drug therapy were outlined and discussed by the participants. A report of each meeting was presented to the course team and recommendations for the development of the course were made.

Secondly, the second draft of each module was sent to a group including general practitioners, course organizers, recent trainees, clinical tutors and a postgraduate dean. They were asked to work through the draft and its activities and to annotate it as fairly and fully as possible with their thoughts, reactions, comments and criticisms. Reports were discussed in course team meetings and revisions made in the drafts.

Finally, the group sessions and draft group leader's notes were tested in practice with an established, informal continuing education peer group of general practitioners and a vocational training group. As it would be in practice, each tutor planned and used the module and ran the group meetings according to his own needs and those of the group. The group meetings were observed by evaluators and notes taken. In addition, the group leader was asked a variety of specific questions about the adequacy of the guidance he had been given. All findings were taken into account in preparing the final group leader's notes.

Topics in drug therapy has now been available and used for over a year. During this time a field testing programme using survey and observation methods has been underway. Results will be available this year when the possibility of producing further modules will be reviewed.

Further information and order forms can be obtained from Ms Monica Howes, Centre for Continuing Education, The Open University, PO Box 188, Sherwood House, Sherwood Drive, Bletchley, Milton Keynes MK3 6HW. Tel: 0908-71231.

LETTERS

Discarding Patients' Records

Sir,

I wish to make a plea to my fellow general practitioners to be more scrupulous about a practice which to my mind has a disturbing currency. When records are being prepared for summarization, some letters and some continuation cards are being systematically destroyed on a rather wholesale basis, often because they are bulky or old. No doubt summarization is well intended: problem orientation, prominence of salient information, storage space liberation, an instantly accessible yet often not updated medical history useful for referral letters and insurance forms, computer record preparation and so on.

However, once the records are summarized and tagged into chronological order, the temptation is to discard some of the original letters and pathology forms. Some of these are repetitive and have copies elsewhere and some of these details can be entered retrospectively onto the continuation cards. There may be, then, a good case for carefully discarding some of them.

My concern arises when continuation cards themselves are discarded. The views often stated in defence of this practice are that the entries are trivial, irrelevant, illegible or not significant, or, indefensibly, not disposed to easy summarization.

My views on this practice are that it is misguided and presumptuous.

Doctors do not own patients' records. They are held on trust, and the patients expect the doctor to keep them carefully, in their entirety, even if the edges are trimmed here and there. Also, a doctor has a right to expect that what he writes will be preserved. If continuation cards are destroyed, there is no way of knowing how many have been destroyed, by whom or for what reason.

I reserve the right to make my own summaries without the earlier evidence being destroyed. It is all too easy to rely on other people's summaries uncritically. I have little confidence in them. Summarization is particularly arbitrary and mistakes are inevitable. Omissions are inherent. (How could one be sure that adenoids were removed with the tonsils, or that one or both ovaries had been preserved following a hysterectomy, without the original details being kept?)

When summarizing, no doctor has the right to predetermine some categories of events, problems, diagnoses or other labels as being worthy of a place on a summary card, to the exclusion of others. Some of these must be uncategorizable, and are only definable in the way that they have already been expressed, in full, in the contemporaneous entries on the continuation cards. Some doctors are accomplished artists in using these records in a manner likened to using a canvas on which images of the patient are dabbed on in a variety of colours and strokes whenever the patient presents. A lot can be learned from the picture as it develops: how the patient is helped or not helped, attended or did not attend, the mood the doctor was in, the diffuseness or conciseness of the entry, what was said by the patient and so on.

Even the most subtle punctuation can relay a message. A question mark placed before a diagnosis may represent the doctor sticking his neck out; if placed after the diagnosis, maybe second thoughts. Such brushwork defies classification and should be preserved, even if open to several interpretations. It is often more accurate in its own way than a label on a problem list.

Unfortunately, I find when looking through old records that most are ungraphic, often dreary, too often unintelligible and ever too often illegible. The remedy is not to destroy what was written, but to be careful not to perpetuate these qualities in what we currently write.

Indeed we should be ever mindful of the next general practitioner inheriting our records: as patients change doctor more often, records are entrusted to us on an increasingly temporary basis. To help the next general practitioner we could, for example, spruce up our notes before forwarding them, and maybe write an appropriate epilogue.

In the meantime, we should make it our business to preserve the records carefully without discarding the irreplaceable material in the continuation cards.

MICHAEL JOLLES
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John Stevens Memorial Fund

Sir,

In 1983, (April *Journal,* p.250) I reported the loss of John Stevens at sea and asked for suggestions for ways in which we might remember him and his work.

