of a maximum of 56. Their resultant salary cuts will not be used to increase manpower because limits have already been set; instead working conditions are to be made even more deplorable.

A militant group of junior hospital doctors, many of whom will spend a mere two to three years in hospital medicine, all too vocally campaigned for these unconditional settlement terms. Inexperienced, fresh from medical school, and possibly destined for non-hospital careers, their blinkered militance and short term career aspirations have blinded them in their consideration of their less vocal, more senior colleagues, many of whom are destined to spend 10 or more years in junior hospital posts. For them they have effectively negotiated a 20% salary cut while for themselves they have earned a welcome reduction in what I accept were unacceptably arduous rotas.

Before the dictat is finally implemented an urgent revision of all one in two rotas must be undertaken. A distinction must be made between resident and non-resident rotas. Doubtless the minister will resist any move which will result in the loss of new found revenue. The committee must return to the negotiating table to protect the interests of those who innocently suffered as a result of their impetuous campaign. Reinstatement of selected rotas cannot be decided at regional level. Ministerial approval is called for. That approval will be forthcoming only if the committee moves swiftly before the infrastructure is dismembered.

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1 Coulter A, Noone A, Goldacre M. General practitioners' referrals to specialist outpatient clinics. *Br Med J* 1989;**299**:304-8. (29 July.)

General practitioners' referrals

SIR,—The articles by Ms Angela Coulter and her colleagues are timely in view of the fact that we must soon make contracts with hospitals to which we refer patients.[1]

I looked at referrals in our practice of 13 000 patients. Within three months in 1989 we made 564 referrals, 52 of them outside the district. We used 25 hospitals outside our district, many of them in London, where we were seeking specialist opinions. Nevertheless, referrals from general practice underestimate the number of attenders at outpatient clinics because they exclude tertiary referrals and patients attending hospital for follow up. For example, in July we referred patients to eight hospitals outside our district but we had incoming letters from 20. Data about referral patterns certainly could be collected by general practitioners, but there would be an element of inaccuracy as incoming letters do not correlate with the number of outpatient attendances, since hospitals may not write a letter or they may write more than one letter for one outpatient attendance if tests have been carried out. If hospitals collected their data about referrals they could identify general practitioners by using the general practitioners' NHS number.

If health authorities and practices with budgets are to arrange contracts by 1 April 1991 they probably need six months to do so. But they also need accurate information and that can be obtained only by surveying all outpatient and inpatient attendances in the whole NHS from 1 October 1989 to 30 September 1990. This does not seem likely to happen, but if the information is not collected the contracts made will not reflect current referral patterns.

I can understand the need for an internal market and for targets, but I suspect that the secretary of state did not realise the complexity of referral patterns when he thought of general practitioners contracting for services.

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NHS review

SIR,—Rumours abound of plans for general practitioners to introduce sanctions[1] as if we were borrowing a programme of action from anti-apartheid campaigners. They won't work, so what do we do?

Doctors must persuade the public that there is a better way to improve the health service and not just rail against the government's ideas. We must produce an alternative medical manifesto. The following suggestions come from an alternative medical manifesto drawn up by the 60 doctors of the Fareham Medical Society and emphasise what we want to help improve our service:

- The ability to offer longer appointment times, to give more time to patients so their health screening needs can be addressed as well as their illnesses—which means more doctors and smaller lists
- The right to prescribe without financial restraint coming between the doctor, the patient, and the most appropriate treatment while recognising the need for economic and rational use of the formulary
- The right of the general practitioner to refer patients to the hospital and consultant of his or her choice, and to demand specifically stated maximum limits for waiting times for appointments and subsequent procedures in all specialties
- Increased pressure from the government to encourage a high uptake of vaccinations and immunisations instead of trying to bribe general practitioners into forcing patients to comply
- A statutory limit on doctors' hours of continuous work
- Coordinated technology to allow general practitioners to communicate directly with family practitioner committees, hospitals, laboratories, and x ray and outpatient departments. This would improve efficiency far more than dedicating such technology to administrative and management roles.

How are we to achieve all this? We must re-emphasise that we are near the bottom of the league in the percentage of the gross national product that Britain spends on health care and dismiss government bleating about how much it has increased NHS funding, which has not been enough. And the method? More item of service fees, which are a good, well proved incentive that will not need new, untried administrative and management structures.

The BMA should spend some of its advertising campaign money on promoting constructive proposals: a general practitioners' medical manifesto is the answer. Public support will be overwhelming. Mr Clarke will have to listen as he knows this issue might cost his party the next election.

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1 Anonymous. Minister imposes GPs' contract as GMSC holds special meeting. *Br Med J* 1989;**299**:461. (12 August.)

Twenty four hour care in inner cities

SIR,—We welcome the paper by Dr A E Livingstone and colleagues on the high out of hours workload in general practices in deprived areas.[1] Their findings mirror our own in a detailed audit of our practice's out of hours workload from April 1984 to April 1985, and we strongly endorse their conclusions.

We practise in a large postwar peripheral council estate in a health centre with 7800 patients. Bristol City Council surveys identify the area as one of the two most deprived in Bristol. In our audit the total number of patient contacts, between 7 pm and 7 am on weekdays and 12 noon on Saturday to 7 am on Monday were 1635. Of these, 347 were between 11 pm and 7 am (44·5/1000 patients/year) and telephone advice resolved only 308 (18·9%); 1326 (81·1%) were visited, often because the extent of patient deprivation leads to inadequate telephone communication.

We link our high out of hours contact rate, particularly that from 11 pm to 7 am, closely to the extent of deprivation in families with children under 5 years. Children under 5 make up 10·8% of our list (the national average is 8%). In 66% of these families the major wage earner is unemployed; in 70% one or both parents are under 21; 48·5% are single parent families (often living in high rise blocks); and 30% receive support from social workers, probation officers, or the National Society for the Prevention of Cruelty to Children.

The high out of hours workload is mirrored in our daytime workload, which is linked to the higher morbidity levels of socially deprived communities. To give high quality medical care in deprived areas, where the medical and social morbidity is higher, we need much smaller than average list sizes, and our doctor to patient ratio is 1:1560 (national average is 1:2020). The implications for income are self evident, and the failure of the current system of remuneration to reflect workload, which depends on medical and social morbidity levels, concerns us. We expect the 1990 contract to worsen the situation. We are concerned that the Jarman index gives a comparatively low weighting to the "forgotten areas of deprivation" —the large peripheral council estates, where unemployment, morbidity, mortality, and numbers of preschool children are high.

We would like to make a cri de coeur on behalf of deprived patients and the health professionals serving them. The system needs to recognise that those most in need of health care are those who get sickest and those who are least able to help themselves. And the carers need the resources to do the job.

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1 Livingstone AE, Jewell JA, Robson J. Twenty four hour care in inner cities: two years' out of hours workload in east London general practice. *Br Med J* 1989;**299**:368-70. (5 August.)

Tunga penetrans: the tale of a physician

SIR,—Although we agree with Dr Janet McLelland and colleagues that tungiasis may become commoner as more people travel to the tropics,[1] we are concerned by their suggestion that its treatment is merely a matter of excising the flea and her eggs. Tetanus is a recognised complication of this condition,[2] and patients must be fully immunised against it.

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1 McLelland J, McLelland C, Cox NH. Tunga penetrans: the tale of a physician. *Br Med J* 1989;**298**:136. (8 July.)
2 Smit FGAM. Siphonaptera. In: Smith KGV, ed. *Insects and other arthropods of medical importance*. London: Trustees of The British Museum, 1973.