Day surgery and domiciliary visits by anaesthetists

Day surgery often does not save money, although potentially an effective way of doing so, Dr Nevill thinks. A real saving is made only if beds in surgical wards are closed and the staff looking after them cut or redeployed. All too often beds are left empty and nurses underemployed.

One way of saving money on routine operations that Dr Nevill has thought of is introducing domiciliary visits by anaesthetists for preoperative assessment of some surgical patients. Instead of a patient coming into hospital the day before an operation, an anaesthetist could visit him at home and question him, examine him, and do lung function tests and electrocardiograms on the spot. As well as saving money this scheme would allow the anaesthetist to see the social circumstances of his patients and would bring him more into the community. Dr Nevill thinks that this would be a cheaper scheme than seeing patients in the outpatient department, which in his hospital is overworked, and which in every hospital is expensive to run with the overheads of the salaries of nursing staff, receptionists, and phlebotomists, and the cost and inconvenience of transporting patients to hospital. Several attempts in his hospital to co-ordinate surgical and anaesthetic outpatient clinics have failed. A final advantage of the anaesthetist seeing the patients in their own home before operation is that the few that are discovered not yet to be fit for operation can be put off before they have been through the time-consuming and expensive admission process.

I then asked Dr Nevill for his reactions to the idea of introducing technician anaesthetists. He has seen them working in the USA and Canada and is not against them in principle but does not think that any money can be saved by using them here. "I have done eight cases in this afternoon's session," he said, "and that works out at about £3 an anaesthetic, and at the same time I was teaching. How much room is there for saving there? Also, every technician anaesthetist must be supervised and work a 40-hour week. I think that there would be no financial saving, indeed it might be more expensive, and there would be a considerable drop in standards."

Neither does Dr Nevill believe that operating in each theatre at night would lead to many savings, although utilising the emergency team, when they are not concerned with urgent cases, might be useful. "The expense of operating is not in the capital used to build theatres but in the salaries of the people who work in them—and that would remain just the same." Nor is there much to be saved, he believes, in introducing a limited list of drugs that can be prescribed or in resterilising disposable equipment. "We must remember that only biting into the overstaffing will reduce costs appreciably; everything else is just dabbling."

My Student Elective

Desert medicine in Oman

EDMUND JESSOP

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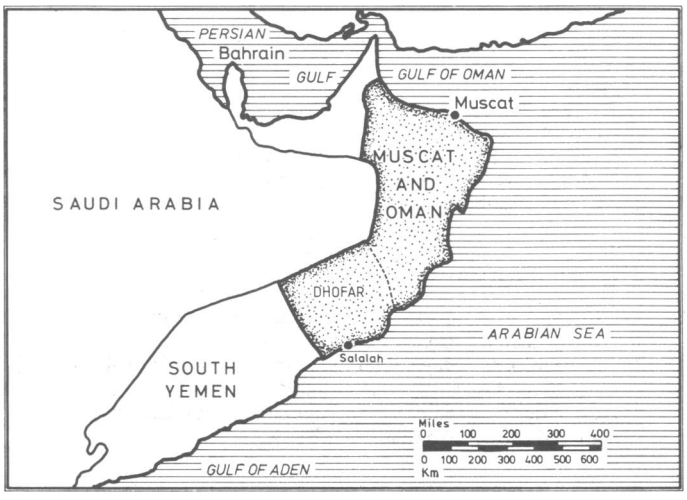
Medicine in Oman is not easy. I suppose the difficulties are no different from those facing the average general practitioner in Britain: getting to the patient, extracting a history, performing an examination, perhaps doing some investigations, and then offering appropriate treatment. But the desert sun illuminates all the obstacles in management with brilliant clarity.

Dhofar, the southern province of Oman, is about the size of Wales. Half of its population live in the main town, Salalah. The other half, scattered in hamlets and tents, are the responsibility of the Rural Health Service, my hosts in 1978.

Getting to the patient was never easy, but always fun: bouncing along dirt tracks in a cloud of dust, flying to landing strips on remote beaches, dropping by helicopter on to rocky eyries—our arrivals never lacked drama.

The excitement of travel did not conceal the real difficulty of visiting people scattered all over hills too tough even for land-rovers. Except near the coast, food and water were too scarce to permit more than a handful of people to live together. No hamlet could receive more of our time than half an hour a week; the chance of catching an acute illness in a treatable stage was thus small. I was pointing this out to our pilot one day as we sat drinking the scalding black tea that the always hospitable Omanis never failed to provide when the man squatting opposite me suffered an epileptic fit. After we had managed to convince them that this problem was medical, not religious, his friends agreed to let us fly him with us to the hospital in Salalah. The pilot then said that the thin, hot air of the desert plateau would not support the aircraft with another



Freeman Hospital, Newcastle upon Tyne NE7 7DN
EDMUND JESSOP, MB, CHB, senior house officer

passenger inside, so one of our band would have to remain behind—several days' journey by landrover from our base. Travel by air was necessary, but expensive. Each week the health service spent the price of a new landrover buying helicopter flying time.

