Medicine in the seventies—attitudes and expectations

SIR,—I am sure it is our fault as much as that of Professor C T Dollery that so little information about health education as an arm of preventive medicine has come his way. His comments (27 December, p 750) take no account of the official emphasis given to health education by the Department of Health[1] and their urgings of area health authorities to use resources to secure the highly effective and cost-effective benefits which well-established educational practices confer. Two of the priorities mentioned by Professor Dollery, moreover, have been the subject of successful campaigns conducted by this council: a pilot venture in the north-east persuaded, by means of publicity, large numbers of people with early or incipient drinking problems to seek help before their affliction reached a serious stage; and pregnant smokers, in the course of two campaigns, have undoubtedly been persuaded by educative methods to stop. As regards his third priority—obesity—it is simply not true that there is little concern about this problem. The difficulty, however, is that the resources available for informing children and their parents about wise eating habits and the risks that failing to follow them creates are minute compared with the enormous sums spent on advertising foods that are either nutritionally useless or positively damaging.

It is true that some efforts to prevent children from taking up smoking or to make them stop have been disappointing. Experience shows, however, that selection of the method is the critical factor.[2-4] This is because health education is not concerned only with the communication of information, but with personal and group motivations and attitudes. The contribution of the behavioural sciences to health education has significantly raised our expectations of its effectiveness, and therefore the statement that "we should not suppose that health education would necessarily do any good" will not stand up in the light of the experience of health education specialists not only in this country but in most European countries and the USA.

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1 Department of Health and Social Security, *Reorganisation of the National Health Service and of Local Government: Operation and Development of Services—Health Education*, HRC/74. London, DHSS, 1974.
2 Bynner, J M, *The Young Smoker*. London, HMSO, 1969.
3 Eriksson, A W E, *Health Education Journal*, 1966, **25**, 177.
4 Watson, L M, *Health Bulletin (Scotland)*, 1966, **24**, 5.

Academic general practice

SIR,—Both your leading article (27 December, p 724) and Professor I M Richardson's article on the value of a university department of general practice (p 740) seem to me to be written in obscurantist language reflecting, I believe, some muddled thinking.

All general practitioners want to see developments which will improve the quality of our work and the reputation of our branch of medicine. But what is worrying about the active fellows and members of the royal college and our "academic" colleagues is their evident aim for a hierarchical structure in general practice. This élitist or hierarchical structure would be tolerable if it could be based on clearly defined and recognisable criteria of excellence. The doctors scoring most points on these criteria could be accepted as the élite. But I think we can see from Professor Richardson's article that the special qualities he cites are not measurable. Therefore there is a risk that a general practice career ladder will have at the top doctors of no more than average ability. The implications of this require examination and it will be appreciated that I am not casting personal aspersions.

Suppose, however, that it were possible to select or elect a convincing élite, is this what we want? I suggest that our aim should rather be to involve as many GPs as possible in group professional educational and social activities, with particular regard to those of us who are especially isolated professionally and who have a lower than average standard of practice. The teaching of general practice to undergraduates should obviously be undertaken by GPs themselves. But I submit that this is not best done by specialist "academics" but by the organising of seminars among groups of doctors and students, the planning of these to be a joint undertaking. I believe also that if students were allowed to select the practices to which to attach themselves as pupils their choice would more accurately reflect the relative quality of practices than would their allocation by academic departments on the basis of undisclosed criteria.

I feel that an open discussion of this controversial issue of the future of general practice should take place before it is too late.

DENIS GLYN
London SW15

RHA or AHA?

SIR,—At a recent meeting of the medical staff committee of this hospital the Department of Health letter of 30 October 1975, addressed to the chairmen of regional health authorities, was discussed. This letter gives a reassurance that it is not proposed to drop the regional tier or to make any sudden, drastic change in any of the tiers.

My colleagues regard this reassurance as most ominous and wish to publicise their view, reached through bitter experience, that the regional and district levels are those that should be retained and that the disappearance of the area health authorities can only be of benefit to the NHS. They hope that their colleagues in other parts of the country, and the BMA, will strongly support this view.

D ZUCK
Chairman,
Medical Staff Committee,
Chase Farm Hospital
Enfield, Middx

Consultants' ballot

SIR,—Many of the profession see present governmental trends as a threat to freedom in medicine both for patients and doctors. Indeed, many regard them as a move towards State monopoly on East European lines. They wish to defend this freedom and therefore welcome the BMA ballot of consultants.

