Our own contribution to the thinking on this point is our insistence that a system should be devised which will allow doctors to change from their current records to a computer system gradually and at their own pace, so that the whole exercise can be spread over as many years as the doctor might wish. The system we envisage would be compatible with both computer and manual records, and I believe that this might well be an acceptable solution to what is, admittedly, a major problem.

CLIFFORD R. KAY
Chairman
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Sir,

May I congratulate Dr Clifford Kay and his Working Party on their report *Computers in Primary Care* (RCGP, 1980). After so much discussion, correspondence, and debate, it is a most significant step, and no mean achievement, to set down so many practical details and recommendations.

However, I fear that the report may go the same way as so many before it, and fade away in a haze of the usual talks, discussions, committee minutes, and referrals up and down the bureaucratic scale. It will be a case of yesterday's problems being planned for implementation tomorrow, mañana!

I believe that if the College is to take a lead in this field, it must very soon set up a small team dedicated to initiating a handful of pilot trials and to assisting practices to become computerized. If two or three enthusiastic doctors, with a programmer, a systems analyst, and a technician, were to be available to help interested practices to install and run their own computers, on however modest a scale, then the ball would be set rolling. It can only be through such practical experience that ideas, attitudes, and opinions will be generated which will form the 'data-base' for the evolution of computers in primary care.

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Reference

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WHY NOT SCREEN FOR HYPERTENSION?

Sir,

I think we are all agreed that hypertension can be treated with advantage and that only about half the cases in the population have been detected and are receiving treatment. The question is not 'why' but 'how', since we are obviously under an obligation to find these cases and treat them.

I find routine blood pressure estimations very tiring and boring, and though they might lengthen my patients' lives they will surely shorten mine. I feel that these patients cannot be screened in the current framework of general practice, and that we should make use of the tactics of public health for this purpose, such as those used to screen for pulmonary tuberculosis.

Fortunately the apparatus required is cheap and readily available. In my surgery I use a digital blood pressure measuring unit called a U Check Super made by the Brethuen Corporation of Japan and costing about £70. It gives an accurate reading of blood pressure and pulse rate with very little trouble. One nurse could run four or five of these machines in parallel. One would therefore require a hall with screens and couches for about five patients. The patients would lie down and the nurse apply the cuff and pump up the machine, leaving it to take an automatic reading while she went on to the next patient. By the time she returned to the first patient the machine would have automatically taken the blood pressure and pulse rate which the nurse would write down before asking a new patient to take his place and starting the process all over again.

Patients who gave a high reading should have their estimation repeated until its significance was determined. Patients giving consistently high figures, e.g. above 160/95, would be referred to their general practitioners for further investigation and treatment. Compared with my own measurements with a sphygmomanometer, this machine gives readings which are a little high; however, they seem very consistent, so it may be my own which are low.

This seems to me to be an extremely worthwhile and practical approach to the problem, and I would like to hear from other general practitioners who might wish to adopt it so that we can take some concerted action.

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THE DIVISION IN BRITISH MEDICINE

Sir,

In the course of challenging the fairness of your review of what now appears to be only the first instalment of his book (Honigsbaum, 1979), Mr F. Honigsbaum (August *Journal,* p. 501) attributes to me a preference ("would rather be recognized as the most versatile of medical social workers than the least of medical men") which was in fact not mine—though I would not be ashamed of it. It was quoted by me in 1965 from the correspondence columns of the *British Medical Journal* the year before. In any case, although the College may move in mysterious ways it is hardly likely to appoint its Dean of Studies on the strength of this or that expressed sentiment—even if it was aware of it.

The particular dichotomy referred to by Mr Honigsbaum came about largely through previous comparative neglect, and is rapidly becoming meaningless as general practitioners appreciate the importance of being competent both as body technicians and as counsellors in order to discharge their responsibilities effectively.

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Reference

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CLINICAL MEDICAL OFFICERS

Sir,

From the wide-ranging discussions which have taken place regarding the future of clinical medical officers engaged in child health, there would appear to be considerable agreement that their training should be such as to make them eligible to move into general practice or to seek to specialize in paediatrics by engaging in further training. As the three-year vocational training programme for general practice can include up to 18 months' paediatric experience (and also includes one year in general practice) the Joint Paediatric Committee of the Royal Colleges of Physicians and the British Paediatric Association, and the Royal College of General Practitioners consider that appropriate training programmes for these clinical medical officers can be encompassed