A retrospective survey such as that presented here can never be satisfactory, as significant data are not collected and not all cases are reported. Thus no statistical analysis of dose, time relationships, or incidence rates can be calculated. Only by insisting that chloramphenicol and other drug-induced dyscrasias are notified to some responsible authority as they occur can the case be made whether the popularity or efficiency of this drug as an antibiotic outweighs its established toxic effect.

The purpose of this paper has been to stress once more the dangers of using this antibiotic and to appeal for the compulsory notification of this and other drug-induced blood dyscrasias to a responsible central body in order that a true assessment of the relative risks can be made. This appeal is especially pertinent to the present concern of the medical profession and lay public regarding the dangers of modern drug therapy.

In the meantime this Committee would be grateful if any doctor encountering a case where it is suspected that chloramphenicol might have produced damage to the bone-marrow would send the relevant data to the secretary of this Committee.

The Committee expresses its thanks to the Council of the Association of Clinical Pathologists for their encouragement and permission to publish these data; to the Chairman of Council, Professor D. F. Cappell, for his criticism and advice; and to all those members of the Association who took the trouble to supply the Committee with case reports. It also wishes to thank Dr. M. M. Wintrobe, Chairman of the Study Group of Blood Dyscrasias of the American Medical Association, for his advice and encouragement.

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"A more detailed knowledge of the facts of life and death as they are; the creation through 'health planning'—in association with the other 'planners' of the essential public health services and an administrative structure to maintain and support them; the control and where possible the eradication of communicable diseases; the building up of a cadre of trained men and women to work in the health services, and research—both into the causes and cure of disease, and into the operations of the health services themselves. This is the prescription. Perhaps it may be described as 'administrative polypharmacy.' But for the completion of any such programme as I have outlined—and it should be remembered that it is also the programme of the conference—money is the essential prerequisite. We are only now beginning to study the relationship between health budgets and the overall expenditures of governments, and the available information is scanty. But one cannot escape the conclusion that in the cutting of the financial cake in many countries—the health portion not only should but might be greater. Money will be required for the great capital investment programmes in environmental sanitation; health centres, hospitals, laboratories, medical and other training schools. Funds will be required for the maintenance of all these installations and institutions and for the increased numbers of health personnel who will be required to staff them. All this is investment in health in the broadest sense and it will pay dividends in proportion." (Address by Dr. M. G. Candau, U.N. Conference on Application of Science and Technology for Benefit of Less Developed Areas.)

Special Article

WHY ARE THEY WAITING?
A SURVEY OF OUT-PATIENT REFERRALS

BY

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After 14 years of the National Health Service it is surprising to find that only four reports have been made concerning the varying habits of family doctors in referring their patients to hospital. Hopkins (1956), Logan and Forsyth (1958), Fry (1959), and Scott *et al.* (1960) each reported on the rates of referral of their patients to hospital in-patient and out-patient departments.

We, in one industrial practice, were interested in our out-patient referral rate, but were more concerned with the delays involved (a) in obtaining out-patient appointments, and (b) in receiving the report of these consultations—delays often prolonging the patients' absence from work.

To investigate this problem we designed a card which was printed for us by the medical department, Ardeer Factory (Nobel Division, I.C.I.). The data which interested us were: (1) the age and sex of the patient, (2) the clinic to which he was referred, (3) the date on which the request for an appointment was made, (4) the date on which the patient was seen, and (5) the date on which we received the specialist's report. We thought of incorporating the total time the patient was absent from work, the time spent in travelling to and from hospital, the time spent waiting in the out-patient department, and the number of return visits paid, but since we intended this as a pilot survey only, these important items of information were sacrificed for simplicity of recording.

Our secretary made out a card for each out-patient referred. These were filed in the patient's record envelope and extracted and completed when the specialist's report was received. Records were kept for one complete year. The number referred and their age and sex distribution are seen in Table I.

