that a patient ought to be detained, and supposing the doctor had been inexperienced too? Nevertheless, the old mental welfare officer must have been inexperienced once.

"When reorganization came many older people retired or were promoted, and there was this vast influx of new social workers, with much theoretical knowledge but no practical experience. Dr. B had a patient who had had a stroke and was to be nursed at home by our district nurse, who is 77 and four feet ten inches high, so Dr. B asked for a hoist and so on, on Friday. Monday came and nothing happened, so Dr. B rang in rage, and was told someone was coming to inspect. Next day comes a dear little girl with a notebook, who starts gathering information in a proper way. When Dr. B protested that she knew what she wanted, the girl said, 'I must do my casework the right way.' That was 18 months ago: now we know the way to ask to get things done. The social workers feel there are lots of people in social need, and only some of them are patients. Doctors think social workers are only there to look after patients, and they want them to be handmaids. A man with a stroke may be a proper subject for casework in that he may have all sorts of other needs apart from his medical ones. Doctors are sometimes a bit arrogant about this, and feel they can decide everything. They think everything social workers do is for patients, but of course it isn't.

Case Conferences Are Necessary

"District nurses can put in a request, but sometimes doctors

are asked to countersign. Some general practitioners are very possessive, you mustn't go to Family Planning if they don't want you to, or have a wheelchair if they want you to walk. There are a lot more case conferences, which enrage some general practitioners, but are very necessary. The social services are very short of staff. Old-timers would work 24 hours a day; the new sort quite rightly aren't allowed to. Eighteen months ago we were prepared to say that the social services were hopeless; we didn't know what they were doing and vice versa; ring them up and they weren't there, or couldn't come. For instance, Dr. A rang up about a young family in distress, a young girl answered the phone, and said is it an urgent matter or not. Well, everything a general practitioner does is urgent, he doesn't want to stay on the phone another minute, and, of course, if you say urgent it doesn't get done because everyone says the same. It is only by getting down to discussion that you find the best procedure to use. It is surprising how often you ring up about someone and find they are already on file; they have their regulars just as doctors do.

"Meeting your team and being able to call them by name is possible in a village or small town, but it must be an enormous problem in big cities, where you have a lot of single-handed general practitioners who haven't time or staff to contact anybody, and you have a shifting population. We have our system under control, but in London, for instance, everything is short—housing, transport, police, ambulances, casualty services, not just the social services. Everything is wrong for people."

Hospital Topics

Structure and Function of a Middle-sized Accident Department

R. H. HARDY

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Summary

An account of the working of a middle-sized accident department is given, based on the study of nearly 33,000 attendance records. The work load, management, and staffing as it is actually organized is briefly described. The effectiveness of the service given is bedevilled by certain features of the N.H.S.—in particular, the deplorable conditions of employment of staff in casualty departments.

Introduction

Much has been written about accident and emergency services.^{1 22} Though 109 out of 224 accident departments in-

vestigated in 1969¹ had a yearly attendance of new patients of between 9,000 and 25,000 there is little on record about how an accident department of this size may be successfully run. Most writers agree that accident services are important, not as good as they should be, understaffed or staffed by the wrong people, and could be improved by adopting the particular writer's remedy.

The department I write from handles about 16,000 new patients a year. It has its own particular function because of its size, locality, and environment. It also has its own peculiar problems.

Work Load

Some 16,000 new patients per year is a lot for a staff of four to handle (fig. 1). We have one temporary medical assistant, who has held his post for nearly three years and three senior house officers, who change every six months. We can also call on the intermittent help of one experienced surgeon as clinical assistant to fill in our recurrent gaps.

We serve an extensive rural area, from parts of Gloucestershire to central Wales, from south Shropshire to parts of Monmouth. Hereford, the one major city in this area, is a bit off-

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FIG. 1—Yearly number of new patients 1965-73.

FIG. 2—Analysis of new attendances in 12-month period (1st August 1971-31st July 1972). "Major Trauma" includes fractures of long bones and axial skeleton. "Myalgia" includes non-traumatic soft-tissue disorders.

centre (so that journeys from the far west are long and wearisome to the injured) and has its own population of 47,000 (1972) with a large dormitory area in the villages within roughly a 10-mile (16-km) radius. Its industries are varied and its industrial relations good, which makes for a less demanding clientele than in some less fortunate areas. Its rural population is independent, self-sufficient, and admirable.

