A FRAMEWORK FOR EFFECTIVE HEALTH CARE

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THE PROBLEM OF THE PROVISION of health care services can be approached from numerous angles. An attempt is made to base means upon needs and to consider the requirements of those who form the demand for care and those who provide it at different levels.

The levels chosen are as follows:

(1) The patient needs help
(2) The doctor needs help
(3) The specialist needs help
(4) The community needs help

(1) *The patient needs help*

The nature of the demand for medical services has changed in the last decade and people seek advice from a doctor on matters which would otherwise have been ignored or considered at a lower level of sophistication. In consequence medically qualified people are mis-spending time attending to problems the solution of which requires different training.

An immediate need is to train nursing, social welfare and other ancillary staff and deploy them to help patients with simpler problems of life and social administration. To some extent these workers, operating between the patient and the doctor, would screen the practitioner, but the screen would be permeable. A patient would continue to have direct access to his doctor on request, though the doctor might redirect him to a nursing colleague.

The need of the patient for all aspects of preventive as well as therapeutic care involves him with the medical officer of health. The situation at the first level can be represented as in figure 1.

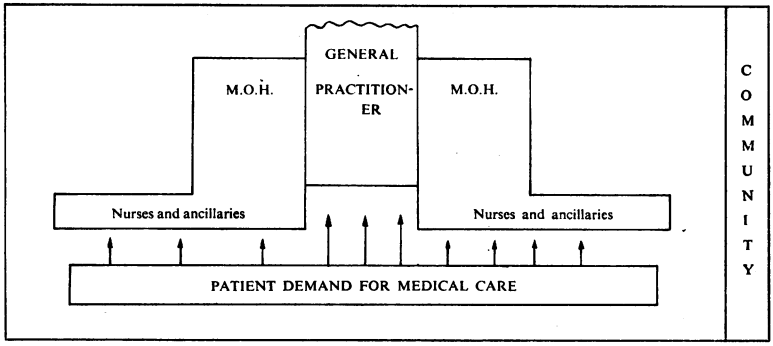

Figure 1

The nurse and other qualified ancillaries must be given power of decision. This is a break with the tradition whereby nurses and medical

auxiliaries are subordinate to doctors and operate by implementing decisions made by them.

There would be two-way communication between the practitioner and the medical officer of health, whose working environment would be fused so far as possible, and both would share in the services and training of nurses, midwives and other medical auxiliaries.

At this level the structure could be achieved by fusing the personal health services of local authorities with the general medical services provided by executive councils. The effect would be to make available the kind of help that people require at the present stage in our social evolution.

(2) *The doctor needs help*

Problems will reach the general practitioner either directly or indirectly. Some will be introduced by his ancillary staff at a partly developed level, others will reach him 'raw'. He will be called upon to decide which can be handled throughout under his care alone and with which he will require help beyond the resources of his practice. His needs may be outlined as under:

Preventive. Assistance in maintaining an awareness of health matters and a satisfactory level of health education among those under his care. A satisfactory level of herd immunity against certain communicable diseases must also be maintained. This help will derive naturally from close working association with the medical officer of health.

Social. The doctor needs help in maintaining the patients in his care in equilibrium with their surroundings whatever may be the nature of their disability. This presupposes social and nursing services readily and directly available to him. Nursing and midwifery are included in this and there are special problems in relation to employment and the chronic sick.

Diagnostic. The practitioner requires those aids which will enable him to differentiate between trivial illness and more serious illness and enable him to make a working diagnosis in the latter.

He requires:

(1) Access to a range of services which his skills enable him to use with competence.

(2) Access to a range of skills which extend his abilities in particular respects and directions.

Both of the above are normally provided by the hospital services but some (Public Health Laboratory Services and Mass Miniature Radiography for example) are not hospital responsibilities.

The four areas of hospital skill of which the practitioner most frequently wishes to avail himself are those of the general physician, the general surgeon, the psychiatrist and, less frequently, the paediatrician. These he regards as clinical specialties in which the experience of the specialist may justify his use as a consultant. The general physician and general surgeon could be general practitioners holding a staff appointment.

There are areas of special skill such as the diagnosis of epidemic infectious disease or the assessment of educational subnormality where the consultant is not in a hospital but is in a public health department.

