Rampton Hospital allegations

SIR,—Another inquiry seems imminent, continuing the series starting with the Ely Hospital Report of 1969. We know from the work of Hart¹ that the more industrialised areas of Britain receive less care from the Health Service, and from that of Townsend² that mental illness and handicap hospitals have less finance, so that patients' meals cost less per week, and buildings are less well maintained. At Normansfield Hospital, a member of the medical profession was found to be a convenient scapegoat. He could hardly be blamed for the serious leaks in the hospital roof.

Modern medical care has proved highly successful, so that there is less serious illness in middle age. In Cardiff the maximum age of admission to the acute medical wards of one of the teaching hospitals has been raised from 65 to 70 as the resident medical staff were not having enough admissions. In the same city two geriatric wards are empty as adequate nursing staff cannot be paid for, and there is a shortfall of 70 psychogeriatric day places. Yet middle-aged stroke victims are transferred from acute medical wards to a less well-staffed geriatric ward for rehabilitation.

Medical attitudes are formed in teaching hospitals, and it is significant that the recent correspondence about what to teach medical students concentrated little on the vital specialty of care and compassion for the most handicapped patients, who are destined to live out their lives in institutions. Despite earlier optimism, institutions of one form or another seem likely to survive, and the demand for places continues unabated.

The Resources Allocation Working Party was set up to correct the inequalities revealed by Hart, though its initial momentum seems to be dissipating. How many more ineffective inquiries into inhuman treatment of patients in understaffed, underfinanced hospitals must we tolerate before a similar redistribution based on Townsend's work is instituted?

GARETH JONES

Whitchurch Hospital,
Cardiff CF4 7XB

¹ Hart, T J, *Lancet*, 1971, 1, 405.

² Townsend, P, *Lancet*, 1974, 1, 1179.

The time for plain speaking

SIR,—Isn't it time that those of us who actually deal directly with patients in the National Health Service, the doctors and the nurses, made our voices heard above the nasty din of political activists? It is surely now our clear duty to inform other employees in the service, as well as members of the general public, of the following important facts.

Firstly, private beds account for an insignificant 1% of all beds in NHS hospitals. Secondly, the private wards which have already been closed have *not* been converted to public beds and there is no evidence that further closures, should they occur, would be treated in a different manner. These wards have been closed for purely doctrinaire political motives and, by reducing total bed availability, have actually *increased* the waiting list times in the Health Service. Thirdly, the principal cause of long waiting lists is an intense shortage of nurses. Most hospitals throughout the country suffer extensive cancellations of

operating theatre lists and are forced into ward closures because there are no nurses to staff these departments. Finally, inflammatory statements by union officials only lower morale still further, encourage resignations and emigration, and inhibit recruitment.

Most of us put patients above politics. If health union officials really have the good of the NHS at heart, let them join us in trying to improve morale, recruitment, and working conditions in the service—and would they please leave their dialectic materialism outside the hospital gates?

HAROLD ELLIS

Surgical Unit,
Westminster Medical School,
London SW1P 2AP

Training in urology

SIR,—As a recently appointed consultant in general surgery, I would like to comment on the letter (12 May, p 1281) from Mr J R C Logie, president of the Association of Surgeons in Training.

Since urology began to expand as a separate discipline, more and more senior registrars are being exposed to less and less training in urology on general surgical wards (which is where most of our senior surgeons obtained their training in urology). The only place, therefore, where modern urology can be learned is on a urological unit, under the supervision of trained urologists. I entirely endorse Mr Logie's contention that further training in urology at the senior registrar level must be given to all senior registrars before they go out into the periphery to practise general surgery, which still includes in many instances 30% of urological cases.

ANDREW JOHNSON

Ormskirk and District General Hospital,
Ormskirk, Lancs L39 2AZ

Patients' groups

SIR,—Doctors in general practice who have the wisdom and foresight to have patients' committees should not be put off by the recent rumblings from the Central Ethical Committee. We have a patients' committee which was started over two years ago before we moved into our new health centre. It has served two functions. The first is to channel complaints and suggestions from the patients about the running and administration of the primary care service, and the second is to run a health education programme.

There are three group practices in our health centre and two practices in their own premises outside. The patients' committee serves all the practices in the area and the community in general. Its activities in the health education field are open to all who live in this particular community.

We believe that good Health Education coming from a genuine desire in the community itself is the only way to break the deadlock in a disease- and illness-orientated Health Service. Although the patients' committee is free and independent from the doctors it must have local publicity in order to survive and be of any use. The committee also needs the stimulus of ideas from the doctors as well as their encouragement in general. It is highly unlikely that a committee formed in this way could be deemed to be advertising for any particular doctor or practice. We hope

that practices or individual general practitioners who are aspiring to form their own patients' committee will not be put off by this rather "sour grapes" attitude from on high. Surely we are all looking for ways of improving our practices and the general standard of primary care. The formation of active, useful patient committees seems to be an obvious way of doing this and we think that the future will prove this right.

