Letters

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Editor's choice

The second RCGP Health and Justice conference was held at Rampton this September. The consensus position of the conference agreed that more can be done to help prisoners who reach the end of their lives while imprisoned. Both Rampton Hospital and Whatton Prison demonstrated the excellent end-of-life care facilities which they have developed to treat prisoners who choose to or are required to die in a secure setting. The Prison Reform Trust revealed remarkable statistics that only approximately 10 prisoners per year are released from prison to die in the community either in their homes or in a hospice.

The RCGP Secure Environments Group and clinicians who work in secure settings from across the UK call on the Ministry of Justice to review the strict criteria which mean that only a tiny number of prisoners who are at the very end stage of their lives are allowed early compassionate release or release on temporary licence to die in the community. There are many cases where prisoners are clearly only days or weeks away from an expected death yet they are forced to die in prisons.

Marcus Bicknell,
Chair – RCGP Secure Environments Group, Nottingham.
E-mail: seg@rcgp.org.uk

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The future NHS: time for another change?

How I agree with Roger Jones' insightful editorial.[1] The NHS has experienced an artificial (but nonetheless increasing) divide between primary and secondary care for nearly a quarter of a century now. A parlance has evolved which incorporates concepts such as 'spend' 'provider' and 'activity'. It is regrettable that a whole generation of young medical and nursing staff don't know any different.

Prior to leaving general practice a year ago I crossed the primary/secondary care divide for 1 day a week working as a GP with special interest in acute medicine. It was soon apparent that not only did staff in emergency departments speak negatively about 'the GP' or 'the community' but neither had they the slightest idea what went on outside their establishment. Surprisingly perhaps the converse was also true: hospital practice has changed out of all proportion since many of us were juniors.

I still believe that being a GP is a wonderful career and things can only go upwards. However it is no coincidence that the most common question I was asked by junior hospital doctor colleagues and those that I trained was how to become a GPwSI in acute medicine.

Michael Houghton,
Leagram, Nr Preston, Lancashire.
E-mail: mike.houghton@nhs.net

REFERENCE

1. Jones R. The future NHS: time for another change? *Br J Gen Pract* 2014; **64(628):** 550–551.

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Delays in diagnosis of young females with symptomatic cervical cancer in England

Thank you for an interesting article which highlights the role of cervical visualisation in the timely diagnosis of cervical cancer and suggests that some GPs may forego pelvic examination (PE) despite the presence of abnormal vaginal bleeding.[1] A male medical student who had just completed his primary care attachment told me that during a supervised surgery, a patient presented with a gynaecological condition. As he was unable to do the required PE he advised the patient that the supervising female GP would do it instead. The GP responded by stating that no PE was required as the patient would be referred to secondary care regardless of whether an examination took place or not.

I cannot think of any other body system that a GP would not examine prior to referral. Pelvic examination is more difficult than placing a stethoscope on a patient's chest in terms of time, chaperone requirements, issues of embarrassment for patients, etc, but I find it difficult to accept that the way to deal with these difficulties is to not do it. The history provides the majority of referral information but examination is vitally important in how we determine the nature of referral, routine or urgent, and how it is triaged in secondary care.

The evidence base for PE in primary care is limited, but what we do know is that performing PE does reduce the diagnostic interval in those diagnosed with a gynaecological cancer. Until we have a complete understanding of the role of PE in primary care, it must continue to be an integral component of our practice.

Pauline Williams,
Academic GP Fellow, University of Aberdeen.
E-mail: pauline.williams@abdn.ac.uk

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1. Lim AW, Ramirez AJ, Hamilton W, *et al.* Delays in diagnosis of young females with symptomatic cervical cancer in England: an interview-based study. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X681757.

DOI: 10.3399/bjgp14X682645

Vision loss as a presenting symptom of type 2 diabetes mellitus

We read the article on sight-threatening diabetic eye disease with interest,[1] and would like to report an unusual case of undiagnosed type 2 diabetes mellitus presenting as visual loss. A 41-year-old male kennel owner presented with a 2-day