how you legislate to prevent junior staff ordering unnecessary investigations.

Notes and communications—Dr Marsh is on dangerous ground when he suggests drastic pruning of notes and abandoning ritualistic recording. The lawyers will confirm (and so will the defence societies) that the standard of clinical notes in hospitals leaves much to be desired. I spend a lot of time teaching, for sound medicolegal reasons, that more not less should be recorded in the notes. Communications between doctors are obligatory in the interest of the patients. We must be allowed to express our thoughts in our own particular style; the suggestion made by Dr Marsh would produce a serious deterioration in professional relationships, which sadly are not always of the highest standard.

I hope that Dr Marsh's stimulating article will have the effect for which it was no doubt written—namely, to stimulate debate on the most important and, until recently, neglected aspect of the NHS.

NIGEL H HARRIS

London W1

What is "emergency"?

SIR,—I am prompted to write this letter by the review (7 June, p 1372) of the textbook *Accident and Emergency Medicine*.¹

What a pity that the authors have perpetuated (p 3) the misconception about that noble, precise, and explicit word "casualty" contained in the Platt Report² and should have given us, except in terms of the patients already there, no guidance on which "emergencies" are to go to the accident and "emergency" department—guidance so urgently called for in the Lewin Report.³ By giving the green light to the medical interpretation of the word "emergency" (p vii) we help to foster confused hysteria which seems here to be overtaking the profession.

Far from meaning the same thing (p 3) as accident and emergency, "casualty" was introduced into hospital administration 400 years ago⁴ to designate those who, overtaken by some chance calamity, were immediately rendered "community dependent." Given the presence of illness, it was this "community dependence"—the need for immediate assistance from the independent citizen—which defined the function of our casualty departments; referral within the GP consultative service, more recently and laboriously established by our forebears, was for the family or domestic environment. There is a difference between renal colic at home and in the high street; and the importance of interpreting the word "emergency" in the newly titled accident and emergency departments sociologically—that is, in terms of attendant circumstances rather than in any medical context—was emphasised in the Casualty Surgeons' Association's evidence to the Royal Commission and the Expenditure Committee⁵ and in its Memorandum.⁶ Calnan's work⁷ adds weight to this evidence.

"Emergency" means precisely what the user wishes it to mean. For the patient every new symptom causes anxiety and may represent an "emergency" until he has a diagnosis. For the GP it means "out-of-hour" calls or those cases that require a same-day appointment, and for most consultants those admissions which cannot be arranged through outpatient consultations. Who is to tell the public, the DHSS,

or the local committees (suggested by the authors) which "emergency" should go to hospital? It has taken doctors years to learn to make the decision—and only when they see the case. So how is the layman to be told, much less a committee?

Have we accepted the principle of the hospital-based GP emergency service? Are our departments to become polyclinics (Russian style) or emergency rooms (American style)? We are already half way back to the "Dispensary Movement" with its horrors of overcrowding and 20 seconds a patient, the intruder—the "casualty"—waiting in one corner.⁸

What will happen to our GP consultative service? Are GPs no longer to participate in treating anything remotely urgent? Should the nationwide telephone operator, receiving a domestic 999 call, or the casualty sister, not ask, "Have you tried your doctor?" Who is to staff these open houses?

The authors are to be congratulated on the rest of the text. But I would really like to know what "accident medicine" is.

E P ABSON

Chairman, Accident and
Emergency Subcommittee,
CCHMS

Casualty Department,
Kent and Canterbury Hospital,
Canterbury CT1 3NG

¹ Rutherford WH, Belson PG, Weston PAM, Wilson DH. *Accident and emergency medicine*. Tunbridge Wells: Pitman Medical, 1980.

² Standing Advisory Medical Committee. *Accident and emergency services. Report of the subcommittee*. (Platt Report.) London: HMSO, 1962:23-5.

³ Lewin W. *Medical staffing and accident and emergency services*. London: Joint Consultants Committee, 1978:27.

