For Debate . . .

The NHS is dead: long live the NHS

An open letter to Sir Alec Merrison

TERRY F DAVIES

British Medical Journal, 1976, 2, 1376-1378

Dear Sir,

Your recent visit and excellent lecture in Newcastle upon Tyne¹ has prompted me to write a public letter to affirm the view that democracy must have time for the individual. May I remind you that your message was to beware of the malicious influence of the Civil Service on, not only Ministers of the Crown, but also on nominated advisory bodies, of which you have had considerable experience.

I am horrified that you are already falling into the very pit of which you warned us in your talk. I believe there is now evidence of considerable pressure on you, not only from the "true Civil Service" but also from the higher echelons of the medical profession exerting a "civil-servant like" influence on your royal commission. I completely fail to understand why the Secretary of State cannot accept some of the justified criticism concerning, for example, the membership of the commission. I feel sure that you realise how inappropriate it was to have excluded members with recent experience of acute hospital medicine and surgery, since these specialties absorb so much capital, revenue, and manpower. The answer that members are bringing only their experience, expertise, and wisdom to the Commission² is most unsatisfactory, since that would exclude everyone with practical experience of the Health Service. At least five of your 15 members would therefore be unacceptable.³ I cannot believe that you have to remain silent on this matter.

Having reinforced the views of others, I should now tell you the real purpose of my letter. I understand that you have already asked over 800 associations to submit evidence. They will all undoubtedly have a vested interest in preserving and strengthening themselves. It is simply not good enough to say that anyone else can submit evidence to you if they so wish. It is imperative that you select a random sample of the health profession and the general public and subject them to a census-like information search or simply ask them directly for their views on a number of selected topics. I cannot help feeling that new ideas and common sense are unlikely to arise out of vested interests and am frightened that you and your colleagues will be unduly influenced by facts and figures from well-dressed medical professionals.

Please bear with me in supposing that you took my humble advice and wrote asking for my opinions. What follows is the

sort of dissertation I would send you concerning the long-term plans for the Health Service.

Assessment

The combination of the White Paper on devolution, *Our Changing Democracy*,⁴ and the inauguration of the Royal Commission on the National Health Service is not widely appreciated as the last chance for a radical change in health care management in this country for many years to come. Never before has the breakdown of the National Health Service been so apparent, with an embittered medical profession and a public just awakening to its many deficiencies. It is widely known that despite enormous increases in manpower and revenue absorbed by the Health Service, the actual health of the nation has been little improved. Examples which come immediately to mind are the unsatisfactory infant mortality rate⁵ and our rising incidence of myocardial infarction compared with the decreasing rates in other developed countries.⁶ The same statistics are found even in areas where the highest Health Service spending has occurred, such as Scotland.⁷

Undoubtedly we now spend money in the Health Service for its employees' sake but with remarkably little concern for the patients, their children, or society as a whole. What is urgently required is a way of assessing the quality of medical care. The American Working Group on Preventable and Manageable Diseases has suggested a method of assessing unnecessary disease, disability, and untimely death and this is a technique the NHS may use to assess itself.⁸ This type of investigation is so necessary because of the rapid increase in what one may call "dubious treatment." By this I mean that more and more time and effort is now being diverted to the "incurable" diseases, since the "curable" patients are by definition less of a burden to us. As time has passed, however, the ratio of the incurable to the curable has increased greatly and the resulting reputation of medicine has fallen on hard times.

If we divide the Service into four arbitrary parts—primary care, community health, the peripheral hospital service, and the centres of excellence—only one has reached its expectations and successfully fulfilled its role. Only the teaching and research centres have managed to thrive with a continuing effective treatment programme alongside international reputations in research and applied medicine. The peripheral hospitals have not, and cannot, function efficiently with their present resources and commitments, and, similarly, general practice has failed to be the effective form of primary health care we had all hoped. Although the work of the community health service has had some success, it has totally failed in one of its basic aims: to educate. I shall try to give some evidence for my beliefs and suggest possible solutions. The model suggested may well be worth a trial period in a selected area rather than complete

Department of Medicine, Royal Victoria Infirmary, Newcastle upon Tyne

TERRY F DAVIES, MB, MRCP, senior research associate

acceptance or rejection. Proposals for health care should undergo clinical trials like other uncertainties in medicine.

