PRACTICE OBSERVED

Overlapping with General Practice

MP's surgery

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It is no accident that a member of Parliament usually refers to his advice bureau sessions as "surgeries" or "clinics." Yet if one judged by the functions of the parliamentarian and doctor overlap purely because of the similarity of our "surgery" contacts it would not be an adequate comparison. Just as the general practitioner has a whole range of responsibilities other than the face-to-face meetings with his patient, so does the MP. In both cases one accepts responsibilities for complete coverage for seven days of the week and for the whole of the year.

How can the constituent judge the quality of the service given by his MP? One may also ask how does the patient judge the competence of his family doctor? Before I went into Parliament in 1959 I was the national organiser for the Medical Practitioners Union. In this capacity I met 300 or 400 GPs every year. The brass plates all looked the same. The letters after the name were similar. Yet I learned that although I encountered doctors to whom I would unhesitatingly commit my life and the health needs of my wife and children, I met some who could not command my confidence.

Some MPs are known as "good constituency members." Others take the view that they are elected to Parliament to work in that field, engaged in legislation and all of the other central responsibilities that find their centre of gravity in Westminster. "It is not my job," said one colleague to me, "to be a glorified social worker. There are other avenues for that kind of thing, and it would detract from the value of my input into governing the country." It is a matter of personal choice. For my part, I am a constituency MP because I find that my constant relationship with the people of Brent South keeps my feet on the ground and

prevents my head getting lost somewhere at the top of Big Ben.

One of the annoying comments that an MP hears is that he doesn't really know what ordinary people are actually thinking; he is removed from the hurly burly. No way! I cannot have a quiet drink at my local workingmen's club without every single member wanting to buttonhole me and tell me about the problems of the day. Especially what the "lads in the factory" think.

We share with the doctor the difficulty of getting away from our job. The doctor goes to a social gathering, is introduced as Dr Smith, and immediately the person says "my aunt has got this problem with her hip, or 'I've had this sore throat. . ."

Likewise the MP is always tied to his profession. Often one is asked to address a non-political occasion and the secretary may say, rather anxiously, "I hope you don't mind—no politics." In fact, we are delighted. It is a poor MP who cannot respond to every situation in which he finds himself. At our surgeries we learn very early in our careers that there are more cases presented to us about which we can give very little help than those that we are able to resolve. An MP has two great assets. The first is to be able to listen, and to let the constituent get it off his chest to someone he thinks is important. To listen with sympathy. The second asset is a piece of notepaper: the august heading of the House of Commons, London SW1, complete with portcullis crest. And even if there is very little of practical use in the reply one sends, the constituent feels that at least somebody has taken the trouble to examine his difficulties and try to help.

Power

I think that perhaps like the family doctor we suffer from the fact that people think we have more power than we actually do. We are presented with many problems that do not lie within our

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competence to solve, except to advise another course that may assist or offer some understanding of the situation. If ever we start becoming self important we are soon put in our places by the constituent who says "and, Mr Pavitt, if you can't do anything, I'll write to the *New York Times*." That makes it quite clear where power really rests!

Night calls? It is so happens that I have the highest number of constituents from the "night" sessions in July (which is the boundaries of my borough. That means that I get at least half a dozen cases of immigration problems a week. Most of these have a standard procedure because they can only be processed on written documentation. There are, however, the Heathrow and Gatwick cases. On the weekends at 11 o'clock at night there may be an urgent call to say that Mr Patel has arrived at Heathrow, was refused immigration, and is about to be deported. This is where we are grateful for the all-night duty life and the Home Office who can hold the deportation until the MP has been given a chance to present a case for the would-be immigrant.

Unlike the GP, we are not called out by individuals, but, like the GP, if you look at the parliamentary sessions in July (which is known by us as the Mad Month), and see the number of times there were all-night sessions or the House rose at 2 am or 3 am, you will be surprised. Alas, we cannot employ a deputising service, either for late nights or constituency weekends.

I still chuckle at a case I had a few years back. A woman presented at my surgery with a marital problem. An unhappy wife who thinks that her member of Parliament can restore her husband's fidelity is an example of despair—"I don't know which way to turn." After listening with sympathy it is invariably a case to pass on—to the marriage guidance council, or to social workers, or to the priest, or to a voluntary body. On this occasion I was surprised when the woman said, "I am most grateful to the borough, they have been very helpful." The borough council? How can they be helpful on the breakup of a marriage? The explanation was that "my husband is the lavatory attendant at Silver Lane and he has fallen in love with the woman in charge of the Ladies next door. So the council have shifted her to the other side of the town, but my husband still refuses to give her up." But then she said very wisely, "The difficulty is that neither of us is getting any younger. I'm 69 and he is 71."

