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.

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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 Unpublished.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.

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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.

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NIGHT CALLS

Sir,

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