

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.,

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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.,

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### 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.,

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