There is a tradition of responsible general practice of a high quality, and it is one of our first aims to maintain good relations with general practitioners. The vast preponderance of trauma

among those attending the department, and the low incidence of "general medical" and ear, nose and throat attendances are the best evidence of this (see fig. 2). There is in addition a ready acceptance by general practitioners of patients who mistakenly attend the accident department and of those who are referred back to the family doctor after their first attendance and treatment. It is difficult to overestimate the importance of this relationship and of maintaining good lines of communication and co-operation between the two parties. Given this co-operation an accident department can largely select and control its own work load, which is essential for effective running with limited staff and premises.

Our first concern must always be to give sufficient primary care to the injured and to the victims of acute medical emergencies. No other hospital department can do this, and certainly no imaginable rearrangement of the family doctor service could make room for it. There must be a medical service available every minute of every day to deal with this sort of acute crisis and to deal with it expertly.

Further evidence of our good fortune in serving a community which has not yet been destroyed by contemporary antisocial pressures is our happy relationship with the police and ambulance services and, perhaps oddly, the low incidence of eye injuries (see fig. 2). It is unusual for simple eye emergencies to present themselves to us simply because the availability and excellence of the casualty service at the Victoria Eye Hospital is known throughout the community. Eye emergencies are referred or betake themselves direct.

Two factors in the field of general practice operate effectively to complicate this issue: firstly, the almost universal appointments system, inevitable and well run though it is. When there is disagreement whether Mrs. Smith's trouble constitutes an "emergency" or not there is an automatic increase in the rate of attendance. The second factor that increases work load is the withdrawal of most general practitioners from the treatment of trauma in any form, even the simple dressing of wounds, largely because the "nurse" has been replaced by the "receptionist."

It is only fair to admit that both these factors, like the rise in attendances in the accident department, are largely attributable to the inexhaustible public demand for medical care which has been generated by the provision of a free health service and by the increasingly dependent attitudes of an urban and industrial population.

It is certainly not the role of any accident department to run a sort of para-general practitioner service. To attempt this is useless, unhelpful to real general practitioners, and makes a proper accident service unattainable. Nevertheless, there are bound to be some patients whose troubles seem to them to be major and urgent however minor and intrusive they may seem to us. We have to be able to give them our attention wholeheartedly and allow them the benefit of the doubt even when we may think them irresponsible, immature, or merely exhibitionist. This much tribute at least must be paid to our ancient ethos, even in these over-organized days.

There is besides a residuum of patients who are left largely unaided by the reorganized general practitioner service and the increasingly busy practitioners of sophisticated hospital medicine. There is no one but the accident service (donning for the moment its ancient and battered "casualty" hat) to open the abscesses, remove the foreign bodies, dig out the lumps and bumps, change the catheters, and sympathize with the increasing numbers of the homeless, wandering, and desocialized who have no official existence in the organizational network of the present day. These must never be forgotten for their need is great however grimly the casualty officer has to battle to keep their numbers and their demands within bounds.

ANALYSIS OF NEW ATTENDANCES

The analysis of new attendances made for this study (fig. 2)

covered all the departmental records of patients attending in the 12-month period 1 August 1971-31 July 1972. The striking feature was the vast preponderance of minor injuries. These included all the cuts, lacerations, and contusions which came in their daily dozens and all the minor and greenstick fractures which did not need manipulative reduction. Hand and tendon injuries were listed separately as they have an importance of their own, both because of their significance to the patient and because of the skill and time required of the casualty officer. Foot and ankle injuries were so common and often so easily dealt with that they seemed to warrant a category of their own. Otherwise all these categories might well have been grouped together as "minor injuries," giving a total of 9,953 (62.5% of the annual total). The small group of major injuries included multiple injuries and abdominothoracic injuries as well as all fractures of long bones needing reduction and fractures of the axial skeleton. Trauma accounted for 74% of attendances.

Management

We aim to give definitive primary treatment to all accidents and emergencies. We have no access to beds at all—not even to the traditional "casualty ward" where the inebriated can recover in peace and safety. When we are warned in advance by the ambulance service that there is to be an influx of seriously injured people—for example, from a multiple road traffic accident—we have to call on second-line troops to come to our aid, in the shape of the orthopaedic registrar, senior house officer, and houseman; the duty anaesthetist; and any other residents who can be winkled out of their various crevices. We find that their help is given readily and efficiently if it is not called on irresponsibly. Once primary treatment is completed we dispose of all admissions to wards under the care of appropriate specialists as soon as possible.