W D HARPER
D W EVANS
J W BRADSHAW
D G PARRY
W C CHASE
J H CLARK

J F MOORE
J G RIGBY
A PRICE
P D BARNARD
H C LANCELEY
O S CROSTHWAITE

West Kirby, Merseyside L48 4HZ

SIR,—I note the recent declaration of the BMA's Central Ethical Committee with regard to patient participation groups.¹ The apparent attitude of the BMA to these groups is purportedly on the grounds of potential advertising. To my mind this old chestnut hides a fear of patients being allowed to share responsibility for their health.

We must ask ourselves why doctors in general and the BMA in particular should have this fear of patient participation. Why does the BMA feel threatened? In my view we should welcome the help of our own patients, but perhaps other doctors feel this would undermine their natural sense of superiority over their fellow beings.

R LEETE

Silverton, Devon

¹ *Medical News*, 17 May 1979, 1.

Clinical medical officers

SIR,—Sir John Brotherston in his letter (26 May, p 1427) is consistent in advocating the penultimate act in the disappearance of the former public health service.

The first stage of separation of social work from community medical departments has led to constant disputes over medicosocial problems in the community. The second stage was the removal of the medical officer from the local authority scene—much to the regret of the public and members of local authorities, who now have no source of medical advice in the "town hall." Now we have the third act, where he advocates child health doctors being transferred to the supervision of hospital paediatric departments.

Community medicine cannot flourish in a vacuum and it is particularly sad, when the Warnock Report offers a new multiprofessional approach to child health problems, to read that the president of the faculty is advocating the retreat of the clinical medical officer from community activities.

H B BROWN

Dumfries DG2 7AQ

Opticians' salaries

SIR,—I have followed the correspondence with regard to fees paid to ophthalmic medical practitioners for refraction under the general optical services. This is all, I feel, part of a wider problem. We seem to be slipping behind other advanced nations, and arrangements whereby an optician newly qualified from his three-year course and one year preregistration should receive a greater overall fee than, say, a

consultant eye surgeon doing the same work is only one facet of an unsatisfactory climate.

The great problem is that in the hospital service we are working in a money-losing organisation, whereas opticians in normal high-street practice are in a profit-earning organisation. We now find ourselves in a position where the hospital eye service is able to offer an optician commencing his career an annual salary of only £3 912, with a scale rising by some eight annual increments to a little short of £5 000 per year. In contrast, I understand that the majority of optical firms will offer a newly qualified optician £8 000 a year as a commencing salary. Later he may get a five-figure salary plus perquisites such as a company car. There can be little surprise therefore that hospitals are by and large unable to attract opticians.

D M J BURNS

St Paul's Eye Hospital,
Liverpool

Community medicine

SIR,—The word "community" as related to health services for children has always been a nuisance and now threatens to become a menace. "Community medicine" was transplanted into our language from the United States and was variously seen as a new name for social medicine or public health, or a hybrid. This is entirely reasonable. The word community means (*Chambers Twentieth Century Dictionary*) "the public in general" or "a body of persons in the same locality." It refers to a group of people, not a place. Community medicine is concerned with the health of populations.

The danger crept in with the invention and wide use of the term "in the community," as if the community were a place, never defined but by implication excluding hospitals (and perhaps prisons). The invention of "community hospitals" further confused the issue. It took the Court Report to point out, in italics: "*The community is too often thought of as what happens outside the hospital; for us the hospital is one important activity in a community health service.*"¹

The menace appears with the implication that "community child health" and "community paediatrics" are a part of community medicine. The health of child populations clearly is, but the care of individual children in clinics, schools, and health centres is not. The work of clinical medical officers may be seen as part of paediatrics, as part of general practice, or as a bit of both; and it is within these disciplines that their future lies. The discipline of community medicine, as its senior representatives are the first to agree,² is not concerned with training clinicians. The sooner this fundamental truth is grasped—by the community—the better.

R W SMITHELLS

President,
British Paediatric Association

University Department of
Paediatrics and Child Health,
Leeds LS1 3ET

¹ Committee on Child Health Services, *Fit for the Future*, vol 1, para 12.18. London, HMSO, 1976. (Court Report.)

² Brotherston, J, *Lancet*, 1979, **1**, 1150.

SIR,—Community health doctors will be interested to know that at the Council meeting held on Wednesday, 30 May, the report of the Executive Committee of Council included

reference to the discussion document on community health doctors, which will be presented to the community medicine craft conference on 16 June.

