graphy. During the oral treatment period the increased blood flow was maintained or improved further, as shown by the following fluorescein angiograms. Tolerance to these high doses, both intravenous and oral, was excellent.

A similar trial is also running in advanced cases of chronic ischaemic legs, unsuitable for reconstructive arterial surgery, using high doses of intravenous hydroxyethylrutosides. We have about 20 cases in this study to date; and most results, both clinically and with serial fluorescein angiography are similar to those reported here for Raynaud's syndrome. These results will be reported in full when we have finished a detailed analysis of the material.

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Not a career for academic high fliers?

SIR,—The Finniston Report on the engineering profession¹ illustrates a serious deficiency in the way we manage our affairs. A technologically based society—and all advanced societies and most others have to be—needs good technicians, scientists, and engineers. Of course, medics are also important, but—like their nostrums—only in moderation. We must moderate our desire for ever more and brighter students, and for two reasons: firstly, because medicine has the jobs for only a few academic high fliers—bread-and-butter medicine does not use or satisfy their special abilities—and, secondly, because (as the Finniston Report demonstrated) there is a much greater need for the bright ones in other branches of science and technology. Society cannot afford a medicine which scoops up too many scientists, particularly academic high fliers.

The fact that medicine is so attractive to our bright school leavers has less to do with the merits of the subject, or the needs of society, than to medicine's high rating as a career. Our deans must act with unaccustomed humility: the corollary to Finniston is fewer medical students and three Cs as the going grade; a special case must be made for taking more than a few with higher grades.

Medics like to take credit for a concern for individuals and society: now is the opportunity for us to show we deserve it.

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¹ Committee of Inquiry into the Engineering Profession. *Engineering Our Future*. Cmd 7794. London: HMSO, 1980.

Patients first

SIR,—I write to point out what appears to be an error in the title of the consultative document *Patients First*. Should not the title be *Hospital Patients First*? With this correction

the document reads well and the changes suggested seem reasonable. If, however, the title is not in error I must express concern about other than hospital patients in the care of the NHS—for example, those who are the responsibility of the primary care and preventive health services.

What is not clear from the consultative document is how the NHS, particularly at local level, will serve all patients and not just those in hospital. It is suggested that there will be a triumvirate at the district general hospital, or its equivalent, of senior and experienced people, paid accordingly, to administer the hospital. Will they also be responsible for the majority of patients who are cared for outside hospital, or will there be a second triumvirate to promote the health of the total community of the catchment area of the hospital, with a responsibility for the primary care and the community health services (for example, the child and school health services)?

The suggested philosophy of the consultative document is to bring health services nearer to the patient. It is therefore essential that local administrative and management arrangements are right. It would seem that insufficient thought has been given to this by those who have prepared the document. Although there has been much criticism of the reorganised Health Service, there appears to be an acceptance that one of its benefits has been the bringing together of previously fragmented health services. We need to build on this important advance and not by new (some may say a return to old) administrative changes create a partite structure within the reorganised health service.

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Cleaning hospital wards

SIR,—In your leading article (22-29 December, p 1610) you make a plea for the ward sister again to have responsibility for the day-to-day control of the ward cleaners; but let me add a word of support for the hospital cleaning departments, which have a responsibility for training domestics and providing them with the necessary equipment. Surely the best arrangement would be for the domestics to be on the sister's staff for day-to-day control, but under the general supervision, so far as standards of work are concerned, the domestic supervisor. In the good/bad old days the matron's staff was responsible for buying the cleaning equipment, and this was far from satisfactory. Today at least domestics have the appropriate equipment for cleaning and are instructed in its use.

There is another aspect to this problem beyond the control both of the ward sisters and of the domestic supervisor. Going round a number of London hospitals last year I noted with dismay the numbers of wards and, even more, kitchens where there was a high-tide mark at six feet (1.8 m). Below this level the walls can be cleaned by the domestics, but above they may be washed only by the painters.

With the continuing problem of cross-infection there is a medical aspect and there should be good liaison with the hospital consultant hygiene officer. I remember a patient in a side ward who damped down the enthusiasm of the ward cleaner who had set to

work on a cupboard: "Hi! Stop! That's where I keep my streptococci." He was right, and unhappily he almost died from a severe postoperative wound sepsis.

There are simple answers, such as long-handled mops with self-squeezing mechanisms, or re-establishing the routine of pulling the beds out and having the walls washed down. I remember this was done in half a morning at Bart's, where under the eagle eye of Professor L P Garrod the wards really were kept clean.

