Hospital Attachments

SIR,—Many of your correspondents have referred to the desire of general practitioners to participate in the hospital services. Few if any concrete suggestions for implementing this have emerged. The general practitioners of the Farnham and Aldershot area (27 January, p. 247) expressed their anxiety that the building of a large general hospital at Frimley might result in the closure of the several smaller hospitals where they have been able to treat their own patients. For the great majority of family doctors up and down the country there are no such hospital beds available for their use in this way. Further, it seems to be agreed that there is no prospect of more general-practitioner beds being made available in the near future.

But there are other ways in which general practitioners can participate in the work of the hospitals, and where these have been tried out it seems that they have been an acknowledged success. Outpatient clinical assistantships held by local general practitioners have been and are a feature in many hospitals. More recently general practitioners have undertaken one or more weekly sessions in casualty departments on a clinical-assistant basis, with resulting increase in efficiency. With the widespread and increasing shortage of hospital junior staff throughout the country, the Surrey Branch Council believes that the time has come to carry this system a step further to include inpatient clinical assistantships for general practitioners. They have

recommended that their Divisions should encourage the study of this project by general practitioners and consultants, with a view to organizing a pilot scheme. From my own experience as a surgeon I have always been aware of the lack of general medical care in surgical wards. In so far as the busy houseman has time to exercise this part of his duties, he usually suffers from a very limited experience of medical and geriatric conditions, and none of general practice. If one or more general practitioners were attached to a surgical firm they might give one or two visits to the firm's wards each week to check new admissions, and attend the regular weekly ward round, thereby contributing one or two clinical assistant sessions per week. There are, no doubt, other ways in which general practitioners who have the necessary time to give could provide regular assistance in the care of inpatients.

In the present situation as between the profession and the Ministry of Health there is a paramount need for solidarity between the two main categories of doctors. Regular contacts and co-operation between family doctors and consultants in the service of hospital patients must lead to a better mutual understanding and appreciation, and indeed to a greater unity of purpose.—I am, etc.,

G. N. GOLDEN,

President,
Guildford, Surrey. Surrey Branch, B.M.A.

General Practice—A Worth-while Career

SIR,—I was interested to read Dr. T. P. Linehan's impassioned plea for more general-practitioner beds (9 March, p. 644) and the result of a survey carried out by the Inner London Executive Council which found that London doctors wanted more of these beds to be available.

However, facts speak for themselves, and it is noteworthy that a well-staffed general-practitioner hospital in north London found it necessary last year to send a circular to general practitioners in the area begging them to make greater use of the facilities and beds available to them. It also stated that if general practitioners did not take it upon themselves to use the hospital then the beds would be filled in some other way. It has recently been announced that the hospital board has sensibly decided to use the hospital for geriatric patients. This helps to fulfil a much greater need in our society than to provide general practitioners with beds they manifestly do not wish to use. In towns such as London, where in most areas there are excellent diagnostic facilities available, it is useful to remember that good family medicine can be practised without the need for general-practitioner beds.

I agree with Dr. J. C. Cameron (24 February, p. 506) that general practice, or, to be in vogue, domiciliary practice, is a worthwhile and enjoyable career, and now that hospital laboratories and radiography departments are thrown open to us it can also be a satisfying scientific experience.—I am, etc.,

London N.19.

A. C. INWALD.

SIR,—Dr. J. C. Cameron (24 February, p. 506) makes a case for general practice

which, as a young doctor on the threshold of a career, I should find very convincing. Nearly 20 years in general practice has certainly demonstrated to me that general practice is a satisfying career, but I would hasten to add that if any one factor more than another has made it thus it is one's ability to treat one's patients in one's own cottage hospital beds. Dr. Cameron says, "We aim to extend these opportunities." In the same week the Minister of Health threatens to close small, uneconomic hospitals which *The Times* reports as being "... a first propaganda shot to get people used to the idea."

Before advising young people to take up general practice I think we are entitled to know where we stand in this matter. Without hospital beds I certainly would not have taken up general practice, and if general practitioner beds (which are largely synonymous with cottage hospital beds) are not available I would advise any young man to specialize or, if keen to follow general practice, to do so in a country other than Great Britain.—I am, etc.,

Crickhowell,
Breconshire.

R. C. HUMPHREYS.

REFERENCE

The Times, 4 March 1968.

Australia Next?

SIR,—As a recent migrant to Australia, let me first agree with Drs. A. D. MacAdam and E. C. Gambrill (3 February, p. 320) that Dr. A. Clements's smugness (3 January p. 121) is overwhelming. If all his assertions are true he is in a Utopia which I have failed to

find in country or city practice here. Dr. E. O. Evans (same page) points to the main professional reason for emigration: general practitioners with ability and many with specialized training are, in most areas of Britain, unable to utilize their skill because of lack of hospital facilities.

