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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Cutting the cost of the National Health Service

SIR,—The concept expressed in my paper (3 May, p 1140) of shifting a large amount of highly expensive institutionally based care into the community seems to engender a lot of support. Many doctors have contacted me to say this and Mr N G M Legg (14 June, p 1450) agrees that "the potential for saving in the hospital service is enormous." Professor Alwyn Smith (p 1449) writes that "a number of studies have shown that community care is generally more expensive than care in hospital if similar levels of care are maintained." I suspect that the evidence from them is not quite as cast-iron as he maintains and attempts to obtain references from him have met with no response. Anyway, who wants to set "similar levels of care" and perpetuate the unnecessary routines and rituals of the hospital ward for the improving patient back in his own home? And the cost of the community care of chronic long-term psychiatric patients discharged wholesale in earlier decades is neither relevant nor valid.

Over-medicating of all our patients, the use of highly expensive proprietary brands, and the routine drugging of inpatients in hospital seems to be widely deplored (Mr N H Harris, 21 June, p 1535); Dr B Jarman, 19 July, p 230). If Mr Harris were in general practice he would be dismayed to discover a welter of outpatient follow-up letters concerning themselves with conditions which the general practitioner himself could (and often does in duplicate) follow up. Incidentally, Mr Harris, home visiting is an esteemed part of good general practice in many parts of Britain and the follow-up of severely ill patients in their own homes by general practitioners and their teams will become if anything more frequent.

Mr Harris suggests that it would be "dangerous" to educate patients about minor illness. For his information, we do not diagnose carcinomas of lung or bowel by virtuously seeing thousands and thousands of episodes of upper respiratory tract infection and diarrhoea. If anything they obscure our view. Good general practitioners *must* continue to educate their patients and pass care back to them whenever it is safe and appropriate.[1] This is one way of slowing down the "industrialised, conveyor-belt" type of medicine which so concerns Dr J Tudor Hart (14 June, p 1449).

I am sorry that Dr M J Leverton (p 1450) cannot manage more than 2200 patients and that he will have to retire in his mid-50s because of the strain. I must remind him that at a meeting of the Royal College of General Practitioners[2] 27% of those present voted that "this house believes that most general practitioners can provide good care for 5000 patients"—so it's not just me. The most comprehensive review of the subject[3] concludes that there is no good evidence that large lists generate a poor standard of practice. Alas, Dr Leverton, I cannot clone my cells but I do teach young doctors and do research, and write, and try to persuade my colleagues.

Reading between the lines, I think Dr P V Scott (21 June, p 1535) must be having a bad time in Bromsgrove. I am well aware that admission to hospital in the first place is frequently a function of the general practitioner. This practice has an inpatient referral rate of two-thirds the national average and an outpatient rate of one-third. Many organised team practices are similar and as their number increases referrals could fall—particularly if specialist colleagues do not sap our clinical confidence with unwarranted lauding of the latest hospital technology.

My paper certainly seemed to make Dr Hart (p 1449) see red, but I cannot accept his implication that because the money saved on the National Health Service might be misused in other areas then 'twere better not saved. It is the equivalent of wasteful business lunches and generals' campaigns carried out within the National Health Service that I as a doctor wish to end. Dr Hart will recall that the greatest healer of all time preached, "Why beholdest thou the mote that is in thy brother's eye, but considerest not the beam that is in thine own eye?"[4]

Young Dr A R Scott (p 1450) has stumbled on the full potential of team care in an underdeveloped country and now concludes that the National Health Service is overstaffed. Dr Hart writes of "my well-known and sensible proposal for an expanded primary care team with development (in fact, if not in name) of a nurse-practitioner grade." This is no proposal: these teams are functioning increasingly effectively in many parts of Britain. Having worked with nurse practitioners and physician assistants in Canada and the United States let me assure Dr Hart that our British quartet of nurse/midwife/health visitor/social worker is a far superior equivalent. Their work expands and their share of the caring increases as they find their feet in a democratic team. Dr Hart's suggestion that because a nurse may undertake some current "doctor" task one is obligated to pay her the same as the doctor is a nonsense. Prior to the BMA charter[5] doctors frequently ushered their patients in and out, and wrote their own letters. When receptionists and secretaries arrived they were not paid as doctors. By stumbling over this financial misconception Dr Hart may well be precluding the eventual increase in esteem and job satisfaction that nurses get when their potential expands. It is doctors with their rigid attitudes to roles and remuneration and their frequently