in males. It is for this reason that the wait-and-see policy referred to in your leading article (28 August, p 490) needs to be compared with radiotherapy in younger men with localised disease.

However, old habits are not easily discarded and a non-investigative approach to the management of these patients has become widespread. The TNM classification provides a good "shorthand" system of tumour characterisation but requires moderately sophisticated, and certainly expensive, techniques. We cannot share Dr Rostom's confidence in the accuracy of lymphography. Pedal lymphography does not opacify the obturator and internal iliac group of nodes, which are the most common site of nodal deposits. Moreover, in a recent study we have shown a 25% error rate, mainly false-negative, in the interpretation of opacified nodes. Thus a negative lymphogram has no value in staging, and pelvic lymphadenectomy must be considered for improving the accuracy of staging in selected younger patients. If the proposed clinical trials for localised prostatic carcinoma are to yield meaningful results, then detailed investigation to fulfil the TNM requirements must be accepted.

E P N O'DONOGHUE
G D CHISHOLM

St Peter's Group of Hospitals
and Hammersmith Hospital,
London

¹ Bailar, J C, III, and Byar, D C, *Cancer*, 1970, **26**, 257.
² Blackard, C E, *Cancer Chemotherapy Reports*, 1975, **59**, 225.

Student health

SIR,—I was interested to note in your leading article (13 November, p 1160) that the *BMJ* is to provide a short series of articles on student health. I hope that some attention will be paid to the health problems of the student nurse population. The case of such students is far from uniform, in spite of centres of excellence. Indeed, one might go farther and inquire about the vexed question of the care of the health of hospital staff in general.

Whatever became of the Tunbridge Report of 1968?¹

DAVID ILLINGWORTH

Edinburgh

¹ Ministry of Health, *The Care of the Health of Hospital Staff*, Report of the Joint Committee. London, HMSO, 1968.

Promotion of new drugs on television

SIR,—I was shocked at the blatant advertising of the new histamine H₂ receptor antagonist cimetidine (marketed by Smith, Kline, and French under the trade name of Tagamet). This occurred on the 9 pm news on BBC 1 on Thursday 18 November. The trade name of this no doubt excellent product was clearly visible to viewers in at least two shots.

In general practice we had received the literature (plus statutory data sheet) only on Wednesday 17 November; in my case it was the first I had heard about this new drug, now freely prescribable on an FP 10 (price not mentioned in the literature).

I understand that I am by no means alone in my concern over this trap into which the BBC reporters fell. By all means let us have authoritative information put over on or in

the media by the responsible medical authorities, but this occasion cannot be allowed to pass without protest. I understand that an official protest is to be made to the Association of British Pharmaceutical Industry over this matter.

H M WHITE

Bromsgrove, Worcs

Aortic incompetence in systemic lupus erythematosus

SIR,—With reference to my letter on this subject (20 November, p 1260) I should like to make it clear that this was a follow-up report of the patient originally described in more detail by Oh *et al*¹ and does not represent a new case.

A J ISAACS

Westminster Hospital,
London SW1

¹ Oh, W M C, Taylor, R T, and Olsen, E G J, *British Heart Journal*, 1974, **36**, 413.

Appointments in community medicine

SIR,—I have waited with interest for some public response from the Faculty of Community Medicine to my earlier letter (28 August, p 523). An unexpectedly silent watchdog may be highly significant.¹ Some who were appropriately qualified, trained, and experienced to be appointed specialists at the time of reorganisation have been seriously and permanently affected by failure then to separate personal specialist grading from appointment to specific posts. They have resented the arbitrary and seemingly uncontrolled way in which the career grade continues to be conferred. It would be revealing to know the criteria (other than expediency) advised for adoption by faculty representatives on specialist appointment committees and to have confirmation that the Faculty, in refusing to recognise subspecialties, regards all specialists so far appointed as generalists within the broad specialty.

If community medicine is to be regarded as allied to clinical medicine and therefore to achieve the exemption not so far granted from the current review of management costs, it is essential for the faculty to demonstrate that standards for appointment to the permanent career grade have been, and continue to be, no less demanding than those for clinical consultants. The available evidence is largely anecdotal but not reassuring. Since much stress is laid on the need for evaluation in health services² and the specialty is that branch of medicine which deals with the health of populations or groups, it is particularly appropriate to inquire: (a) the proportion of founder fellows or members not meeting the full and specific criteria originally established under standing order 6; (b) the number of specialist community physicians already appointed who were not currently fellows or members of the faculty; and (c) the number of appointments made to the subspecialist grade as a proportion of all appointments made to specialist posts.

It may well be that the creation of the proposed new grade of hospital specialist (a permanent subconsultant grade) could provide a fortunate opportunity for a review of all existing specialists in community medicine on a personal basis, those with appropriate

qualifications and experience being regraded as consultants in community medicine. Meanwhile, the faculty board should carefully reconsider their continued silence on these matters, and reflect whether this furthers the consolidation and development of the emerging specialty.

