discussing the problems of working with the elderly, and the usefulness of bringing in aspects of normal life and using appropriate activities as a means of counteracting the apathy of institutional life. We hope and believe that this form of specific intervention by social workers has made a difference in some small way to the quality of life of the elderly people we worked with, and that there is much more urgent work to be done in this field.

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Services for the mentally handicapped

SIR,—I would like to support Dr N S Gordon's letter (9 February, p 403) on the principle that all doctors have a duty towards the mentally handicapped; and it is to be hoped that paediatricians, neurologists, and child psychiatrists will have sufficient interest to take over much of the specialist work.

It is, however, difficult to find consultants sufficiently versed in all the three main areas of need. These are: (i) the ability to understand the psychodynamics of a "handicapped family" and to offer a sensitive response with the appropriate techniques of family therapy; (ii) the implications of developmental neurology and psychology, particularly in relation to perceptual and communication problems; (iii) the management of the emotional and psychiatric problems peculiar to the severely brain damaged.

All these areas are grossly under-researched and should be sufficiently challenging to attract consultants specialising in this complex field.

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Possible cancer hazard associated with 5-methoxypsoralen in suntan preparation

SIR,—Professor M J Ashwood-Smith raised some questions concerning the use of 5-methoxypsoralen in sun products to induce tanning (3 November, p 1144).

The Bergasol line of products was designed to facilitate tanning without erythema and without ultraviolet burning. The rationale is that pigmentation is the best known protection against carcinogenesis induced by ultraviolet burning and possibly against all types of insults leading to damage and aging of the skin.

The concern about 5-methoxypsoralen is based on its chemical analogy to 8-methoxypsoralen, as pointed out by Professor Ashwood-Smith. He was of necessity limited to information from published data on 5-methoxypsoralen. Laboratoires Goupil have been accumulating data which show *biological* differences between 8-methoxypsoralen and 5-methoxypsoralen. Some of these are quantitative and some are qualitative. They include: (1) The acute and subchronic toxicity of 5-methoxypsoralen in several species is much less than that of 8-methoxypsoralen, with and without ultraviolet radiation. (2) The intracellular distribution appears different. (3)

Studies in progress indicate that 8-methoxypsoralen causes significantly more nuclear damage than 5-methoxypsoralen as measured by sunburn cells in hairless mice. (4) The extent of reaction with nuclear material seems different in quantity and perhaps in the kind of binding.

Since there is benefit in the tanning effect and the extent of risk is implied and not yet really known, the difficult question of how to balance benefit and risk is present. Laboratoires Goupil are very conscious of their responsibility to continue to investigate both sides of this question and are doing so at this time.

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Emergency admission arrangements in hospital with inadequate resources

SIR,—I concur with all that Dr J Andrews says in his letter (9 February, p 405). There are manifold effects of inadequate resources, some of which I would like to add to those mentioned in that letter.

(1) Inappropriate discharges home. As hospitals have progressively fewer beds to admit patients there is increasing pressure on junior staff to send a patient home when it would be more prudent to admit him to hospital. It is impossible to get junior staff to refrain from taking a chance because the realities in the accident and emergency department easily override all proffered advice. I myself have often been influenced by the bed state in making a decision whether to send a patient home, and many of my colleagues admit to the same.

(2) Difficult interrelationships in the accident and emergency department. As doctors request more investigations on patients, in an attempt to screen them more efficiently so that as many patients as possible can be sent home, stretcher boys are not available for doctors to examine other patients and the waiting time in the casualty department increases. The nurses resent constantly explaining to patients the cause of delay.

(3) Deterioration in relationships between casualty and other departments. As casualty officers request second opinions more frequently than before, other residents object to being called out at night, with a consequent deterioration in relationships.

(4) Stopping acute admissions. Administrators do not often see the urgency of getting more beds available and closing the hospital to acute admissions. I have known of hospitals where three patients with myocardial infarction were waiting in the casualty department with no bed in the hospital into which to admit them.

(5) Medical patients in surgical wards. In urban areas, particularly in London, the number of emergency medical admissions is greater than surgical and bed shortages prompt cancellation of booked admissions. The surgical specialties inevitably suffer by these cancellations.

(6) Deterioration in patient-hospital relationships. Increased waiting times, repeated cancelling of cold admissions, and a general sloppiness in attending to patients' needs results in patients' losing confidence in a hospital.

