Economics of Rapid Discharge from Hospital

SIR,—The standard measurement of hospital efficiency would seem to be considerably influenced by bed occupancy and length of stay in hospital. Hospital groups which have higher costs than a regional average would appear to be unable to increase their facilities available to the public owing to lack of finance over and above their previous allocation.

It is a distinct impression in clinical practice that patients who have been in hospital until their immediate postoperative rehabilitation has been completed are invariably back at their normal work within a much shorter time than patients discharged early owing to bed shortage, whose rehabilitation is almost entirely as outpatients. The overall cost to the country in loss of production and payment of sick benefit, etc., would appear to outweigh the increased cost of hospitalization. Patients with longer hospital rehabilitation in fact cost the country less than the "quick turn round" patient.

Surely a proper independent inquiry in selected groups of conditions such as meniscectomy, varicose veins, and herniorrhaphy as to hospital stay and return to full normal work in different hospital regions would provide much more useful information regarding the true efficiency of hospitals and their relative costs to the country.—I am, etc.,

PHILIP BLISS.

Bath, Somerset.

Pay-beds in N.H.S. Hospitals

SIR,—Mr. H. H. Langston (24 February, p. 517) mentions that the chairman of the Joint Consultants Committee wrote to all consultants in January 1967 and told them what was going on. No doubt by this he means the package agreement referred to in the letter which has affected the number of pay-beds available in N.H.S. hospitals. Package deals often have unfortunate results in medicine, and in my opinion the lesson of the pay-bed situation is that package deals should never again be made on behalf of the profession.

Mr. Reginald Murley (17 February, p. 449) is right in considering that asking for comments and giving no opportunity for discussion is not consultation.

At a time when one working party advocates a system of managing directors in hospitals, and another a military style reorganization of hospital medical work, discussions on the important subject of organ transplantation are to be held by the Minister's nominees rather than by the profession as a whole. Regional committees might ponder all this with profit.—I am, etc.,

Briercliffe,
Nr. Burnley.

A. F. ROBINSON.

SIR,—I appreciate Mr. H. H. Langston's reply (24 February, p. 517), but would point out that I only advocated resignation from the B.M.A. "if our duly elected representatives fail to address themselves effectively to this task." I know only too well the complexity of the system whereby hospital doctors make their views known to the Ministry, and nobody would claim that it is particularly satisfactory. However, the Royal Colleges are precluded by their charters, *qua* Colleges, from partaking in political activity.

Therefore I would agree that it would be as futile to resign my fellowship of the R.C.S. as my licentiatehip of the R.C.P.

Unfair though it may seem to make the B.M.A. the whipping-boy for the present state of affairs, it does of course provide all of the permanent officials and a good deal of the sinews of war. We should either work effectively within the B.M.A. or sever all connexions and "go it alone." The formation of an entirely separate organization might well, as in the case of the junior doctors, result in a more effective B.M.A. and a more responsive Ministry.

Mr. Langston refers to the information sent out by the Joint Consultants Committee, of which I am fully aware. The lack of consultation to which I referred was between the hospital authorities and the doctors. Indeed, most of the management committees remained blissfully unaware of the threat to their private beds even after some of the facts had been exposed by persistent Parliamentary questions. The biggest blunder of our negotiators was to accept (and not for the first time) a package deal which gave the Minister a free hand with the private beds. When all the published documents show that our negotiators were rightly shocked by the savage recommended cut in pay-beds it surely savours of "double-think" to represent a 24% cut as "no small feat by the Joint Consultants Committee" in their "preservation of three-quarters of the pay-beds from closure."—I am, etc.,

London W.1.

REGINALD S. MURLEY.

* * A note on recent action on pay-beds by the Joint Consultants Committee and the Central Committee for Hospital Medical Services appears at p. 82 of the *Supplement*.—Ed., B.M.J.

Public Health Officers and Pensions

SIR,—My committee is anxious to obtain evidence of the deterrent effect which the present abatement of pensions regulations may have on the re-employment of public health medical officers. This might help in negotiating amendments to the abatement rules. May I therefore, through the courtesy of your columns, invite public health medical officers to send to me any evidence they may have of the present arrangements which act as a deterrent to their seeking re-employment after retirement?—I am, etc.,

J. B. S. MORGAN,
Chairman,
Compensation and Superannuation
Committee, B.M.A.

London W.C.1.

General Practice—A Worth-while Career

SIR,—In spite of my warm personal regard for Dr. J. C. Cameron I must challenge his optimistic letter (24 February, p. 506). He writes with obvious sincerity to promote British N.H.S. general practice in the teeth of its two main competitors—British hospital practice and overseas general practice. In fairness to the reader, therefore, his claims must be weighed against the attractions of these alternative careers. I cannot speak for the hospitals, but have had 10 years' experience in group general practice—nine in Britain and one in Australia. I would say unhesitatingly that this last year in Australia

has been the most testing yet rewarding of my professional life.

