Correspondence

Letters to the Editor should not exceed 500 words.

Intrauterine Contraceptive Device and Population

SIR,—To comment on the *B.M.J.* editorial (31 July, p. 249) on intrauterine contraceptive devices, and the letters by Mr. J. A. Stallworthy (21 August, p. 476) and Mr. H. V. Corbett (11 September, p. 643), the introduction of oral contraceptives has been highly successful in many parts of Africa. The "pill" is aesthetically acceptable (attendance of Indian women at Natal Family Clinics was 14,000 in 1963, 28,000 in 1964), but for a large minority of Asian or African women the intrauterine device is, for various reasons, a suitable alternative. But the family planning clinics from which these contraceptives are as yet available are situated in the larger towns. Very little contraception is undertaken in rural areas because of the shortage of staff, etc.

The criticisms by Mr. Stallworthy or by Mr. Corbett of the suitability of either contraceptive for use in Africa suggest a conflict of choice where none in fact exists. They seem to merge, or identify, the problem of contraception for the individual woman with birth control of the populace as a whole. In practice, a doctor who is organizing a new family planning clinic in a small town still needs to depend on oral contraceptives while conducting the *fundamentally important* campaign of instruction, of teaching the ethical importance and the economic necessity of responsible "planned" parenthood, because of the ever-increasing population, etc. But nation-wide birth control needs be sponsored by or initiated by the State. No large-scale campaign has begun in Africa as yet, and it would seem excessive optimism to hope that either or both of the contraceptives presently in use will achieve adequate early birth control in any State. But in the meantime many thousands of mothers enjoy the experience of relief from fear of unwanted pregnancies.

The attitude of all sensible mothers is one of grave concern, and the decision to control conception creates a delicate social or professional situation. Contraception is the crying, literally the crying, need of thousands of mothers everywhere in Africa. Some time ago, on entering the maternity ward of the hospital in Mbabane, the capital of Swaziland, I was hailed by a loud cry of distress from an African mother in the throes of childbirth, "Doctor! doctor!" she cried, "tie my tubes, this is my twelfth baby and I can't afford to feed them all." This educated woman knew nothing of oral contraceptives, although "pills" were on sale in the local pharmacy. It was even more disturbing to learn that none of the African nursing staff had any knowledge of contraceptive practices either, although excessive births and malnutrition are grave problems in Swaziland. In this context one may consider the *B.M.J.* editorial "Africa's Need" (10 April, p. 939) and the many letters which have flowed in contributory comment. In the opinion of a doctor long resident in the African colonies, and experienced in the problems of excessive childbirth and the prevailing malnutrition, these contributions are remarkable in that not one of the authors expresses concern or shows awareness of existing over-population and recognition of the fact that improved health services, if unaccompanied by birth control, will aggravate the problem of over-population. It is 17 years since Dr. William Vogt published his important book *The Road to Survival*; in this he castigates the medical profession for ". . . causing the population everywhere to multiply in ever-increasing numbers without regard to the consequences. . . . They wash their hands of responsibility 'for it all.'"

We should surely excuse our colleagues for their conventional professional outlook in 1948, but is it excusable in 1965? Surely the altered human situation requires a more enlightened ethical attitude—the recognition of the situation that improved death control needs to be balanced by birth control? To a colleague who replies "Birth control is not my responsibility," one may fairly protest, "If not *your* responsibility, *whose* duty do you think it is?" In this context it is apposite to refer to the letter by Mr. E. E. Philipp (*B.M.J.*, 31 October 1964, p. 1132) which considers the failure of the London teaching hospitals to instruct students on the subject of contraception and the need for birth-control (in the Commonwealth). Is the fair verdict that "new disciplines require new minds"?

In the meantime, under the guidance of the International Planned Parenthood Federation, family-planning clinics bring relief to many thousands of mothers. These continue to be organized mainly by women volunteers; enlightened humanists, they are the practical missionaries of our time; some have been martyrs.—I am, etc.,

Capetown, South Africa. F. M. PURCELL.

Standardization of Medical Records

SIR,—I would like to comment on certain aspects of the recent Ministry of Health report on the *Standardization of Medical Records* (see *B.M.J.*, 16 October, p. 892). The views expressed in pages one to five are indisputable, but it would surely be unwise to adopt unaltered the recommendations on management contained in pages six to eight, and also the method of filing proposed in paragraph 45.

It is, for example, overambitious to presuppose that all primary documents in a folder can be tied securely in book form, and it really is not good enough to suggest a method of filing which involves the use of a fastener, admitting at the same time that "the ideal fastener has yet to be discovered." A book folder would perhaps suffice for the patient who attends a department on a few occasions, but not for the many who are seen by more than one consultant over a number of years. Furthermore, permanent folders which are not contained in envelopes, when bundled together and carried by persons who have no reason to be tenderly disposed towards them, are liable to be damaged, and enclosures which are torn may be irretrievably lost.

