practice need have no current significance. Finally, we noted that the rate of emigration by doctors was no higher than the general rate."¹

A number of criticisms may be made. Firstly, the whole subject of medical emigration was outside the terms of reference of the Commission as set out in the Royal Warrant. Secondly, the information given was misleading, as air movements were not considered and no differentiation was made between doctors and dentists in the data provided. Thirdly, and most alarming of all, the conclusions reached were at variance with the evidence given to the Commission.

While the figures provided were obviously inaccurate, trends were nevertheless apparent. For example, during the period under review (1951-7) the Commission was informed that 1,522 Indian and Pakistani doctors entered the U.K. while 930 left.² Those who remained were clearly providing semi-permanent staffing within the N.H.S. This theory has received powerful support from the Platt Committee³ and more recently from the Sheffield Regional Hospital Board, who have revealed 58% of their junior hospital posts held by overseas doctors.⁴

There was considerable immigration of South African doctors to the U.K. in the early and mid 1950s. The African continent as a whole, however, seems to have been poorly served, for there was a net annual export of only 10 doctors from the U.K. Interpretation of the African figures should be made in the light of the following remarks extracted from the Commission's Report (paragraph 141): "... The number of doctors leaving Great Britain by sea each year is collected, but many of these are men of overseas origin returning to their home countries after qualifying as doctors here. On arrival they are counted as undifferentiated students, but on departure as doctors, a fact which can give a false impression of the balance of migration."

Emigration from the U.K. was mainly to Canada, U.S.A., and Australasia. I have criticized the Canadian figures elsewhere.⁵ So far as America is concerned, our own Board of Trade found a net export of 208 British doctors during the years 1953-6, inclusive, whereas the U.S. Department of Justice issued 270 permanent visas to British doctors during this period. The position with regard to Australasia is also confused, largely because the Commission failed to differentiate between doctors and dentists. Many Australian dentists migrated to the U.K. at the inception of the N.H.S. to enjoy a bonanza era of British dentistry. It would be imprudent to predict any trend from these figures, although other sources suggest that medical migration to the Antipodes is similar to that to North America. For example, Martin has claimed that the medical migration of British doctors to Western Australia from 1955 to 1960 was 13 times the general rate.⁶

Conclusion

Taking the North American continent as a whole, we find that on an average we have exported 311 doctors annually during the years 1953-60, inclusive—the output of three medical schools. Although the figures for 1961 are not yet complete, our medical manpower loss over a nine-year period is equivalent to the total G.P. and specialist services of the cities of Manchester, Leeds, Liverpool, Sheffield, and Bristol combined. Leaving numbers aside, there can be no denying that many highly skilled doctors settled in the U.S. during the 1950s. The cause is not difficult to find. Not only has

the N.H.S. provided outrageous terms and conditions of service, it has completely failed to inspire respect among the younger members of the profession, who see through its Fabian humbug.

The size of the medical migration rates is matched only by the complacency of our leaders. The proposed expansion of our medical schools⁷ is claimed to be the answer to our present shortage of doctors. Yet if it were not for the excessive medical emigration no shortage would exist.⁸ We are about to watch the manpower losses of nationalized medicine written off in the same fashion as the financial deficits of our nationalized industries—by asking for more.

Nor can any pride be taken in the fact that our hospital service relies on medical labour from the under-developed countries. According to the Board of Trade, there is a net annual import of 90 doctors from India and Pakistan. Now that this supply shows signs of dwindling Lord Taylor has suggested that the advent of the Common Market will permit us to import Italian doctors to run our Health Service.⁹ Clearly 14 years of socialism have made us completely shameless, for no one can believe these policies to be in the national interest.

Recommendations

1. Our Health Service should be reformed along the lines proposed by D. N. Lees in his Hobart paper, "Health through Choice."¹⁰

2. Our *Medical Register* should be reorganized along the lines suggested by me last year.⁵ This would enable the Government to obtain reliable statistical data.

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ARE SPECIAL HOSPITALS DOOMED?

BY

SOMERVILLE HASTINGS, M.S., F.R.C.S.

What is the place of special hospitals in the ideal system we are trying to build? Or is there no place for them at all? No sensible person would suggest the immediate scrapping of reasonably up-to-date efficient hospitals conveniently situated for service to the public. But before we can even start building such a hospital system we must have some idea of the edifice we want eventually to create, though the blueprint that we have in mind may require repeated revision.

