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CORRESPONDENCE

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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