example of a definite and in the event expensive change of policy without finding out properly first whether it worked or not.

Shaw maintained that all progress depends on the unreasonable man. I am going to be unreasonable and say that I think that the objectives of RAWP—namely, a more equitable distribution of health resources nationally—are admirable, but I do not think they go far enough. The underprovision of resources for Trent is obscene when compared with the relative wealth of North-east and North-west Thames. The rest of us lag a long way behind the London area, but in a roughly comparable but less urgently demanding way. In the event it is probably not possible to devise a fairer method than the RAWP formula. The main imbalance lies between London and the rest of us, and it will be a long time before extra finance is likely to be available for the Health Service.

The DHSS therefore, it seems to me, must think a little harder about what to do with Greater London. The imbalance of health care within the London area is in its way just as striking as the contrast of Thames generally with Trent; or perhaps the contrast between Canterbury and inner London. The problem seems to be the gross overprovision of very expensive facilities in the inner London area. The siting of health facilities has just not followed the shift in population. Planning in the Health Service is so slow and capital building so underfinanced that we have been quite unable to provide the flexibility needed to keep pace with modern conditions. We have spent very large sums of money on expensive provision of prestige centres in inner London when the population has gone to live somewhere else.

We must be very careful that by reallocating finance we do not do irreparable harm to our excellent London teaching and postgraduate hospitals. I would be the last to advocate damaging our prestige hospitals. They are far too valuable and have done so much to develop health care nationally and internationally, but *they are in the wrong place*. They should follow the example of St George's Hospital and move to where the population is. I suspect that we could with profit amalgamate the specialist hospitals into two centres—one for London and, say, one for Birmingham or Manchester. We should have the courage to move two or three of the London teaching hospitals to areas where large populations exist and attach them to a university without a medical school—for example, Exeter perhaps, or York. This would entail an enormous upheaval for the staff concerned and they would need to be treated generously and with great sympathy. Nevertheless, other areas would benefit by the bringing of staff of great skill and experience to underprivileged areas where there would be no shortage of work, and the status and excellence of the hospitals would be maintained. They would have a clearly defined sphere of influence to serve, keeping of course their undergraduates by establishing new university medical schools without increasing the overall number of students. The problem of inner London would be at least part way solved by such a move. Perhaps the third teaching hospital could move out to peripheral London to where the people live.

I have no doubt this letter will cause anger and dismay, and sadly nothing will probably be done and I shall have merely merited much abuse. But cannot we have the courage

occasionally to open our eyes and *look* at our problems? The plain truth is that we do not distribute our health resources overall either rationally or fairly. A patient has a reasonable right to good health care within reasonable distance of his or her home, whether that patient lives in the north, south, east, or west of England. As caring doctors we should have something constructive to say about that.

A K THOULD

Royal Cornwall Hospital (Treliske),
Truro

¹ Department of Health and Social Security, *Sharing Resources for Health in England. Report of the Resource Allocation Working Party*. London, HMSO, 1976.

² Department of Health and Social Security, *Priorities in the Health and Social Services: The Way Forward*. London, HMSO, 1977.

Emergency in emergency departments

SIR,—How widely is it known that the accident and emergency departments of Britain may all shortly have to close?

The result of the revaluing of the junior doctors' pay, involving the payment of varying extra units of medical time for hours of duty rather than amount of work done and responsibility taken, has been to make work in the accident and emergency departments less attractive than ever before. Invariably the appointees to accident and emergency departments are now the least experienced of all senior house officers. Even in rotating posts it is policy that work in the accident and emergency department is the first undertaken. If it is arranged later doctors will default before moving to accident and emergency work. Repeated recent advertisements for posts in accident and emergency work only have elicited no response or have attracted an occasional overseas graduate with no previous experience of work in this country.

It should be accepted by general practitioners and consultants alike that the accident and emergency posts in our major hospitals should be the last posts not to be filled if there is a shortage of doctors. Further, where posts are not needed for training, it could be a career grade for hospital doctors without specialist degrees.

The whole pay structure needs urgent reviewing so that any doctor undertaking resident hospital posts progresses to the accident and emergency department after his other posts because it is the most highly paid in that grade. This rate should be related to hours first on call and possibly graded in proportion to the work load of the accident and emergency department concerned. Only by arranging this can we attract doctors with the necessary width of experience to work in our accident departments.

CYRIL C SLACK

Orthopaedic Department,
Tynemouth Victoria Jubilee
Infirmary,
North Shields, Tyne and Wear

Decline of visiting

SIR,—I have long been perturbed about the increasing tendency for visiting to be kept to a minimum and sick people brought to the surgery. However, I have now heard the ultimate.

A patient 10 weeks short of delivery began to lose liquor and blood at 4 am. At 7 am, not having wished to disturb her doctor earlier,

she rang through to her GP and the answering phone put her on to a deputy. She carefully explained the situation to the deputy (incidentally, a lady doctor), who told her to "come to the surgery, which starts at 9 am."

A E LODEN

Tunbridge Wells, Kent

Points from Letters

Human tick infestation in Britain

Drs I P GORMLEY and J A RAEBURN (Edinburgh) write: Dr J A Slater (29 October, p 1158) expresses an interest in tick infestation in Britain. From personal experience we know that man commonly acquires ticks in the hill-farming areas of the North-west of Scotland which have carried infested sheep and cattle. Holidaymakers and children are most prone to these parasites while walking or sitting in long grass or heather as, unlike those working with stock, their clothing often leaves areas of skin uncovered. . . .

Dr T NORMAN (Blandford, Dorset) writes: . . . Ixodid ("hard") ticks occur commonly in this country where cattle and sheep are grazed, particularly on old, unploughed pastures and downland, and can be a nuisance to the minority of humans whom they like to bite. I find that these tiny ticks (presumably the nymphal stages) take 12-24 hours to become firmly anchored, when they will make their presence known by a red, itchy patch. If found early enough they can be pulled off fairly easily. . . .

Dr ELEANOR P BUTLER (London SE3) writes: Experience with tick infestation in our spaniels has led us to a treatment regimen quite suitable for any human being unfortunate enough to be attacked. The tick can be anaesthetised by placing a Mediswab or pad soaked in ether over it for two minutes. It can then easily be lifted off (head and body together) with forceps. . . .

Dr ELIZABETH J F HARRIES (Wellington, Somerset) writes: . . . The treatment is to squeeze (or singe) the body of the tick—I do it by pressing hard with my fingers protected by a tissue. The embedded head thereafter drops off without further harm. It is a mistake to attempt to pull the ticks out. . . .

Dr T L HENDERSON (Grantown-on-Spey, Morayshire) writes: I was interested to read Dr J A Slater's lively account of his tick bite (29 October, p 1158). May I recommend that when next *Ixodes ricinus* fixes on him to feed he treats his visitor to some topical whisky or methylated ether or even a burn with a lighted cigarette. Removal of the hard tick is then much easier and is more likely to be complete, so that local reaction is much reduced. In over 20 years of practice in Strathspey I have never seen any systemic reaction from, or illness subsequent to, tick bites in human beings, and such bites have been seen in people of all ages from larval, nymphal, and adult ticks. . . .

*.*This correspondence is now closed.—Ed, BMJ.