

69-71. London: The Red Cross Society.

*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:

<i>Certified Cause of Death</i>	<i>Autopsy Diagnosis</i>
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.
Coronary thrombosis.	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<sup>1</sup> (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<sup>2</sup> states

"new preparations so rapidly appear and are so efficiently familiarized to us . . . that we sometimes find ourselves using new and strange preparations without realizing that we are unfamiliar with their special properties. What can we do about it?" . . .

Your contributor is indicting the profession for using new medications without fully understanding their properties and, by implication, the manufacturers for not adequately informing prescribers. Research based pharmaceutical companies, such as my own have evolved in our laboratories about 90 per cent of the therapeutic revolution of the last 25 years. We recognise that a new and potent medication is useless until doctors know that it exists; and when and when not to use it. The communication of this information may be said to be the penultimate link in the research process, the final one being its application by the clinician.

How to communicate this information drawn from world wide experience to busy physicians is a problem for the manufacturer. Surprisingly there is often strong resistance from the profession.

The implications are that modern medicaments are potent and require special caution in their use. The old adage: "use few drugs and be familiar with all their properties", is wisely proffered by your editorial. Applied too rigorously, however, this can lead to excessively conservative treatment.

Pharmaceutical manufacturers are anxious to ensure that prescribers are in full possession of all relevant information so that they can exercise their professional judgment in deciding whether a new medication has a role in their own armamentarium. The traditional methods of communicating this information comprise visits by trained medical representatives complete with the provision of comprehensive literature outlining concisely those properties of a medication which the prescriber must know and understand. May I commend to your readers, in answer to the question—what can we do about it?—in your editorial that the growth of the postgraduate medical centres surely provides a new and fruitful arena where pharmaceutical companies should be invited to present their data? In such circumstances any fallacious arguments can be adequately probed by local experts. In this way general practitioners will be able to obtain a better understanding of new drugs, with attendant benefits both to themselves and their patients.

RONALD LEVIN,  
*Marketing Director.*

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Maidenhead,  
Berkshire.

## REFERENCES

- 1 Wilson, D. G. (1971). *Journal of the Royal College of General Practitioners*, 21, 558.
- 2 *Journal of the Royal College of General Practitioners*. (1971). Editorial, 509–10.

## Married women doctors

Sir,

I read the extract from the College tutors' newsletter 13 (November *Journal*) with despair. Does it mention anywhere that married women doctors working part-time are not normally eligible to enter re-training programmes and are rarely even to claim financial assistance to attend postgraduate courses?

When will the profession abandon the attitude that some doctors are more equal than others?

HELEN SAPPER,

19 Lavington Road,  
London, W13 9NN.

## REFERENCE

*Journal of the Royal College of General Practitioners*, (1971). 21, 699.

## The Handedness of Kerrs

Sir,

An Associated Press article datelined, "London 4 January 1972" in the *Washington Post* indicated a survey is under way on left-handed Carr-Kerr namesakes.

I am a left-handed American Carr. My paternal side stemmed from English Kerrs, and they in turn from the German Karres. I'd be delighted to participate in the survey although I'm not too keen on knowing whether my umbilical cord was clockwise or counter-clockwise. The fact I had one and survived its twist is reasonable sufficient knowledge at this late date.

HERBERT W. CARR,

4900 Red Fox Drive,  
Annandale,  
Virginia 22003,  
U.S.A.

## REFERENCE

*Journal of the Royal College of General Practitioners*, (1971). Editorial, 693–694.

Sir,

My name is Mike Kerr. I am nine years old. I live in Oklahoma City, Oklahoma. I read your article about people with the name of Kerr that are left handed. I am left handed and my father had a cousin that was left handed also. My great-grandfather Robert Samuel Kerr came to Oklahoma during the land rush of 1889.

MIKE KERR,

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Oklahoma City,  
Oklahoma 73106,  
U.S.A.