Births

Less than one per cent of births took place at home in Scotland in 1978 and 13 per cent of patients were delivered in hospital by forceps and 10 per cent by caesarian section.

Immunization

Whooping cough vaccination rates continued their downward trend and fell below 50 per cent for the first time in 1978; at the same time the number of cases of whooping cough rose to 3,500 cases notified in 1978 compared with 943 in 1977. Acceptance rates for immunization against other disease rose slightly to 79 per cent for diphtheria and polio, to 55 per cent for measles, and to 74 per cent for 13-year-old girls against rubella.

Accident and emergency departments

Attendances at accident and emergency departments in Scotland reached almost 930,000 for new outpatients, an increase of 71 per cent over the 1965 figure of 543,000, and three per cent higher than 1977 (906,000). Accident and emergency patients represented 47 per cent of all new outpatients seen in 1978.

POSTGRADUATE DIPLOMAS AND COURSES 1980

The 1980 edition of the *Summary of Postgraduate Diplomas and Courses in Medicine,* published by the Council for Postgraduate Medical Education in England and Wales, is now available.

It follows the pattern of last year and includes a section devoted to courses and attachments approved under the Advanced Postgraduate Training Scheme. The pages relating to each specialty have been reprinted as leaflets and these are available to doctors seeking information on a particular specialty.

Copies of the *Summary* can be seen in postgraduate medical centres or may be obtained from the Council at 7 Marylebone Road, London NW1 5HH, price £3·50 (post free in UK). Leaflets on particular specialties are available, free of charge, on application with a stamped and addressed envelope to the Council.

LETTERS TO THE EDITOR

VERTIGO IN THE ELDERLY

Sir,

Dr Colin Waters, reviewing a textbook in a recent issue of the *Journal* (p. 627) describes as 'quaint' a statement about the management of vertigo that "education about posture and movement will be required". In fact most cases of vertigo presenting to the general practitioner are of a transient but repeated nature occurring in elderly persons and associated with postural changes. These are commonly accepted as being due to narrowing of the main arteries in the neck, aggravated by flexion, extension, or rotation of the head on the shoulders, and much can be achieved by education in such cases.

I always try to explain the mechanism of these attacks to my patients, emphasizing how much more easily an artery with a small lumen and a thick wall can be occluded beyond a critical point by being bent or twisted than can one with a wide lumen and thin walls. A Littman-type stethoscope held so that the chest-piece represents the patient's head and the ear-pieces his legs can be used to demonstrate this visually. I also show how rapid bodily movements, such as bending, rising up, and looking upwards or behind the back, are accompanied by marked movements of the neck, whereas, when similar bodily movements are performed slowly the head hardly moves in relation to the shoulders.

These considerations lead to the obvious advice that if the patient trains himself to move slowly when changing posture, his vertigo will be minimized. This does indeed work and is much more effective than drugs. I see nothing 'quaint' about it and I think that Dr Waters is mistaken on this point, although his general criticism of the book may be fair enough.

M. CURWEN

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MRCGP EXAMINATION

Sir,

I read that there are proposals before the College to make it easier for greybeards and incipient dements to pass the MRCGP examination. As one of this group who did the examination some years ago on equal terms with the youngsters, I write to object most strongly to this.

There are objections of detail, such as what the cut-off age should be and why, say, someone of 59 years and 364 days should have a more difficult time than someone of 60 years and one day. But the main objection of principle is that it devalues the whole examination for everybody, young and old. There is some scepticism about the value of the examination anyway, although having experienced it I think it is not all that bad. To have what will essentially be two standards will reduce it to a laughing stock.

Don't do it!

A. M. RANKIN

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Sir,

Dr D. R. M. Stuart's letter (January *Journal,* p. 60) reminds me of a cartoon I saw many years ago, depicting a notice-board reading "It is forbidden to throw stones at this notice-board", and I sincerely hope he wrote it with his tongue in his cheek. You don't take an examination just for the sake of passing it. Are trainee general practitioners to be drilled until they merely perform in a stereotyped manner most likely to be acceptable at their examinations? The next step might well be (as in the driving test) to deny them any opportunity of justifying to their examiners any deviation from the prescribed responses. There would be a danger that doctors could become so brainwashed as to react like robots rather than rationally. That is about all that intensive training in examination techniques would be likely to achieve, except for ensuing disasters.

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TERMINAL CARE AT HOME

Sir,

Bold claims are made about the efficiency of opiates and tranquillizers in those with painful terminal illnesses. In my limited experience of looking after three such patients at home I found the greatest problem was getting them to take adequate amounts of analgesics. I was surprised to find that even after

getting them to take an adequate dose and experiencing pain relief without unpleasant side-effects, the next day they had gone back to homeopathic doses.

