the National Health Service 4 G.P.s to 1 health visitor, to 1 district midwife, and to 1.5 home nurses. These ratios vary from area to area, but they do suggest that units of population of 10,000 could be served by four G.P.s working together with one health visitor, one midwife, and one or two home nurses. Consideration should also be given to the place of an all-purpose nurse *cum* social worker in general practice.

What we are convinced of is that the time is surely past when general practitioners and health visitors worked independently out of sight and out of touch in mutual antagonism. They are endeavouring to provide medical care for the good of our community, and this is, after all, best provided by a joint and co-operative team-approach.

We acknowledge the support given to us by Dr. A. Elliott, County Medical Officer of Health of Kent, and to Miss A. Clarke, the Superintendent of Health Visitors of Kent. We also wish to thank Miss P. Robinson and Mrs. G. Towey, the health visitors who worked in the practice at the start of the scheme.

REFERENCE

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Co-operative Effort to Reduce a Waiting-list

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A significant proportion of a general surgical waiting-list is made up of cases of hernia repair awaiting operation ; these are continually being displaced by more urgent or more desperate cases. Consequently the waiting-list tends to grow and the hernia cases are further delayed.

This report shows the favourable effect on a growing waiting-list of a well-organized co-operative scheme for the early discharge of hernia cases.

In 1961 I began a scheme for the early discharge of my herniorrhaphy cases ; they were transferred to Blackwell Recovery Hospital, 14 miles (22.5 km.) from this hospital, by ambulance, on the second post-operative day. Although 140 were dealt with in this way, the waiting-list was still growing after 18 months and there were difficulties in persuading patients to accept transfer, mainly because of difficulty of transport for visiting.

I decided, therefore, to inaugurate a home-discharge scheme, and with the concurrence of general practitioners and the City Medical Officer of Health the plan outlined below was devised, and an explanatory letter was sent to all G.P.s in the district.

The New Scheme

I reserve two beds for hernia cases—admitting on Monday, operating on Tuesday, discharging home or to Blackwell on Thursday ; admitting at once a successor to the bed for operation on Friday and discharge on Monday, and so on. This keeps the patient under my eye until I am fairly certain all is well. It also keeps the bed in continuous use and is a protection against temptation to put another case into the space left. This may be weak in theory, but is not so in practice, since we have approximately 60% of emergency admissions to wards to compete for beds.

A simple form has been devised by which to notify the M.O.H. and the G.P. when a patient has been sent for. The patient is notified about 14 days before admission, and at the same time a form is sent to the G.P. and also to the M.O.H. The M.O.H. arranges for a district nurse to visit the home and report on the conditions ; if these are unfavourable arrangements are made for the patient to be admitted to Blackwell Recovery Hospital. There are other advantages from this visit. Some patients may have moved house and not let us know, or may have colds or domestic trouble and wish to defer their operation. Experience shows that such patients are just as likely to ignore the bidding notice as to fail to inform us of their difficulties, and so a bed is wasted. With this scheme, however, the M.O.H. notifies us in time to send for another patient.

On the patient's discharge the supervisor of district nursing of the area is informed by telephone. She then arranges for post-operative visits and for removal of the sutures on the date given by us. An appointment is made for the patient to be reviewed in the out-patient department three weeks after discharge.

This scheme came into operation in 1963. The accompanying Table gives figures for the last six months of the old scheme and the first six months of the new one ; 136 hernias were dealt with in the first six months of the new scheme compared with only 37 in the last six months of the old one. Indeed, in 18 months of the previous arrangement only 140 hernia cases were removed from the waiting-list as against 136 in the first six months of the present scheme.

One Year—Proportion of Total Admissions to Waiting-list

	Total Admissions to Ward	Total Waiting-list Admissions	Hernias Admitted	Total Waiting-list Additions	Balance of List
Six months of old scheme					
October 1962	74	22	8	40	+18
November 1962	68	19	6	24	+5
December 1962	72	28	7	36	+8
January 1963	70	18	4	29	+11
February 1963	68	20	5	25	+5
March 1963	70	24	7	26	+2
Six months of new scheme					
April 1963	102	36	12	26	−10
May 1963	106	50	20	23	−27
June 1963	85	45	24	20	−25
July 1963	98	58	30	41	−17
August 1963	108	58	30	28	−30
September 1963	70	40	20	24	−16

Operative Technique

The usual standard procedures are carried out. Nylon monofilament on an atraumatic needle is used for repairs of all types. Fascial grafts have not been done, but nylon darn and implants

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have been used. Particular attention is paid to haemostasis, since delay in discharge due to infection of haematoma disturbs the whole scheme. Fabric dressings on the skin are not used, the wound being sealed by Nobecutane spray. This has eliminated the moisture of skin edges seen in covered wounds and the almost invariable slight soreness of skin under adhesive plaster, both factors which encourage infection from the surface post-operatively.

