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.,

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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.