Centres of excellence

Modern hospital medicine can be viewed as essentially the art of applied technology. The great advances in this technology have not been made by the medical profession, but rather by the pure scientists who have mastered their specialty: from heart pacemakers to Teflon bypass grafts, from antibiotics to body scans—the list is long and impressive. The physician's role has been to apply this technology to the patient in the most appropriate way. He has had the difficult, and often impossible, task of preserving humanity in an ever more sophisticated environment. Comfort and care have had to be balanced with electrodes and oxygen masks. Unfortunately, the practitioners of this art are largely unknown and utterly unheralded. No merit awards for doctoring. So far as the scientific advances are concerned, this has been most successful in those institutions where a partnership has existed between the physician and the scientist. Nowhere has this partnership been better used than in the most appropriate places—the teaching and research centres that are scattered unevenly around the land. The maldistribution of medical schools and postgraduate and research institutions⁹ is even worse than the well-known maldistribution of NHS funds.¹⁰ In practice, the centres of excellence generate high quality facilities for health care and graduates prefer to settle where they train. Areas without such centres therefore suffer from a lack of high quality medical support.

If anyone doubts the university contribution to medical knowledge they should read the report of Comroe and Dripps,¹¹ who conclude that two-thirds of the contributions responsible for the major advances in diagnosis, prevention, and treatment of, for example, cardiopulmonary disease, were from basic research and that most of this was done in medical schools and other university departments.

Peripheral hospitals

In complete contrast to the centres of excellence are the peripheral hospitals, including many district general hospitals, which have been starved of the glamour and resources that are so essential for staff morale and efficiency. Many people's experience and statistical evaluation shows that there are often two standards of care in the hospital service: the teaching centres and the rest. The table shows, for example, the mortality figures for myocardial infarction in several hospitals in the Northern Region. These particular figures vary from about 8-12% in the teaching hospitals and some peripheral hospitals to 20-24%, in some of the other peripheral hospitals. There is no evidence of different admission procedures in this age group in the region, and some of the differences are so large as to be alarming. What is worse is that similar figures can be found for almost all medical and surgical procedures—for example, diabetes, prostatectomy, etc. Not surprisingly, therefore, this has led to an ever-increasing dependence by peripheral hospitals and family doctors on their nearest teaching centre.¹² It is surprising that the consultants from the peripheral hospitals rather than our own teaching centre have been most vociferous in their defence of private practice within the NHS. The private practice controversy pales into insignificance when compared with the

general state of the health system and, in particular, the state of the peripheral hospitals. Incidentally, why are there no statistics for private medicine?

Primary medical care

Primary medical care should be a disease prevention service combined with appropriate screening programmes. Instead of this we have a patient-orientated system that responds principally to self-diagnosed ill health. I think we need to ask the question: Would a disease-orientated primary health service be preferable? When 50% of ill patients are seen in less than five minutes, and in this time a history is taken, an examination made, and a prescription written,¹³ it suggests that the standard of primary care is no longer compatible with that of modern medicine. What is more difficult to determine is how satisfied the patients are. McKenna and Wacker¹⁴ suggested that patients prefer the quality of the service to the continuity of single doctor care, and my own experience supports that view. The fact that a third of family doctors now contract for their emergency work to be done by commercial deputising services suggests just how easily the public have been duped into accepting whatever they are given.¹⁵ One could of course interpret this in a different way: the public may prefer the emergency locum to their own general practitioner.

It is now time for the family doctor to join the 20th century and return to the practice of medicine as we understand it today. We are told so often that the role of the physician is changing. The concept of family doctors replacing the clergy as problem solvers and soothers is false and unrealistic since they should be catalysts to each other. Furthermore, by taking this role on themselves the family doctors of today have only themselves to blame for their apparent inability to advance their standard of actual medical care, which is what they are trained and paid to do. The Isis Centre at Oxford is an example of a counselling service for people to solve their problems by discussion rather than medication.¹⁶ Here expensive psychiatrists can be used with a high degree of efficiency and should relieve local family doctors considerably.

