that the results look the same at 3 and 23 h after giving the beta-blockers because these drugs only block β -adrenoceptors. The trial design does not make it possible to know the heart rates achieved by the level of exercise before therapy commenced, there is a lack of control values with patients on placebo, and the standard dose of atenolol (100 mg/day) has not been compared with that of metoprolol.

Thirdly, evidence is available from studies using atenolol in volunteers² and in patients³ that the attenuation of the heart rate response to exercise after acute and chronic administration is similar.

Lastly, I agree with Professor Barber's view that one should be wary in extrapolating results about the relative potencies of atenolol and metoprolol from volunteer studies to patients on therapy, but not for his reasons (based on his trial design). One needs to be careful because of the relevance of the measure used to determine the relative potencies (that is, the attenuation of the heart rate response to exercise) to their potencies as agents in therapy, a point not considered by Professor Barber. A good case can be made that the increase is relevant to therapy of angina pectoris by beta-blockers,⁴ but it may be dubious in other cardiovascular diseases which require therapy with beta-blockers.

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¹ Carruthers, S G, et al, *British Journal of Clinical Pharmacology*, 1976, 3, 991.

² Brown, H C, et al, *Clinical Pharmacology and Therapeutics*, 1976, 20, 524.

³ Wolfson, A T J, et al, *Proceedings of the Royal Society of Medicine*, 1977, 70, suppl 5, p 36.

⁴ Robinson, B F, *Postgraduate Medical Journal*, 1971, 47, suppl 2, p 41.

Lost pedestal?

SIR,—I have just finished my paediatric medical outpatients. Of a total of 18 patients, including six new ones, seven patients, including one new referral, failed to attend. Is this indicative that the pedestal on which the doctor certainly was, and certainly ought to be, has been eventually and sadly knocked from underneath him?

A GUSSET

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Lord Mayor Treloar Hospital, Alton

SIR,—In the interests of accuracy and clarification it is necessary for us to reply to a letter from 11 orthopaedic surgeons (5 August, p 436) concerning the future of the orthopaedic centre at Lord Mayor Treloar Hospital, Alton.

This orthopaedic centre was developed in 1970 to meet a shortage of facilities throughout Hampshire and adjacent parts of Wessex. It was set up on an interim basis pending the development of adequate local services nearer to the patients' homes. This policy was clearly established by the former regional hospital board, which set in hand plans for locating full orthopaedic services within each district hospital. As part of these plans a large orthopaedic unit is being developed in the new teaching hospital at Southampton—the main user of orthopaedic facilities at Lord Mayor Treloar Hospital, 31 miles distant.

By 1982-3 district hospital facilities for

orthopaedics will have been satisfactorily developed in line with the region's policy, and it is then that the health authorities intend to transfer services from the Lord Mayor Treloar Hospital.

The Hampshire Area Health Authority has set up a special panel of its members to ensure that the Lord Mayor Treloar Hospital maintains effective orthopaedic services until the carefully planned arrangements have been implemented. This panel will also supervise arrangements for the transfer of work from Alton. Personnel policies to safeguard the interests of staff have been adopted by the authority.

The area authority's reaffirmation of the policy that the orthopaedic services at Lord Mayor Treloar Hospital should eventually transfer to district hospitals was in no way a hasty one. It was the culmination of years of consultation, planning, and expenditure to make this possible.

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General practice records

SIR,—Dr J Tudor Hart (15 July, p 207) calls for some fresh endeavour to overcome the present stalemate in our efforts to introduce A4 records into general practice. He suggests a conference of interested parties. Such a conference was held recently under the auspices of the King's Fund in London with Sir Francis Avery Jones as its chairman. I am uncomfortably aware that we owe Dr Tudor Hart a sincere apology for not making sure that he was present. The least I can do to make amends is to give a brief account of a conference that gave those attending some real hope that a solution might be possible.

Perhaps the most important outcome of the conference was the recognition that, at least at the present time, the general introduction of A4 records for all patients was not a practical objective because of its cost. On the other hand it is abundantly clear that A4 filing is essential for that important minority of patients with voluminous notes (10-15% of a doctor's list). The other essential requirement is for a simple and adequate method for the storage of important background information. This is needed for all patients and can be achieved using cards of existing size and appropriate design.

At the conference I proposed the following compromise solution as the way ahead for A4 records in general practice. Existing cards (FP7 and 8) would continue to be used for the doctor's own clinical recording. Appropriately designed cards of the same size would be used with them for the recording of important background information. A4 files would be used so as to allow letters and reports to be filed without folding. They could be used for all patients in the practice or only for those with thick notes. When records are transferred to another doctor the existing record envelope would be used. The A4 file would be kept in the practice and reconstructed for another patient.

A compromise system of this sort has several advantages when considering the introduction of A4 records into general

practice at the present time. Firstly, it can be introduced gradually as individual practices find themselves able to achieve a partial or complete conversion. Secondly, the system does nothing to increase the difficulties of those doctors who continue to use existing record envelopes, since no additional A4 insert sheets are produced. Further, the difficulty and cost involved in the transfer of A4 records from doctor to doctor through the family practitioner committee is avoided.

A flexible and gradual introduction of A4 records made possible by this system will not present the Department of Health and Social Security with the need to find large funds over a short period to finance a general conversion to a total A4 record system. It would seem perfectly possible for the DHSS to supply both the background data cards, once the design of these has been agreed with the profession, and A4 files to any doctor wishing to use them for some or all of his patients. Furthermore, this system can still form the basis of a total conversion to A4 records (including the use of A4 insert sheets) at some future date if that proves to be the wish of the profession.

I would submit that we do not need another conference: we need action. The profession must stop crying for the moon in the shape of A4 records and new surgeries for all, while the DHSS must face up to the comparatively modest cost of supplying suitable background data cards and A4 files in the quantities needed. It is now over 10 years since the Wantage trial demonstrated the practicality of using A4 files together with existing records in general practice. Since that time the whole effort to reform our records appears to have become bogged down over the question of the financial consequences of a total conversion to A4. We would do better to accept what we have a chance of getting.

It is imperative that we do something now to improve the quality of our records. We are about to introduce mandatory training for general practice. To miseducate a whole new generation of doctors in the appalling standards of note-keeping current in British general practice would surely be unforgivable.

At the conference Sir Francis Avery Jones referred to the long-standing interest of the King's Fund in medical records. The fund is taking up the problem of how to increase the number of general practices using a record system capable of accommodating A4-size documents and it hopes to build up a body of knowledge about the practical consequences of a total or partial changeover.

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Negotiating rights for junior hospital doctors

SIR,—Dr J N Johnson's reply (5 August, p 436) to my letter (22 July, p 282) shows his maturing skill as a politician. He attacks me for alleging that preplanned filibustering prevented debate on Motion 104 at the Hospital Junior Staff Conference and the remainder of his letter is a polished explanation of why such allegations are unjust.

His skill lies in the fact that I made no such allegations—I would as soon involve myself in a Paisley v Vatican debate on the doctrine of Papal infallibility as an argument about the reasons for Motion 104's demise. Such debates