The contrast with patients in hospital who readily accept opiates is marked. The comfort of being at home seems to give them the courage to do without so much analgesia. I should be interested to know if refusal of adequate analgesia is common among patients dying at home.

A. HILLYARD

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THE JOURNAL

Sir,

I have been an ardent supporter of the RCGP since the day it was born. I still am. I am full of admiration for those marvellous people who had the foresight to dream up and actually start the College. It took great dedication and tenacity: no-one except those few originals ever thought it would emerge from its chrysalis, let alone grow into the respected body it is now. It has come to stay, is held in as high esteem by the general public as are the other Royal Colleges, and has definitely put general practice on the map.

In my view it has one blot. A large unhappy blot: its *Journal.* I have tried over and over again to decide why I do not like the *Journal.* Most of the articles if taken separately seem reasonable, but when put together the appetite wanes rapidly. Apart from the jargon, the endless statistics, the controversial articles which never seem controversial, the inconclusive conclusions, the overwhelmingly dull topics—there remain only the summaries of the main articles to whet the appetite rarely, and usually to prevent me reading the main text.

When Update took over the publication I was full of new hope. I fear this rapidly faded. The print and the lay-out are impeccable. So what is really wrong?

I have thought long and frequently on this and have reached a sad conclusion. I find it terribly dull, and insufferably boring. It does not at all seem to reflect the vital, exciting, ever changing, constantly challenging world of general practice. I have never yet found one 'live' article which makes me want to jump for joy, burst a blood vessel, get hot under the collar or even keep it for future reference. And I never ever get a laugh; yet every day in practice has its humour, from which I learn.

You, Sir, who yourself write so well and speak so eloquently, please take no offence. Get your staff together and have another look at our *Journal,* which should reflect our College as an index reflects a book. Find out if I alone hold these views. I suspect not. Try a '*Journal* audit' and find out the views at the grass roots. (How's that for jargon, the new infectious ailment?!)

Try a transfusion. Be erudite, by all means, but interest always, teach sometimes, and bore never.

CYRIL JOSEPHS

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PERSONAL CARE

Sir,

It is to be hoped that the simultaneous publication of two articles by Dr Pereira Gray and Dr Russell (November *Journal,* pp. 666 and 679) reviewing the limitations of combined lists and large group practices reflects the numerical ascendency of those who are tending towards a radical change in general practice.

Combined lists are usually contrary to the development of that close understanding between patient and doctor which is the continuing hallmark of the art of general practice. Their continuance, despite all the shortcomings, is fostered by a reluctance to enjoy the full responsibilities that come with having one's own list, whether it be inside or outside group practice. Despite the iniquities of the NHS (which are a reminder of our lack of virility rather than of a failing of our patients), if we are to do ourselves and our patients justice in our difficult task at the interface between the capabilities of modern medicine and the daily lives of our patients, we cannot forever escape a reversion to personalized primary care. The heartening paradox found even by the less altruistic of us is that accepting a marginally greater commitment removes many of the problems currently resident in our work.

These two prophetic articles deserve study by all who have an interest in the future of their own practices in particular and primary care in general. They portend the end of the era when we became one of the butts of British humour because of our apparent unwillingness to adhere to the traditions of being caring family doctors in favour of the transient glamour and superficial ease of being part of a depersonalized system. Whilst the application of such idealism may not be universally acceptable, it is the inevitable way forward if we are to alleviate job dissatisfaction and partnership discords, and it is probably the only way in which we can exploit fully the ever increasing potential of our future.

P. GROUT

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HOSPITAL POSTS FOR VOCATIONAL TRAINING

Sir,

I was recently looking at job advertisements in the *Journal* and came across one advertising four places in a well known vocational training scheme. On closer scrutiny I was surprised to see that two of the rotations advertised included no paediatrics, and the other two included no obstetrics. All four included three months of ENT and ophthalmology.

I am deeply worried that this sort of scheme, with the convenience of a package holiday, will become the 'normal' way of entering general practice, whereas the doctor who chooses suitable individual house jobs and does a separate trainee year will become a rarity. There is no doubt in my mind that the latter method, assuming it included paediatrics and obstetrics, would provide a more adequately trained general practitioner.

Enthusiasts for vocational training schemes will, of course, point to the half-day release course as being the great advantage of such schemes. Any benefits this may have, and none has been proven, cannot possibly compensate for the lack of clinical experience in vital subjects.

When vocational training schemes first originated, many doctors were anxious that these would be used by consultants to fill unpopular house jobs. Their fears cannot be allayed yet.

M. J. HAWKINS

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WOMEN GENERAL PRACTITIONERS

Sir,

I have read with interest the correspondence following your editorial. Recently I gave a lecture to a group of trainees about the problems of finding a partnership, and as one third of the trainees were women, the discussion naturally covered the problems that they might encounter.

Many women will opt for part-time partnerships. By working over 20 hours