the major problems encountered were gastro-oesophageal reflux, peptic ulceration, biliary tract disease, the irritable bowel syndrome, functional dyspepsia, and psychiatric problems, with most of the sophisticated conditions which occupy so much space in the specialized gastroenterological journals being seen comparatively rarely. Clearly these figures in no way reflect the true incidence of gastrointestinal disease in the area but do show the problems with which the general practitioners need most help and highlight the divorce between "ivory-tower gastroenterology" and the specialty as it is practised at the grass roots.

The "miscellaneous" group (see table) included such diverse conditions as hyperthyroidism, diabetes, carcinoma of the bronchus, ischaemic heart disease, urinary tract disorders, bacterial endocarditis, etc., which emphasizes the necessity for any clinician interested in gastroenterology to retain a general approach.

Only 28% of the total referrals were judged to need operations, which rapidly dispels the belief that most patients referred to a gastroenterology clinic need abdominal surgery.

Advantages

The main advantage and *raison d'être* of the combined approach is undoubtedly that of improved clinical management. The patients clearly benefit from a firm plan of action drawn up at their first visit and a consequent acceleration of the diagnostic process. This attempt to reduce to a minimum the number of times a patient has to attend hospital is particularly important in a predominantly rural area such as ours where transport is a problem.

The correct sequence of radiological investigations is selected by discussion and unnecessary radiography avoided. Unnecessary surgery may occasionally also be avoided, and conversely the physician can be stopped from procrastination when surgical intervention is patently necessary.

The educational value of this co-operative venture is another major advantage, and is appreciated by the consultant members as well as the junior staff, who are extremely keen to attend. They grasp the opportunity to see patients under supervision, to present cases, and participate in the joint discussion. We have also been able to institute some small research projects with a strong pragmatic and clinical, rather than academic and laboratory, orientation.

We are aware from both the continuing flow of new referrals

and informal discussion that the local general practitioners find ours a useful service.

Possible Disadvantages

There was a natural concern among the remaining general surgeons that a clinic aimed at attracting gastroenterological problems would seriously affect the distribution of clinical cases. Our intention, however, was not to create a gastro-intestinal monopoly, and their fears have not been realized. As we expected there has been no apparent reduction in gastroenterological referrals to either the general medical or surgical clinics, and neither scrutiny of operation lists nor an analysis of gastroenterological x-ray requests from the surgical department indicates any significant change from the previous pattern.

Concern was also expressed lest the clinic surgeon would be faced with an excessive operation load. This fear resulted from the basic misconception that most patients referred to a gastroenterology clinic need abdominal surgery. Clearly, however, the effect of a combined approach is often to recommend a more conservative management, and less than one-third of the total referrals in the first year needed surgical intervention.

There was also some anxiety lest the establishment of the combined gastroenterology clinic would lengthen the waiting time for non-gastroenterological referrals to be seen at the general medical or surgical clinics. This has not been so in the surgical department and has been prevented on the medical unit by the institution of an extra outpatient session.

Conclusions

We have shown that a combined gastroenterology clinic at district hospital level is a viable proposition, the only requirement being the enthusiasm and co-operation of those concerned. The major advantage of a combined approach has been to improve patient management, and no major disadvantages have become apparent.

We hope that our experience will encourage gastroenterologists elsewhere who are at present working in isolation to consider whether this concept might be applicable in their own situation.

We thank Mrs. J. Jackson for typing the manuscript. We are also indebted to Miss S. Davidson for willingly assuming the secretarial responsibility for this venture.

Letter from . . . Canada

Musings from the Hot Stove League

PETER J. BANKS

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The elevation of hypocrisy to the level of principle is a Canadian characteristic. With a heavy cultural inheritance from Scottish Presbyterianism, we come by this honestly enough and naturally our politicians are not slow to utilize the potential.

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The Conference of Federal and Provincial Health Ministers held in Ottawa in January decided that they should limit immigrant doctors coming to Canada, to those with either "a firm job offer, or those ready to move into underserved areas." The reasons given were, "to better balance the supply and distribution of physicians and to give priority to Canadians aspiring to medical careers." The real reason, of course, was money, and everybody in Canada knows it. The subsidiary reason, which every Canadian will at once deny, is prejudice, with stolid overtones of racial intolerance. The concealing euphemism here is that Canada should not draw away precious citizens from the underdeveloped countries.

