

whole family unit is the *local paediatrician*. Unfortunately, many paediatricians, while they hear of cot deaths, have little or no experience of them or of the problems involved—though I should emphasize that this does not apply to my own colleagues. We have heard of parents who have asked their paediatricians about cot deaths being brushed off with “We don’t see them,” “the experts argue about them,” “we know nothing about them—” paediatricians who treat children in cots and not in family units. Most paediatricians, however, are very willing to help these families—if asked. The very absence of this type of paediatric family support has led to the formation of self-help groups among parents of children sustaining cot deaths in several countries, and recently one had been formed in Britain and has produced some excellent literature for parents.*

Parent support groups for the families of children with chronic diseases such as cystic fibrosis or spina bifida can be of real help; the families in these conditions need *sustained* help and support. The best help that the parents in cases of cot death can have is that which diverts their energies away from the subject into other directions. Thus such guilds, while devised from excellent motives, are apt to be of more harm than use. Our local answer to this problem has been for the paediatric pathologist to see the parents, but it is not possible to continue this in any extensive way and this has now been superseded by a letter giving answers to the most common questions asked.

This letter has been given to the parents by the coroner’s officer at the same time as he gives them the Death Certificate. The parents are told to take the letter away, read it, and inquire to a specific person at the local children’s hospital if they need

* British Guild for Sudden Infant Death Study, honorary secretary Mrs. Jean Knight, 28 Ty Gwyn Crescent, Penylan, Cardiff, Wales.

further information. Such a letter has been modified and is used by the welfare committee of the new Foundation for the Study of Infant Deaths.† Such hand-outs, while perhaps helping in the end, do not prevent the present unnecessary trauma to the families experiencing such deaths and are no substitute for the help that could easily be given to the family by an interview with an interested paediatrician. There seems to be no reason at all why the coroner or his officer could not have access to the secretary of some local willing paediatrician and make an appointment for the parents to see the paediatrician at his hospital outpatients department. This would be done with the knowledge of the family general practitioner or instead by the general practitioner himself.

At the present time the cot death or sudden unexpected death of a child is a major problem in childhood care; it affects about one in every 400 children born. As was recently pointed out in a Northern Ireland survey,³ we have a definite concern with the attitude of mind of parents with a fear of a cot death.⁴ While at the moment we are unable to prevent these deaths we could do much to alleviate the family suffering associated with them.

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† Foundation for the study of Infant Deaths, honorary secretary Mrs. N. Hunter Gray, 10 Ripplevale Grove, London N1 1HU.

Hospital Topics

Cogwheel Report in Relation to the Smaller Hospital Group

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Though the first report of the joint working party on the organization of medical work in hospitals (Cogwheel report)¹ has now been implemented in some of the larger hospital groups so far this has happened in few of the smaller groups. With the increasing pressure from the Department of Health for all groups to adopt a form of medical administration along Cogwheel lines it seems opportune to give our personal experience of implementing this type of administration in a smaller group over the past two-and-a-half years and our views on future developments. The group contains a major district hospital and smaller satellite hospitals, a total of 901 beds (non-psychiatric), and has 50 consultants, of whom 40 are principally employed within the group. The recommendations of the Salmon report² have been almost totally implemented within the group by the nursing staff.

Medical Executive Committee, Peterborough and Stamford Group of Hospitals

F. J. FAWCETT, M.R.C.P., M.R.C.PATH., Secretary and Medical Staff Committee Representative
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Divisional System of Medical Administration

A system of medical administration with divisions and a small medical executive committee was adopted in the group shortly after the opening of a new district hospital. Soon afterwards 15 new consultants were appointed to the hospital staff, and many felt that the meetings of the medical advisory committee were rather cumbersome, with all the consultants present, discussing matters many of which were of little concern to the majority and coming to decisions which were sometimes changed the following month by a more vociferous member of the staff swaying the committee in the opposite direction. It was hoped that by meeting within divisions medical staff with comparable problems could meet together to discuss only the problems that were of concern to themselves and along with a small executive committee meeting at regular intervals could form a more effective administrative machine than the old medical advisory committee.

