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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Medicine and the humane society

SIR,—In his review of my book *Getting Doctored* Dr Julian Tudor Hart (17 November, p 1285) characterises me as a "radical pessimist." He agrees with me that the solutions to the problems of medicine are not easy, but he insists that "there are some difficult ones, and it will require tenacity, optimism, and ultimate faith in our science and our profession to work them through."

In my book I contend that some important problems of medicine, including the authoritarianism of many physicians, alienated social relations among health workers, and the often destructive and exploitative relationships between the providers and recipients of care are, in fact, problems of society as a whole that are manifest in many other institutions and professions. Authoritarianism, inhumanity, and greed are products of the socially mediated consciousness of our citizens and of the socio-economic organisation of society. As such, these problems cannot be willed away, although many individuals do act in exceptional and commendable ways.

For humane, non-exploitative medical practice to be widely realised, I believe that we need to develop a humane and non-exploitative society. In this sense, then, I am a radical; but am I a pessimist? Dr Hart does not deny the accuracy of my criticisms of medicine, but he feels that there are too many of them. Can there be too many? Horkheimer has said that "the denunciation of everything that mutilates its free development rests on confidence in man."[1] It is as an optimist that I insist that a decent society be achieved.

Yet I reject neither reforms to the existing health system nor efforts to function humanely within it. In my book I indicate that I prefer a health service such as Britain's to present arrangements in North America, where many people do not have access to regular primary care. A major reason for writing my book was to exhort those who work in medicine to try to avoid some of the unfortunate behaviour patterns into which so many slip.

It is realistic, not pessimistic, to acknowledge that such efforts are only half measures. It is optimistic, not pessimistic, to strive for the best possible medicine in the best possible society. Dr Hart, on the other hand, suggests that we seek solutions to medical problems apart from efforts to change society, and that we have faith in our science and our profession rather than in humanity's ability to transform society and to sustain all that is good in science and medical practice while so doing. Thus is Dr Hart the true pessimist—the one who is willing to settle for less than what can and should be.

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[1] Horkheimer M. *The eclipse of reason.* New York: Oxford University Press, 1947:187.

Hypertension and general practice

SIR,—Results of the US Hypertension Detection and Follow-up Program on effects of controlling hypertension in the diastolic range 90-104 mm Hg[1] make this discussion three times more important, urgent, and difficult than appeared when this correspondence began; 70% of all hypertensives are in this range. However achieved, reductions in mortality of 20% for all causes, 46% for stroke, and 47% for myocardial infarction in a five-year study with about 7000 screened and randomised subjects suggests a major effect from properly organised treatment. The concentration of effect in black Americans

remarked on by Professor W S Peart and Dr W E Miall (19 January, p 180) could well be an effect of social class rather than skin colour, for in Britain also there is a very steep gradient in stroke mortality by social class,[2] and a smaller one for ischaemic heart disease; so that here also one would expect a disproportionate effect on social classes IV and V in any controlled study.

General practitioners who have attempted systematic case finding, follow-up, and recall have mostly concentrated on those under 65 and above a diastolic threshold of 105 mm Hg. This policy was justified by evidence, but also pressed on us by circumstance. We simply did not have the time, the nursing and office help, or the clinical traditions to support any bigger undertaking. The group with diastolic pressure over 105 mm Hg represented about 4% of total practice populations at all ages, or about 7% of adults aged 20-64. As Dr D G Beevers rightly said (12 January, p 108), very few practices are attempting even as much as this; and about half of these people are still untreated, or at least uncontrolled. Now we are faced with a task three times as great.

I sympathise with Dr S L Barley's exasperation (12 January, p 109) with hospital programmes for screening and following up hypertensives in the community. Such schemes are wasteful and lead to further fragmentation of care and abdication from clinical responsibility in general practice. But I cannot share his outrage: if general practitioners in Brighton were already doing the necessary work, the hospital scheme would never have started. Such evidence as we have (from a study in the Lothian Health Board Area[3]) suggested that about 18% of general practitioners referred nearly all their hypertensives to hospitals and another 18% dealt with them almost entirely themselves; in uncomplicated cases of mild-to-moderate hypertension 84% followed up patients themselves after initial hospital assessment and 16% preferred shared care. Achievement of target pressures seems to be about equal between general practitioners and hospitals,[4] and case finding and follow-up are about equally bad in general practice and in hospitals.[5 6] It is futile for general practitioners (or anyone else) to claim exclusive rights to territory they are unable or unwilling to occupy.

I think and hope that we are more unable than unwilling, but time is running out. The job must be done by someone, and we are running out of legitimate excuses for inaction. We are not discussing an optional luxury that might reasonably be omitted from the threadbare residue of our National Health Service, nor is it any longer a suitable subject for token experiment by a few zealous enthusiasts. Either we shall get a large new public investment in a nationwide programme of expanded community care or the breach between what is done and what could be done will widen to an extent intolerable to an informed public—and we must see to it that the public *is* informed.

