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ABC of First Aid. (1968). P. 27. London: The Red Cross Society.

First Aid Junior Manual. (1969). pp. 12–13. London: The Red Cross Society.

Sudden death in coronary thrombosis

Sir,

I can confirm Dr Walford's view (November *Journal*) that the diagnosis of coronary thrombosis on death certificates is often inaccurate.

It was the custom in the hospital in which I worked for the death certificate to be completed and claimed before a post-mortem examination was carried out. This, therefore, gave us the opportunity of comparing the clinical and autopsy findings in each case. The autopsy findings for one complete year (1948) were compared with the statements of the cause of death on the certificate. Eighteen cases of coronary thrombosis came to autopsy and only two-thirds were diagnosed ante-mortem. The mistakes can be seen from the list below:

Certified Cause of Death	*Autopsy Diagnosis*
Hypertensive heart failure	Coronary thrombosis.
Heart failure. Diabetes mellitus.	Coronary thrombosis.
Hypertensive heart failure	Coronary thrombosis.
Diabetic coma.	Coronary thrombosis.
Rheumatic carditis.	Coronary thrombosis.
Strangulated femoral hernia.	Coronary thrombosis.
Coronary thrombosis.	Dissecting aortic aneurysm (3 cases).
Coronary thrombosis.	Shock following urethral catheterisation.
Coronary thrombosis.	Ruptured aortic aneurysm.
Coronary thrombosis.	Bronchiectasis.
Coronary thrombosis.	Post-operative pulmonary embolism (2 cases).
Coronary thrombosis.	Bronchogenic carcinoma.
Coronary thrombosis.	Pulmonary embolism. Phlebothrombosis.
Coronary thrombosis.	Carcinoma of stomach

It would seem that this discrepancy between ante-mortem and post-mortem diagnosis requires careful consideration in assessing accuracy of the Registrar General's statistics.

J. B. HOLROYD,

Kirkby Malzeard,
Ripon.

REFERENCE

Walford, T. A., (1971). *Journal of the Royal College of General Practitioners*, **21**, 654–663.

Sir,

Dr Walford's paper (November *Journal*) on the accuracy of certification of death from coronary thrombosis is important, but would be of even greater value if he could give us a further breakdown by age and sex written in full.

The numbers would be small, but could be a useful pilot for a further project concentrating attention on men aged 35–54. I suggest this group because it contains the greatest regional differences in mortality and so probably in the precision and accuracy of death certification, with a higher proportion of post-mortem and of ante-mortem investigations. Mortality figures including those over 64 are swamped with elderly deaths, in which certification is probably not very precise and where death is in any case a more natural event. We really must begin to concentrate attention on the younger male group, which is not only of much greater clinical urgency, but probably also contains the important clues to causation.

JULIAN TUDOR HART,

Glyncorrwg Health Centre
Nr. Port Talbot,
Glamorgan, Wales.

REFERENCE

Walford, T. A. (1971). *Journal of the Royal College of General Practitioners*, **21**, 654–663.

Organisation of group practice

Sir,

May I congratulate you on your editorial on the Organisation of Group Practice? (November *Journal*). You boldly recognise the danger of our losing sight of the object of organisation—better patient care—a danger also noted in the report of Dr Harvard Davies' committee.

Too often secretaries are dragons ' protecting ' the doctor from his patients, too often are appointment systems used to prevent access of patients to their doctors, and ancillary staff utilised to relieve the doctor of his basic duties—which are to diagnose and to prescribe. Too often are such abuses paraded as virtues of modern organisation.

Of faith, hope and charity we are assured charity is the greatest. In our motto we boast science with charity, perhaps even in this age, charity remains the greater.

J. R. CALDWELL,

Newick Lodge,
Newick,
Sussex.

REFERENCE

Journal of the Royal College of General Practitioners, **21**, 627–628.

Fashions in pharmacy

Sir,

Dr Wilson[1] (September *Journal*) found, to his apparent amazement that over a period of 12 months, he had issued prescriptions for 148 different drugs, falling within 13 pharmacological classes with an average of 13 drugs for each class. Based on this doctor's experience, which is probably fairly representative, your editorial[2] states