What I would say to the Royal Commission

Them and us

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British Medical Journal, 1976, 2, 996-997

That the "sacred cow" of the Health Service is now a very sick animal is so obvious as to require no further amplification. Suggesting remedies is less easy: they may be considered under two broad headings—finance and morale—and, though separate, they are closely interrelated.

Finance

Since its inception the NHS has been bedevilled by lack of money; the UK spends less on her health services than most other developed countries. Financially, health is a bottomless pit; the demand for medical care is insatiable, new methods of investigation and treatment are vastly expensive, and the scope of the service is always increasing, as witness the introduction of facilities for abortion and family planning in recent years.

It follows that some form of rationing is inevitable, overt or concealed. However unpalatable this may be, it must be realised that it exists now in the form of long, and ever-lengthening, waiting lists.

We are left with one of the oldest dilemmas in the world: how can more money be raised? Over the years the administrative structure—it would be a semantic confidence trick to call it the "administrative tail"—of the NHS has increased enormously, out of all proportion to the increase in medical facilities available. The much vaunted 1974 reorganisation has been a costly fiasco, producing little or no benefit to the patient, but, instead, an avalanche of paper for the doctor, and more and more committees and meetings. A reduction in, and simplification of, administration are clearly imperative; this would release large sums of money for actual patient care.

Experience in Britain, and, for example, in Ontario, has shown that "free at the time" care leads to abuse, or at any rate overuse, of the service. It is a truism that people don't appreciate what they seem to get for nothing. A fee, payable at the time of consultation, would create new funds, and, as a fringe benefit, reduce frivolous and trivial demands on a doctor's time and skill. A similar system operates in New Zealand and apparently works well. Objection may be raised on the grounds that this scheme places a financial burden on the patient, but as there always seems to be enough money for beer and tobacco, why not for medical advice? A contribution from the patient towards his keep while in hospital seems an unexceptionable measure, which would impose no hardship on most people; after all, if a man is ill at home the Government does not provide his meals.

The inescapable truth remains that if the country wants a first-class health service it must be prepared to pay for it.

Morale—in general

Successive governments, of whatever political colour, have cynically and ruthlessly exploited the goodwill and dedication of all those who work in the NHS. The criterion for wage and salary scales, and for conditions of employment, has been the lowest that could be paid without provoking open rebellion. Who can blame doctors for emigrating to the New World, where facilities are better and where they can earn at least double or three times as much as they do in this country?

As a result of these niggardly and cheeseparating attitudes morale is at its lowest ebb, and militant action is commonplace—a posture entirely foreign to the medical profession of 15-20 years ago. Only a sincere and sympathetic attempt by the Secretary of State (untrammelled by doctrinaire ideas) to understand the difficulties facing the NHS, and a real effort to sort them out, can offer any hope of undoing the damage that has been done and restore confidence.

Five minutes as a witness

As a witness, therefore, I would emphasise the importance of morale in general practice. In family medicine much has been achieved in the past 10 years, largely thanks to the efforts of the doctors themselves—but much still remains to be done.

One of the sad effects of the introduction of the NHS in 1948 was the wedge that was driven between hospital doctors and those outside: general practitioners became, in effect, second-class citizens, without direct access to a hospital in most cases. This state of affairs has gradually improved, and now most doctors have access to pathology, x-ray, and ECG services, if only on a limited basis. There is no reason why GPs should not have full access to these departments, as of right, and be able to ask for the more esoteric examinations. The argument that they would adopt a less responsible attitude to ordering these tests than their consultant colleagues is nonsense, as witness the skill of family practitioners in running the road accident and coronary care schemes.

Facilities for outpatient investigations should also be available; there can be no objection to competent GPs doing such examinations as sigmoidoscopy and laryngoscopy. Admittedly these can be done at the surgery, but are very much easier to do in a hospital. General-practitioner obstetric beds are now well established and function effectively. If the doctor finds that he is getting into difficulties he has no sense of shame or failure when he calls in the consultant obstetrician. Beds in such specialties as medicine, paediatrics, geriatrics, and dermatology must be made available to family doctors on similar terms. I do not suggest, however, that the GP should finish his morning surgery,

have a quick cup of coffee, and then go to the hospital to try his hand at a partial gastrectomy.

