arriving during the session or for treatment of patients seen by a doctor but not needing to go into an examination room. At other than consultation times she can use the treatment and examination rooms for treatment or follow-up examination of patients referred to her by a doctor, such as the types of case listed by McGuinness (1970).

Discussion

It is becoming accepted that a nurse is a valuable asset in a general practitioner surgery, but the use made of her services is influenced by the type of service given by local authority nurses in the home. Some local authorities are quite willing to attach a district nurse to a practice so that she may carry out more efficiently in a surgery the routine dressings and injections formerly given in the home, but they are less inclined to allow an attached nurse to take part in the general running of the surgery. From the local authority standpoint a treatment room in a health centre well away from the consulting rooms may appear to be an adequate arrangement. To general practitioners who have had an ex-theatre sister at their elbows for 20 years it is primitive in the extreme. Moreover, in a small establishment such as a general-practitioner surgery no member of the staff should be isolated. Secretaries, receptionists, and nurses must be willing and able, if only in small measure, to give help where it is needed. But to be able and willing is not enough; premises must be so planned that help is possible.

There are without doubt many small surgeries up and down the country where the nurse or the receptionist gives the doctor the type of help we describe. Either its value has not been recognized by designers of premises or they have found it too difficult to provide for it in group-practice-surgery designs. The Ministry of Health (1967) visualizes a nurse only in a treatment room. The National Building Agency and College of General Practitioners (1967) do not, in their plans, make provision for close proximity between examination rooms and nurse/treatment rooms.

One of the attractions of general practice is that to a greater or less extent, every general practitioner can shape his practice to conform to his own individual desires. We fully recognize that many do not wish to use separate examination rooms or to work in close co-operation with nurses, and will therefore need premises planned accordingly. To those who want both separate examination rooms and nursing assistance and are considering building or adapting new premises, we suggest that the present plan will be a better basis for improvement or adaptation to suit their own needs than many of those published in offical guides.

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HOSPITAL TOPICS

The Middle Care Round

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Summary: As an experiment in postgraduate education a 25-week course in weekly ward rounds for general practitioners and local authority nurses was established at a district general hospital of 340 beds. A total of 73 rounds were held, divided into 12-, 4-, and 9-week courses, from January to December 1969. Ninety-nine general practitioners and district nurses (including health visitors) attended one or more of these rounds. Seventeen consultants participated and there were 273 doctor attendances and 190 nurse attendances. The average attendance per round was four doctors and two nurses. The number of rounds conducted by each of the consultants throughout the course varied from two to six. This paper presents an evaluation of the course.

Introduction

In relation to the patient and his general practitioner the "middle care" round was evolved to fill the gap between the care of the patient by the general practitioner and local authority nurse before admission to hospital and subsequent care after discharge. Thus the objectives of these rounds were not for the consultant to bring in cases of special interest, nor to keep such patients back from discharge.

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The rounds demonstrated middle care to general practitioners and district nurses by means of (*a*) advances in technique in regard to investigation and diagnosis, (*b*) preoperative and postoperative care, and (*c*) medical and nursing management of acute or chronic illness.

Postgraduate Course of Rounds

Recognition.—In October 1968, three months before the course began, approval was obtained from the dean of postgraduate studies, Cambridge, for recognition of each round as a third session (one and a half hours). Forms GPRC 3 and 5 were made available for completion.

Preparation.—After recognition had been secured 17 of the hospital consultants submitted information on which days and times they could conduct ward rounds for this purpose. A four- or six-week cycle was prepared comprising three rounds a week involving different specialties. Each cycle so prepared was circulated to consultants, general practitioners, and nurses before the start of each cycle and a reminder for each week was dispatched the week before. The course avoided the Easter, summer, and Christmas holiday periods. The full co-operation of the hospital nursing staff on each ward concerned was obtained. Each round was notified to 90 doctors and 123 nurses. The distribution of the rounds is shown in the Table.

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Distribution of Rounds

Specialty	No. of Consultants	No. of Rounds
Medicine	3	17
Surgery	4	17
Paediatrics	2	10
Orthopaedics	2	9
Gynaecology	3	7
Intensive care	1 (Anaesthetist)	6
Ophthalmology	1	4
Child psychiatry	1	3

Evaluation.—A total of 41 doctors (45%) and 58 nurses (47%) attended one or more of the 73 rounds. The doctors shared 273 attendances and the nurses 190 attendances, the average per round being four doctors and two nurses. Some rounds attracted only one or two doctors (mostly the early morning rounds), while in others, particularly those in medicine and paediatrics, from 10 to 20 general practitioners and nurses presented. By far the most popular rounds early in the course were the medical and paediatric, and in the spring of 1969 the nursing superintendents of the city and county councils had to restrict nurse attendance through a booking system.