Many may, however, feel that resignation is not the best defence nor the most effective measure. The ballot provides no place for any alternative. There is no box to allow the suggestion that other active measures could be started or continued. It should have been possible to indicate on the form whether, for example, the measures at present in operation by many of the profession should continue.

It may be that some might wish to indicate this by writing a suitable comment next to box 10, such as "other action should be taken." The enumerators could then, if necessary, make a count of such views.

J B KINMONTH
Department of Surgery,
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London SE1

Industrial action

SIR,—I am appalled by the recent decisions of the Council to support industrial action by junior hospital doctors and consultants—decisions which, I am convinced, do not reflect the feelings of most individual members of the Association. Surely it is not yet too late for the BMA to hoist a banner saying, "We do not strike."

Those doctors who have taken industrial action do not realise the importance of public confidence as part of the healing art. The NHS framework is essentially excellent for the practice of medicine. It is not perfect, but all our efforts should be towards preserving and improving it. Basic pay and overtime are not the way for doctors to be paid; payment should be for the job.

Our work is, in conjunction with administrators and politicians, to help the people, and it is essential, and not difficult, to work in harmony with all these three groups. If we as a profession were to state categorically that we do not strike we should regain all the public support we are now in danger of losing; and with such support I am quite sure that across the table with politicians of any party we could work out reasonable conditions. The BMA is no more perfect than the NHS, but it is the one organisation which could unite all doctors.

And if such a banner were raised who knows but that the idea might spread to other working groups in the community? In a democracy such as ours strikes are similar to kidnappings and hijackings.

PETER VICARY
Weybridge, Surrey

Admission of GPs to restricted areas

SIR,—We are grateful to Dr A M Maiden (3 January, p 45) for identifying an incorrect statistic in our article on the designated areas (7 June 1975, p 571). The statistic in question, showing that 45% of the net inflow of doctors entering general practice in 1972-3 went into restricted areas, was supplied to us by the DHSS in July 1974. It was so surprising that we wrote to Dr Maiden asking if it represented a change in the policy of negative direction operated by the Medical Practices Committee. In his reply to us Dr Maiden offered a number of possible explanations for the figure, but he explicitly accepted the accuracy of the figure itself.

In view of this we feel justified in having used the statistic in the way we did. We understand that it was only after the article appeared that Dr Maiden asked the DHSS to recheck the figure, and it was only then that the error was finally uncovered. Since we did not have access to the raw material from which the statistic was compiled, there was obviously no way in which we could ourselves have checked its accuracy.

We are naturally very pleased that the true situation is that represented in the revised figure which Dr Maiden gives in his letter and that the policy of negative direction has not changed. In view of this we readily withdraw our comments about the committee's current policies. The incident does, however, serve to illustrate the need for extreme care in the preparation of official statistics. This particular statistic is vitally important, being the only national indication of the net inflow of doctors into each class of practice area, and it is obviously important to those concerned with manpower movements that it should be correct. Had we not included it in our article its inaccuracy would presumably not have been exposed. We hope that the lesson to be drawn from this episode will be heeded.

Finally, may we add that our comments in the article about negative direction formed only a minor part of the total argument. We were more concerned, in this article and in our other publications, with evaluating the designated area allowance and the medical practice areas and with exploring the assumptions underlying current policies for the distribution of primary medical manpower.

J R BUTLER
R KNIGHT

Health Services Research Unit,
The University,
Canterbury, Kent

Entry to hospital practitioner grade

SIR,—I have noted recent correspondence in regard to the new hospital practitioner grade. This is applicable only to principals in general practice, but in fact there are a number of other doctors who would be of great use in filling sessional gaps in the hospital service. I refer to retired hospital consultants, married women, and retired specialists from the armed Forces and colonial service. The hospital practitioner grade was considered by the Central Committee for Hospital Medical Services some five or more years ago and this particular point was ventilated and agreed at that time.

For some reason the regulations which now apply to this grade limit employment to principals in general practice. As a result there are a number of doctors, some with higher qualifications and certainly wide experience, who take part in the hospital service in the grade of clinical assistant and at a very much lower rate of remuneration than that of the hospital practitioner grade. This is clearly an absurd situation which must be rectified either by allowing suitable doctors into the hospital practitioner grade, even if not in general practice, or by creating a new and appropriate grade.

