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.

ALAN COHEN
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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

attention to the serious situation which exists. General practice has, as you say, rightly become an established part of the curricula of medical schools in this country (and many others). This development is seriously threatened by the failure of the NHS and universities to acknowledge the financial implications of this shift of basic medical education from hospitals into the community.

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PERSONAL CARE

Sir,
In response to Dr P. Grout's call for more personalized care (April *Journal*, p.243), how will these practices accommodate vocational trainees other than feeding them 'one-off' consultations? Otherwise, the patient who demands the personal, continuing care that is generally offered by the principal will feel aggrieved at being passed on to a temporary doctor.

R. J. GALLOW
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Herts.

BLEEDERS COME FIRST

Sir,
Of necessity, critical review of published work is a matter of personal opinion and taste. However, I feel compelled to defend Colin Douglas' *Bleeders Come First* against John Miles' unfair review (May *Journal*, p. 310).

I have been in practice as trainee and principal for six years, but still remember with anger general practitioners who were "lazy, ignorant and inaccessible, and employ professional obstructionists to deal with their telephone calls". Indeed, it is those experiences which have stimulated me to attempt to achieve high standards in my own practice.

Is Dr Miles so far removed from his own experiences as a hospital doctor that he does not remember such general practitioners who by the very standard of their practice contribute a disproportionate number of poor hospital referrals?

Colin Douglas has certainly overstated the position, but this is no reason for Dr Miles to dispense patronizing advice to the author "to rid himself of his little hangup".

Is it impossible for an academic journal to publish a review concerned only with literary merit, without introducing traditional intra-professional sniping?

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BOOK REVIEWS

THE HYPERTENSIVE PATIENT

Eds Andrew J. Marshall and D. W. Barritt

Pitman Medical
Tunbridge Wells (1980)
517 pages. Price £26.50

The prevention of cardiovascular disease is coming to play an increasing role in general practice, especially through the effective treatment of hypertension. Because of the numbers of patients involved, hypertension will have to be investigated and treated, for the most part, outside hospital. Because it is asymptomatic and needs maintenance treatment over a long period, the style of care will be different from that which has characterized general practice in the past. A new book on the hypertensive patient is therefore of great interest.

The introduction states that it is designed for "the bedside doctor". The words are symptomatic as it is written almost entirely from the viewpoint of the hospital physician. The contributors are authorities in their own disciplines but none has experience of general practice. The balance of the book is therefore tipped heavily in favour of pathophysiology and the mechanisms of secondary hypertension (239 pages).

The chapters are variable in quality and there is a good deal of duplication. For instance, there is overlapping information on the renin-angiotensin system by three authors and Folkow's work on resistance vessels is expounded twice with the same graph reproduced (pages 98 and 121). On the other hand, I looked in vain for any reference to methods of improving compliance, to patient education, or to the problems of screening.

Dr Barrit's 12 lines on the problem of hypertension in the elderly is completely inadequate given the importance of the subject and he seems to advise the routine use of the random-zero sphygmomanometer in clinical practice without any justification. Professor Ledingham, on the other hand, recommends that blood pressures should be taken twice, supine and erect, and that 140 mm Hg systolic and/or 90 mm Hg diastolic or above should initiate investigation without any reference to the workload that this would entail. Owners of ECG machines will be encouraged by the statement (p. 345) that "almost all patients with changes due to pressure alone will need electrocardiographic treatment but the converse does not hold".

I would not recommend general practitioners to buy this book, but it would be worth borrowing from the library for Professor Rose's chapters on epidemiology and the measurement of blood pressure, the chapters devoted to the principal therapeutic agents, and the final section on clinical trials.

JOHN COOPE

ESSENTIAL HYPERTENSION

Ed. Richard Thurm

YB Medical Publishers
London (1979)
418 pages. Price £22.50

This is not a general review of the subject, but the report of a rather patchy WHO symposium held in Yugoslavia in 1978. There are several interesting summaries by world authorities on the present state of their work, all readily available elsewhere, many trivial or repetitive studies almost none of which break new ground, and a very good panel discussion on treatment covering 24 pages.

An exception to the unimaginative nature of most of the studies is a report by a Yugoslav group which taught 9,600