deputizing service, negligible guidance, poor support, and inadequate symptom control, the family will never quite forget nor quite forgive. And why should they?

The Working Group Report summarizes current national policy and seems to favour the further evaluation of support teams in hospital and community. It discourages the costly building of special units save when these are linked with the social deprivation of big cities or a major teaching role. Many hospices have been founded because of the glaring deficiencies of our health care system, and largely because of their pioneer work we are seeing important changes for the better. Matthews today (p. 472) describes some of the problems involved in setting up such units.

As general practitioners we must be grateful for these achievements, and respect and support these centres of excellence. We must be wary, however, that the care of the dying does not gain the eccentric status of a specialty. It is part of general practice and we can and must be worthy of it.

Chair of General Practice at Zagreb

NOWADAYS we do not comment every time a new Chair of General Practice is established in a foreign country. Zagreb has a special claim, because of the debt which British practitioners owe to the work of Professor Vuletić in influencing some of our own patterns for vocational training, and because there have been many personal contacts between British doctors and doctors in Zagreb and Croatia. Professor Jaksić, the present Head of the Andrija Stampar Public Health School, is a familiar face and valued friend in several centres in the United Kingdom.

The first Chair of General Practice was established at Zagreb on 28 March 1980. The Royal College of General Practitioners was represented at the ceremony by the President, Dr J. P. Horder. Dr Grahovać, a practitioner in Zagreb, becomes the first Professor. Three appointments, in fact, contribute to the 'Chair', which in Yugoslavia implies not so much a Professorship as a Professorial Department. Dr A. Budak and Dr M. Sućur were also appointed as Senior Staff members.

The new Department will have an inner ring of six general practitioner teachers and an outer ring of about 60. Since it is the first and only Chair in Croatia (population 4·4 million), it accepts indirect responsibility for the whole of the country, covering basic (undergraduate), specific (vocational), and continuing training. Training does, however, already take place at three other centres.

Despite Professor Vuletić's work, which began in a practical form 20 years ago, opposition to the establishment of a Professorship has been more persistent than in the United Kingdom.

Although student career choice for this branch is rising, it does so at a level considerably lower than in the United Kingdom and in the past the ratio of specialists to general practitioners has been much higher. Specialists earn more than general practitioners. However, the middle tier of community paediatricians and gynaecologists, to whom there has hitherto been direct access, is being eliminated over the next five years, in favour of primary care by family doctors.

The now well known three-year course of specific training for general practice ends with an examination. This includes a clinical component held in the practice premises of examiners. This is something we have not yet achieved. An exchange of examiners is being organized this year between Zagreb and the Royal College of General Practitioners.

Hypertension in primary care

IT seems from the Framingham data (Kannel et al., *1975) that the rule of halves still prevails: half the severe hypertensives are unknown, half of those known are not treated, and half of those treated are not controlled. Why is this happening?*

Tudor Hart (1980)

These and other issues were discussed at a symposium on hypertension in primary care held in Reykjavik, Iceland, in April 1978, and today we publish a report of this symposium as *Occasional Paper 12.* This wide-ranging symposium not only considers the evidence about hypertension itself, but looks at blood pressure as part of a coronary risk profile. For instance, Stone, Director of the Leigh Research Unit of the Royal College of General Practitioners, emphasizes that

obesity still plays a significant part in influencing blood pressure level and considers that blood pressure, plasma lipoprotein concentrations, and cigarette smoking remain the three most "powerful risk factors [for coronary artery disease] identified so far".

Unfortunately, the evidence for the effectiveness of intervention, at least in British general practice, is not yet clear, as D'Souza states. At a time when a considerable move to much more active intervention on a large number of symptom-free patients is proposed it must act as a potent spur for further research. Recent reports from the United States (Hypertension Detection and Follow-up Program Cooperative Group, 1979) and also the current prospective study conducted by the Medical Research Council (1977) indicate that more studies are greatly needed.

At a time when, as Barber points out, better drugs are becoming available, the need for planning co-ordinated care, devising appropriate protocols, and sharing the work with nursing colleagues becomes ever more important. Pijl's co-operation card, which he uses in his practice in the Netherlands, is one practical suggestion. Another comes from Professor Humerfelt, who chaired the symposium, who urges that doctors should sometimes see the husband and wife together to ensure compliance. Van Veen from Amsterdam considers that "patient education strategies that do not involve the personal physician are a miscalculation", and feels that non-adherence is the main obstacle to controlling hypertension in the community. He calls for research into the reasons for good and bad adherence to treatment, including sociological studies of sick roles for such patients.

On the other hand, in one of the discussion sections, Professor Paul Backer of Copenhagen is quoted as using the patient's resources in relation to managing the chronic disease, a phrase reminiscent of patient-centred medicine, and in a timely paper on "the true incidence of side-effects" Hudson reminded the symposium of the very high incidence that has sometimes been reported and that one of the biggest surveys (Slone *et al.*, 1966) found ranges of 10 to 20 per cent for many of the commonly used treatments.

Nor can it be assumed that drug treatment will remain only or even the main treatment. Haines, from Northwick Park Hospital, Harrow, discusses the place of salt restriction, diet, and behavioural techniques in treating hypertension. Non-pharmacological methods could prove to be more economical and cause less iatrogenic disease than pharmacological methods, but more work is necessary to determine their long-term efficacy and to assess patient compliance. Primary care provides the most logical setting for such studies.

Hypertension in Primary Care, Occasional Paper 12, is published today, price £3.75 including postage, and is available from the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU.

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Looking after the elderly and the disabled at home

"Most elderly and disabled people want to live in their own homes. Their families and friends want to be in a position to care for them," Mrs Lynda Chalker, Parliamentary Secretary at the Department of Health and Social Security, told the annual meeting of the National Council for the Single Woman and Her Dependants in London on 30 April 1980.

"Many single women face formidable problems in caring for a relative at home, so it is most important that adequate attention should be paid to the needs of the careers," said Mrs Chalker.

Cimetidine in oesophageal reflux

The effect of cimetidine (Tagamet) in oesophageal reflux and reflux oesophagitis was investigated in a double-blind trial.

Cimetidine was more effective than placebo in relieving epigestric or substernal pain, and the episodes of reflux symptoms were reduced. It had no effect on histological oesophagitis.

Reference

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