

children who are in the midst of bereavement to work through their loss, stage by stage—by being both sympathetic and honest, particularly the latter. Adults whose aims are to help bereaved children must give up the pretence that life is unchanged. Children will respect the person who refuses to act out the charade of denial. We must encourage children to talk about death because silence deprives the child of the opportunity to share his grief. We must learn to listen and to respond by letting children know that we understand what they are trying to say. We must not offer final answers to children because there are no such answers to give. If, by working on this basis, we can accomplish these aims we may be able to bring solace and some understanding to children who mourn.

Epilogue

Death is perhaps one of the few remaining taboo subjects. If this were not true why is the subject seldom found in the school curriculum? Teachers and other adults may believe that children need to be protected from the facts of death, but perhaps it is their own fears and attitudes that prevent them from mentioning the subject. Children like to talk. But if they are not encouraged to take part in discussion and if their questions remain unanswered how are children to learn?

The average child is very tough and resilient and can cope amazingly well with bereavement, even with the death of a parent, so long as adequate subsequent care is provided. Brown² comments that "death and the relief of bereavement, mourning, and deprivation are at the centre of most religions of the world and the appropriate handling of these problems is an important step towards the improvement of mental health." Perhaps it

would be better if these subjects could find a "resting" place within the context of health education. Then death, bereavement, and mourning could be dealt with by doctors, nurses, other health professionals, and teachers. If these people are actively concerned in child care they will know that the creed and the colour do not matter, for children are just children, and their needs are the concern of us all.

"Any man's death diminishes me, because I am involved in mankind."
—JOHN DONNE 1572-1631.

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Personal Paper

Labile hypertension and jogging: new diagnostic tool or spurious discovery?

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Abstract

A labile hypertensive black man reviews his own personal history of hypertension, based on intensive self-study. The evidence suggests that aerobic isotonic exercise (jogging) depresses labile pressure values, forcing them down to near basal levels and preventing a rise to previous blood pressure levels for several hours.

Introduction

During a routine medical examination on 3 September 1975, I learnt I had high blood pressure (178/100 mm Hg). A diagnosis of "essential hypertension" was not unexpected in a patient who

was black, 44 years old, unemployed, and spending 12-15 hours a day writing a doctoral dissertation in a tiny rented room in Harlem. Yet despite being mindful of the denial syndrome, I simply could not dismiss a lifetime pressure reading of 120/70 mm Hg—a reading that only four months earlier had been verified by a doctor. I neither drank nor smoked, faithfully jogged about 4.84 km (3 miles) a day, my resting pulse was 47 and serum cholesterol concentration 136 mg/100 ml, and I averaged seven hours of sleep a night. Nevertheless, my doctor had no choice but to prescribe drugs (alpha-methyldopa, 500 mg, and triamterene, 100 mg, daily).

The treatment was effective for several months, but then I noticed incremental rises in my blood pressure to 150/102 mm Hg and increasingly severe side effects.

After consulting my doctor, I abandoned drugs and began a new regimen based on dietary regulation and aerobic exercise. I also maintained a record of home blood pressure readings. The distribution of my readings in my doctor's office tended toward the high side but was counterbalanced by my lower home readings. Once again my diagnosis was changed, this time to "labile hypertension."

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A postdoctoral fellowship in the Department of Community Medicine of a respected medical school became available, and I applied myself to the study of labile hypertension, using a risk factor perspective and other behavioural science techniques.

Lability issue

I found that patient overreaction to blood pressure measurement was not at all uncommon. Often these excessive responders have spuriously raised arterial pressure, which reverts to normal or near normal on calmer occasions. Doctors are reluctant to treat this condition pharmacologically since the lower readings are thought more nearly to represent basal pressure.

