(4) *Experimental* health centres, as became possible, to be set up in suitable areas, and their functioning studied.

(5) A joint advisory body, with freely elected medical members, to be set up to study ways and means of improving and adding to the service as time went on and opportunity offered.

(6) The improved service to be introduced by stages, according to the means and personnel available at the time, and no attempt to be made to introduce at one leap a fully fledged comprehensive service regardless of the existence or otherwise of suitable premises, nursing staff, medical and surgical personnel, and equipment. Indeed, an attempt to do so, as at present proposed by the Government, would result in as much chaos and as disastrous a failure as would have resulted from an attack on Festung Europa launched in 1942 in response to irresponsible demands chalked upon walls to "open the second front now."

Mr. Bevan is intelligent enough to realize full well what chaos will result from an attempt to implement his Health Service Act on July 5, and I believe that he also knows that it will be quite impossible to give a deluded public one tithe of the gifts and benefits he has so rashly promised them. Before it is too late, then, I urge him to think again and so to reap the gratitude of a great nation and the enthusiastic co-operation of a great profession.—I am, etc.,

Wolverhampton. A. VICTOR RUSSELL.

Payment for Work Done

SIR,—I quite agree with Mr. W. Adams, who at our last meeting described the N.H.S. as a gigantic fraud. I for my part will brook no interference between me and my private patients, whom I regard as friends. How would Mr. Bevan like it if I suggested that we reversed matters and undertook to pay each of our patients, say, 20 visits a year—no less and no more—on condition that we drew as much money as we wanted when and how we liked. We might limit it to, say, £10,000 a year. If it is fair one way it is fair the other. My own view is that if we must have a scheme it should be on the lines of the National Deposit Society, whereby the doctor marked down each item and was paid accordingly, so much a visit, etc., by the Society—i.e., paid for work done.—I am, etc.,

Bristol. E. BLAKE GARLAND.

Conflicting Advice

SIR,—Now that the voting is over I would wish to draw attention to one matter which appeared to me unfortunate. Taking the chair at a general meeting of practitioners in my area, among the correspondence there was read out a memorandum sent by a group of members of the Association stating that they were either members of the Council or Representatives, and advising the meeting to vote as they had done before. Whilst agreeing that a Representative has a right to express his own opinion to his constituents, I much regret that certain members of the Council should sign and agree to circulate a document the contents of which did not tally with the advice given by the Council and circulated with the plebiscite papers, unless such publication had been agreed to in Council.—I am, etc.,

London, W.1. PEARSE WILLIAMS.

Doctors' Houses

SIR,—Drs. E. T. Wright and G. H. Rossdale (May 1, p. 855) have indicated serious issues in their letter. I beg leave to elaborate one point—namely, the doctor's house and surgery. As doctors die or retire from general practice the well-known landmarks of long-established doctors' houses will disappear and the populace will have to face ever-shifting doctors' surgeries. This must occur if doctors are obliged to sell their houses by public auction in order to avoid Government legal action for attempting to sell goodwill with their houses. It follows that after July 5 no sensible N.H.S. doctor will buy or build a house with surgery and waiting-room accommodation. No doubt Mr. Bevan in his capacity as Minister of Housing will then produce priorities for G.P.s to become tenants of local authorities and live and work in council houses and prefabs. A doctor will of course need two council houses or two prefabs in order to carry on his practice. Under present circumstances no other course is feasible unless the Government decide to let doctors buy and sell the goodwill of their practices instead of demanding the sole monopoly of this valuable commodity by the State.

It is very probable that Mr. Bevan will in reality be pleased at the prospect of doctors so early becoming the tenants of local authorities and living and working in council houses and prefabs as comrades of the propertyless proletariat. There is little difference between this and the health centre idea, which is primarily to make the doctor's surgery one of many rented from a local authority. The basic idea of the commonplace mind is that the masses are really very stupid and will soon believe that one doctor is just as good as another however much they may at present claim the right to choose their own doctor.

It has been held by the various medical agencies that the prestige of doctors is invariably lowered in the eyes of their patients if they are obliged to live and practice in council houses and prefabs, but as the Government have set themselves irrevocably against the buying and selling of practices this levelling down of general practitioners as a profession must inevitably follow, with disastrous effect on the recruitment of G.P.s to the new Service and the standard of service rendered.—I am, etc.,

Slough, Bucks. N. C. HYPHER.

Appeal to the Courts

SIR,—I am astonished at the decision of the Council of the British Medical Association. We should not willingly accept service under the Health Act unless we can appeal to the courts. If we are treated justly there will be no need to appeal to the courts, but the fact that we are not allowed to appeal to the courts indicates that the Minister of Health intends to treat us unjustly. If he intends to be fair he should be willing to amend the Act to allow appeal to the courts.—I am, etc.,

Liverpool. H. E. ROAF.