R B ROBINSON

Hursley,
Nr Winchester

¹ Doyle, A C, *Silver Blaze*. London, Murray, 1890.

² Horner, J S, *British Medical Journal*, 1976, **2**, 827.

General practitioners and coronary care

SIR,—The implication that the general practitioner cannot play a useful role in the operation of prehospital coronary care schemes because calls from general practitioners for an ambulance in Nottingham are usually long delayed (Drs J D Hill and J R Hampton, 30 October, p 1035) cannot go unchallenged. Since its inception in 1966 the majority of calls for the Belfast mobile unit have come from general practitioners. The median delay between onset of symptoms and intensive care has been 100 min.¹ Over a quarter of the patients have been reached during the first 60 min.

In drawing their conclusions the authors assume, wrongly, that the response of an individual to the development of symptoms and the delay on the part of the general practitioner are innate and immutable. Adaptation is usually possible when necessary. As James Russell Lowell said in 1889, "New occasions teach new duties: time makes ancient good uncouth".

Activation of a mobile unit from whatever source at the earliest possible moment is, of course, to be encouraged. Nevertheless, exclusion of the general practitioner from this area of acute medicine is in the interests of neither the patients nor their doctors. Rumination over the obstacles does nothing to save lives. Drs Hill and Hampton will do a better service if they will now direct their energies toward bringing treatments of proved value to the maximum number of patients at the time of greatest risk, whether medical advice is sought through a general practitioner or the emergency ambulance service.

J S GEDDES

Cardiac Department,
Royal Victoria Hospital,
Belfast

¹ Pantridge, J F, *et al*, *The Acute Coronary Attack*. Tunbridge Wells, Pitman Medical, 1975.

The elderly in a coronary unit

SIR,—Dr F F Thompson (2 October, p 814) is indignant at the attitude of Dr B O Williams and his colleagues (21 August, p 451) concerning the admission of elderly patients, mainly over the age of 70, to a coronary care unit, and his sentiments are shared to some extent by Dr M S Pathy (18 September, p 696).

I must say that I find the comments of Dr Williams and his co-authors sensible and humane: "Keeping them at home when possible, at the expense of a few lives in the mild group not saved by immediate defibrillation, may often be kinder, sounder from the psychological point of view, and beneficial therapeutically"—that is quite apart from obvious practical and economical considera-

tions. This would apply especially to the over-75s who, if circumstances necessitated admission to hospital, could be admitted to the comparative calm and comfort of a general medical or acute geriatric ward. This would obviate the undesirable necessity of transferring recovering patients from the coronary unit to general wards, where many old patients would be found to be suffering from other additional ailments.

At any rate, many elderly coronary patients have no obvious pain and they may be admitted to an acute ward under a number of different guises, the underlying myocardial infarct being recognised only after admission to an acute medical or acute geriatric ward. Surely it would not be suggested that they be immediately transferred to the intensive care unit, if available, only to be transferred back again to the ward in the event of early recovery. Old people do not stand up very well to being pushed around to that extent. Moreover, by the time older coronary patients are able to call a doctor and are eventually admitted to hospital the dangerous dysrhythmic period—the first few hours—may already have passed.

Dr Thompson feels that patients should not be deprived of special coronary care facilities just because they are over a certain age, but I would take the view that they are in fact the lucky ones to be spared the starkly clinical and catecholamine-arousing atmosphere of an intensive care unit. With deep respect for the work that is done in those departments, I have the feeling that some of us who are not yet "geriatric" would prefer to be left in peace at home, with a plentiful supply of pain killers and sedatives, and to take the small and calculated risk.

R G SIMPSON

Geriatric Unit,
Burghmuir Hospital, Perth

Managing mild hypertension

SIR,—Your comments on the management of mild hypertension (leading article, 30 October, p 1025) were welcome. While one would agree with many of your observations concerning young and middle-aged people, no mention was made of the management of the elderly patient with so-called mild or moderate hypertension. Many of those who are primarily concerned with disease in the elderly are becoming increasingly cynical about the whole question of blood-pressure measurement in these people. There is considerable doubt whether sphygmomanometer readings in the elderly with arteriosclerotic arteries really correlate closely with intra-arterial pressures. Similarly one frequently sees old people with persistently very high systolic and diastolic pressures but no associated retinal vessel and electrocardiographic changes. Since they are asymptomatic and have no measureable renal impairment, should they be treated? If they are, many will develop postural hypotension, falls, and strokes.

My own prospective studies involved 162 patients aged 70 years and over who were followed up for a 40-month period.¹ One hundred and eleven patients had diastolic blood pressures of 100 mm Hg or more after rest on more than one occasion. When the survival tables were constructed for these patients and were compared with those of the 51 who had diastolic blood pressures of less than 100 mm Hg it was shown that there was a significantly higher survival time ($P < 0.02$) for those with the higher blood pressures.

