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LEADING ARTICLES

Poliomyelitis vaccines: killed or live?.....	845	Chenic acid for gall stones.....	847
Nutrition and the patient with cancer.....	846	Cost-effectiveness studies.....	848
Living with multiple sclerosis.....	847	Prognosis of cryptogenic fibrosing alveolitis....	849

PAPERS AND ORIGINALS

Low-cholesterol diet: enhancement of effect of CDCA in patients with gall stones D P MAUDGAL, R BIRD, W S BLACKWOOD, T C NORTHFIELD.....	851
Mortality and morbidity of reusing dialysers A J WING, F P BRUNNER, H O A BRYNGER, C CHANTLER, R A DONCKERWOLCKE, H J GURLAND, C JACOBS, N H SELWOOD.....	853
Postpartum haemorrhage after induced and spontaneous labour P R S BRINSDEN, A D CLARK.....	855
A method for self-assessment of disability before and after hip replacement operations I W MCDOWELL, C J M MARTINI, W WAUGH.....	857
Screening for impaired visual acuity in middle age in general practice DAVID H STONE, DAVID J SHANNON	859
Effect of cirrhosis of the liver on the pharmacokinetics of chlormethiazole P J PENTIKÄINEN, P J NEUVONEN, S TARPILA, E SYVÄLAHTI.....	861
Simultaneous measurement of a deficit in total body calcium and phosphorus in diagnosis of hyperparathyroidism KEITH BODDY, E D WILLIAMS, J K HAYWOOD, I HARVEY, I S HENDERSON, D R MORGAN, A C KENNEDY.....	864
Soft tissue sarcomas and intramuscular injections: an epidemiological survey M B MCILLMURRAY, M J S LANGMAN.....	864
PUVA-induced suppression of contact sensitivity to mustine hydrochloride in mycosis fungoides G VOLDEN, L MOLIN, K THOMSEN.....	866
Prolonged treatment of high-renin hypertension with a converting enzyme inhibitor M J VANDENBURG, V L SHARMAN, F P MARSH, E J RUCINSKA.....	866

MEDICAL PRACTICE

Clinicopathological Conference: Two children with kidney disease DEMONSTRATED AT THE ROYAL COLLEGE OF PHYSICIANS OF LONDON.....	867
Epidemiology for the Uninitiated: What is a case? Dichotomy or continuum? GEOFFREY ROSE, D J P BARKER.....	873
Letter from Canada: Lament for Captain Cook PETER J BANKS.....	874
How to organise an international medical meeting—VI: The social programme IAN CAPPERAULD, A I S MACPHERSON....	875
Preventing deaths from malaria A P HALL.....	877
Isolating patients in hospital to control infection—Part V: An isolation system K D BAGSHAW, R BLOWERS, O M LIDWELL ..	879
Hypertension F O SIMPSON.....	882
Medicine and Books (with correction).....	884
Any Questions?.....	883
Medicine and the Media.....	888
Materia Non Medica—Contributions from HUGH DUDLEY, PHILIP RADFORD, VIVIAN JONES.....	881
Personal View DAVID M LEVY.....	889
Correction: Digitalis in general practice	883

CORRESPONDENCE—List of Contents.....	890
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NEWS AND NOTES

Views.....	899
Epidemiology—Q fever: 1976-7.....	900
Medical News—WHO at the Guildhall	900
BMA Notices.....	901
Instructions to authors.....	901

OBITUARY.....	902
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SUPPLEMENT

The Week.....	905
GP partnerships.....	906
MASC: Effects of NHS planning on education.....	908
BMA Notices: Ophthalmic Group Committee.....	908

CORRESPONDENCE

Waiting lists for cardiac surgery K K Nair, FRCS, and S R Dunn, FFARCS.... 890	Radiology work load M D Rosewarne, FRCR; K Swinburne, DMRD; Joyce F Andrews, TDCR 893	Arenaviruses in perspective K M Pavri 896
Medical care in inner cities D C Morrell, FRCGP 890	Beta-blockers in treatment of hypertension D M Harris, MD, and D A Richards, MD.. 894	Underdiagnosis of childhood asthma A D Clift, MD, and B Jean Day 896
Sexual pressures on children G R Kinghorn, MRCP; Valerie Riches; Reverend J B Metcalfe, MB; Madeleine Simms, MSC; M Jarmulowicz 891	Investigating stroke F Mills, MRCP 894	HDL cholesterol and coronary artery occlusion J J Barboriak, SCD 897
Hospital equipment "Which?" P M Harms, MIEE 892	Chlormethiazole addiction M M Glatt, FRCPSYCH 894	Adverse reactions to intravenous induction agents H L Thornton, FFARCS 897
Comparison of the tine and Mantoux tuberculin tests A J Johnson, MRCP, and J A Lunn, MD.... 892	Breathing other people's smoke R S F Schilling, FRCP, and A Bouhuys; B J-L Sudan, MD; Betty Brody 895	Lord Mayor Treloar Hospital, Alton M C Wilkinson, FRCS 897
Health Service planning and medical education R Wilkinson, MRCP 892	Uniform style for biomedical journals R Carlisle, FRCP, and others 895	Negotiating rights for junior hospital doctors T McFarlane, MRCOG 897
Confidentiality of medical records A O Staines, MB 892	Misdiagnosis of amoebiasis A L Jeanes, FRCPATH 895	Distribution of registrars V M Demmery 898
Postoperative morbidity and mortality after bleomycin treatment I G Schraibman, FRCS; P L Goldiner, MD, and G C Carlon, MD 892	Melatonin as a marker for pineal tumours S G Barber, MRCP 896	General practice records J T Hart, FRCGP; H W K Acheson, FRCGP.. 898
	Whooping cough D Jenkinson, MB 896	Related ancillary staff H Gordon, MFCM 898
		Priorities in planning R H Hardy, DM 898

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