Such investment should be made through general practice, but on a scale that must change the nature of our contract. The genuine teamwork required and the shift from passive response to symptoms to active pastoral care imply fundamental changes (from both sides) in our relationships with our clerical staffs and our employed and attached nurses, with our colleagues in community medicine and specialised hospital departments, and with the communities we serve. If we cannot learn to relax our unrealistic claims to total autonomy and immunity from peer or consumer criticism the investment will be made elsewhere, or (more probably) not at all.

Perhaps this is the jolt that will set us moving.

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[1] Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 1979;**242**:2562-77.
[2] Hart JT. *Practitioner* 1979;**223**:662-5.
[3] Fulton M, Kellett RJ, Maclean DW, Parkin DM, Ryan MP. *J Roy Coll Gen Pract*; 1979:**29**:583-7.
[4] Parkin DM, Kellett RJ, Maclean DW, Ryan MP, Fulton M. *J Roy Coll Gen Pract* 1979;**29**:590-4.
[5] Heller RF, Rose G. *Br Med J* 1977;i:1441-2.
[6] Heller RF, Rose G. *Br Med J* 1977;i:1442-4.

SIR,—Dr D G Beevers (12 January, p 108) states that "research-minded general practices are few and far between," and for this reason widespread screening for hypertension in general practice is unlikely to be successful. The quality of general practice in inner cities and particularly London has declined to a level that the Royal Commission on the National Health Service reported that in such areas "the NHS is failing dismally to provide an adequate primary care service to its patients"[1] and recommended that research opportunities should be encouraged.

A study is under way in this area aimed at detecting and treating serious hypertension with a view to reducing the incidence in the community as a whole of hypertension-related morbid events—the City and East London pilot programme to detect serious hypertension. This study, designed by hospital-based physicians, clinical epidemiologists, and academic community physicians in co-operation with general practitioners and instigated by the department of community medicine at the area health authority, has been able to recruit 22 general practitioners from eight general practices in the East End of London. Research-minded general practitioners are available and perhaps it is a major function of community physicians to seek out and find them.

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[1] Royal Commission on the National Health Service. Report. London: HMSO, 1979:89.

Labile hypertension

SIR,—Your leading article (5 January, p 4) "Labile hypertension" is a problem in life assurance underwriting, since it is difficult to disregard an elevated reading even if it is suspected of being due to "examination apprehension."

Underwriters tend to have the blood pressure retaken—usually three readings—and work on an averaging basis, unless there are clear indications that the initial reading was what some have termed a "rogue" blood pressure reading. Rechecks often produce further doubts since, although some applicants may become more relaxed as they grow used to having their blood pressure taken, others, fearing that the recheck implies something wrong, grow more apprehensive and their recheck readings may be even higher.

Another difficulty is that readings which are only slightly raised, and are often not considered worth investigating and treating by medical practitioners, may be rateable from the underwriting viewpoint. The medical practitioner can "keep an eye on it," reacting as appropriate; but the life companies have only one opportunity and their decision, often for high, life-long cover, is then binding.

Labile, symptomless, untreated, arterial hypertension is the most resented of all the reasons for loaded premiums. I wonder if the research highlighted in your article indicates that the benefit of the doubt may be given more readily to applicants with labile hypertension?

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Proximal myopathy during beta-blockade

SIR,—The letter of Dr M Uusitupa and colleagues (19 January, p 183) quite rightly identifies the importance of occult thyrotoxicosis in the differential diagnosis of proximal myopathy and how this diagnosis may be masked by concurrent administration of beta-blocking drugs.

We must stress, however, that thyrotoxicosis was excluded in the patient reported by us (24 November, p 1331) by the finding (documented in the report) of normal levels of circulating thyroid hormones and, more importantly a normal plasma thyrotrophin response 20 minutes after intravenous thyrotrophin releasing hormone (200 μg) was given.

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SIR,—Your correspondent Dr R Stone (15 December, p 1583) rightly points out that many patients complain of muscle weakness while taking β-adrenoceptor-blocking drugs. While this may not be of importance when angina is the limiting factor for muscular exercise, the increasing use of beta-blockers in the treatment of hypertension means that many people who may feel perfectly well untreated are having symptoms when on treatment.

Current evidence suggests that this muscle weakness may be the result of an impairment of energy metabolism through retardation of the catecholamine-induced increase of muscle glycogenolysis. It is believed that the breakdown of glycogen to glucose in skeletal muscle is mediated via β_2-receptors. One would predict therefore that the use of non-selective beta-blockers would inhibit this breakdown and thus reduce the supply of glucose for energy production in working muscle cells. Lack of substrate would be the explanation for the commonly seen leg fatigue during exercise during non-selective beta-blockade.

Franz and Lohmann[1] have shown marked differences between non-selective (pindolol) and selective (metoprolol) beta-blockers in hypertensive patients who exercised both moderately and to exhaustion. They found that blood glucose fell to hypoglycaemic levels during exercise in patients on pindolol, implying a considerable reduction in physical capacity. This impairment of physical fitness

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