Clean hospitals are important. Like Minerva (5 January, p 53), I look forward to the time when the DHSS awards a handsome prize to the domestic supervisor of the hospital judged to be the cleanest in England and Wales.

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Medically qualified preclinical academics

SIR,—I fully agree with Mr N A Green and Professor R E Coupland (12 January, p 116) that medically qualified preclinical teachers are essential for the medical direction of education, particularly in anatomy. In these days of shortened anatomy curricula there is an enormous advantage in having medically qualified staff who are able to select the clinically relevant facts from the vast amount of anatomical knowledge. Furthermore, as the late Professor W J Hamilton frequently pointed out, medically qualified staff are usually much more versatile than their non-medical colleagues, being able to teach cytology, histology, embryology, and neuroanatomy as well as gross anatomy.

I also agree that a clinical presence in pre-clinical courses can be of great value, particularly in motivation of students. I have been co-ordinator for a number of years of a clinical neuroanatomy course which includes contributions from neurologists, neurosurgeons, otolaryngologists, and ophthalmologists; and have participated in limb anatomy courses which are jointly run by the departments of anatomy and orthopaedic surgery. I willingly acknowledge the value of these courses.

I am not, however, convinced that by doing clinical sessions preclinical staff would in any way improve their teaching standards; nor do I believe that clinical sessions would be of any value in improving recruitment and retention of junior staff, for the simple reason that the basic salaries of preclinical and clinical lecturers do not differ greatly. The major difference is in the payment of UMTs, which presumably would not be paid for two sessions a week. The problem is not unique to pre-clinical staff but has also severely affected recruitment to paraclinical laboratory disciplines. Unfortunately it seems likely that the new consultant contract will aggravate the situation by extending the salary differential in laboratory disciplines to the consultant grade.

There are numerous practical difficulties involved in finding appropriate clinical sessions for the majority of preclinical teachers. Many clinicians argue that it is not possible to develop clinical expertise where clinical contact is restricted to one or two sessions a week and would strongly oppose clinical involvement of preclinical staff at anything higher than SHO level, a point of view which is understandable. The most valuable type of

contribution which preclinical staff can make is in making available their expertise in research techniques in a clinical or paraclinical environment, but this is not possible in all areas of research.

Unfortunately, at present laboratory medicine, whether paraclinical or preclinical, is not a popular career choice among medical graduates, largely owing to the inadequate remuneration, especially in junior grades when most recently qualified doctors have the problems of small children and large mortgages. There is also the subtle propaganda which infers that anyone working in a laboratory instead of dealing with live patients at the bedside is somehow an inferior member of the profession. As long as this attitude prevails the outlook for laboratory medicine in this country is bleak.

The only body which can alter the preclinical remuneration is the BMA, but it will not do so until it obtains the right to negotiate on behalf of medically qualified preclinical staff. The BMA has assiduously avoided trying to obtain this right. It must be rare for a trade union to avoid trying to obtain negotiating rights for a group of its members whose importance to the profession it proclaims annually.

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The scandal of the notional rent

SIR,—When our partnership of three decided we ought to move into larger premises some surprising and alarming facts emerged. We are at present practising from a surgery converted from a three-bedroomed, semi-detached house: although an extension had been added five years ago the waiting area has proved quite inadequate, one of the doctors has to stay upstairs, and there is only a restricted parking area, away from the main road.

The new premises we envisaged fulfilled all the conditions we hoped for, even in their present condition—a large waiting and reception area, a nursing room downstairs, and four surgeries upstairs. It has all the space required for future building alterations to provide all facilities on the ground floor, and for adding an extended parking area.

Then what do we find? The asking price was £85,000, and an £80,000 mortgage from the General Practice Finance Corporation would mean, at £1850 per £10,000 per annum (20 years at 18%), an outgoing of £15 000 per annum on accommodation alone—and we still have to live and run our cars and pay for public utility services, etc. To modify this sum we considered putting in all the monies to be obtained from the sale of the present surgery, which should give us about £20 000 clear. This would still leave us with £60 000 to pay and a bill of £11 000 a year. We then found that the notional rent would not exceed £3500 per annum (£2900 on the £40 000 property owned) simply because it is a notional and not a commercial rent. The present commercial rent would be twice to three times as much (at say £6 per ft²). Yet this notional rent proposal is apparently regarded by authority as special treatment extended to doctors because they are judged to be not quite a commercial undertaking (though considered to be such by the Post Office, electricity and gas boards, rating authorities, and so on). In short, we are offered mortgage facilities of up to 100%, but

at a commercial mortgage rate (at present 18%)—and not allowed a commercial rent in return for it.