There is the closest collaboration between the accident and orthopaedic departments. We can get help and advice about fractures and we set out to treat all orthopaedic cases in such a way that there can be a smooth take over or follow up by the fracture clinics. All orthopaedic patients should arrive in the ward having been appropriately dealt with in the accident department so that their subsequent care and treatment can be carried out with a minimum of friction or interruption.

MAJOR INJURIES

A set up of this sort naturally directs attention to three categories of injury in which we might be expected to be particularly weak, putting the seriously injured in unnecessary jeopardy. A second analysis was therefore made of all cases of multiple injury, abdominal and thoracic injury, and head injury with unconsciousness in whom associated injuries could easily be overlooked.

This analysis covered all such cases in a 12-month period, from 1 August 1972 to 31 July 1973, and entailed comparison of the admission findings, diagnosis, and treatment in the accident department with everything relevant that could be extracted from inpatient records and subsequent outpatient attendances, or postmortem findings (see table). Out of 125 cases of multiple injury eight patients were dead on arrival, one died in the accident department, and one died subsequently in the ward. Four patients out of 88 with head injuries resulting in loss of consciousness and one patient out of 15 with intra-abdominal or intra-thoracic injuries also died in the ward after being admitted from the accident department. Reference is made to those dead on arrival as there is no aetiological discontinuity between them and the victims of injury who die after their arrival; this is merely an accident of circumstances, whether of duration of the injury or the degree of its severity.

Breakdown of these figures presents a hard core of difficult cases which are presumably a problem to every level of accident department, from the Birmingham Accident Hospital to the

Cause of Death in 19 Cases of Major Injury

	Case No.	Cause of Death
<i>Multiple Injuries</i>		
Dead on arrival	1	Ruptured R. atrium and arch of aorta
	2	Extensive brain damage; ruptured liver and kidney; 14 rib fractures
	3	Extensive cerebral contusion
	4	Fracture of all bones of skull; extensive brain damage
Died in accident department	5	Laceration of pulmonary veins
	6	Extensive and diffuse brain damage
	7	Ruptured thoracic aorta
	8	Ruptured L. atrium and aorta
Died in ward	9	Severe head injury; no necropsy
	10	Myocardial infarct
	11	Strangulated femoral hernia
	12	Congestive cardiac failure
	13	Haemorrhage from renal neoplasm; ruptured diaphragm
	14	Multiple major fractures; no necropsy
<i>Head Injuries</i>		
Died in ward	15	Comminuted skull fractures; extensive brain damage; R. haemothorax due to multiple perforation of lung
	16	Parieto-occipital fracture with necrosis of L. hemisphere
	17	Probably brain damage; no necropsy
	18	Extensive basal fracture extending into anterior cranial fossa
<i>Intra-abdominal and Intrathoracic Injuries</i>		
Died in ward	19	Aged 70; multiple perforation of lungs; ruptured spleen

remote cottage hospital. Some injuries are, and will remain, difficult to identify and difficult to treat, and one cannot, alas, have the leading exponent of every surgical speciality on duty night and day in every accident department in the kingdom. Would the appointment of full time qualified surgeons (at least four would be necessary to give cover round the clock all round the year) really be helpful, even if it were possible?

Who should be called upon to deal with the emergency thoracotomy or the large vessel repairs which are said to be a routine duty of the casualty officer in a properly constituted accident service?²³ If men of the necessary qualifications and experience were available would they be either equipped or contented to deal with the high-pressure sorting and repair of minor injuries and fractures which necessarily occupy three quarters of the casualty officer's time?

Though there was no outstanding case in the 12-month period here reviewed in which internal injury proved fatal, and possibly avoidably so, impertinent memory recalls the case of a young man who was the victim of a multiple road accident. He was brought in apparently the least seriously injured of five; he was conscious, his pulse volume good, his pains tolerable, and his wounds apparently minor. Half an hour later his heart stopped beating. Energetic resuscitation was of no avail, and necropsy revealed a rupture of the left ventricle, small and probably reparable. He died of undiagnosed cardiac tamponade.

Another instance occurred of an elderly man with a steering wheel injury of the chest. His condition was generally good, though he was unconscious from a not very severe head injury. It seemed clinically that he was bleeding slowly into his upper mediastinum, probably from a damaged internal mammary artery. He subsequently died in the ward without operation. Necropsy confirmed the tentative diagnosis.