Therapeutic. The therapeutic services required by the practitioner are those which he can employ himself and those to which he has access through others. The dispensing chemist, the relative in the home, attached and district nursing staffs come under this category as do ward beds and staffs where direct access to these exist.

The need for access to therapeutic, as opposed to diagnostic resources is a frequent reason for referral outside a practice. Referrals so made are:

(1) To the 'clinical' specialties as defined above.

(2) To the 'therapeutic' specialties, e.g. ENT, orthopaedic surgery, gynaecology where the most frequent need is for the performance of a specialized therapy on indications which the practitioner can himself determine.

It is essential that the help of the 'clinical' and 'therapeutic' specialties can be given outside as well as inside hospitals and the structure should permit overlap so that hospital doctors may work in the community as well as practitioners in hospital.

The relation of need to means is represented in figure 2.

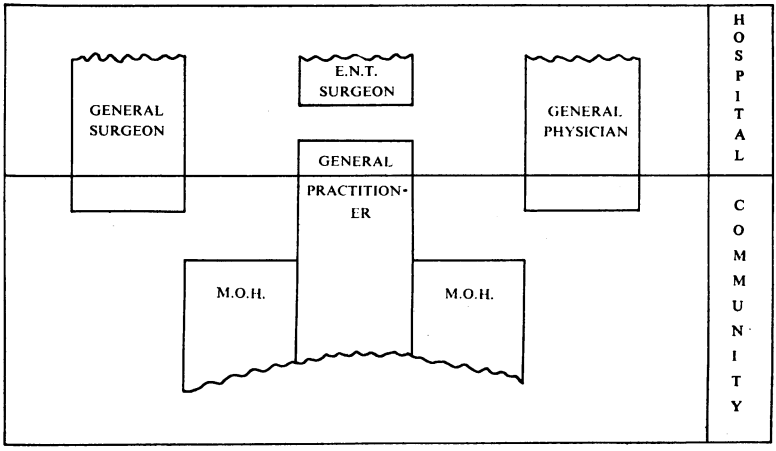

Figure 2

The horizontal line indicates the hospital wall. The practitioner is is shown to bridge this as are the general specialists in the clinical specialties. The extent of the overlap may vary with the specialty. A paediatrician might work more extensively away from his hospital than a surgeon.

A situation approaching the above would be effected by:

(1) Provision of general-practitioner beds in hospitals.

(2) Provision of specialist clinics at group-practice centres.

The above are administrative feasibilities to be effected by arrangement between practitioners and regional hospital boards or ultimately by the complete fusion of the R.H.B.: G.M.S.: M.O.H. complex.

(3) *The consultant needs help*

Consultants have been known to admit that they cannot themselves be masters of every aspect of their craft in whatever field they practise. Not every physician will be equally at home in the management of an extra-

corporeal kidney and a patient with myasthenia gravis. Not all surgeons will undertake open reduction of fractures along with tonsillectomy or open heart surgery. From these extremes it is clear that specialties within specialties are inevitable.

The general physician, equally with his general practitioner colleague requires help in the extension of his skills in turn in directions which he can identify with precision. His needs are twofold. Diagnostic and therapeutic.

(1) *Diagnostic.* The obvious sources of diagnostic aid to which the specialist will turn are the departments of pathology (themselves fragmented into many sub-specialties) and of radiology. These constitute the 'technical' specialties.

(2) *Therapeutic.* At this level he needs the help of his colleagues with specially refined skills as above, as well as the departments of the medical social worker, the physiotherapist, chiropodist, dietician and others.

The help which the general physician (surgeon etc.) receives should also come from the practitioner from whom his raw material in terms of problems, will come. The strength of the bridge between hospital and community care depends on the number of practitioners who work in the former and the frequency with which specialists work outside them.