Questionaries

One questionary was directed to general practitioners and another to local authority nurses, and each sought opinions on the following points: (1) the concept of the combined round, accepting that the teaching content of the round was at "doctor" level throughout; (2) the value of the information received; (3) the optimum numbers for such a round; and (4) the best time for these rounds.

According to 90% of the returns from doctors and 46% from nurses the results were as follows: (1) Of the 41 doctors 19 approved of the combined round, compared with 23 of the 58 nurses; (2) all doctors and nurses were agreed about the intrinsic value of the rounds; (3) the optimum number for a round appeared to be eight; and (4) most of the doctors and nurses showed a preference for afternoon rounds.

Comments on Value of Round

General Practitioners

"Surprisingly enough, I understand the talk at 'doctor' level and have learned something from each round."

"For the most part invaluable—one or two exceptions."

"Personal tuition from experienced teachers . . . Opportunities for mutual appraisal of consultants and general practitioners . . . . Opportunities for friendship to develop and be fostered between hospital staff and general practitioners . . . . The presence of nurses is helpful provided they don't outnumber the doctors."

"I am sure that these rounds are of considerable benefit to all who attend and I sincerely hope they will continue. Incidentally, they are a very 'painless' way of obtaining sufficient sessions to qualify for seniority payments."

"I think both the nursing and medical problems involved are of value to the general practitioner and just as we are prepared to listen to the nurses' side of the problem so they should be prepared to tolerate the more technical of some of the strictly medical or surgical aspects of patient care."

"The rounds are excellent and the time given up by the consultants is very much appreciated."

"These rounds are of great help to general practitioners for they serve to fill the gap between ourselves and our hospital colleagues and to show how problems can be resolved and new techniques absorbed."

"As a practitioner of 30 years since, I have found them extremely interesting and instructive . . . an ordinary ward round is of much greater value to G.P.s than a profound and learned dissertation on a few rare cases."

"The most important part of the round is the rapport which can be obtained between the general practitioners and consultants and the chats which take place."

"Nurses should have rounds of their own as in teaching hospitals. Doctors' rounds should be for doctors."

"Excellent way of keeping in touch with up-to-date medicine and learning the fate of our patients in hospital . . . a good chance to question consultants, who all seem very co-operative. I prefer to see patients than have a set lecture."

Local Authority Nurses

"The middle care rounds are most interesting and one can gain a considerable amount of knowledge from them."

"Very useful as regards keeping up to date with modern procedures and methods of treatment" (several replied in this fashion).

"Opportunity for meeting other members of the staff" (several times).

"Valuable postgraduate tuition."

"Discussion with one's medical colleagues is very much appreciated."

"Some rounds are helpful for nurses as well as doctors—others need to be geared to the nursing aspect of the case."

"The rounds have been very helpful in keeping district staff up to date on equipment, drugs, and treatment . . . adding a great deal to the help and reassurance we are able to give to a patient after discharge and during convalescence at home" (health visitor).

View of Consultants

Most of the consultants who took part did not object to combined general-practitioner and nurse rounds, and by mid-summer, when the course was well established, the initial high attendances had settled to between four and eight, depending somewhat on the specialty and the time. The consultants enjoyed doing the rounds and meeting those general practitioners who attended. Coffee or tea and biscuits were provided at ward level at the end of each round—this was an essential and appreciated part of the session.

Discussion centred on differential diagnosis and investigations in relation to common problems in hospital, together with treatment and aftercare. Discussion of pertinent sociological problems from time to time revealed the relevance of this aspect of patient-care, not only in paediatrics and psychiatry. At ward level it was obvious that the local authority nurses appreciated both the medical discussion and the opportunity to establish contact with the nursing staff on the ward and the exchange of views on mutual problems to the benefit of patient-care.

Teaching Content

Teaching content depended entirely on the availability of cases at the time. Over the whole period the following subjects were discussed in the various specialties and illustrated by patients in the wards.

Medicine

The common subjects on these rounds were hypertension, anaemia, bronchitis, bleeding ulcer, and coronary thrombosis. Symptomatology, differential diagnosis, and management were discussed at or near the bedside as appropriate. Two or three patients anaemic from different causes would form a basis for illustrating the value and significance of investigations leading to a specific diagnosis, such cases being readily available in a district hospital.

A bleeding peptic ulcer, besides illustrating the need for exclusion of iatrogenic cause, provided the physician with an opportunity to discuss criteria for medical and surgical man-

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agement. Coronary cases of differing severity enabled contrast and comparison in history and clinical findings to be fully evaluated. Of course, the pros and cons of anticoagulants invariably entered the discussion. The modes of action and indications for the various hypotensive drugs were explained when the ward round came to such a patient, and the rationale behind the particular treatment in that one case was underlined. The place and timing of assistance from the ancillary departments of physiotherapy and occupational therapy was emphasized in relation to patients with bronchitis, arthritis, or strokes as part of their general management.