It may be unrealistic to expect more money from the Government in the present economic

state and perhaps the only way out for doctors is to tell the patients squarely the difficulties of the system.

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Radiotherapy work-load statistics

SIR,—The useful work load of radiotherapy departments is very easy to assess but not, I think, by means of DHSS SH3 returns, as the article by Dr R F Mould (16 February, p 501) would suggest.

We add together all the salaries paid to department staff in a year and a machine and room cost (about £18 000 per cobalt machine, a little more for linear accelerators). From the cancer registry we know not only the number of cases treated but the number cured. At Pembury it cost £10 a day to treat an out-patient and £40-50 to treat an inpatient, so it costs £250 to cure a case of testicular cancer (mostly curable) and perhaps £300-400 for Hodgkin's disease. Although each patient is treated as an individual, radiotherapy departments are much more like small factories than any other part of the hospital service in that their work can be costed.

I would like to argue that we must look at particular departments and diseases and make decisions about closure on such real evidence.

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Are health services important to the people's health?

SIR,—Dr J N Morris in his article "Are health services important to the people's health?" (19 January, p 167) raises important issues which are fundamental to the better provision of "health."

"Prevention" of disease is politically attractive but in practice conventional preventive medicine has little to offer the majority of patients. Dr Morris raises the novel concept of "prevention" as applicable to the "prevention" of deterioration in a chronic illness; this polemical argument may have a significant practical advantage if by invoking the "prevention" label it is possible to reverse the current trend of depleting the acute hospitals of resources in order to provide more facilities for the chronically ill *after* their disability has irreversibly progressed.

Successive governments have failed to take the necessary measures to curb alcohol, tobacco, and food addiction and to promote health education; this has a disproportionately severe effect on the lower social classes, who thereby are most liable to develop ill health—provision for which is already jeopardised by the curtailment of facilities for the prevention of chronic ill health. The serious debate asked for by Dr Morris must include consideration of the proposition that the National Health Service is a misnomer¹; the National Health Service is really an amalgam of three services—a National Illness Service, a National Wellness Service, and a National Social Service. At present what is happening is that the National Illness Service is being depleted in favour of the other services, whereas in fact the National Illness Service, particularly the

acute hospitals, contributes most to the prevention of progression of disease even if it is unable to prevent the onset of disease. In practice, so-called preventive medicine contributes very little to the prevention of ill health.

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¹ Davies IJT. *Br Med J* 1978;i:104-5.

Where have all the nurses gone?

SIR,—I feel that many of the writers who have so far contributed to the correspondence (9 February, p 406; 16 February, p 486) about "Where have all the nurses gone?" (19 January, p 199) have shown a degree of emotion which is totally inappropriate, and also that doctors are always very anxious to correct the deficiencies in nursing without looking at their own failings. Furthermore, it is impossible to be aware of the work entailed in any job unless one has been the job-holder. A number of erroneous statements have been made by your correspondents, and I would like to correct these.

Firstly, nursing is not a profession in the true sense of the word, and our medical colleagues are frequently the first to ensure that it is not regarded as such. Secondly, it is untrue to say that doctors are no longer asked to give lectures to nurses. They are asked very frequently but often decline the offer. In addition, some of the lectures which are presented are of such poor quality that those who deliver them are not requested to repeat their performances. The "myriads" of nurse tutors to which reference was made in one letter spend a great deal of their time attempting to cajole truculent physicians and surgeons into sharing their knowledge with nursing colleagues. These tutors also spend many hours interpreting those lectures which are incomprehensible to their students.

I would like to state that, contrary to common thought, most nurses find the role of the nursing officer to be ambiguous. I am sad to say, however, that when I attempted to warn one of the consultants with whom I worked in 1966 that the outcome of "Salmon" would not be favourable he accused me of overreacting. With regard to the reduction in working hours, most nurses, again, consider it unnecessary.

Finally, may I ask doctors to consider their attitudes towards nurses, and the pressure of work to which they subject them. If some attention were paid to both of these, not only would relationships improve but more of us might continue to practise the skills in which we were trained.

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Medical advisory machinery

SIR,—The debate on medical advisory machinery in the National Health Service promises to be one of the major issues for the Association in 1980. I would remind your readers that the issue was referred to Council after a full debate in the Northern Regional Council last October. I am grateful that the matter has been fully reported in your journal (9 February, p 418). What are the main issues at the present time?