⁴ Copeland AJ. *Bridewell Royal Hospital, past and present*. Wells, Gardner, Dartan, and Co, 1888:35.

⁵ Fourth Report from the Expenditure Committee. *Session 1973-74: Accident and emergency services*, vol 1. London: HMSO, 1979:xvii.

⁶ Casualty Surgeons Association. *An integrated emergency service*. Casualty Surgeons Association, 1973:3-4.

⁷ Calnan M. *Pathways to the accident and emergency department*. Canterbury: Health Services Research Unit, University of Kent, 1979.

⁸ Loudon ISL. *Br Med J* 1978;i:974-7.

Multiple sclerosis in Africans

SIR,—In 1970¹ Dr J R Harries and I published a paper reporting two cases of multiple sclerosis occurring in Africans in Kenya. Because there were many reports about that time declaring that the disease was unknown in black Africans, our paper was published only after the opinions of other physician colleagues had been sought, and they were in agreement that the diagnosis was multiple sclerosis. Dr R Hoffenberg, reviewing *A Companion to Clinical Medicine in the Tropics and Sub-tropics* by Professor E B Adams (5 January, p 36), stated that "multiple sclerosis is yet to be described in a black African." My co-author and I wish to disagree with him.

R M FOSTER

St Mary's Hospital,
Newport, Isle of Wight PO30 5TG

¹ Foster R M, Harries J R. *Br Med J* 1970;iii:628.

Motor neurone disease

SIR,—Mr Roger Carus's Personal Paper (16 February, p 455) made doubly distressing reading—firstly, because of his graphic description of the disease and, secondly,

because he was nowhere told by the professional people he approached that the Muscular Dystrophy Group was, in fact, vitally concerned with motor neurone disease.

The Muscular Dystrophy Group covers, and has covered for some years, research into this and many other debilitating neuromuscular diseases; and we hope that gradually the organisation is becoming better known for this fact. Mrs Carus wrote to us in February last year, having discovered that the group financed research into neuromuscular diseases, and said in her letter that she felt there was something wrong with a system where doctors and social workers were unable to provide her with this information when it was needed. The simple reason for this is of course that most of the 40 or so diseases covered by the Muscular Dystrophy Group are relatively rare and therefore engender very little interest among general practitioners and social workers until a solitary case happens to impinge on them. There are therefore only a few specialists who can provide information and constructive advice for patients and for their families. This is the reason, surely, for the continued existence of voluntary agencies such as ours.

Because of the entirely understandable wish for better identification, a group of people has set up a separate organisation, the Motor Neurone Association. However, it is inconceivable that research into every rare disease can be effectively supported by small organisations working in isolation, and it is our hope that not only will the Muscular Dystrophy Group become better known as a "blanket" organisation but that the Government will realise the pressing need to contribute to the research funds.

Recently Professor Sir John Walton, at the Eighth Symposium on Current Research Into Neuromuscular Diseases, quoted the author Joyce Cary, who suffered from motor neurone disease, on the difficulties of climbing stairs, walking, and, ultimately, writing. It helped to remind those who work with minute fragments of muscle and other tissues that these are human diseases restricting and curtailing the lives of many people. Similarly, we hope that stories like that of Roger Carus will serve to remind us that, however rare the disease, the suffering of one person is no less important than that of many, and that person deserves our attention.

SUSAN BERRY

Muscular Dystrophy Group of
Great Britain,
London SW4 0QP

Management of acute stroke

SIR,—Dr W M Garraway and his colleagues (12 April, p 1040) are to be congratulated on their important report of one of the first (if not the first) controlled trials of the value of a stroke unit.

They also make an interesting point concerning those patients with strokes who are transferred from an acute medical unit to a geriatric or rehabilitation unit. They indicate that there are no obvious benefits in terms of earlier discharge from hospital or greater independence for those so transferred. However, they do not give enough information about the factors leading to transfer of these patients. Perhaps they could extend their work with a randomised controlled trial of patients