a man it is almost certain that she would have continued her work and devised further studies to test her hypothesis. Instead, she left academic life to indulge in childbearing and childrearing, and is only now—six years later—beginning to turn her thoughts towards the continuation of her earlier work.

STEPHEN J. WATKINS
187 Park Lane
Macclesfield
Cheshire.

References

Burrage, H. F. (1973). *Women scientists.* M.SC. Dissertation, University of Salford.
Kelly, A. (1974). *An Unfair Profession.* University of Edinburgh Centre for Educational Sociology.
Kelly, A. (1976). Women in science. *Durham Research Review,* 7, 36.
Leeson, J. & Gray, J. (1978). *Women in Medicine.* p.43. London: Tavistock Publications.
Parsons, T. & Shils, E. A. (1951). *Towards a General Theory of Action.* London: Harper and Row.
Seear, N., Roberts, V. & Brock, J. (1964). *A Career for Women in Industry.* Edinburgh: Oliver and Boyd for London School of Economics.
Stevens, J. L. (1978). Unpublished lecture at Postgraduate Medical Institute, Exeter.

TRAINING STAFF

Sir,
In the June issue of the *Journal* (p. 372) you were kind enough to publish a letter setting out the terms of reference and activities of a joint working party set up by the Royal College of General Practitioners and the Association of Medical Secretaries earlier this year.

The working party wishes to collect and examine documentation relating to:

1. Practice handbooks or notes for the use/instruction of receptionists and secretaries.
2. Job descriptions of practice ancillary staff.

If any member can help by sending us such documentation we should be most grateful to receive it.

S. OLIVER
Chairman
RCGP/AMS Working Party
14 Princes Gate
London SW7 1PU.

ROLE OF PRACTICE NURSES

Sir,
We should be most grateful if general practitioners who are interested in the education and role definition of their own directly employed nurses would contact me at the address below. The University is running a pilot course for practice nurses this autumn and would very much appreciate the help of general practitioners in telling us what their nurses are doing, what they would like them to do, and what they consider to be the medico-legal problems in nurses doing hitherto medical (as distinct from nursing) tasks. A three-year study by Dr B. L. E. C. Reedy of the University of Newcastle-upon-Tyne shows that practice nurses are extending their role considerably and it would help us to have the views of your readers about this.

Y. V. DAVIDSON
Course Co-ordinator
Royal College of Nursing
University of Surrey
Guildford.

BEHAVIOURAL PROBLEMS IN GENERAL PRACTICE

Sir,
May I comment on your excellent editorial "Behavioural problems in general practice" (June *Journal,* p. 323). I write as a social worker married to a general practitioner. Yes, I know of the mutual antagonism between some general practitioners and social workers!

It is gratifying that at last some general practitioners are now aware of the "non-physical element" of their patient. However, these enlightened general practitioners are certainly paying, I feel, for their pill-orientated colleagues who dish out tranquillizers and other unnecessary medicines (at great cost to the country) instead of *listening.* Most patients have been led to expect a medicine for everything, including the common cold, which we know gets better by itself! People have lost confidence in themselves *not* to go to a doctor.

Obviously, tranquillizers are relevant to some conditions. I think all general practitioners, social workers, and nurses should be made to see the play "Whose Life Is It Anyway?". In it the chronically paralysed patient refuses tranquillizers from the well meaning, but misguided, housemen on the grounds that they were prescribed for him because the doctor could not accept the fact that there are patients who cannot be helped medically—except to die—and who think. The patient suggests that the housemen should take the tranquillizers!

I speak as someone who has multiple sclerosis, so I ask for no heroics, just an acceptance that some patients are actually quite intelligent and sometimes know what is best for them. My general practitioner does, thank goodness!

Finally, in most cases—except where the medical condition is paramount and relevant to general practitioner counselling—I think there are other professions better trained (most general practitioners are not anyway) to do counselling, like social workers and marriage guidance counsellors.

MARGARET HOWLETT
Social Worker
3 Western Elms Avenue
Reading
Berkshire RG3 2AL.

A4 RECORDS

Sir,
Dr R. M. Milne (June *Journal,* p. 373) asks for evidence of the value of A4 records. As far as I am aware, there is no-one who can give him objective evidence that medical care is improved as a result of converting records from the old medical record envelope to A4 format.

Dr Milne has found that the act of conversion has forced him to examine carefully the contents of the brown bags stuffed with cardboard and paper in his practice, and this has given him more information about his patients.

Any practitioner who subsequently comes to care for his patients will be able to get that information without the same scramble, and any information which Dr Milne records in the future, such as that relating to immunizations performed, past illnesses, screening procedures, and investigations, will be organized, each in its own place and easily found. Having used the medical record envelope for 18 years and the A4 format for eight years, I have no doubt that I prefer the latter.

I have never seen any comments from general practitioners who use medical record envelopes who receive patients from practices using A4 records. What do they do with the old A4 record? Does its presence create any difficulties?

H. W. K. ACHESON
Department of General Practice
University of Manchester
Darbishire House
Upper Brook Street
Manchester M13 0FW.

Sir,
I am sorry that Dr R. M. Milne (June *Journal,* p. 373) has feelings of guilt about A4 records, because our article (February *Journal,* p. 85) recorded the

subjective opinions of those doctors already using these records in their general practices. Dr Milne may not be aware that all post-war developments in general practice have come from the doctors and not the patient/consumer. Indeed repeated studies amongst patients have shown 80 per cent satisfaction regardless of the type of practice they come from.

