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Conversations with Consultants

Dr S the gastroenterologist

TONY SMITH

This is the third in a series of interviews recorded with NHS consultants (the first appeared on 2 January, p 45). Dr S works in a large district hospital within 50 miles of London, and his hospital still refers some patients to centres in London. The district is a RAWP gainer.

In answer to your opening question, compared with five years ago I rate my morale to be as good or better. I am sure that I am getting more work satisfaction than I was five years ago. On the other hand, some of my consultant colleagues, particularly the ones who are older than I, seem to be getting less satisfaction from their work and their morale is lower than it was.

Our district is a RAWP gainer and there have been no recent changes in the number of beds available to me, but my workload has increased. My surgical colleagues have enormous problems with operating theatre time and I regret that this is due to bad planning by the regional administrators. Everybody knew that the old operating theatres were falling down, and the regional health authority did not provide an adequate number of new operating theatres, and the ones which they did build have been plagued by poor design and faulty construction. So operating theatre time is a

problem to our surgeons and gynaecologists and has been the cause of long waiting lists. We have not seen any change in the availability of outpatient clinic space, which is adequate, and the endoscopy service has been built up substantially over the past five years. What we have done is to train general practitioners to perform basic gastroscopy and they make a very valuable contribution to our service.

Waiting lists

Waiting lists vary from specialty to specialty. The waiting list in my specialty has not changed for the past five years; it has remained at an unacceptable level for non-urgent patients, and this also applies to a few other specialties in our district. For non-urgent referral in my specialty waiting time to be seen in clinic has remained between six and seven months in the past five years. I have therefore encouraged general practitioners to send patients to London hospitals in the full knowledge that I cannot cope.

You asked about any changes in the number of ancillary staff (porters, cleaners, etc), laboratory staff, secretarial staff, and so on. We always seem to be chronically short of porters and this has a big effect on operating lists and may cause procedures to be cancelled. Things haven't changed or improved in the past five years. With the cleaners I have not noticed any difference. With laboratory staff, secretarial and other grades, I have a feeling that we are just slightly

short of all of them and a slight shortage of, for instance, secretarial staff can mean a huge deficiency in services if one of them has to take time off owing to sickness.

Terrible pay

For both ancillary staff and secretaries the hours are reasonable but the pay is terrible. Furthermore, our medical secretaries often put in unpaid overtime, simply because they are so dedicated. I think their services are abused by the health authority. Quite a lot of our secretaries have left to work in London and though they work longer hours they make a lot more money. The NHS does not begin to compete for secretarial salaries. If my secretary or clinic clerk goes on leave or cannot get to work because of illness the system seems to collapse, literally within hours, because there are just not any people who are trained to replace them; and when the regular staff come back they are faced with a mountain of work to catch up with, which they find depressing. Our secretaries are mostly young and bright and extremely competent, but some have babies and leave. If only we had a crèche we might be able to hang on to some of them. As it is we spend a lot of time worrying about whether or not we will be able to find a satisfactory replacement.

Nevertheless, so far as our patients are concerned, I can safely say that the service we offer is broader than five years ago. We have appointed new consultants and are offering more diagnostic and therapeutic techniques. Colposcopy, chorionic villus sampling, a fertility clinic, the special care baby unit has expanded vastly, laser surgery in ophthalmology, artificial knee replacement, ultrasonography, computerised tomography, arteriography, and parenteral nutrition are some examples. Others include bronchoscopy, colonoscopy, and ERCP (endoscopic retrograde cholangiopancreatography). Only six or seven years ago we would have to be on the telephone or writing a letter probably to a London teaching centre about a patient who needed a colonoscopy. That led to an enormous amount of extra administrative work. Three years ago we were spending time on the telephone trying to arrange for urgent computerised tomography, which we can now do ourselves. These improvements have made a substantial difference in the way we practise medicine day to day.

You asked me about the recent expansion in the private sector throughout Britain. We no longer have dedicated private beds here. Beds are nominated as private in side rooms after discussion with the local administration. There is a private hospital, a 40 bedded unit, five miles away, and yes they have taken some of our trained nurses, but the nursing shortage is a chronic and universal problem, and we did not notice a sudden or drastic shortage of nurses when that hospital opened up three years ago.

Economic factors

These answers to your questions make it clear that I am working in an expanding service in a district hospital. We have been able to increase the hospital budget rather more than the average in the country, because we are in a district which is gaining from the RAWP system of reallocation of money from London to the periphery of this region, although the region is a net RAWP loser. Economies have been made by the district administration, and therefore have provided for some of these services, but I am told that we are about to go into budget deficit next year for the first time, largely as a result of increases in NHS salaries. If we do go into deficit we might have to start cutting services, but that is what has been happening all over London.

In our district, and with the services provided for our patients by the teaching hospitals in London, the National Health Service is

almost working. Its main defect is that waiting lists are much longer than they should be. It is probably the most cost effective health delivery system in the world, and the fact that it nearly works seems to me to be quite a remarkable achievement. It is chronically under-financed; it works within hospital buildings which are decaying; it has deficiencies in administration with little forward planning; it has an undisciplined consultant workforce; and the junior medical staff are overworked, exploited, and held to ransom by the reference system. The nurses, secretaries, and ancillary workers are terribly paid, and yet the National Health Service almost works.

As far as nurses are concerned, there has always been a slight shortage, although we are quite lucky as this is a semi-industrialised town with lots of young people looking for jobs. There is also an element of local pride; nurses are pleased to be able to enrol for training and help to run the hospital. When I look around I am always impressed by the smartness, efficiency, and dedication of our nurses, and I see them as an asset which is totally irreplaceable. If they were not so professional and dedicated the service would collapse immediately. Within a few years demographic changes may alter all of this and there may be fewer young women available to take up this sort of work, particularly if they are not paid properly.

You asked me about privatisation. Some has taken place in the ancillary services, but I have not noticed that it has made any difference in day to day life in the hospital.

Shabbiness

The main cloud on the horizon is that we seem to be moving towards budget deficit. This is going to be difficult. The administration will be forced to cut more corners in services, so we might become more shabby than we are now. This would be a great shame, because I have a feeling that if there was just a little more money we could be a bright, sparkling example of what the health service can achieve.

The shabbiness is irritating. I should like a better office, and the windows on the medical ward block should not rattle when it is windy and should not let in icy cold draughts in winter. The wards should have acoustic tiles to make them less noisy at night. Signposting in and around the hospital leaves a lot to be desired. Attention to detail has not been given to the fabric of our buildings. It is depressing that the initial impact of our hospital on patients and visitors can be the smell of urine from the lavatories in the entrance hall.

In the near future we hope that more money is going to be made available to build a new block and so provide much more outpatient space. This is essential because these days so much medicine is organised on an outpatient basis. It will also provide a new day bed unit and more theatres, which are desperately needed. I am sure that if the block is built it will make a huge contribution to the reduction of our waiting lists. The big question, of course, is will we be able to afford to run it? That is a political decision about which we can do very little.

We do still refer patients to London teaching hospitals for cardiological investigation and surgery, for neurosurgery, and, for example, renal failure. We know that the hospitals to which we refer them have closed wards and have great difficulties with finding beds, yet somehow they still provide us with an excellent service. These centres must be working extremely hard under very adverse conditions. I am surprised that they do so well. When these specialist centres cannot provide a service and do not have a bed for an emergency, then patients' lives are threatened. I am sure that this happens already, and when it does happen the public and politicians must know about it. We all know that money is the problem, but of course I do not have the answer to this perpetual issue. More and more has simply not been enough.