The family practitioner in hospital may well be able to help the consultant: the former deals with people, and the latter often only with cases. Patients still come back from hospital complaining that no one told them anything, and that they were too afraid to ask. Experience as a clinical assistant in this country, and as a locum GP in Canada, has convinced me that part-time work in hospital is the best form of postgraduate education.

"Admitting privileges" to hospital in North America are valued by practitioners, and are certainly not abused. There is no genuine reason why they should not be instituted in Britain

for those doctors who would like them; they add interest to a GP's life and could, to some extent, ease the load on consultants.

The medical record envelope has changed little since it was introduced in Lloyd George's original health scheme, but steps are now being taken to provide A4 folders. This is a welcome innovation but it entails some expense, and the DHSS must give financial help towards the provision of new filing systems and the larger amount of storage space required for them.

Someone once asked Groucho Marx what he thought about sex. "Its here to stay," was his reply. The Health Service is undoubtedly "here to stay" so the final plea is—"Give the family doctor scope to realise his full potential."

Today's Treatment

Diseases of the alimentary system

Constipation and laxative abuse

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British Medical Journal, 1976, 2, 997-1000

Normal defecation is characterised by the easy, regular, and complete passage of formed motions. The elimination of dietary waste is a fundamental physiological process, but the range of normal bowel pattern is wide, as individual bowel habit is determined by cultural, social, and psychological factors. Surveys have shown that most apparently healthy people have a bowel action between three times a day and three times a week.¹ Medical opinion has now swung away from its earlier rigid insistence on the need for a regular bowel action, and there is no evidence that infrequent bowel motions cause autointoxication or result in various common symptoms such as headache and lassitude. Nevertheless, this widespread misconception, fostered by popular myth and assiduous advertising, dies hard among the public. In a survey of Londoners² over 30% were found to be self-medicating with laxatives, and in both Britain and the United States vast sums are spent yearly on prescribed and over-the-counter cathartics. For most people this drug habit is quite unnecessary. Although a harmless waste of money in most cases, laxative abuse by a few patients constitutes an appreciable health hazard.

Physiology of defecation

Rational treatment of the various forms of constipation depends on understanding normal and disordered colonic physiology. Two aspects are briefly considered here.

Colonic motility and transport—After absorption of nutrients in the small intestine the residue is presented to the colon, where further absorption of water and electrolytes takes place. Waste material is moved towards the rectum by several types of motor activity, including tonic contraction, segmentation, and transport (peristalsis or less commonly mass movement). Much recent understanding of colonic activity has been derived from measuring intraluminal pressures. From such studies has come the concept of "paradoxical motility." High intraluminal pressures (as may occur in diverticular disease and the irritable colon syndrome) may indicate slow or absent transport, as high pressures are generated by decreased volume together with an obstruction to the outlet. Conversely, rapid transport occurs in the absence of outlet obstruction, so that any pressure gradient will result in rapid movement of contents. Thus constipation, which is popularly thought to result from a lax, atonic colon, may also be associated with a hypersegmenting, high-pressure bowel. (Similarly, diarrhoea may occur in patients with a tube-like, low-pressure colon.) The practical implication of these findings is that while antispasmodics may be beneficial in constipation associated with high intraluminal pressure the use of stimulant laxatives in this form of colonic dysmotility is irrational.

Mechanism of defecation—Continence is maintained by the anal sphincters and the flap-valve mechanism of the anorectal angle. As the rectum fills and becomes distended the desire to defecate occurs and the reflex is started. The sphincters and puborectalis relax, abdominal and chest wall muscles contract, intra-abdominal pressure increases, and the rectum is evacuated. Defecation may be voluntarily inhibited, and an important factor in the development of constipation is the failure to answer the call to stool. If this is persistently ignored the sensory stimuli evoked by rectal distension eventually are suppressed and reflex defecation is inhibited.

Constipation

True constipation may be defined as a decrease in the frequency of bowel movements accompanied by the difficult passage of excessively hard stools. Defecation is prolonged and may be accompanied by local anorectal pain and a sense of incomplete evacuation.³ Indeed, severe constipation, especially in the elderly, may result in impaction of rock-like faeces in the rectum and be associated with spurious diarrhoea.

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