The consultants who conducted these rounds would readily admit of the "basic medicine" character of the demonstrations and discussion. Nevertheless, from the viewpoint of the general practitioner and local authority nurse it became a relatively painless way of coming up to date and closing the gap between their days in hospital and the present situation. Not unnaturally, one or two of the rounds included a case of more unusual interest; for example, brain tumour—the type of case which is comparatively common in hospital but comparatively rare in any one practice. Though not always pertinent to the problems of general practice, such hospital cases on the round evoked a great interest.

Gynaecology

These rounds invoked discussion on the technique and results of various types of repair operations, indications for hysterectomy, and the question of ovary preservation. Almost invariably there would be patients who exemplified the need for care in the diagnosis of the acute abdomen or ectopic pregnancy. Sometimes one of the consultants in gynaecology demonstrated with slides the problems of cervical cytology and the relief of pain in labour. Another subject, relatively new and interesting to consultant and doctor alike, was that of osteomalacia in Asian immigrants during pregnancy. Not unexpectedly the rounds threw up the complexities of pregnancy terminations.

Child Psychiatry

These were not rounds in the normal sense but case demonstrations, including behaviour disorders and psychosomatic conditions in children. The value of these lay in improvement in the understanding of referral of patients and a clearer interpretation of those situations where a child needed only firmness and control and those where there was a definite psychiatric disturbance. The advantages of the three groups—consultant, general practitioner, and nurse—in these sessions went a long way towards clarifying the issues of the role of the psychiatric clinic in relation to the parent, the child, and the children's department.

Intensive Care Rounds

In principle these illustrated the need for minute-by-minute nursing, observation, and care, and hour-by-hour medical observation and treatment. There was no dearth of material on any of these rounds and typical cases were coronary thrombosis, overdose, postoperative major surgery, and preoperative or postoperative major trauma.

The mechanism, function, and indications for modern ventilators and oscillographs were easily demonstrated in actual use at the time of the rounds. Later in the year a hyperbaric oxygen machine was installed, and this added to the interest already shown on these particular rounds.

Ophthalmology

Here the main points of interest concerned glaucoma, cataract, squints, and detachments, with their present-day management. Cases presenting problems of diagnosis in the acute red eye, dendritic ulceration, uveitis, and injuries often occurred. The use of cryosurgery and its results provoked interest. These rounds were considerably helped by visual aids, such as diagrams, coloured drawings, or paintings.

Paediatrics

Here were perhaps the most consistently well-attended rounds and, indeed, still are. They covered a wide range of common conditions and many rare cases. Instances of the former were feeding problems, iron-deficiency anaemia, and urinary infections—all of which prompted discussion on diagnosis and management. Congenital abnormalities—namely, cardiac and neurological—sponsored the outlining of modern approaches to corrective and relieving operations. Those attending also heard of the problems of care after initial successful recovery in such cases as spina bifida. Enzymatic deficiencies and screening methods showed on many occasions that new ground had been broken in further education, while relatively new techniques, such as jejunal biopsy and its findings, likewise confirmed the need in this direction. It was often made clear to the consultant that talks on basic immunology, modern-day endocrinology, and genetics, with case illustration, stimulated keen interest.

Orthopaedics

As is so often the case in a district hospital that is also an accident centre the management of major fractures entered into most ward rounds. Equally sought after, however, was information on up-to-date surgery in joint disease, particularly the indications and optimal time for operation.

Surgery

Perhaps the commonest cases were peptic ulcer, lumps in the breast, varicose veins, and renal and prostate problems. In peptic ulcer and renal surgery both practitioners and nurses enjoyed the experience of demonstrable radiological evidence coupled with summaries of operative findings and procedures.

The present-day attitudes to breast cancer were brought home to listeners via a cross-section of viewpoints which left both the consultant and his colleagues in general practice in doubt about the right and proper treatment of any one specific case in relation to long-term results. As regards varicose veins and ulcer complications much discussion centred round these disabling conditions. The many advantages of new outpatient injection techniques were contrasted with operative results in selected cases. The varied techniques of ulcer treatment, including hyperbaric oxygen, elicited much comment from doctor and nurse alike.

The criteria for operation and the method used in prostate obstruction occupied many of the rounds, while in general a wide-ranging discussion on wound dressing, drainage techniques, and early discharge was also fruitful. So-called "surgical" jaundice was singled out on one or two occasions to illustrate the difficulties of inadequate information on drugs before entry to hospital.

