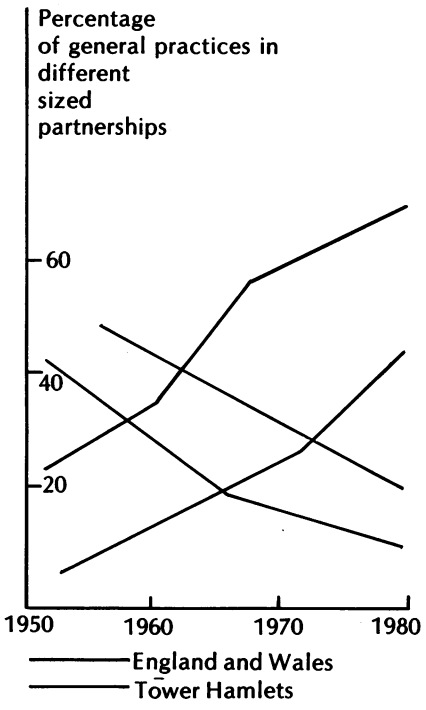
The General Practitioner in The Inner City

Sir,

The paper by Drs Heath and Sims (April *Journal*, p.199) surveying general practice in Tower Hamlets confirms much of what has previously been reported on the state of inner city primary care.[1,2] In particular they stress poor premises, lack of functioning teams, little emphasis on prevention and inappropriate postgraduate education.

We have recently completed a survey of changes in general practice in the east end of London over the past 40 years.[3] Using past executive council records we have been able to plot the changing size of partnerships in Tower Hamlets compared to those in England and Wales. (Figure 1.)

Figure 1. *General practitioners in single-handed practices and in partnerships of more than 3.*



These figures demonstrate that the development of general practice in Tower Hamlets, as measured by partnership size, is lagging behind that of the country as a whole by about fifteen years.

Some of the factors contributing to this are:

1. The continuing environmental blight following war damage and redevelopment.
2. The difficulty of improving premises. High site values and the administrative and financial obstacles associated with building and converting in London are problems which are not solved by the cost rent scheme. Moreover, the GLC and local authority, owners of much local land, do not consider providing sites for doctors' surgeries as a priority.
3. The lack of a coherent plan for general practice services, compounded by the absence of a fixed retirement age. In an area of social deprivation and unusual need this lack of planning becomes clearer.

However, changes are occurring. Since the inception of the vocational training scheme in 1979 almost 50 per cent of trainees have settled in this area. These form part of a corps of younger doctors who expect to work in teams and to have relevant postgraduate education organized by general practitioners. The recently founded department of general practice is an encouraging development, but its success in promoting change will be related to funding.

Innovative schemes, such as attaching young principals to elderly general practitioners with a commitment to retire, could harness a shift towards anticipatory care whilst retaining local knowledge and maintaining continuity of care. These will need extra finance, as will developing primary care teams by increasing the very low level of attached staff in Tower Hamlets. Staffing levels need to be increased as hospital cutbacks take effect and early discharge continues. Indeed, any proffered solutions will need money. There has been official recognition of the problems for some years now, but a reluctance to implement changes which may be costly.

General practice services are both cost effective and potentially adaptive to their populations. At present there is a pressing need for investment in premises, practice organization, teamwork and appropriate education in order to allow general practice in Tower Hamlets to develop.

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References

1. London Health Care Planning Consortium. Primary Health Care in Inner London (Acheson report) *London LHPC*, 1981.
2. Jarman B. A survey of primary care in London. Occasional paper 16. *RCGP*, 1981.
3. Unpublished report. Presented at the General Practice section of The Royal Society of Medicine 1984.

Protection against Tetanus

Sir,

I was interested to read H. R. Guly's letter (April *Journal*, p.246) on protection against tetanus. I would like to add the following:

Normally a booster dose after a tetanus-prone wound need not be given within five years of a previous booster dose in persons who have had the full course of immunization.

Tetanus vaccine became available for use with Armed Forces personnel in 1938. Male patients who were in the British Forces and fought during the Second World War were fully immunized. A considerable number of male teenagers would have received tetanus immunization during their period of conscription in the immediate years following the war.

While many health authorities had provided tetanus vaccination previously, it was not until 1961 that childhood immunization against tetanus was recommended nationally by the DHSS. Tetanus vaccination was also offered to members of groups who were at particular risk, for example farm workers.

Administration of tetanus toxoid during the first year after a booster is contra-indicated. If a patient who has not been in the Armed Forces and was born before 1961 cannot recall whether or not he/she had a full antitetanus course, one may consider performing yearly vaccinations for three years (full course).[1] This is something the casualty officers should have in mind. On many occasions patients attending casualty departments are given indiscriminately a tetanus course or a letter for their general practitioner with instructions to complete the tetanus course.

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Reference

1. Kassianos GC. When not to immunize: a check list of precautions. *Modern Medicine*, October, 1983.

Demands Made on General Practice by Women Before and After an Abortion

Sir,

Normally I find your *Journal* lucid and illuminating, and it was therefore with dismay that I read this article (June *Journal*, p.310). Several points were unclear and/or inaccurate.

The abbreviation TOP and the con-