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.

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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.

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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

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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.

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* * * 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-