LETTERS

Access to Radiology

Sir,
I would like to take the opportunity through your columns to thank all the Faculty Secretaries who replied to my letter enquiring about access to radiological facilities by general practioners. As expected, the picture is variable throughout the country, from total access to none at all.

The document from the joint Working Party of the RCGP and College of Radiologists (September *Journal,* p.528) is to be welcomed, but is valueless if it is not used as a lever in these areas where access is still denied or inadequate.

The denial of access, in some cases as a decision without discussion, cannot be tolerated and we must stand firm with our colleagues on this important matter, as it threatens the professional discipline and status of general practice.

The details of problems with access provided as a result of replies to my enquiries will be raised at the next meeting of the RCGP/GMSC Liaison Committee for further discussion.

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Health Service Planning

Sir,
As a general practitioner turned planner I was encouraged by your editorial "General Practitioners and National Health Service Planning" (July *Journal,* p.389). Doctors frequently complain that planning and decision-making are being taken over by the administrators and I can confirm that this is the case: not because of administrators' sinister ambitions but by our own default.

Doctors have not become less responsible, but have failed to adjust to changes in the nature of the decisions necessary. The days of relatively uncritical NHS expansion have passed and we are faced with assessing priorities, examining options and determining the best use of limited resources.

This requires value judgements about different patient services, medical specialties, treatments and procedures which must be made, with or without sound medical advice. Should clinical doctors be involved in this process? Opting out reduced the role of the doctor to that of a medical technician, but the presence of doctors on District Management Teams can only be logically justified because of the breadth, rather than the depth, of their contribution. Many other professions are now working with us and demanding equivalent status, and doctors will be able to maintain their privileged position only if they have more to offer than their technology.

Why have District and Area medical committees been so disappointing that their abolition has been recommended? Hospital consultants have long been used to offering advice to managing authorities, but only within the confines of their specialties; if not taboo for one specialty to question the priority of another, it certainly is not cricket. Maybe it is desirable for the specialist to retain this single-minded approach, but if so, consultants will have little part to play in the major decisions of the future.

General practitioners, because of their broader viewpoint, have far greater potential for giving the type of advice authorities need, but firstly they have been unfamiliar both with the task of advising management and with the detailed, hospital organizational matters which have unnecessarily dominated agendas; and secondly they have lacked the confidence to question the views of consultants on hospital service issues.

While they cannot challenge the specialists within their fields, no-one is better placed than general practitioners to assess ultimate benefits to the consumer and to judge which service deficiencies most need improvement. Lack of such critical examination produces 'shopping list' advice which the authority cannot use, thereby frustrating the advisers and diminishing the credibility of the profession.

The present system has had many successes but needs more time to develop. If the proposal to abolish joint medical committees had not come from a medical group, one would have suspected a deliberate attempt to emasculate the profession. There would be an absence of coordinated medical opinion and another triumph for the divide-and-rule principle.

Admittedly, the quality of planning in the NHS to date has been poor, with much wasted effort, but this must not discourage doctors from maintaining their seats around the planning tables. All doctors, and especially general practitioners, must give serious attention to these matters in the months ahead.

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Spring Meeting

Sir,
I feel compelled to reply to Dr Preston-Whyte's letter about the Spring Meeting in the July issue of the *Journal* (p.445). The organizers have received a considerable number of letters congratulating them on the academic content of the meeting which are at variance with his opinion.

On the question of lack of discussion: each participant was provided with a summary of the lectures and a list of statements relevant to the topics which we thought would be worth discussing. A covering letter with these papers explained that with such a large audience (400+) individual participation is difficult and this was an attempt to overcome the problem. Members who have attended a number of Spring Meetings felt that this innovation had been successful.

It seems unfortunate that the letter published did not note the efforts made to overcome the passive situation of the lecture.

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Hypertension in Finland

Sir,
I was very surprised to note that Dr. J. Tudor Hart (July *Journal,* p.442) had entirely misunderstood what I was saying in my article (April *Journal* p.239.) On the basis of this misunderstanding Dr Hart then heavily criticized my findings. Obviously we wrote about different things.

According to Dr Hart, I found a total of 169 patients from a health centre population of 14,500 identified as hypertensives. What I said was, however: ". . . I listed the names of those persons, who in 1975 had received the right to free antihypertensive medication. . . ", which means that I was not talking about the prevalence of hypertension nor even about the annual incidence but only about all those persons who during the year 1975 received the right to free antihypertensive medication in that district. Every year since 1970 some people have received and will receive these rights. The annual number depends on many things, their own activity and the activity of their doctors among others. Taking everyone who received this right during one particular year, and then these same persons again two years later, allowed an evaluation of the effectiveness of the free medicine scheme with this particular cohort of patients and an assessment of the quality of hypertension care in this particular health centre district. All of these patients had already been treated for various lengths of time before the certificates for free medicines were written by the doctors.

