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.

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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.

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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.

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References

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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