large companies as ‘person-based organisations’ (Keen 1994a). ‘The key lies in integrating information across the various parts of health and social care to achieve a single or "whole" system centred around the individual...’ (DoH 2001, 3.1). In practice, however, as argued above and as a function of the government’s underlying purpose, the centrality of the patient in system elides quickly into that of the record in the network. Nevertheless, a new kind of state entails a new kind of citizen, certainly de facto, if not by design. In what ways does the reinvention of government in health care, realised at least in part through the reconstruction of the patient record, impact on the patient herself? What does it mean to be a patient in this changed order of things?

Much of the logic of the policy change described here - the concern for effectiveness and efficiency in the context of new technological opportunity - is not specific to any particular health system. A common modernising discourse makes for broadly similar changes in the way health care is managed and delivered. But it interacts with different sets of everyday assumptions and practices in different national contexts, reflecting and reproducing them in different ways.

The NHS patient is unlikely to be aware of changes in medical record-keeping: simply, she has no need to be. When the new NHS number was introduced, the Executive distributed an explanatory leaflet, in question-and-answer format. In response to the patient’s ‘What do I need to do?’ it explains that ‘You don't need to do anything - not even remember your NHS number! In fact you'll only notice
that you've got a new number when you change GP or attend hospital' (NHS Executive, nd). Just as revealing as the patient not needing to know her number is that the decision about what she needs to know is taken for her. In making recommendations for the protection of patient confidentiality, the Caldicott report (DoH 1997a, above) used the paternalistic formulation of the 'guardian', if with some awkwardness (the term being used in quotation marks throughout). Similarly, in guidance related to the issue of the new number, the Executive found it necessary to point out to NHS staff that a patient does have a right to know his or her number (NHS Executive 1998b). There is an enduring sense that the number is the NHS's, not the patient's.

In France, by contrast, patienthood is modified in significant ways. The patient's relationship with the sickness fund is now partially mediated by the health care professional: the feuille is sent electronically by the doctor from a desk-top terminal, rather than by post and on paper by the patient.35 But that contact can only be made by means of a card - the carte SESAM-Vitale - held by the patient. The symbol of entitlement, of the immatriculation of the assuré, is retained and modernised.

The card has its own symbolism. It is the size of a credit card or phone card, other tokens of access and entitlement. It is green, the colour of the age, and of health and the environment. It has four words, carte d'assurance maladie runs along the top in white and in lower case; vitale, also in lower case, is twice the size of the others, in a bold yellow. There is also a multi-digit number, much smaller, in black. There's a strong connotation of a sunflower.36 It looks and feels... well, very modern, very 1990s.

The doctor has a card, too. Public information from the strategic policy unit explains that 'L'assuré a sa carte Vitale et le professionnel sa Carte de Professionnel de Santé' (MES 2001). A sense of reciprocity, if not equity, is (re)created.37 The cards are used together to engage the electronic system; in combination, the constitute a virtual signature, testifying to the legality and legitimacy of the claim.38 In this way a subtle shift takes place from what was constructed as a simple exchange

35 By the same token, of course, it introduces a new, direct contact between the payer and the office-based provider.
36 An equivalent Canadian card, used in Quebec and showing an ambiguous sunrise/sunset, is known as 'la carte soleil'.
37 The doctor's card is a token of social status. It is a yellowish, buff or mustard colour showing the detail of what looks like a renaissance drawing. The figure is of a head, young, with full, wavy hair but non-specific as to gender, actively looking. The association is with high art, or perhaps classical music; it might be a CD cover. A CPS logo, top right in black and lower-case, has a flattened, tilted and elongated S like an f, or the shape cut from the sound box of a stringed instrument, like a viola. Red bands at top and bottom of the card carry lettering in white and upper-case; at the top MEDECIN, spaced to cover the full width of the card, and at the bottom, CARTE DE PROFESSIONNEL DE SANTE.
38 Les cartes signent les feuilles de soins : cela veut dire qu'il est techniquement possible de prouver que les deux cartes étaient présentes lorsque la feuille de soins a été produite et que le document n'a pas été altéré depuis. Cette signature électronique conjointe (par le professionnel et l'assuré) remplace les signatures manuscrites actuelles : le document électronique devenant lui-même une pièce justificative, le papier est supprimé, alors que les télétransmissions pratiquées aujourd'hui (tiers
relationship to a joint or collaborative one. Patient and doctor are actively enrolled in a new system of administration.

**Discussion**

The essential argument of this paper is that information policy in health care can be thought of as a kind of state building. What is happening is that government is defining and defending new administrative territory, building an infrastructure which will enable new and sophisticated kinds of social and economic activity to take place. In turn, this involves making a new kind of citizen.

For what appears to be required by technology in fact constitutes an act of government. In changing the way information is gathered, stored and used, government is changing the terms on which health care is delivered and paid for. And what is crucial in this is that health service information is both an object (something to be managed) and instrument (something to manage with) of government. Policy in this area is quintessentially a set of communications about communications: what concerns government, to coin a phrase, is not so much the 'conduct of conduct' but the conduct of discourse.

