Economies through improved dermatology services

SIR,—All of us who are directly concerned with the care of patients have been aware of financial stringency for many years and have tried to utilise the limited resources available to the best advantage. Now the situation is very much worse and I am sure that district and area health authorities, by the expenditure of a relatively small sum of money on improving their facilities for treating patients suffering from skin disease as outpatients, could not only reduce the numbers of patients requiring admission to hospital but also enable many patients to return to work much more quickly. This would benefit both the economic state of the country and prevent much unnecessary patient distress.

In Oxford we have had such an outpatient treatment centre working for the past 15 or more years, and as a direct result the number of admissions for skin disease has been halved, although the total number of new patients seen has increased by 25%. Existing outpatient departments can usually be easily modified along the lines indicated in the recently issued "Accommodation for Hospital Dermatology Services,"¹ thereby achieving a very real saving in hospital costs. An even greater saving is possible by instructing nursing staff in health centres in skin management, supervision being provided by the hospital department when necessary.

Throughout the country the number of new patients referred to hospital with skin disease is as high as 75% of those referred to medical outpatients, which indicates the size of the problem. Since the great majority of our patients do not die and since they can be cured or relieved without recourse to such spectacular procedures as skin transplants, often the department of dermatology does not receive the financial support necessary to help this large number of patients. I hope in these days of financial squeeze that such provision will be sanctioned to bring about a real improvement both in the quality and cost of patient care.

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¹ Department of Health and Social Security, *Accommodation for Hospital Dermatology Services: A Design Guide*. London, HMSO, 1976.

The NHS is dead: long live the NHS

SIR,—If Sir Alec Merrison is persuaded to read the article by Dr T F Davies under the above title (4 December, p 1376) I hope that he can be also persuaded to read what Mr Keith Norcross has expressed as a Personal View in the same issue (p 1380).

It is fortunate for the profession that the views of Dr Davies are personal ones because many will disagree with him concerning the work done in district general hospitals (DGHs). The centres of excellence, in the main the teaching hospitals, can attain high standards particularly in certain highly specialised fields—the subregional or regional specialties—because they are well endowed with staff of all grades and with equipment. The staffing costs of the average teaching hospital are four times those for the same number of beds in a DGH. I consider that the consultant and other staff in the average DGH, whether in good buildings or in adapted premises, are doing excellent work

and this must be the view accepted by the teaching hospital staff, who are sending more and more medical students to these hospitals for training.

I would suggest to the Royal Commission that less money be spent on teaching hospitals and more on DGHs. The teaching hospital should really be a "district" hospital for its own community, with facilities for regional specialties and the necessary extra for teaching students. If this policy was adopted there would be more money for DGHs and primary care; and more patients could be treated within reasonable distance of their homes instead of being transported many miles to a teaching hospital and adding problems for the families and the patient's own general practitioner.

Dr Davies's comments on primary medical care relate only part of the story. While the number of doctors and other staff in the hospital service has more than trebled since 1948 the total number of general practitioners in the country has remained virtually static, and with higher expectations on the part of patients and greater use of primary care services it is hardly surprising that each consultation only lasts on average five minutes. The answer is to reduce the number of patients on each doctor's list, but this will take time. As a short-term and effective measure I would like to recommend to the commission a substantial increase in the support staff forming the primary care team—district nurses, community psychiatric nurses, night nurses, nursing auxiliaries, home helps, and better support from social workers. Existing facilities, such as open access to laboratories and x-ray departments and use of ECG equipment, would need to be reviewed and, if necessary, extended. Decent practice premises would be needed for the staff of primary care teams and access in all areas of general practitioner beds in community hospitals. I can speak with personal experience of the improvement in GP care that has taken place in recent years in this area because of a policy of attaching nursing and other staff to GPs.

Obviously teaching hospitals as centres of excellence have an important part to play in medical training and care. But the bulk of acute medicine—and here I embrace all specialties except those centred at regional level—will continue to be practised at DGHs and I hope that the Royal Commission will be made very aware of this from those concerned. Better financing of DGHs and improved primary medical care, as outlined above, could fundamentally change the structure of the NHS for the better, and the centres of excellence would then take their place, quite naturally, in the new set-up. If we can achieve this, then I consider that some of the values put forward by Mr Norcross in his article could be re-established.

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The London hospitals scene

SIR,—I am glad to see that the London teaching hospitals are not to be spared in the economic recession of the Health Service. While it is vital that centres of medical excellence survive in London, surely only two or three hospitals need remain as the *crème de la crème*?

As for the training of medical students, the teaching material of these hospitals is suspect,

giving as it does an entirely false idea of the prevalence and relative importance of the rarer diseases. The training of students would be far more effectively done in the peripheral hospitals where clinical material more closely reflects the major medical problems of our time and where the interesting but rare case does not obscure the overwhelming importance of the more common problems. In any case, the largest proportion of students will go on to become general practitioners and do not need to know as much about the rarer diseases. Of greater importance is the so called "minor" illness, so often neglected by the teaching hospitals and yet so prevalent and so important to the future practitioner. For those who choose the hospital service as a career the teaching hospitals would provide excellent postgraduate training.

Unfortunately there exists in some quarters the idea that peripheral hospitals are poor relatives of the "proper" medicine as practised in the teaching hospitals. One has only to go to the provinces to find out how wrong this idea is. The London hospitals give a howl of dismay when their beds are threatened with closure for lack of finance, but how would they react if they had to use wards originally built as temporary shelters for the wounded of the first world war (as happens at Colchester) or half the geriatric unit serving a wide area had to shut for lack of nursing staff? (And a fully staffed ward in Colchester has three nurses on it at any one time, if you're lucky.)

For too long the teaching hospitals have had too much money, too many staff, too much influence over the training of new doctors; and, I suspect, too much say in medical politics without enough contact with real-life medicine. I for one will welcome the spread of their much-needed resources of money and manpower to the excellent but poorly supported peripheral hospitals.

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SIR,—Being a simple sort of fellow one cannot hope to emulate the erudition of Sir Francis Avery Jones or the satire of Mr Roger Hole (11 December, p 1443) but like many of my colleagues at the periphery I am becoming increasingly irritated by the protests from the metropolis at the Resource Allocation Working Party's proposals. The involvement of the *BMJ* as well as the Royal College of Surgeons of England is distasteful, and both would do well to remember that they represent both the periphery and the centre and that to take sides in the argument can only be divisive in the long run.

We are, Sir, in a prison camp situation. We are nothing more than the prisoners of a monopoly service and our guardians, the politicians, faced with economic cuts necessitated by balance of payment deficits and International Monetary Fund strictures, are now sending in less and less supplies—Red Cross parcels, if you like. Is there any justification for the available resources not being shared evenly and fairly throughout the country? It would seem that the establishment of the Metropolitan Oflag feel that they should maintain their supplies with little regard to the problems of their colleagues in less well-endowed areas. Mr Hole refers to the staffing differences between his department and that in London. Many of us held high hopes that the manpower committees would be able to