trials were the solution to our medical problems there would be no need for alternative medicine. As it is, practitioners of paramedical specialties such as osteopathy and homoeopathy are increasingly popular because they provide what patients are looking for in terms of human care and understanding. Even more important, the treatment they use subscribes to the old maxim *primum non nocere*.

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SIR,—Your leading article "The flight from science" (5 January, p 1) illustrates the entrenched and conservative ignorance of the medical profession. You pretend to be rational while ignoring the scientific information at your disposal.

Acupuncture, a subject that I am qualified to speak about, does seem to have a scientific basis. The work that is available at the moment shows that there is a neurological¹ and neuro-humoral² basis for the mechanism of action of acupuncture. It does stimulate the release of cerebrospinal fluid endorphins and this does help to control pain.³ These facts, however, are not mentioned—you refer only to the belief in "yin and yang." Furthermore, acupuncture has existed as a therapeutic method for about 3000 years so it has stood the test of time.

A proper scientific evaluation of the subject is mandatory, but please do not dismiss the work that has already been done on acupuncture. Some of this work does satisfy the standards of scientific excellence.

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- ¹ McLeod JG. *Proc Aust Assoc Neurol* 1974;11:127-31.
² Pomeranz B. *Adv Biochem Psychopharmacol* 1978; 18:351-9.
³ Akil H, Richardson DE, Hughes J, Barchas J. *Science* 1978;201:463-5.

SIR,—Your leading article "The flight from science" (5 January, p 1) rightly states that "orthodox medicine has every right to be proud of its record of objective evaluation of claims. . ." Orthodox medicine may, however, have reason to be ashamed of its prejudice against any form of therapy which has developed outside its ranks.

I learned chiropractic at the Anglo-European College of Chiropractic, where the emphasis was on musculoskeletal conditions. The results were impressive enough for me to abandon my career in general practice and specialise in chiropractic. I am able to palpate fixation of intervertebral joints. I adjust (or manipulate) them and observe an immediate change in spinal mechanics. I know from experience that in most patients, after a number of adjustments, I will have successfully corrected the functional disturbance so that the spine becomes free of any major fixation. Since both my observations and my treatment are manual, to convince a sceptic I have first to train him in the examination of intersegmental movement—which takes time and patience. I believe that most chiropractors would be happy to take part in a controlled trial to prove the effectiveness of their treatment, but have not the facilities and would require the co-operation of hospital departments.

No doubt a number of effects of chiropractic on health have been claimed and remain unproved. One thing is certain. The reason

for the popularity of chiropractic is that it has been successful in treating common diseases for which orthodox medical treatment has proved a failure.¹ I refer particularly to the group of ailments popularly known as "rheumatism." Though it may be important to be able to recognise and treat uncommon yet potentially fatal or crippling disorders, is it not equally important to be able to rid patients of symptoms of lumbago, sciatica, neck and arm pains, headaches, "non-organic" chest and abdominal pains, etc? Chiropractors successfully and safely treat the ailments which interfere with the well-being of 90% of the human race.

Too much publicity, you assert, has been given to the adverse effects of oral contraceptives. It took years for the ill effects of the pill to be recognised. Yet common sense should tell us that deliberately to upset the hormone balance of a healthy young woman cannot but be detrimental to her health. Natural family planning by the ovulation method (Billings) has suffered from similar prejudice. Yet the scientific basis has been well demonstrated.² Statistical evidence of its effectiveness is at present being gathered from trials in a number of countries by the WHO.

Surely, more worrying than the public's "flight from science" is the refusal of our profession to consider anything which does not require the use of modern technology, operative surgery, or drugs.

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- ¹ Breen AC. *Rheumatol Rehabil* 1977;16:46-53.
² Billings EL, Billings JJ, Brown JB, Burger HG. *Lancet* 1972;i:282-4.

Hypertension and special clinics

SIR,—The US Hypertension Detection and Follow-up Program has recently reported¹ that mortality over five years was 17% lower among 5485 hypertensives who received care at special clinics than in a randomly chosen group of patients referred to their own doctors. This impressive result, which revealed most benefit within the mild hypertension range, led us to consider carefully the implications for doctors and patients participating in the Medical Research Council's mild-to-moderate hypertension trial. The issues raised will also interest other doctors who are reconsidering their policy in the light of these new results.

One may accept without reservation the authenticity of the results, as well as the study's conclusion—namely, that "these findings . . . indicate that the systematic effective management of hypertension has a great potential for reducing mortality." The difficulty is to know which components of care contributed to the success. There was no untreated control group, and the more actively managed group received many advantages, including free and closer all-round care and advice on diet and smoking. The possibility that better general care contributed to the result is supported by the fact that the net reduction in deaths from non-cardiovascular causes (14%) was almost as great as that from cardiovascular causes (19%). This is perhaps as much a trial of medical care as of antihypertensive drugs.

Other factors too make it difficult to apply the results of this trial to the UK. A quarter of the patients entering the American trial were already being treated for hypertension; hence

the average blood pressure at entry (159/101 mm Hg) would correspond to some higher but unknown level in untreated patients. Seventy seven per cent of the difference in deaths between the special clinic and referred care groups occurred in black participants, although blacks comprised only 44% of the study population. The benefit for white men was less and not statistically significant, and for white women there was no benefit at all.

We conclude that these results fall far short of proving whether or not we in the UK ought to be giving drug treatment to all middle-aged people with mild hypertension. The MRC trial, which seeks to resolve this issue, now assumes added importance.

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¹ Hypertension Detection and Follow-up Program Cooperative Group. *JAMA* 1979;242:2562-77.

Hypertension in general practice

SIR,—Dr Hamish Nicol's concern (24 November, p 1368) about heavy work load and shortage of doctors in general practice may be justified, but that does not alter the fact that diagnosis and treatment of hypertension in Great Britain and elsewhere is patchy and in general leaves much to be desired.

Fejfar estimated several years ago that half of the world's hypertensives were undiagnosed, a quarter were being treated, and only an eighth were being treated efficaciously.¹ In our studies in Paisley² we screened 12 446 men and women aged 45-64 years (an 80% response from eligible residents), and detected 257 (4.5%) males and 318 (4.7%) females with diastolic blood pressures over 109 mm Hg (mean of four observations taken seated at two examinations separated by four weeks using London School of Hygiene and Tropical Medicine sphygmomanometers and recording phase 5). Two-thirds of these patients were undiagnosed, a sixth were known, and the remainder were on treatment. There were 680 males and 679 females in the range 97-109 mm Hg; 80% and 70% respectively were undiagnosed.

Internationally there is great interest in the 8% decline in coronary heart disease rates from 1969 to 1973 in the United States white population compared with an increase in England and Wales, Northern Ireland, and Scotland of 12%.^{3,4} The US decline in death rates over all age groups from 1970 to 1975 were 35%, 18%, and 14% for hypertensive disease, stroke, and coronary heart disease respectively.⁵ Responsibility for these changes is variously attributed, according to personal commitment, to exercise, diet, less smoking, or control of hypertension; but the combined findings of six independent studies involving review of the current status of diagnosis and treatment of blood pressure after 1972 in the United States supports hypertension control as an important factor. In 1 235 281 males and females across a range of ages and including some non-whites, 64 459 (5.2%)