mative institutions have *had* to study the painful problems that everyone else is inclined to sweep under the carpet yet which are everywhere so pressing—how to prevent, control, redirect, utilize our own aggressive-destructive impulses.

In this sense the prisons should no longer be the Cinderella of the social services and should no longer be tucked as far as possible out of sight—they might pay good dividends; and if we fail to face these problems we shall be displaying just the

same weaknesses and irresponsibility as the delinquents and criminals themselves.

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GENERAL PRACTICE OBSERVED

District Nursing Sister Attached to Hospital Surgical Department

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Summary: An experiment of attaching a district nursing sister to the surgical department of a general hospital was designed to show the use of the district nursing service for the after-care of patients discharged from hospital after surgical treatment. In a 15-week period about 590 bed days were saved, and only six out of 126 patients discharged early had to be readmitted. Most of the patients and the general practitioners who replied to questionnaires about the scheme were in favour of it.

Introduction

The idea of early discharge of hospital patients is not new. This was possibly first put into practice in the field of obstetrics and later of general surgery, notably herniorrhaphy. Whereas the duration of aftercare for maternity patients is statutorily defined, no such legislation exists for general surgical aftercare. By tradition the minimum period of postoperative care in hospital has extended at least up to the time of removal of sutures or clips, but this is itself variable. If no normal period of hospital care is defined the concept of early discharge has no meaning other than that created by custom and tradition. A break with tradition would therefore eventually change the norm. Such a change would seem to be in line with current thinking on the expansion of community care.

Reported here are the preliminary findings of an experiment linking a district nursing sister with the surgical department of a busy general hospital. The plan for the experiment arose as a result of concern expressed by a senior surgical consultant about his formidable waiting-list of patients requiring cold surgery. Usually he kept all his surgical patients in hospital until at least their sutures or clips were removed—that is for about five to ten days. The district nursing service in the town was not usually asked to care for patients who had been discharged from the surgical unit, mainly because the district nursing sisters were an unknown quantity to the surgeon. For this reason he was somewhat undecided and apprehensive about discharging patients who still needed care. The experiment was initiated to show the surgeon and his team that continuity of care by the district nursing service could be a workable and desirable proposition.

The Experiment

After initial discussions with all the parties involved, the Queen's Institute proposed a mutually acceptable experiment and agreed to finance and analyse it.

A senior district nursing sister was relieved on her district to enable her to work with the surgical team on a full-time basis. Her first two weeks were spent on observing and initiating the type of treatment and after-care favoured by the surgeon. After this period her duty was to see the patients in

the wards with the consultant and to follow them up in their homes after discharge for supervision or care as necessary. The period of the experiment was 15 weeks. During this time hospital secretary provided statistical data about the patients the district nursing sister kept a record of her work, and the discharged under the special scheme. Some time after their discharge the patients completed a brief questionnaire asking for their views. General practitioners also provided information about requests for visits to these patients, and their opinions were invited about the scheme and its possible extension.

Altogether, 126 patients were discharged under the experimental scheme—that is, they were discharged earlier than would otherwise have been the case. The criteria for suita-

TABLE I.—Age and Sex Distribution of Patients

Age Group	Male	Female	Total
0-14	2	3	5
15-20	3	15	18
21-30	3	8	11
31-40	10	10	20
41-50	7	16	23
51-60	12	11	23
61-64	1	2	3
65-70	1	7	8
71-74	1	7	8
75-79	..	3	3
80 plus	1	3	4
Total	41	85	126

TABLE II.—Type and Frequency of 126 Surgical Procedures

Appendicectomy	25
Herniorrhaphy	17
Excision of cyst of breast	13
Excision of tumour	9
Cholecystectomy	7
Various surgical procedures for varicose veins	7
Mastectomy	6
Repair of anal fissure	6
Laparotomy	5
Abscess	4
Excision of gland	3
Preparation for and/or skin graft	3
Hiatus hernia (and vagotomy)	3
Others*	18

*Including procedures performed not more than twice.

TABLE III.—Number of "Early" Days in Each Age Group in the 126 Patients

Age Group	Average No. of "Early" Days	No. of Patients in Group
0-14	5.4	5
15-20	3.6	18
21-30	4.9	11
31-40	3.8	20
41-50	4.6	23
51-60	4.7	23
61-70	5.2	11
71-79	6.4	11
80 plus	6.0	4

Total number of "early" days = 587.2. Average number of "early" days per patient = 4.7.

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TABLE IV.—Length of Hospital Stay, Number of "Early" Days, and Amount of District Nursing Care for Patients after Most Frequent Surgical Procedures

Surgical Procedure	Average Total Length of Stay (Days)	Average Postoperative Length of Stay (Days)	Average No. of "Early" Days	No. of Patients in Group	Average No. of Days on District Nursing Sister's Books	Average No. of Visits by District Nursing Sister
Appendicectomy	5.8	5.0	4.3	25	7.1	4.2
Herniorrhaphy	7.2	6.4	5.4	17	10.1	4.6
Excision of cyst of breast	2.3	1.8	4.0	13	8.8	4.1
Excision of tumour	2.7	2.1	4.2	9	11.1	4.5
Cholecystectomy	11.8	10.1	3.6	7	10.9	5.6
Treatment of varicose veins	3.1	2.7	6.0	7	21.6	8.5
Repair of anal fissure	5.2	2.4	6.2	6	29.8	32.0
Mastectomy	8.2	6.4	6.8	6	20.5	13.1
Laparotomy	16.2	12.2	5.4	5	9.6	6.6

bility for discharge were (1) the patient's postsurgical progress, which included his physical and mental condition; (2) the availability of appropriate facilities in his own home; and (3) the patient's preference.

