Editorials

CO-OPERATION IN PATIENT CARE

THE share of the total National Health Service expenditure absorbed by the hospital service stands at 60 per cent. The total percentage of national morbidity dealt with by the hospital service is about 10 per cent. The percentage of national income allocated to the National Health Service overall is rising slowly, if at all. Somehow, somewhere we must break through these incompatible methods and resolve the problem of how to obtain the best for our money and use the resources available to the best advantage.

Previous studies[1 2] by the QIDN have made a notable contribution to this, particularly those associated with Miss L. Hockey's authorship. Now she has joined with another highly-qualified Queen's nurse to publish two studies which examine ways by which we might redevelop or redeploy our resources.

In the first study Miss Hockey analyzes an experiment in the early discharge of surgical patients to the care of a liaison district sister attached to the surgical team, who visits the patients in the surgical wards and continues their care at home. This sister is seen by the patient on the ward round and thus the creditability of the continuation of treatment at home is high in the patient's eyes.

Under 'acknowledgements' there is a coy note by the Queen's Institute that they support the use of the term 'District nursing sister' but to ensure clarity in this report which also refers to 'ward sisters', the term 'district nurse' is used throughout. Surely it is about time that the district nursing sister is clearly acknowledged and the excuse of confusion or whatever ceases. The surgical ward sister does not get confused with the medical ward sister or maternity ward sister. We must rid ourselves of these unconsciously degrading terminologies and acknowledge the district nursing sister for what she is and what she has trained herself to be, particularly as we are having many less highly trained, but equally valuable district nurses (SENs) working in the community.

When examining the tables concerning the patients' assessment of early discharge they are reminiscent of the situation when with much trepidation a group of doctors introduced an appointment system. Several weeks later when they met and analyzed everybody's reactions, the only pungent criticism came from a patient who remarked dryly "Why did you not introduce this system years ago?" Here too the patients are clearly ahead of the profession: 87 out of 126 preferred to be discharged early; ten had no preference and eight preferred convalescent home; 21 made no response to this question. In the same vein, four patients out of 126 thought they had been in hospital too long in spite of early discharge; 16 thought they had been too short a time in hospital; 86

thought it was just right and 20 made no response to the question. All 126 were unanimous about the excellence of the aftercare received by the district nursing sister.

Some interesting comments from patients deserve note: "I was upset by the troubles of other patients". "The care I needed and received I could easily have had at home." The patient who had been operated on for anal fissures made the specific point of the privacy of defaecation at home in contrast to hospital. It seems that man prefers to perform these necessary operations in solitude. Do we respect this?

As expected, some of the benefits of such a scheme were proved by this study:

(*a*) Waiting lists were reduced
(*b*) Severely-ill patients could be kept in hospital longer owing to less pressure on beds
(*c*) There was less overcrowding in the wards
(*d*) The need for pre-convalescent beds fell sharply
(*e*) £3,600 was saved for the hospitals, though possibly an extra £600 was spent on additional district nursing costs.

One all too typical demarcation dispute arose: Who was to supply the postoperative dressings? The local authority? The general practitioner? The hospital? How preoccupied with administrative riddles can we get when it all comes out of the same pocket in the end. Roll on integration if it means the end of this sort of quibble.

What is disturbingly revealed by this book is that by setting up such an experiment and developing a specific district nursing sister in a liaison hospital situation, with a special name for this scheme "Liaison attachment to hospital", the fact is overlooked that this ought to have been a development in the team of each of those 50+ general practitioners whose patients were so treated. Surely the 'team' in general practice is able and willing to do just that—what the liaison district sister did, based on the hospital end of the work and how confident the patients would have been if *their* district sister and *their* family doctor had coped with their early discharge. In the future when we have our priorities and values right these 'early' discharges will be 'proper' or 'regular' or 'standard' discharges.

We have seen the change of medical practice in obstetrics, in coronary care, in the mental health field. Surely the surgeons must follow suit, but let us not plan this with a proliferation of various liaison schemes but base it squarely on the general-practice team of the patients own practitioner. As a pre-requisite to this we need to put our house in order as the second study by Anne Buttimore clearly demonstrates. Here seven district nurse–general practice attachment schemes are studied and the uneven pattern of work performed by the district sisters indicates how unsure the general practitioner is in delegating. The need to allow the nurse to use her skill and so free the practitioner from all the work which she can do as well or better. is acted upon and carried out very unevenly as the various tables on nurse's activities demonstrate. The value of this and similar studies is that they force us to reassess our own method of work. This sort of analysis of what work we ask our nursing-team members to undertake must become the backbone of repeated staff discussions and postgraduate sessions where nursing sisters and general practitioners can learn from each other.

Obviously we have to learn what our hospital colleagues have been able to practise, a clear routine of sharing our work with the nursing profession so that it amounts to more than baths, bedmaking or maternity work. In some of the practices observed, time spent on communications or administration was either non-existent or amounted to nearly one third of the total clinical working time of the nursing sister. It is apparent that we have yet to undergo more growing pains in this field of co-operation. The final paragraph in which we are reminded that nurses must work *with* the practitioner not

for him is most emphatically true. This volume will stir controversy quite beyond the quantity of its print but when the dust settles the patients will have better care and the nation will have spent its money better.

REFERENCES

1. Hockey, L. (1968). *Care in the balance*. London. Queens Institute of District Nursing.
2. Hockey, L. (1966). *Feeling the pulse*. London. Queens Institute of District Nursing.
3. Hockey, L., and Buttimore, A. (1970). *Co-operation in patient care: Studies of obstetric nurses attached to hospitals and general medical practitioners*.