When Dr. Cameron remarks that "in the greater part of Britain" open access to investigation exists, I would ask when it may be expected that general practitioners everywhere will have these facilities as of right, as they do in Australia and North America. Can he deny that British x-ray departments here and there are actually withdrawing these facilities because of staff shortage? And what of the waiting-lists for investigation—frustration for patient and doctor? I compare the three-month wait for barium-meal or enema in our local hospital in Britain in 1966 with one week for my patients here.

His sense of priorities in putting general-practitioner beds ahead of his remarks on remuneration shows acute perception. This is the one reform above all others that would restore morale in, and respect for, general practice. But let us be realistic. Dr. N. A. Silverston (on the same page) points out that in England and Wales 7,000 acute beds are available for general practitioners—approximately one-third of a bed per doctor. I compare this with the 100-bed modern hospital which I share with five other colleagues, and reflect that admitting privileges are the rule, not the exception, in Australia and North America. Furthermore, does not the Hospital Plan envisage final closure of general-practitioner units within 10 years?

I do not doubt that he "aims to extend these opportunities," but, having sat with him on the General Medical Services Committee for a brief period, I am well aware (as he must be) that his aims conflict with those of the Ministry of Health. At no time has the Ministry stated an intention to reorientate the N.H.S. to give every general practitioner clinical charge of his own patients in hospital. Instead, their declared policy is for domiciliary medicine (of inevitably limited scope) from health centres, with clinical assistantships where shortages of hospital staff make them economic.

It is debatable whether remuneration is "now more closely related to work done and responsibility borne." Certainly it is not *directly* related, and cannot be, short of the introduction of fee-for-service as obtains abroad. Again, the Ministry is implacable; its face is set firmly against fee-for-service and towards salary.

Dr. Cameron has worked, and is working, harder than anyone for general practice in Britain. I take no pleasure in crossing swords with him, but British general practice will not recover its dignity and attraction on the basis of vaguely optimistic generalizations at variance with the facts.—I am, etc.,

Mudgee, N.S.W.,
Australia.

ALAN BUSSEY.

SIR,—Dr. J. C. Cameron has rightly pointed out (24 February, p. 506) that general practice is a full, interesting, and possibly unique career among the medical sciences—and indeed will also always remain, as long as it lives, an art.

But there are two points upon which we would take issue with him. In the greater part of Britain the family doctor may have open access to hospital diagnostic departments—but where in the field of radiodiagnosis this "privilege" is confined to the taking of chest and bone x-rays, as it is in many areas, then the facility is so restricted

as to be farcical. If the general practitioner has to refer all cases requiring, for example, a barium meal or I.V.P. to a hospital outpatient department, then he may as well pack up trying to be a doctor. Secondly, most general practitioners have not got hospital beds, which is professionally frustrating and is bound to tend to depress clinical standards, as Dr. N. A. Silverston points out (24 February, p. 506). While a general practitioner's remuneration may now be "more closely related to work done and responsibility borne" this proximity could well be likened to the relative closeness of a man standing on a six-foot ladder to the moon, as compared with that of a fellow with his feet on the ground.

However, we do not think that pay is the thing that will make general practice a worth-while career again. What young men going into general practice have always wanted, and always will want, is the facility to practise medicine—real medicine—not to be artificially limited and frustrated in their ability to diagnose and treat their patients. To get the best doctors, let alone sufficient doctors, into general practice, full diagnostic facilities—not just chest x-rays and haemoglobins—and general medical beds must be provided where geographically possible. Until this is done, and no excuse can rectify the omission, then we could not wholeheartedly recommend any young doctors, in this day of very scientific medicine, to enter general practice.—We are, etc.,

DAVID BARLOW.

Barnstaple, Devon.

R. D. ABERNETHY.

Common Weal

SIR,—I can only assume that the silly season of letters to the Editor is once more upon us. The suggestion that the profession should accept a further pay standstill (24 February, p. 517), which should include contractual year increases in salary, is of course so absurd as to be ludicrous.

The profession as a whole already underwrites an enormous amount of free work, especially by those in the hospital service, and to suggest that the salary increments should be forgone by those who are at the start of their careers, marriages, or mortgages is quite obviously wrong. I am sure that there are many young doctors like me who were only able to buy their houses on the assumption that the salary increments would continue.

In the *B.M.J.* (20 January, *Supplement*, p. 12) there is once more talk of increasing the B.M.A. subscription. This will be vigorously opposed by me, and I hope all other members, until we see the results of the Review Body report and the inevitable reference of the Review Body's findings to the Prices and Incomes Board.—I am, etc.,

COLIN FLOWERS.

Taunton and Somerset Hospital,
Taunton.

Real Reasons for Emigrating

SIR,—The report of the Ministry of Health Interview Board (6 January, p. 45) makes interesting reading, especially Appendix A, which compares general practice in

Canada and U.S.A. with that in the National Health Service.