Patients of all age groups were included in the scheme (Table I), and they had undergone a wide variety of surgical procedures, of which the most frequent are listed in Table II.

One of the aims of the experiment was to find out how many hospital bed days could be saved by discharging patients earlier than would normally have been the case through making use of the local authority nursing service. The days thus saved are referred to as "early" days.

Any calculation of early days must be to some extent hypothetical. The hospital secretary provided this information for each patient based on (a) the usual period of stay in hospital for the specific procedure and (b) the condition of the patient as assessed by the consultant. On this basis the total number of early days for the 126 patients was about 590—that is, an average of 4.7 days per patient. That the number of early days was not related to the patient's age is shown in Table III.

Clearly the number of early days needs to be considered against the actual length of hospital stay, particularly the interval between operation and discharge. In this particular hospital the total stay for, say, appendicectomy would have been 10 days or for mastectomy 15 days (Table IV). Though this may be longer than the length of stay in some other hospitals, the use of the district nursing service almost halved these periods.

The district sister, who continued the care of the patients in their own homes, coped well with the demands made of her. After seeing the patients in hospital she visited them at home either on the day of discharge or, more usually, the next day. Most patients were visited daily, at least for the first few days; occasionally it was necessary to visit twice a day. The 126 patients together had just under 700 district nursing visits—that is, an average of roughly 5.5 visits per patient from the day of his discharge from hospital to his discharge from the district sister's visiting-list. Almost all the district sister's visits were for the purpose of giving some specific kind of nursing treatment, mostly a surgical dressing. The district sister was also responsible for the removal of sutures or clips.

The average number of the district sister's visits to the patients who had undergone one of the nine most frequent surgical procedures and the number of days these patients were retained on the sister's visiting-list are shown in Table IV. The surgical procedure demanding most nursing after-care was repair of anal fissure. Nearly all the patients (120) were discharged from the district sister's visiting-list because they no longer required care. Though the remaining six patients were readmitted for hospital care, their early discharge did not appear to be responsible for their readmission. Of the six patients four had further hospital treatment already planned, one had an embolism, and the other contracted another illness altogether which required hospital care.

As mentioned above, the patients, some time after their discharge from hospital and after completion of their district nursing treatment, were sent a questionnaire asking for their

views and opinions. A total of 106 patients co-operated in the inquiry, a response rate of 84%. Reasons for non-response included readmission to hospital, change of address, and the death of one patient. In only four cases could the reason for non-response not be discovered. When interpreting their answers the fact that these patients constituted a biased sample—inasmuch as they had opted for early discharge—must be borne in mind. On the other hand, the option had been presented to them partly as a means of easing the pressure on the hospital beds. For this reason, it may be assumed that at least some of the patients agreed to go home early because they felt morally bound to do so; this is supported by comments in the questionnaires.

The patients' own views on the length of their hospital stay did not seem to be related to their age (Table V). The patients were also asked for their preference in relation to after-care should they be faced with a similar situation again. They were predominantly in favour of early discharge, irrespective of how

TABLE V.—Patients' Views of Their Length of Hospital Stay by Age

Age Group	Length of Hospital Stay				Total
	Too Long	Too Short	Just Right	No Response	
*0-14 ..		1	1	3	5
15-20 ..		1	12	5	18
21-30 ..		4	6	1	11
31-40 ..	1	2	16	1	20
41-50 ..		1	18	4	23
51-60 ..		2	17	4	23
61-64 ..		2	2	1	5
65-70 ..	1	2	5		8
71-74 ..	2	2	4		8
75-79 ..		1	2		3
80 plus ..			3	1	4
Total ..	4	16	86	20	126

*It is reasonable to assume that parents answered on behalf of this group.

TABLE VI.—Patient's Preference, Should They Ever Require Another Operation, by Amount of District Nursing Care

	Average No. of Days on District Sister's Books	Average No. of Visits by District Sister
Would prefer to go to convalescent home ..	11.4	7.6
Would prefer to go home early with visits from district nurse ..	13.2	7.7
No preference ..	11.6	7.5
No response ..	10.9	5.2

much district nursing care they had needed (Table VI). It is interesting, though not significant, to note that four of the eight patients who stated a preference for a convalescent home had undergone herniorrhaphy, one of the first of the surgical procedures for which early discharge schemes had been introduced.