Agreed I cannot on Commonwealth benefits prescribe unlimited quantities of drugs, but then here, as in Britain, the problem is over- not under-prescribing, and apart from the increasing evidence of the dangers and side-effects of many of the new wonder drugs of today any general practitioner will testify to the large amounts of expensive and unneeded drugs found stacked up, not only in medicine cupboards, but in the bewildering variety of "hidy holes" about the house. I would disagree that better financial rewards and material benefits of themselves cause emigration—doctors are comparatively well off in most societies and salary and tax grumbles are a way of life and by no means confined to the medical profession.

No! After two years' National Service and eight years in the National Health Service I decided the national malaise had become too much for me; politics and leadership of the country had become a matter of saying one thing, doing another. Leadership, as has been amply demonstrated since I left in April 1966, was inward-looking; and Britain has now, at least in this part of the world, hardly a soul who believes a word she says.

The advantages Dr. Gambrill hints at, presumably the greater cultural and educational heritage of Britain, are certainly factors that cause heart-searching before taking the plunge, but perhaps we who emigrate, not only the doctors, but the million or so who have come to Australia since the last world war, find ample compensation in what this country has to offer.—I am, etc.,

Warrilla, N.S.W.,
Australia.

S. MCPHERSON.

Real Reasons for Emigrating

SIR,—I was interested to read the report of the Ministry of Health Interview Board (6 January, p. 45) concerning their recent mission in North America.

The Board freely admits "that there are insufficient doctors both in the United States and in Canada, and that medical services there would suffer much strain without an annual intake of overseas graduates. This is also true of the United Kingdom. . . ." Is it not time that it was recognized that the United States, Canada, and the United Kingdom form a very small part of the world? The medical needs of many Asian and African countries are far greater. It would be interesting, and a change, to be told what proportion of the "drain" has emigrated eastwards instead of westwards.

The developing countries are unable to offer the "higher financial rewards" that appear to be an attraction of the West, but they do offer a vast experience in all branches of our profession. As one of those who "aspired to a specialist career but failed to acquire the appropriate higher qualifications," I left the United Kingdom eight years ago. This failure, however, was by no means my sole reason for emigrating. Since then I

have worked in Indonesia, Uganda, and Korea. Barred from surgery in the United Kingdom, in Indonesia I found myself in sole charge of a 300-bedded hospital with around 200 outpatients a day, responsible for the surgery, medicine, obstetrics, etc., for a population of 45,000 persons, the only doctor in a large tract of land. Thus it is interesting to note that the Interview Board believes that non-specialists who undertake surgery add considerably to their income and interest, but that it "cannot always be in the best interest of the patients." I agree that the practice of surgery adds to one's interest, but working for the impoverished Indonesians I considered myself fortunate to receive the equivalent of 7s. 6d. for a radical mastectomy. Further, I wonder on what grounds the Board slurs the work of the non-specialist surgeons in North America. Were the patients seen and examined? Were the "surgeons" watched at work? I note there was no surgeon on the Board. Or is it just that the non-possession of a higher surgical degree makes one so inferior that one is unable to help one's fellow men?

Recently many views have been advanced to account for the drain, but there is one view I have not yet seen in print. In many instances surely the emigration is only partly caused by a dissatisfaction with medical matters in the United Kingdom. The "medical" dissatisfaction is combined with a greater or equally great complete disenchantment with the United Kingdom as a whole. It is no light decision to leave the country of one's birth with the firm intention of not returning, and I seriously doubt if a mere dissatisfaction with purely professional matters would provide a sufficient stimulus. Your leading article (6 January, p. 1) stated that most of the interviewed emigrants in North America now wished to return for the benefit of their children. Thus they originally left their country for their profession but now renounce their better professional opportunities for their children. Many hundreds of us, however, prefer to keep our new and better lives and to send our children to boarding-schools in the United Kingdom.—I am, etc.,

FRANCIS M. SHATTOCK.

"Save the Children Fund,"
Pusan, Korea.

Prescription Charges

SIR,—We understand on reading the papers today (5 March), the source of most of our information on the N.H.S. these days, that patients exempt from payment for prescriptions are to be issued with embossed cards by the executive councils. Machines are to be distributed to chemists and dispensing doctors by which details on these cards are to be transferred to the backs of prescription forms at the same time as the drugs are given to the patient. No doubt this matter will be debated in due course by executive councils and local medical committees, but we fear that we have been presented with a *fait accompli* and no amount of debating will alter it.

Our purpose in writing is to draw attention to the complications which will arise in large dispensing practices such as our own. We issue drugs from the main surgery, where there is ancillary staff, from two branch

surgeries (no ancillary staff), from our cars when visiting patients in distant villages with no bus services, and from our own houses when we are on duty at week-ends. Can you imagine the chaos if every time a drug is issued and a prescription written for an exempt patient we have to stamp the patient's embossed card on to the prescription form? If we do not no doubt we shall be liable for finding the 2s 6d. from our own pockets.