The lability issue generates considerable controversy. Many clinical teachers hold that labile patients should not be treated if any of the readings are normal or borderline. Charles Curry, director of cardiovascular diseases at Howard University Hospital and Medical School, however, counsels chemical intervention if the pressure is high on two of three office visits.¹ William Kannel, director of the Framingham study, cites statistics showing some labile and stable hypertensive subjects at equal risk for cardiovascular disorders, the risk being related to the average pressure maintained. He recommends treatment if the mean values remain raised over several office visits.²

Kannel's method itself does not go unchallenged. Many experts, including Edward Freis and Maurice Sikolow, insist that a group of lower risk labile hypertensive patients does, indeed exist.³ Long ago, Smirk *et al* published evidence that would seem to indicate that the life expectancy of hypertensives is closely related to basal, not casual, blood pressure.³ Difficulties abound and the impression remains that unstable blood pressure is often a vexing problem to the examining doctor.

Self-study

Between 1976 and 1979 I intensively investigated myself. Using a standard sphygmomanometer I measured my blood pressure three times daily in series of threes, usually once in the morning and twice more after the evening shower. All food consumed was carefully recorded, together with activity patterns and any perceived psychosocial stress. Over 7000 separate readings were taken during the study period. I jogged 60 New York City blocks (4.84 km or 3 miles) in about 25 minutes five days a week. This pace was aimed at maintaining an age-adjusted exercising heart rate of 70% of maximum effort, calculated from published data⁴ requiring a man of 45 to achieve a submaximal exercise rate of 123. This I routinely exceeded. Jogging did not alter my weight, and I remained about 10% above the Metropolitan Life Insurance Company's ideal weight standards for my height and body build.⁵

In time it became abundantly clear that my lability state was strongly influenced by medical authority figures. In my doctor's office my blood pressure, pulse, and respiration rates increased dramatically but fell just as dramatically on returning home. The table lists my measurements over a single 16-hour period on 22 November 1977, and these figures are representative. Yet the stress factor was unable to account for all the observations. For example, on infrequent occasions—but always after exercise and hours later—I experienced pronounced symptoms of postural hypotension, my pressure dropping sometimes as low as 104/65 mm Hg.

In order to better understand the dynamics I switched my exercise regimen to early mornings and measured my blood pressure immediately before and at intervals after exercising. Serendipity led to the discovery that 25 or more minutes of sustained jogging activity depressed my high labile pressure to what seemed to be basal levels about 50 minutes after completing the run. These baseline values then described a flat, slowly rising curve over the next several hours. Sometimes my pressure rose to pre-jogging levels within four to ten hours and sometimes it did not. Two other middle-aged labile hypertensive men of my

acquaintance, one black and one white, were tested with the same results.

Blood pressure, pulse, and respiration rates

	Time	Blood pressure (mm Hg)	Pulse	Respiration
At home	07 30	140/88; 144/90; 140/90	60	—
Doctor's office	14 40	170/106; 150/94	96	32
At home	16 25	140/84; 130/82; 130/80	58	22
Jogging	16 50	—	128	—
At home	17 30	120/76; 122/72; 120/72	75	22
In bed	23 30	—	47	16

Related phenomena

My findings bear only superficial resemblance to reported treadmill-induced hypotension.⁶⁻¹¹ The decrease in pressure after jogging represents a normal reaction to prolonged energy output, while treadmill-induced hypotension is usually considered an abnormal reaction to relatively brief physical exertion.

Postexercise hypotension seems to be common, apparently resulting from blood pooling in the extremities (E E Smith, personal communication) caused by local vasodilatation. Re-establishment of hydrostatic equilibrium in the circulation is one of the primary reasons for emphasising the "warming down" period after exercise.

