THE LONDON SPECIALIST POSTGRADUATE HOSPITALS

– a review and commentary on their future

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THE LONDON SPECIALIST POSTGRADUATE HOSPITALS

– a review and commentary on their future

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Foreword by **Lord Cottesloe GBE TD,** chairman of the steering committee

Introduction by **Professor G A Smart MD BSc FRCP,** director of the British Postgraduate Medical Federation, written for this publication at the request of the King's Fund

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'It is of first importance to understand that successful research depends upon the man engaged in it. This principle receives frequent lip service but it is insufficiently ingrained in discussions and actions relating to the promotion of original work. Corporations may plan, panels of medical men may scheme, the charitably inclined and public funds may provide elaborate facilities; the wrong man is chosen, or the right man is chosen and put to the wrong *ad hoc* job, and the whole comes to nought. Meanwhile, in some cupboard of a place, ill-equipped and unfinanced, his mind fanatically centred on a problem of his own choice, a man hitherto unsuspected of the gift, reveals important truths. That is not to say that men should be put to work in cupboards or starved of equipment. But it throws emphasis where it belongs, as it would not be thrown if this section were written under the caption "Organisation of research and recruitment of workers". Recruitment should take precedence and organisation proceed to meet the needs of the worker as these arise; that should be the almost invariable principle. The usual failure of *ad hoc* organisation, other than as it affects work further exploring original discoveries, is very widely recognised; yet these schemes continue to be frequent.

'Many quite legitimately doubt if organised research is not a mistake. Unquestionably it has led to a flood of second and third rate work and writing. And here it is to be noted that a flood of such work is often not merely harmless, it may be very harmful in obscuring channels of progress. The idea prevalent in the teaching medical institutes of some countries, that a showing of "research" is an obligatory permit of entry to the staff is foolish. The idea is prolific of rubbishy work and it overlooks the obvious fact that men without aptitude for original work may nevertheless possess wide knowledge and conspicuous powers of discrimination, qualities which go far towards the making of first rate teachers. The fundamental point is to allow and encourage men to develop their own aptitudes.'

From Sir Thomas Lewis's memorandum of evidence to the Goodenough Committee.[8]

Acknowledgements

Many people have contributed to the contents of this report and many organisations have been consulted. We should like to thank them all for readily giving their time to discuss the present situation and prospects for the future with us. We wish to make clear, however, that the conclusions and recommendations are our own.

Useful written material was provided by many people. In particular we should like to thank the records officers of the specialist postgraduate hospitals for extracting from their files the considerable amount of data necessary for the patient origin survey. We should also like to thank the London Teaching Hospitals Management Services Unit for their invaluable assistance in analysing the data.

We are grateful to Sir Douglas Logan, principal of the University of London, for permission to reprint as Appendix 5 his note, *Position with Regard to the Implementation in London of the Recommendations of the Royal Commission on Medical Education*; to Miss Isabel E P Menzies, consultant at the Tavistock Institute of Human Relations, for permission to quote from her letter to the Department of Health and Social Security on social work at the Royal National Orthopaedic Hospital; to the Nuffield Provincial Hospitals Trust for permission to reprint as Figure 5 the diagram, Organisation of Postgraduate Medical Education, from *Postgraduate Medical Education – Retrospect and Prospect* by John Revans and Gordon McLachlan.

Finally, we should like to thank Mr S C Merivale for making the many arrangements and appointments which were necessary, and secondly, all those whose general guidance and critical comment have proved invaluable in this study.

FW
PP
London
1975

Notes on Authors

Frank Wellman is a senior consultant with SCICON, principally concerned with management information and the use of operational research methods in organisational and strategic planning. He read applied science at Durham University, graduating in 1958 with first-class honours, and spent nine years in research, the last three of which were concerned with planning and management of long-term research projects.

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Joint Secretaries		
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	S C Merivale CBE	secretary, Teaching Hospitals Association

Foreword

During the last half-dozen years successive governments have commissioned a number of studies concerned with the organisation of medical education, nursing, the funding of government research and the major reorganisation of the administrative structure of the health services. The outcome of all this activity will have a profound influence on the work and organisation of the London specialist postgraduate hospitals and institutes. The reorganisation of the health services will inevitably be accompanied by changes of emphasis and have an impact on the allocation of resources between specialties as well as between service, teaching and research activities. Against this background of change we cannot assume that the role of the London specialist postgraduate hospitals will remain unchanged in the future.

Whatever the changes, specialist medical teaching and research will always be of vital importance in the forefront of medicine, and there must be further discussion devoted to identifying the place of these hospitals in the new pattern and to resolving the crucial question of the continuing provision of funds to enable them effectively to fulfil their role. This report illustrates vividly and draws together the issues that must be considered. It will also serve as a useful catalyst for future discussion on the position of postgraduate specialist work generally in the health services.

Cottesloe
1975

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Introduction

by G A Smart

The investigation which led up to this report was commissioned by the Teaching Hospitals Association and generously supported by King Edward's Hospital Fund for London. The background is well enough known to those closely concerned with the London hospital scene. London, because of the size of its population and the concentration of its considerable medical talent into a geographically small area, was able to pioneer many developments in medical education and specialist hospital services both at the undergraduate and at the postgraduate levels. Much of this development occurred long before the National Health Service existed and some of it before the University of London came into being. However, vast changes have occurred on an accelerating scale particularly during the last 50 years, not only in medical science and technology but in the whole environment in which the teaching hospitals of London work.

These changes quite obviously created many problems, and in the past a number of bodies have been set up to advise what changes should be made. Their recommendations are summarised in this report, but for a variety of reasons only limited action was ever taken to implement them, perhaps the most important being the formation of the British (now Royal) Postgraduate Medical School.