This system will be difficult (and costly) enough for chemists to work. For dispensing doctors it will be well-nigh impossible, unless there is to be serious curtailment of existing services to patients in outlying rural areas. The machines would have to be carried from the doctor's car to the patient's house (or the patient will have to bring his card to the car to be stamped) and from the doctor's car to each branch surgery. Even then we estimate that in our practice a minimum of four stamping machines will be necessary.

We write as doctors strongly in favour of making charges to patients who can afford it. We are willing to go to a lot of trouble to support this fundamental principle. But we have the gravest doubts about the practicability of the scheme outlined to us in today's papers. Is it worth it?—We are, etc.,

Yaxley,
Peterborough.

C. J. HART.
I. H. REDHEAD.

SIR,—The problem of introducing prescription charges with specified exemptions is impossible to solve perfectly fairly. Certain categories of chronicity are well defined and require either continuous therapy or frequent enough courses of therapy to present no difficulty.

It is the recurrent conditions and those with frequent remissions which are difficult to assess—namely, urinary infections and respiratory infections such as chronic bronchitis. Both of these do not start off by being chronic, and there is usually no clear-cut delineation between the acute stages and the chronic. In order to cover these with exemptions from charges some sort of qualifying conditions must be applied which can relate only to the number and frequency of attacks, duration, or severity, which of course only the doctor can assess. It is difficult to apply a mere name to an exempted condition, since the onus is still on the doctor to classify it, and the onus should not be on the doctor to decide how to apply Government decisions. Conditions like neurosis can be extremely difficult to assess.

Schemes of this sort should be cut-and-dried before announcement of intention to apply them. It will be simpler and probably not much dearer to drop the scheme altogether.—I am, etc.,

Cambridge.

K. B. HALLAM.

SIR,—I read with dismay the announcement that patients exempted from paying prescription charges are to have embossed cards issued to them (at a cost of several hundred thousand pounds), and that the chronic sick are to be determined by Ministry definition only.

Surely the general practitioners in Britain can be trusted to decide which patients are

"chronic sick" within definitions laid down by the Ministry and from their experience of the patient. Furthermore, should a chronic sick patient with rheumatoid arthritis, for example, be given a free prescription for cough linctus when they catch a cold?

A simpler, inexpensive system would consist in issuing all practitioners with E.C.10s printed on a different-coloured paper entitling the recipient to free drugs prescribed thereon. The white paper E.C.10s already issued would continue to be used for items which have to be paid for.—I am, etc.,

Gosport,
Hampshire.

J. E. GODRICH.

SIR,—As a dispensing doctor I look forward with the utmost alarm to the introduction of prescription charges. Experience in the past showed that it was distasteful and troublesome to a degree. Distasteful because patients regarded it as a direct payment for services rendered, and nothing would convince them that it was a tax. One soon wearied of explanations to the question, "How much do I owe you, doctor?" Troublesome because of the difficulties of collection. Arrangements had to be made when leaving medicine to be collected, often at outlying points. It was irksome to be continually handling grubby heaps of pence and halfpence, to give change for £1 notes, to be stopped continually when out with patients proffering long-forgotten owed sums. Still troublesome when all the cash was stolen, as happened to me on three occasions. Now we are to have all this again and in addition we will no doubt have to decide who is exempt, to account for our decisions, to issue exemption cards and so forth, as in our case there is no pharmacist to do it for us.

We are a small group, perhaps 700 in all but we believe we render a service to the community in rural areas. We met in Witney some time ago and achieved a useful unity of opinion. Is it not time we met again?—I am, etc.,

Tenterden,
Kent.

B. W. WYLLIE.

Points from Letters

Records in General Practice

Dr. A. J. LAIDLAW (Thorneloe Lodge, 29 Barbourne Road, Worcester) writes: I have been awarded an Upjohn Travelling Fellowship by the Royal College of General Practitioners to study records in general practice. This study will mainly be concerned with medical records, but all other forms of recording, administration, etc., will be included. I would be pleased to hear from anyone who can be of assistance to me in this study.

Prescription Charges

Dr. L. A. PYKE (Birmingham) writes: It has not yet been revealed how some patients with chronic illnesses are to be exempted from payment of prescription charges. In this practice of 7,500 patients there are 2,020 under the age of 16 and 838 over the age of 65, so that 40% of the practice are exempt for this reason. This 40%, however, produce 50% of the consultations. How chronic illness is to be defined we are yet to find out. In addition, about 150 patients receive antenatal care at any one time, and presumably these will also be exempt from prescription charges.