Here, the record plays a critical role, though it remains also to some degree chimerical. Different versions of records are proposed and developed, while their content remains sometimes surprisingly ill-defined. In part, this is because the record has a political function as a rhetorical space or 'floating signifier': in mediating between competing professional, managerial and government projects it is something akin to Gallie's 'essentially contested concept'. At the same time, however, it can be both critical and chimerical because what matters is not just the information it contains, but the connections it makes: the record is truly a 'space of flows'.

One of the principal elements of successful state-building is the establishment of a national or official language. In a 1996 paper for the NHS, James Read, Director of the NHS Centre for Coding and Classification, suggested that its various systems - which included Read terms, ICD classifications of diseases, OPCS classifications of surgical procedures and Healthcare Resource Groups/Health Benefit Groups - could be collectively described as 'the "language of health", an essential element of the electronic clinical record', enabling 'more effective and efficient healthcare delivery' (Read 1996, abstract). This is by way of saying that the medical record does for the health care state what was done for the state as such by the elementary school and the radio. It has been made the vehicle of common standards of communication. Its purpose is to erase dialects of class and region - of different professional groups and the different local agencies in which they work.

*payant en pharmacie, cliniques...) doivent être confirmées par des documents classiques' (MES 2001).*
Subtly but significantly, this changes the ways practitioner and patient interact, the terms on which they work together to produce the medical encounter. In the translation of the record from one medium to another, from paper to computer, what Garfinkel (1974, above) described as the therapeutic contract is itself rewritten. What was an implicit audit function has become explicit. The record is no longer simply a resource on which the practitioner draws to account for what he or she has done, both to other practitioners and, over time, to him- or herself; it is becoming the means by which the system accounts for itself. The electronic medical record is the means by which practice is made amenable to management; it represents the collectivisation of the individual medical encounter.

Meanwhile, the legal status of citizenship rests on multiple documents, one of which is the medical record (Ewald 1986; Berg and Bowker 1997). To the extent that this is so, the partial remaking of the record in part remakes the citizen. But the NHS patient is innocent of this transformation. The role of the person is to supply the patient, and the doctor does the rest: the manipulation of the patient, the body-in-the-record, continues as information is processed by the physician and the health service manager. In this respect, the dominant discourse of the NHS is unaffected by technological change.

In France, however, the administrative work the patient must do to access the system means that she/he is necessarily involved or enrolled in its modernisation. She carries a new plastic card in the same way that she used to carry a paper one. The information it contains is machine-readable, which is to say that it has been made invisible. The card can be 'opened' only by another card, the doctor's. In this way, the government of the patient comes to have less to do with the person than it did before.

It has become a truism of a certain kind of political science that 'institutions create interests'. This paper makes the claim that one of the ways in which they do so is by creating identities. Institutions create interests; technologies redefine social roles; artefacts make people. Some ways of being are made possible while others are denied.

Note on electronic sources


References
Keen, J (1994b) ‘Should the National Health Service have an information strategy? Public Administration 72 33-53
Laughlin, R (1991) ‘Can the information systems for the NHS internal market work?’ Public Money and Management
NAO (1996a) Seeing the wood, sparing the trees. Efficiency scrutiny into the burdens of paperwork in NHS Trusts and Health Authorities, Leeds: Department of Health
NHS Executive (1996b) Patients not paper
NHS Executive (1996c) The Protection and Use of Patient Information HSG(96)18/LASSL(96)5, Leeds: Department of Health
NHS Executive (1997) The NHS Number: putting the NHS number to work, IMG ref C3209, Wetherby: Department of Health
NHS Executive (1998b) General Principles in the Use of the NHS Number, IMG ref C3228, Wetherby: Department of Health
NHS Executive (2000) Electronic Patient Medical Records in Primary Care. Changes to the GP terms of service, PC-01/10/00, Leeds: Department of Health
NHS Executive (nd) Your new NHS number, IMG ref C3109, Wetherby: Department of Health
Royal Commission on the National Health Service (1979) Report, cm 7615, London: HMSO
Winner, L (1980) 'Do artifacts have politics?' *Daedalus* 109 121-136
The terms medical record, health record, and medical chart are used somewhat interchangeably to describe the systematic documentation of a single patient's medical history and care across time within one particular health care provider's jurisdiction. The medical record includes a variety of types of "notes" entered over time by health care professionals, recording observations and administration of drugs and therapies, orders for the administration of drugs and therapies, test results, x-rays. If a medical record cannot be located, the patient may suffer because information, which could be vital for their continuing care, is not available. If the medical/health record cannot be produced when needed for patient care, the medical record system is not working properly and confidence in the overall work of the medical/health record service is affected. A large teaching hospital. Aim of the Manual: prepare a diagram of the flow of medical/health care data in your health care facility and identify possible problem areas; explain a hospital information system (HIS) and discuss the areas within your Medical Record Department, which could be computerized as the first step to the development of a HIS; and.