What I would say to the Royal Commission

Our neglected wastelands

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By the time you read this I shall be an NHS employee again, one of those quaintly-named "junior" hospital doctors. During my two years in research most of my friends in the hospital service have bettered themselves—by emigrating, by becoming GPs, or by achieving promotion—while I have had a more detached view of the Health Service and its problems. Perhaps because my medical experience has been confined to hospitals I feel it is their problems which have most need of the cool appraising gaze of a Royal Commission.

Buildings

On looking at our hospitals from the outside, the first thing that frightens both patients and potential staff alike is the appearance of the buildings. Grimy Victorian poorhouses with haphazard plasterboard additions are so much a part of our expectation of British hospitals that they excite no comment from us now, unless (as once happened here) patients catch things from the birds' nests. Since 1963 over £1200 million has been spent on NHS building, but I wonder how many of our 387 094 beds in 1976 are covered by roofs constructed in the twentieth century? In the absence of official figures, one relies on personal impressions: for example, the hospital I am returning to was built in 1908 as Leith Poorhouse. Rebuilding of Edinburgh Royal Infirmary (1874 vintage) has only just begun and will probably take at least 20 years. Last year my grandfather was admitted to his local hospital, which was built during the second world war as a huddle of temporary huts, replacement of which is not even planned.

Are these impressions relevant? I think so. One district hospital which *was* completed nine years ago has attracted several of my friends to work there. I asked one of them how much the modern conditions contributed to his obvious job satisfaction, and he said 80%. Immaculate modern medicine can be, and is, practised amid Dickensian surroundings, but a

pleasant working place tends to widen the choice of staff beyond those with an abnormal dedication to medicine or insensitivity to architecture.

Staff

The medical career structure is the other neglected wasteland of the hospital service. There are 2300 hospitals in England, but all consultant appointments are made from the 34 teaching hospitals: prospects for junior staff in the other 2266 are grim. In my own specialty, obstetrics and gynaecology, the ratio of registrars to senior registrars is 4:1, which means that three-quarters of us, mostly in non-teaching hospitals, are training to acquire skills that we shall be unable to use in this country.

Non-teaching hospitals are, therefore, staffed largely by foreign graduates studying for higher diplomas. The staffing structure of peripheral hospitals, like the buildings themselves, is a relic of our Victorian colonial past, with doctors coming here because they hope that a diploma from the Mother Country will help their careers. Our colleges accept the flood of revenue from these candidates, receive Government grants for postgraduate education, and fail over 90% of them. These bizarre conditions will not last for ever: the British Empire was breaking up when the NHS was founded, and sooner or later the medical raj will follow suit. For the moment the hospital service is the Black Man's Burden, and increasing the numbers of British medical students will not provide people willing to take it from him.

Solutions

The cost of the NHS in 1974-5 was £4107m, more than half of which was used by hospitals. Capital expenditure was £268m—only 6% of the total. Yet when savings are to be made it is "hospital building" that suffers. The recent frightening 20% cut in capital expenditure represents only 1% of the total NHS bill. By comparison, the cost of Social Security benefits in 1975 was £9712m, and the £280m spent on war pensions was more than that allowed for the entire hospital building programme. The administration alone of social security cost £366m.

I quote these figures to illustrate that the problem is one of priorities. I am certainly not suggesting that war pensions should be reduced to pay for hospitals; I am not even going to compare Edinburgh's Infirmary with her social security office, though these are 100 yards and 100 years apart. I feel simply that hospital building, in fat years as well as lean, has been given too low a priority. The warped perspectives of Government are glaringly exemplified on Page 1 of this year's DHSS report, where four paragraphs are devoted to the prime achievement of the current administration in health—the phasing out of the notorious pay beds. One cannot resist pointing out that the income from them (which, apparently, we can do without) is

£25m—half the amount cut from the building programme. The question of paying for new hospitals is one of political priorities, and I cannot help feeling it is unfortunate that there is no political ideology which makes it imperative to rebuild the shack in which my grandfather died.

