intervention can be recommended. In addition, use of a daytime average of 160/95 mm Hg must deny treatment to many patients who would receive it on the basis of the World Health Organisation criteria,⁴ and may deny some of them the benefits in terms of preventing stroke. Furthermore, as a separate issue, we are concerned that the common assumption that patients with "white coat" hypertension are not at risk may be flawed.⁵

We believe that there is a need for prospectively collected data on the clinical outcome of patients managed on the basis of ambulatory rather than clinic pressures and suggest that this is an urgent concern. Such data might be collected by the joint action of academic centres working in this research area. Until such data have been collected, wholesale introduction of this technique in clinical practice may be premature.

DAVID J WEBB
MICHAEL J STEWART
PAUL L PADFIELD

University Department of Medicine,
Western General Hospital,
Edinburgh EH4 2XU

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Frequency of citation and outcome of cholesterol lowering trials

EDITOR,—When I answered the critics of my paper¹ I had not read the letter from Gilbert R Thompson,² who thinks that frequent citation of trials reflects their quality, not their outcome. I have grouped the trials according to their quality (table) scoring -1 for unblindedness or use of a drug with frequent and typical side effects (trials 11-17, 19, 23-26, 28, 31, 32, 34 in the original paper); fewer than 500 subjects (trials 11-17, 21, 26); multifactorial approach (trials 28, 31, 32); not using intention to treat data (trial 27); not using randomisation (trials 11, 32); and sponsorship by a drug company (trials 12, 13, 21, 25, 33). I have followed the objection from Durrington and colleagues³ as regards randomisation; I apologise for having misunderstood the methods on that point in some of the papers.

As seen the best trials (groups 0 and -1) were cited four times more often than the others (groups -2 and -3). In the three best groups, however, the trials considered supportive by their directors were cited four to seven times more often than un-

Mean annual citation of trials arranged in four quality groups. Figures in parentheses are numbers of trials

	Quality groups			
	0	-1	-2	-3
All trials	38.8 (5)	48.3 (6)	13.1 (9)	8.8 (4)
"Supportive" trials	59.0 (3)	67.5 (4)	22.5 (4)	7.7 (3)
"Unsupportive" trials	8.5 (2)	10.0 (2)	5.6 (5)	12 (1)

supportive trials. Admittedly, the scoring is crude and arbitrary; nevertheless it is obvious that frequent citation may also reflect irrelevant matters such as a favourable outcome.

UFFE RAVNSKOV

Råbygatan 2,
S-223 61 Lund,
Sweden

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Health care for elderly in Japan

EDITOR,—Yuzo Okamoto's paper on the crisis in the care of elderly people in Japan does not mention one reason why the problems exist and are likely to become worse.¹ Having visited Japan as part of a global survey of primary care, I believe that the basic fault in the Japanese health system is a near total neglect of primary personal care and social care. Since the beginning of this century, and more so since the second world war, the emphasis has been on specialist and hospital services. This has been due to the influence of German medical educational methods before the first world war and American health care philosophies since the second. As a consequence primary care is not recognised as a specialty. There is no special training and no strong professional grouping or political representation.

First contact physicians do exist but are drop outs from hospital specialty training. They set up in the community to provide primary care and endeavour to combine this with their specialist interests. There are 80 000 of them—one per 1500 population—and most work alone. A most unusual custom is that they are allowed to provide clinics as part of their service. These have up to 20 beds, in which they can treat their patients for extra fees: remuneration is by fees for services. These services, however, are not coordinated with community needs and facilities. Home visiting is rare, and primary health teams do not exist. In fact, there is competition to provide primary care between hospital emergency rooms and specialists, to whom Japanese people have free access.

To prevent the crisis to which Okamoto refers a reconstruction of the whole health system is urgently required, in which primary medical and community services are properly planned and funded.

JOHN FRY

Beckenham, Kent BR3 2TT

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The death penalty

EDITOR,—In his editorial on the death penalty Richard Bonnie drew attention to the paradox faced by some of our medical colleagues, a paradox many of us choose to ignore—due in part, I suspect, to the disturbing questions, the uncomfortable facts, and lack of easy solutions posed by the problem.¹ The problem is, of course, that of medical participation, medical collaboration, or medical acquiescence in punishment (physical, mental, social, legally sanctioned or otherwise) and torture, both of which may at the extremes result in death.

It is time we looked again at the Hippocratic oath of "first do no harm." As stated in the editorial, "doctors hold their medical knowledge in trust for the collective wellbeing of mankind and they must

guard against the exploitation of that knowledge in ways that compromise the supreme aspiration of the profession." Where there is a conflict does harm refer to the long term or short term, to the individual or to the community? The monitoring of the degree of isolation which an individual can withstand means that the individual concerned has at least some safeguards. However, does such monitoring perpetuate a dehumanising punishment; does it impair the development of better or worse forms?

In the absence of crime it is the doctor who decides whether a person is mentally ill, mentally handicapped, in need of treatment, etc. In the event of crime the ultimate decisionmaker in any contested case as to whether a person is competent to be executed is the judge, not the doctor. I feel that Bonnie is drawing a fine line when he seems to differ from the working party that claimed that determining competence for execution is necessarily equivalent to medical permission. It certainly is a major step in determining whether the ultimate punishment of the death penalty will be applied. As for treatment of the incompetent prisoner or patient, surely he or she should be dealt with as are other incompetent patients. A prisoner remains a person with rights.

"The dignity of the condemned should not be subordinated to the dignity of the medical profession." Nor should the dignity of the medical profession be used to legitimise or maintain dehumanising practices, some of which are in current use; practices which many of us ignore. It is time for all in the medical profession and in the media in general to acknowledge how medicine and medics are used in punishment and torture practices and perhaps to campaign actively to abolish the word "punishment" and refocus on the word "rehabilitation." Unless and until we reclaim and redeclare "first do no harm" we will as a profession—be it by default, neglect, or reluctance to enter into and maintain the needed debate until alternatives are found—continue to acquiesce to the practice of "minimise the harm."

MAIRE O'CONNOR

Department of Health Promotion,
University College Galway,
Galway, Ireland

- 1 Bonnie RJ. The death penalty. *BMJ* 1992;305:381-2. (15 August.)

EDITOR,—Richard J Bonnie, a professor of law, contends that doctors should participate in capital cases—those in which a guilty verdict may result in the defendant being judicially executed.¹ A doctor's evidence may promote a guilty verdict, for instance, by excluding a mental disorder or from the presentation of forensic medical evidence.

But if a doctor's professional testimony contributes to a guilty verdict for which the sentence is execution then, in effect, that doctor's professional expertise has become one of the tools used to kill someone. It is difficult to see any real distinction between that and the circumstance Bonnie rightly condemns, where a doctor is "serving as an agent of the state's punitive apparatus" if he decides whether or not a person is fit for a punishment or directs how a punishment should be administered. The inconsistency of the professor's position is that in the former instance he exhorts doctors to influence verdicts which happen to carry the death penalty and in the latter he condemns medical influence facilitating the predictable consequences of the same guilty verdict. The niceties of the distinction are likely to be lost on the person being executed.

A recent infamous case illustrates the point. Judith Ward was found guilty of carrying out IRA bombings, in part, as a result of the psychiatric report. The widespread disapprobrium heaped on the psychiatrist's head was excited not so much by Miss Ward being found guilty of a crime she did