I am not certain where, in the order of primary documents (page seven), it is proposed to insert a copy of the hospital doctor's out-patient letter to the family doctor. If typed directly on to a used continuation sheet secretaries will be for ever fastening and unfastening records, and if on to a new one, in order to keep entries consecutive, space will inevitably be wasted.

It is not usual to record the abnormal feature of every diagnostic report on the history sheet (paragraph 23). One of the purposes of medical records, after all, is to maintain efficiency, and it is inefficient to have to reproduce in illegible longhand something which is already neatly typed and sometimes lengthy. There are occasions when the results of "ancient" investigations should be immediately accessible, and how tedious it would be if vital information were to be filed away in a secondary document, its counterpart in the folder hiding somewhere on one of many sheets bespattered with irrelevancies. I do not believe that hospital doctors concern themselves overmuch with the design, size, or colour of forms (paragraph 12)—although we would like to feel that the concluding sentence on H.M.R. 300 (fig. 16) is superfluous—but we do aspire towards the ideal record folder, simple in design to avoid mistakes in filing, sturdy of build to survive undue wear and tear, and endowed with just a little elegance.

Four years ago at the Haverfordwest Hospitals we introduced a system based on the following principles:

(1) Case records are divisible into four parts.

(*a*) Identification sheet, history and clinical findings, progress and other follow-up notes.

(*b*) Correspondence, beginning with the general practitioner's letter of introduction and including discharge notes and summaries and all subsequent letters between doctors.

(*c*) The results of pathological, x-ray, and other investigations, including in this section all items recorded on standardized forms—for example, consent for operation and details of anaesthesia.

(*d*) Charts and other miscellanea, which we will henceforth label "transitory documents."

(2) Sections (*a*) to (*d*) are inserted separately into an envelope with a flap and also a gusset for transitional notes, and one considerable advantage of this method is that the sheets in each section, attached consecutively in a thin folder, are unlikely to tear.

Recently we have been able to compare our system with another introduced in a neigh-

bouring hospital, where the four sections are similar but are tied together as separate chapters in a book. This method, for the reasons I have given, has not proved entirely satisfactory.

There are of course equally efficient and better ways of managing medical records already in use in hospitals throughout this country, and before we are all committed irrevocably to an experiment in standardization it would be reassuring to know that somewhere the new method had already been tried and proved.—I am, etc.,

Pembroke County War Memorial Hospital, Haverfordwest, Pembs. EIRIAN WILLIAMS.

SIR,—Medicine is professedly based on observation, yet the report of the Subcommittee of the Standing Medical Advisory Committee, to which your leading article (16 October, p. 892) referred, has given no guidance on a form to record these observations other than to provide a blank sheet. The "detailed" kind of form is dismissed in the recommendations as being "inhibiting to those who have not been concerned in their design"—yet the adoption of this kind of comprehensive form would not preclude the allocation of space on the form for additional comment.

The basis of a sound medical record must be the accumulation and accurate recording of the detail relative to the patient's history, both medical and social. It is therefore of prime importance to have a detailed history sheet to act as a foundation on which to build the record. The value of this procedure lies in its ability to progressively guide the doctor through the patient's history, building a picture in his mind, while allowing him the maximum ease of recording the facts. Details on the form might be set out under headings which cover the family history, personal and social history, and then other headings relative to symptomatic inquiry, examination, and then a summary of positive clinical data.

Having provided a basic structure on which to build, it will be necessary to agree on the most efficient method of filing within the case folder. Opinion may well be divided on this issue between (*a*) with the latest entries at the beginning of the record or vice versa, (*b*) with out-patient notes separate from in-patient notes, or (*c*) whether each specialty should have its own notes. To expect national approval of any method would seem to be too exacting, yet filing within the folder could be one of the ingredients—if not the cause—of the chaos which is much in evidence, and for which there does not exist any official guidance or policy. Exploration of these procedures must lead to a decision on the case folder, which must be an efficient vehicle for safely carrying the documents, and yet be capable of presenting the notes easily and quickly, so that identification of significant detail is not uneconomical in time and labour. Its size, design, and colour can be of paramount importance, and it would seem that a lot of the apparent forecast difficulties could be overcome by a slight reduction in the length of the folder.

This would allow the new folders to be accommodated in cabinets and shelves *now in use*, and furthermore the new size of forms necessitated by this reduction could be introduced into folders now in use—solving the problem of implementation. These are three problems on which, if agreement could be reached, the structural standardization of the medical record will have graduated from its present idealistic world into the world of reality, and the case note could be expected to serve a long and useful life, with the extraction of detail for computerization (when such a procedure is made available) made very much easier.—We are, etc.,

J. SLOWE.
I. M. KING.
J. R. SMITH.

Medical Records Office, Hammersmith Hospital, London W.12.

