My A5 double-pocket wallet opens like a book with two inside gussetted pockets, which are able to take the usual hospital letter unfolded. The only item requiring folding is the large A4 hospital report. There are a number of minor advantages with this system.

The Department of Health and Social Security and the General Medical Services Committee have already given their opinions on the new A4 record size folder for general practice. About 90% of medical records in general practice do not require the large A4 hospital size of record. The A5 folder would be immensely less expensive and more convenient in the office and cheaper to produce and reduce conversion costs in practice.

Dr. Gillian Strube's second point was the change to a numerical system of filing. This has been tried in a few practices and, although I have not been persuaded of its value, it is a system any general practitioner can use without inconveniencing any others.

I do not agree that the A4 folders need take up no more floor space than the old medical record envelopes. The A4 folders are large, bulky, and take up more than twice as much room.

I agree that the computer storage of records for general practice is a long way off and may never occur in ordinary general practice. I also have many personal doubts as to whether this system is in the interests of the patient, particularly when confidential information is being recorded.—I am, etc.,

A. J. LAIDLAW

Worcester

SIR,—Before 20,000 general practitioners find themselves persuaded by the enthusiasts such as Dr. J. K. Hawkey and others (11 December 1971, p. 667) and Dr. Gillian Strube (19 February, p. 513) and by the administrators that a larger (A4) size of record folder is desirable they should consider some of the defects of larger folders apart from the obvious one of sheer bulk. Worst of all defects is that they allow or actually encourage the accumulation of rubbish which is already too common in collections of medical notes both in hospital and outside.

I have recently started to collect gems from general practice notes, such as that dated 1949 saying "I would be grateful for a reply to my letter of three months ago" and still filed 22 years later (did he ever get a reply?); such gems abound. Then there is the series of letters which read "Mr. A has a hernia: I will repair it"; "I have just repaired Mr. A's hernia"; "Mr. A has left hospital after his hernia repair"; and "Mr. A has recovered from his hernia"—only one of which need usually be kept. Then again, there is the string of letters which say that Mr. B is making satisfactory progress and will be seen again soon, each of which supersedes its predecessor. Larger folders mean less incentive to consign these superfluous letters to the waste paper basket.

Another disadvantage of bigger folders is that they encourage the use of backing sheets as permanent mounts for laboratory reports of ephemeral value. I have recently received a set of notes from a doctor who is a distinguished exponent of the virtues of larger folders. I increased the value of the notes in reducing them to a third of their previous bulk by removing a large, tough backing sheet and most of its adherent haemoglobin reports which had been collected during a pregnancy which ended a year ago. The reports had been valuable then but were now too numerous to be studied afresh each time; just two, unmounted, were sufficient to show later doctors the general trend. Devices like backing sheets are impressive at the time but we must remember that any plan we follow must allow for 50 years or more of the accumulation of information.

I suggest, Sir, that if any patient's old general practice (or hospital?) notes have become too numerous or too bulky to fit into the present 5 x 7½ inch (12 x 18 cm) record envelope they are too numerous to be read except on very rare occasions, and will take so much time to digest that they will detract from the care of other patients. They may as well be put, complete, untouched, into the dustbin (also, presumably, size A4).—I am, etc.,

JOHN L. STRUTHERS

Southampton

Confusion of Ampoules

SIR,—A recent report in the national press (*Daily Express*, 8 March) of an ampoule of morphine being found alongside a vial of penicillin in general practice instead of distilled water prompts me to draw attention to a practice that I have carried out for years. When prescribing penicillin preparations for injection I always specify the water in 5 ml ampoules. The basic price is only a fraction of a penny more than the 2 ml, but it ensures that there can be no confusion with any other 2 ml ampoules which during its life in a visiting bag may lose its markings.—I am, etc.,

DENYS E. HOWELLS

London N.W.10

Discontinuation of Evening Surgery

SIR,—My practice decided to dispense with evening surgeries for all time two years ago. The decision gave cause for considerable but yet not unsurmountable resentment. This major reform of our practice routine would have enjoyed a much less grudging acceptance than it did had it not been considered by the local press as a dastardly retrograde step.

Press hostilities culminated in criticism of myself and colleagues in the national daily newspapers. Ironically, the net results of these reports has been that other doctors have become intrigued and they have inquired as to how we effected our changes and the nature of the difficulties we encountered.

My partners and I hope that our experiences will encourage many more general practitioners to reappraise their practice arrangements. We are the first to recognize that the changes we have implemented cannot be adopted universally, and we do not necessarily advocate universal application. Many general practitioners have hospital and other appointments outside general practice and their practice routine is arranged accordingly. However, we are convinced that there are also many general practitioners who have evening surgeries more through force of habit and the fear of untrodden paths than for patient needs.

Our reorganized day has brought us immeasurable benefits. We have now a regular eight-hour day (9 a.m.-5 p.m.), which, incidentally, is also a sound business proposition, and we have filled the gaps between morning and afternoon surgeries with home visiting and a variety of new clinic sessions. We are much happier in our work and more efficient. Our families have suddenly become aware of our physical existence and we can to some extent participate in regular pastimes. It has been our experience that the health of our patients has not been adversely affected by the absence of evening surgeries.

All this has been achieved without detriment to our 24-hour responsibility.—I am, etc.,

T. TERNENT

Partington, Manchester

Radiological Equipment

SIR,—As a radiologist in a busy hospital, I am becoming increasingly exasperated with the unreliability and over-sophistication of the modern *x*-ray apparatus which we are forced to buy. We are in the hands of the manufacturers who, year by year, add to the complication of their machinery.

Soon after installation of our very expensive new apparatus we began to suffer failure of the gadgetry which revealed multiple defects in design and manufacture. We also discovered deficiencies in service facilities and unavailability of replacement parts, whch can be the most damaging feature of all. At a time when the demand for *x*-ray examinations is rising at 10% per annum, we are constantly in danger of being unable to fulfil our commitments owing to endless equipment failure.

The manufacturers have provided us with some excellent equipment in the past which has enabled us to cope with an ever-increasing work-load, but now they seem to be more concerned with promoting unreliable electronic trickery than with providing soundly designed and robust apparatus with a long working life.

It is high time that the Department of Health established a radiological laboratory to test all the new apparatus before it is purchased for the National Health Service, and equipment thus tested should be given an appropriate certificate.—I am, etc.,

J. W. MILLS

Ipswich, Suffolk

"Academic" G.P.s

SIR,—It is debated whether general practice can constitute an academic discipline.[1] Dr. W. Anthony Ball evades the debate (19 February, p. 513) while denigrating the lecturer in general practice because he is "an academic." However, Professor A. P. M. Forrest has recently defined the academic as one who works in a university department.[2] To be an academic is therefore a concomitant of, and not a prerequisite for, a university appointment.

In any general practice the three elements of service, teaching, and research are not mutually exclusive. This is reflected in the work of academic departments of general