risky contraceptive beyond this age with presumably little intention of adding to their family.

In the light of the Manchester Report, future use of the oral contraceptive may be more appropriate and the change to surgical or other contraception more timely.

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#### References

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## HYPERTENSION IN GENERAL PRACTICE

Sir,

As many of your readers will know, the Medical Research Council (1977) has completed the pilot phase of a randomized controlled trial for the treatment of mild hypertension which has shown the feasibility and ethical justification for a full-scale study. The main trial has now been authorized and will require the rapid recruitment for a five-year study of an estimated 18,000 patients, aged 35 to 64 years, with diastolic (v) pressures within the 90-109 mm range. It will be predominantly based on general practice.

A total of 200 group practices, of average total list size of about 10,000, will be needed and we would be glad to hear from any such practices which are interested in learning more about the trial. It has been our policy to ensure that practices collaborating in the study do so without incurring undue additional workload or financial burden. Mobile, fully staffed screening caravans are available where needed to relieve the practices of the screening load. The cost of extra nursing and medical assistance is provided. Costs of compiling age-sex registers, and use of ECGs are covered. The workload, once screening is complete, is relatively light and can be largely covered by a competent part-time nurse, provided she has ready access to medical advice. After the first year, the workload for a practice with a total list size of 10,000 requires about seven hours of the nurse's time and one or two hours of the doctor's time each week.

Further details, and the names and addresses of practices already in the study who would be willing to be visited, are available from: The Co-ordinating Centre, MRC Treatment Trial for Mild Hypertension, MRC/DHSS Epidemiology and Medical Care Unit, Northwick Park Hospital, Watford Road, Harrow HA1 3UJ.

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## COELIAC ARTERY COMPRESSION SYNDROME

Sir,

The very existence of coeliac artery compression syndrome is controversial, as Dr McSherry (November *Journal*, p. 684) points out. Expecting to find two convincing case reports, I was surprised to find that the first had many features of coeliac disease: the patient had diarrhoea, had lost weight, and x-rays showed a "pattern of malabsorption". The coeliac decompression had no effect on the diarrhoea, but the patient "put herself on a gluten-free diet, with rapid resolution of the problem".

It is difficult to accept this as a genuine case of coeliac artery compression syndrome in the face of the coexistence of another major small bowel disease.

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## INDEPENDENT CONTRACTOR STATUS

Sir,

Dr Pereira Gray's article (December *Journal*, p. 746) on the independent contractor status is important. The Royal College of General Practitioners, devoted to the pursuit of truth and excellence to the exclusion of the material realities of money and medical politics, nevertheless affirmed to the Royal Commission on the NHS its opinion on the central importance of general-practitioner autonomy to any future for progressive general practice. No specific mandate was sought from the membership on this point, but it was certainly affirmed by most if not all the faculties, and I have no doubt that it coincides with the views of a large majority of members. If a political opinion is held by a sufficient majority in any group, it may within that group be removed from the questionable area of politics and change to the safer ground of religious rhetoric and constancy.

Still, the state of this established religion is like many others: all need more than habit to justify them. Dr Pereira Gray correctly observes that neither our College nor the BMA has published any theoretical justification for it. Has he really done so himself? Though he refers to "the remarkable and often unsung benefits of the independent contractor status", all he actually provides us with is a songsheet, a selective chat about his theme to others he assumes agree with him, reviewing those aspects of the subject that appear to conform with his hypothesis. Though he later refers to his "analysis of the independent contractor status, using the behavioural sciences", I could find no such analysis. His use of the behavioural sciences is limited to three sociological terms (bureaucracy, spiralists, and burgesses), and four non-specific references to sociological authors. Despite a wealth of empirical data available to support or question his assertions, none are either presented or referred to. It is not an analysis, but an apologia, a declaration of faith.

Let me pose a few of the difficult questions this paper should have faced. Is independent contractor status necessarily the antithesis of the sort of impersonal bureaucracy he asserts to be the inevitable consequence of any salaried service? We have massive evidence that the organizational autonomy of general practitioners is often used—consciously, not accidentally—to control access and limit relationships between patients and doctors. The autonomous general practitioner is a despot. The College exists to help him to be a benevolent despot. There is a large body of evidence, much of it from Ann Cartwright, on the shifting proportions of despotic altruism on the one hand, and egotism on the other, encountered by patients and relatives when they actually test the terms of the independent contract. Review of this evidence certainly does not justify any complacency; even if Cartwright did find that about 80 per cent of patients were satisfied with their general practitioners, are *we* satisfied? Satisfaction depends in part on expectation, and the expectation of most British patients, particularly working-class patients, is low by international standards in the