A working group of the Central Committee for Hospital Medical Services has recently produced detailed comments on the discussion document and the Executive Committee has expressed the hope that an early meeting of interested parties could be arranged to explore common ground between the proposals of the Central Committee for Community Medicine and the views of other craft committees. The Executive Committee believes that such joint consultations are essential if a training programme and career structure for doctors in the community health service is to have the support of the profession. It has invited the craft committees to begin such joint consultations as early as possible.

The future quality of the child health services, including the school health services, and the training arrangements, the career prospects, and the interrelationship of the various groups of doctors dedicated to working in the child health service urgently demands a joint solution by all those concerned—consultant paediatricians, community health doctors and general practitioners.

I am sure that community health doctors will welcome these joint consultations, which have the support of the Council.

JAMES R PRESTON

Chairman,

Working Party on Community Health Doctors
Sutton Coldfield,
West Midlands B74 2TH

Points

The wrong drug

Dr E N S FRY (Department of Anaesthesia, North Tees General Hospital, Stockton-on-Tees, Cleveland TS19 8PE) writes: Your leading article "The wrong drug" (12 May, p 1233) reminds me that some years ago a solution of sodium thiopentone in 20% potassium chloride was injected. Fortunately the anaesthetist expiated his carelessness by the recognition and effective treatment of the cardiac arrest. But since then, in this hospital, concentrated solutions of potassium salts are stored in the drug cupboard well separated from ampoules of water and saline.

Doctors and children's teeth

Dr A J ROSE (London SW3 3NR) writes: With reference to your leading article (12 May, p 1231), I live in an area where I am reliably informed that fluoride is not added to the water. This information was not easily obtained, and I think that the DHSS should ensure that local practitioners know about the fluoride content of the water in their locality.

The case against neonatal circumcision

Dr DAVID MORRIS (London W1M 7AD) writes: There is one aspect of circumcision not mentioned in your excellent leading article (5 May, p 1163), nor can I find mention of it elsewhere. In the routine examination of young boys over the age of three, I frequently find a degree of foreskin adhesion which doesn't look as though it could be retracted without pain or difficulty, confirmed on gently attempting to

push back the foreskin. Sometimes the parents have been attempting to do just this (say, at bath time) but without success. I usually encourage them to go on trying for the next six to nine months or until the age of 4 or more, when I advise "reduction" under oral sedation. I use Vallergran Forte (trimeprazine tartrate), 6 mg/kg, and pethidine, 1 mg/kg, given together two hours before the procedure. It is surprising how easy it is to do and how little time it takes. Of the many hundreds I have done, there have been only two where I have felt unable to reduce the adhesions and have arranged for circumcision. . . .

Low back pain

Dr STANLEY P BOHRER (People-to-People Health Foundation, Cartagena, Colombia) writes: . . . I was recently suffering from chronic low backache myself and happened to be in a house that uses hammocks as extra beds. One night I decided to try one, and for the first time in weeks slept comfortably and woke up free of low backache. I have continued to sleep in a hammock for several months now and it continues to be ideal for my back. . . .

Hallucinogenic fungus

Dr P PETCH (King's Lynn, Norfolk PE31 6HA) writes: I wonder how confidently Mr C Benjamin's patient identified *Psilocybe semilanceata* when he ate 25 specimens in a pub (19 May, p 1319). This tiny fragile fungus, half an inch high, is not recognised as a mushroom in this country, and the quantity reported would not make much of a mouthful. Other hallucinogenic species occur, and it would be interesting to have further details before accepting this episode as a cause of persistent psychiatric symptoms.

Dr A P RADFORD (Bristol BS10 7JE) writes: . . . I question whether it is correct to refer to the fungus *Psilocybe semilanceata* (19 May, p 1319) as a mushroom; if a popular term is wanted then I suggest that "toadstool" is more appropriate . . . indicating their smaller size and poisonous nature. Mushrooms are fungi of substantial size which are normally considered to be edible. . . .

BMA-sponsored candidates for GMC election

Dr A ALLIBONE (Holt, Norfolk NR25 6BH) writes: The Secretary's comments on my letter (12 May, p 1286) do nothing to rebut the charge that the BMA has failed in its duty to "ensure proper representation of the profession as a whole," which was their instruction by a resolution of the 1975 SRM. There is no mention of why there are so few serving general practitioners in relation to the other groups within the profession. He explains but does not justify why 80% of the general practitioners and consultants sponsored by the BMA are present members of either the GMSC or the CCHMS. Nor does he tell us why four paid full-time BMA officials from a mere handful of such doctors have been so successful in securing nomination in preference to other candidates. This makes a mockery of the Association's complaint that the Secretary of State was behaving undemocratically by insisting that his four chief medical officers should be members of the new GMC because officials had an unfair advantage over the ordinary member.