The notional system suggests that the aim of the Government is to make sure general practitioners do not have proper returns on their property. Thus the doctors can never afford new premises except in a Government-owned setting, such as health centres, and under the General Practice Finance Corporation lease plan. The plain fact seems to be that all these difficulties are part of Government long-term planning to convert GPs into a salaried service. The socialist-imbued National Health Service administration has failed to learn from the disastrous results of the Communist health systems, where everything and everyone is salaried. It does not make for good health care: the doctor's self-interest in this respect is linked with that of the patients and would be reflected by the greater numbers of patients attending, and the higher appreciation of the medical service given by the practice.

General practitioners' salaries and income are now inadequate to buy even an ordinary semi-detached or terraced house in London, or to open an independent general practice as a business, so if the present trend continues there will be no single GPs or even partnerships able to undertake to look after the practice of a retiring doctor or to set up independently, for they would be unable to afford surgery premises with the present notional rent levels. As a result, everyone will be forced into practising in the health centres, with even more of the impersonal secretaries than now, serving a consortium of doctors, placed far from patient groups, and serving larger populations with less individual attention. So it all moves towards less convenient and less personal service for the price of salaried service for doctors, plus an enormous increase in administrative costs.

What do the BMA and the Review Body Committee intend to do about this inequitable and destructive policy? As a first and urgent step, all that is required is to make the notional rent into a commercial rent at today's figures; then we would not need Government grants, and could manage to provide adequate premises for ourselves without the Government administrative costs and the incidental depersonalisation of our service.

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*.*The Secretary writes: "Many GPs have expressed dissatisfaction with the notional rent system and the GMSC Practice Premises Subcommittee has been examining ways in which it might be improved. This examination is now at an advanced stage and we hope to be able to place proposals before the Health Departments in the very near future."—ED, *BMJ*.

Entertainment versus scientific inquiry

SIR,—Many of your readers may have seen the television programme on Friday 18 January discussing the use of drugs to control the behaviour of emotionally disturbed adolescents at Kendall House, a complex and controversial subject which is important enough to merit serious investigation. [This programme was reviewed by HBV (26

January, p 245).—ED, *BMJ*.] It must be extremely difficult to produce an informed discussion which will simultaneously enlighten and interest a mass audience, but does this excuse the producers in so completely subordinating the methods of scientific inquiry to the needs of the theatre?

Assessment of any treatment is a long, difficult, and sometimes tedious matter and it may take years to establish the precise indications and the efficacy of a drug. Side effects create an additional problem—they may be so devastating in some individuals as to rule out further treatment, but in other patients they may be less severe or negligible; certainly they call for careful clinical and ethical evaluation in each case. How the general public were helped in their judgment by being shown a wedding was far from clear. The young woman had obviously improved greatly while being fostered by a robust, warm-hearted woman and presumably courtship had had a pleasantly euphoriant effect on her moods, but what conclusion were the audience expected to reach? Still more confusing was the introduction of Yvonne. We were told she was potentially homicidal, she had been transformed into a zombie by drugs, she had held people at knife point—and then the lady vanished, if one may use such an expression for someone who never actually appeared on the screen. The difficulty of reaching a verdict is very great when one can neither hear nor see nor question one of the principal witnesses.

Over the past 25 years tranquillisers have in my opinion been shown to help many patients by reducing their fear and anger, and consequently there has been much less need to curtail their liberty. Can extremely disturbed adolescents be helped in a similar way, so that we avoid the need to restrict their freedom? This is the question. I am unable to follow the logic of the argument that Modecate (fluphenazine) must not be used because Soviet Russia used it against the dissidents, but the innuendo is obvious.

The Open University programmes have demonstrated television's capacity for the exposition of complex matters; the *You the Jury* programme has shown that radio can intelligently debate controversial issues; and the programme under discussion shows how entertaining it can be to watch someone else in the hot seat. However, as such programmes have a wide audience, the producers would do well to follow the good example of the tobacco manufacturers and show the warning caption "This feature has a high concentration of propaganda."

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Corrections

Assessing improvement of low back pain

In the letter by Dr M E Burleigh Carson (12 January, p 111) the organisation of which he is secretary general was incorrectly named owing to a typing error. It should be the International Federation of Manual Medicine.

Drug names that look or sound alike

In the letter by Dr Neil C Fraser (19 January, p 185) we regret that Daktrin was misprinted as Dakatrin.