Editorials

HOSPITAL STAFFING

No health service can be perfect. In any large organization there are inevitably weak links. A government-controlled service is particularly liable to have defects. In saying this, we are not levelling charges at the National Health Service which has operated smoothly and, for the most part, to the satisfaction of those who work in it and those who receive its benefits. An enquiry into the Social Services by PEP and recently published showed that in 1957 eighty-five per cent of mothers were satisfied with their doctors.

Where faults exist they should be remedied if possible, but in the nature of things some individuals will suffer hardship in the process. We are not concerned in this college to argue on terms and conditions of service or on the minutiae of regulations. We are very much concerned, however, that the sick of this country receive the best treatment that they can get and that those in family practice are in a position to provide. We have a duty to endeavour to prevent any trend developing in the medical services which is to the detriment of either the doctor or patient. For some years now we have watched a rift widening between the general practitioner and the hospital doctor; a rift which we have tried to stop by all the means in our power. In an organization in which the two major branches of the profession are able to work almost independently and in which the only continuing contact between them is the patient, very little can be achieved.

These thoughts arose from reading the report on the *Medical Staffing Structure in the Hospital Service* recently published. This Joint Working Party under the chairmanship of Sir Robert Platt was composed of consultants representing the Royal Colleges, the Royal Scottish Corporations, and the British Medical Association and representatives of the Minister of Health. There were no general-practitioner representatives. The working party owed its creation to the plight of many senior registrars who, when their training was finished and their period of engagement ended, found no vacancies in the consultant ranks and, having no previous experience of general practice, were unable to find a practice or partnership vacancy. In the course of its investigations the working party made several observations of interest to general practitioners. Information received from the Birmingham Hospital Region suggests that the equivalent of more than 800 whole-time doctors is provided by general practitioners working in hospitals as clinical assistants in this country. This is good, but we wonder if the Birmingham

Regional Hospital Board is a fair example of what pertains in other regions.

The working party defines doctors of consultant rank as being the only doctors recognized in the hospital service qualified by professional experience and training to take full personal responsibility for the complete medical care of all patients within their own particular specialties. A comparison with the duties of the general practitioner may justly be made here. The family doctor assumes full responsibility for his patient in all episodes of sickness on which he is consulted. His responsibility does not end when he refers his patient to a consultant, and if the patient is admitted to hospital it is only suspended, to be resumed again immediately on discharge. The report finds that, in the hospital service, work properly belonging to consultant posts is being regularly discharged by senior registrars and members of more junior grades. This is well known to the general practitioner who when he wishes to obtain an opinion upon a patient chooses with care the doctor whom he thinks would best supply the needs of his patient. Quite frequently, and sometimes only after a long delay which is bad for the patient and costly to the State, the patient is seen by some junior house officer the value of whose opinion is unknown. We therefore welcome the categorical statement that " there can be no question that duties and responsibilities of a consultant post should be discharged as a regular thing by a consultant only ". To achieve this there must be some reorganization in the structure of the hospital staff. This we agree. The main duty of the consultant must be to consult with and advise other doctors, both within the hospital service and outside it, on the diagnosis and treatment of illness; whenever possible the consultant should return the patient to the doctor in charge and not take over the treatment himself.

The recommendations of the report are in effect aimed at providing ways in which the consultant may be allowed to perform the duties required of him and be relieved of work which can suitably be performed by others. The " firm " system in use in some hospitals is commended as a way in which consultants can share their responsibilities. To counteract the shortage of junior hospital staff, it is suggested that more young doctors should spend three years in hospital before entering general practice. Many general practitioners will agree with this, and some graduates do plan their postgraduate training along these lines so as to become better acquainted with the special branches of medicine that they expect often to meet in family practice. So that this extra experience of hospital medicine will not be lost to the hospital service and in order to relieve the work of the consultant, the working party envisage an extension of the hospital posts available to general

