BRITISH MEDICAL JOURNAL

SATURDAY 30 NOVEMBER 1974

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NO. 5943 BRITISH MEDICAL JOURNAL 1974 VOLUME 4 485-546 ASTM CODEN: BMJOAE 4 (5943) 485-546 (1974)
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR. SECOND CLASS POSTAGE PAID AT NEW YORK N.Y. WEEKLY 50p

CORRESPONDENCE

Correspondents are asked to be brief

New Alternatives in the N.H.S.

SIR,—There is much good sense in your leading article (2 November, p. 247). It is a pity, therefore, that you end—as do too many medicopolitical leaders in the *B.M.J.*—with a routine sneer at "the politicians." Which politicians claimed that "the N.H.S. offered all available treatments to every patient"? What on earth does "all available treatments" mean? One of the supreme faults of our profession is—and always has been—the prescription of futile, nonsensical, or even positively harmful treatment. Think of all the absurd operations—stomach pleating, shortening of the round ligaments, removal of septic foci—the tonics and stimulants, the antibiotics for viral illnesses, the amphetamines and the tranquillizers by the bucket, the bed rest for weeks on end, the absurd fussy diets, etc., etc. And we should accept the whole blame for all this and not pretend that it is the fault of "the politicians" or the public demand.

We should also accept the blame for giving the public the impression that we can do a great deal "over the whole range of medicine." You implied this yourself in another leading article (10 August, p. 376). In fact, for a huge proportion of human maladies, including those due to arterial disease, most rheumatic disorders, the viral illnesses, and most psychological disorders, we can do very little.—I am, etc.,

JOHN W. TODD

Farnham, Surrey

SIR,—There are a couple of statements in your second report on the Winchester Conference (9 November, p. 327) which are so hair-raising that one would like a fuller exposition.

Mr. Rudolf Klein (p. 332), in making the point that British living standards are falling in relation to other developed countries, says that "the more successful the centres of excellence are in turning out graduates, the less likely these doctors will stay in Britain." So one solution, in his view, would be to train them to a much lower standard. This makes them unemployable elsewhere. This is a degree of cynicism which needs wider publicity.

Professor H. A. Dudley takes up this point by observing, "We're already training doctors here for a type of work they won't find elsewhere. Furthermore, the requirements set by centres in Canada and Australia are becoming increasingly difficult to meet unless the immigrant leaves Britain immediately after qualifying." Leaving aside the advertisements in the *B.M.J.* from those countries, this is another statement that is so disquieting to a practising clinician that one must insist on amplification.—I am, etc.,

H. W. FLADEE

Maidenhead, Berks

SIR,—Mr. George Teeling-Smith (16 November, p. 406) is well known for his criticisms of loose thinking and unsupported claims in relation to the N.H.S. His admonitions tend to be couched in a somewhat embellished style which makes useful dialogue difficult, particularly as he is not himself directly confronted with the clinical situation. Nevertheless, as I was largely responsible for both the statements he castigates, I feel I should mildly reply.

He is quite right that his theoretical model of the 400 bed/20 ward hospital with one empty bed per ward can be shown to generate economies if it is possible to rationalize (his word) the distribution of patients. Perhaps he would like to try this in practice because it is in fact extremely difficult (*a*) to run at 100% occupancy and (*b*) to undertake the complex reshuffling of medical services within a hospital that would be needed if patients are to be redistributed. My ignorance of this, as in many other matters, is profound, but I do not know of any study in which cost savings have been shown by progressive patient care or other reshuffling techniques. Particularly with the already minimal stay of most acute patients with defined problems I hold to my belief that further rationalization except by radical restructuring of the patient mix so that say we have a hernia hospital or a veins' hospital is likely to lead to only small reductions in overheads.

I am basically opposed to reporting controlled clinical trials as "personal communications," but as Mr. Teeling-Smith has done so I will say that Mr. John Hobbs at St. Mary's Hospital is my authority for the view that a significant number of patients managed by injection therapy will require further treatment. I agree that "nearly all" is a loose statement. The number is such—and Mr. Hobbs will be publishing his results shortly—that I think it calls in question the view that a continuum of treatment has necessary cost advantages over single interventionist management. Of course the cost model