Some of the saddest cases fall under the heading of housing. In my borough there are more than 10 000 on the waiting list for accommodation. A very rigorous points system decides priorities and in the allocation three points are allowed for medical need. Many constituents go to the family doctor and get the necessary certificate; this then may be turned down by the community physician. Then the MP is expected to give a clinical judgment. A good MP never attempts to move from his own field of competence.

Too many of the sad cases presented to me are of young couples who have decided that on getting married they will live temporarily with his mother or with hers. In my typical inner-city area this means moving into inadequate accommodation right from the outset, and then when the baby comes into tension grows. I need to say that the wife who comes out of hospital to survive is a roof of their own. But there are not enough roofs.

In Wiltshire two-thirds of families share a house or live in high-rise blocks. An elderly couple may be living "upstairs" when the husband has a coronary. When he comes out of hospital he is told: "No stairs." Then comes the heartache for the MP. With all the good will in the world he tries to move heaven and earth, just to get a downstairs flat. Once I even got front page publicity in the local newspaper only to have the widow come in to thank me for my unavailing effort three months later.

One thing that "surgeries" teach politicians is humility. People are so sure that one has power far beyond that which we actually possess. Do patients go to doctors also expecting a magic wand? Just as the GP must get to know his back-up team—health visitors, social service workers, hospital casualty departments, hospital administrators, pharmacists, and others who form part of the provision of service to his patient, so too a member of Parliament. He knows personally the director of

housing, director of social services, hospital administrators, the council for social services, the leaders of the youth clubs, the clergymen in the Church of England and the Methodist, Baptist, and Catholic churches, the rabbi of the synagogue, the local councillors, the local community relations council, the Joint Council for the Welfare of Immigrants, and the law centre. Because I have to deal so much with both the Department of Health and Social Security (because health is my specialty) and the Home Office, one gets to know the private offices in the ministries concerned.

One gets involved in good causes—in my case with Action on Smoking and Health and the Royal College of Physicians in trying to prevent rather than treat chest and heart diseases. I work with the Child Poverty Action Group, MIND, Age Concern, the Brent Aid for the Disabled, and other organisations for the welfare of the elderly.

We attend the Christmas party of the Darby and John Clubs and the carol concerts at the primary schools. During my time in Parliament I have passed the 4000 mark of the number of schoolchildren I have taken on a tour of the Palace of Westminster.

In common with many doctors who attend an international conference or seminar I too enjoy meeting parliamentarians from other countries and exchange experiences. As a non-graduate and layman one of the most fascinating jobs I had was serving as a member of the Medical Research Council for three years. This is the only body that has a provision in its charter for an MP from the "back benches" to become a member. But he must not be paid a single penny, as this would mean an immediate veto. It is the equivalent of "applying for the Children's Fund."

Like the doctor's, my job is probably overfull—too many hours, too many commitments. Yet like the doctor's it has in it the same ingredients of satisfactions, frustrations, enjoyment, misery, excitement, boredom, achievement, and disappointment. Nevertheless, if we didn't like the job we wouldn't do it. So never grumble.

The touchstone is the human characteristic—to like people of all kinds, all colours, all races, all creeds, the infinite variety of human personalities. If you do not like people never be either a doctor or a member of Parliament.

Diary of Urban Marks: 1880-1849

The column mentioned earlier served for some weeks and acted as house surgeon to Mr Brook while I was engaged with Elsworth. Between us we organised the work and each took an equal share of it as far as the surgical work was concerned. At that time there was very little medical work and I have known the house physician, Miss Florence Price, to sit up all night with a pneumonia case, so rare were they in the hospital. In fact any acute case was rare and the medical ward was given over to chronic cases such as are found in the infirmary. Miss Price attended in the Eye Hospital and eventually married Frank Thomas, the ophthalmic surgeon. But it took him a long time to find out that he loved her. Miss Price had been the house physician for a year before I went to the hospital and during that year a man called King Jones was house surgeon along with Isaac. Jones and Price became engaged and in my year of office, she could talk of nothing else but Jones. The usual presents were exchanged. On one occasion Jones came for a weekend and stayed in the hospital. Next morning on arriving down to breakfast, I found the legs of a very large armchair broken and the seat resting on the floor. But Jones was a bulky man and the legs of the chair may have been torn. Towards the end of the year, Miss Price came to me to inform me that the engagement was broken. King had returned all her presents and she did not know what to do with them because they were all engraved. They could not be used again. I suggested pawning them but this she would not do. We went to a jeweller in the town and sold them for the current prices of gold and silver. I advised her to keep her own presents and I think she did so. I never saw King Jones again but I saw that he was killed in the Great War.