The Royal Commission could, perhaps, suggest that we devote more money to hospital building, or at least try to put it on the same time scale as other constructions of comparable complexity—Spaghetti Junction and the North Sea oil platforms didn't take decades to complete.

The Commission has also been asked to make recommendations about manpower. It might ask whether it is necessary for three-quarters of registrars to be in "dead-end" jobs. Those who fail to become senior registrars are all too often those with the best *clinical* training. Patient-orientated district hospitals and rat-race-orientated teaching hospitals would both benefit from an end to the distinction between them: there could be grouping into teaching areas, such as occurs to some extent in London. This would facilitate wider use of "rotational" schemes, which, if sensibly co-ordinated with further promotion, would be a legitimate way of filling unpopular jobs—just as house jobs and casualty posts are filled because of GMC and FRCS regulations.

Ultimately, however, doctors are going to be drawn into hospital training only by the rewards of becoming a consultant. The Commission should ask itself whether these rewards are adequate. The medical manpower market in the Western world is still free, and the NHS will get only what it pays for. Low pay differentials are accompanied in communist countries by restrictions on emigration: if Britain offers poor rewards to highly-trained men she should not be surprised if the more enterprising ones leave.

Five minutes as a witness

This unfortunate Commission will be bombarded with facts, figures, and indignation. If I had five minutes of their time, I should tell them first of all that most of the medicine I have seen practised in our tumbledown hospitals has been superb, in contrast to hair-raising hearsay evidence about standards in the plush private sector. Next I should point to the striking (if you'll pardon the phrase) lengthening of waiting lists in 1975 as evidence of the effect of staff morale on the service enjoyed by patients. Only by raising this morale, I would say (thumping the table), can this service be improved: we cannot be legislated into being punctual, sympathetic, or more industrious.

Then I might offer some impressions of misspending: the relentless increase in the numbers of administrators and high-ranking nurses; the creed that something disposable is cheaper than something we can use again (economic sense, but common-sense nonsense); the idea that building and patching up temporary premises is cheaper than proper permanent accommodation; or the fact that never once have I been asked to justify prescribing an expensive drug.

Lastly I should plead eloquently for some way of converting our suggestions and complaints into visible improvements; at present they seem merely to be adroitly fielded and thrown into a pigeon hole. Indeed (and I wouldn't dare say *this* to them), perhaps the whole idea of a Royal Commission is one huge governmental pigeonhole: "Ah, yes, well, we can't do anything here until the Royal Commission has reported." Does the Commission, already famous for its "experience, expertise, and wisdom," really believe that its cultured voice will influence an administration that has looked unmoved at the unthinkable sight of doctors going on strike? Or am I being too cynical?

Today's Treatment

Diseases of the alimentary system

Absorption, distribution, and metabolism of drugs; effects of disease of the gut

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Because the pharmacological and therapeutic effects of drugs are usually related to their free concentration in extracellular fluid a knowledge of the factors governing absorption, distribution, and elimination is essential to rational prescribing. Since most drugs are given by mouth, both for the convenience of the patient and because of the wide margin of safety that this route affords, the initial section of this article is confined to factors affecting absorption from the gut. It should, however, be remembered that advantages may result from a failure of drugs to be absorbed—for example, topical treatment with sulphonamides

and corticosteroids may reduce the systemic side effects of these drugs in inflammatory disorders of the bowel.

Drug absorption

The most important factors influencing absorption of drugs from the gastrointestinal tract are formulation, gastric and intestinal motility, physicochemical characteristics of the drug, and the surface area available for absorption.

FORMULATION

Drugs may be given by mouth in solution or suspension or as tablets, capsules, and slow-release preparations. Optimal absorption, however, cannot occur unless drugs are in solution by the time they reach the small intestine. Thus formulation is a major factor determining the rate and extent of absorption. An average tablet is a complex product with 20 or so constituents distributed between the core and its coating mass; typical ingredients include binding agents, diluents,

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