TABLE I.—Age and Sex Distribution of Patients Referred to Out-patient Departments

Males				Females			
Under 15	15-65	Over 65	Total	Under 15	15-65	Over 65	Total
60	161	23	244	37	228	19	284

There were 528 patients referred in the year. Our practice population for the survey year averaged 5,585 patients, giving a percentage referral rate to out-patient departments of 9.5%. In the year, 37,479 patient-doctor contacts were made in the home or surgery. Therefore an out-patient opinion was considered necessary in one out of 71 consultations given by us.

In our analysis of the overall waiting-time—from the request for an appointment to receipt of the report—

only those clinics to which we had referred 10 or more patients were included. These were out-patient clinics held at: (1) Kilmarnock Infirmary (general non-teaching hospital), (2) Ayrshire Central Hospital, Irvine (chest, obstetrics and gynaecology), (3) Seafield Hospital, Ayr (paediatrics), and (4) the Western Infirmary, Glasgow (general teaching hospital). The results are summarized in Table II.

TABLE II.—*Waiting-times Involved in Out-patient Referrals to Various Clinics*

Hospital and Clinic	No. of Patients Referred	Average Waiting Time		
		For Appointment	For Report after Consultation	Total (From Referral to Report)
Kilmarnock Infirmary:				
Surgical ..	65	8.6 days	3.0 days	11.6 days
Orthopaedic ..	44	23.3 "	4.7 "	28.0 "
Skin ..	39	6.6 "	4.2 "	10.8 "
E.N.T. ..	34	18.1 "	2.3 "	20.4 "
Ophthalmology ..	33	21.4 "	4.0 "	25.4 "
Medical ..	14	16.7 "	5.2 "	21.9 "
Radiology ..	11	17.0 "	3.0 "	20.0 "
Ayrshire Central Hospital:				
Chest ..	37	8.8 "	2.5 "	11.3 "
Gynaecology ..	48	13.9 "	1.4 "	15.3 "
Antenatal ..	13	7.1 "	1.4 "	8.5 "
Seafield Hospital:				
E.N.T. ..	28	16.3 "	1.8 "	18.1 "
Orthopaedic ..	12	8.3 "	5.3 "	13.6 "
Surgical ..	10	13.1 "	2.6 "	15.7 "
Western Infirmary Glasgow:				
Orthopaedic ..	19	18.3 "	5.7 "	24.0 "
Medical ..	10	15.9 "	18.4 "	34.3 "

Discussion

The result of this survey shows that when we refer any patient to an out-patient clinic in our area the average time we have to wait until we receive a report of the consultation is 19.7 days. This fact alone makes the hospital out-patient department much less accessible than it should be. Often the decision to refer a patient who is already off work is delayed in the hope that he will recover sufficiently to return without a second opinion being sought. This leads, of course, to further delay if referral becomes necessary despite our procrastination, and a further period of at least three weeks' absence from work can be reckoned on. This may well be longer if the patient is sent for ancillary investigations or becomes "lost" for weeks in the physiotherapy department.

If the waiting-time for appointment is used as the yardstick, the most overworked clinics seem to be those of the so-called minor specialties. There is only one answer to this problem—we need more medical staffing in these clinics. The number of referrals to these departments may also reflect to some extent the meagre time allotted to the undergraduate teaching of these subjects, a fact that may be corrected in future planning of curricula.

It would also appear that extra secretarial staff in some departments is urgently required. To have to wait an average of 18.4 days to receive a report after the patient is seen, in one department, seems to us to be inexcusable. Surely a brief report of clinical impressions could either be dictated or taped immediately after the consultation, and any other positive ancillary findings communicated at a later date. We would draw attention to one hospital department whose reports reach us, on an average, only 1.4 days after the patient is seen.

We would also like to issue a plea to our consultant colleagues that only relevant findings are of interest to us. We assume that their examination will be thorough or we would not refer our patients to them. To list negative clinical findings is therefore time-wasting to all concerned, and often it is difficult to pick out important details from a verbose report at a later date.

