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.

JOHN D HARRY

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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

Royal Devon and Exeter Hospital
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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.

W J E MCKEE

Regional Medical Officer,
Wessex Regional Health Authority

T MCL GALLOWAY

Area Medical Officer,
Hampshire Area Health Authority (Teaching)
Winchester

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.

IAN TAIT

Aldeburgh, Suffolk

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

are not only esoteric but conducted from inflexible viewpoints, making it unlikely that either side can be persuaded of the merits of the other's case. (Not that I would wish the HJS Conference to be deprived of such debates; after all, they provide healthy exercise for the participants and splendid pyrotechnics for the spectator.)

The corollary of his attacking me for something which I did not say is that he omits reference to the main theme of my letter, which was that negotiations for juniors are conducted by the Hospital Junior Staff Committee which the minority organisations—the Junior Hospital Doctors Association and the Medical Practitioners Union/Association of Scientific, Technical, and Managerial Staffs—believe to be BMA-dominated. As a result they seek separate negotiating rights, threatening fragmentation of the juniors' negotiating machinery if successful. Better then to devise a formula which would involve them in the HJS Committee, allowing it to be the sole negotiating voice. As stated in my letter, such a formula would be difficult to devise; but unless the BMA has a crystal ball telling it that the Advisory, Conciliation and Arbitration Service will deny negotiating rights to the minority organisations it would be of benefit to it (as well as to junior doctors and the JHDA and MPU) at least to explore the possibility. I should add that I have no personal axe to grind; I belong to neither of the minority organisations and though I value the different contributions which they make to junior politics, it is my personal view that their structures consign them to numerically minor though, I hope, continuing roles.

In conclusion, may I reiterate the hope expressed in the conclusion of my letter that the brouhaha surrounding the allegations of filibustering will not prevent objective assessment of Motion 104 when it reaches the HJS Committee—that is, the feasibility of juniors so organising themselves that they deal in unison with the Health Departments in future negotiations?

TOM MCFARLANE

Manchester

Primary care in inner cities

SIR,—I entirely endorse Dr R A Keable-Elliott's call at the Annual Representative Meeting (29 July, p 371) for more flexible assistance by the Department of Health towards the provision of practice premises. Apart from anything else health centres are quite the most costly means of housing general practitioners and I am far from convinced that it is necessary, except for attached nurses, to locate the other health authority services in the same buildings as medical practices.

I would go further and question whether group medical practice with attached nurses and appointment systems, which is suitable for most of the country and particularly so for middle-class, settled, favoured areas, is the most appropriate way of providing primary health care in inner cities with their shifting populations. Clinics or dispensaries akin to the old casualty departments can be more accessible to deal with acute episodic illness and to act as a filter, possibly supported by specialist teams for groups of patients with longer-term disabilities. Casualty departments evolved over many years in response to need and it may be that they are more suitable for inner

cities than present conventional wisdom suggests.

GEOFFREY PATEY

Bury St Edmunds Health
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Bury St Edmunds, Suffolk

BMA and social workers

SIR,—The report of the Annual Representative Meeting debate on social workers (5 August, p 446) is remarkable for the arrogance it demonstrates in the medical profession. Who else would discuss another profession at length in the absence of any representatives from that profession? It is typical of doctors to assume their own importance and to need to be in command. It is obvious from the reported discussion that the majority of the representatives know little about the social work task, and have taken little trouble to find out (a notable exception being Dr Joan StV Dawkins).

These are two professions whose areas of common interest, though of undoubted importance, are small compared with the range of knowledge and expertise in each. What we would all like to see is an increased number of social workers (paid in accordance with their responsibilities), so there would be time for non-statutory work, and improved facilities in the community for them to use. Why doesn't the Council of the BMA ask the Department of Health and Social Security for this?

B PAUL

Leeds

Points

Confidentiality of medical records

Dr O TROUGHTON (Pontefract, Yorks) writes: Dr A O Staines (15 July, p 206) may like to know that parental consent is not needed for a paediatrician to send copy letters to the district community physician "provided this is done in the interests of the child." This was the opinion given in October 1976 by a well-known medical defence organisation.

Dirt by any other name

Dr G I WATSON (Peaslake, Surrey) writes: Your informative leader on "Breathing other people's smoke" (12 August, p 453) was interesting but tailed off like a damp squib, only asking British Rail to segregate smokers from normal people on long-distance trains. I use the word "normal" advisedly, rather than "non-smoker" which you use, because the majority of the population does not smoke. I am no more a non-smoker than a non-spitter or a non-shoplifter. Let us call a dirty habit dirty rather than non-clean.

Assessment of severity of paraquat poisoning

Mr J KNEPIL (Biochemistry Department, Gartnavel General Hospital, Glasgow) writes: . . . Dr N Wright and his colleagues (5 August, p 396) state that "until a rapid, easy, and reliable blood [paraquat] assay is available, urinary excretion rate is the only way of assessing severity of paraquat

poisoning." A method for measuring plasma paraquat concentrations has been described¹ and is of sufficient rapidity, ease, and sensitivity to provide a guide to the assessment of severity of paraquat poisoning.

¹ Knepil, J, *Clinica Chimica Acta*, 1977, **79**, 387.

Scope of surgery for intracranial aneurysm in the elderly

Mr E J GIBNEY (medical student, Mater Misericordiae Hospital, Dublin) writes: In their article on this subject (22 July, p 246) Mr R P Sengupta and his colleagues state that "a 24% incidence of recurrent haemorrhage with increasing morbidity after antifibrinolytic treatment cannot be regarded as very effective." Further on in the same paragraph they state: "The surgical outcome in this series confirms that at least three-quarters of patients in the 60-65-year age group can be made safe from future haemorrhage without inflicting major neurological deficit." Food for thought. "At least three-quarters" means "at least 75%." But what does at least 75% mean in comparison with 76% (100-24)?

Diagnosis of retrobulbar neuritis

Dr V L IRWIN (Ware, Herts) writes: General practitioners often lack both the equipment and the time to carry out the full field of vision examination and as a result may find it difficult to diagnose retrobulbar neuritis. I have recently suffered an attack of unilateral retrobulbar neuritis and noticed a symptom that could form the basis of a simple test for this condition. If the affected eye is looked at in a mirror in a good light and the unaffected eye is then closed the iris of the affected eye appears to disappear or blend with the pupil. As the condition begins to resolve details of the iris of the affected eye begin to become visible again.

Male sterilisations

Dr J A MCEWAN (King's College Hospital, London SE5) writes: In a Parliamentary answer by the Social Services Minister (15 July, p 213) giving the number of vasectomies carried out in NHS family planning clinics in the various regions in 1976, South-east Thames is shown as having achieved 126 vasectomies. This is a mysterious figure, since the 1976 annual report of the family planning department at King's College Hospital indicated that no fewer than 533 NHS vasectomies had been carried out. Any advance from other clinics in the region?

Unexpected encounter

Mr M G GOTTS (Commonwealth Bureau of Animal Health, Weybridge, Surrey) writes: I saw with regret the note from Dr G D Oakley (*Materia Non Medica*, 22 July, p 261) revealing the location of a peregrine nesting site. Although it is to be hoped that egg collectors, would-be falconers, and illegal dealers in birds of prey are not among the readership of the *BMJ*, this rare bird is not helped by the publication of an account of the disturbance of a breeding pair and the name of the breeding site.