Future trends are now more apparent. They include area health boards and the development of powerful groups within the hospital environment, such as the new form of nursing administration envisaged in the Salmon report and the increasingly powerful area supplies department. Thus it is

essential that the medical staff have an equally streamlined form of medical administration to compare with these. It is also apparent that we are now in the era where team work within medicine is increasingly important, yet at the same time it is important to retain individuality.

Implementation of Cogwheel Report

The Cogwheel report needs tailoring to the requirements of each hospital group, and much of it is impracticable for the small group. Most consultants are suspicious of this new form of administration and fear that they will be organized by a few colleagues over whom they will have no control. This has been largely circumvented within our group by each division electing their own chairman, the medical staff committee appointing their own representative on the executive committee, and the provision of the right for all senior members of the medical staff to appeal against any decision made by the executive committee within seven days of the decision being made. These three amendments to the report reassured the medical staff and have worked satisfactorily in practice.

Divisions

In our small group we have three divisions—medicine, surgery, and pathology/radiology. The medical division contains all the physicians, both general and specialist, and the surgical division all the surgeons, including the gynaecologists and also the anaesthetists. Thus half of the medical staff are within the surgical division, but we consider it essential that in the smaller hospital group all users of the operating theatres should meet together within the same division to sort out their common problems. Nevertheless, if the surgical division becomes larger than its present 25 members it may have to be split into two. The divisions elect their own chairman and meet at intervals of four to six weeks. The various specialties within the divisions usually have a short meeting of their own before the main divisional meeting to consider any business to be put on the agenda of the divisional meeting or to formulate their views on other items on the agenda. Senior registrars, medical assistants, and clinical assistants are included within the division but registrars and house officers are not. Nevertheless, they may ask to be present at any particular meeting or discuss any business with the chairman of the division before the meeting. The senior nursing officers within the division may ask to come along to the divisional meetings to discuss matters or they may be asked to come to discuss a mutual problem. Group officers may also be invited along to discuss matters at the divisional meetings in the same way.

Medical Executive Committee

The medical executive committee comprises the chairman of the three divisions, the medical superintendent who was in post at the time the report was implemented, and the medical staff committee representative or ombudsman, who was thought necessary initially to safeguard minority interests and keep a watching brief on behalf of the medical staff committee. The divisional chairman and medical staff committee representative are elected for three years with annual review and are ineligible to be re-elected for a further three years. The medical executive committee elects its own chairman and also a secretary, who takes all the minutes and deals with the incoming and outgoing correspondence; nevertheless, the increasing work load is such that it will soon be essential to have a clerical officer present at the meetings to take the minutes, though we feel that it is important for one of the members to oversee their production and to be responsible for the correspondence.

The medical executive committee meets weekly, usually for about two hours. Business is received from the divisions, the group officers, the hospital management committee, and the regional hospital board. Some matters can be dealt with immediately but some have to be passed back to the divisions for their consideration. When decisions are taken by the executive without referral back to the divisions we have a "fail safe" mechanism. The minutes of each executive meeting are published the day after the meeting and any member of a division may object to any decision within seven days of its being made. The matter remains sub judice from the time of appeal until the objector can attend the medical executive committee to present his case. There have been fewer than 10 objections over the past two-and-a-half years, all of which have eventually been settled amicably and on no occasion has the chairman had to overrule an objection, which he can do in cases of extreme urgency.

The chairman of the executive committee meets the group secretary and chief nursing officer weekly when he presents the views of the medical executive committee and also brings back the views of these group officers to the next meeting of the executive committee. The chairman is also a member of the hospital management committee and is the group's representative on the regional medical advisory committee.

The Future

Hospital activity analysis has not yet started in the group so the present statistics are relatively crude. But those that are available are used to scrutinize the use of beds throughout the group, the waiting lists both for outpatient appointments and for admission to hospital, as well as the distribution of work load between the wards. It is essential that the medical staff are organized in such a way that they can ask for hospital activity analysis to provide statistics which evaluate their work correctly, rather than have only the statistics requested by the non-medical administrators.

The nursing staff are already provided with an annual budget and have a considerable say in how the money is spent. Probably now the medical staff are also going to have the opportunity to have a greater say in how the hospital budget is spent. But this will necessitate an efficient form of medical administration along the lines envisaged by the Cogwheel report and a closer link between the bodies concerned. The McKinsey type of administration as instituted in Oxford³ cannot be translated directly to smaller groups but some sort of adaptation would be needed, comparable to our own group's adaptation of the Cogwheel report.

