degree of specialization was inevitable but *not* to the detriment of my partners' experience. They have to assume control in my absence, and also be aware of the possible drug interactions when prescribing for their patients. In fact, we all agree there has been negligible intrusion upon my partners' and his patients' relationship.

Therefore, I would like to stress that I do not share Dr Pereira Gray's blanket view against specializing within general practice, as long as it does not breach the continuing care pattern that is so necessary in general practice (as threatened by the Court Committee, 1976). In fact it could well be this lack of mini-specialization that has led to the poverty of clinical research in general practice.

Research to date has been dominated by defining the role of the general practitioner and describing and auditing his mode of practice (often detrimentally). I have wholeheartedly condoned this in the past, but feel that general practitioner research should now change direction: one vast, untapped field is to question, and possibly alter, much of the statistics, theory, and management originating from the hospital specialist of conditions which occur far more commonly in general practice. This is most likely to be achieved by general practitioner 'specialists' who will keep abreast of their subject as well as general topics, and may draw on more patients than their personal list allows. In time we may even take more notice of the theoretical or therapeutic results prepared by one of our own even though he may be . . . just a GP.

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Reference

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THE MECHANICAL ARTHROPATHIES

Sir,

In November 1948 I was called to a male patient aged 35, who had a severe pain over the right sacro-iliac joint and was unable to stand. It had come on suddenly while he was gardening and he lay on the settee clutching a garden rake. The history suggested that this was a condition of mechanical origin and I therefore proposed to him that I should attempt to relieve it by mechanical means. A manipulation devised ad hoc was entirely successful. The patient was rendered pain free and functionally normal and the condition did not recur. It soon became apparent that mechanical arthropathy of the sacro-iliac joint was one of a group of such arthropathies, mainly affecting the plane joints, such as the intervertebral and costovertebral joints, and subsequently a group of manipulations (Eastwood, 1964) became part of my clinical stock in trade. Last week I was called to a woman aged 37, who had severe pain in both sacro-iliac joints and who was able to stand only in a bent-double position. I manipulated both joints, with complete relief of her pain and disability.

In the 32 years intervening between these two cases, I have successfully manipulated about three or four patients per week in the normal course of my practice work, and have therefore conducted in all about 5,000 immediately successful manipulations of various kinds without untoward incident. How it comes about that a category of disability can be almost totally ignored in the teaching hospitals, and that medical students can qualify as doctors and go into practice without ever having had the opportunity of undertaking manipulations or seeing them done, is a matter for speculation. The General Medical Council, as representative of the public interest in medical education, surely has a responsibility here. Suffice it to say that there is a group of medical conditions usually passed off as fibrositis, neuritis, non-articular rheumatism, or even as psychological illness, which can easily be treated by anyone who takes the trouble to learn the manipulations required. The scientific interpretation of the manipulable lesion is less easy.

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Reference

Eastwood, N. B. (1964). Six manipulations suitable for use in general practice. *Journal of the College of General Practitioners,* 7, 144-146.

THE DIVISION OF BRITISH MEDICINE

Sir,

In his review of my book, *The Division in British Medicine* (April *Journal,* p. 245) Dr D. J. Pereira Gray does not seem to recognize that my history deals mainly with the period before 1948. The development of general practice since the Health Service began is discussed only briefly and therefore it was not appropriate to explain at length the contribution made by the Royal College of General Practitioners. A fuller analysis of the College's influence will appear in my next book which will cover the period from 1948 onwards in greater detail.

It is also important to recognize that my book does not neglect those who formulated the philosophy of general practice which the Royal College inherited. The leading proponent of this school was Sir Henry Brackenbury of the British Medical Association and a good deal of my study is concerned with his policies and influence, presented in a full and fair manner. In the biographical profile devoted to him, I have made it clear that he was one of the great medical leaders of this century.

In describing his philosophy as the "social work concept of general practice", I do not mean to imply that it excludes the treatment of organic disease. What it suggests, rather, is a tendency to assign a higher priority to the social and psychological components of illness. Brackenbury believed it more important to extend general practitioner interest in this direction than to create conditions of work that would enable him to enlarge his treatment of organic disease. The Royal College apparently endorses this view, for the doctor it has made its Dean of Studies, Dr J. S. Norell, declared in 1965 that the general practitioner "would rather be recognized as the most versatile of medical social workers than the least of medical men" (see p. 311 of my book).

If my book devotes a good deal of space to the policies of socialist groups, that is only understandable, for it was the Labour Party that created the National Health Service and one cannot understand Labour policy on health care without tracing the influences that shaped it.

As for Mackenzie, it is true that he held an appointment at the London Hospital (and at other hospitals as well) but this did not provide him with a proper, satisfying or enduring place in the hospital world. That is what I meant by the words quoted by Dr Pereira Gray and they should be read in conjunction with the sentences that follow, but I should have stated the whole point more clearly so as to avoid any misunderstanding. Lord Knutsford, the chairman of the London Hospital, apparently had great difficulty securing beds for Mackenzie after he joined the staff about 1913 and, according to the obituary notice which appeared in the *British Medical Journal* (31 January 1925, p. 242), Mackenzie's wards were taken from him and used for military purposes after the First World War broke out in 1914. He thus seems to have had

beds of his own at the London Hospital for only a short period of time, and that (combined with personal reasons) probably explains why he left for St Andrew's in 1917.

