that is the electrocardiographic reading. The fact that a patient has hypertension does not change that reading. However, the trained clinician with confidence in the history and blood pressure values may then conclude that left ventricular hypertrophy is more likely.

DAVID H SPODICK

University of Massachusetts Medical School,
St Vincent Hospital,
Worcester, MA 01604
USA

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Informing the hospital of patients' drug regimens

SIR,—Dr Charles Claoué and Mr A R Elkington reported (11 January, p 101) a marked discrepancy between the number of drugs the general practitioners recorded and those the patient was actually taking.

I found a similar discrepancy in a small study undertaken in a cardiac outpatient clinic. Over six months all new patients completed a questionnaire which included the heading: "Present treatment —please note down any tablets or medicines you are taking." I compared the patients' lists with those supplied by the referring general practitioners, most of whom used the standard referral form, which has a specific section for listing the drugs the patient is taking.

Of 96 consecutive patients, 59 stated that they were taking one or more drugs. In 41 of these cases the list given by the general practitioner agreed with that of the patient, but in 18 cases the information given in the referral letter was incomplete. In four cases there was no mention of the fact that the patient was on a diuretic, and in two other cases there was no mention of other cardiac drugs (isosorbide and timolol). Other omissions included sedatives or anxiolytics in five cases, analgesics in three, and a variety of other drugs in eight patients (vitamins, nicotinic acid, oxytetracycline, thyroxine, Microgynon, mebeverine hydrochloride, and pizotifen).

Thus, in almost one third of the patients who were on drugs the information supplied by the referring doctor was incomplete. Long experience of practice in north east Scotland leads me to believe that the standard of general practice in this area is higher than average. If so, it is likely that the discrepancies are higher in other areas.

The best answer to this problem is to send each outpatient a form to complete at home and bring to the consultation. Even better would be a well designed questionnaire covering symptoms, history, and other relevant information, as well as drugs.

DAVID SHORT

Aberdeen AB9 2PL

Management training for clinicians

SIR,—Dr Helena Waters recently put forward a cogent argument supporting the integration of management education and training in clinical skills.[1] The Griffiths management reforms have highlighted the need for clinicians with managerial skill as well as medically trained full time administrators. Australia too recognises the need for such training for clinicians.

The Royal Australian College of Medical Administrators (RACMA) was inaugurated in 1967 to provide the education needed by the professional medical administrator. Two important goals were set for the college: firstly, to lay the ghost that doctors are not suitable to be administrators, and, secondly, to convince doctor-administrators that they needed specialised training in administration. Eighteen years later there is no doubting the success of the college in achieving these aims.[2]

I now believe there is a further phase in the development of medical administration, that of the clinicians, who, because of the complexity of the health care system and the organisation of hospitals, need a thorough grounding in managerial skills if they are to operate efficiently within a hospital department or other health care agency.

The RACMA has recently been attempting to fill the void in management training for practising clinicians by running one or two day programmes on administrative skills of practising clinicians. The course is designed for practitioners whose interests are primarily clinical yet who want to broaden their knowledge of issues related to administration and to function more effectively in their managerial roles.

In a very short time health care services will need and should have on their staff clinicians who also possess a number of management skills. This will enhance both their own efficiency within the health service and that of the health service itself.

T J WOOD

Alfred Hospital,
Prahran 3181,
Victoria,
Australia

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Massive bladder haemorrhage

SIR,—Unlike Dr J A Murray and colleagues (4 January, p 57), we support the views of Mr Nigel Bullock and Mr Robert H Whittaker on the disadvantages of intravesical formalin for massive bladder haemorrhage (30 November, p 1522). Seven patients with such bleeding have presented to our department in the past five years. Four were treated with intravesical formalin, in two with a 10% and in two a 4% solution. Three of the four patients developed significant ureteral damage, presumably due to reflux of formalin. In view of the various reports on the hazards of formalin (as described by Messrs Bullock and Whittaker) we treated the next three patients with intravesical alum. This treatment was successful in controlling the bleeding in all three patients without complications.

Alum, though requiring more time and nursing supervision, is preferable to formalin, even when the latter is in more dilute solution (1%). The use of intravesical alum requires no anaesthetic. Ureteric reflux is of no consequence and hence the elaborate pretreatment and operative precautions of formalin instillation are unnecessary. Alum is therefore a safe and effective treatment for intractable bladder bleeding. In view of this and its lack of complications it should now replace formalin in the treatment of this condition.

PATRICK J B SMITH
RICHARD D POCOCK
MICHAEL A FERRO

Department of Urology,
Bristol Royal Infirmary,
Bristol BS2 8HW

Patients' access to personal health information

SIR,—I read with surprise the Personal View by Dr Dora Black (14 December, p 1718). She comments that "Doctors should consider carefully before setting up open access records. They must publicise to all concerned and particularly consultants to whom they refer patients that their reports will be read by patients."

In the United States office records are usually dictated and typed in the records. They constitute a legal document and a record of the care provided. They are available to anybody who has the right to review them. This would include the patient, the doctor, and any of their legal representatives in the event of an action.

I cannot see any reason why a patient should not be permitted access to his records any more than a taxpayer should not have access to documents in the town hall explaining why his house is to be demolished. What we say in print should recognise that it may be read by others and it should therefore not contain personal or prejudicial comments. If the advice of Dr Black was her honest opinion I can see no conflict of interest in her having to defend it openly.

Lastly, her "solution" of writing a letter stating "Thank you for referring your patient. I have seen and advised" is fine in the National Health Service, where there is essentially no patient choice and an undersupply of skilled specialists. In the USA such a letter would guarantee no more referrals from the general practitioner and in a short while no patients.

LAURENCE A KIRWAN

Kansas City Medical School,
Kansas City,
USA

Hazards of glass ampoules

SIR,—I read with interest the article by Dr N J Shaw and E G H Lyall (16 November, p 1390). In Japan it is has been known for more than 10 years that contamination with glass particles can occur when the ampoule is broken open by hand. We suggested that intravenous infusions of glass particles might cause pulmonary embolism in bedfast patients with chronic illness.[1] It has also been shown that the problem of contamination can be greatly reduced not only by filing but also by swabbing the ampoule.

The authorities now require that every set of instructions for glass ampoules in general use in Japan should include the following instruction: "In order to avoid the contamination of glass particles when opening the ampoule, you must clean it with an ethanol swab after filing and then open."

HIROSHI KAWANE

Kawasaki Medical School,
Kurashiki City,
Okayama 701-01,
Japan

1 Nishimoto Y, Kawane H, Nishida O. Pulmonary embolism and infarction. *Diagnosis and Treatment* 1977;65:437-42 [in Japanese].

Prevalence of asthma in children under 16

SIR,—While Dr Jan Heijne Den Bak's paper on the epidemiology of childhood asthma confirms previous studies claiming underdiagnosis, it also makes some implications which are suspect (18 January, p 175).

Dr Den Bak implies that actively treating these unidentified patients would be beneficial. There is no evidence for this. He states that 18 children missed a total of 190 days from school—an average of 10·5 days per child. This must be viewed against average absenteeism from school, which in this area varies from 27 to 40 days a year.

Research showing the benefit of asthma pro-

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