The East Anglia Faculty have formed a Trust Fund to be known as the John Stevens Memorial Fund. The Fund will be administered by four trustees ap-

pointed by the Board of the East Anglia Faculty to whom the trustees will be responsible. The following purposes have been proposed for the Fund:

1. To award 'bursarships' to individual doctors or medical students in East Anglia to support personal visits intended to advance their professional education. In seeking to encourage such visits the trustees have in mind John Stevens' special gifts as a personal teacher, and how much he gave to those who visited him in his practice.
2. To finance visits to individual general practitioners or groups of them in East Anglia by selected persons whom it is felt would make a particular contribution to the professional work of those visited.
3. To support special meetings organized by or through the Faculty Board to encourage the exchange of ideas and stimulate activities designed to improve the standard of general practice education and clinical practice.

The trustees are appealing personally to all members and associates of the College in East Anglia for contributions to the Memorial Fund and also to all ex-trainees of the Ipswich Vocational Training Scheme. We have already received donations from John's personal friends in the College both here and abroad. We are aware that there may be others in the College who have happy memories of John and would like to contribute to this Fund which we feel will support enterprises which were of special interest to him.

Donations should be sent to the John Stevens Memorial Fund, c/o Dr Bernard Reiss, 18 Maids Causeway, Cambridge. Best of all, if you are able to covenant a gift Bernard Reiss will send you details and appropriate forms on request.

IAN TAIT

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A Follow-up of some North East London Trainees

Sir,

I read Dr Bloomfield's follow-up of North East London trainees (January *Journal,* p.47) with interest, but I am dismayed by the criteria used in the 'Index of Attainment'. Their implication is clear; members of the College are better doctors than non-members and teaching practices are better than the rest.

This seems now to be the accepted wisdom, but is there any supporting evidence? Few regions can have such complete records of training practices as do Devon and Cornwall, but presentations of their data, like the most recent,[1] fail to refer to standards in non-training practices. Is it not possible that 'ordinary' practices are changing just as quickly as training practices?

At a time when the College is pontificating on the use of deputizing services and launching its quality initiative, it will do well not to appear to talk down to the rest of the profession and further alienate non-members.

After all, passing the MRCGP examination indicates no more than scoring sufficient points in a highly stylized test. For myself, a rating of 7 on the 'Index of Attainment' seems to have no bearing on my standing as a general practitioner; that depends on the quality of the service I give my patients.

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Reference

1. Pereira Gray DJ. Selecting general practitioner trainees. *Br Med J* 1984; **288:** 195-198.

Acute Illness in Infants: a General Practice Study

Sir,

The preliminary report of the DHSS multicentre study of infant mortality suggested that an important minority of children who die at home have major symptoms during their terminal illnesses.[1] This arbitrary classification of major symptoms provoked controversy as many thousands of children are seen daily with these common symptoms which were defined as those needing a medical opinion on the same day and included such conditions as wheeze, cough, diarrhoea and vomiting, drowsiness, irritability, fever and being off feeds.

In a follow-up study by Wilson and colleagues, 84 per cent of consultations for acute illness in children contained at least one major symptom (March *Journal,* p155). There was no significant relationship between the reported presence of a major symptom and management of the illness as measured by the issue of a prescription or arrangement for follow-up. This latest study also showed that parents' perceptions of which symptoms were important were at variance with a classification into major and minor. These findings confirm that major symptoms as defined by Stanton and colleagues are too prevalent in general practice to be useful in determining outcome.

Wilson and colleagues hint that study of general practitioners' and patients' perceptions of symptoms may provide a ranking order of potentially hazardous problems, but given the wide variation in interpretation this is unlikely to prove a fruitful approach. A method worthy of consideration is to classify combinations of symptoms in terms of severity—for example, is a combination of fever, wheeze and poor feeding a 'cluster' which is more likely to warrant close scrutiny than a combination of cough, irritability and altered cry? Taken in conjunction with previous history and duration of complaints, 'symptom/sign clusters' may hold the key to outcome rather than symptoms taken individually. 'Clusters' might provide more useful pointers for the general practitioner when he has to take decisions about management and follow-up.

Answers to these questions would require much larger numbers than those in the study reported but could be achieved by asking general practitioners to record information about children seen on selected days or weeks, rather than by attempting to get busy doctors to record continuously over a prolonged period of time. Selective recording provides more reliable results and should be considered by those wishing to pursue the natural history of acute illness in young children.

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References

1. Stanton AN, Downham MAPS, Oakley JR *et al.* Terminal symptoms in children dying suddenly and unexpectedly at home. *Br Med J* 1978; **2:** 1249-1251.

Low Prevalence of Hypertension in Falkland Islands Men

Sir,

Long ago John Fry found, as I remember, about four times as many women hypertensives as men in Beckenham, and Peter Hodgkin found about seven times as many hypertensive women as men in Yorkshire. Being modest men, they did not claim that this represented the prevalence of hypertension in the general population, and in both cases the proportion of male hypertensives has since risen, as blood pressure re-