Miracle Cures

SIR,—With reference to the opening paragraph of your leading article (5 July, p. 1), a much more likely diagnosis than Parkinson's disease in the case of the woman commemorated in St. Luke's Gospel would seem to be some affection of the spine such as ankylosing spondylitis or congenital kyphosis. In the authorized version it says (Chapter 13, *v.* 11) that she "was bowed together and could in no wise lift up herself," and, after her cure (*v.* 13), "immediately she was made straight."—I am, etc.,

JOHN CAPWELL

Aylsham, Norwich

Hypertension—Which Arm?

SIR,—The following problem was encountered recently during blood-pressure screening men aged 50-54 in general practice. The blood pressure was measured in both arms in 33 patients and in 25 (76%) of them the diastolic pressure consistently differed between the two arms by at least 10 mm Hg. There was a corresponding variation in systolic pressure. The pressure was usually higher in the right arm than in the left, whichever was monitored first.

This seems a generally unrecognized problem both in defining mild hypertension and in monitoring treatment, unless all doctors concerned with the patient use the same arm for all readings. Five men out of 160 were clearly and consistently hypertensive, with diastolic pressures above 105 mm Hg. All were asymptomatic. A further 21 had one high reading.—I am, etc.,

R. A. SWALLOW

Burton-on-Trent,
Staffs

N.H.S. Reorganization

SIR,—Glancing through your report of your Chichester conference on the reorganization of the N.H.S. one is struck by the extreme good sense of Dr. A. Paton (28 June, p. 729) and the density of the brick wall he is facing. The only reorganization which would command respect would be a commitment to reduce the administrative staff by 10% per annum. Round here we used to have a secretary for each hospital plus an area secretary. We have retained all this but have added another group of secretaries who apparently control two hospitals each, and six quite adequate social workers have mushroomed to 64 in three years.

As your contributor from Australia, Dr. D. Meyers (21 June, p. 677), said, the private sector does its administration on the side, the public sector employs a corps of administrators. Central direction is clumsy, inefficient, and destructive of morale. We put up lockers, curtains, and day rooms for our geriatric patients as soon as we could get the money. What we did not need was someone from the centre to tell us about it.

Sometimes after a busy surgery in general practice or a ward round in the hospital, when I have seen a great number of patients, I say to myself that this is what it is all about—the actual consultation, the actual contact—and that all the rest—the administration, the committees, the learned sociologists, the theorists—are something that I and men and women like me are carrying on our backs. Like it or not, we are paying them. Perhaps we should stop doing so.—I am, etc.,

W. H. FLADÉE

Maidenhead, Berks

SIR,—We have read with great interest the reports of your Chichester conference on N.H.S. reorganization (28 June, p. 729, 5 July, p. 22, and 12 July, p. 81), but we feel that what has not been sufficiently stressed is the financial cost.

Our health district is already deprived of adequate clinical services, and yet on 10 July, at a special meeting of our district medical committee, we were asked to consider plans for cutting these services further in the light of "guidance" from our area and region, asking plans to be made for possible cuts of 3½% in real terms over the next three years.

At the same time the money being spent on the administration of the N.H.S. has enormously increased. In our case both the regional and district administrative staff are slightly larger than before, but in addition there is the new and rapidly expanding structure at area level. Not only is this additional tier very expensive but the new structure appears to have reduced the efficiency of the service. There are so many more people to be informed of every move, so many more committees, that the process of making decisions has become more nebulous instead of more clear cut.

We hear it said on every side "Yes, there is one tier too many." If this is so the sooner serious consideration is given to the practical and political difficulties involved in dismantling either the regional or area tier the less damaging will be the change. Our district medical committee was so concerned about the money being diverted from clinical services to administration, particularly in the new area structure, that it asked us to try to raise the matter by all available means at national level: hence this letter.—We are, etc.,

TOM DUNN
Chairman,
ARNOLD ELLIOTT
Vice-chairman,
East Roding D.M.C.,
Redbridge and Waltham Forest Health Area

Doctors as Managers

SIR,—Your leading article (5 July, p. 6) queries the value of the co-ordinating role of the community physician. The questions which must therefore be answered are whether there is need for a co-ordinator and, if so, is the community physician the best person to fill this role? Those efficiency experts who wrote the management document upon which the reorganization of the National Health Service is based (the "Grey Book") had no doubt that the keystones of the new planning system were to be the health care planning teams, which would crystallize the needs of the districts. For the health care planning teams to work effectively they must have the advice of a trained epidemiologist who can point out the gaps between the needs and resources, and this is the role of the community physician.

Multi-disciplinary management is here to stay and in the absence of the community physician the clinical members of the district management teams may find that the medical needs of the Service become subordinated to the intricacies of finance and administration. The community physician has the duty of defining what are the urgent priorities in each district and suggesting any alternative ways in which these needs can be met.

The history of the N.H.S. is littered with white elephants of the planners. If the community physicians can help prevent repetition of those expensive mistakes then their co-ordinating role is clearly worthwhile.—I am, etc.,

H. BINYSH

Truro

Deaths from Non-accidental Injuries in Childhood

SIR,—Dr. Catherine S. Peckham and Megan Jobling (21 June, p. 686) rightly quote the Registrar General's statistics when they question the speculative estimates of over 700 infant deaths a year from non-accidental injury. Statistics abstracted from the Registrar General's statistical reviews, supplied by the Office of Population Censuses and Surveys, and presented for discussion at the 24th Annual Conference of Police Surgeons of Great Britain (Eastbourne, 7-10 May), show that since the beginning of this century deaths in children aged under 5 years due to "homicide and injury purposely inflicted by other persons (not in war)" have steadily declined. In 1910 115 such deaths were recorded but by 1972 the total had fallen to 80. The population of England and Wales during this time had increased from 36·07 to 48·59 millions. These figures were not challenged.

The term "battered baby" is unknown to the law. The law is concerned with assault or with cruelty of a specific kind. Criminal proceedings for assault are brought under the Offences against the Person Act, 1861 (SS. 18, 20, and 47), and those for cruelty of a specified kind under the Children and Young Persons Act, 1933 (S.1). Such proceedings are not common. In Birmingham, where between seven and 12 adult and two juvenile courts sit daily, between 12 and 24 such cases are brought annually.[1] Dr. A. White Franklin, of the Tunbridge Wells Study Group, wrote[2] to justify his group's statistics of infant deaths due to violence and to question those of the Registrar General. He believes that children are pushed through windows and that their deaths are recorded as accidental and that a child dying from pneumonia after physical injury would be certified as death due to pneumonia without mention of the injury inflicted. This is not possible. All deaths in which there has been any suggestion of violence, however remote, or of poison, neglect, or industrial disease are automatically referred to the coroner. The coroner is obliged to hold an inquest and to sit with a jury. He receives death notifications from many sources.

A coroner's court can return a verdict of death due to (1) natural causes, (2) accident, (3) misadventure, (4) suicide, (5) felonious killing, or (6) an open verdict. A verdict of felonious killing is rare because the police are usually already involved and somebody is charged. The coroner opens his inquest and adjourns his court. After the criminal trial the court administrator notifies the coroner of the judicial verdict. The coroner