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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.

Waiting lists for cardiac surgery

SIR,—Recently it has been revealed that there is a variation in the length of waiting lists for cardiac operations in England. This culminated in two patients going to private clinics in London for their operations.

At the cardiothoracic unit in Castle Hill Hospital, Cottingham, North Humberside, there is no waiting list for cardiac operations. The maintenance of expertise, facilities, and medical, nursing, and technical personnel is expensive. Is it time for us to have a national waiting list for this type of surgery? Within the NHS we could avoid some of the waiting-list mortality which occurs in some parts of the country.

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Medical care in inner cities

SIR,—I have read with interest the opinions expressed in the discussion on medical care in inner cities (19 August, p 545) and the ensuing correspondence. Dr R Law (9 September, p 767) condemns the medical schools of London for their lack of interest in this problem. My contribution to this correspondence is based on facts collected by the district administrator and myself in visits to the surgeries of 50% of the general practitioners in the St Thomas's District. From this survey and a study of the problems of other boroughs, it is possible to draw certain conclusions.

(1) The inner city problem in London varies from one borough to another. In Lambeth, for instance, patients have no problem in finding a general practitioner. This is in contrast to the serious problems experienced in Kensington, Chelsea, and Westminster, where list sizes tend to be low but many doctors are engaged in private practice. Dr D Stephens (p 767) draws attention to this problem and suggests that if practice in Southwark was more profitable than in Harley Street the standard of care would be the best in the world. I know of no evidence that the standards of general practitioner care in Harley Street are superior to those in Southwark and would be intrigued to apply the criteria suggested by Dr John Fry (p 767) in both situations.

(2) The provision of suitable premises presents a serious problem in London and many are too small to make possible the development of the primary health care team. Most of the doctors we visited were not interested in health centres, some because they were afraid of increased expenses, some because they did not see the relevance to the primary health care team, and some because the recent behaviour of our political leaders in the Health Service made them anxious about their professional freedom. The best premises we visited were purpose-built by local authorities and rented by the doctors, but many doctors described difficulties in obtaining planning permission and space to develop their own premises.

(3) The question of recruitment to general practice in London is crucial. New vocationally trained doctors are unlikely to practise in London unless they are taken into an existing partnership. Death and retirement vacancies tend to go to doctors who have qualified abroad and spent several years as assistants in general practice in Britain. The experience in general practice which they have acquired in this way gives them a great advantage with selection committees.

(4) The greatest problem which we encountered in our visits was that of isolation. Nearly one-third of the doctors were single-handed and had little contact with their colleagues in general practice, the specialists to whom they referred patients, their community nurses, or health visitors. Despite this, most of them were content with the services they provided, the premises in which they worked, and the facilities provided by the hospital. The fact that general practice in the last two decades has changed from a demand-orientated service to one concerned with continuity of care and prevention was not always appreciated. This is not a problem which can be solved by legislation; it requires education.

It would be a great pity if the concept of primary, personal, and continuing care by independent contractors was rejected in the inner cities simply because the problems are difficult to solve. It is only in one or two boroughs that the mobility of the population precludes continuity of care. In most areas the mobility is confined to about 20% of the population while 60 to 80% remain stable. What is required is a careful analysis of the problems at district level, and in London this