PRIMARY CARE IN LONDON

The current health service reorganization is a last chance to get things right for London's patients, according to a report by a group of London CHCs and the Association of CHCs (*The Management of Health Services in London* from the Association of CHCs, 362 Euston Road, London NW1). The report identifies poor primary care as the capital's main problem and says that the new district health authorities should have the same boundaries as local government. It argues that the strategy of closing acute beds will not help, and the CHCs believe that the influence of the teaching hospitals continues to distort the planning of services. Health visitors should be integrated into the community medicine structure, says the report. It also suggests that, as acute beds are closed, hospital nurses should be offered retraining and posts in community nursing.

Source: *CHC News* (1981), **66**, 4.

MOLD COMMUNITY HOSPITAL

This new hospital is to be one of the community hospitals supporting the Wrexham District General Hospital. It is to be constructed on the land within the curtilage of the existing Mold Cottage Hospital, which will be effectively replaced. The total cost will be about £1·5m and construction will take two years. It will include a 20-bed general medical ward, a 20-bed geriatric ward, a 15-place day hospital, an outpatient department and full supporting services. Work is expected to begin in August 1981 on this, the first purpose-built community hospital in Wales.

VISITING PROFESSORSHIP

Dr Julian Tudor Hart of Glyncorrwg, Glamorgan, has been appointed visiting professor at the University of North Carolina Medical School at Chapel Hill. He is to work in the department of family medicine in August and September of this year.

CHC SURVEYS

Of the 228 CHCs in England and Wales, 194 have responded to a questionnaire sent out by *CHC News*. The surveys were classified in alphabetical order, and indicate what services have been looked into and by which CHCs these have been done. The largest number were on maternity care, closely followed by those about the elderly; 28 were about general practice and primary care. A full list can be seen in *CHC News* for May 1981, pages 10-11.

MSD FOUNDATION: NEW PROGRAMMES

The MSD Foundation supports medical education in the UK by producing audiovisual material for use with small groups of doctors. The following new programmes are now available:

105. *The Management of the Arthritic Patient in General Practice.* Videocassette. Part 1, 30 min; Part 2, 18 min. Diagnostic methods, early detection, management, chronic conditions. Includes project work.

201/6. *Consultation Selection A.* Videocassette. Part 1, 13 min; Part 2, 11 min; Part 3, 14 min; Part 5, 10 min. Recordings of four consultations, verbal and non-verbal behaviour.

201/7. *Consultation Selection B.* Videocassette. Part 1, 18 min; Part 2, 8 min; Part 3, 20 min. As above.

201/8. *Doctor at work—Dr Paul Freeling.* Videocassette. Consultations and techniques.

304. *Dorothy Parsons.* Videocassette. Dramatized programme on terminal illness: symptoms, feelings of relatives; community resources; hospital care.

305. *Darren Cooper.* Videocassette. 16 min. Dramatization. The child as presentation of family disorder; small stature; child abuse and maternal depression; community resources; consultation with children.

406. *Safer Prescribing.* Tape/slide. Part 1, 14 min; Part 2, 10 min; audit; repeat prescribing; assessing information about drugs.

408. *Medical Records. The Third Party in the Consultation.* Videocassette. Extracts from consultations. Organizing and using record systems; record systems and the consultation.

501. *Upper Respiratory Tract Infections in Children.* Tape/slide. 15 min. Natural history and epidemiology; management; family anxiety; classifications. Four cases presented.

504. *Child Health Surveillance.* Videocassette. Interviews with mothers and doctors. Aims of surveillance; organization; skills.

All material available from the MSD Foundation, Tavistock House, Tavistock Square, London WC1H 9LG.

MEETINGS AND COURSES

Science and Medicine 1981

Royal College of Physicians of London, 11 St Andrew's Place, Regent's Park, London NW1 4LE, 11-13 November. Sessions on physiology, messengers and receptors, immunology, genes and proteins, electronics and ultrasound. For further details contact the Conference Secretary, address as above.

Alcoholism

The FARE Annual Symposium, York University, 28-30 September. For further details contact The Administrator, FARE, Federation of Alcoholic Rehabilitation Establishments, 3 Grosvenor Crescent, London SW1X 7EE.

Psychosexual Medicine

International conference organized by the Institute of Psychosexual Medicine, Brighton, 7-10 July. For further details contact Caroline Rodney, Medical Conference Organizers, 100 Park Road, London NW1 4RN.

LETTERS TO THE EDITOR

WORKING ABROAD

Sir,

The members of the East Anglia Faculty Board would heartily agree with Dr J. R. D. Brown on his advice to doctors, "Why not shed a little moss?" (February *Journal*). At the same time, we would like to draw the attention of general practitioners to the virtual cessation of the possibility of working abroad on a short-term or exchange basis. Whilst this embargo does not apply to the EEC countries (but who has the language fluency?) and the 'Third World', throughout most of the English-speaking world an iron curtain has come down that effectively excludes

foreign graduates. As many of these countries are over-producing doctors, security of employment for their own graduates is quite understandable. Yet we are not concerning ourselves about permanent emigration but solely with the short-term exchange (three to six months) of general practitioners for the stimulus of working in a foreign country with a different system of health care and for the opportunity of meeting colleagues with different outlooks.