Not only does the family doctor need to practise diagnostic and curative medicine again: he also needs to be responsible for preventive health to a far greater degree than he has before. Of course, to say that we will devote greater effort to prevention also requires careful planning,¹⁷ and we must organise ourselves to prevent the preventable and monitor our success. We should also remember why there is considerable political pressure against widespread screening programmes. Kjeldsen¹⁸ has shown convincingly that the result of reducing the incidence of most diseases would be a fall in the proportion of people of productive age, which would lead to an enormous increase in social service spending.

A plan for the future

There is a possible plan for the Health Service that would satisfy many of my criticisms. The obvious course of action is to expand the successful parts of the service and contract or replace the failing parts.

The peripheral hospitals need to be converted into community hospitals. The Government White Paper¹⁸ envisaged the use of these hospitals primarily for geriatric and preconvalescent care.

Hospital mortality of patients aged 45-64 with primary diagnosis of myocardial infarction in 17 hospitals in Northern Region in 1975

Hospital: Mortality (%):	A*	B*	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
	12	11.2	19.1	16.1	8.8	7.6	17.9	12.7	24.0	11.3	11.7	18.7	18.6	20.8	20.0	7.7	17.5

*Teaching hospitals.

This concept is quite wrong¹⁹ because the work of most successfully established community hospitals is principally acute medicine and surgery, thus relieving the local district hospital, but, of course, geriatric care must be an important function in the future. Community hospital beds, when used efficiently in a self-contained unit, are likely to cost considerably less, overall, than those of district general hospitals. The reduced expense of medical staffing and the increased use of voluntary help from the local community should be two important cost-saving factors. Here, the primary care physicians and surgeons could practise their art and their science. If they could make the definitive diagnosis sooner, by early appropriate investigations, then the increasing demand for routine work in the centres of excellence would decrease considerably.

The primary care physicians would have specialised training and experience and could retain their independent contractor status. They would be the primary contact still but different doctors would represent many specialties. Visiting consultant support would be available from the local teaching centre. The problem of the "subconsultant grade" would no longer exist since the specialist consultant would continue in his own department while the straightforward cases could be dealt with by the experienced team of primary practitioners and nurse assistants. I can see no reason why family doctors cannot correct hernias, strip varicose veins, investigate hypertension, or correct hypothyroidism, nor can I see why a medical audit of their work should be unacceptable.

Furthermore, by involving the general practitioners in our hospitals to a much greater degree, we could drastically reduce the numbers of junior doctors and narrow the pyramid with the ever-growing base. The centres of excellence would have to be increased in number and the geographical disparity corrected.

Is there an optimum schedule for giving oral antibiotics such as ampicillin or tetracycline (Achromycin) to geriatric patients with respiratory infections?

Antibiotics are of two types, bactericidal and bacteriostatic. Penicillin is a bactericidal antibiotic, and it kills the bacteria most effectively when there is a peak blood level soon after taking the drug. With this type of antibiotic it is the intermittent peaks that are important, not the average level, and except in critical conditions it is probably not important if the drug is not given strictly at six- or eight-hour intervals. Even so, in a geriatric ward, where the staff have many commitments, it would be better to use a preparation such as amoxycillin (Amoxil), which is given three times daily rather than four. Other antibiotics such as the tetracycline group are bacteriostatic. They stop bacterial multiplication but do not kill. Here it is the average blood level throughout 24 hours that is important, and regular administration at the intervals prescribed by the manufacturers is essential. Among the tetracycline group doxycycline (Vibramycin) needs only to be given once a day and again this is more convenient.

How safe is it for tourists to drink tapwater when visiting other European countries?

There is no simple answer. Public water supplies suitable for drinking are usually derived from ground or surface waters. Ground water obtained from underground wells 50-300 m deep by bore holes is biologically clean but may contain high concentrations of suspended inorganic solids. Water from underground rivers is usually pure. Surface waters derived from uplying districts, such as storage lakes and reservoirs in mountain areas, are usually pure if stored for a minimum of seven days, but lowland river water that has been polluted with sewage and industrial effluent needs intensive treatment that may include chemical coagulation, sedimentation, rapid filtration, slow sand filtration, refining with inactivated carbon, hyperchlorination, and then dechlorination. In some countries, including England and Holland, it is common to leave some residual chlorine in the

public water supplies, but this is not done everywhere. Even in areas where the public water supply is derived from the pure ground waters, postchlorination is considered to be important as a safeguard in maintaining the bacterial quality of the distribution system.

