Hospital Attachments

SIR,—Many of your correspondents have referred to the desire of general practitioners to participate in the hospital services. Few if any concrete suggestions for implementing this have emerged. The general practitioners of the Farnham and Aldershot area (27 January, p. 247) expressed their anxiety that the building of a large general hospital at Frimley might result in the closure of the several smaller hospitals where they have been able to treat their own patients. For the great majority of family doctors up and down the country there are no such hospital beds available for their use in this way. Further, it seems to be agreed that there is no prospect of more general-practitioner beds being made available in the near future.

But there are other ways in which general practitioners can participate in the work of the hospitals, and where these have been tried out it seems that they have been an acknowledged success. Outpatient clinical assistantships held by local general practitioners have been and are a feature in many hospitals. More recently general practitioners have undertaken one or more weekly sessions in casualty departments on a clinical-assistant basis, with resulting increase in efficiency. With the widespread and increasing shortage of hospital junior staff throughout the country, the Surrey Branch Council believes that the time has come to carry this system a step further to include inpatient clinical assistantships for general practitioners. They have recommended that their Divisions should encourage the study of this project by general practitioners and consultants, with a view to organizing a pilot scheme. From my own experience as a surgeon I have always been aware of the lack of general medical care in surgical wards. In so far as the busy houseman has time to exercise this part of his duties, he usually suffers from a very limited experience of medical and geriatric conditions, and none of general practice. If one or more general practitioners were attached to a surgical firm they might give one or two visits to the firm's wards each week to check new admissions, and attend the regular weekly ward round, thereby contributing one or two clinical assistant sessions per week. There are, no doubt, other ways in which general practitioners who have the necessary time to give could provide regular assistance in the care of inpatients.

In the present situation as between the profession and the Ministry of Health there is a paramount need for solidarity between the two main categories of doctors. Regular contacts and co-operation between family doctors and consultants in the service of hospital patients must lead to a better mutual understanding and appreciation, and indeed to a greater unity of purpose.—I am, etc.,

G. N. GOLDEN,
President,
Surrey Branch, B.M.A.

Guildford, Surrey.

General Practice—A Worth-while Career

SIR,—I was interested to read Dr. T. P. Linehan's impassioned plea for more general-practitioner beds (9 March, p. 644) and the result of a survey carried out by the Inner London Executive Council which found that London doctors wanted more of these beds to be available.

However, facts speak for themselves, and it is noteworthy that a well-staffed general-practitioner hospital in north London found it necessary last year to send a circular to general practitioners in the area begging them to make greater use of the facilities and beds available to them. It also stated that if general practitioners did not take it upon themselves to use the hospital then the beds would be filled in some other way. It has recently been announced that the hospital board has sensibly decided to use the hospital for geriatric patients. This helps to fulfil a much greater need in our society than to provide general practitioners with beds they manifestly do not wish to use. In towns such as London, where in most areas there are excellent diagnostic facilities available, it is useful to remember that good family medicine can be practised without the need for general-practitioner beds.

I agree with Dr. J. C. Cameron (24 February, p. 506) that general practice, or, to be in vogue, domiciliary practice, is a worthwhile and enjoyable career, and now that hospital laboratories and radiography departments are thrown open to us it can also be a satisfying scientific experience.—I am, etc.,

A. C. INWALD.

London N.19.

SIR,—Dr. J. C. Cameron (24 February, p. 506) makes a case for general practice which, as a young doctor on the threshold of a career, I should find very convincing. Nearly 20 years in general practice has certainly demonstrated to me that general practice is a satisfying career, but I would hasten to add that if any one factor more than another has made it thus it is one's ability to treat one's patients in one's own cottage hospital beds. Dr. Cameron says, "We aim to extend these opportunities." In the same week the Minister of Health threatens to close small, uneconomic hospitals which *The Times* reports as being "... a first propaganda shot to get people used to the idea."[1]

Before advising young people to take up general practice I think we are entitled to know where we stand in this matter. Without hospital beds I certainly would not have taken up general practice, and if general practitioner beds (which are largely synonymous with cottage hospital beds) are not available I would advise any young man to specialize or, if keen to follow general practice, to do so in a country other than Great Britain.—I am, etc.,

R. C. HUMPHREYS.

Crickhowell,
Breconshire.

REFERENCE

[1] *The Times*, 4 March 1968.

Australia Next?

SIR,—As a recent migrant to Australia, let me first agree with Drs. A. D. MacAdam and E. C. Gambrill (3 February, p. 320) that Dr. A. Clements's smugness (3 January p. 121) is overwhelming. If all his assertions are true he is in a Utopia which I have failed to find in country or city practice here. Dr. E. O. Evans (same page) points to the main professional reason for emigration: general practitioners with ability and many with specialized training are, in most areas of Britain, unable to utilize their skill because of lack of hospital facilities.

Agreed I cannot on Commonwealth benefits prescribe unlimited quantities of drugs, but then here, as in Britain, the problem is over- not under-prescribing, and apart from the increasing evidence of the dangers and side-effects of many of the new wonder drugs of today any general practitioner will testify to the large amounts of expensive and unneeded drugs found stacked up, not only in medicine cupboards, but in the bewildering variety of "hidy holes" about the house. I would disagree that better financial rewards and material benefits of themselves cause emigration—doctors are comparatively well off in most societies and salary and tax grumbles are a way of life and by no means confined to the medical profession.

No! After two years' National Service and eight years in the National Health Service I decided the national malaise had become too much for me; politics and leadership of the country had become a matter of saying one thing, doing another. Leadership, as has been amply demonstrated since I left in April 1966, was inward-looking; and Britain has now, at least in this part of the world, hardly a soul who believes a word she says.

The advantages Dr. Gambrill hints at, presumably the greater cultural and educational heritage of Britain, are certainly factors that cause heart-searching before taking the plunge, but perhaps we who emigrate, not only the doctors, but the million or so who have come to Australia since the last world war, find ample compensation in what this country has to offer.—I am, etc.,

S. MCPHERSON.

Warrilla, N.S.W.,
Australia.

Real Reasons for Emigrating

SIR,—I was interested to read the report of the Ministry of Health Interview Board (6 January, p. 45) concerning their recent mission in North America.

The Board freely admits "that there are insufficient doctors both in the United States and in Canada, and that medical services there would suffer much strain without an annual intake of overseas graduates. This is also true of the United Kingdom. . . ." Is it not time that it was recognized that the United States, Canada, and the United Kingdom form a very small part of the world? The medical needs of many Asian and African countries are far greater. It would be interesting, and a change, to be told what proportion of the "drain" has emigrated eastwards instead of westwards.

The developing countries are unable to offer the "higher financial rewards" that appear to be an attraction of the West, but they do offer a vast experience in all branches of our profession. As one of those who "aspired to a specialist career but failed to acquire the appropriate higher qualifications," I left the United Kingdom eight years ago. This failure, however, was by no means my sole reason for emigrating. Since then I