One of us (B.V.) has made a special study of the registration requirements of a number of foreign countries, and the restrictive practices already in being effectively preventing UK graduates from working *temporarily* abroad are really quite formidable. Indeed, there seems to be no distinction made between temporary or permanent movement.

We feel that there is a most urgent need for the College to enter into a dialogue with sister colleges in other countries in order to set up the machinery for creating a temporary registration system, which is the prerequisite for any exchange. We accept that the difficulties will be considerable, but they should not, with goodwill, prove to be insurmountable. It will prove to be an excellent investment of time and effort and we hope that many Faculty Boards will support East Anglia in this particular crusade.

NEVILLE SILVERSTON
Chairman
BARBARA VAUDREY
STEPHEN OLIVER
PHILIP EVANS

East Anglia Faculty
The Royal College of General Practitioners
Beaulieu House
Bottisham
Cambridge CB5 9DZ.

ASSESSING THE ADEQUACY OF ANTIHYPERTENSIVE TREATMENT IN A HEALTH CENTRE IN FINLAND

Sir,

The data presented by Pertti Kekki (April *Journal*) are interesting, but incompletely developed.

He found 169 patients from a health centre population of 14,500, identified as hypertensives. He does not say what cutting point was used, but on a very conservative definition (diastolic 105+) one would expect 580 hypertensives between 20 and 64 years of age in a total adult population of this size. It looks as though only about one third of the severe hypertensives in that population were even identified.

The evidence he gives of ineffective treatment in this one third who were diagnosed is convincing enough, but very difficult to analyse. No information is given about the mean pressure of the whole group before it was treated. Williamson's definition of an adequate level of control (95 per cent with diastolic pressures below 100) which Kekki has used is completely unrealistic. So far as I know, no hospital or general practitioner series anywhere in the world has come anywhere near this level of control. Our experience at Glyncorrwg has been that we usually have from 80 to 85 per cent of our patients controlled (diastolic pressure below 100). The reduction in both systolic and diastolic pressure in the treated group as a whole is about 30 per cent, including those with poor control or none at all.

It also seems doubtful what relevance any of this has to the Finnish policy of free treatment of hypertensives. Whether the prescriptions are paid for or not seems to have little to do with the argument, though there can be little doubt that financial penalties will not improve compliance. Surely the main thing is that treatment and follow-up must be planned and controlled, and that simple forms of audit must be applied by the medical teams responsible for treatment. It would be a pity if they discouraged themselves by continuing to use Williamson's criteria as Kekki has done. To be fair, Williamson only used this definition on the recommendation of hospital clinicians and I doubt very much if he would recommend it himself now.

J. TUDOR HART

The Queens
Glyncorrwg
West Glamorgan SA13 3BL.

SORE THROATS

Sir,

General practitioners have to manage patients in a 'probabilistic' way (Crombie, 1966); managing every patient as if he has a life-threatening disorder is impracticable and, as has been shown on many occasions, is not the way most general practitioners work. Yet Michael Everett (May *Journal*, pp. 313-314) suggests that we should assume that all inflamed throats could be caused by the very dangerous streptococcus and treat them all with penicillin or a similar antibiotic. He criticizes our paper (Whitfield and Hughes 1981) on the grounds that it is about a symptom and not a disease, and then goes on to base his arguments on whether a throat is inflamed or not, also hardly an accurate diagnostic term.

In our study we had 108 patients with purulent tonsils (one of his criteria for inflamed throats) and 363 patients with what the doctors described as red throats. Neither of these groups of patients got significantly better with penicillin than with placebo. We have shown to our satisfaction that no matter whether a throat is inflamed or not, it does not respond more quickly to penicillin than to placebo. I must therefore differ from Dr Everett's final conclusion that antibiotic treatment is indicated for all inflamed throats.

MICHAEL WHITFIELD
24 Hanbury Road
Clifton
Bristol BS8 2EP.

References

Crombie, D. L. (1966). Probability and diagnosis. In: *Evidence of the College of General Practitioners to the Royal Commission on Medical Education. Reports from General Practice 5.* Appendix 1, 27-32.

Whitfield, M. J. & Hughes, A. O. (1981) Pencillin in sore throat. *Practitioner*, **225**, 234-239.

GENERAL PRACTITIONER OBSTETRICS

Sir,

The College's discussion document "Obstetrics and gynaecology for general practice" (February *Journal*) raises many problems about what training is appropriate for general practitioner care in obstetrics. Much of what is said I would agree with, but there are certain areas where the recommendations are unnecessarily restrictive.

I would agree that the provision of antenatal and post-natal care should be an essential component of general practitioner care, as are family planning, child health and so on, and that intranatal care can be considered separately. Those general practitioners wishing to provide intranatal care will obviously need appropriate hospital training to get sufficient experience. It would seem desirable that, as part of this training, trainee general practitioners should also be exposed to intranatal care within general practitioner units. The type of care provided in such units is very different from that provided in consultant units.

I am, however, worried about the training programme proposed for those general practitioners wishing to provide antenatal and post-natal care. Three months' hospital experience, where the