While these results are not conclusive because of the relatively small numbers and the inevitable coexistence of factors other than age, they may certainly be used to question the wisdom of treating hypertension, or what I would prefer to call "measured high blood pressure," in the elderly.

ANTHONY MARTIN

Department of Geriatric Medicine,
Crawley Hospital,
Crawley, Surrey

¹ Martin, A, MD thesis, University of London, 1974.

Confidence and medical appointments

SIR,—May I correct a misleading statement by your Legal Correspondent writing on the provisions of the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 (16 October, p 950)?

He points out (correctly) that a spent conviction is not covered by the Act where an application is made for employment "concerned with the provision of health services . . . and of such a kind as to enable the holder to have access to persons in receipt of such services in the course of his normal duties". He goes on to say that this presumably would not cover laboratory technicians.

This is not so. In this district and in very many others laboratory technicians regularly see and deal with patients and, presumably, any spent conviction by an applicant for a laboratory post involving such duties to patients would not be covered by the Act.

HAROLD CAPLAN

Chairman,
Enfield District Medical Executive
Committee

Enfield District Hospital,
London N21

Junior hospital doctors and Europe

SIR,—As 19 December approaches, the date on which the Directives on Mutual Recognition of Medical Qualifications between the nine member States of the European Community becomes effective, it is perhaps time to answer the question, What has the BMA's Hospital Junior Staffs Committee been doing about this? The answer is: a great deal.

The HJS Committee (and its predecessor the HJS Group Council) has been active in Europe since 1972, when it first sent a representative to a meeting of FNIHAS—an organisation of French junior doctors—in Avignon. After this, with the UK in the EEC and the BMA having become aware of the draft Directives on Mutual Recognition of Qualifications, HJSC representatives attended several meetings of various European organisations, including the Association Européenne des Médecins Hospitaliers (AEMH) and the Fédération Européenne des Médecins Collectivités (FEMC), to examine the existing organisations representing doctors at a European level and to see if it would be advantageous to UK junior doctors for the HJSC to affiliate to any of them to allow it a voice in Europe.

The pros and cons of these organisations were discussed in the HJS Committee and eventually it was decided that as none of the existing organisations—though they might include a proportion of juniors—really afforded a channel for the expression of an independent junior voice it would be worth while trying to set up a new European Organisation of Hos-

pital Junior Staff. This view was shared by the organisations representing juniors in France and Denmark. Accordingly, a series of meetings were held from October 1974 onwards attended by representatives of organisations representing hospital junior staff in all the EEC countries, together with, on several occasions, representatives from Switzerland, Austria, Sweden, and Finland.

This culminated in the signing of an agreement setting up a formal organisation at a meeting in Germany in May 1976, titled the Permanent Working Group of European Junior Hospital Doctors. What is this group doing? The answer is: providing information. Much of the preliminary meetings were spent in learning how other health care systems work—of value, of course, in preparing evidence for the Royal Commission on the NHS—and also on different forms and structures of training and practice.

Of immediate interest are the directives themselves, and the working group has produced a series of booklets—one for each country—entitled "Where Do I Find?," intended as a simple guide to anyone wishing to go to work or further their training in another European country. These booklets will be available by the end of the year and are to be followed in the spring by a more detailed booklet entitled "How Do You Do?" giving more detailed information.

Throughout the past three years, owing largely to its continuing participation in Europe, the HJSC, through its representatives on the Joint Consultants Committee, the Central Council for Postgraduate Medical Education, and the Joint Committee for Higher Training in Surgery, has participated in discussions in these bodies on the definition of a level of training equivalent to that of a "European specialist." Furthermore, through the BMA's EEC Committee, and thence to the Standing Committee of Doctors of the EEC, the HJSC has been able to participate in discussions on the draft directives and, after their adoption, discussions (which included DHSS representatives) on their implementation.

Undoubtedly, 19 December will be a significant date. The directives' precise effect on the movement of doctors cannot be predicted, but certainly one can hope that the opening of frontiers will allow for further cross-fertilisation of ideas at all levels in medicine. The HJS Committee has, I feel, prepared the ground well and it will continue to participate fully in what will be a fascinating and important field.

PATRICK McNALLY
Chairman, HJS Committee's
EEC Subcommittee

BMA House, London WC1

* * * The Secretary writes: "One thing which Mr McNally has failed to mention is that the BMA has regularly included a junior doctor (usually Mr McNally himself) in the British delegation to meetings of the Standing Committee of Doctors of the EEC"—Ed, *BMJ*.

Health Service charges

SIR,—Professor R S Illingworth's advocacy (23 October, p 1015) of "modest payments" for medical services is timely and sensible, but too diffident. With each new financial crisis, NHS doctors are urged to reduce fundamental services to patients so as to shore up a tottering superstructure.¹ We must conquer our reluct-