77

BRITISH MEDICAL JOURNAL

SATURDAY 27 NOVEMBER 1971

LEADING ARTICLES

PAPERS AND ORIGINALS

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO. 5786 BRITISH MEDICAL JOURNAL 1971 VOLUME 4 505-570 WEEKLY PRICE 35p
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR TELEPHONE 01-387 4499

CORRESPONDENCE

Correspondents are asked to be brief

Hospital Waiting Lists

SIR,—There are more important reasons why offered beds are wasted other than the one given by Mr. D. P. Choyce (13 November, p. 428). Patients are generally sent for with a maximum of seven days' notice; this is quite inadequate for the mother with young children, or someone with a job. The postal service is such that even with a 3p letter the seven days is reduced to four or five. Patients who have been on a list for months or years may have moved and failed to notify a forwarding address. I do not like the suggestions made by Mr. Choyce, and surely he is aware that computers are by no means infallible—or perhaps he has been luckier than I with his bank statements and tax returns, for example.

There is a very simple solution which I have used successfully at two general hospitals (one teaching) over the last two years, and I commend it to Mr. Choyce and others.

The consultant keeps a diary in his clinic and when he sees patients requiring admission he offers them a date which suits the patient and himself. The name and other details are inserted into the diary. The patient is given the appropriate admission papers which avoids the need to write to the patient. At regular intervals the admission office sends a list of patients to come in to the ward for perhaps a month or more in advance.

On the ward round the consultant will know what beds he requires for the following week. He can then arrange for his discharges on that day when the patients are due to come in. The system must be in the sole charge of the consultant, and it will fail if these important duties are delegated to the frequently changing junior staff or clerks.

There is no need to have a waiting list, leaving patients in doubt until the last moment as to when they will be admitted. This system has the additional advantage that patients are not invited to come in and then told on arrival to go home as the bed has been taken by an emergency. Furthermore, the hospital does not have to rely on the vagaries of the postal service or the patient notifying a change of address.

Let those who are sceptical try it for a year, but I stress again that the consultant himself must actively control the system, which really involves very little extra work and time.—I am, etc.,

NIGEL H. HARRIS

London W.1

Factors Influencing Return to Work

SIR,—May I make a few (unavoidably belated) comments on the paper by Dr. D. A. Brewerton and Mr. J. W. Daniel (30 October, p. 227)?

For their study of factors influencing return to work patients with severe brachial plexus injuries were most suitable. Either anatomically or functionally many of these unfortunate young men ended up one-armed; major readjustment was necessary. Yet in one way this choice was unfortunate. It is only recently that the dense mist that enshrouded this most complex of all nerve injuries began to lift, and the reluctance of surgeons to make a firm prognosis at an early stage was understandable. However, looking back on the time when, as part of the attack on this problem, the Royal National Orthopaedic Hospital, in conjunction with Roehampton, established a special clinic for the study of these patients, I am sure our approach to it was too academic. We were so absorbed by investigation, prognosis, and treatment that we gave too little thought to what sort of work was suited to each man's disability and temperament. Dr. Brewerton and Mr. Daniel are right in drawing attention to clinicians', including our own, neglect of resettlement.

This leads to a second topic, the disablement resettlement officers. These men work under the Ministry of Labour, and there are obviously good reasons for this; the Health Department is so satisfied with this arrangement that it will not allow it to be questioned. Yet there are two reasons why it should be. If, as Dr. Brewerton and Mr. Daniel argue, clinicians need stirring up, the chances of this coming about are better if the district rehabilitation officer is in the hospital (he can serve several). Like the medical social worker, he is linked anyway with part of it by the nature of his work. Secondly, the initial steps, especially if a patient with a serious injury is to be tackled early, can be very delicate, and the D.R.O. must be a person, rather than an official, as dedicated to the patients' welfare as are nurses and doctors. His job must be an end in itself, not a rung on a departmental ladder.

I have no first-hand experience of the ordinary run of D.R.Os; some are no doubt good, some indifferent. What I am sure about is the unvarying excellence of the two hospital-based resettlement officers with whom I have worked over a number of years. I cannot apportion the significance of the character of the men themselves or of