him because no police car can be there to go a quarter of a mile behind him to find out what speed he is doing.

Mr Gissane: In answer to the question what overcomes us when we get into a motor car, and why do we behave in that way, it is interesting when one looks at one's hospital beds to find that in the female wards very few people are in there from a road traffic accident; in the male wards over 50 per cent are there from road traffic accidents. I often wonder if it wouldn't be a wise thing if we always went out with a back seat driver.

THE INTEGRATION OF HOSPITAL AND PRACTICE WORK

J. Fry, M.D., F.R.C.S. (*Beckenham*)

In considering the problem of integration I would like to divide it up into three parts: the problem of the practitioner; the problem of the hospital; and the problem of the public. Accidents, as distinct from emergencies (the emergency of the coronary, and so on), account for some ten per cent of the general practitioner's work. We also know that most of them are relatively minor, including the strains, sprains, lacerations, and bruises, though the practitioner will have to refer some 90 per cent of his fractures, if he works in a built-up area. On the other hand, the practitioner will probably deal with more than 90 per cent of the bruises, the lacerations, and the minor sepsis, so it is really a to and fro mechanism. The problems in dealing with these accidents in general practice are not very great. The technical ones, including anaesthesia, operative techniques, sterility, and assistance in carrying out surgical procedures, can usually be overcome by improvisation and adjustment to the situation. The relations with the casualty department include more than trauma, and I think we should also discuss this topic because at the moment these casualty departments do deal with more than trauma, although variations exist from area to area. There is a tendency, certainly in the built-up areas, and this is where most of our population live, for some practitioners to use the department for access to pathological and radiological investigations which they cannot perform themselves, for a second opinion by a much more junior colleague, for admission through the back door of the hospital,

and for the proverbial passing of the buck. I say this quite bluntly and frankly, although it is a criticism of some of my practitioner colleagues, but I think it has to be faced, and needs careful thought and correction. On the other hand, we in general practice feel there is a need to get closer to these departments. Communication between the two is often very poor; often we do not write the type of letter we should when referring these patients, and much more often we never receive one back. As there are frequent changes of staff in these departments, we never get to know the casualty officer in charge, and there is usually no consultant in charge that we can approach. These are down to earth problems and not concerned with the dramatic accidents that we heard about in the previous session.

What about the problems facing the hospital? The problems here are, I think, greater than the ones facing the practitioner, and much consideration has been given, and is being given to them. We have had studies from Oxford, from Birmingham, from individual practitioners, we recently had the Nuffield Report with which I was associated, and also committees, such as the Accident Services Committee, are considering these problems. The casualty department, as distinct from the accident centre, is the entry point in many hospitals for accidents, and for much else, and we need fresh thinking. This is why the Nuffield Report was termed *Casualty Services and their Setting*. We particularly did not consider the accident service because we felt that the existing casualty services themselves need review as distinct at the moment from the actual accident services. This report was planned and started because, at a conference of certain medical persons some years ago, we felt that there was a need to study two aspects of the hospital services above all else. One was the casualty and the other was the outpatient department, and we planned this study to collect facts, and also to see what information could be obtained apart from facts by a team visiting these hospitals and seeing what actually goes on there. Twenty hospitals were visited, serving a population of five million or ten per cent of our population. General practitioners were seen and questioned, problems were discussed with them before the actual hospitals were seen, and then the hospitals were visited. We found that on the whole the conditions were very poor; there was no leadership from a registrar or a consultant to supervise, train, and look after the young staff, who are medically qualified to look after patients in these departments, the accommodation was poor, the comfort of the patients was poor, in fact everything was poor in most of the hospitals, apart from the standards of nursing and the sisters in charge; these universally were found to be very good.

These are results probably found by anyone else doing this

particular study. Another thing we found was that these casualty departments in fact were dealing with 70 per cent casuals, people referring themselves there, and only 30 per cent of real casualties. This is a different figure from the one that Mr Scott quoted, but perhaps he looked at a different interpretation. Of the patients, 50 per cent to 75 per cent came on their own, only ten per cent to 20 per cent were brought in by ambulance or other means, and only ten per cent to 20 per cent were referred by their general practitioners. The problem is really, what should these casualty departments be? Should they be there to treat casualties, that is, emergencies, traumatic and otherwise, which occur at any time? Should they be there to form a safeguard and a cover to inadequate general practice, because this is what many of them are doing? We have heard already that in a south east London area this is in fact what the casualty officers think that they are doing. Obviously, this does not represent the standard of general practice as a whole, but it does represent a standard somewhere. Is there a need for these departments to exist as a cover to these people?

I would like before considering the future to say a few words about the public attitude. This is after all what we are mostly concerned with; we are trying to do the best for our patients, and we are trying to get the best possible services for them. What are the patient's views and customs and habits? They vary from area to area, but in certain parts of the country, especially round the large teaching hospitals, the public have been accustomed to view the casualty department as the place to go for any sudden happening, whether this happening is a sudden earache, pain in the belly, or a traumatic incident.

These are habits that have been built up. We have heard also that perhaps in some situations the practitioner is not available, or he just leaves his post unattended, or the patients do not feel like disturbing the practitioner out of hours. If we think that it is not right that these departments should be supernumerary to the practitioners to ensure general practice, we have to make sure that standards in general practice, and facilities offered by general practitioners are adequate if some of these departments are to be shut. And we will have to consider that very carefully before taking the next step and thinking in terms of rationalization of departments, closing some down, and forming big accident centres and so on.

What about the future? Ultimately probably the right method is to follow Mr Gissane's views, and to have big departments to provide adequate 24 hour service. But before we do that—and as we have heard already hospitals might be built with inadequate premises because they are already out of date—the first and foremost

thing is to gather more facts and to define the problems. As I have tried to suggest, these facts and problems differ from area to area. We ought to carry out surveys such as the Nuffield Trust studies, and they were carried out very simply by having a co-operative team of consultants, epidemiologists, and a practitioner who went round these hospitals to see what was going on. This they did in their spare time. They were not appointed full-time for this service. They did it because they were interested in it. Surveys should be carried out in each hospital area by such groups to look at the problems, perhaps the problems which we came across in this particular survey. Not until these surveys have been carried out, and the problems defined, do I think we ought to go on to the next step, and see what ought to be done in each particular area. We have to do it step by step. We might find problems of staffing, problems of centralization and sizing, problems of the role of the casualty department. It is most important that one, two, or more practitioners should be on this local survey team to put forward the views of the practitioner on the spot. It may well be that it is not a problem of money and finance and buildings, but a problem of re-organization in which we all have to play our parts as a team to look after the welfare of patients and public not just the problem of accidents which over a certain grade have to be left to our consultant colleagues in the hospitals. The problem which is really facing the hospitals, the public and ourselves is the problem of the casualty departments as distinct from the accident services, although the accident services present a problem of their own.

THE INTEGRATION OF HOSPITAL AND PRACTICE WORK

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Dr Fry has given an indication of the problem of dealing with casualties from the general practitioner's side. I would like to turn the penny over and look at it from a regional hospital board point of view. I take the Midland region because it has particular problems. It is a region which is the largest in the country, responsible for the care of a population not far short of four and three quarter