Discussion

As a new venture in postgraduate education the middle care round has established a link between consultant and general practitioner on the common ground of patient care.

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Understanding of problems both in and out of hospital has been substantially clarified. Those general practitioners who attended have learnt at first-hand of the modern approach to disease requiring admission to hospital. The barrier of "us and them" has been penetrated to the benefit of both. Despite a certain reluctance, no great harm appears to have resulted from inviting senior nurses from outside into the ward situation.

Much has been written recently about the integration of the general practitioner into the hospital service. The import of "integration" is a paid service on a regular sessional basis. Some aspects of hospital work lend themselves to such a service, and there are a few, appropriately qualified and with time to spare, willing to offer their services to their local hospital. So far these services have been limited to certain departments of hospital work and no one has seriously contemplated integration at ward level in many of the specialties involved in these middle care rounds.

Conclusion

The primary objectives of these rounds in relation to general practitioners were threefold: (1) to bring the doctor back to the hospital atmosphere, (2) to bring him up to date, and (3) to renew and strengthen the link between him and his hospital colleagues. Both the questionaries and personal conversations with many of those who attended confirmed that these objectives had been achieved.

Undoubtedly some of the practitioners welcomed the opportunity to revive their interest in hospital clinical practice. The fact that most of the material on these rounds was routine day-to-day work of any district hospital suggested that here was a nucleus of general practitioners who, if time and opportunity offered, could well have been interested in a closer integration. For the present, however, the demands of practice would inevitably preclude such a possibility. Nevertheless, should future reorganization of general practice turn possibility into fact, then this sort of postgraduate education, unsophisticated and at grass-root level, might well serve as an introductory course to a service integration likely to benefit both hospital and practitioner.

I wish to express my appreciation to all my consultant colleagues for their invaluable help, and to the hospital, nursing, and local authority administration who have co-operated so fully in the exercise.

ONE HUNDRED YEARS AGO

From the Report of the Thirty-eighth Annual Meeting of the B.M.A., in the British Medical Journal, 1 October 1870

The Diet of Parturient Women. By HUGH MILLER, M.D.—The author, after referring to the increased attention paid to the study of dietetics in disease, called attention to the very vague instructions still given by obstetric writers on this subject. Particulars of a case were given, in which careful nourishing diet given during utero-gestation enabled the patient in her last confinement to escape suffering from uterine inertia. From an examination into the physiology of the changes in the uterus and breast, Dr. Miller believed that the fat-cells existing in abundance in the milk during the first few weeks were due to the changes in the womb after parturition; that the disintegrating uterus was broken up into fat-cells, which were absorbed by the blood, and through the circulation were secreted by the mammary glands. Hence a heat-forming diet was neither necessary nor was indicated, and at times might be positively injurious; whereas a flesh-forming diet, by maintaining the strength, enabled the woman to make up for the waste of tissue during labour, gave her support, and maintained the vigour of her body while the further changes were going on. The author had found great benefit through selecting the parturient woman's diet from as nearly as possible the kind of food which she was in the daily habit of taking, giving it in a liquid form and in diminished quantity. The advantages in adopting a nourishing diet to the mother he believed to be; 1. Maintaining her muscular strength; 2. Avoiding irritation to the mammary glands and enabling her to suckle sooner; 3. Securing a quicker and better recovery.

Dr. PROTHEROE SMITH quite endorsed the opinions expressed in Dr. Miller's paper. For a long series of years he had been in the habit of treating parturient women, in consequence of the extra exertion required from them, with a very generous diet; and he was certain that was the system of a great many other practitioners.—Dr. KEILLER (Edinburgh) agreed with what Dr. Miller had stated with regard to the propriety of giving a nourishing diet to women immediately, or soon after, parturition. He was quite satisfied that it was the proper course, independently altogether of any theoretical explanations of the treatment. He was, indeed, in the habit of leaving the treatment of his patients very much in the hands of good, sensible, feeding nurses. He told them to fix a rule, according, as Dr. Miller had said, to their usual mode of living, and to be guided by it. He considered it a great mistake to place a parturient woman who had been in the habit of living well on a low diet and making her a rigid teetotaller. Dr. Miller had mentioned a case in which his patient was able to leave her bed under three days. Dr. Keiller had seen a woman up and at the washing-tub a day after her confinement; and it was well known that a number of women who had illegitimate children must, to escape detection, resume their ordinary duties soon after parturition. One night he was called to a young woman whom he found in a cab. She told him she had given birth to a child, and that it was still attached; and she begged him to come with her. He took her to an hospital, separated the child, and the young woman insisted on going home within one hour after confinement. She went home within that time, and none of her friends knew that she had had a child. He mentioned also that a short time ago a young woman came to him carrying a full-grown child with the placenta still attached. He could mention still more important cases.

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