Advertising of Antibiotics

SIR,—We would like to comment on certain aspects of the correspondence which has followed the publication of our letter on this subject (14 April, p. 116), particularly with reference to amoxycillin and cephadrine.

We agree with Dr. E. T. Knudsen (28 April, p. 240) that changing a molecule in a compound may alter its action, but this is by no means invariable. For example, the May 1973 issue of *MIMS* contains 40 preparations of tetracycline and its derivatives which have different formulae but virtually identical antibacterial spectra.

We are not opposed to amoxycillin which, as Dr. Knudsen pointed out, is superior to ampicillin, and indeed it has been suggested that amoxycillin may shortly replace ampicillin in therapy.¹ May and Ingold² consider it better than ampicillin in chest infections, and in our own small series of women with bacteriuria amoxycillin produced better results than we had previously obtained with ampicillin.³ Amoxycillin does have different pharmacological properties from ampicillin, but emphasizing the differences and ignoring the points of similarity only confuses the prescriber. All doctors are aware of the indications and side effects of ampicillin, and if they had been told that amoxycillin has an almost identical antibacterial spectrum to that of ampicillin, but was twice as well absorbed, they would have been fully informed as to its place in the treatment of patients suffering from infections.

Professor L. P. Garrod (28 April, p. 239) was right in saying that “a new orally administered cephalosporin must stand or fall by comparison with the only other such compound available in this country—namely, cephalixin.” We have obtained a sample of cephadrine by courtesy of Smith, Kline, and French Ltd., and some comparative sensitivities for cephadrine and cephalixin are illustrated in the accompanying table. The antibacterial activity of the two compounds was almost identical for the organisms tested—staphylococci and various Gram-negative bacilli. There may, of course, be pharmacological or toxicological differences between the two compounds which have not yet been elucidated. Meanwhile, there are now four oral cephalosporin preparations with similar antibacterial spectra: Ceporex and Keflex (both cepha-

lexin) and Eskacef and Velocef (both cephradine).

We thank Mrs. J. Andrews, FILMT and Mr. K. Bedford, B.Sc., for technical assistance.

Dudley Road Hospital,
Birmingham
East Birmingham Hospital

J. D. WILLIAMS
A. M. GEDDES

- 1 Garrod, L. P., *British Medical Journal*, 1972, 4, 473.
- 2 May, J. R., and Ingold, A., *British Journal of Diseases of the Chest*, 1972, 66, 185.
- 3 Kosmidis, J., Williams, J. D., Andrews, J., Goodall, J. A. D., and Geddes, A. M., *British Journal of Clinical Practice*, 1972, 26, 341.

Risks of the Good Samaritan

SIR,—It is commonly asserted that doctors are reluctant to render emergency aid at the scene of an accident because they fear that they will be sued for malpractice in the event of an unfortunate outcome. It would seem that there is a widespread assumption that many malpractice actions have resulted from such circumstances.

It is gratifying to note that in its report¹ the commission that was convened in the U.S.A. two years ago to examine the medical malpractice problem in that country has exploded this myth. The commission was aware of only one reported case in which an injured person filed a malpractice suit against a doctor in such circumstances and this was in Hawaii. Furthermore, the commission had no information about any out of court settlement of any action that arose out of a doctor rendering emergency treatment at the scene of an accident. The Medical Defence Union has never been involved in such an action.

Though the fears of doctors about their potential liability for rendering emergency aid may be real, they appear to be based on little more than rumour or hearsay, generated and perpetuated in large part by the mass media. The legal risks in rendering emergency aid to accident victims are infinitesimal and there is no factual basis for the commonly asserted belief that actions are likely to stem from rendering emergency aid at the scene of an accident. Publicity should be given to this fact in order to allay the fears of

doctors and nurses in this regard and to encourage the rendering of emergency treatment at the scene of an accident.—I am, etc.,

PHILIP H. ADDISON
Secretary,
Medical Defence Union

London W.1

¹ Report of the Secretary's Commission on Medical Malpractice, Washington, U.S. Department of Health, Education and Welfare, 1973.

Redesign of Medical Records in General Practice

SIR,—The anxieties expressed by Drs. J. M. Brown, D. Jarratt, and H. C. I. Bywater (26 May, p. 483) in relation to the contents of ECN 946 are understandable, but in some respects wide of the mark. It is only fair to state that the Health Departments' acceptance of the recommendation that A4 size folders should be adopted for general practice records follows a resolution passed by the Conference of Local Medical Committees in 1971¹ “that as a matter of policy the future medical record should be of a size to contain unfolded paper of A4 size. . . .” This is the opinion of the elected representatives of the profession. It is reinforced by the findings of research involving a random sample of general practitioners in Scotland,² where there was substantial support (especially among more recent graduates) for the concept of A4-sized folders, and also by the comments of practitioners involved in the experimental Wantage records project.³

Far from being inconvenient, the vast majority of doctors who have reported experience in the use of A4 folders have found this system to be a more versatile, more efficient, and more satisfactory clinical tool in patient care than the system it is designed to supersede. There are many reasons for this but one of the most important in this era of expanding communication is the simple one of the ease with which letters filed flat and in chronological order can be scanned and, when appropriate (and it is often appropriate), “weeded” to rid files of obsolete data, thus reducing bulk.

The problems of finding or making space for these larger record folders and for financing the exercise are recognized to be difficult ones, but the introduction of the system will be gradual and voluntary and the accumulated experience of practices which elect to convert their records should provide more accurate calculations on the basis of which negotiations will doubtless continue.

Your correspondents who believe that a records system designed in 1920 is adequate for the greatly changed medical scene of the 1970s are of course entitled to their opinion, but not to an unsubstantiated claim that they speak for a “silent majority.” Meanwhile they should not seek to impede the voluntary introduction of a system which both theory and practice have shown to have considerable potential for increased efficiency and better patient care.—I am, etc.,

J. J. C. CORMACK
Edinburgh

- ¹ *British Medical Journal Supplement*, 1971, 3, 17.
- ² Cormack, J. J. C., *The General Practitioner's Use of Medical Records: Scottish Health Services Studies No. 15* Edinburgh, Scottish Home and Health Department, 1971.
- ³ Oxford Regional Hospital Board, O and M productivity Services Unit, *Evaluation of Wantage Medical Records Project*, O.R.H.B., 1971.

Comparison of Sensitivity of Organisms to Cephadrine (C1) and Cephalixin (C2)

Organism	Strains Tested	Minimum Inhibitory Concentrations (µg/ml)							
			0.5	1	2	4	8	16	32
<i>Staphylococcus pyogenes</i>	50	C1	4	14	13	6	2	4	7
		C2	5	19	10	5	—	7	4
<i>Staph. albus</i>	25	C1	6	10	4	2	2		
		C2	10	7	5	1	2		
<i>Proteus spp.</i>	63	C1	12		3	21	16	1	22
		C2		1	1	36	8	2	15
<i>Klebsiella spp.</i>	71	C1		1	18	46	2	1	3
		C2		2	53	13			3
<i>Escherichia coli</i>	68	C1			6	50	4	3	5
		C2	1	2	28	26	5	1	5
Other enterobacteria*	31	C1			2	10	2	3	14
		C2			3	6	6	1	15
<i>Haemophilus influenzae</i>	38	C1			4	6	19	10	3
		C2				18	7	7	2

*These include *Bacillus anitrat* (7), *Serratia marcescens* (3), *Providencia spp.* (5), *Enterobacter spp.* (9), and atypical *E. coli* (7).

**In Spring 1971 the General Medical Ser-