This report realistically emphasizes two attractive features of transatlantic general practice: "hospital facilities" and "very large, relatively lightly taxed incomes." A third attractive feature, which the report ought to have mentioned but did not, is the amount of time that can be devoted to each patient presenting at the doctor's office. In Canada it is unusual for a general practitioner to see more than five or six patients an hour on average in his office, and some doctors would consider this rate too high. But in Great Britain a general practitioner, if he is to earn a reasonable income, must work at twice this speed. It does not seem unusual in N.H.S. practice for a doctor to be faced with a surgery of 20 or more, all to be got through in a couple of hours or so, and often this occurs twice daily. What else can he do but get the patients in and out of his surgery as quickly as possible?

The tragedy is that this high-speed medicine is coming to be accepted as the normal role of the general practitioner. So can one really wonder that young doctors continue to emigrate, or that, as the report says, "it did not seem likely that many of those who had already emigrated were seriously considering exchanging general practice in North America for general practice in Britain"?—I am, etc.,

Victoria, B.C.,
Canada.

H. J. CRONHELM.

SIR,—I hope that those considering emigration will not be misled by remarks made in the Ministry of Health Interview Board (6 January, p. 45). There are more than 500 British graduates in British Columbia alone, and probably more than 3,000 in Canada as a whole. The opinions of some 72 doctors selected cannot be considered representative. No mention is made of the very real shortage of general practitioners in Canada, and those who do come from Britain should not expect "often to do major surgery." A doctor here is usually willing and able to take on anything a junior registrar does in Britain—and nothing more, unless one works in the Northwest territories. The posts with "high sounding, but meaningless academic titles" are especially reserved for émigrés who have been emaculated by 10 or more years' work in the London teaching hospitals. Commercialism is really no problem to patients now that Medicare has arrived, and covers 90% of the population. Last year 850 foreign doctors entered Canada to settle.

The happiest British doctors are those who have no doubt about what the N.H.S. has to offer as a professional career.—I am, etc.,

RICHARD DAVISON.

North Vancouver, B.C.,
Canada.

Reduction in Sickness Certification

SIR,—With the decreasing numbers of doctors in this country, particularly in general practice, it seems that any method of reducing the work load of the existing doctors should be examined critically.

One such method would be a reduction in certification. This was particularly brought

home during the recent influenza epidemic, when intelligent patients quite capable of looking after themselves at home apologetically sent for the doctor "because they needed a certificate."

I suggest that any acute illness lasting a week or less should require no signature from the doctor. The patient or his relatives could obtain a National Health certificate from, say, the post office or local office of the Ministry of National Insurance, fill it in and claim benefit accordingly. Most patients could be trusted to do this, and in my opinion abuse would be minimal. Any illness of longer than one week could still require a doctor's signature. Local firms requiring "private certificates" would of course have to be persuaded to trust their employees; I am sure that such trust at both local and national level would be justified.—I am, etc.,

Burton-on-Trent,
Staffs.

P. ALLEBONE.

Points from Letters

Australia Next?

Dr. A. CLEMENTS (Victoria, Australia) writes: May I please be granted the privilege of responding to two of the replies to my original letter (13 January, p. 121)? Neither mentioned the Ministry of Health Interview Board on Emigration (6 January, p. 45) and its possible future bearing on Australia. Dr. A. D. MacAdam (3 February, p. 320) accuses me of smugness. However, delighted as I was to learn of his "marvellous holiday in the Rockies," I submit that he is hardly in a position to pronounce in quite such a sweeping fashion on a country he has never visited. It is surely quite wrong to assume that the practice of medicine does not differ from one country, Commonwealth or otherwise, to another. Two statements in Dr. E. C. Gambrill's letter (3 February, p. 320) I must challenge, since both are manifestly untrue. The doctors here, Australian and British, who have had the benefit of practice in both countries are quite clearly in no doubt that their standards of medical practice are far higher here and the facilities available to them far better. Dr. Gambrill mentions N.H.S. facilities which are the exception rather than the rule, and he would do well to note the experience of the 73 poor devils who wrote (27 January, p. 247) of the tragically imminent loss of their hospital privileges. Probably the most significant recommendation of the Interview Board's report related to this vital issue.

The suggestion that antidepressants and ampicillin are unavailable for any indications is nonsense, and creates a quite erroneous impression. They are freely prescribable.

Walking with a Hemiplegic

Dr. S. LONG (Langdon Hills, Essex) writes: Nursing a severely disabled hemiplegic patient in the home is a heavy responsibility for a relative, and I feel that any new nursing manoeuvre which can ease this burden is worthy of being drawn to the attention of your readers. This manoeuvre enables the attendant more easily to assist the patient to walk. . . . To carry it out, the attendant stands facing the same way as the standing patient and at the hemiplegic side. She then places the patient's affected foot on the dorsum of her own foot, and with her adjacent arm round the patient's waist the attendant and patient walk as in a three-legged race. The first time I witnessed this in practice I was so amazed at the effortless and effective way this mobility was achieved, despite the disparity in size between the attendant and patient, that I tried it myself, and confirmed my first impressions. . . .