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LEADING ARTICLES

Health and safety at work.....	715	Link between hepatoma and hepatitis B.....	718
Asthma in children.....	716	Radioimmunoassay of serum prostatic acid phosphatase in prostatic cancer.....	719
Paediatric anaesthesia.....	717	Treatment of ankylosing spondylitis.....	720
Myocardial imaging.....	717		

PAPERS AND ORIGINALS

Regular Review: Contraceptive methods: risks and benefits	M P VESSEY.....	721
Effect of stopping low-phenylalanine diet on intellectual progress of children with phenylketonuria	I SMITH, M E LOBASCHER, J E STEVENSON, O H WOLFF, H SCHMIDT, S GRUBEL-KAISER, H BICKEL.....	723
Two types of febrile seizure: anoxic (syncopal) and epileptic mechanisms differentiated by oculocardiac reflex	J B P STEPHENSON.....	726
Sampling pure fetal blood by fetoscopy in second trimester of pregnancy	C H RODECK, S CAMPBELL.....	728
Natural history and prognosis of recurrent breast cancer	S KARABALI-DALAMAGA, R L SOUHAMI, N J O'HIGGINS, A SOUMILAS, C G CLARK.....	730
Ventricular tachycardia due to cardiac ischaemia: assessment by exercise electrocardiography	STEPHEN TALBOT, DAVID KILPATRICK, DENNIS KRIKLER, CELIA M OAKLEY.....	733
Diffusional-induced cholestatic jaundice	JONATHAN S WARREN.....	736
Contact allergy to clotrimazole	JAMES A ROLLER.....	737
Ingrowing toenails in infancy	F B BAILIE, D M EVANS.....	737
Anterior T wave changes in the ECG of an athlete	R J C HALL, R V GIBSON.....	738
Hypercalciuria and recurrent urinary stone formation despite successful surgery for primary hyperparathyroidism	J W MUIR, L R I BAKER.....	738
Scombrototoxic fish poisoning	J G CRUICKSHANK, H R WILLIAMS.....	739
Abnormal cerebrovascular regulation in hypertensive patients	D N W GRIFFITH, I M JAMES, P A NEWBURY, M L WOOLLARD.....	740

MEDICAL PRACTICE

Personal Therapeutics: Better prescribing	FLEMMING FRØLUND.....	741
How to organise an international medical meeting—IV: Registration: the mechanics	IAN CAPPERAULD, A I S MACPHERSON.....	742
Isolating patients in hospital to control infection: Part III—Design and construction of isolation accommodation	K D BAGSHAW, R BLOWERS, O M LIDWELL.....	744
William Stokes 1804-78: the development of a doctor	EOIN O'BRIEN.....	749
Diagnosis and management of obscure gastrointestinal bleeding	D TARIN, D J ALLISON, I M MODLIN, G NEALE.....	751
Taxonomic map of the schizophrenias, with special reference to puerperal psychosis	P HAYS.....	755
Medicine and Books		758
Any Questions?		750, 757
Words		754
Medicine and the Media		763
Materia Non Medica—Contributions from JOHN F CALDER, ALEX PATON, HUGH DUDLEY		748
Personal View	DAPHNE GLOAG.....	765

CORRESPONDENCE—List of Contents.....	766
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OBITUARY.....	777
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Instructions to authors.....	780
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NEWS AND NOTES

Views.....	779
Medical News.....	780
BMA Notices.....	780

CORRESPONDENCE

Medical care in inner cities

J Robson, MB; J Fry, FRCP; R Law, MRCP; D Stephens, MRCS; F R Corfe, MRCS 766

Breakfast and Crohn's disease

A H James, FRCP; P J Whorwell, MRCP, and I W Davidson, PHD; W B Graham, FRCS, and others 767

Whooping cough

G T Stewart, FFCM; J A Davis, FRCP 768

Misdiagnosis of amoebiasis

B G Macgrath, FRCP; J E M Whitehead, FRCPATH; Air Vice-Marshal W P Stamm, FRCP 769

