who had could be defined as having 'moderate' hypertension on repeat testing, which presumably the practice thought to be still worth treating.

Out of the group with less than three blood pressure measurements, how many had life-threatening complications of hypertension (for example hypertensive heart failure) and how many had unequivocal evidence of end-organ damage making further measurements unnecessary? Again, these figures must have been readily available, yet we are not given them.

That many of the people could be reclassified as having 'moderate' hypertension is not surprising, bearing in mind that the Gaussian distribution of blood pressure makes 'severe' hypertension much less common than 'moderate' hypertension.

Although the data may suggest that some people are treated needlessly for hypertension, the suggested figure is not a measure of this but a measure of the variance of opinion between a small number of doctors, none of whom is 'correct' because we do not yet have the results of the relevant clinical trials.

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Care of the Long-term Neurologically Handicapped

Sir,

As a member of the South West Thames Board of the Chartered Society of Physiotherapy, I write to express the concern of the Board for the future welfare of the long-term neurologically handicapped in the community.

It is the present policy of this government to encourage the transfer of the handicapped from institutional care to that of the community. Whilst this is an admirable aim, the provision of adequate care in the community for certain sections of the handicapped is sadly lacking.

The care in the community of those suffering the results of multiple sclerosis, Parkinson's disease, stroke, spina bifida, motor neurone disease, cerebral palsy and so on produces a demand on the resources of chartered physiotherapists which we are unable to meet. Lack of both manpower and finance leaves us unable to provide the standard of care and rehabilitation which is required and for which we are trained.

The quality and quantity of care are not only benefits to the patient who is seeking to maintain independence, but are an essential support to families who remain ultimately responsible for the day to day care of these patients.

The purpose of this letter is not only to express our concern but to request the help of the members of the College to indicate ways of increasing our resources, and therefore to enable us to provide the standard of care which is in demand.

We are fully aware that most sources of financial help are fully stretched at this time, but the scope of the problem is such that we feel that we must explore all possible ways of increasing the volume of care we are able to provide.

All known areas of aid are being fully used and there is cooperation between chartered physiotherapists employed within the NHS and those in private practice where this is possible.

On the principle that 'two heads are better than one', we would be most grateful for your suggestions on any new and *positive* avenues of aid which we could explore.

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Register of Interests

Sir,

The report of the Council meeting on 3 December 1983 (February *Journal,* p.109) includes mention of the debate about the creation of a Register of Interests of Council members, presumably to identify possible bias. Whilst this would attract Council members whose view of democracy demands that only those who have no 'interest' in a subject may be trusted to debate, it has serious practical disadvantages.

For example: all general practitioners may have some bias about general practice; all CND members may have a bias about radiology, including nuclear magnetic resonance because of its alliterative connection; all who have opted out of 'out-of-hours' cover may have a bias about deputizing arrangements; all prescribers may have a bias about prescribing; all junior partners may have a bias about senior partners.

Indeed, all who have ever expressed a view about a subject may have a bias about it. *Reductio ad absurdum?*

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Undergraduate Learning in General Practice

Sir,

We were interested to read this paper by Professor I. M. Richardson (November *Journal,* p. 728). Feedback from students about what they have learned during their undergraduate attachments is an important aspect of the evaluation process and course tutors find it useful in planning their teaching.[1] In Bristol, students have completed structured questionnaires to identify any apparent learning deficiencies of the undergraduate attachments in general practice.[2] Questionnaires have also been used to study how the experience of these attachments alters students' approach to patient management.[3]

As well as the methods used in Bristol and Aberdeen, techniques to assess general practice teaching have been developed in other medical schools. It might be appropriate for the College to review what is now available and to consider whether any methodologies should be adopted on a more widespread basis. For example, findings from one, or a selection of these methods applied to groups of students in several medical schools could provide interesting comparisons. Teaching arrangements for general practice, the number of years and the time devoted to this teaching differ between medical schools.[4] The findings from such comparisons could help to identify any need for Professor Richardson's suggestion that general practice should be given the same extended clinical teaching as hospital-based specialities.

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