Amongst all the hospital reconstructions envisaged by the Minister of Health (1962) in his recent White Paper, the hospital out-patient department warrants scant mention in paragraph 21. However, it is at least recognized that changes are required to ensure that this vital cog in the hospital service should fulfil its purpose most effectively. But does the White Paper go far enough? Are out-patient theatres and day wards sufficient to cope with present inadequacies if the medical and nursing staff necessary to operate the existing facilities is already numerically inadequate? More hope lies in the proposed establishment of peripheral clinics and diagnostic centres where the specialist and family doctor could work more closely together.

The argument is continually being brought forward that the cost of new hospital buildings, with the extra medical and secretarial staff required, is prohibitive. With this in mind we found it interesting to postulate the following. Suppose that the 161 males of working age whom we referred each received National Insurance benefit at the rate of £4 12s. 6d. per week—that is, the benefit paid to a married man with no children. If we assume each is absent from work during the 19.7 days awaiting the report of his visit to hospital, then the total amount paid in benefit to these 161 patients would be £1,986 11s. 3d. Even if this figure is halved it still amounts to a very considerable sum when multiplied by the many family doctors using the same out-patient facilities as ourselves. It seems to us that too much attention is given to the high cost of running the National Health Service with no evident correlation to the colossal bill which must be footed each week in meeting Health Insurance claims, not to mention the vast sums that must be lost in industry through absence of employees from work.

Summary and Conclusions

An account is given of the out-patient referrals from one practice during a complete year. The referral rate was 9.5% of the practice population, and one out-patient consultation was requested for every 71 consultations given by ourselves. Particular attention has been paid to the waiting-time from referral of the patient to receipt of the specialist's report. The waiting-time averaged 19.7 days. Some suggestions are made on how out-patient facilities may be improved, and it is also suggested that many useful data concerning the general running of out-patient departments are at present in the hands of hospital administrators waiting to be used for the benefit of the specialist, the family doctor, and their patients.

We think the figures we have produced may be of some value, but it is sad to think that these have had to be presented, in a very limited way, by three family doctors. For years these facts have been available in a much more complete form to all hospital administrators from their out-patient records, but so far as we are aware have been allowed to lie dormant and not used as they might have been to promote improvement in out-

patient facilities. Who knows, the position in other areas may be much worse.

We should like to thank all our specialist colleagues for their close co-operation, past and present. This is in no way a criticism of their work. We are also indebted to Dr. D. McColl and the medical staff of Ardeer Factory for printing the record cards which we used, and to our secretaries, Miss D. H. McKenzie and Miss S. Perry, for completing them for us.

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SOCIETY OF MEDICAL OFFICERS OF HEALTH

SECOND ANNUAL SYMPOSIUM

The symposium was held on February 22 in the Wellcome Building, Euston Road, London, with an attendance of over 350. The morning session was devoted to a consideration of mental health—"The Adult Psychiatric Patient in the Community." In the afternoon the subject was "Preventive Aspects of Degenerative Diseases."

Mental Health

For the morning session Sir KENNETH COWAN (Edinburgh) was in the chair, and the opening address was given by the President, Dr. EDWARD HUGHES (Reading), who emphasized the need to keep an open mind, and as a warning referred to the spirit of Galen which had bound medicine for 1,300 years. How far, he asked, should community care be extended? In public health work there was a great opportunity to see the effect of mental sickness of the individual on the home and to study epidemiology. Administration and research could be combined to give real interest and stimulus.

Sir KENNETH COWAN remarked that the family care system was not new but was receiving a new slant. In Norway 50% of psychiatric patients were living in the community. This underlined the need to evaluate variations in day hospitals and the increasing readmission rate. We should consider critically how to help the patient, but avoid detriment to the family or undermining family responsibility.