Post-operative Course.—Patients are allowed out of bed in the evening of the day of operation if they feel like it, but are not pushed ; in any case, they are up next day. They are told to move about as freely as they can when they go home, but not to lift or fetch and carry, and so need to be waited upon.

Care at Home.—Care at home is therefore minimal. The district nurses have already become acquainted with the patient and his home by their first visit. Subsequent visits involve removal of sutures and re-spraying of the wound. If in trouble the nurse contacts the patient's doctor, who decides on what action to take. If he thinks the patient should be readmitted to hospital, we admit him without delay to his original ward. It is important that confidence between hospital and doctor should be complete in this respect.

Complications.—During the whole period from 1961, covering 276 cases of the old and six months of the present scheme, I have had only three " returns "—one a saphenous-vein thrombosis which began at home on the fourth post-operative day ; one red but bacteriologically negative wound, which resolved spontaneously ; and one early recurrence (six months) of a direct hernia in a patient of 55 years with a fat abdominal wall and very flabby tissue. It is as yet too early to give any figures for late recurrences.

More theatre time, surgeons, anaesthetists, and nursing-time is required, as these cases lengthen the lists ; and the reaction does not end there, because one gets the bigger cases off the waiting-list more quickly, and there is a limit to what one can efficiently perform.

Nursing-staff Reactions

It has been argued that this more intensive use of beds exhausts the nursing staff by taking out of the ward the easy cases and raising the level of activity. This has not been entirely our experience. Nurses, like all of us, wish to see results from their labour, and they take pride in having a good ward turnover and satisfactory recoveries—and hernia is *par excellence* such a condition. They are interested, too, in the problem of waiting-lists and keen to help solve it.

Furthermore, since the amount of nursing required in a hernia operation is almost the least among surgical cases, and since the cases are clean and the patients usually active, medical ward sisters have been very pleased to take them at slack times, especially because of their short stay.

Patient-reaction

At first, when patients have the scheme clearly explained to them, some are a little apprehensive, but most have expressed relief at the prospect of being able to recover at home and not having to stay in hospital for 10 days.

Patients at their final check have all said they thought the scheme a good one, and most of them have immediately grasped its financial implications to the Health Service. Patients are not so clueless in this field as is often made out. Latterly, when beginning my explanation, I have found patients cutting in with a remark that they heard about the scheme from a friend or neighbour who had been in, and have asked to be sent along. On the whole the " consumer reaction " seems favourable.

Discussion

There is no doubt that a definite timed scheme of this kind has a considerable advantage over less cut-and-dried methods in its effect on the flow of cases through the wards, and so on the waiting-list. It does involve more work for surgeons and anaesthetists, and this has to be allowed for. We have had no adverse comments from our nursing staff on the more intensive use of beds ; on the contrary, they are interested in the problem of long waiting-lists and in any attempt to solve it.

We have also found that, as medical wards tend to be lightly occupied in summer, medical ward sisters have been pleased to house cases for us at that time.

The scheme has been accepted with alacrity, and gradually the news gets around, and patients ask if they can be sent home early. They are very alive to the implications of such a scheme in terms of cost to the Health Service and the maximum use of beds. I do not, however, think that they appreciate the extra load thrown on the medical staff, other than in a very nebulous way, or that in reality the staffs are, by their own efforts, bolstering inadequate material facilities. I suggest that schemes of this kind, while of great value in containing a problem within certain limits, are in fact expedients, and I do not think they should necessarily be regarded as desirable in themselves. It would surely be a mistake to plan hospital buildings to work along these lines. Such plans would only serve to perpetuate existing shortages, and would continue to conceal what is only too evident to hospital staffs at the moment—a lack of capital facilities in the service.

Summary

A scheme of close co-operation with the general practitioners and District Nursing Service is described and its success in reducing or controlling waiting-lists is shown.

Reactions of the hospital nursing staff and of patients are described.

It is suggested that such schemes are expedients to cover shortage rather than being desirable in themselves.

It is shown how the waiting-lists are reduced ; the earlier scheme, operating over a period of 18 months, dealt with 140 cases, whereas in the first six months of the new scheme the number was increased to 136 cases, and since writing this article the rate of work has continued at the same level. Figures for the last six months of the old scheme and for the first six months of the present scheme are compared.

I wish to thank the district nurses for their help in the problem—only by their effort can it work. I wish also to thank Dr. E. L. M. Miller, City Medical Officer of Health, and his staff for their help and continuing co-operation.