Have We Enough?

The fact that is behind the collective decision of the Ministers is that the ratio of doctors to patients in Canada is rapidly decreasing; on 31 December 1972, it was one doctor to 633 Canadians and by 1981 it is estimated it will be one to 488.¹ The primary reason for this is immigration. From 1964 to 1969 the number of immigrant doctors exceeded the total output of all Canadian Medical Schools. A large proportion of these new Canadians came from Asia, Africa, and the Orient. In addition, under long and heavy pressure from the medical profession, the federal and provincial governments are slowly increasing the output of Canadian graduates. Yet in 1972, 1178 fully acceptable applicants were still turned away. It is very much cheaper to import doctors trained at some other country's expense than to build more medical schools.

Increasing output and heavy immigration combined are pushing the doctor-patient ratio rapidly downwards, especially in the cities and in the more popular provinces of Ontario and British Columbia. Each new doctor costs money; directly in that the average net income of doctors is now approaching \$45 000 per annum, and indirectly in their overhead costs and in their use of expensive hospital facilities.

Because as a nation we have contracted to supply all Canadians with all the care they need, before defining need as opposed to desire, nobody really knows how many doctors are necessary. We are developing statistics which show that in such special fields as neurosurgery and neurology, we can achieve a saturation point² but in the wide-open areas of family practice, paediatrics, and psychiatry, when is enough enough? To attempt to get some answers to these questions the federal government, with the co-operation of the profession, has established a nationwide manpower study. As Canadian doctors are paid on a fee-for-service basis, the computers are churning out an avalanche of statistics which tell us exactly who is doing what, where. Why, is open to cynical comment or emotional justification, depending on where you sit. Nevertheless, the analysis of these data, if

they are to be used as any kind of yardstick of need, must make some daunting assumptions.

Firstly, that all services that have been done were all done of necessity, and, secondly, that nothing that needed to be done was undone. When the unpredictable needs of medical advance are added and the traditional but temporarily decreased emigration of Canadian doctors to the United States is subtracted, and when the unknown impact of the various types of doctor assistants and substitutes is estimated, the final figures of the national manpower study will have to be accepted with a good deal of faith. The lessons of the Willinck Report have not gone unmarked on this side of the Atlantic.

Real Villains

The politicians must realize that they may as well act now under the pricks of increasing cost as wait for the questionable justification of the figures of the manpower study. Not surprisingly, the media have reacted strongly to their decision. Immigrant doctors have always made a considerable contribution to Canadian medicine. The profession, while assuming a posture of pious innocence, is not escaping the accusation that they are the real villains in the background, and that they have conned the innocent politicians into this decision solely to protect professional income.

It remains to be seen if under pressure our masters in Ottawa will stick to their guns. In the meantime, if any aspiring young doctors want to become Canadians, don't despair, there will always be room in Hungry Moose Creek.

References

- ¹ Leclair, M., An Over View of the Canadian Health Care System, Sun Valley Conference, Idaho, August 1974.
- ² Armstrong, R. A., *Some Observations on Methods of Physician Remuneration in Canada*, Ottawa, 1973.

Social Medicine

Cost to National Health Service of Social Outcasts with Organic Disease

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Summary

The hospital medical records of a patient with chronic lung disease and intractable social problems have been analysed. Multiple admissions resulted in the patient spending nearly three years out of seven and a quarter years in Edinburgh hospitals and in the performance of repeated and often unnecessary medical investigations. Such patients are a source of considerable uneconomic

expense to the National Health Service, but at present it is difficult to see how their medical and social demands can be met in any other way.

Introduction

Much publicity has been given recently to the exploitation of the National Health Service by patients with so-called Munchausen's syndrome.¹ These people, for reasons which are not fully understood and are never divulged by the patient, manipulate their admission to hospital at frequent intervals, usually a different hospital each time, by presenting themselves to a casualty department, often in the middle of the night, with symptoms mimicking a medical or surgical emergency.

A less blatant but more common misuse of N.H.S. hospital facilities, for which the patients themselves are not wholly responsible, is made by patients, usually vagabonds or social

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