practitioners. " The kind of post which would best help in the junior staffing problem would require a daily visit of two or three hours to supervise the work of the house officers, to see newly admitted cases with them, to undertake or supervise the performance of technical procedures in the ward, and in certain cases to perform operations and undertake other responsible duties after consultation with the consultant in charge ". It goes further, as indeed it must if the appointments of this kind are to be worth anything; " In some instances a general practitioner who has continued to work in the hospital service in such a capacity might later be chosen for a consultant post and pursue a career as a consultant concurrently with one as a general practitioner ". Does the wheel turn full circle? The suggestion is fascinating and if implemented must surely bring benefit to British medicine. Many, but not, we think, the majority of general practitioners would welcome more opportunities of working in hospital and the influence on the standard of practice in both departments must be good.

At present the gap between the consultant and the senior grades of hospital officer is filled by the senior hospital medical officer, a grade which was invented at the inception of the National Health Service to mitigate the hardship to those who had served the hospitals before 1948, but who were not considered to be sufficiently well qualified to hold consultant rank. This grade has always been unpopular and the working party recommend its discontinuance. Instead, it proposes a new grade of unlimited tenure in which both those who fail to achieve consultant rank and general practitioners experienced in hospital medicine could work. The holders of these appointments would be called medical assistants. The new grade is not envisaged as a step on the consultant ladder but rather as a firm platform on which the hospital doctor may halt, but from which he will again be able to seek the highest rank, or sidestep into general practice. General practitioners in this grade would also be able to apply for consultant grading.

This partial solution to the problem of the senior registrar seems sound enough, but criticism will doubtless be levelled at the term " medical assistant ". Neither the senior registrar around whom there is a certain reflected glory nor the general practitioner working in hospital will be quite happy at the name of " assistant ". Is there not a case for a revival of that outmoded term " the specialist " for this particular rank? Doubtless, its use would imply that not all specialists are consultants; but this we know already.

The working party " visualize that general practitioners will continue to be employed at cottage hospitals in which they maintain responsibility for their own cases with advice available from consultants visiting regularly. We favour the continuation of experiments in the provision of general practitioner wards in general hospitals. Such provision may relieve the consultants' beds of some

cases, but we think it unlikely that it will make a major contribution to the staffing needs for the care of consultants' cases ".

In our opinion, if a greater number of beds are allocated to general practitioners for the treatment of those patients who do not require continuing attention from a consultant or specialist, the consultants will have more time to spend on those patients whose needs rightly fall within their competence, and more hospital beds will be freed for their use.

The ideas put forward in the report are interesting and should receive careful study. The opportunities offered to the general practitioner to enter into and share in the work of a hospital are especially welcome. The feeling still lingers that a patient when admitted to hospital necessarily requires medical skills which the family doctor is unable to provide. Doctors Crombie and Cross in their paper published on page 214 of this *Journal* demonstrate that in Birmingham about six times as many " patients with serious illness not requiring therapeutic or diagnostic services at hospital level " are cared for at home as in hospital. The reason for sending to hospital patients with this type of illness is mainly social—lack of nursing, home help, and so forth. These patients would receive as adequate treatment in hospital from the general practitioner as from the consultant.

There is neither time nor space to deal with all the recommendations in this interesting report. We hope that they will be carefully considered by all. Those in which the general practitioner is concerned may go far to bring closer together the two branches of the profession.

COMPREHENSIVE DOCTORING

There is a world of difference between the type of medicine practised in a big hospital and that in a general practice. The precision of hospital medicine and its scientific detachment are obvious, even on the most superficial acquaintance. But is this precision achieved by ignoring conditions which do not lend themselves to diagnosis by traditional methods? Are failures avoided by labelling the case as functional, and arranging for the patient and his family to go abroad?

These and other interesting questions are tackled in a report published elsewhere in this journal (p. 228) on Undergraduate Teaching in Comprehensive Medicine by Dr M. B. Clyne. He studied methods at a large teaching hospital, a health centre, and at the General Practice Teaching Unit at Edinburgh. His findings are of importance to everyone interested in student training.