General Practitioner Hospitals

Challenges for general practitioner hospitals

C D SHAW

During the late 1960s many small hospitals were closed and the staff and number of beds of many more were severely pruned. The national policy was to replace small peripheral hospitals by large central ones. Fifteen years and some monstrous sized hospitals later, the tide has turned and the current policy (born partly of economic necessity) is to make the most of existing capital stock. Moreover, the trend world wide is to develop primary care services rather than high technology centres, and in Britain at least a growing consumer voice demands that health services should become more personal. This, combined with a resurgence of community support in cash and kind, has put small local hospitals in a relatively strong position.

Unless the costs of running such hospitals are acceptable, however, the potential revenue saved by closing them will be closely scrutinised by district managers. Their future security depends on the support, if not the initiative, of the medical staff. Many of the ideas in this article are based on observation of general practitioner hospitals in the south west, but the principles may apply also to other hospitals and to other regions.

Characteristics

General practitioner hospitals are usually small, independent, and traditional. These traits, which endear them to local staff and communities, unfortunately, also make them particularly vulnerable to problems that encourage their demise and that are recognised too late to prevent closure or withdrawal of services such as maternity, surgery, casualty, and radiology. Smallness is not a problem but implies a need for general practitioner hospitals (unless larger hospitals) to prove that they are efficient and adequate. Like many minorities, such hospitals have to show that they are at least as good as, if not better than, their competitors. Independence and tradition, however, may be superfluous in being out of step and out of date. General practitioner hospitals must adapt to changes in health care needs, in technology, and in management if they are to remain an important ingredient of the services provided in a district.

External management

If the image of a cottage hospital left undisturbed by the district management team seems idyllic, it is also misleading. If only to secure continued financing small hospitals must be recognised as providing a positive contribution to health care

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and this must be written into the overall planning of services in the district. Thus they must have policies defining what services they will (or will not) provide and how the services will be provided.

The Department of Health and Social Security¹ has recommended general policies for admissions and discharges in these community hospitals agreed by general practitioners, consultants, and nurses and coherent with district planning. These have been endorsed by many independent groups²⁻⁴; but few hospitals have such policies. If the task is not made clear the appropriate resources cannot be determined, let alone made available. Moreover, there will be perennial skirmishes—for example, between general practitioners, surgeons, and geriatricians—over who controls beds and what they should be used for.

Apart from the need for clinical liaison, small hospitals should also maintain contacts in the district centre to balance the dominant lobby of the district general hospital. Despite the recent emphasis on smaller "units," the day to day decisions on their management are often made miles away and possibly with inadequate information. There must therefore be effective formal links between the hospital and district management. Furthermore, the medical staff at general practitioner hospitals must be adequately represented in the medical advisory structure. Few general practitioners have sufficient experience of small hospitals to represent their problems at district level without careful briefing, and many who do live too far to attend meetings regularly.

Internal management

Two other traditional views sometimes prevent small hospitals from resolving their problems before someone else steps in to do for them. One view is that there is no need for formal regular meetings between representatives of the medical, nursing, and administrative staff, on the assumption that everyone is always available should the need arise. This may generally be true with regard to resolving clinical problems but not for resolving general issues that concern more than one doctor or patient. If all of the doctors (or their recognised representative) are not available to help to manage problems, decisions will often be taken on their behalf by someone else.

The other view is that doctors have neither the right nor the need to restrict each other's autonomy; there is therefore no need for a staff structure or a spokesman. In practice, there are rules, usually unwritten, by which doctors organise their work in the hospital and all is well as long as the rules are acceptable to other staff (especially nurses) and are the same for all doctors. But if a doctor ignores the maternity booking policy or is unavailable to cover casualty the patients and the effectiveness (and thus the future) of the hospital are put at risk. An example is the casualty unit that has to cope with a different policy on tetanus immunisation for each doctor. Hospitals served by a single group practice need less formal organisation,

but must have long outgrown the tradition of an unstructured medical staff.