"Cogwheel Administration" and Medical Staff Committee

Our medical advisory committee has been retained to act as a forum for discussion of terms and conditions of service of the medical staff in the broadest sense, and as it no longer advises the hospital management committee its name has been changed to the medical staff committee and now meets quarterly.

The hospital management committee and the regional hospital board have accepted that all local medical advice comes through the medical executive committee and that they address all medical questions to this committee and not to individuals.

Problems

The greatest problem for the medical staff in this form of administration is the large amount of time that the members of the executive committee have to spend on administration. This is partly offset by the saving of time spent by other members of the medical staff in committee as they now attend meetings only when matters of interest to them are being discussed.

We have been fortunate in our group that the executive committee has elected the medical superintendent as chairman of the executive committee. He has in the past spent a large amount of time on administration, so this position did not require him to radically alter his timetable. Nevertheless, in groups where the chairman does not already spend a large part of his time on administrative duties he must get considerable support from his colleagues within his specialty. But any clinician must be able to act as chairman either of his division or of the medical executive committee. The fact that one of our four consultant general surgeons is at the present time mayor of the city illustrates that many consultants can find time for this amount of administration if the will is there.

Any group contemplating setting up this type of administration must insist on adequate clerical help to assist both the executive committee and the divisions with clerical work and also to produce and collate the necessary statistics.

We agree with the Cogwheel report that it is difficult for hospitals with fewer than 20 to 30 consultants to have a divisional system of administration but consider that all but the smallest groups could elect a small executive committee from their medical advisory committee, who could then meet more

regularly than the main committee and come to decisions more quickly and effectively than previously.

Conclusions

We agree with the Cogwheel report that each individual group must tailor the suggestions to their own requirements. If the hospital medical staff do not streamline their own administration before the reunification of the health service and the setting up of area health boards we will probably be administered increasingly by non-medical administrators and have little say in the running of our hospitals.

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Clinical Problems

Diagnostic Abdominal Paracentesis

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Summary

Diagnostic abdominal paracentesis was performed in 43 patients in whom the diagnosis was uncertain. It was found to be particularly useful in abdominal pain resulting from trauma. In 12 patients the findings led to their being spared a laparotomy while in several other patients they led to very early diagnosis of the lesion responsible enabling early surgical treatment to be undertaken. A false-negative result was obtained in only one patient. It is concluded that diagnostic abdominal paracentesis is an extremely reliable diagnostic aid and can lead to improved surgical care of the patient with atypical acute abdominal pain.

Introduction

It is sometimes difficult to make a firm diagnosis when a patient has acute abdominal pain, and occasionally an exploratory laparotomy is performed to exclude a serious intra-abdominal disorder. These difficulties arise particularly when the patient

has superficial abdominal injuries and localized tenderness prevents a complete examination or when there are severe injuries, as after a road-traffic accident, when any observed changes in pulse rate or blood pressure may be wrongly ascribed to other injuries and the diagnosis, perhaps of a ruptured spleen, is made only after the patient is nearly exsanguinated.

Diagnostic abdominal paracentesis has been suggested as a useful diagnostic aid,¹ but the technique—a four-quadrant abdominal tap with a sharp needle—has not found favour, presumably owing to fears of puncturing a hollow viscus and the risk of a false-negative tap.² Various approaches have been suggested, including palpating the abdomen in the area of maximal tenderness³ and aspirating in the flanks with a variety of needles, including glass needles, intramuscular needles, and spinal needles.

From our experience with peritoneal dialysis it became apparent that fluid always collected in the pouch of Douglas and that this part of the abdominal cavity will still contain fluid when the rest of the cavity is free from fluid. It seemed logical therefore that a catheter placed there would greatly improve the chances of obtaining a sample of any free fluid if there was any abdominal morbidity and would minimize the risk of a false-negative result. A preliminary report was published⁴ indicating that this technique could be a useful diagnostic aid, and as a result of further experience we report our assessment of the usefulness of abdominal paracentesis in acute abdominal conditions.

Methods

Over the past few years abdominal paracentesis has been used as a diagnostic aid in the intensive care ward of Sundsvall

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