Having reached the patient, drunk tea, and established a clinic either ad hoc in a tent or in one of the new purpose-built buildings, we encountered the next difficulty. I often needed two interpreters: one to translate from English into Arabic, the second to convert Arabic into the local dialect. Even when a literal translation was achieved conceptual difficulty remained. Just as an English patient may express the severity of his symptom by saying, "It's chronic, doctor," so too the Omani who says that he has had a cough for months may mean that the cough is very bad: he may have been perfectly well on the previous week's visit. Occasionally, a classical history broke through all barriers of race and custom: an old woman told of episodes of seeing flashing lights that heralded a severe unilateral headache.

Examination of female patients was hampered by Islamic custom. In many places the ladies would reveal no more than the umbilicus for examination, though a stethoscope can sometimes be manoeuvred subsartorially to listen to chest or heart. Diagnosing fever in the desert is difficult: I never recorded an oral temperature below 38°C. As with history taking, the diagnosis was sometimes tragically obvious: a child with cerebral palsy, a patient with leprosy or with asthma. Fortunately Dhofar was not the museum of advanced pathology I had callously expected before my visit.

The hospital in Salalah was young and its laboratory not fully developed. Confirming a clinical diagnosis with investigations was not often practicable. It was easy for one's thoughts to follow a circle. Thus a relapsing febrile illness with rigors was diagnosed as malaria and treated as such; a diagnosis was entered into the records; the statistics then showed a high incidence of malaria; so febrile illness with rigors was likely to be malaria. I began to wonder whether anyone had ever seen a malarial parasite in Dhofar—but my suspicions never interrupted my own habit of taking antimalarial tablets.

The final difficulty was to institute appropriate management. The British routine for threatened abortion does not appeal to a mother with four young children and a herd of goats to tend. Patients with tuberculosis could not be persuaded to take their drugs faithfully every day for a year, and drugs sometimes ran out while the monthly supply from the north was awaited. The concept of immunisation was impossible to explain, but fortunately our sessions were regarded as great entertainment.

Of course, an elective is not all medicine: there are people to meet, places to visit, things to see. The Omanis are immensely charming and everyone who looked after me, native and expatriate, was kind and generous. The north of the country has many fine mediaeval castles, and along the coast from Salalah lie the ruins of Samhuran, the main port for exporting frankincense in Roman times. The deadwood of school geography texts sparks into fire: rocks, strata, faults, erosion, coastal plains, three-layer cultivation—all are obvious. Biblical parables come alive: who in England can really understand how a house came to be built on sand? In Oman you can see just what Jesus meant. There is plenty to interest the zoologist and botanist too. If you have a chance to visit Oman, seize it.

Reading for Pleasure

An autumn collection

K B THOMAS

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On these still autumn days when nature seems to pause for a while in her progress, to contemplate and dream, I am glad of this opportunity to do the same—to stop for a moment and remember what I have read, and tell you about some of the impressions which come into my mind. What follows is the result of this interlude.

Reading about work

When I began to think about what I had read during the last six months, I had a dreadful feeling that perhaps it was confined to the journals. And, although I soon realised that this was not so, there is no doubt that the journals do occupy a large part of my reading time. It is strange how interesting it is to read what other people think and feel about work which in itself is often tiresome and sometimes unbearable. Journals, like doctors, view general practice in different ways. *Update*, an excellently produced magazine, sees general practice as hospital medicine. A succession of cases of patients with disease, mainly organic, are well described and discussed; the editorials, however, are often more adventurous. *World Medicine*, a much messier magazine, appeals to me more. It sows doubt and dissension along the way, suggesting that things are not what they seem to be, and, as this is how I frequently find them to be, I enjoy it. The *Practitioner*, in spite of its new format, has a respectable Victorian air about it. I am not the least surprised to note that it was founded in 1868. General practice is viewed as the serious and sensible treatment of real disease, and the journal frequently has historical articles which I enjoy.

The *Journal of the Royal College of General Practitioners* appears strangely detached from everyday life. Its contributors are not greatly interested in organic disease, and prefer to see the patient as suffering from psychological or social factors. And it seems to me to have little relevance to ordinary general practice. Because the MRCGP is seen as a means of advancement the college will probably grow, and this influx of new blood may well change the nature of the journal—which at present seems a little lost and inward looking. Perhaps some psychotherapy would help.

The Surgery, Forest End, Waterlooville, Portsmouth PO7 7AH
K B THOMAS, MD, general practitioner