It is the urgency of the need for thoracic surgery in the severely injured which makes theirs a special case. It is difficult not to feel the lack of a readily available thoracic surgeon to deal with such patients from the earliest possible moment after arrival.

There is of course, no ready answer to problems of this sort, but their existence must never be forgotten in planning an adequate accident service.

Staffing

Staffing, then, is a major problem. This department is run in

close collaboration with the orthopaedic department and is under the nominal direction of an orthopaedic consultant who, by nature of his occupation, is "absolutely elsewhere" for much of his time. In fact the onus of providing counsel and support at night in the absence of the senior casualty officer falls almost entirely on the orthopaedic registrar. The immediate management, however, is by me—a temporary medical assistant of long experience, if of no other desirable qualifications. How temporary he will be depends on various factors in no way related to any desideratum inherent in the local accident and emergency requirements or the wishes of the persons concerned. The remainder of the regular staff consists of three senior house officers. Many men who have filled these posts have been unfamiliar with the English language and British social mores. They are generally kind, conscientious, clever, and hard working, but their limitations are real ones.

In future it may well be that the institution of a two-year vocational training programme by the Royal College of General Practitioners will produce junior recruits who will not be concerned to jam themselves into a consultant bottle neck at the end of the day. I have no doubt that a period of work in a well run accident department is of unique value to any postulant general practitioner.

Certainly a higher quality of applicant is obtained by the offer of a share in a rotation scheme rather than by the offer of a series of stop-gap appointments; and a combination of a surgical rotation with a vocational rotation for general practitioners would form an excellent basis for recruiting interested and educable staff.

Junior staff should not, ideally be left to run such a department on their own. It is important that an experienced casualty officer should be available at short notice to help in times of doubt or stress and that he should be in a position to encourage and direct even when not called on. The acceptance of this view would entail increasing the number of accident medical staff, and on other grounds this is a desirable aim. It would allow for the sharing of work shifts between the senior and junior staff, which is probably the most effective way of training in accident work.

Unfortunately the insistence of the N.H.S. on the division of hospital staff into house officers, registrars, and permanent consultants does not encourage (or even make it possible for) senior men with an interest in accident and emergency work to make an assured career in it. There is a great need—greater perhaps in accident work than in other branches of medicine and surgery—for properly paid and established posts for senior men who do not have ambitions to build empires or set the Thames alight. The ruthless use and abuse of part-time clinical assistants which is forced on hospital management committees by N.H.S. policy has only to be seen to be condemned out of hand. It shows neither justice nor efficiency. The curious absence of consultation between senior medical and nursing officers which has grown up since the introduction of the Salmon recommendations badly needs reform. The importance of experienced nursing staff in accident work who are able to work in close collaboration with their medical colleagues is too obvious to mention.

Availability of Works of Reference

In making the best use of the staff that we have, we have found it invaluable to have a fairly comprehensive departmental codex. This runs to some 110 typed pages containing clearly stated principles of treatment, illustrated where appropriate, together with local and general information useful to newly appointed junior staff and expatriate doctors working in the department. It is presented alphabetically in loose-leaf form for easy reference and is regularly revised and brought up to date. All newcomers to the department are expected to make themselves familiar with its contents, and it provides an effective basis of uniform practice as well as a *vade mecum* for the inexperienced.

A comprehensive reference library on the spot is essential. Emergency work does not allow hurried consultation with works held in a remote library building. It must cover the whole spectrum of medical, surgical, orthopaedic, gynaecological, and paediatric practice at a fairly simple level; anatomy and accident treatment at an advanced level; and contain sufficient books of reference to give quick and reliable information about poisons, poisonous plants and fungi, legal and industrial aspects of injury, and recent advances in treatment. We find it best to have extracts from relevant journals photocopied and filed on the spot.

Conclusions

No sophistication of technique nor elaboration of organization²⁴ will produce a major improvement in the quality of accident and emergency Services in circumstances such as I have described. I do not think that cleverness solves all clinical problems nor does experience suggest that any system, however cunningly designed, is truly idiot proof.

More staff are needed than are at present permitted so that inexperienced junior staff are not left coping unaided for long periods. A slightly higher rate of pay is also needed to attract suitably experienced and qualified staff. I am not suggesting that we could or should aspire to the dizzy heights of general practitioners' remuneration, but if the monetary reward offered were raised from that of an unskilled dock labourer (as at present) to that of, for example, a bricklayer or carpenter it would be easier to draw recruits into a service which offers work of unrivalled importance to the community and of inexhaustible interest to the practitioner.