Incidentally, it is somewhat misleading to describe Rosemary Stevens as an American. Though she became an American citizen after marrying an American, she was born and bred in Britain.

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Dr Pereira Gray replies as follows:

The title of Mr Honigsbaum's book is *The Division in British Medicine. A History of the Separation of General Practice from Hospital Care 1911 to 1968.*

AUDITING VOCATIONAL TRAINING SCHEMES

Sir,

Much has been written about audit in general practice and the difficulty with which it is being accepted. Perhaps the concept would gain more credence if it was applied to vocational training schemes and became an integral part of the education of trainees.

The vocational training scheme is fast becoming the major source of general practitioners—it is producing "a cohort of highly trained practitioners", yet the course itself has no form of self-criticism and thus tends to stagnation.

How could one, then, audit a vocational training scheme with a view to increasing the quality of practitioners so produced? Possible questions could include those about the quality of hospital posts and their consultants' desire to train general practitioners, or the use (and abuse) of the half-day release. Is this the best method of training general practitioners or are there any alternatives? Does the scheme provide any 'after care' in the way of jobs, follow-up, and advice once in practice? The ultimate question is: how can a scheme assess its own success or failure? Is the success at the College examination the sole factor?

At present I am a trainee in a London teaching practice with friends in schemes from Basingstoke to Newcastle, and can see how widely schemes differ; yet, throughout there is the same degree of *laissez-faire,* of enthusiasm moderated by stagnation of ideas. Introducing audit into vocational training schemes would provide the impetus for change and improvement which is needed if trainees, trainers, and course organizers are to be able to design schemes that will truly deliver a better class of general practitioner.

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GENERAL PRACTITIONER OBSTETRICS

Sir,

The perinatal statistics presented by Dr M. J. V. Bull in his informative article (April *Journal,* p. 208) give food for thought.

In the first triennium, 1968-1970, 22·8 per cent of births booked were transferred to the consultant hospital during pregnancy and 9·5 per cent during labour; in the last triennium, 1975-1977, the percentages were 26·8 and 8·6. In 1975-1977 the perinatal mortality rate per 1,000 births (all) was 9·2. It would have been only 8·1 if the proportion transferred had remained the same as in 1968-1970!

In 1968-1970 the perinatal mortality rate per 1,000 births transferred in pregnancy (56·0) was nearly 30 times that for those not transferred (1·95); in 1975-1977 the ratio was nearly 40 times (26·8 against 0·75). The reasons for transfer, in order of frequency, were toxaemia, post-maturity, suspected disproportion, malpresentation, and antepartum haemorrhage. The national survey of 1970 (Chamberlain *et al.,* 1978) established that the overall perinatal mortality rate associated with severe toxaemia was just over twice that associated with no toxaemia; likewise, the rate at over 42 weeks' gestation was just over twice that at 39-42 weeks. The disproportion or malpresentation may have necessitated caesarean section, for which the perinatal mortality rate was two and a half times that for spontaneous cephalic presentations; for the very small proportion of breech presentations it was less than 10 times the normal rate. The perinatal mortality rate associated with antepartum haemorrhage was less than four times that associated with no bleeding.

Thus, one might expect a group made up of such high risk births to have a perinatal mortality rate about three to four times that for a low-risk group drawn from the same area. Perhaps, since the rate for the low-risk group was so very low, the multiplying factor might be rather larger, but is it not staggering that it should be 10 times larger? One has seriously to question what advantage accrued from the transfer for the group as a whole and, *a fortiori,* what justification there is for increasing the proportion transferred. Would general practitioners, who have been so very successful with low risk births, really expect to be over 40 times less successful with many of the births at higher risk which in earlier years they undertook? There seems to be a good case for trying to find out.

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Reference

Chamberlain, G., Philipp, E., Howlett, B. & Masters, K. (1978). *British Births 1970.* Vol. 2. London: Heinemann.

TEACHING STUDENTS

Sir,

Without appearing pedantic, may I correct the continued use of the term 'undergraduates' when referring to 'medical students'? The term is used inaccurately in the editorial of your May issue (p. 259), and quite incorrectly as the heading for my article on "Medical Student Attitudes and General Practice" (the students who participated being graduates) (May *Journal,* p. 307). The two terms are not synonymous. In this medical school (and others), all clinical students are necessarily graduates and, while not medical graduates, nor are they undergraduates. 'Medical student' is a more accurate term and should be used, preceded by 'pre-clinical' or 'clinical' if appropriate and necessary.

Semantics apart, may I congratulate you on your editorial on general practice teaching of students. General practice teaching in our medical schools is grossly underfunded. Payments to general practitioners who teach students—a vital part of any general practice teaching programme—vary widely but are everywhere inadequate and in some medical schools ludicrously so, or even non-existent. The contrast between payments to trainers under the vocational training arrangements and those to teachers of students is remarkable; a trainer now receives over £2,500 a year for his teaching (plus the service benefit of a trainee).

You are right to overcome your abhorrence of involvement in matters of payment and politics and in drawing