The quality of the work carried out in any hospital, general or special, must inevitably depend to a very large extent on the capacity and diligence of its medical and nursing staff. Specialists may be divided roughly into three main classes. (1) Some doctors specialize in the diagnosis or treatment of special types of disease:

such are pathologists, radiologists, and cancer specialists. Specialists of this type often find it necessary to call in regional specialists to assist them in the application of treatment. (2) Others specialize in the diagnosis and treatment of diseases of many kinds, but in one organ or region of the body: so we have gynaecologists, skin specialists, ophthalmologists, and ear-nose-and-throat surgeons. (3) Lastly there is the specialist who deals with illnesses of a special class of people. The best example is the paediatrician or children's specialist. In actual fact, however, the paediatrician does not deal with all types of disease in children but only with medical affections, and does not undertake surgery or the diagnosis and treatment of such special organs as the eye, ear, nose, or throat, etc.

As we have three types of specialist so we have three types of special hospital. (1) There are hospitals for the treatment of particular affections, such as cancer, rheumatism, and accidents. (2) We have hospitals for diseases of the skin, eye, ear, nose, and throat, etc. (3) There are hospitals for most, though not quite all, illnesses of special classes of patients, the best example being the children's hospital.

The Hospital of the Future

It is generally agreed that so far as our present knowledge and experience goes the hospital to be worked for—the hospital of the future—is the large general hospital. It should be large, about 800 beds, so that there will be enough work for experienced nurses and doctors in each department. The specialist in charge should live within easy reach of such a hospital, especially if his department is a surgical one, so as to be readily available in any emergency. The specialist who attends a lot of small scattered hospitals must find it difficult to undertake work of first-class quality in each and to be available to all in case of emergency. Out-patient departments for consultation and, if necessary, treatment in outlying districts, but without hospital beds, can be associated with such a large general hospital.

There can be no doubt that work of excellent quality in the specialty for which they were founded is carried out in many, indeed most, special hospitals. But you cannot cut the body up into little bits and treat each part separately, and it is not always easy to secure within its walls the very best advice for affections other than those for which the special hospital was founded, should this be necessary. On the other hand, specialized treatment for all ordinary types of disease, both acute and chronic, is available within the precincts of a large general hospital.

There is another point which needs careful consideration. It cannot be economical to provide pathological and x-ray facilities in every small hospital, necessary as these must be.

Certain hospitals call for special mention. *Cottage hospitals* are much beloved by the public. They are often near a patient's home and friends, so that visiting is easy. The wards are small and cosy and discipline is relaxed. The doctor in charge is often well known and trusted by his patients. There are, however, certain serious objections. The general practitioner may be inclined to undertake cases or perform operations for which he has not the necessary skill or experience. Moreover, although a consultant staff is available, at least on paper, they are not always easy to get hold of

and the doctor may be inclined to "sit on" cases too long. In neither case is the doctor completely to blame, as his patient almost invariably assures him of his entire confidence and urges him to retain the sole control of his case. Not a few general hospitals provide beds in which local general practitioners can care for their own patients. There can be no objection to this, as a second opinion is readily available in a general hospital at which specialists of all kinds attend regularly. The main drawback is that busy general practitioners often find it difficult to visit patients as regularly as is desirable.

To protect the public from infection, especially by serious diseases such as smallpox, there will always be a place for *infectious disease hospitals*. It is best to associate such a hospital with a general hospital so that the services of specialists may be readily available. Some go so far as to advise that infectious disease (except smallpox) should be treated within the curtilage of a general hospital.

Mainly for the protection of the public also, *mental disease* has long been dealt with in large barrack-like hospitals well isolated from centres of population. Several years ago some mental disorders were thought to be associated with or caused by physical disease, and there were wards for mental cases in a good many of the large general hospitals. There must, of course, be facilities for diagnosis and treatment of physical disease in association with every mental hospital, but it is at least doubtful whether it is desirable to separate patients more amenable to treatment from the more chronic and treat them in general hospitals. Great progress has been made in the last two decades in the treatment of mental disease and it would seem best to provide facilities for mental specialists to deal with all types of case in a single hospital.

Children's Hospitals

These hospitals are really general hospitals for children. Although there is much less sickness in children to-day, even compared with but two or three decades previously, there is still an honoured place for such hospitals. Children's hospitals have special departments as do general hospitals, and should have wards to which mothers can be admitted with a seriously ill child.

It may be said generally that, except for hospitals for children, mental disease, and infectious disease, the work carried out at most special hospitals would be better undertaken either in, or in close association with, a general hospital in which full facilities are available for diagnosis and treatment of all types of illness. An important exception perhaps is the specialist hospital in which postgraduate teaching and research is being carried out, as, for instance, ophthalmic hospitals. But even in such hospitals it is important to be certain that there is full cover for the diagnosis and treatment of any incidental illnesses.

Unfortunately much that is ideal cannot be immediately practicable. Most general hospitals have waiting-lists, and it is difficult to justify the closure of any well-equipped hospital of reasonable size. If the special hospitals in the area are associated with a general hospital and made part of it, though physically removed from it, a decision can be reached on the best use of each, and some no doubt will be adapted for the post-operative care of cases treated in the parent hospital.