It was inherent in the scheme that the discharged patients would be readmitted immediately should this prove to be necessary. Once the patients were home, however, their general practitioners reassumed medical responsibility for them, and it was therefore important to obtain the doctors' views of the scheme. The patients in this experiment were represented by 53

general practitioners who were invited to co-operate in a postal inquiry. As only 38 doctors responded, a response rate of 72%, some of the data must be interpreted with caution. It is possible that the non-respondents were fiercely opposed to the scheme and therefore did not participate in the inquiry. It is equally possible that those who did not favour the scheme were pleased to have an opportunity to say so. Because neither the hospital authorities nor the medical officer of health nor the secretary of the local medical committee had received definite complaints, it is likely that non-response was not related to strong feelings for or against the scheme. Thirty-three general practitioner respondents considered an early discharge scheme such as this one desirable, and 16 of these felt that other types of patients could be included. Medical, midwifery, gynaecological, and orthopaedic patients were mentioned, in that order of frequency.

It might have been suspected that the five doctors who did not favour the scheme had been excessively burdened by requests for extra visits or perhaps by night calls. This was not so. The total number of requests for home visits was very small indeed and only two general practitioners had been called out at night, one of whom approved of the scheme.

Discussion

One of the aims of this experiment was to reduce the length of the surgical waiting-list by allowing the local authority district nursing service to play a bigger part in the postoperative care of patients. It was hoped to increase the surgeon's confidence in the service by showing its use. The experiment resulted in a saving of about 590 hospital bed days in a 15-week period. In the event, it was not possible to shorten the waiting-list appreciably because surgical manpower and other facilities were already used to capacity. The greater throughput which had been achieved, however, resulted in a considerable reduction of overcrowding of the wards, and this was

stated by the hospital secretary to have been the most outstanding and obvious benefit of the scheme. Moreover, the surgeon's wish to continue the scheme beyond the experimental period suggested that he had confidence in the district nursing service to provide continuity of nursing care for his patients after their early discharge. Though in this experiment one district nursing sister had been specifically designated to provide this care, there is no reason why surgical aftercare should not fall within the normal scope of the district nursing service whatever its administrative structure may be.

Clearly the wide implementation of a scheme such as this has far-reaching implications for a hospital. If the more rapid turnover of surgical patients is to be exploited, surgical manpower will have to be increased and theatre facilities either more fully utilized or expanded. There are other financial considerations: whereas the cost per patient treated in hospital would be reduced, the cost per bed might well be increased, because of the intensified care each patient would require. The resulting increased volume of nursing care would also need to be borne in mind. Eventually the district nursing service would have an increased work-load, but the type of work is well within its normal range of ability and skills. It would add interest and scope to the work of the general practitioner and the community nursing team.

A reduction of surgical waiting-lists must ultimately result in a healthier community. Moreover, that earliest possible discharge from hospital is, in many cases, in the interest of the patient, his family, and the Health Service can hardly be disputed.

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UNHEARD VOICES

The Paediatrician

[FROM A SPECIAL CORRESPONDENT]

"Two things make this job possible," said Dr. Newhurst, "the telephone and experienced, dedicated senior nursing staff." She was the sole consultant paediatrician in the group, responsible for two paediatric units, two neonatal units, and on call for neonatal problems for G.P. obstetric units scattered throughout half the county. "When I came here," she told me, "I had to drive 90 miles to do a complete round of all my beds. My predecessor had left the job so that he could see something of his family. Since then I've given up my sessions across the river in Staplebury, but I still work a 50-hour-week—as a part-time consultant."

Dr. Newhurst had got her consultant post after twelve years' junior appointments, mostly spent in academic units. One of the real difficulties of working in an isolated sheep-farming area was the lack of even one other person with whom she could talk paediatric shop at her own level. "Again the telephone comes to the rescue," she explained. "Fortunately I have a good relationship with the staff of the children's hospital at the teaching centre 80 miles away in Comerford—and I find that if I phone them they are always friendly and helpful."

Staff Shortages

The hospitals in which she worked were typical of the N.H.S. at the start of the 1970s. Basic buildings of Victorian red brick had been enlarged and upgraded, annexes built on,

and most of the space between the blocks filled with structures built of wood, asbestos, breeze-block, and sometimes plastic; these served as operating theatres, a central sterile supply unit, an outpatient hall, and a nurses training school. But despite this effort and the provision of modern equipment, the services provided sometimes faltered—and the reason was the shortage of staff. "We cannot attract girls to be radiographers, laboratory technicians, physiotherapists and so on," Dr. Newhurst explained. "The pay does not compare with the local industries; and only too often we send good girls away on a course and they return full of enthusiasm—and wanting to move to the bright lights of Comerford." The problem was not limited to ancillaries. Within the region it had become clear that as radiologists retired the vacancies might remain unfilled—no candidates came forward even as locums.

The hospital had no arrangement with the teaching centre for junior staff. The consultants did what they could to help their residents. The library was well stocked, and there were regular postgraduate teaching sessions three times a week. Some excellent married quarters had been built recently, but the single accommodation was still very poor. Dr. Newhurst had a paediatric S.H.O., who worked a rota with the medical residents to give paediatric cover. "Unfortunately," she continued, "the medical registrars have usually had no experience with neonates, and their commitments rarely allow