The centre will be open on weekday afternoons between 14.00 and 16.30 hours and will be staffed by a receptionist and a nurse, and a doctor will attend on two or three afternoons a week.

The project will be evaluated by the Department of Community Medicine at the Middlesex Hospital Medical School in conjunction with Birkbeck College, University of London.

## JOINT COMMITTEE ON POSTGRADUATE TRAINING FOR GENERAL PRACTICE

The Joint Committee on Postgraduate Training for General Practice and the Royal College of General Practitioners have approved the following vocational training schemes: Grimsby, Glasgow Northern District, East Glamorgan, Oxford Scheme 3, and West Wales General Hospital.

The following vocational training schemes have been reapproved: Burton-on-Trent, Frimley Park Hospital, and Medway.

These schemes are recognized by the Royal College of General Practitioners for the purpose of the MRCGP examination.

## NHS EXPENDITURE

The total expenditure on the NHS as a percentage of the gross national product in the following years was as follows:

| | |
|---|---|
| 1964 | *3.93* |
| 1965 | *4.17* |
| 1966 | *4.33* |
| 1967 | *4.50* |
| 1968 | *4.54* |
| 1969 | *4.52* |
| 1970 | *4.84* |
| 1971 | *4.91* |
| 1972 | *5.00* |
| 1973 | *4.91* |
| 1974 | *5.16* |

**Reference**

Central Statistical Office (1975). *Annual Abstract of Statistics.* No. 112. London: HMSO.

## JOURNAL OF THE ROYAL SOCIETY OF MEDICINE

With effect from January 1978 the *Proceedings of the Royal Society of Medicine* will appear under the new title of *Journal of the Royal Society of Medicine.*

This *Journal* was founded in 1907 and will continue to be published monthly.

## THE BEGINNINGS OF LIFE

The Winnicott Memorial Fund of the British Psychoanalytical Society is arranging a day conference in association with the Royal College of Midwives on "The Beginnings of Life" on Friday, 21 April. Further details can be obtained from: Mrs Joyce Coles, 120 Corringway, London W5 3HA.

## MARIE CURIE MEMORIAL FOUNDATION SYMPOSIUM

The Marie Curie Memorial Foundation's tenth annual symposium, "Cancer—Solutions within our Grasp", will be held on Tuesday, 16 May 1978 in the Edward Lumley Hall at the Royal College of Surgeons of England. Enquiries should be addressed to: The Secretary, 124 Sloane Street, London SW1X 9BP.

# LETTERS TO THE EDITOR

**Editorial note**

*The Editor welcomes the increasing number of letters being submitted for publication. The pressure on space is, however, becoming intense and in recent months several lengthy letters have been received. Correspondents are asked to be brief and letters of more than 400 words are unlikely to be accepted in future.*

## RAISED BLOOD PRESSURE AND PSORIASIS

Sir,

I read with interest the clinical study in general practice reported by Dr Preece (December *Journal,* p. 713) in which there appeared to be an association between psoriasis and hypertension in male patients.

When such associations are demonstrated it is important to consider the possible causes. One that immediately springs to mind is therapy. This can work in both directions. For instance, psoriasiform lesions have been described with nearly all the commonly used beta-adrenergic receptor blockers, which are most often given in the management of hypertension. These lesions are histologically unlike true psoriasis but the superficial appearances are similar.

On the other hand, psoriasis is often treated with liberal applications of a variety of corticosteroid creams and ointments. The danger here is the absorption of systemically significant amounts of corticosteroids which can increase salt and water retention and perhaps lead to a higher incidence of hypertension.

It would be interesting to know whether Dr Preece has any data which might throw light on these possibilities.

D. M. BURLEY
*Head of Medical Services*
CIBA Laboratories
Wimblehurst Road
Horsham
West Sussex RH12 4AB.

## THE PILL

Sir,

The Jubilee editorial (November *Journal,* p.644) comments on a recent paper from the Manchester Research Unit (1977) which describes the increased risks run by contraceptive pill-takers over the age of 35. While fully accepting the need to modify my advice to patients, I wonder if colleagues might be surprised, as I was, at the numbers likely to be affected by this change of policy.

Last July a 1:10 random sample of married women in my practice, between 37 and 51 years, was drawn and a postal questionnaire sent out. Ninety-four out of 97 women replied and of these ten (10·6 per cent) were currently taking an oral contraceptive. Thus, in a practice of 9,000 patients, probably 100 women between 37 years and the menopause were still on the Pill, and 30 of these were also smokers.

Though I practise in a new town, the percentage of women in this age group is very similar to that for Scotland as a whole.

The RCGP Report was also widely publicized in the daily press and in this practice we have noted a marked increase in requests and referrals for sterilization and a modest revival of the dutch cap. For the whole sample the mean age at delivery of last child was 31·0 years and a substantial number of women have continued an increasingly

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.

A. F. WRIGHT
Glenwood Health Centre
Glenrothes
Fife KY6 1HL.

#### References

Royal College of General Practitioners (1977). *Lancet*, **ii**, 727-736.

## 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.

W. S. PEART
*Chairman*
W. E. MIALL
*Secretrary*
MRC Working Party on Mild to Moderate Hypertension
MRC/DHSS Epidemiology and Medical Care Unit
Northwick Park Hospital
Watford Road
Harrow HA1 3UJ.

#### Reference

Medical Research Council Working Party on Mild to Moderate Hypertension (1977). Report. *British Medical Journal*, **1**, 1437.

## 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.

ROGER PEPPIATT
10 Kennerley Avenue
Exeter
Devon EX4 8BW.

## 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