

ones in a little space and naive to think that bad note-takers will be induced to write good ones by providing much.

Any doctor who has been in practice for a few years will have seen examples of notes made by many colleagues all over the country. No fair-minded observer could fail to conclude that the general standard is very low: some make no notes; some note treatment only; some make occasional observations rarely selective of salient features; some write a few unimportant words scattered over many lines; almost worse are those who write amorphous full notes legible only to the author.

Regrettably, for all these reasons it is almost always easier to elicit the main features of a new patient's history by reading the letters from hospitals. These are frequently folded up in the way they were originally posted and it is necessary to open them out, arrange them chronologically, discard the majority (e.g., "Thank you for referring . . . a cholecystogram showed . . . your patient was discharged to-day . . . the wound is well healed . . .") and staple together the inpatient summaries, important outpatient letters, and x-ray and laboratory reports. Clear working notes can be made on the present record cards by using a system of underlining and boxing of the main symptoms, features, and diagnoses which enables any doctor to pick them out rapidly. By these techniques adequate and useful notes can be confined within the present envelopes, usually without need for the gusseted form.

No reader of *Parkinson's Law*<sup>1</sup> and hospital records will deny that "Notes expand to fill the space available." Bulging hospital folders usually contain the records of one or two illnesses; a total life history on the same scale would require a suitcase, and the extraction of an important fact would be as difficult as finding a needle in a haystack.

Notes in general practice may be improved by education, conceivably by rod and carrot, but certainly not by acres of paper.—I am, etc.,

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<sup>1</sup> Parkinson, C. N., *Parkinson's Law; or the Pursuit of Progress*, London, Murray, 1958.

### Breech Management with Fetal Blood Sampling

SIR,—We have read with considerable interest the correspondence following the paper by Mr. B. W. Eliot and Mr. J. G. Hill (23 December 1972, p. 703) on the management of breech labour. There seems little doubt that fetal blood pH measurements can improve the management of these cases, but we cannot agree with the assertion of these authors (30 June, p. 775) that, as against continuous heart monitoring, "fetal blood sampling gives an earlier warning of fetal anoxia."

Myers *et al.*<sup>3</sup> have shown in fetal monkeys that reduction of blood PO<sub>2</sub> produces late decelerations of the continuous fetal heart rate before there is any change in pH, though this would eventually fall. Wood *et al.*<sup>2</sup> state that "changes in the fetal heart rate usually precede a fall of fetal blood pH. Fetal circulatory changes do provide an early warning of fetal disturbance. . . ." Indeed, present knowledge of

circulatory responses to hypoxia leads one to expect the following sequence of events: hypoxia, changes in heart rate, acidosis. The question is, At what point in this hypoxic process is the fetus at risk from neurological damage? Because there is as yet no definite evidence on this question we have made the reasonable assumption that damage from hypoxia is unlikely while the pH is still normal. A fall in pH indicates the onset of widespread tissue hypoxia as opposed to transitory hypoxaemia, when the pH remains within normal limits.

All are agreed that early detection of fetal hypoxia is the primary objective of monitoring in labour. Thus the question is not whether continuous fetal heart rate monitoring is preferable to fetal pH measurements but whether it is preferable to intermittent auscultation as the earliest indicator that the fetus is becoming hypoxic. No comparative study has been done to settle this point, but indirect evidence suggests that the cardiocotograph is superior. A review of intrapartum stillbirths at Queen Charlotte's Hospital<sup>3</sup> over a 30-month period when fetal blood sampling was available shows that in 11 of the avoidable stillbirths there was no abnormality of the fetal heart rate by intermittent auscultation which would have indicated the need to collect a fetal blood sample. In favour of the cardiocotograph, Schifrin and Dame<sup>4</sup> state that they had seen no documented case of unexpected intrapartum death among monitored fetuses. Our experience has been similar though we would add that a scalp electrode should be used in preference to external ultrasound or phonocardiography whenever possible.—We are, etc.,

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<sup>1</sup> Myers, R., Mueller-Heubach, E., and Adamsons, K., *American Journal of Obstetrics and Gynaecology*, 1973, 115, 1083.

<sup>2</sup> Wood, C., Lumley, J., and Renou, P., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1967, 74, 823.

<sup>3</sup> Beard, R. W., *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1968, 75, 1291.

<sup>4</sup> Schifrin, B. S., and Dame, L., *Journal of the American Medical Association*, 1972, 219, 1322.

### Endotoxic Shock Complicating Transhepatic Cholangiography

SIR,—In a series of well over 100 percutaneous cholangiograms I have twice encountered the complication reported by Mr. M. R. B. Keighley and others (21 July, p. 147), once with almost fatal results. It then became apparent on scrutiny of the films of the first case that the evidence for the presence of a "blood-bile fistula" was demonstrated by the appearance of opaque medium in the renal tract within two minutes of the commencement of injection into the biliary tree. The importance of this sign was not appreciated at the time but was responsible for the starting of extremely vigorous treatment of the second patient within minutes of occurrence. It may merely be a happy coincidence that the second patient had only a minimal reaction.

It is not our policy to carry out these

examinations under antibiotic cover but immediate treatment is instituted in the event of the demonstration of an incidental pyelogram.—I am, etc.,

DOUGLAS NELSON

Royal Victoria Hospital,  
Folkestone, Kent

### Witwatersrand Golden Jubilee

SIR,—In 1924 the first four graduates emerged from the medical school of the University of the Witwatersrand. The 50th anniversary of this event will be celebrated in 1974. The Medical Graduates' Association of the university is organizing a year of commemoration that will serve as a focus for an evaluation of the rôle of the medical school and for planning for the future.

In the 50 years since 1924 more than 4,000 graduates in medicine of the university have entered many fields of medical practice to serve health care needs throughout the world. The medical school has no record of the achievements of these graduates, and the Medical Graduates' Association is compiling information on each individual medical graduate. We have the addresses of only two-thirds of our graduates, and to these we are sending in September 1973 a questionnaire about themselves to ascertain information about their professional and non-professional lives. Through the columns of the *B.M.J.* we appeal to all graduates to complete and return this questionnaire. Those who do not receive a copy are asked to write to: The Secretary, Medical Graduates' Association, University of the Witwatersrand, Johannesburg, South Africa.—I am, etc.,

G. R. BEATON

President,  
Medical Graduates' Association  
University of the Witwatersrand

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### Women Doctors and Family Planning

SIR,—I should like to assure Dr. Elphris Christopher (21 July, p. 176) and Dr. Jean E. Lawrie (4 August p. 296) that the future of Family Planning Association clinic doctors, both men and women, after family planning becomes the responsibility of area health authorities, is very much in the forefront of our minds.

I am having regular meetings with officials at the Department of Health and Social Security at which procedures for handing over our clinics are discussed, and in April I was assured by the Department that the aim would broadly be to see that no one suffered financially or otherwise as a result of transferring to the National Health Service.

Area health authorities will obviously be anxious to maintain the standards already set up by local authorities and the F.P.A. As the F.P.A. through its National Family Planning Agency Scheme, provides the bulk of present clinic services it seems sensible to presume that area health authorities will wish to retain the services of the F.P.A. doctors who have made these high standards possible.—I am etc.,

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