The relation between the general consultant and his specialist and departmental colleagues may be represented as under:

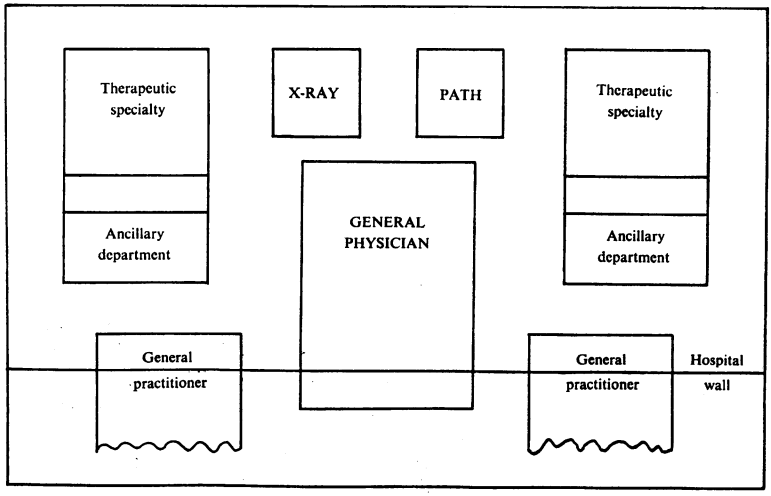

Figure 3

In preparing the series of diagrams many inter-relationships are implicit. They will be the lines of communication already existing between professional workers, which are effective or inadequate as a function of personalities concerned rather than for any intrinsic reason.

To achieve a structure of this kind it is necessary to remove the antipathy felt by the specialist towards the generalist, particularly the generalist whose scope includes the specialty with which the protagonist is con-

cerned. The belief that depth has merit where breadth has none has operated to the disadvantage of medicine at more than one academic level.

(4) *The community needs help*

The community needs help to make its arrangements for health care more effective so that it can, with even fewer doctors, cope with an increasing number of old people in an age in which stress disorders are increasingly prevalent. It needs a structure within which to operate its health care services economically and effectively.

Such a structure might be achieved by the summation of the figures in figure 4.

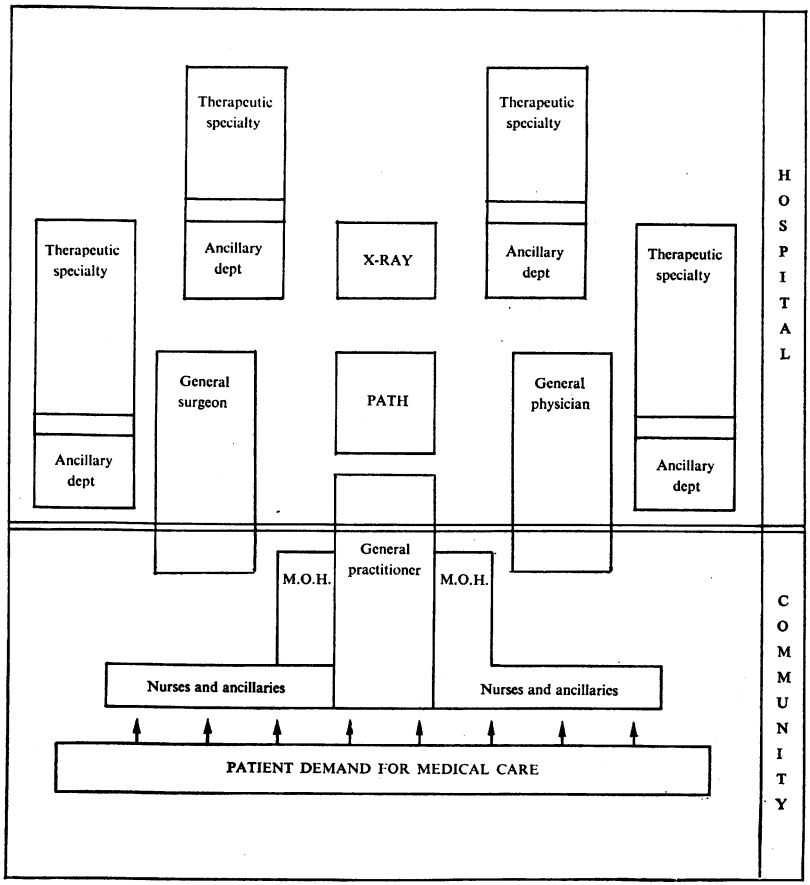

Figure 4

The above structure could be achieved only by a reorientation of thought, the eradication of deeply-rooted preconceptions and the submersion of vested interests. If the community is to achieve standards of care which modern technology makes possible, this effort of mind and will must be made without delay.