Old People and Mental Hospitals

SIR,—May I once more crave space in your columns to reply to those who have kindly written to the *B.M.J.* or to me personally to render support or make helpful suggestions in response to my letter (11 September, p. 643)?

It was an interesting coincidence to receive about the same time Ministry of Health Circular H.M. (65) 77 on the care of the elderly, and to find in the *Lancet* (18 September, p. 583) J. A. Whitehead's report from Severalls Hospital. Both these publications, as well as Dr. Parnell's letter (25 September, p. 756), stress *inter alia* the need for a more positive policy which aims at the discharge or at least a temporary or intermittent return home of the elderly patient.

No doubt such a policy, if successfully implemented, would soon free some beds and inspire the whole service with a greater sense of meaningful bustle. We shall certainly try to follow the good example of others who claim to be successful in this venture.

It should, however, not be forgotten that most of these measures had to be implemented, not as the ideal way of looking after elderly patients but as ways and means of overcoming material shortages, which are not thereby resolved. Nothing is more effective in precipitating confusion in the elderly than a change of scenery. Nothing, also, is more abhorrent to the elderly, who once happily settled prefer to stay where they are. Statistical advantages, expressed in numbers of beds and discharge figures, must be balanced against the more elusive factor of distress inflicted on both patients and relatives by measures which after all are primarily designed to make limited facilities yield maximum returns.

But there is in addition a disturbing discrepancy between the written word and reality. The hard facts are that even the most assiduous search for reversible physical factors and the most energetic treatment of marginal abnormalities in the early weeks after admission are not often rewarded by material improvement in the patient's mental state; that even the most devoted relatives can display a surprising change of heart once the patient is happily settled in hospital; and that a substantial number of elderly patients have been living alone prior to admission, so that the question of discharge never arises.

Finally, may I be allowed to say a word on semantics? Politicians notoriously disguise unpleasant facts with honeyed words and neologisms. Let us not fall into that trap. We know what is meant by the term senile dementia, and there seems little point in clouding the issue by pretending that there is no such thing. The condition is basically irreversible and progressive, but its natural fluctuations permit of a degree of reversibility, which depends on the chance given to the patient to use his residual powers of adaptation to the full. This is the reason, no doubt, why patients are so much more manageable in hospital than at home. If we do not like the term any more there is no reason why it should not be changed by common consent to a happier label. Just at present, however, even if it can lay claim to no other virtue, the term senile dementia does seem to enjoy a certain grammatical superiority over its suggested rivals—"she was subacutely delirious on admission but her condition stabilized into one of elderly confusion with a course of parenteral vitamins."—I am, etc.,

Brookwood Hospital, Woking, Surrey. R. EMERY.

Vascular Lesions in Diabetes

SIR,—Regarding Dr. T. M. Ferrier's comments (2 October, p. 819) on our recent article (3 July, p. 19) we felt justified in saying we had confirmed the work of Goldenberg *et al.* in so far as we found histological evidence of "non-atheromatous peripheral vascular disease of the lower extremity in diabetes mellitus," to use the title of their pioneer paper. Like them, we demonstrated a lesion with endothelial proliferation and deposition of a P.A.S.-positive material in the small vessels of most diabetics. It is true that in most of our cases the proliferative part of the lesion was much less obvious than in Goldenberg's illustrations, and that we found the changes in the arterioles and larger capillaries more marked than in the small arteries. However, some of our grade-IV sections did include a few vessels showing a lesion somewhat similar to that in Goldenberg's digital artery sections; his Fig. 11 demonstrates a neutral arteriole with an appearance more like our typical examples.

It is stated in Dr. Ferrier's letter that other workers (Aagenaes and Moe, Banson and Lacy, Weber and Wicht) had been unable to demonstrate a specific endothelial proliferation in the smallest arteries and arterioles. We should like to point out that in fact these workers examined skin and subcutaneous tissue only, and naturally they made no comment about the state of the arteries; admittedly they found no endothelial proliferation in the smaller vessels.

Dr. Ferrier doubts whether the type of lesion we described is a specific diabetic one. Certainly we found the angiopathy present in 3 out of 52 non-diabetics, but surely our blind assessment of the skin biopsies is significant; 78 cases were allocated to the diabetic or non-diabetic groups merely on the histological appearance of the small blood-vessels, and the allocation was correct in 90%. We look forward to the publication of the Brisbane Hospital study of amputated limbs, and we note that Dr. Ferrier found intimal proliferation and more marked medial calcification in the metatarsal arteries of diabetics; it would be most interesting if he could submit his sections to blind allocation, as we did with our skin biopsies.