investigated and found guilty of being unaware of the existence of his community, and not only that, but treating patients to the detriment of his community even—as far as I can tell—to the extent of saving their lives by dialysis. I require Dr Pilbrick's arithmetic to be applied rigorously to the nephrologist, and one can only sympathise with the nephrologist for not realising that one patient out of a hundred is much less important than one out of ten.

The message is clear. In future, dermatologists should hide their warts; gastro-entrologists their piles; urologists their stones. Dr Pilbrick has learned to count, but not to reason.

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SIR,—I have read with interest the various views expressed by those interviewed in the series “If I was forced to cut.” Some of the opinions are sensible enough, but the recent utterings of “Dr Burrowdean” (20 October, p 985) require comment. It is reasonable to make informed comment in a respectable Medical journal which is read and discussed by the lay press, but when that comment is completely uninformed and at the same time damaging an appropriate reply is necessary.

The comments on remedial gymnasts are inexcusable. That a consultant physician should be completely unaware of a profession that has existed since 1945 and has had a three-year training course since 1961 is bad enough, but the admission that he is “not sure what they do” is unbelievable. I would suggest that Dr Burrowdean spends less time cleaning his office and more time looking at what happens to the numerous patients who rely for their rehabilitation following strokes, fractures, amputations, and spinal injuries, etc. (to mention but a few conditions) “on this new kind of creature—who makes no real contribution.”

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SIR.—The Conservative Party conference recently passed a resolution “that the NHS is sufficiently funded and that the apparent shortage of money is due to a large proportion of the present funds being misapplied to the detriment of the patient.” This sentiment would no doubt be applauded by your pseudonymous consultant Dr Burrowdean (20 October, p 985), who thinks that all the departments in his hospital are overstaffed, yet wants more cuts to be made by “practising doctors.” Nevertheless, he condemns the use of remedial gymnasts, who are presumably there as the result of decisions made by other practising doctors in his own hospital. Who is in the right between opposing staff? And if clinical teams are to be given a budget to manage themselves who is to decide on the size of the initial budget? This seems to me to be an admirable recipe for intra-professional dispute. And how is a regional or superregional service, such as nephrology, going to control its costs when it has no means of controlling the justifiable demands? By making “clinically sensitive” decisions to refuse dialysis or transplantation?

Your backwoods correspondent Scrutator earlier this year hailed the advent of Sir Frank Hartley and his team to run our local area health authority. The results to date of this administration have been the closure of St John’s Hospital, Lewisham; the threatened closure of inpatient facilities at St Olaves, Bermondsey; and a number of other reductions in services (for that is what they are) in each of the three districts. Most of these actions are not the result of any rational plan to redeploy resources, but simply a means to achieve a rapid saving of money—not primarily RAWP money either, but money to cover VAT and inflation costs not allowed for by the cash limits. From newspaper reports it appears that the same dismal story is being repeated across the country.

Unfortunately, among many in the profession there appears to be a passive acceptance of the Government’s thesis—that public expenditure must be cut and that the NHS must bear its share (without reduction of service). This is, however, a debatable argument and some proclaimed monetarists, including the Government’s new economic advisers, Dr John Maynard Keynes, consider the extent of the proposed reductions to be excessive. French doctors recently struck for a day against their government’s intention to cut health care expenditure. I would not advocate that, but would urge doctors to campaign by all democratic means against such administrative actions which reduce present services. As a local councillor said at the same Conservative Party conference, “... redeploying every wasted penny will not adequately fund the Health Service. Let us not delude ourselves by passing motions as trite and cliché’d as this one.”

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SIR,—The first three people interviewed in the series “If I was forced to cut” (13 October, p 905; 20 October, p 985; and 27 October, p 1057) all suggest as part of good housekeeping that remedial gymnasts should be used for longer periods than is now customary. They appear to be unaware that this leads not to cuts but to increased expenditure because more staff will be needed to run them. I am a medical officer at area level (not in Nottingham) and suggest that in order to open x-ray departments in the evening an increase in radiographers only was required. This is not so; clerical and administrative staff are needed just as during the day and an increase in radiologist sessions are required to report on the increased number of films. Further, the more tests done on an autoanalyser and the more examinations performed on an x-ray machine the sooner will replacements be needed because the machines will wear out more quickly. Thus this good housekeeping means an increase in expenditure for salaries, disposables, and capital replacement.

W E WARD (p 1057) states that it is necessary to limit demand for laboratory tests, and this was also the burden of your leading article on diagnostic imaging (22 September, p 690). This presupposes that many tests are unnecessary and I think this a very dangerous position in radiology in the United Kingdom. Radiology in the UK has expanded with open access for family practitioners and the establishment of ultrasound and isotope diagnostic services, and most likely will need to expand further to accommodate computed tomography (CT). This expansion has been without regard to manpower levels. The mismatch between supply and demand for services has existed for at least the last few years and despite recruitment that has been as good as for anaesthetists.

The resulting mismatch in work load and available staff has led to the loss of morale evidenced in correspondence in your columns last year (from 2 September to 28 October 1978). The number of radiologists required can be calculated by comparing the number of examinations for which each radiologist should be responsible (15 000) with the number of examinations per head of population (0·4 in the London area) and isotope studies (1977's guide for ultrasound, isotope, and CT services).

Calculations such as these suggest that the target should be to double the number of radiologists. Similar calculations can no doubt be made for pathology. “Dr Burrowdean” (p 985) suggests that most departments of the hospital are overstaffed. This is not so for medical staff in radiology and pathology departments. He further states that once the NHS has the staff and the machines it makes sense to train the staff to be better doctors, not to do less; clearly he does not recognise the importance of having expert medical diagnosticians in radiology and pathology departments, or appreciate that the work load of the departments depend on the capacity of these medical staff. It is only if there are sufficient consultants in these departments that they can, by discussion, show clinicians why certain diagnostic pathways are unproductive and suggest a more appropriate use of the tests and the department. The increased medical staffing necessary in diagnostic departments means that the fears about the unemployment of doctors referred to by Dr R G Wilkins (29 September, p 800) are groundless.

The diagnostic departments, although conventionally regarded as part of the acute services, support most branches of the NHS. Without adequate diagnosis and assessment in pills do not replace in pills and are unproductive. The diagnostic services cannot be rationalised by cutting demand or provision: money must be spent on them. I suggest that they should consider a priority area in the new reorganisation and that more effective efforts be made to attract “hired guns” (on the lines of the American College of Radiology's recruitment campaign) are required to stimulate recruitment into these basic and fascinating disciplines.

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Correction
Wanted: a new wound dressing
We regret that in the letter by Dr L E Hughes et al (27 October, p 1076) "unable" in the fifth line of the third paragraph is a misspelling for “able.”