expected if tonsillitis *per se* was being assessed.

As such, their results could represent a bias towards absence of penicillin response, as un-inflamed sore throats will not respond. The point of this argument is to enable qualification of the authors' conclusion. Their recommendation does apply to un-inflamed sore throats, assuming other features of the illness do not require antibiotic treatment, but I think it wrong to extrapolate the conclusion to include inflamed sore throats, as this group includes streptococcal infection.

The Group A B-haemolytic streptococcus can still behave unpredictably and I have seen some very severe infections and one fatality (septicaemia complicating chicken pox in a mother of two young children). The literature (*British Medical Journal,* 1972, 1978) also records fatalities and warns that this organism should be recognized as a dangerous adversary. It would seem foolhardy to approach the streptococcus too lightheartedly.

The duration of antibiotic treatment is a different argument altogether, and I would agree with the authors that rheumatic fever prevention is not the primary concern, hence a short course will usually be adequate.

There need be no confusion about who to treat and who not to treat: if the throat is inflamed, treatment is advisable; if un-inflamed, then an antibiotic will usually not be necessary for the throat itself.

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ANTIBIOTICS AND COLDS

Sir,
Dr J. A. McSherry (January *Journal,* p.49) asks "Why not prescribe antibiotics for heavy colds?" Unfortunately he does not define what is meant by a "heavy cold". If he means the situation described in his last paragraph, "an acute respiratory infection associated with a fever of over 100°F lasting for three days, especially if accompanied by profuse yellow or green sputum," I suspect very few general practitioners would withhold an antibiotic, but of course this is the clinical picture in a very small proportion of respiratory infections. The majority of people suffering from what they feel is a heavy cold are afebrile, and most studies have shown little or no benefit when antibiotic treatment is used in this situation. Even if one accepts that *Mycoplasma pneumoniae* is responsible for between 16 and 23 per cent of cases of acute respiratory disease (and the proportion was very much smaller when we did a survey in our own practice), then this is by no means proof that antibiotics are likely to be helpful. For example, many cases of gastroenteritis are susceptible to antibiotics, but with a few exceptions antibiotics have been shown to have little benefit in the absence of prolonged bacteraemia.

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PRACTICE REPORTS

Sir,
Dr McGuinness's suggestion (December *Journal,* p.744) of an annual practice report is an important one and, although it has been around for some time, and indeed was the subject of a competition in *Update* some years ago, it does not appear to have been pursued on a very wide scale since then. The reports that I have seen have tended to concentrate on such things as staffing, premises and activity analysis related to morbidity. There does not seem to have been much attention paid to prevention statistics, which is something I am interested in, and I would be most grateful to hear from anyone who has addressed themselves to this issue or who wishes to pursue it further, and I would be grateful to receive any copies of annual practice reports which have been produced.

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CORNEAS FOR TRANSPLANTATION

Sir,
It has occurred to me that general practitioners are in an ideal position to collect donor eyes for corneal transplantation. For the last few months, where I felt it appropriate, I have asked the relatives whether they would like to donate the dead person's eyes for corneal transplantation in the local hospital. The response has been very encouraging. About one-third of those asked have in fact agreed to donate the eyes; none of the rest appears to have been upset by being asked and, indeed, some of them are grateful to have been asked. Technically, the collection of the eyes is very easy and does not require much expertise. Speed is not essential, as the material is viable for at least 24 hours after death and, because of this, there is no suggestion that we are dealing with people who might not be dead.

If anyone was interested to obtain materials for their local hospital, the simplest thing to do would be to contact the eye department, where one of the consultants would probably be more than pleased to arrange any material and the cover of any transport costs.

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COMPUTERS IN GENERAL PRACTICE

Sir,
The Central Information Service for General Medical Practice is collecting information on all aspects of computers with a view to providing an information service to general practitioners who are interested in computers.

We would like to build up a complete file of computer users, detailing the type of computer installed, the uses to which it has been put as well as details of pitfalls or unfortunate experiences. The latter information can be treated confidentially if required.