The medical staff should accept responsibility for the medical management of the hospital and for the ethical and professional conduct of its members. Specific functions should include:

- organising clinical services in the hospital and in relation to the community and other hospitals;
 - organising the medical staff such as availability of cover for casualty services;
 - reviewing clinical practice and use of facilities;
 - promoting postgraduate education for medical, nursing, and other clinical staff;
 - developing hospital policies such as general criteria for admission, transfer, and discharge of patients, infection control, and adequate medical records;
 - agreeing recommendations for allocation of resources;
 - controlling prescribing and distribution of drugs in the hospital with a hospital pharmacist.
- The medical staff may function as a committee, or they may appoint an executive to act on their behalf. The medical staff committee should: (i) include representatives from nursing, administration, and visiting consultants; (ii) meet formally at least quarterly; (iii) elect one or more representatives to manage day to day problems; (iv) keep records of subjects discussed and decisions taken.

Particular problems

Many common problems of organisation that occur in general practitioner hospitals could be resolved by the doctors concerned, but in practice effective and lasting solutions are usually achieved only if the whole staff support them. For example, case selection is probably the most important single determinant of the value of maternity, casualty, and surgery services in general practitioner hospitals. Unlike larger hospitals, which have a wide range of diagnostic and therapeutic facilities to cater for the unexpected, small hospitals rely heavily on avoiding the unexpected. Although the selection of individual cases suitable for admission depends ultimately on the doctor in charge, general policies should be defined and monitored by the staff based on the skills of the staff and the facilities. Limitations of smaller hospitals may be minimised if steps are taken to ensure that inappropriate cases either are not admitted or are transferred out. Regular liaison with consultant colleagues is therefore essential. The medical staff should also consider general organisation and individual clinical problems.

Continuity of care is a further challenge, which leads to the question of who ultimately takes clinical responsibility. For example, in many hospitals where surgery is performed the operating is done by a visiting consultant with the help of an anaesthetist who first sees the patients on the day of the operation. After the operation the patient is attended again by general practitioners on the staff. It is essential that all the staff concerned are clear about what is happening to the patient and who is in charge.

Clinically it may be of little relevance but it is interesting to consider the legal position of general practitioners providing postoperative care after surgery performed by a visiting consultant. Because of the bed fund payments and the lack of a clinical assistant contract, it may be assumed that the general practitioner is acting in his own right and not as a "junior" on behalf of the consultant. But what relationship is there between a general practitioner anaesthetist who is paid on a sessional basis and the district coordinator or other consultant anaesthetists? In theory the last two are responsible, but they often have limited practical control over anaesthetic policies, procedures, equipment, and training.

Postgraduate education in general presents particular problems to general practitioner hospitals partly because programmes are often based on the assumption that all staff have easy access to

the district centre. In practice, many general practitioner hospitals are too far away for lunchtime meetings, and nursing staff, for example, cannot be spared for full day release courses. Furthermore, postgraduate education after evening hours for hospital specialists or for primary care services in the community, but all staff in general practitioner hospitals need a combination of the two. In some districts general practitioner hospitals have solved such problems by arranging with the organisers of postgraduate education to provide sessions that are tailor made. Such a scheme requires the commitment and support of the whole staff.

Medical records and statistics also have something to contribute to the general practitioner hospital. Although they both receive more and more attention in surgeries and health centres, they are often ignored in peripheral hospitals. The need for communication and continuity has already been referred to in the interests of clinical care, but what statistics are recorded and how they may be used—for example, in monitoring use by the district or in reviewing clinical care by local clinical staff—should also be of interest to general practitioner hospital staff. Statistics that are collected routinely now determine payment for inpatient and casualty cover. In view of the importance of records and statistics, surprisingly little attention is given to them either by local clinical staff or by district records officers.

Conclusions

The general recipe for progress in general practitioner hospitals is to define their functions and incorporate these into district planning. They are not quaint reminders of the past but are providers of the care that the community needs. To do this, the staff in each hospital must recognise the weaknesses in each, work towards improving them, and demonstrate the quality of the service they provide. Furthermore, general practitioner hospitals must not only be effective and economical but also politically adept at proving it.

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Diary of Urban Marks: 1880-1849

The end of my year of office as house surgeon coincided with the termination of Miss Price's as house physician. We both put in an application for the vacancy and we were asked how long we would guarantee to stop. Miss Price said 12 months, but I could not see my way clear to stay longer than six months and in consequence Miss Price was re-elected. She stayed another year—1907—and then had to resign, having held the post for three years. Then Frank suddenly woke up and they became engaged. They were married in the early part of 1908 and for years have practised in partnership as ophthalmic surgeons. Their married partnership has also been successful. They have four children, one of whom is training for the medical profession.