The mean pretreatment pressure for the whole group, which to Dr Hart seemed to be missing, was not given because the doctors had not indicated the pretreatment readings for all the patients in their certificates, from which this piece of information was abstracted. However, in this particular context, this omission is not important. Considering the free treatment programme one might even become curious about whether, in fact, the patients with missing pretreatment information (27 out of the 169) were hypertensives at all, or were merely taking their free medicines on their doctors' prescriptions.

In my article I clearly explained my criteria of the therapeutic outcome assessment and it is up to the readers to accept them or not.

Finally, I do not believe that the findings I presented discourage medical teams, as Dr Hart seems to fear. On the contrary findings such as mine should encourage doctors to study more closely what they are doing and to learn more about their daily activities. Such learning could then be used to improve the quality of care and the health status of the patients.

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Prison Medical Services

Sir,

There has recently been a surge in interest and controversy regarding the ill-treatment of prision inmates.

Last year there were some 2,800 complaints against the police alleging assault of prisoners. No systematic attempt to measure the prevalence of injuries in custody has been attempted, although some suggest that maltreatment in custody is far from rare and is more frequent than the public realizes or the authorities care to admit. Should these allegations be true, there is a need for closer supervision, particularly at the time of interrogation, to eliminate the possibility of assault. The fact that some injuries are self-inflicted is noteworth.

I use, by way of illustration, the example of a 43 year old, unmarried-labourer with a criminal record for offences of theft and violence. He presented himself at a night shelter complaining of severe ear ache and difficulty in hearing.

This man had an unspectacular medical history. There was no abnormality in the cardiovascular system, central nervous system or respiratory system. On examination, the ear canal was completely obscured by wax. There was a puzzling, shining object just visible, the nature of which could not be discovered because of the large quantity of wax present. The ear was syringed and it was then seen that a large, coarse, piece of tin foil had been embedded proximal to the ear drum. The foreign body was removed and it could be seen that the ear drum was severely scarred. There was increased vascularity of the whole tympanic membrane.

After some close questioning it transpired that he had inserted the piece of foil into his ear and had pushed it as far as possible into his ear with a pencil. He admitted that this process had been extremely painful and the only explanation he could offer for this behaviour was boredom while in prison.

This sort of injury is commonly considered not to be self-inflicted and I believe there is no similar report in any medical literature. I frequently encounter individuals who claim to have been assaulted by the police but it soon becomes apparent that their injuries were sustained before their arrest (usually while drunk) and later conveniently attributed to police brutality.

The prisoners' rights group (PROP), supported by the Howard League for Penal Reform, have recently called for the prison medical service to be disbanded and for the responsibility for prisoners' health to be transferred to local NHS doctors of the prisoner's choice. The fact that many such individuals are not registered with a general practitioner has been overlooked, and many doctors are unaware of the devious nature of such individuals.

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We showed Dr Shanks' letter to the Assistant Director of the Howard League for Penal Reform, whose reply follows:

Sir,

Your correspondent is right to suggest that some allegations of assaults on prisoners are ill-founded, but this in no way weakens the case for abolishing the Prison Medical Service and integrating its services with the normal community health agencies.

The problem of self-injury is not essentially different from that of self neglect, and doctors have to deal with many such patients each day, whether they neglect their health through smoking, excessive drinking or overworking. It seems wrong to point to special groups as being especially neglectful.

In fairness it should be noted that homeless people frequently find that general practitioners are unwilling to take them onto their lists. I have known of many cases where homeless people and those who assist them have gone from surgery to surgery without success. I am afraid that Family Practitioner Committees are sometimes unable to rectify these problems promptly.

The questions posed by medical services are quite different again. Should doctors for prisons be appointed by the same authorities who manage the prison service? Should prisoners have the right of access to alternative medical advice when they want it? At present, this is permitted only if either the Prison Medical Officer allows it or if the prisoner is a party to litigation where medical evidence is material.

All doctors working in prisons in England and Wales are appointed by the Home Office's Prison Medical Service. Most work full time in prisons, although a few are NHS doctors, who work part time for the Home Office. It is wrong in principle that the Home Office, which is responsible for managing prisons, should also have the responsibility to appoint doctors. When there are not infrequent allegations of brutality and when living conditions