Dr. J. K. WING (M.R.C. Social Psychiatry Research Unit) commented on the fact that 25% of admissions, 50% of residents, and 75% of the over two-years inmates were schizophrenic, and that this type of illness constituted the bulk of the long-term problem. Hospital discharges had increased, but so had the rate for readmission. A survey had shown that 50% of relations were favourable to care in the community even at considerable sacrifice to themselves. A problem was the low level of employability, and the Ministry of Labour had a big responsibility to provide facilities. The survey had shown a rising level of emotional involvement of the relatives, which had an adverse effect on both patient and relations.

Community Care

A paper by Dr. IAN SKOTTOWE (Oxford) was, in his absence, presented most excellently by Dr. C. BURNS (Leicester). He stressed the need to ascertain the proportion of mental patients who can benefit from community care. Although 10,000 patients had been discharged after a mean stay of 10 years in hospital, there was increased frequency and length of stay on readmission. Social and interpersonal problems bulked large. He suggested that preventive social

work with adolescents to improve insight into family relations during the transition period might be helpful. There was need for practical training of social workers, and selected individuals even without long academic training could be most helpful. The G.P. had a major part to play, but was greatly hampered by the time-factor.

Dr. S. L. WRIGHT (Croydon) presented the point of view of the medical officer of health, and suggested a parallel with the organization to deal with tuberculosis. Much difficulty was caused by failure of social adaptation, and there was a need for social case-workers integrated with the Service and working under the supervision of a consultant psychiatrist in close association with the G.P. Discharge in some cases could, to use a recent phrase, "transfer the snake-pit from the hospital to the home."

The discussion which followed emphasized the need for community support and prevention. An enlightened community could have a therapeutic effect. Marriage-guidance methods had something to offer. Services to help selected families and adolescents deserved consideration and trial.

Diet and Disease

In the afternoon Dr. J. DURNIN (Glasgow) discussed calorie needs and diet with possible reference to disease. He pointed out that there was little expenditure of energy by the young or the middle-aged apart from work. The expenditure of both groups was very similar. In a British survey the calories from fat were between 40 and 45% of the total diet, while in Switzerland for much harder work the proportion was only 30%. This might have important implications.

Professor J. N. MORRIS gave some illuminating statistics concerning the incidence of diabetes known and found on survey. He underlined the urgent need to cease "dragging our feet" in preventive and educational work, and gave as an instance the use of the test for cervical carcinoma of the uterus. Over 100,000 women were affected in this country: over one in 50 of all women who had had a child. Some teaching departments were not using the tests, and so medical students were not being adequately prepared nor the public enlightened.

On the question of smoking, two million men smoked heavily and many thousands would die prematurely. The younger you started the worse the damage and the earlier the death. It was a major health and economic problem. What were we going to do?

Health Education

Dr. IAN TAYLOR (London County Council) spoke of health education and the need for a wide approach. In the case of cholera the association with sewage-contaminated water was known long before the cholera germ was identified. Action was taken. Surely the situation with regard to smoking and lung cancer was similar. Why did we refuse to act? On average the death rate for smokers was twice the average rate for the population. For both smoking and drinking it was necessary to prevent the formation of dangerous habits in the young, and every effort should be made to help older people to understand the dangers sufficiently to lead to a modification of their habits and the use of available services.

In discussion the "Public Health Dilemmas" (*B.M.J.*, February 16, p. 419) came to the fore, but there was no doubt in the minds of the participants that the opportunities of the Public Health Service were great and varied. In a real sense mental health was public health, and health must be promoted through right education, a task for community co-operation by all the services—medical, educational, and social. More experiments were needed. The Public Health Service had opportunities in the fields of administration and research—clinical, epidemiological, and statistical, as well as educational. Staffing, organization, and integration needed to be given serious consideration. Doctors must not cling to duties which had lost validity or could equally well be done by others. They should be free to move ahead as community patterns changed and the conception of health developed.