Transfer of medical records

Sir,

In response to Dr Hall's letter regarding transfer of medical records (July *Journal,* p.323), I thought it may be interesting to review the results of a brief survey conducted in the Cheshire practice where I am a trainee.

The figures were taken from registration dates between 1 June 1987 and 30 May 1988. Of the total 517 patients registered, 418 (81%) of the records had been received within one year and 99 (19%) were still to be received.

The times elapsed before receipt of the 418 records were as follows:

0–3 weeks	32%	(26% of the total)
4–12 weeks	49%	(40% of the total)
13–25 weeks	18%	(15% of the total)
26–52 weeks	1%	(1% of the total)

Of the 99 records still to be received the times elapsed since they were requested were as follows:

0–13 weeks	63%
14–25 weeks	24%
26–39 weeks	7%
40–52 weeks	6%

On examination of the registration data there were no common features of either age, distance moved or particular family practitioner committee.

Previous work carried out by Graham and Livesley[1] shows an average time of 141 days (about 20 weeks) for the transfer of medical records, compared with eight weeks which we found. However, all newly registered patients were included in our study. It often takes less than a week for newly born babies to be registered and this would account for the much lower time of eight weeks.

I consider that a system in which only two-thirds of all the records are received by three months is inefficient, and it is hoped that with the increase in computerization by family practitioner committees this will be improved.

So in answer to Dr Hall's question (is 14 years a record?) the research did not go back that far, but I should hope that Cheshire family practitioner committee is more efficient than North Yorkshire.

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Reference

1. Graham HJ, Livesley B. Newly registered elderly patients: who are they and why such delay in the transfer of their medical records? *Br Med J* 1988; **296**: 340-342.

General practice in Italy

Sir,

In his editorial (August *Journal,* p.341) Professor Horder states that the Italian government has taken no steps to control the entry of students to medical schools. However, this is no longer the case. Recent government legislation in Italy requires fixed entry quotas of students to each medical school. All medical schools must comply with this legislation by the academic year 1989–90. Some smaller medical schools have already enforced the quota system. For example, Pisa university has taken a quota of 200 students this year, compared with an intake of 1200 students in 1978.

Although a cohort of excessive numbers of doctors will be present for many years, one would hope that in the long term general practice in Italy will have been helped by this legislation.

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Coronary heart disease prevention

Sir,

Dr Fowler's editorial on coronary heart disease prevention (September *Journal,* p.391) was thought-provoking and stimulating. As indicated in the final paragraph, few general practitioners will be able to make much impact on the problem unless a team approach is adopted. However, the editorial is largely based on a mechanistic model of disease; the risk factors mentioned are selective, and I fear that the outcome of policies based on such risk factors would be disappointing.

Nixon and colleagues at the Hammersmith Hospital have pointed out that the standard risk factors 'are implicated in less than half the cases of coronary heart disease'.[1] Furthermore, a study in Massachusetts suggested that the most important prognostic indicator for surviving heart disease 'was not non-smoking, normal blood pressure, or low cholesterol levels but job satisfaction'.[2]

Nixon and colleagues go on to suggest that the physiological disturbance caused by hyperventilation may be a significant factor in many cases of sudden cardiac death.[1] Such hyperventilation may be a result of inappropriate adaptation to stress. As this may be developed early in life, Nixon suggests that breathing exercises and 'something of what is taught in the martial arts' should perhaps be introduced to schools.

The assumption of the purely mechanistic approach is that we, as physicians, will be able to go on refining the 'tuning' of the individual human machine, that is, our patients, *ad infinitum.* I fear that such an approach is flawed. Recently I was almost shocked to read these words, written more than 25 years ago: 'The gap between human need and the capacity of the allopathic strategy to meet that need widens daily. That is why allopathic medicine is a passing stage in the evolution of medicine'.[3]

Some of us may reject such a view outright; yet the potential futility of having to treat people with mild hypertension for an average of 425 person years before preventing a stroke[4] brings home the limitations of some of our current practice.

We must attempt to embrace a wider concept of preventive medicine that can be achieved solely by measuring blood lipid levels and so on. Albert Einstein once said: 'The unleashed power of the atom has changed everything except our way of thinking ... We need an essentially new way of thinking if mankind is to survive.' Perhaps we need a new way of thinking regarding preventive medicine in general and coronary heart disease in particular. Several years ago Patrick Pietroni wrote: 'As the importance and fundamental value of the educational model is appreciated, then certain basic changes in patterns of work will alter. Patients will be seen together in a "classroom" setting. The architecture of our health centres and hospitals will alter to allow for these activities, including the provision for a meditation or quiet room'.[5]

This appears to be the right direction to be going in; but if we are to avoid medicalizing relaxation, perhaps much of such therapy should be introduced outwith the hospital and primary care setting.

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References

1. Nixon PGF, Freeman LJ, King JC. Breathing and thinking: unacknowledged coronary risk factors. *Holistic Medicine* 1987; **2**: 133-136.
2. Kaptchuk T. *The mystery of illness. The healing arts.* London: BBC, 1986.
3. Korr IM. Osteopathy and medical evolution. *Holistic Medicine* 1988; **3**: 19-26 (based on paper given in 1961).
4. Medical Research Council Working Party. MRC trial of treatment of mild hypertension: principal results. *Br Med J* 1985; **291**: 97-104.
5. Pietroni PC. Holistic medicine. New map, old territory. *Br J Holistic Med* 1984; **1**: 3-13.

Medical knowledge: a 'clinical drift'

Sir,

In the editorial by Dr Styles (September *Journal,* p.389), we learn that the Committee for Postgraduate Medical Education has advocated that experience in general practice would be of benefit to doctors intending to pursue a hospital specialty and Dr Styles outlines some of the arguments in favour of this. There are more fundamental reasons, however, for