Some experts relate the hypotensive response directly to the duration and intensity of the exercise. (E E Smith, personal communication). Others challenge that interpretation—for example, Dale Groom studied the Tarahumara Indians who engage in kickball as a tribal sport, often running 56 km (28.6 miles) over rugged terrain. Medical examinations of some of these players during and immediately after the races showed diastolic readings of zero, rising within a few minutes to 60-80 mm Hg.¹² What I inadvertently discovered seems to suggest that sustained aerobic isotonic exercise not only might produce a short-term hypotensive effect on labile blood pressure but perhaps may provide a simple means of determining basal pressures. The present jogging craze may have found a new diagnostic tool. Suppose a habitual jogger presents with labile hypertension. Following the previously described protocol, the patient should jog 2.75-3 miles (4.4-4.8 km) at 9 minutes a mile (1.6 km) over a prescribed course. (Substituting a treadmill is inadvisable since that may introduce complicating or compounding factors, presently unknown.) The postexercise measurements, I suspect, would provide a reasonable estimate of true basal pressure. Reading in multiples of threes is imperative to capture fluctuations during single sittings.¹³

If the patient presents as a non-jogger the state of fitness, physical deconditioning, or stress-load potential would need to be ascertained, but age and cardiovascular disease need not contraindicate aerobic isotonic activity.

Call to the medical profession

Probably one of the high-priority secrets among airline pilots is how those with hypertension manage to pass their annual medicals undetected. Some are known to avoid mandatory suspension by surreptitiously jogging just before the medical appointment. Cardiologist George Sheehan, a prolific writer on running topics, claims that one of his hypertensive friends annually survives qualifying medicals in this way.

But in the final analysis do these findings refute Kannel's central argument that the lability of blood pressure may be a statistical artefact that hides habitually raised values?² Obviously, they do not. But if these data prove valid, behavioural control of lability could be possible. The hypotensive effect and slow recovery curve created by jogging twice daily—say, in the mornings and in the evenings—could hold labile pressures at lower levels over an extended period. None of the personal data presented here, however, can be of value until the medical

profession decides to determine with scientific rigour if jogging is truly a new diagnostic tool and if it warrants use as a management regimen for labile hypertensive patients.

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Dealing with the Disadvantaged

Communicating with deaf patients

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Hearing loss is a common hidden handicap: in Britain about one in 500 children under 5 and one in five people over 16 have some hearing loss. Every doctor will have to deal with deaf people, and by remembering certain points and following some simple rules he can make the consultation much easier for the deaf person.

Three points about deaf people should always be remembered. Firstly, although deafness creates language problems and a communication barrier, it is not an immediately apparent handicap. Secondly, a child born deaf has different problems from a person who suddenly becomes deaf in adult life, who in turn has different problems from an adult who has become slowly and progressively deaf. Thirdly, it is a common misconception that hearing aids can restore defective hearing to normal; they can help, but speech still sounds distorted.

If the following suggestions are carried out communication will be much improved.

At reception

(1) The patient can lip read more easily if you put down your pen or the telephone when talking and keep your hands away from your face.

(2) Speak a little more slowly than normal without raising your voice or distorting your lips.

(3) Look directly at the patient. This will help him understand you more easily.

(4) Remember to stop talking if you need to turn away from the patient.

(5) Label records (perhaps with a coloured sticker) to show clearly that the patient is deaf. This will minimise confusion.

In consultation

(1) Reduce extraneous noise by shutting doors and windows.

(2) Make sure that your face is in a good light so that the patient can lip read you clearly (do not have your back to the window). It is also worth remembering that it is more difficult to lip read a man with a beard or someone wearing darkened glasses.

(3) Turn your chair to face the patient and maintain eye-to-eye contact.

(4) Keep your hands away from your face and as still as possible. Hand movements (Biro clicking, finger drumming, taking glasses on and off) may be very distracting.

(5) If the patient does not understand a question then repeat it. If he still does not understand rephrase the question in a simpler way. If this fails write the question down.

(6) Indicate when you intend to change to a new topic. The range of vocabulary is likely to be different, and any cue is useful to the deaf person struggling to understand you.

(7) If you have to examine the patient explain clearly what you are going to do and how you wish him to co-operate.

(8) Remember that if you want to give the patient a further instruction you must be in front of him and clearly visible when you speak. If you are behind the patient he will be unaware that you have spoken.

(9) The deaf patient will appreciate any instructions about treatment being written down.

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