Students' International Clinical Congress

SIR,—In July this year an International Clinical Congress of Medical Students—the first of its kind—is to be held in Britain under the auspices of the British Medical Students' Association. Up to date 130 delegates from 30 different countries have accepted our invitation, and a programme of lectures, visits, and ward rounds in various teaching hospitals, discussions, and entertainments for the visitors has been arranged to take place in the Universities of London, Oxford, and Birmingham.

The organizational expenses of the Congress have been met by grants from the British Medical Association and the International Union of Students. The response to invitations so far shows, however, that delegates from many countries are experiencing difficulty in meeting the necessary expense of the attendance. The British Council has generously agreed to cover the Congress fee for a number of delegates, but many countries will have to remain unrepresented unless further support is forthcoming.

May we therefore appeal through your columns for contributions from individual members of the public or from societies which have at heart the furtherance of friendship and understanding of students from all over the world, so that this important event will be truly international in character. Cheques will be gratefully received by the Treasurer, Students' International Clinical Congress, the British Medical Students' Association, B.M.A. House, Tavistock Square, London, W.C.1.—We are, etc.,

JOHN A. RYLE.
Honorary President of the Congress.
STEPHEN DRANCZ.
President of the British Medical Students' Association.
HERBERT E. REISS.
London, W.C.1. Chairman of the Congress Organizing Committee.

Temperature Records and Ovarian Activity

SIR,—Dr. Mary Barton (April 24, p. 806) has not convinced me that I should take rectal rather than oral temperatures. When I use basal temperature records to help me to determine whether a cycle is ovular or non-ovular, the "occasional deceptively low reading due to extraneous factors such as mouth-breathing" is not going to deter me unless she can produce a series of cases in which simultaneous oral and rectal temperatures have been recorded which show that the patients mouth-

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breathe so frequently only during the luteal phase that the oral method is unreliable. Should I decide to rely upon basal temperature records to diagnose glandulo-cystic hyperplasia or ovarian cysts, I should require records of the patient's temperature taken over a period of some months before she developed the suspected pathological condition to enable me to determine whether the *absolute* temperature level was of any significance. As for early pregnancy, Dr. Barton still has to prove to me that she demonstrates it more often than I do by my oral temperatures, and the same is true of the drop which occurs when abortion is imminent.

Dr. Barton states that my letter reflects certain common misconceptions concerning the significance of temperature records in the study of infecundity. It is a pity that she did not indicate what those misconceptions are. In my simplicity I employ these records in my Fertility Clinic only to determine whether ovulation takes place, and I should be glad of any evidence she has, based on a detailed analysis of a stated number of cases, that oral temperatures are more unreliable than rectal in this connexion, or that any other infecundity factor may be elucidated by rectal temperatures.

Dr. Barton mentions " thousands of cycles," " several hundred women," " more than 1,500 records gathered from private practice," " observed pregnancies (numbering about 150, and including nearly 90 cases recorded for two months or longer after conception)." She must therefore forgive me if I consider her experience of this subject to be unique. I do, however, believe it to be sufficiently unique to be capable of providing a valuable treatise, based on an analysis of a clearly defined number of cases and/or cycles, which should greatly advance our knowledge of this still controversial subject.—I am, etc.,

London, W.1. P. M. F. BISHOP.

Identification of Medical Documents

SIR,—The article entitled " Identification of Medical Documents " by Prof. Lancelot Hogben and his colleagues (April 3, p. 632) outlines a convenient and relatively simple system of numerical coding which would be a most useful and economical means of patient identification in a punched-card installation. It is doubtful, however, whether the code, employed additionally as a filing instrument, could be conveniently implemented in the majority of our hospitals. Prior to implementing the system it would be necessary to ensure : (1) that there was, in fact, in most hospitals a problem of patient identification that was not completely solved by existing means ; and (2) that the code would lead to greater convenience in filing than can be obtained by the present systems.

I would be grateful if you would allow me through the courtesy of your columns to apply these two criteria to Prof. Hogben's code, taking into account also the general procedures for medical documentation at present in operation in our hospitals.

The usual means of patient identification is a card index arranged in alphabetical order, on which are recorded the patient's full name, address, date of birth, employment, and date of admission and discharge, as well as the hospital registration number, which provides the link with the case-notes folder. The largest branch of this hospital has had an alphabetical identifying index of between 200,000–300,000 cards over the course of the past few years, yet there have been very few instances of confusion arising through similarity of surnames, and these have always been satisfactorily solved after additional details have been obtained. The occasions of difficulty have been so few that it is probable that a broadly similar result would have been obtained if Prof. Hogben's code had been employed, since there can be but little doubt that the chances of clerical error are greater in the process of coding than in the mere mechanical process of recording identifying particulars.

