their local cottage-hospital rather than many miles distant from friends and family in a big sterile impersonal clinical setting.

You quote Nye's 'efficient if cold altruism'. While we need to question the efficiency of the organisation of larger institutions and distances, we also need to take a moment to consider their 'altruism'. The 'big hospital' is no longer altruistic in its management style or operation: it works for money from the commissioners of care, and often is seen as being sly in its pursuit of profit. A number of the staff remain altruistic, enthusiastic, and dedicated, but this attitude does not fit with management styles, and is being actively driven out of clinical staff, with barriers to flexibility and altruism and rewards for the opposite throughout juniors' careers. We can already see the effects; no longer looking at what is possible, but at what seems to benefit the individual, in terms of career progress.

We need a shift in managerial attitude away from the merely financially measurable, to a holistic approach to all the functions of the hospital. We need a pervasive change in attitude in the community, to rediscover the values of altruism, mutual support, and community pride. Many may consider these too close to religious aims or virtues, but is that wrong?

Real achievement can be made in the face of adversity outside huge institutions. If people will persist in getting ill and having accidents in our rural areas, it is prompt access to local services that is needed, along with the ability to tolerate difficult conditions, stabilise patients, and fix those who then do not need to make long, expensive journeys to big hospitals, rather than the ridiculous campaign for a big, efficient hospital right next door to every patient.

So, yes, I treat wet, muddy patients on occasion, and manage them in the expectation they will have a cold shower back at the camp-site, but also have to pick out those where I believe this will not do, and instruct them to get someone to drop them off at a 'big hospital' on the way home some hours later, or even commit one of our rare precious ambulances to do the job.

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Health inequalities in primary care

I was very pleased to read Chris Weatherburn's reply and to feel that my article may have prompted consideration of some important issues. However, the thought that I may be guilty of 'vague political rhetoric' and peddling abstract ideals prompts me to reply. Additionally, and less egotistically, I feel compelled to counter the implication that we, as GPs, are already doing all we can to tackle health inequities.¹

Social injustices will not get resolved in the consulting room. However, as I tried to point out, injustices can be exacerbated by our failure to acknowledge social determinants of our patients' health and behaviour. Or, as Dr Weatherburn more positively suggests, injustices may be ameliorated by efforts to empathise and respond to our patients' needs. But we can do more than that. Outside the clinic, the RCGP can advocate politically, commissioners can maintain this issue on their agenda, and researchers can provide evidence for decision-makers. The rest of us would do well to consider our own values and priorities, for, to a considerable degree, tackling this issue will demand that we are honest about whether, or to what extent, we are prepared to put social justice before self-interest.

Events this year have not been encouraging.

In March, Julian Tudor Hart had to remind us that progressive taxation was a fairer way of funding the health service than means-tested patient charges (co-payments).²

In May, Alan Milburn highlighted the 'palpable unfairness' limiting access to careers in medicine for people from poor backgrounds. 'Medicine has made far too little progress and shown far too little interest in the issue of fair access,' he said, warning of a society of 'entrenched disadvantage at the bottom'.³

In June, the BMA's strike action prompted *The Daily Telegraph* to cynically quote back to us the words of RCGP President Iona Heath: 'Dr Heath has written [that] people motivated by "economic self-interest" are "indifferent to the fate of others". I wonder whether she will be going on strike...'⁴

As members of a profession committed to improving people's wellbeing I feel certain that we are capable of making more positive contributions toward resolving health and wealth inequities in the future. My article was intended to prompt discussion rather than to claim to define solutions. Nonetheless,

it is apparent to me that while the problem of wealth and health inequity worsens, any amount of complacency is not an answer.

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Possible increased potency of current levothyroxine

Last year one brand of generic thyroxine marketed by Teva was withdrawn by the MHRA. This followed reports of concerns about its effectiveness, including those highlighted by the Vision users group. Since then we have seen an increase in patients with abnormally high T4 levels and suppressed TSH levels in our practice.

An audit comparing thyroid results last year when Teva thyroxine was available and the present time shows a significant rise in T4 levels in some patients who have remained on the same dose of thyroxine throughout.

There may be several reasons for this, including increased potency of current generic thyroxine, changes in concordance, changes in drug interactions, and changes in laboratory testing.

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