pointed by the Board of the East Anglia Faculty to whom the trustees will be responsible. The following purposes have been proposed for the Fund:

1. To award 'bursarships' to individual doctors or medical students in East Anglia to support personal visits intended to advance their professional education. In seeking to encourage such visits the trustees have in mind John Stevens' special gifts as a personal teacher, and how much he gave to those who visited him in his practice.
2. To finance visits to individual general practitioners or groups of them in East Anglia by selected persons whom it is felt would make a particular contribution to the professional work of those visited.
3. To support special meetings organized by or through the Faculty Board to encourage the exchange of ideas and stimulate activities designed to improve the standard of general practice education and clinical practice.

The trustees are appealing personally to all members and associates of the College in East Anglia for contributions to the Memorial Fund and also to all ex-trainees of the Ipswich Vocational Training Scheme. We have already received donations from John's personal friends in the College both here and abroad. We are aware that there may be others in the College who have happy memories of John and would like to contribute to this Fund which we feel will support enterprises which were of special interest to him.

Donations should be sent to the John Stevens Memorial Fund, c/o Dr Bernard Reiss, 18 Maids Causeway, Cambridge. Best of all, if you are able to covenant a gift Bernard Reiss will send you details and appropriate forms on request.

IAN TAIT

15 Lee Road
Aldburgh
Suffolk IP15 5HG

A Follow-up of some North East London Trainees

Sir,

I read Dr Bloomfield's follow-up of North East London trainees (January *Journal,* p.47) with interest, but I am dismayed by the criteria used in the 'Index of Attainment'. Their implication is clear; members of the College are better doctors than non-members and teaching practices are better than the rest.

This seems now to be the accepted wisdom, but is there any supporting evidence? Few regions can have such complete records of training practices as do Devon and Cornwall, but presentations of their data, like the most recent,[1] fail to refer to standards in non-training practices. Is it not possible that 'ordinary' practices are changing just as quickly as training practices?

At a time when the College is pontificating on the use of deputizing services and launching its quality initiative, it will do well not to appear to talk down to the rest of the profession and further alienate non-members.

After all, passing the MRCGP examination indicates no more than scoring sufficient points in a highly stylized test. For myself, a rating of 7 on the 'Index of Attainment' seems to have no bearing on my standing as a general practitioner; that depends on the quality of the service I give my patients.

PAUL ROBINSON

The Surgery
Station Road
Snainton
Scarborough
N. Yorks.

Reference

1. Pereira Gray DJ. Selecting general practitioner trainees. *Br Med J* 1984; **288:** 195-198.

Acute Illness in Infants: a General Practice Study

Sir,

The preliminary report of the DHSS multicentre study of infant mortality suggested that an important minority of children who die at home have major symptoms during their terminal illnesses.[1] This arbitrary classification of major symptoms provoked controversy as many thousands of children are seen daily with these common symptoms which were defined as those needing a medical opinion on the same day and included such conditions as wheeze, cough, diarrhoea and vomiting, drowsiness, irritability, fever and being off feeds.

In a follow-up study by Wilson and colleagues, 84 per cent of consultations for acute illness in children contained at least one major symptom (March *Journal,* p155). There was no significant relationship between the reported presence of a major symptom and management of the illness as measured by the issue of a prescription or arrangement for follow-up. This latest study also showed that parents' perceptions of which symptoms were important were at variance with a classification into major and minor. These findings confirm that major symptoms as defined by Stanton and colleagues are too prevalent in general practice to be useful in determining outcome.

Wilson and colleagues hint that study of general practitioners' and patients' perceptions of symptoms may provide a ranking order of potentially hazardous problems, but given the wide variation in interpretation this is unlikely to prove a fruitful approach. A method worthy of consideration is to classify combinations of symptoms in terms of severity—for example, is a combination of fever, wheeze and poor feeding a 'cluster' which is more likely to warrant close scrutiny than a combination of cough, irritability and altered cry? Taken in conjunction with previous history and duration of complaints, 'symptom/sign clusters' may hold the key to outcome rather than symptoms taken individually. 'Clusters' might provide more useful pointers for the general practitioner when he has to take decisions about management and follow-up.

Answers to these questions would require much larger numbers than those in the study reported but could be achieved by asking general practitioners to record information about children seen on selected days or weeks, rather than by attempting to get busy doctors to record continuously over a prolonged period of time. Selective recording provides more reliable results and should be considered by those wishing to pursue the natural history of acute illness in young children.

D. J. G. BAIN
Professor of Primary Medical Care

Aldermoor Health Centre
Southampton SO1 6ST.

References

1. Stanton AN, Downham MAPS, Oakley JR *et al.* Terminal symptoms in children dying suddenly and unexpectedly at home. *Br Med J* 1978; **2:** 1249-1251.

Low Prevalence of Hypertension in Falkland Islands Men

Sir,

Long ago John Fry found, as I remember, about four times as many women hypertensives as men in Beckenham, and Peter Hodgkin found about seven times as many hypertensive women as men in Yorkshire. Being modest men, they did not claim that this represented the prevalence of hypertension in the general population, and in both cases the proportion of male hypertensives has since risen, as blood pressure re-

cording becomes more universal and is applied to younger age groups. All population studies that I know of, in all parts of the world, show a higher prevalence of hypertension (on any definition) in young men than in young women, and an excess of female hypertension from about 45-50 years which increases with age. The excess in the aged is almost certainly due to preferential survival for women, probably because of their much lower associated risk of myocardial infarction.