References

- ¹ Merrison, A, "Advice and Consent (Government and its independent advisers)." 55th Earl Grey Lecture, University of Newcastle upon Tyne, 29 April 1976.
- ² *British Medical Journal*, 1976, **2**, 130.
- ³ *British Medical Journal*, 1976, **1**, 1221.
- ⁴ *Our Changing Democracy: Devolution to Scotland and Wales*. London, HMSO, 1975.
- ⁵ Taylor, S, *British Medical Journal*, 1975, **4**, 207.
- ⁶ *British Medical Journal*, 1976, **1**, 58.
- ⁷ Hogarth, J, *British Medical Journal*, 1976, **2**, 1129.
- ⁸ Rutstein, D D, et al, *New England Journal of Medicine*, 1976, **294**, 582.
- ⁹ Kerr, D N S, *British Medical Journal*, 1974, **2**, 328.
- ¹⁰ Rickard, J H, *British Medical Journal*, 1976, **1**, 299.
- ¹¹ Comroe, J H, and Dripps, R D, *Science*, 1976, **102**, 105.
- ¹² Davies, T F, *British Medical Journal*, 1976, **1**, 236.
- ¹³ Marsh, G N, Wallace, R B, and Whewell, J, *British Medical Journal*, 1976, **1**, 1321.
- ¹⁴ McKenna, M S, and Wacker, W E G, *New England Journal of Medicine*, 1976, **295**, 279.
- ¹⁵ *British Medical Journal*, 1976, **1**, 732.
- ¹⁶ Agulnik, P, Holroyd, P, and Mandelbrose, B, *British Medical Journal*, 1976, **2**, 355.
- ¹⁷ Meade, T W, *Lancet*, 1975, **2**, 1053.
- ¹⁸ Kjeldsen, K, *Bulletin of the World Health Organisation*, 1975, **52**, 369.
- ¹⁹ *Community Hospitals: Their Role and Development in the National Health Service*. London, HMSO, 1974.

public water supplies, but this is not done everywhere. Even in areas where the public water supply is derived from the pure ground waters, postchlorination is considered to be important as a safeguard in maintaining the bacterial quality of the distribution system.

The World Health Organisation publishes standards for drinking water that are somewhat higher for European countries¹ than for the rest of the world.² These standards require not only a certain microbiological and chemical purity, but they also consider its aesthetic qualities and the frequency and methods of sampling water supplies. These standards are recommendations, and not all areas, even in Europe, can achieve them consistently. There is no published information on which countries rigorously follow the WHO recommendations; hence it is not possible to recommend some countries to the exclusion of others. Moreover, within countries in general public water supplies to cities are safer than those to rural areas, and indeed the WHO itself recognises that "not all small rural supplies could reasonably be expected to conform to the standards suggested for piped supplies."¹

The well-being of the local inhabitants may be misleading as they may have become immune to the micro-organisms present in their water supply, which may cause illness in visitors. Moreover, changes in chemical content alone, as for example between hard and soft waters, may give rise to mild gastrointestinal disorders. These factors suggest that, although it is probably safe for the traveller to drink cold mains tap water in most large towns in Europe, it may be advisable to avoid doing so. Hot tap water (about 70°C) can be collected in a suitably clean container and drunk when cool. The addition of halazone chlorinating tablets to cold tap water in the recommended concentration will render it safe from bacteria after 30 minutes, but the extent of their effect on protozoa such as giardia and amoebae is not known. The taste of surplus chlorine can be removed by adding sodium thiosulphate tablets. The only really safe method, however, is to boil all water that is to be put into the mouth, even for brushing teeth. Travellers should remember that ice may have been made from contaminated water, but may assume that bottled beverages of brands with a world-wide reputation are safe.

¹ World Health Organisation, *European Standards for Drinking Water*, 2nd edn. Copenhagen, Regional Office for Europe, 1970.

² World Health Organisation, *International Standards for Drinking Water*, 3rd edn. Copenhagen, Regional Office for Europe, 1971.