available to fund the National Health Service, and a similar one to dispel that perpetuated by your previous nine anonymous correspondents that the application of cash limits to NHS funding necessarily means that there would be a reduction in the service to the patient.

As the demand for health care is infinite, it is likely that even if the whole of the gross national product was available to fund the NHS there would still be a demand for more finance. Similar problems relate to the manpower situation. As the largest employer in the country, the NHS ought to be able to provide a reasonable service; yet the clamour for more staff continues. It should be remembered that wages and salaries form the major part of NHS expenditure, and that the capacity of the community to provide more people to work in the NHS must soon reach its limit.

Dr Marsh has chipped away at the edges of the major user of NHS resources, the hospital service; but we need to do more than this. A radical reappraisal of the way in which hospital services are organised and funded is necessary. We must go back to square one, define the objectives of the hospital service, and see how these can best be provided with the resources available. The present trend of making expensive structural alterations to outdated buildings and plant must cease (the knobs on knobs syndrome). Sad as it may seem, this will mean the closure of hospitals well loved by local communities. The cost of maintaining them is often more than building anew.

The potential for saving in the hospital service is enormous. It does not relate only to the drug bill. Expenditure on energy, telephones, transport, and a host of others can be reduced; but it is all too easy to point an accusing finger at someone else's department when reductions are called for. As Dr Marsh points out, in general practice there is a very real incentive to economise; in the hospital service money saved is available for other uses.

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SIR,—Several of the recommendations in Dr G N Marsh's article (3 May, p 1140) already apply in my practice. I provide most of the medical care of my patients myself.

This means that I am fully occupied by giving general practice care to approximately 2200 patients (my share of the practice list). I am unable to delegate more of my work, because my work needs to be done by a person with the aptitudes and training (and salary aspirations) of a doctor. I cannot imagine any way of caring for 3000 patients.

It is clear from Dr Marsh's published work that he is something exceptional. Perhaps a way of economising in general practice in the National Health Service would be to clone some of his cells to produce 15 000 replacements for the next generation. I believe that I am a more average general practitioner, and I know that I shall be forced to change my employment at least 10 years before the usual retirement age because I shall not sustain the work load generated by my present number of patients.

I agree with Dr Marsh that medication is not necessary for minor self-limiting illness. I believe that my patients are typical patients

and, unlike Dr Marsh, I cannot educate them to know clearly what is a minor self-limiting illness. Last week a mother's failure to understand the difference between a cold and earache led to her daughter's admission to hospital with mastoiditis from my practice.

Our work load, as measured by number of patients looked after, should fall if the "caring general practitioners" whom Dr Marsh describes are not to be overloaded. If the number of patients rises as he recommends they will go to casualty to demand attention.

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SIR,—The consultant paediatrician in your series "If I was forced to cut" (15 December, p 1570) thought that the number of junior doctors could be reduced. I heartily agree with him but for vastly different reasons.

As a radical medical student I was convinced that as regards the medical profession the NHS was greatly undermined. This view was confirmed during my houseman's year, when I worked very long hours flaunting my newly acquired skills. As an SHO (in paediatrics), however, an embryo of dissent appeared; but such thoughts were suppressed by sleep deprivation. Since October 1979 I have been one of two doctors looking after a 120-bed hospital in Tanzania. We are greatly aided by two "medical assistants" and once every 10 weeks get a visit from the flying doctor service. One soon learns about priorities and it was not long before—*eureka*—there seemed not too few doctors in the NHS but too many. How else does one explain a system which demands five years' training so that one may be able to take blood, put up drips, sew up minor cuts and episiotomies, and give intravenous injections? This ensures that the junior doctor is disturbed on at least two or three occasions the night he is on call, which gives him the satisfied feeling that he is overworked and underpaid. This iniquitous situation is encouraged by the hierarchy of the medical and nursing professions.

In most cases the junior doctor is overtrained for the work he does. I am not suggesting that we adopt a system employing lesser trained staff (for example, medical assistants, as in Tanzania) for I do not believe the British public would accept this—many people are no longer content with their GP and demand a specialist opinion. I would advocate, though, removing the trivia from a junior doctor's schedule and asking the nursing profession to pull its weight and regain some of its respect. If this were achieved the doctor could get on with the real business of tending the sick.

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Long-term care of patients with major illness

SIR,—Dr I S L Loudon (26 April, p 1118) will find many hospital doctors who agree with him that the long-term care of patients who have been admitted to hospital for major illness should be in the hands of the general practitioner. In my own practice this has been the case for several years. Apart from the fact that it is more convenient for the patient and

more economic of transport, it would not be possible, with our staff and the time and space available in the surgical outpatient department, to see all such patients. By referring most back to the care of their practitioner, which in this area (from which Dr Loudon writes) is done with no little confidence, we have more time available for those who particularly need hospital follow-up.

It is the practice in this as in other areas for medical and surgical consultants to conduct outpatient clinics in peripheral hospitals and health centres—for example, seven different centres are visited by general surgeons from the John Radcliffe Hospital and seven by general physicians, quite apart from the orthopaedic, ENT, rheumatology, and other specialist clinics which are held. The purpose of these visits is threefold: to see urgent new patients before a hospital appointment is available; to ease the follow-up of the young, the old, and the unwell; and to ensure regular contact between specialist and practitioner. The last should answer the plea in Dr Loudon's ultimate paragraph.

With increasing hospital specialisation the referral of patients by general practitioners is to more and different outpatient departments than in the past and this may contribute to the "reality so far as long-term care is concerned" as Dr Loudon sees it. Two suggestions come to mind to help improve this unnecessarily gloomy account, so far as this area is concerned: firstly, fuller use of the existing resources available at the peripheral hospitals and health centres; and, secondly, a means (perhaps by recorded telephone message) by which hospital staff might at any time transmit without delay to the practitioner's surgery or health centre up-to-date information, particularly that referring to the patient's discharge from hospital and the necessary follow-up requirements.

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Epidemiology and clinical practice

SIR,—I read with interest the letter by Professor E D Acheson and colleagues (26 April, p 1122). I think there is no doubt that epidemiology adds a dimension to clinical methods and can often be employed in the sort of situation general practitioners encounter.

Among its great uses are to survey populations at risk and to define risk factors and disease entities which would otherwise not be obvious when the size of these problems is unknown. I think it is worth saying that these problems are not always appreciated in general practice, but if good epidemiology methods are used they can be quantified.

There are, of course, great opportunities for epidemiological research in general practice and we are perhaps unique in having a fairly well defined population under our care. This means that a clinician can look at the whole group of patients and be informed on the clinical aspects of disease in a fuller manner than observers of a bigger population can do. These patients are actually under his care and remain under surveillance for many years. The situation, I am sure, does not hold in the rest of the continent of Europe, or in the United States, where it is very difficult for