Drs King and Bleaney (February *Journal,* p.95) have made no case at all for anything unusual in the Falkland Islands, except perhaps a culture lag in general practitioner clinical behaviour. As there were under 2,000 people in the study, we are presumably observing the clinical behaviour of only one or two doctors, and since this is essentially a study of doctor behaviour and not of the population distribution of blood pressure, this hardly achieves statistical significance. It's a pity that the title 'Low prevalence of hypertension in Falkland Islands men' has now entered the Cumulative Index Medicus, and will be disgorged every time someone presses a computer button for a literature search in this field.

JULIAN TUDOR HART

The Queens
Glyncorrwg
West Glamorgan SA13 3BL.

Protection against Tetanus

Sir,

Tetanus is rare, with only between 15 and 24 cases being reported each year in England and Wales, although the true figure may be four to five times as high.[1] In spite of its rarity we should not become complacent about it as it is an unpleasant disease with an appreciably mortality and it may complicate any wound including burns and varicose ulcers and also recurs in patients with no history of any wound at all.[2] The causative organism, *clostridium tetanus,* is widely distributed and so will never be eliminated as the smallpox virus has been, but the disease it causes is totally preventable.

The best prevention is active immunization with a course of tetanus toxoid injections. This is cheap, effective and has very few side effects, and a course gives protection for 10 years.[3] This covers the patient not only for serious wounds for which they will seek medical help anyway, but also for *all* the minor wounds which they treat themselves. Unfortunately, much of the population, especially the elderly, is still unprotected.

If a non-immune patient gets a contaminated wound a single injection of tetanus toxoid gives no protection. He should be given human tetanus immunoglobulin (costing £14.30 if the proprietory preparation is used) and at the same time should be started on a course of tetanus toxoid. He may be given an injection of 'Triplopen' for good measure. This will prevent tetanus (though at a much greater cost than active immunization) but unfortunately the system frequently breaks down.

Firstly, the patient may not get the human tetanus immunoglobulin as few general practitioners keep it in the surgery and many casualty officers seem reluctant to prescribe it for reasons that are not altogether clear but may relate to folk memories of anti-tetanus serum and its complications and may relate to cost.

Secondly, the patient should leave the accident and emergency department with a letter to the general practitioner (which may or may not get delivered) and instructions to have a second dose of toxoid after six weeks (which may or may not be given) and a third after six to twelve months (which almost certainly does not get given). So, when the patient attends later with another wound, we start again. Unfortunately, neither hospital nor general practitioner has any means of checking that the patient gets his immunization.

All patients, including the elderly, need adequate active immunization against tetanus. An organized campaign such as exists for child immunization would be costly and probably ineffective and so this is probably best done when the patient attends the surgery for some other purpose. My plea is that questions relating to tetanus immune status should be routine at the geriatric screening clinic, the pre-employment medical, the post-natal clinic, the BUPA style 'check-up' and so on, and that full immunization should be given to those who are not immune.

H. R. GULY

Consultant in Accident and Emergency

The Royal Hospital
Wolverhampton.

References

1. PHLS. Tetanus surveillance and prophylaxis. *Br Med J* 1982; **1:** 1715-1716.
2. Edmonson RS, Flowers MW. Intensive care in tetanus: management, complications and mortality in 100 cases. *Br Med J* 1979; **1:** 1401-1404.
3. Smith JWG, Lawrence DR, Evans DG. Prevention of tetanus in the wounded. *Br Med J* 1975; **3:** 453-455.

Sale of Cigarettes to Children

Sir,

In May 1983 Council held a reception at the House of Commons to try to secure a dialogue with MPs on matters of mutual interest and concern. This was successful and a number of relationships were established centrally, which continue to develop.

In order both to extend this initiative, and I hope to reduce the sale of cigarettes to children, I have suggested that secretaries ask faculty board members to contact their local MPs, either personally or by letter, and ask them to support *and sign* the following Early Day Motion (number 346), which has been put down by Mr Charles Irving, MP for Cheltenham.

> 'That this House notes that almost £60,000,000 is spent annually by children on cigarettes; and calls on the Government to uphold more effectively the law relating to the sale of cigarettes to children, as defined in the Children and Young Persons Act 1933, and to undertake urgently a review of the terms of the Act and the level of penalties for convictions under it.'

My action was prompted by the paper by N. C. A. Bradley relating to the sale of cigarettes to children in Exeter (September *Journal,* p.559) and the results of a recent Government survey.[2]

The response by faculty boards has been good and I hope that this can be reinforced by all College members using this opportunity to initiate contact with their local Parliamentary representatives.

When I wrote to faculty board members the indications were that there had been no prosecutions for offences relating to the sale of cigarettes over the last five years. However, the statistical section of the House of Commons library has finally produced the figure of seven prosecutions in England and Wales in 1982, the same year in which the Government survey indicated that £60 million had been spent by children on cigarettes! A very convincing reason for the profession to be concerned.

I enclose a few other relevant details which doctors might like to pass on to their local MPs.

1. 85 per cent of tobacco retailers profess ignorance of the law on the sale of cigarettes to children.[1]
2. The maximum penalty (£200) is not sufficient deterrent to support effective policing of the law (Gloucestershire Police Authority).
3. The mortality from smoking-related