Correspondence

Letters to the Editor should not exceed 500 words.

Casualty Department—or G.P. Service?

SIR,—A survey of patients was undertaken at this hospital to determine the way the casualty department was used. Each year about 11,500 new patients are seen, and there is a total attendance of 25,000. Eighty per cent. of the new patients and all re-attendances are seen by the casualty officers between the hours of 9 a.m. and 9 p.m. The remainder of the new patients presenting during the night are seen by the resident house-officers.

An analysis of all new patients attending over the three-month period from October 1966 to January 1967 was made. They were divided into four main groups.[1]

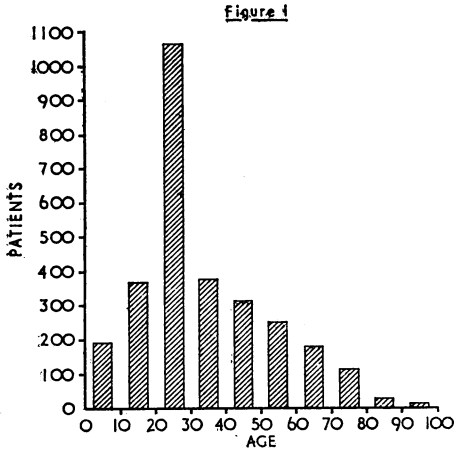
(1) Accidents.
(2) Medical emergencies.
(3) Surgical emergencies.
(4) Casual attenders.

All were then considered in relation to age. The reason why patients in Group 4, the casual attenders, came to hospital was also examined.[1-4] The survey was completed by correlating the cases with the population and type of area which the hospital serves.

Accident cases account for 52% of the patients seen, medical emergencies 9%, surgical emergencies 11%, and casual attenders 28%. These figures represent the average for all age groups, but there was no marked variation when each decade was considered separately.

A most striking feature which emerged was that nearly 40% of all new patients attending the department were between 20 and 29 years (Fig. 1).

Figure 1



The reasons given by casual attenders for their call on the hospital service were:

(1) The patient had no general practitioner in this area—37%.

(2) It was more convenient to come to the hospital than to see or call their own doctor—27%.

(3) The patient's own doctor had no surgery that day or was not available—15%.

(4) Patient was a visitor to London—8%.

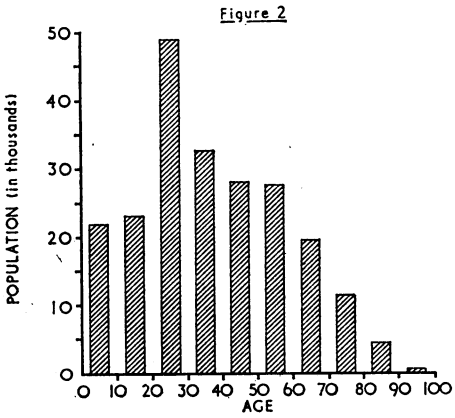
(5) The patient was under the care of the hospital for some complaint and therefore felt he or she should always be seen at the hospital—7%.

(6) The patient wanted a second opinion—6%.

The hospital serves mainly the Kensington and Chelsea districts—that is, the following London regions, W.8, S.W.5, S.W.7, and part of W.14. It is a densely populated area with heavy urban traffic, many hotels, but very little industry. All social classes are represented; there is a high student population and many young people living in "bed-sitters" and flats.

The number of young patients attending the casualty department is high, and this is probably typical of most casualty and accident departments.[1 2 5] It also conforms to the age distribution of the local population (Fig. 2).

Figure 2



There is a high percentage of casual attenders, but the department is still called "casualty" rather than an "accident and emergency department." We feel that a change to the latter would not cause a significant drop in the number of casual attenders because:

(1) A certain number of people will always present themselves at a hospital demanding attention.

(2) Type of area served: the department sees visitors to London if they are taken ill in this area.

(3) The shortage of general practitioners.

This last factor seems significant. Nearly 40% of the casual attenders are not registered with a general practitioner in this locality, and of these nearly a quarter had tried to register with one or more doctors before seeking the aid of the casualty department. We assume that if the other three-quarters of the casual attenders with no local doctor attempted to register they would meet with the same problem. Of our casual attenders 10% are registered with a practitioner in another area. About 25% of all our patients resident in this area (as opposed to visitors and those in transit) have no local general practitioner. It has been stated that there is no need for hospitals to provide a general-practitioner service.[2 5] Our experience suggests that if this hospital did not maintain its "open door" policy many people in this locality who required medical attention would receive none.—We are, etc.,

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2 Fry, L., ibid., 1960, 1, 163.
3 Lowden, T. G., ibid., 1956, 1, 955.
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5 Report of the Subcommittee on Accident and Emergency Services, Ministry of Health Standing Medical Advisory Committee, Central Health Services Council, 1962. H.M.S.O.

Endotracheal Tubes

SIR,—Reviewing the changing pattern of anaesthesia in a general hospital, Professor W. W. Mushin and his colleagues note that the greatest number of operations in any one year of life occurred in children up to 1 year.[1] It is probable that there is an increased use of endotracheal anaesthesia in infancy.

In 1962 experts from the Admiralty, War Office, Air Ministry, and others assisted the British Standards Institution to draw up a specification for endotracheal tubes.[2] Tubes to this standard are now marked according to the internal diameter. They are available from 2.5 mm. to 11 mm. in 0.5-mm. steps with an allowed tolerance of ±0.2 mm. The thickness of the wall in the first five tubes is identical—namely, 0.6 mm., with a tolerance of +0.2 mm. or −0.1 mm. A 4.5-mm. tube has a wall thickness of 0.6 mm., but a 5.5-mm. tube has a wall twice as thick—1.2 mm. Thus what at first sight appears to be an even grading results in considerable differences in external diameters. Also the limits of tolerance allowed the manufacturers permits quite a large variation.

The area of the air passage at the level of the cricoid ring of the newborn is approximately 14 sq. mm.,[3] and 1 mm. of oedema will reduce this area by 65%.[3] Familiarity with the Hagen-Poiseuille law may tempt junior anaesthetists to use too large a tube for an infant, especially if relying on a formula to calculate the correct size. If tubes were available with a more even progression in their external diameters this law might be more safely and less traumatically applied.—I am, etc.,

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2 *British Standards Institution Specification B.S. 3487*, 1962, p. 11.
3 Wilton, T. N. P., and Wilson, F., *Neonatal Anaesthesia and Allied Problems*, 1965, p. 3., Oxford.