of the need or tendency to use several drugs concurrently. Patient treatment profiles could well be kept by pharmacists, and this would surely be valuable to the doctor and essential to the deputising doctor who often prescribes "cold" without knowledge of either patient or drug-taking record. Pharmacists could well carry out more safely than the receptionist repeat prescribing or referral back to the doctor.

Many years ago I enjoyed an apprenticeship where my master and fourteen doctors had absolute mutual respect and trust and would have died rather than let each other down. We need discussion as to how we help each other and co-exist, but you have made a commendable start and I congratulate you. Let us go forward to greater respect for each other and stop griping.

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Mersey Regional Health
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Health Service Commissioner and the Rhyl case

SIR,—In his understandable wish merely to summarise the disturbing features of the incident at Rhyl, Dr David Williams (14 October, p 1090) gives insufficient detail about the factor of the wishes of the patient in the case.

As I understand it, the patient did not wish to be admitted to hospital. If that were so, she could, I think, be detained if she required to be removed to a place of safety; but indeed she wished to return to one. Otherwise she could only be detained under the Mental Health Act 1959.

But the Government is in process of loosening the compulsory clauses of that Act, and the Select Committee of the House must be well aware of it. So while some eminent ladies and gentlemen may individually or as a group consider that it may have been "inhuman" to send the patient back to the home, it would have been *illegal* for the doctor to have detained her, and might become even more illegal in the future!

For the Ombudsman and Parliament, then, the score is still Rhyl—nil.

JOHN HAPPEL

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Medical manpower: the next twenty years

SIR,—You have published an extract of the DHSS paper on medical manpower (7 October, p 1032); it makes depressing and discouraging reading. It is not a paper really, but a long list of questions for the profession to answer and offers work for several working parties for the next decade, by which time we shall have the answer, correct or not, in the number of medical students going through universities. One of the questions is particularly banal, the one about increasing the productivity of doctors by the better use of technology. This is meaningless; doctors don't produce anything—we are physicians, which means that we use our treatments and our medicines against diseases which affect people, and we use our powers of persuasion, based on our knowledge of pathology, to try to educate people to follow a life style which is most

conducive to the maintenance of health: at least that is what I think we should be doing. Much of what I do could be done by a district nurse, a health visitor, a consultant, a priest, a social worker; but if it were that would not increase my productivity: it would reduce my work load—then I could take on more patients, and continue to delegate, thus still not increasing my productivity but elevating my income.

If we attempt to define the jobs of the different workers in health care, then we shall see the spectre of demarcation disputes and income differentials, two of the contributors to the present industrial unrest: better not to have that in medicine. Besides, I don't believe people should have to be ill if they wish to consult a doctor; we are counsellors as well as diagnosticians and therapists, and advice can be a powerful form of treatment.

Health is the most precious possession an individual can ever have, though few appreciate that until they have lost it. Doctors have enjoyed a unique privileged position in societies, though I doubt if we deserve it all. More doctors, however, will not mean better health. I am sure we have plenty of doctors in Britain: a ratio of approximately one for each thousand of population is a rich endowment of medical personpower. Why can we not accept this, and spend our energies more fruitfully studying what we do, instead of wasting time guessing how many of us should be doing it? I fail to see how any other organisation but the medical profession can be in a position to know how many doctors are needed. We should be giving the lead and telling the DHSS, not waiting for their long lists of questions and then entering interminable discussions and getting very little at the end of it. Can the BMA not be firm for once?

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Medical care in inner cities

SIR,—I have seen the further correspondence on this subject, including the letter from Professor D C Morrell (23 September, p 890) of St Thomas's Hospital Medical School (whose appointment includes patient care in its terms, and thus ensures he can practise what he teaches).

General practice was refinanced 13 years ago, which led to substantial improvements for a modest price. The Government should now lavish funds on academic departments in the subject. Such funding would permit experiments in the teaching of integrated primary care, would bring service and research to where it is needed, and provide a focus for practitioners, as our teaching hospitals do for consultants. London shows many of the problems of providing primary medical care, and yet at the opposite sides of "The Great Wen" neither the London Hospital Medical School nor the Royal Postgraduate Medical School have such academic departments—no wonder locally trained graduates choose Winchester, not Whitechapel.

Professor Morrell regards the question of recruitment to practice as crucial, and doctors qualified abroad have gained experience as assistants which gives them a great advantage with selection committees. However, Professor Margot Jefferys found in Camden that many single-handed, isolated, elderly doctors were immigrants who had escaped religious per-

secution and settled for what little opportunity was available.¹ Our young overseas doctors also settle in the inner cities, as there is little local competition for these posts, and this perpetuates the problem of isolation. This also occurs in the inner cities of the United States.

The GMSC and Government should negotiate an age of retirement for practitioners working in the health service, to be brought into line with other doctors. This would deal honourably with the isolated elderly doctors, and make way for the more active service of local need.

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¹ Sidel, V W, Jefferys, M, and Mansfield, P J, *Journal of the Royal College of General Practitioners*, 1972, 22, suppl No 3.

General ophthalmic services—a practical alternative

SIR,—The general ophthalmic services cost 1.2% of the total NHS budget: an estimated £96m in 1978.¹ One-third of this is spent on sight tests and around six million pairs of NHS spectacles are issued yearly. The Prices Commission was recently reported to be investigating the cost of spectacles, so it is perhaps time for an objective re-examination of the long-standing agreement between the NHS and private opticians over the sale of spectacles to the public.

It was once considered deplorable that many people bought their reading glasses in multiple stores, but that was before the days of free access to general and specialist medical care. In many countries that have universal health care there is no such prohibition of the free sale of reading glasses, the demand for which is overwhelmingly from persons aged over 40, without eye disease or astigmatism.

When in Canada I preferred not to have the free refraction to which I was entitled from an ophthalmologist under Provincial Health Insurance, but I chose instead an excellent pair of reading glasses for \$5.50 from a multiple store. I still prefer them to the rather utilitarian NHS pair that cost me twice as much over here, with an additional charge to the NHS. I have in front of me a mail order catalogue from the USA advertising reading glasses in attractive two-tone frames for \$3.95. Such glasses are often accompanied by a leaflet describing the symptoms of serious eye disease and this could be made mandatory.

The free sale of reading glasses would undoubtedly reduce the financial burden on the public and on the NHS and would allow the ophthalmic services to concentrate on more complex cases.

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¹ Office of Health Economics, *The Cost of the NHS*, Briefing No 7. London, OHE, 1978.

Staffing structures and racial discrimination

SIR,—It was inevitable that the Race Relations Board would interest itself in the fortunes of coloured doctors within the hospital service; after all, there is apparent evidence of widespread discrimination. Coloured juniors tend to be employed in the periphery rather than in teaching centres. Recently published figures