R D ROWLANDS

Taunton, Somerset

Points from Letters

Enteric-coated aspirin overdose and gastric perforation

Dr R J FARRAND (Hope Hospital, Salford) writes: . . . Dr J M Gumpel (13 December, p 648) has doubts about our report (11 October, p 85) because, firstly, he would ascribe death to paracetamol, but perforations do not occur in acute paracetamol overdose. Secondly, he would ascribe death to any other drug, the patient taking another fatal overdose at the same time as 67 or more Safapryn tablets, but the old lady with a broken leg was not scraping the barrel of the hospital pharmacy. Lastly, he would ascribe death to phenylbutazone, but he omits our main reasons for not doing so. The discussion seems more theological than relevant to a stomach showing three perforations and numerous erosions with tablets in contact with them. . . .

Medical tales of captivity

Mr B WILLIAMS (Chichester) writes: Dr J C Cameron (13 December, p 639) in his review of Dr John Borrie's book *Despite Captivity: A Doctor's Life as a Prisoner of War* has described some of the good work done by medical officers in prisoner-of-war camps in Europe. I have heard from several sources of the excellent work in very difficult surroundings also done by medical prisoners of war in the Far East, and I hope that some of those who took part may be persuaded to tell us their story.

Pilonidal sinus

Mr D H PATEY (Hythe, Kent) writes: . . . If, as is now generally recognised, pilonidal sinus as it presents clinically is merely a foreign-body granuloma, excision and a fortiori extensive plastic procedures are as little justified pathologically as they would be for a simple stitch sinus. There are also strong anatomical reasons against excision in the sacrococcygeal region.[1]

1 Patey, D H, *Proceedings of the Royal Society of Medicine*, 1970, **63**, 939.

Cooking the Christmas sausage

Mr P G SHUTE (Leatherhead, Surrey) writes: The interesting article entitled "Cooking the Christmas dinner" (20 December, p 714) reminds me of an investigation carried out many years ago by the late Dr W H Bradley. . . . Two brothers each owned a pork butcher's shop. Each week they bought a pig, which they divided between them and which they turned into sausages. There was an outbreak of trichinosis and Dr Bradley was seconded to investigate. He found that all the cases came from only one of the shops owned by the two brothers. After much probing it was found that all the cases arose from the butcher whose customers had eaten only one or two sausages, whereas the customers who had eaten four, five, or six remained free. So it was that Dr Bradley proved that the butcher who made large sausages was the cause of the epidemic because the cooking was inadequate, whereas the butcher who made only small sausages (chipolatas) escaped. Surely this suggests that small sausages should be preferred by the housewife as a guard against not only salmonella and *Clostridium welchii* but also against pathogenic helminths.

James Joyce—a case history

Dr F R WALSH (Callan, Co Kilkenny) writes): . . . A new look at the possible causes of Joyce's blindness (13 December, p 636) will not be out of place. The family history is relevant. James Joyce was the second of 17 children, of whom the firstborn died at birth and six others died after birth or were stillborn. Joyce's father, when a medical student in Cork, acquired a syphilitic chancre. He treated this by cauterising with carbolic, a method favoured by the textbooks of that day. James Joyce had eye problems literally all his life. From the age of 25 he had recurrent attacks of iritis followed by the late development of glaucoma with disastrous results for his vision. . . . Such a background suggests late congenital syphilis, a relatively frequent problem in the Joyce era.

Better medical writing

Dr J S BRADSHAW (How Caple, Hereford) writes: . . . Inescapable technical jargon aside, why is much medical writing bad and therefore usually not worth the effort of comprehension to the medical reader not especially concerned with the topic in question? One reason lies in our method of selection of medical students.[1] Another is that medical editors accept badly written articles. Suppose they were to refuse such articles, the worst of them as a start: the prospect of imminent rejection might concentrate a man's mind wonderfully. In "Personal View" (13 December, p 644), however, it is stated that "in 'scientific' medical articles language as such is relatively unimportant, compared with the need to avoid pomposity, long-windedness, and obscurity"—that is, to be clear, brief, and simple. Add only "and have a rhythmic texture," however, and one has the four prime guidelines for effective prose of any kind. Did Osler or Oliver Wendell Holmes have two distinct styles, one literary and one medical? I think "relatively unimportant" was not the happiest phrase, for some will take it, even in context, to mean that the words of a medical article hardly matter, that gobbledegook is all right. They will begin to cease to do so only when you and other editors put your feet down. That all this has a much wider connotation was revealed in a recent article[2] showing that of 80 patients seen at a general medical outpatient clinic the referral letter and the history gave what turned out to be the correct final diagnosis in 66. Physical examination (calling for a minimum of verbal communication) was useful in only seven patients, and laboratory investigations, which