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LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

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The NHS versus private medicine

SIR,—Sir Richard Bayliss (21 May, p 1457) documents the recent growth of independent hospitals and states his belief that "the electorate will accept, even welcome, a mixed medical economy, provided, and this is an important proviso, the NHS is improved, and 'free' medical care continues to be available at the time of need." The proviso is of fundamental importance because government ministers assume that encouragement of private hospital practice must benefit the acute hospitals of the NHS. Personal experience suggests that this should not be assumed.

When I was appointed as a consultant surgeon in 1958 the only contract available was for eight sessions so I began to see private patients and, for the reasons given by Sir Richard, found this enjoyable. As the volume of NHS and private work expanded, however, it became increasingly apparent that neither responsibility was being properly discharged. One cannot control workload by picking and choosing among referrals, so after eight years I applied for a whole time contract. This had several effects.

Firstly, instead of visiting four hospitals once or twice each day I could concentrate my efforts in one adult and one children's hospital. There was time to do a full ward round each day with our team and to organise outpatient clinics so that patients were usually seen by the same doctor and without undue haste—this can transform follow up clinics into useful occasions for both parties. We could set up a records system which showed our immediate and long term results. Secondly, there was time to teach. One of the most important tasks of the surgeon is to help the next generation to learn good operative technique, and there is no way to achieve this except for the surgeon to act as first assistant until the trainee is ready for opportunities to operate independently. Assistance will continue to be needed as more complex procedures are tackled. I consider the time given to assisting colleagues at all stages of training to have been most enjoyable and rewarding. The increasing attention being paid to this aspect of surgical apprenticeship is most welcome.[1,2] There is evidence that it still does not receive enough attention,[3] and it is time that it was more widely accepted that some emergencies require technically advanced surgery for the best results and that this requires the presence of an experienced surgeon.

The commitment of the surgeon to any patient is comprehensive, but in private work the lack of junior colleagues means it can be heavy and unpredictable. It is unreasonable to call for more elective surgery to be performed in private hospitals and also to expect overextended surgeons to give as much time as they would wish to teaching and to out of hours emergency work in their NHS units.

What is needed urgently is for consultant staffing to reach a level at which there is time for proper care of all patients, for teaching, and for investigation. There is a sad discrepancy between present surgical waiting lists and the fund of highly trained registrars and senior registrars longing to be given more responsibility. It would be a useful start, amidst all the advocacy of more private care, to give practical encouragement to the many who would be glad to pursue a full time career in academic or NHS hospital practice.

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1 Matheson NA. Surgical technique. *Br J Surg* 1987;**74**:1190.
2 McKeown KC. Reoperative surgery for early complications following abdominal operations. *J R Soc Med* 1988;**81**:307.
3 Buck N, Devlin HB, Lunn JN. *The report of a confidential enquiry into perioperative deaths*. London: Nuffield Provincial Hospitals Trust/King's Fund, 1987:38.

Gas gangrene

SIR,—Dr C R Kirk and others (30 April, p 1236) and Professor Stephen T Holgate (30 April, p 1213) have clarified our position when considering treatment with penicillin in patients giving a history of penicillin allergy.

We would, however, strongly disagree with Dr Kirk and others that primary closure of soiled or penetrating wounds should be delayed. It is quite clear from the case report that the child's wound, although explored and cleaned extensively, was not excised. It was this failure to convert an untidy wound (which contained non-viable tissue) into a tidy one (in which the wound edges were viable) by the simple process of wound excision that led to the onset of gas gangrene. There is now ample evidence that untidy wounds such as deep dermal burns[1] and type III open tibial fractures[2] can safely undergo primary closure provided that adequate wound excision has been performed.

"Primary wound closure" may mean anything from direct suture, to skin grafting, local flaps, or free tissue transfer. It is important that wound excision should not be compromised by the surgeon's ability to close the resultant defect. Ideally the surgeon performing the excision should have access to whichever technique is most appropriate for its closure. Delayed primary closure is still appropriate when the surgeon cannot be certain, whether due to inexperience or the nature of the injury, that wound excision is complete. The real lesson of this case report is the long known importance of wound excision.[3]

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1 Janzekovic Z. A new concept in the early excision and immediate grafting of burns. *J Trauma* 1970;**10**:1103-8.