To the best of knowledge, no reliable method of measuring the quality of primary care has yet been devised (Darke, 1978). Indeed a recent consumer survey has queried whether vocational training has improved the quality of patient care (Cartwright and Anderson, 1979). However, I am glad that Dr Milne, having made the conversion to A4 records, is going to stick with them.

ARNOLD ELLIOTT
Newbury Park Health Centre
Perrymans Farm Road
Barkingside
Ilford
Essex IG2 7LE.

References

Cartwright, A. & Anderson, R. (1979). *Patients and their Doctors. Occasional Paper 8.* London: *Journal of the Royal College of General Practitioners.*

Darke, L. M. (1978). An approach to the evaluation of primary health care services. Report of a study in the North-East Thames Region. Unpublished.

SEAT BELTS

Sir,

Mr Neil Carmichael's Private Member's Bill proposing to make the wearing of seat belts compulsory will be coming before the Houses of Parliament in the near future. This is the single most practical measure to reduce the number of deaths and serious injuries on our roads. It has been estimated that the present death rate of about 8,000 a year could be cut by about 1,000.

We hope that all doctors will write to, and lobby, their MPs and do all they can to make sure this Bill becomes Law.

K. C. EASTON
Chairman
H. M. BAIRD
Vice-Chairman
R. L. HERBERT
Honorary Treasurer
D. C. RAWLINS
Honorary Secretary
British Association of Immediate Care Schemes
14 Princes Gate
London SW7 1PU.

ST JOSEPH'S HOSPICE

Sir,

St Joseph's Hospice has 50 beds for terminal care of patients with advanced cancer. We also have 50 beds for chronic sick and 25 beds for assessment of physically handicapped patients.

Our main work, however, is terminal care and we are now developing teaching facilities for doctors and nurses. This is an important subject relevant to general and hospital practice, yet, it is unfortunate that patients with terminal illness are still having less than adequate care.

We cover the whole range of care—pain relief, symptom control and medication, family support, and communication with the dying patient. We have a large conference room with audiovisual facilities, and meals can be provided. Many visitors—doctors, nurses, and social workers—come here and large numbers from overseas—especially from America and Scandinavia.

We would welcome groups of not more than 20 for half or whole day visits. Perhaps your readers would pass this information to anyone they know who would be interested—particularly those who are planning postgraduate courses.

J. F. HANRATTY
Medical Director
St Joseph's Hospice
Mare Street
Hackney
London E8 4SA.

GIVING A DRUG A BAD NAME

Sir,

As Mapes and Williams record (July *Journal,* p.406), no comparable group of drugs has suffered such a rapid decline in use, nor on so great a scale, as the barbiturates. The justification for this is common knowledge; but effects such as increase of the degradation rate of methyldopa and oral corticosteroids, and interaction with oral anticoagulants, though common enough, seem to be less well known pharmacological reasons for laying them aside. They have been swept from the scene more by abuse in the sociological setting of the 1960s than because they were enzyme inducers. The voluntary ban on their use has at least demonstrated the sense of responsibility of doctors. On the other hand, it has done nothing to prevent abuse of a variety of alternative agents. The upshot has been that doctors have lost their confidence as prescribers. Taylor (July *Journal,* p.420) asked those in the postgraduate training scheme in Aberdeen to grade a series of sleeping drugs according to their 'acceptability'. Although the patient had already found 'Carbrital' very effective in comparison to 'Mogadon', it is clear that what was prescribed was intended to be 'acceptable' to the doctor, rather than the patient. Taylor states: "Commonly, a particular drug falls in or out of favour on account of conviction rather than weight of evidence: this method of teaching encourages a healthy scepticism."

Emboldened by this statement, I should like to ask your readers a question. Recently, I have been reviewing several hundreds of case histories maintained over 25 years of patients over the age of 70 in general practice, whom I have treated myself. Inevitably, before the voluntary ban which I imposed in 1970 on such preparations as 'Nembutal', 'Soneryl', 'Sodium Amytal', and 'Tuinal' as hypnotics, many older patients were using them. It has become anathema in geriatric practice to allow a barbiturate drug to be anywhere near an elderly patient. It is said to confuse, to produce ataxia, depression, even delirium, and I have never attended a symposium on geriatric medicine without feeling a strong sense of guilt for past misdeeds. Yet, Sir, of 437 patients on whom I perpetrated this outrage, I can discover only eight who showed confusion. In every case the drug had been used for a considerable time before the onset of confusion, and in no case was the confusion the sequel of barbiturate introduction. Furthermore, in every case a more potent cause of confusion was present, namely urinary tract infection, pneumonia, constipation, cardiac failure, and the administration of digoxin.

Please understand, I am not advocating a return to the use of barbiturates. But before the use of barbiturate recedes into the folk memory of the profession, I should welcome any well documented evidence of confusion produced in a patient over the age of 70 when such drugs were the only agents used, and when the usual precautions, such as freedom from renal and hepatic impairment, were observed.

M. K. THOMPSON
24 Fryston Avenue
Croydon
Surrey CR0 7HL.

NIGHT CALLS

Sir,

In the article entitled "Night calls in a group practice" by Morton (May