We cannot and certainly should not aim at becoming a second Birmingham Accident Hospital, but there is room for improvement, especially in treating thoracic injuries. The appointment of one casualty consultant *per se* to such a department as ours would not achieve any obvious improvement in the standard of work. However excellent he may be and however well qualified he could not be permanently on duty. We should aim at a general improvement in the use of experienced staff and the closest association with our specialized surgical colleagues.

Clearly observations about a particular district general hospital are not applicable to all accident departments and a general mistake of many who have suggested remedies for improving accident services has been to suppose that any remedy was of general application. It is not. This hospital needs this handling of its problems, that hospital quite another. This is not to say that there are no general conclusions to be drawn. For instance, if the N.H.S. were a less callous and unimaginative employer, staff would probably be more content. If medical politics were a secondary motivation of N.H.S. organization instead of the primary one, priorities would change their order instantly and for the better. If every casualty officer showed the highest degree of experience, wisdom, and devotion to duty, as well as inexhaustible patience and sufficient skill in every branch of the primary care of the injured and acutely ill there would be a general improvement of the standard of service.

Unfortunately the N.H.S. which, like the Company that received Sydney Smith's well known obloquy, "has neither a soul to lose, nor a body to kick," is and will remain a bad employer. It is too big, too comprehensive, and too centralized. Medical politics will continue to bedevil good sense and everyday necessities. Casualty officers will vary in skill and wisdom. But so much can be done by using the remedy on hand for local circumstances as they actually exist that it is incumbent on everybody concerned to collaborate in achieving the best possible service by means of applying common sense and the principles of ordinary justice to problems as they arise. In these ways a useful and reliable service can be provided in which any interested doctor should be happy and proud to work.

We are now, as before, under an obligation to relieve pain,

save life, and repair injury the very best way that we can. There is no other criterion of excellence in organizing an accident service which is worth a moment's consideration.

I am more than grateful to Mr. James Scott for producing order out of chaos in my script.

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Contemporary Themes

The Aftermath of Suicide

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Summary

Forty-four spouses of suicides followed up after five years showed no significant differences from the widowed by other causes in respect of mortality and remarriage rates. A minority were stigmatized and most found the inquest unpleasant. Outcome was evenly polarized into better off and worse off.

Introduction

Death by suicide may have special consequences for the surviving spouse because of its suddenness, the legal inquiry, and the moral disapproval, with all the personal and social censure which that implies, which the widowed from other causes do not experience. Yet there has been no systematic study of these consequences. We present here some findings concerning an unselected sample of 44 spouses bereaved by suicide between 1966-8. The findings cover their experience of the inquest, stigma incurred, effects on mortality, and long term outcome.

Method

The 44 spouses studied, 17 widowers and 27 widows, were the relicts of the married subjects of a previous inquiry which had examined the clinical and social precursors of suicide by interviewing next of kin.¹ The definition of marriage was: "the couple were living together as man and wife within six months of the

suicide." The mean duration of marriage was 22 years, (range 9 months-49 years).

All the spouses were traced; 34 were alive but 10 had died. Of the 34, 31 were interviewed directly, two were ill and relations were seen instead, and one refused. For the 10 dead seven relatives were interviewed and one relation living abroad corresponded. The inquest notes and data from the first research were available for all 44. Death certificates of the 10 dead spouses and hospital notes for the terminal admissions of five were examined.

The suicides died between 1966 and 1968; the follow-up interviews took place during 1973. The mean time between suicide and follow-up was 58 months (range 54-83 months). The interviewers, two psychiatric social workers, used a questionnaire which inquired about the postbereavement aspects of the spouses' health, domestic and economic situation, need and experience of help and about the police inquiry, the inquest, the behaviour of household members, other relatives, and friends and neighbours, communication with children, social activities, and emotional responses and religious attitudes to suicide. Interviews ranged from 20 to 200 minutes (mean 65 minutes). Only a part of the data is discussed here.*

To assess reliability 10 interviews were jointly coded. One social worker interviewed and both independently coded the responses to the 141 items. Differences of coding provided a measure of reliability. Disagreement attributable to differing standards was found for 7% of codings, which was within acceptable limits.

Results

INQUEST

The inquest is a statutory requirement for those who have been bereaved by suicide, accident, or homicide, and it may be a painful experience. Thirty-seven spouses attended the inquest and 29 of them described their response to it and to the police inquiry which preceded it.

*A table showing a quantitative presentation of the data is available on request.

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