administrative offices in the very best position, perhaps rightly so, but the medical records department will probably be located in the basement. It has not been redecorated recently, is miserable and ill equipped, but, never mind, nobody "important" goes there.

Sir Herbert mentions training schemes. No doubt he knows only too well that 99% of new medical records staff are "trained" by sitting next to the girl who has been in the post a month or so longer. We call it "learning from Lucy." I think it an admirable suggestion that a rumpus be made to the Department for recognition, but would suggest that charity begins at home, with the medical staff at hospital level acknowledging the medical records officer as a professional in her own specialized field and supporting her in her attempts to improve and maintain a high standard of record keeping.—I am, etc.,

GWEN GASCOYNE
Medical Records Officer

Bethnal Green Hospital,
London E.2

SIR,—"Is the keeping of medical records and all that has grown out of it something to be taken more seriously?" The Association of Medical Records Officers welcomes the question put by so eminent a member of the medical profession as Sir Herbert Seddon (9 October, p. 103) and is grateful to the *British Medical Journal* for the publication—it is a long time since space was given to this important subject.

Sir Herbert Seddon's comprehensive reflections touched most of the far-flung boundaries of the medical records officer's territory—from being responsible for an impertinent receptionist to the exacting demands of hospital activity analysis.

The Association of Medical Records Officers set out to remedy what was felt to be a serious lack of educational facilities. Despite over 20 years of energetic effort, on an entirely voluntary basis, there is still a dearth of qualified officers with the correct professional approach which the nature of much of the work demands. This is very apparent when senior posts fall vacant or new senior appointments are created. This shortage will increase with the anticipated reorganization of the National Health Service. The appointment of untrained and inexperienced persons to this specialist field is uneconomic and not without risk. The Ministry of Health circular of 1949 (R.H.B. (49)56; H.M.C.(49)44; B.G.(49)48) stimulated interest at that time, but specific training facilities were not made, and are not made, within official schemes.

The challenging demands of the present day are being met by the association's completely revised examination syllabus to cover training for medical records personnel, medical records officers, and the more senior and highly qualified managers of patients' services.

We hope that with the active support of members of the medical profession, the Association of Medical Records Officers can press on with its objective of ensuring an adequate number of appropriately qualified officers.—I am, etc.,

MARY GLEN HAIG
Chairman,
Association of Medical Records Officers

London W.1

Casualties

SIR,—The adjective "casual" is frequently used for various patients attending accident and emergency departments. Dr. P. N. Dixon and Mr. A. F. Morris (23 October, p. 214) say "of these 1,288 new attendances 1,108 (86%) were casual attenders who had not been referred to the accident department by any person with medical or nursing qualifications." Presumably these patients were no more accidental, unforeseen, or occasional than those referred by doctors. The implicaton seems to be that they are casual in the sense of off-hand, negligent, and unceremonious.

This equating of non-referral with casual is most unfortunate. As Dr. Dixon and Mr. Morris point out, some non-referred patients have very serious complaints—chest pain, renal colic, road transport accidents, etc. But even in the case of relatively minor accidents it is quite unreasonable to suggest that, no matter how near the hospital or how difficult to contact their doctor, a patient with a small accident should always go first to his own doctor. The terms medically referred, non-referred, major and minor, accidents and illnesses cover the various categories clearly and succinctly. If the term casual is to be used at all it should be reserved for the patient who reports with a minor complaint after a lapse of many days.

We believe that our department is for major and minor accidents and for major emergency illnesses. At the same time we welcome the development of good services for treating minor illness in health centres and hope to co-operate with them. But we do not foresee a day when our minor accidents will entirely be taken over by health centres.

Whether it is wise that the minor accident department in health centres be run entirely by nurses is open to question. If the nurse should fail to diagnose a fractured scaphoid or a septic arthritis from a pinprick into a finger joint, who is going to be legally responsible if a claim of maltreatment is made?—I am, etc.,

W. H. RUTHERFORD

Accident and Emergency Department,
Royal Victoria Hospital,
Belfast 12

Computer Service for Obstetric Records

SIR,—I have read your article "Computer Service for Obstetric Records" with great interest (2 October, p. 32). Permit me to explain how we solved the problem of data-collecting in our department.

Since 1 July 1969, simultaneously with 11 other European departments, we have transcribed our information on a standardized file. For each delivery a marking sheet is established which is automatically transformable into a punched card or may be directly improved by computer through the optical reader device.

Unfortunately the data are essentially qualitative and allow only punching of the "absent/present" type. Moreover the statistical improvement is performed only once a year. The only advantage of this system is that it gives a global analysis of the activity of 12 departments as well as the individual results of each one of them. This was not satisfactory.

We established a procedure for collecting data of essentially quantitative nature that can be found in a file of prenatal supervision and of delivery. The day after the mother has left the maternity ward each file is read by the same assistant, in order to keep identical standards and definitions. The information is noted on marking-sheets that are Roneo-typed for economy purposes. At the end of each month those sheets are sent to the "centre de calcul" of the university in order to be punched.

On a first card we note, in addition to the identification number, the maternal antecedents, the normal or pathological evolution of the pregnancy, the unfolding of the delivery, and the examination of the child at its birth. The whole contains 42 titles spread over 79 of the 80 columns of the card. A second card assembles the measurements of the biparietal fetal diameter evaluated by ultrasound. Each week of pregnancy occupies a fixed zone of the card. A third card is used for the numbered results of the different methods of prenatal supervision as they are applied in the department.

Each time one or more ultrasonic, cytological, enzymatic, or hormonal examinations are carried out a card is punched. As a result of this, the duration of amenorrhoea being noted in days according to the last menstruation, each card represents the results of examinations undertaken at a clearly determined date of the pregnancy. In that sense, we have an average of ten cards per file. The number of columns reserved to each title is such that no significant figure gets lost.

The advantage of this method is the fact that it allowed us, firstly, to establish the curves of normal value for each one of our laboratories, and, secondly, to give us the evolution, compared to the normal situation, of each one of these parameters in the pathological pregnancies. We also use this method, by means of a sorting machine, as a "library" of the clinical cases. This is very useful for teaching students.—I am, etc.,

P. FLAMME

Hôpital Universitaire Brugmann,
Université Libre de Bruxelles,
Brussels

Undescended Testis

SIR,—I read with interest Mr. W. Van Essen's apt denunciation of the term orchidopexy and of the various tension methods of testicular fixation (23 October, p. 232). It may occasionally prove difficult to mobilize an undescended testis sufficiently to bring it into the lower part of the scrotum, but this certainly seems no reason to vent one's vexation on it by exerting forces of several *g* on the unfortunate organ.

However, I think it is perhaps a little unfair to include a scrotal pouch among the tension methods of testicular fixation he so rightly deplores. It is important that, in the immediate postoperative period, the testicle should adhere to the lowest part of the scrotum rather than the scrotal neck, and some form of surgical manoeuvre is probably justified to ensure this.

I wonder if disappointment with scrotal fixation may sometimes arise from attaching the testicle to the antero-inferior part of the scrotum rather than the postero-inferior part. In a child, particularly, most of the action of the dartos muscle is on the anterior

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