social services and attached to general practice, thus removing any ambiguity about their role or remuneration.

Finally, it is all very well to describe the luxury of one whole-time equivalent social worker in a practice of three doctors with presumably a practice population of around 7,000. This is a level of provision which can only be achieved under the terms of a generous research grant and bears little relation to the country at large. Out in the real world the ratio of basic grade social workers to client population is probably in the order of 1:15,000 or even 1:20,000 in some areas (estimates only). On this basis it would be only reasonable to expect the local authority to allocate a social worker to quite large group practices, or alternatively the social worker would have to be shared by several small groups of general practitioners. Even so the concept of a part-time social work team attached to groups of general practitioners is exciting and I look forward to reading Dr Paine's detailed findings when the results of his researches are published.

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SELF-CARE

Sir,

I read with great interest the article *Symptoms Perceived and Recorded by Patients* by Morrell and Wale (June *Journal*) and would like to raise one or two points.

The statement that only one in 37 symptoms are presented to the doctor cannot be taken as a generalisation. It is surely pertinent only to the group of women studied and therefore not applicable to patients as a whole. Furthermore the type of symptom and the frequency with which patients consult vary considerably with social class, age, and environment (urban or rural), and I think it would be necessary to know these variables before drawing conclusions from the study. Another factor that might have considerable bearing on both the recorded symptoms and consultation rates is the incidence of associated disease either in the patients studied or their families. Morrell and Wale do not mention the presence of disease in their patients.

From the tables showing symptoms recorded in the patients' diaries and presented to the doctor it appears that approximately 75 per cent of the symptoms are those other than some form of pain. It would be interesting to speculate which group of symptoms over-anxious patients tend to present.

Although Morrell and Wale suggest that anxious patients are more likely to record symptoms and consult the doctor than to arrange their own medication, some of the other factors governing self-care are the availability of medical care and access to commercial over-the-counter drugs. For instance, patients having difficulty in obtaining appointments with their doctor on a regular basis in an inefficient practice might be more likely to resort to self-care.

Finally, the presentation of symptoms may be highly dependent on the discussion of those symptoms within the family. Perhaps Drs Morrell and Wale in their further analysis will be able to shed some light on the dynamics of symptom organisation by both patients and their relatives.

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COMMUNITY HOSPITALS

Sir,

To someone who has spent the last three years associated with a perhaps unusually busy and well-equipped community hospital (Kyle, 1971) the recently published report (Royal College of General Practitioners, 1976) on the special educational needs of doctors working in such hospitals proved to be not only fascinating reading, but also apparently to relate to a totally different environment from that which I have experienced here in Brecon.

The report highlights the desirable learning requirements for medical staff in a community hospital in an unusual and revealing order of priority—starting with the study of patterns of organisation of care and sadly ending with the care of the dying.

Particular emphasis is placed on late post-operative care and rehabilitation, but the impression is given that this is a field that can be quite adequately supervised medically by doctors who are totally isolated and uninvolved in the patients' earlier management.

The report appears to endorse the curiously insular British view that there is some sort of rigid distinction that can be drawn between specialist and non-specialist medicine, only the latter being suitable for the general practitioner in his office and community hospital practice. In addition, the suitably educated general practitioner is credited with a new and perhaps unique role in hospital practice, his 'specialist' skills in organisation and rehabilitation somehow distinguishing him from other hospital doctors.

In Brecon the idea that doctors fall into two separate categories — hospital doctors and

general practitioners—has always been resisted. Our medical philosophy has always been that our hospital practice is merely a logical and desirable extension of our outside practice and that our involvement in both spheres should be as total as is reasonable bearing in mind the particular training and experience of the individual doctors, the facilities and support available within the community hospital, and the results of periodic audit of our activities.

We therefore see the acquisition of doctors with extensive specialist experience during their postgraduate training, and higher qualifications where appropriate, as a logical way of improving the staffing of our community hospital. We regard the regular attendance at neighbouring district general hospitals by our staff members as clinical assistants (or hopefully hospital practitioners), and frequent contact with visiting consultants in our own hospital as the two most important aspects of our continuing education to help us fulfil our hospital role.

Expressed at its simplest, we believe that a man who is used to, say, taking out appendices and to taking the decisions that lead to this action and to seeing the case through will provide safer and better quality care for another surgeon's postoperative cases than a doctor who was last involved with surgical care perhaps long ago and then only in a very junior capacity. It must be admitted that the Thames Valley and Breconshire are such environments that the medical role that a community hospital will have to play will be as different as the two areas are culturally and geographically distinct.

However, I feel it is important to state that the educational needs for doctors working in two such very different types of community hospital will also differ and that attempts to define such needs ought to be made giving due consideration to the scale of practice taking place in the area under consideration.

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MEDICAL RECORDS

Sir,

Dr J. D. Harte of Bedford recently described the whole business of noting the age and sex and identity of each patient in general practice as the "denominator of general research". It is surprising to find that even in selected practices, such as those involved in the 1971 National Morbidity Survey, the best rate of non-match for identity is one per cent and the worst was as high as 20 per cent. That means that, in the worst practices in that study, the identity of the records and the patient, to whom they were supposed to relate, could not be matched accurately in one case in five.

The attention of the profession is being drawn to the problem of orientating medical records. Whether a practice decides to use the present size and style of National Health Service stationery or not, would it not be worth a National Study to define the "denominator in general practice research"? A minimum level of accuracy with which it is being recorded can then be set as a criterion for any doctor to achieve who takes part in a National Study of any sort.

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USE OF HONEY

Sir,

Dr Eric Bloomfield's suggestion that clinical research might be conducted into the use of honey for varicose ulcers (August *Journal*), was anticipated by the *Therapeutic Papyrus of Thebes* written in 1552 BC, in which using surgical dressings with honey for bruises and ulcers was mentioned. A survey of literature written since then on the same subject was mentioned in the article *A Base of Honey* (*Interface*, 1974).

Since 1971 the treatment room nurses in this health centre have been treating abrasions and ulcers with a mixture of equal parts of honey and providone-Iodine ointment ('Betadine'). They have continued to do so on their own initiative, especially for adrasions, presumably because they find this treatment works well.

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