creatinine clearance 18 1/24 hours, and results of liver function tests normal.

Captopril was introduced in gradually increasing dosage as recommended by the manufacturers, reaching a dose of 15 mg eight hourly; she had discontinued other medication apart from frusemide on the previous evening. Her blood pressure came under control in 24 hours, falling to 15/1000 mm Hg. At no stage did it fall below 140/90 mm Hg. Three days after treatment began she became pyrexial (38.3°C), and her serum creatinine rose to 325 µmol/l (3.7 mg/100 ml). By the fifth day it was 425 µmol/l (4.8 mg/100 ml) and the drug was stopped. The rise continued for a further three days, peaking at 507 µmol/l (5.7 mg/100 ml) and was back to pretreatment levels (226 µmol/l (2.6 mg/100 ml)) 10 days after the drug was stopped, although her blood pressure did not rise to pretreatment levels over this time.

It is possible that the reduced renal function following captopril was due to reduced renal perfusion pressure with the reduced blood pressure and does not represent renal damage; we did not perform renal biopsy. However, the rise in serum creatinine was accompanied by a pyrexia suggesting a drug reaction. We did not think it justified to expose the patient to the drug again.

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Perinatal mortality by birth order

SIR,—The paper by Professor Leiv Bakketeig and Mr H J Hoffman (22 September, p 693) shows a conclusion, that perinatal mortality falls with increasing parity, which is at variance with explanations given in their text. Their claim was that by taking a longitudinal approach in which sibship size was kept fixed they could show the declining perinatal mortality; this was supposed to contrast with an artefact of cross-sectional surveys by which risk increased with parity, at least for fourth and subsequent babies.

Yet Bakketeig and Hoffman state, "These results are consistent with the known tendency to become pregnant again after a pregnancy with an early adverse outcome and the higher probability of stopping childbearing after a successful outcome of pregnancy." They go on to relate the phenomenon of declining perinatal mortality with increasing parity to this tendency, but show no awareness that their own demonstration would then itself be an artefact.

A simple illustration can bring this out. Suppose the perinatal mortality rate to be constant at 20 per 1000, and that second pregnancies occur with certainty if the first pregnancy results in mortality, only half the time if the first pregnancy is successful. Accordingly, in 100 000 first pregnancies there would be, on average, 2000 failures and 98 000 successes. In the 51 000 second pregnancies (2000 + 98 000/2) there would be, on average, 1020 failures, 40 being repeat failures, 980 first-time failures. If we now compare perinatal mortality rates only for women who have had two pregnancies, we would see $\frac{2000}{51\,000} = 39.2$ per thousand for the first pregnancy, but only $\frac{1020}{51\,000} = 20$ per thousand for the second pregnancy.

By making comparisons fixed on sibship size, Bakketeig and Hoffman have only traded one

artefact for another. Increasing perinatal mortality with parity (but with no concern for sibship size) could as much reflect that higher parity pregnancies include relatively more high-risk mothers as that the risk actually increases with parity.

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Professional standards for consultant appointments

SIR,—In recent times several consultants have been appointed who have not received a full course of training recommended by the appropriate royal college. In my own specialty appointments have been made of candidates who have not completed sufficient training to be eligible for accreditation by the Royal College of Obstetricians and Gynaecologists.

The appointment of such candidates in preference to others raises the whole question as to the value of such accreditation and at a time when there is a large backlog of well-trained and able senior registrars is exceedingly bad for morale in this grade.

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Aggressive patients—what is the answer?

SIR,—The time was 3.15 am when the telephone roused me from my slumbers. An irate voice demanded my presence instantly at his house to attend his sister and grandmother. Being acquainted with the medical history of the two patients concerned, I had no hesitation in accepting the summons, although I was not too keen on the rude language with which it was delivered. I was not given a chance to elicit any more details over the telephone, since all the man could repeat was, "Send the bloody doctor here right now."

I was met at the door by a somewhat hostile young man in his twenties—the owner of the voice—who, even before I had examined the two patients, demanded their immediate removal to hospital. The usual bunch of neighbours and relatives joined the chorus, trying to render moral support to the young man, who was doing all right by himself, and creating more confusion. This concerted attempt to bully me into conceding to their wishes was not successful, since we are fairly used to this kind of behaviour from patients in this area. After examining the two patients, I decided urgent admission would serve no purpose—the elder of the two patients suffered from an advanced inoperable ovarian cancer, and her main complaint was constipation. The second, younger patient suffered from chronic pyelonephritis and hypertension, and she had decided to stop all medication for several days. Although her blood pressure was not unusually high with her medical history, she denied any symptoms of discomfort, apart from slight headache. Both needed reassurance, with the emphasis placed on the continuity of the medication. I spent half an hour with them, and before I left the house I gave the young man a little friendly advice on how to request a home visit, especially at such an unearthly hour.

I must have taken no more than 15 minutes to arrive at the patients' home after receiving the call. While I was en route, however, it transpired that the angry young man had rung my home twice, wondering "where the hell" I was, and promising to "do that bloody doctor in when he comes." Because I was out on the call rather longer than usual, and also because of these threats, my wife eventually decided to ring the local police station and ask someone to go and see if I was still in one piece. I learned of this later bit of nonsense only when I rang my wife from the surgery before returning home. I telephoned the police to let them know I was alive and well, and, although they were relieved to hear it, nevertheless they said they would go along and give the young chap a word of warning, which, in fact, they did. I must say I was impressed by their speed of action in those days when we hear so much criticism of our police service.

My first reaction on returning home was to remove the family from our list; then I began to wonder if this is the only solution to the problem—in fact, it is not a solution at all but merely a case of passing the buck. Abuse of doctors and their families appears to be on the increase all over the country, both in quality and quantity. One hears of doctors being attacked in the Liverpool area, surgeries constantly being vandalised in Glasgow and other major cities, but our patients seem to be second to none in their verbal abuse. If I hear a polite voice on the other end of the telephone, it is an occasion to remember, which, unfortunately, does not happen very often. I have worked in general practice in Hertfordshire, Midlothian, and Derbyshire, and for the past five years in this beautiful part of North Ayrshire, and I never cease to wonder why it is that the patients are so much more aggressive, abusive, and impudent. In fact, the same old offenders are passed from practice to practice with unfailing regularity, whether we like it or not. Is there an answer to this problem? And what is the cause? Is it sheer ignorance of basic common courtesy, lack of education, or social deprivation? Or could it be a compensatory measure for their own inferiority and inadequacy? Or maybe even projection of their guilt in neglecting their loved ones? One can go on rationalising the behaviour of these patients for ever.

Why should it be that patients can report doctors, fairly or unfairly, to the local family practitioner committee (FPC), when doctors are forced to accept abusive and offensive patients on their lists. It seems an unfair and one-sided situation. As far as I am concerned, I see it as gross injustice to our profession that we should be deprived of our right to report these patients to the local FPC or some Government body, who should have the power at least to discipline them or reprimand them for their behaviour, as we are dealt with when reported by patients.

I have often heard it said that patients get the treatment they deserve, and I think it is very true. I am sure that most doctors would agree a little politeness and civility—which cost nothing—would make a world of difference in the doctor/patient relationship. Until someone comes up with a realistic answer to this problem, then I truly fear for the future of the National Health Service, already afflicted with an ailing economy.

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