problem within their specialty as an example. Other initiatives include monitoring referrals and the issue of a standard letter requesting additional information if it is missing from the referral letter.

Until general practitioners find out exactly what consultants do with their referral letters, how much notice they take of the word 'urgent', and whether they should address their letters generally or to a named consultant, they will be no wiser about which consultant can see their patients more quickly. In this district anecdotal evidence also suggests that when patients are consulted about which doctor they wish to see they often do not choose the consultant with the shortest waiting list.

J. BENNETT
L. WADEY
J. SETTERS

Brighton Health Authority
Brighton General Hospital
Elm Grove
Brighton BN2 3EW

Blood pressure intervention programme

Sir,

As part of an intervention programme on cardiovascular risk factors blood pressure was measured annually for patients attending a general practice at Heer.[1] We found 111 men aged 20–65 years with a systolic blood pressure higher than 150 mmHg and/or a diastolic blood pressure higher than 95 mmHg in 1975 and they were followed up until 1979. All patients received dietary advice and those with a diastolic blood pressure higher than 110 mmHg were given antihypertensive medication. Blood pressure values dropped after one year but increased towards the original level for the following three years. Smoking prevalence decreased from 64% to 51% after one year and remained unchanged after that. There was little change in weight and serum cholesterel levels.

Similar programmes such as the multiple risk factor intervention trial and the heart disease prevention project also showed a drop in blood pressure after one year, with values stabilizing thereafter.[2,3] Nevertheless, these programmes were criticized for lack of success. Our blood pressure intervention programme, carried out in a general practice, was even less successful. Some of the problems include the poorer equipment and organization in general practice than in a large epidemiological centre. The curative task has a higher priority in a general practice, and this too might affect the success of the programme after an enthusiastic start. There is also the problem that the programme is patient-oriented. Advising men to consume less salt and fat, stop smoking, consume alcohol moderately and take up jogging isolates them from their family who are not participating in the programme. After the initial effort by the patient, group pressure becomes dominant, and the success of the programme is temporary.

However, everyone could benefit from this programme. Similar programmes without individualization have been more successful, such as a community programme[4,5] and the regional approach of the North Karelia project.[6]

W.M. VAN ZUTPHEN
J. VAN REEK

University of Limburg
PO Box 616
6200 MD Maastricht
The Netherlands

References

1. Seelen AMR, Diederiks JPM, Zutphen WM, Sikkens BT. Identification of cardiovascular risk factors in a general practice. *Huisarts en Wetenschap* 1980; **23:** 325-331.
2. MRFIT Research Group. Risk factor changes and mortality results. *JAMA* 1982; **248:** 1465-1477.
3. Rose G, Heller RF, Pedoe HT, Christies DGS. Heart disease prevention project: a randomized controlled trial in industry. *Br Med J* 1980; **1:** 747-751.
4. Farquhar JW, Maccoby N, Wood P, *et al.* Community education for cardiovascular health. *Lancet* 1977; **1:** 1192-1195.
5. Maccoby N, Farquhar JW, Wood P, Alexander J. Reducing the risk of cardiovascular disease: effects of a community campaign on knowledge and behaviour. *J Community Health* 1977; **3:** 100-114.
6. Salonen JT, Ruska P, Kottke TE, Tuonilehto J. Changes in smoking, serum cholesterol and blood pressure levels during a community-based cardiovascular disease prevention project — the North Karelia Project. *Am J Epidemiol* 1981; **114:** 81-94.

Health checks in general practice

Sir,

The papers by Dr Pill and colleagues (February *Journal,* p.53, p.57) illustrate the problems of postal invitations to a screening clinic in general practice — 34% of patients did not receive the invitation, and of those who did, only 53% attended. Their discussion focuses on whether such clinics have a place in general practice, and they emphasize the alternative of anticipatory care in the consultation. A different conclusion could be that it is the method of invitation rather than the screening clinic itself which is flawed.

In an inner city practice we have recently used regular consultations to invite middle aged men to a well person clinic, at which the practice nurse advises about reduction of risk factors for heart disease, and applies a screening score to identify those at highest risk. Of 120 men invited in the last year, 84 (70%) attended. Those who did attend were given far more time for discussion of heart disease prevention than would be practical in a general practice consultation.

There are dangers in putting unrealistic demands on the consultation. One study has shown that practices with a policy of opportunistic screening for blood pressure and cervical cytology were no more effective than practices with no screening at all.[1] Time is available in the consultation to issue an invitation for a health check, but there may not be sufficient time for effective screening and health promotion.

ANDREW WILSON

Department of General Practice
University of Nottingham
Queen's Medical Centre
Clifton Boulevard
Nottingham NG7 2UH

Reference

1. Fleming DM, Lawrence MSTA, Cross KW. Lists size screening methods and other characteristics of practices in relation to prevention care. *Br Med J* 1985; **291:** 869-872.

Sir,

The articles by Dr Pill and colleagues (February *Journal,* p.53, p.57) are extremely topical and should be compulsory reading for the Government. The papers confirm what most of us have thought for some time, that health checks are taken up by the 'anxious healthy' and largely ignored by those most in need. Indeed, my own practice has recently offered 'lifestyle' appointments to middle aged men and although we made no detailed analysis of the attenders and non-attenders our impression would certainly support this view.

The Government's recommendations in the white paper on primary health care for greater 'consumerism', and American style health maintenance organizations can only lead to a greater proportion demand for health care from relatively young and fit but anxious individuals resulting in an escalation of costs, taking private insurance out of the reach of the less well off and creating a two tier society. Resources will necessarily be diverted from the elderly, chronically ill, disabled and poor, leaving them as second class citizens, and the caring ethos which the National Health Service has epitomized for the last 40 years will be overturned.

J.R. HUGHES

Havant Health Centre
Havant
Hampshire PO9 2AQ