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'CONSULTATION'

Sir,
The word 'consultation' is defined for the purpose of the National Morbidity Survey as "any face-to-face contact between the doctor and patient, at home or at the practice premises" (OPCS, 1974). This is consistent with the definition of a "direct consultation" in the General Practice Glossary (Royal College of General Practitioners, 1973). However, in the National Morbidity Survey "the decision to record more than one diagnosis at any one consultation was left to the recording doctor. In general, if the patient consulted about more than one condition, these

would be recorded separately unless they formed aspects of a single diagnosis . . . this has meant that what appears as the number of consultations is in fact the number of times a disease or condition was the subject of a consultation" (OPCS, 1974). Thus, a 'consultation' in the National Morbidity Survey is more akin in North American terms to a 'problem contact' than to a 'direct encounter' (NAPCRG, 1977).

This ambiguity surfaced when comparing Danish 'visits' with NMS2 'consultations' (Krogh-Jensen and Kilpatrick, 1980) at the recent WONCA meeting in New Orleans. Care should be taken in interpreting those tables of the Second National Morbidity Survey headed 'consultations' or 'consulting'. Dr Crombie, who was responsible for planning NMS2, comfirms that this effect inflates 'consulting' rates by between eight and nine per cent.

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COMPULSORY TRAINING MAYBE . . . STATUTORY TRAINING NO

Sir,

I note that after 15 February 1980 it will be illegal for me to become a principal in NHS general practice unless I conform to the regulations of the National Health Service Act 1977 (Sections 31 and 32) and thus obtain a certificate of prescribed/equivalent experience from the Joint Committee on Postgraduate Training for General Practice.

I am, however, eligible to become a general practitioner in the Isle of Man, Channel Islands, the Republic of Ireland, Australia, Gibraltar, much of Canada, most of the Third World, the British army and privately in Harley Street. Statute bars experienced British doctors from NHS general practice. Are British doctors such rogues and potential criminals that they need to be regulated by an Act of Parliament?

There is no law which bars me from becoming a surgeon, anaesthetist or obstetrician tomorrow if I so choose. Fellowship examinations and higher professional training are essential for the would-be NHS specialist, but they are not legal requirements. Why have general practitioners, who value their freedom and independence, agreed to the imposition of the above legislation? The 1858 Medical Act introduced compulsory basic qualifications and the General Medical Council and the 1950 Medical Act introduced compulsory pre-registration experience. Surely the regulation of training should be in the hands of the medical profession rather than the government. We do not need another Act.

Is it really desirable that experienced British doctors should be faced with the risk of prosecution in the Crown Court if they attempt to become principals in NHS general practice?

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EUROPEAN EXCHANGES

Sir,

Allgemeinmedizin International ("International General Practice") is attempting to establish a register of British doctors who would be interested in changing place with their European counterparts either professionally or for holidays. Any doctor interested in such exchanges should write to me giving the following details: name, address, telephone number, languages spoken, special interests and whether anxious to exchange professionally or for holidays.

It is intended that, subject to numbers, these details will be advertised in the journal in the hope of promoting cultural exchanges.

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BOOK REVIEWS

THE SLIPPED DISC 3RD EDITION

James Cyriax

Gower Publishing Company Farnborough (1980)

236 pages. Price £9.50

It remains an extraordinary fact that whilst he is accepted throughout the world as being an authority on back pain, James Cyriax's methods have never been fully recognized in the United Kingdom. Indeed, discussion of his techniques among doctors tends to verge on the religious: "Do you believe in Cyriax?"

Clearly he must have a great deal to offer. Results of his treatments are consistently good, and most doctors who try his techniques enthuse about the outcome. Why, then, do most British orthopaedic specialists usually reject his teaching? Does he pose too great a threat to their own methods, is he tarnished with irrelevant medical prejudice against osteopathy, or is he just wrong?

The Slipped Disc is a guide to the whole confusing subject of backache. It is aimed at both doctors and laymen, but the detailed theory it describes would be above the heads of most people with no medical training. He deals in detail with causes, treatments that are used and should be used, prevention, diagnosis, and so on, in a total of 19 chapters. There is also a glossary which grades various car seats for their backache potential. In particular, the very clear dermatome maps are the best published anywhere.

It is a well written and stimulating book, but I was nevertheless surprised to read, in a section on gardening, that "no-one should dig". I would like to know how I'll get next year's potatoes in! In another area of prevention he