Prof. Hogben's code, as he describes it at present, consists of ten digits. This number may well have to be increased so as to provide a reasonable degree of specificity for those areas where there are accumulations of similar christian names and surnames in combination—e.g., the Ian " Macs " of Scotland or the Thomas Jones and John Davies of Wales. If the code is employed as a means of filing case histories, it follows that the filing clerk in her work would have to take into account a number consisting of at least ten digits. This is almost certainly impracticable, since the normal clerk finds it difficult to file correctly when the system entails more than six digits. The normal practice in hospital registration numbering rarely exceeds five digits (except for a prefix to indicate the year) and is always in numerical sequence, which itself minimizes misfiling and is, in addition, a means of checking missing case histories. If this procedure is superseded by Prof. Hogben's code, then it is probable that increased misfiling will follow the increase of the number of factors which the filing clerk has to take into account and the loss of the plain numerical sequence; in addition, a convenient means of checking missing case histories would have to be sacrificed.

Prof. Hogben claims that, following the implementation of his code, reference could be made to the case history without recourse to a " name-address admission-and-discharge register." Case-notes folders are now requested either by name or by diagnosis—the former method being associated with the actual treatment of the patient and the latter with research. If Prof. Hogben's system were adopted (there being no alphabetical identifying index), a busy out-patient sister who has urgently requested case histories by name would also have to be asked to supply, (1) the date of birth, (2) the birth rank, and (3) the maiden name in the case of married women. This she would rightly regard as an unnecessary burden. But the only alternative is an identifying index arranged in alphabetical order on which is recorded Prof. Hogben's code in exactly the same manner as the hospital registration number is recorded to-day.

It is agreed that Prof. Hogben's code would ensure that the medical documents relating to the same individual would be found in the same niche of the filing system in any institution. Within the individual hospital, however, the same result can be achieved provided that the unit system of medical documentation (one case-notes folder for each patient, irrespective of the number of admissions or attendances) is adopted. The fact that, additionally, an individual would have the same filing niche in Beachy Head or Birmingham or Bedford is of little importance provided that the records officer in each locality possesses a well-prepared identifying index, arranged in alphabetical order and linked by means of registration numbers to the case-notes folders.

There is no doubt that Prof. Hogben's code would be of great value in a punched-card installation, but one is forced to the conclusion that, rather than simplifying the internal running of a hospital records system, its effects would be the very reverse. The aim of any hospital filing system must be the speedy accessibility of all case-notes folders ; any system which may result in impeding the process should be discarded.—I am, etc.,

RONALD BROWN,
The Royal Liverpool United Hospital. Records Officer.

Accidental Syphilis

SIR,—Dr. R. R. Willcox is to be congratulated on his interesting résumé of the methods of accidental contamination with syphilis (May 1, p. 850). The list could be carried much further, the methods varying according to the customs of different countries. In North Africa, for example, Lacapère (*La Syphilis Arabe,* Paris, 1923) cites as modes of infection cupping of the nape of the neck, circumcision, tattooing, extraction of teeth, sucking of bites and wounds, common cups, *suçoirs* and *narghilés,* the passing of chewing-gum (Louben) from mouth to mouth, etc. Chancres of the head and even of the pubis may be acquired there at the barber's or from a common razor. The high incidence of accidentally acquired syphilis in infants and young children is an indication of the standard of hygiene in North Africa.

I have had it in mind for some time to write on this subject, but from another angle. Since the war ended there has been a noticeable decay in the art of lying among patients with venereal diseases. In the past, according to the patients, syphilis was often contracted through contact with syphilitic cricket balls, billiard tables, bedposts, bulls' horns, etc. Now my patients seem always to contract their diseases by sexual intercourse.

The lavatory seat was seldom cited, and in the Army it could only be claimed as a cause by officers of the rank of colonel or higher. The last time I heard it mentioned was by a patient with a lip chancre who said, " The only difficulty about this business is that nobody will believe I caught it off a lavatory seat."

If Dr. Willcox is correct in his assumptions, and I—like most patients' wives—will need much more convincing evidence than he has produced, it may be necessary to propound yet another theory for the origin of syphilis which should be named the Haringtonian theory (after Sir John Harington, author of *The Metamorphosis of Ajax*).—I am, etc.,

London, S.W.1. JAMES MARSHALL.

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