(1) Health authorities have been receiving medical advice which is fragmented, duplicated, and indeed triplicated. Doctors have complained of the tremendous amount of time being spent debating and redebating the same issues in different committees. (2) Health authorities would certainly welcome one channel of professional advice that they could regard as the voice of authority from the profession. (3) The British Medical Association, enjoying great authority within the profession and even greater authority outside it, is singularly well equipped to offer that advice and to provide the necessary advisory machinery. (4) The debate in Council demonstrated that the issue was divisive, but Dr Ralph Lawrence made the cogent point when he said that "the future of the Association lay in the periphery but the divisions were doing less and less."

The divisions will become more active only if more business is channelled through them, and the taking on of an advisory function not only will strengthen the division but at the same time will boost the membership. True, the divisional structure will have to be so arranged that all crafts are represented therein, but this is a minor issue. Non-members will observe the scale and quality of the business being channelled through divisions; they will not only be ready and anxious to join the Association but would also be prepared to play a full and active role in Association affairs.

In the North of England the Association has always had a strong political role. I am well aware that this position does not obtain everywhere, and this may well be reflected in the attitudes of some members of Council. If at the end of the day the local BMA division does not become the sole source of medical advice, at the very least its right to be consulted must be written into the new advisory structure.

I hope that this major issue will become a topic of lively debate up and down the country.

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An effect of inflation

SIR,—Three years ago I bought my present car for £1740. Today I was offered £1800 in part exchange for an identical but new car. These now cost £3800 with delivery charges, number plates, etc.

In many ways, I am fortunate to be offered so good a price, but it does make nonsense of the fact that my accountant has been allowing me 25% of the remaining value of my car as depreciation each year, on which I am allowed tax relief as I use my car for professional purposes. I will now have to pay back my tax relief, although in practice I need to find £2000 to get the same car new.

I hope that our negotiators will bear this effect of inflation in mind.

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Domiciliary visits by consultants

SIR,—I read with interest the letter from Dr P E Jackson (26 January, p 256) regarding domiciliary visits by consultants, and would like to support the views expressed by him.

Here the communication and discussion with the patients' general practitioners is of

the utmost importance in deciding which patients need an immediate hospital admission, as an emergency, and which patients can be seen and assessed by the consultant in his outpatient clinic. There are outpatient clinics once or twice a week in every specialty in the hospital, and in the specialty of rheumatology they are held four or five times a week. In this way much valuable time of the consultant can be saved, which he can devote to the care of his patients, and to teaching, instructing, and supervising the work of the junior medical staff. This also saves considerable money for the National Health Service.

In my view, the only occasion when a consultant wants to do a domiciliary visit is when he wishes to see the patient who is physically too ill to travel in his domestic and social environment to assess the nature of his disability, and his need of the other social services, so as to keep him at home as long as possible to save an acute hospital bed. Such occasions, however, are few and far between.

I know a number of consultants who do not undertake domiciliary visiting of patients, and there are a number of area and regional health authorities who do not insist that they do so.

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Inner city GPs

SIR,—Although I am sympathetic to Dr G E Crawford's suggestions (16 February, p 500) for attracting general practitioners to our declining inner cities, my experience as chairman of the area health authority's planning team for primary care in Liverpool is that the barriers to their implementation are by no means always as local as he implies. While I would not underestimate the importance of local authority co-operation in the provision of suitable premises, their financing has been considerably hindered by the Government's effective withdrawal of the annual capital allocation for primary care schemes, with the result that the situation has altered from one of positive discrimination to one of open competition with secondary care and other capital schemes in the regional programme.

In the current financial climate the Department of Health and Social Security, must pay more than lip service to developing the community sector if any real shift of resources is to occur. Major investment is a prerequisite to achieving revenue savings through community care, but neither bridging finance¹ nor a revenue investment programme,² one of which would be required to effect this, has ever been forthcoming.

A number of incentives to recruitment, like the special payments to older practitioners making way for younger ones which Dr Crawford suggests, have been put forward in recent times. These have included salaried appointments; limited list sizes; catchment areas and populations; a compulsory retirement age for inner city GPs; the attachment of trainees to elderly single-handed practitioners, with a guarantee that they will "inherit" the practice on the incumbent's retirement; weighting of capitation payments for "high-dependency" groups such as the handicapped; financial incentives (on the lines of the type D allowance) linked to inner city practices; and