PUBLICITY AND THE PILL

WHETHER the number of publications on the oral contraceptives has now reached an all time record for a single subject has probably not been determined. There can be no doubt, however, that no other medical topic has directly concerned people with such a wide range of interests and education. In these circumstances the problems of comprehensible inter-communication become acute. Two recent publications nicely illustrate this point.

The first is a slim volume recording the proceedings of a symposium held in London in September 1969 and called *The pill, biochemical consequences*. It contains ten papers prepared by specialists for specialists and it is unlikely to be regarded as suitable for relaxing bedtime assimilation by the more general medical reader. Much, if not all the material, has been previously published elsewhere, but it is certainly convenient to have these different topics available in a single volume. The more important conclusions may be summarized as follows. The pill has a wide range of effects on the liver, but the author believes that these are probably of little significance, except in patients with a history of jaundice of pregnancy.

The effect of oral contraceptives on non-protein-bound cortisol is dose-dependent. Pills containing 100 micrograms or more of oestrogen produce a detectable, though small, rise, but lower dose oestrogen preparations have a negligible influence. Surprisingly, no such dose dependency has yet been demonstrated in other biochemical studies. All combined and sequential pills apparently cause impairment of glucose tolerance and a rise in serum triglyceride and cholesterol levels. An observation directly relevant to these lipid changes is the finding of an alteration in the behaviour of the platelets of pill users due to the presence in their plasma of an abnormal lecithin—a low density lipoprotein.

The importance of these observations on lipids is that identical changes are found in arteriosclerotic subjects. Furthermore the 'coagulability' of the blood, as far as this highly complex phenomenon can be measured in the laboratory, is increased by all pills containing oestrogen.

Women on the pill have an abnormal metabolism of the amino-acid tryptophan. This can be most easily demonstrated after giving a loading dose of tryptophan, but the abnormality can be corrected if a high dose of pyridoxine (vitamin B_6) is given beforehand. It is of great interest that a similar metabolic abnormality has been demonstrated in certain depressive illnesses. Can the administration of pyridoxine alleviate depression associated with oral contraception? A properly designed clinical trial is clearly necessary. What is the clinical significance of these biochemical observations? Several of the authors stress that we do not know; nor can we predict the long-term effects of the pill.

This is essentially the message of Paul Vaughan's book, *The pill on trial*.* In a field where one specialist finds it difficult to communicate intelligibly with another, Vaughan succeeds triumphantly in conveying all the important facts and complex issues of the pill in language which can be readily understood by the informed layman. To the medical reader his early chapters on the development of the synthetic orally active steroids and

the subsequent emergence of the pill are particularly interesting, but the whole book is thoroughly enjoyable and there will be few doctors who will not learn a great deal from it.

It is a pity, though probably inevitable, that Vaughan should find it necessary to play on the fear of the unknown to achieve his full impact. Doctors, he implies are indulging in a massive gamble, in which their patients may be the losers. Many medical scientists (but, significantly, few clinicians) echo these sentiments. Their warnings are now meaningless. The pill has become an integral part of modern society. It is no more possible now to ban the use of the pill than it is to prevent people travelling in motor vehicles—an undoubtedly more hazardous activity. In the future both will be replaced with a safer alternative. Until then a great responsibility lies with doctors, journalists and politicians. They must appreciate that the manner and content of their pronouncements on the pill may cause excessive public anxiety which could result in more illness and distress than the pill itself will ever engender.

**The pill on trial.* Paul Vaughan (1970).

GOING TO THE DOCTOR?

CHANGES in community living are taking place all the time, slowly in some places but rapidly in others, and medical practice must be sensitive to these changes because it is a service based on the needs and requirements of the community itself.

One facet of change is mobility. In town and country motorways come—and branch railway lines have all but gone. More people than ever have cars, and more are inclined to leave them in the garage because of the crowded confusion on the roads themselves. Perhaps it is easier to go to the shops by 'bus—no parking problems—and what about the doctor?

Information on how patients reach their doctor's practice is scarce. In some practices studies of the operation of a car service are going on and a pilot study (Hutchinson 1969) has provided some information on how patients in a sample of Midland practices get themselves to the doctor using their own resources. How applicable community transport services are to other circumstances remains to be determined—hence the study to be described.

The Research Unit wishes to carry out a study of ways in which patients get to their doctor's practice centre by means of a sample survey. It is hoped to secure the co-operation of practices of all kinds, in all parts of the country, the one prerequisite being that each must have a receptionist who will arrange for patients to complete a simple questionnaire as they reach the waiting room.

The survey will not last for long; sufficient information to enable the pattern characteristics of each practice may be obtained from a hundred consecutive questionnaires, on patients attending during two consecutive weeks. Those who agree to take part, however, will be asked for certain information concerning their practices, as for example, list size, designation (urban, rural or mixed), and number of partners.

If you would like to help in this study would you please inform **Mrs P. J. Jones, General Practice Reasearch Unit, Royal College of General Practitioners, Arthur Thomson House, 146 Hagley Road, Birmingham, 16.**

Those taking part will receive a short practice questionnaire and a stock of forms to be completed at the reception desk and returned to the Research Unit.

REFERENCE

Hutchinson, M. (1969). *Journal of the Royal College of General Practitioners.* **18**, 95.