Course in diagnostic parasitology

W Peters, MD, and H M J Gilles, FRCP 769

Sexual pressures on children

T Ward, MB; Anne Savage, MB 769

Postoperative pain

A M Smith, FRCOG; P W Hutton, FRCP 770

British Epilepsy Association

A G Craig 770

Medicine and the media

D E Hyams, FRCP; R N Rutherford, MRCP 770

Carcinoma of the breast in women under the age of 30

A S Purandare, FRCS, and J A H Finbow, MRCPATH 771

Genital chlamydial infection

B H O'Connor, MB 771

Thyroid function tests

W A Burr, MRCP; M C Davies, BSC, and H Allison, FRCPATH 771

Labetalol in hypertensive emergencies

W Hanna, FFARCSI, and G A C Grell, MRCP; R R Ghose, FRCPED, and W D Morgan, PHD 772

Pre-employment medical examinations

F H Tyrer, MRCS 772

Uniform style for biomedical journals

D J Wright, ALA 773

Axillary hyperhidrosis

K T Scholes, MB 773

Dangers of glass doors

A J Pim, MB 773

Atenolol self-poisoning

F L J Shanahan, MB, and T B Counihan, FRCP 773

Efficacy of rubella vaccination

E D Pereira, MRCOG, and others 773

Infection with Epstein-Barr virus

D A Warrell, FRCP, and others 774

Intravascular coagulation in falciparum malaria

J Stuart, FRCPED 774

Treatment of narcotic poisoning

J W Todd, FRCP 774

Secret list of MCQs

J J Shipman, FRCS 774

Self-examination of the breasts

M Sutton, FRCS 775

Lord Mayor Treloar Hospital, Alton

R A J Baily, FRCS, and others; J A Lunn, MD; D F E Nash, FRCS 775

Ballot of consultants and registrars

R Hopkins, FDSRCS 775

Honorary retirement contracts

R Bewick, FRCS 776

Clinical assistants' salaries

Greta Cawley, MB 776

Removal expenses

R W Davidson-Lamb, FFARCS 776

Health National Service?

N A Simmons, FRCPATH 776

Lost pedestal?

L Haas, FRCP 776

Priorities in planning

Rt Hon David Ennals, MP 776

Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

As stated each week in "Instructions to authors" no letter will be acknowledged unless a stamped addressed envelope or an international reply coupon is enclosed.

Medical care in inner cities

SIR,—As a future general practitioner who has undergone both vocational training and has had paediatric experience as a clinical medical officer in an inner city area, I would like to make some comments on the article by Dr Michael A P S Downham and others (19 August, p 545).

For the well-qualified young GP committed to inner city practice the future is gloomy, and there seems to be no practical and imaginative initiatives for change coming from either the area health authorities or the Royal College of General Practitioners. I have approached the family practitioner committee, the district community physician, and the Medical Practices Committee, but there seems to be no perspective and no practical interest in future planning for primary care in these areas.

In my own district some 30% of general practitioners are due to retire in the next 10 years, and, although the overall problem is one of a restricted area with singlehanded practitioners with small lists serving a declining population, there have been considerable influxes of population in some parts of the borough.

The high retirement prospects and the beginnings of urban renewal present an opportunity to restructure primary care with imagination and foresight. Correlating retirement prospects and plans with areas of population growth would seem a simple enough task, and plans could be drawn up for groups of practitioners to serve specified areas from local authority premises, taking account of both population change and existing paramedical and social services. The possibility of salaried GPs working from local authority health centres and serving defined areas conterminous with social service and local authority health areas has much to offer. Such a service would permit rational planning of primary care facilities and future staffing; promote integration of nurses, health visitors, and social service personnel; and allow the valuable skills of the full-time clinical medical officers to be used, with staff sharing a common record system, just as different specialties have been doing for some considerable time in the hospital.

Morbidity and demand for services are highest in many inner city areas and the

pressures on singlehanded practitioners are considerable. They are often coming towards the end of a working life during which they have endured some of the heaviest work loads with the minimum of resources, support, and recognition for their achievements. Perhaps it is not surprising that in the absence of any other practical alternative most have now delegated responsibility for their patients to deputising services for half the time at risk. There are few who would argue that this is a desirable pattern of care.

In areas with high retirement prospects practitioners could be offered salaried partners or assistants paid by the AHA on the understanding that within a specified time the practice would revert to the new entrant with a view to forming a group with neighbouring practices. This would provide not only valuable support without cost to the existing principal, but would allow 24-hour cover to be organised among practices in the area and the phased introduction of group practices working from health centres planned around such personnel.

The problems presented by inner cities are among the most demanding and complex. If imaginative initiatives are not taken up with the opportunities presented by the next 10 years then we face another 30 years of unplanned, unstructured, and often third rate services in these areas. When do the platitudes end and the planning begin, and who is going to initiate it?

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