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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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

emphasis is often too much on high technology deliveries rather than antenatal and post-natal care, seems inappropriate. I am not convinced that the type of antenatal and post-natal care as practised in most hospitals, with patients seeing different doctors at each visit, is appropriate in the training of general practitioners.

It is obviously important to improve and maintain standards within general practice obstetrics, but the rigid recommendations for training as laid down in the document may end up excluding many able people from general practice. This particularly applies to women wishing to train. Nowhere in the document is any mention made of flexibility or the possibility of part-time training. Many women, and men, may not be able or prepared to work alternate nights in an approved obstetric job to provide antenatal and post-natal care. Many women doctors will have experienced childbirth themselves and will be able to relate antenatal and post-natal care to intranatal care. It would be a shame to exclude this expertise—flexibility of training and attention to individual ability will also be a benefit to standards of practice.

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HAYFEVER

Sir,

The management of 'minor' medical conditions is seldom as straightforward as many experts would have us believe. Hayfever is a disease whose treatment lies almost solely within the domain of the general practitioner, and one which we believe clearly illustrates the truth of this statement. Although numerous pharmacological agents have been shown to be effective in treating symptoms of hayfever in many controlled trials (Norman *et al.*, 1972; Illum *et al.*, 1973; Loeb, 1961), few of these have ever been assessed in comparison trials and little is known about their relative efficacy. There is also little information available about patients' preferences for various forms of treatment.

We would like to present the abbreviated results of two surveys, both of which were carried out as preliminaries to comparative studies designed to produce such a prescribing policy.

1. In the summer of 1978, the hayfever prescribing patterns of six doctors in our urban group practice in Kingston-upon-Thames were examined. Over 20 different treatments were being prescribed, and there was a wide variation between doctors in their average per patient seasonal prescribing costs (ranging from £7·69 to £18·62).

2. In the summer of 1979, 93 patients consulting this practice for hayfever completed a questionnaire about their symptoms and their evaluation of the treatments they had received in the past. Overall, steroid preparations were thought most effective for nasal symptoms, and topical sodium cromoglycate most effective for eye symptoms. The two most expensive treatments available—hyposensitization and topical nasal sodium cromoglycate—were worst in patients' assessment of efficacy. Depot steroid injections were considered very helpful by the small number of patients who had experience of them.

3. Further studies are required to determine whether or not steroid therapy should be selectively employed in the treatment of patients whose hayfever is characterized by nasal blockage (Mygind, 1979).

We believe that these findings indicate that there is a real need for proper comparison trials of the principal treatments for hayfever, so that its management can be placed on a more rational basis. We are currently piloting such studies and we invite any doctor interested in participating in a collaborative trial in the hayfever seasons of 1981 and 1982 to contact us for further information.

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PREVENTION

Sir,

May I express my view regarding the three recent publications on preventive care issued by the College. These appear to me to emphasize the 'God image' that some college academics have of general practice—the idea that nobody within society other than themselves can lead a positive preventive health campaign.

We as general practitioners are already asked by the College to spend more time teaching students and trainees. We are asked to practise 'holistic' medicine, caring for many self-inflicted stresses of life which could have been avoided by correct parental responsibility and educational direction.

If the suggestions the College is now making are taken up within general practice, I can foresee the emergence of a supermarket, streamlined, impersonal approach. I would ask the College to reconsider their 'God image' and encourage us 'down-to-earth' doctors to continue caring for the sick, the dying and those who come to us seeking comfort, support and the occasional cure.

We can, of course, as general practitioners play our part in preventive medicine—in relation to the down-to-earth medical care that I have described. But to organize large screening schedules will not improve the health of the nation but make them more dependent on the medical services which are already under stress and over-financed.

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PREGNANT AT SCHOOL

Sir,

In his review of the Joint Working Party Report on Pregnant Schoolgirls and Schoolgirl Mothers, Alan Hutchinson (January *Journal,* p. 60) comments that "evidence was not submitted to the Working Party by the Royal College of General Practitioners". This statement was made because, in Appendix 3 of the Report, the Royal College of General Practitioners is not listed as an organization submitting evidence to the working party.

In order to set the record straight, I should inform your readers that the College was approached to give evidence to the Working Party and this was prepared on our behalf by Dr Robin Steel. The statement in Alan Hutchinson's review therefore is incorrect, but the mistake is due to our name being omitted in the Report itself.

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