For this and other reasons, not all of them justified by objective scrutiny, the London teaching hospitals have for a number of years been under attack and a great deal of attention was paid to them by the Royal Commission on Medical Education, chaired by Lord Todd, which reported in 1968.[19] Subsequently, the University of London and the Department of Health and Social Security have made considerable efforts to reorganise, where sensible, the hospital and medical schools along the lines of the Royal Commission's recommendations.

Agreement has been reached that ten of the twelve undergraduate hospitals and medical schools should act in pairs, and the future location of all but two of the specialist postgraduate hospitals and institutes has been agreed in principle, but a number of problems remain. The recent reorganisation of the National Health Service has produced the immediate difficulty which gave rise to the investigation by SCICON herein reported. From 1 April 1974 the undergraduate teaching hospitals ceased to have boards of governors and became integral parts of area health authorities (teaching). Such an organisational change was, however, more difficult to arrange sensibly with the specialist postgraduate hospitals which had boards of governors of their own, for they served a far wider community than that encompassed by an area health authority. Their boards of governors have thus been 'preserved' for an interim period of five years during which time the most appropriate administrative changes might be determined.

These specialist centres, many of which are of international importance, have been criticised on two main counts:

1 that they are isolated and out of the main stream of medical advance, and

2 that they deal with specialties which crystallised out during the last century and which therefore are unlikely to be any longer appropriate.

General statements such as these are unlikely to be wholly correct. Most of the specialist hospitals are concerned with specialties dealing with systems or organs – which patients are likely to continue to have, and hence to complain about, for the foreseeable future – and it is at least arguable that there are considerable advantages in having a sizeable group of highly trained and very experienced specialists available to advise on the more obscure and difficult problems. It is at this level that flexibility is needed and evidence about the collaboration of scientific workers in the institutes with each other and with workers in other institutions is perhaps an unfortunate gap in this report, but it is clearly outside the terms of reference which were set.

Finally, the problem is really wider than one concerning only the hospitals with preserved boards of governors, which of course are not the only special hospitals. At national level we need to determine whether or not it is desirable to have national specialist centres of excellence and if so how they might best be financed and administered so that they are on the one hand closely coordinated with the health and medical educational services as a whole, and on the other not at the mercy of pressures which emerge in any society or grouping, particularly in times of financial stringency, and especially when the objectives of the group may not

be those of the special unit contained within it.

In the present investigations, the authors have obtained what objective facts they can and have put forward a number of possible ways in which the special hospitals might be governed. The report in no way represents the views of either the Teaching Hospitals Association or of the British Postgraduate Medical Federation. Many more facts are needed before fully rational decisions can be made, but this report has made a start and should not be regarded as a definitive document, but one which should lead to informed discussion and to the collection of more data where important factual lacunae have been defined.

The study in its setting

Britain has a health service unique amongst the countries of the world. It also has more than 25 years experience of its operation since the National Health Service was inaugurated in 1948. Whilst achievements were clearly immense, especially as regards health services for the physically ill, equally plain and becoming more so, were the gaps in the service, particularly for the aged, the handicapped and the mentally infirm.

Increasing awareness and concern to remedy these deficiencies led to the decision by the Department of Health and Social Security that a radical reorganisation would be necessary to close these gaps and at the same time provide a new concept for British medicine based on total community care.

For this concept to be realised in practice it would be necessary not only to appraise the existing use of medical resources and social services, but in planning for the future, to ensure a continuing supply of highly trained doctors, dentists, nurses and other skilled staff.

In April 1968, the report of the Royal Commission on Medical Education[19] was published and steps are now being taken to implement many of the report's recommendations.

In the autumn of 1968 the government of the day published the first Green Paper on health service reorganisation[9] and this was followed by five years of discussion culminating in the passing of legislation[16], to enable a new administrative structure to be introduced in April 1974.

During the five years of discussion there have been a number of other major studies bearing on the organisation of medical education and research; in particular, the Murray report on the governance of the University of London[2], the Briggs report on nurse training[18], the Rothschild report on the organisation and management of government research and development.[15]

Each study has made far-reaching recommendations in its particular field which, if implemented, will continue to have a profound effect for perhaps a generation to come.

In this present report we have been concerned with the effects of reorganisation on specialist postgraduate medicine in Greater London. The other reports and studies we have referred to all affect the postgraduate hospitals and their associated institutes in one way or another. All have some bearing on future organisation, finance and administrative responsibility. All affect different aspects of these hospitals, for example: location. size, research, nursing and so on.

At present, responsibility for the activities of postgraduate institutes and hospitals is divided between the University of London, the University Grants Committee, the DHSS, the Medical Research Council and others. In addition, there are now the regional health authorities, the area health authorities (teaching), the London Coordinating Committee, and the district management teams, each in some measure either overseeing or requiring the services of the hospitals.

Whilst the future relationship of the postgraduate hospitals to the reorganised health service is being studied in more detail they are to retain boards of governors. Furthermore, during the initial period of the reorganisation, the arrangements for supervising the funding and the general experience of the administration of the undergraduate hospitals, and indeed the functioning of the reorganised service as a whole, will provide additional information on which to base a decision on the postgraduate hospitals.

This report is concerned with drawing together and commenting on the various functions and activities of the postgraduate hospitals. The terms of reference for our study are set out below. The lack of data precluded us from devoting as much attention to the examination of the pattern of sources and dispersion of postgraduate students, junior medical staff and consultants, as the importance of this subject merits. Part I of our report reviews the past and present activities of the hospitals and institutes. Part II looks to the future and identifies some of the crucial matters which must be given attention before decisions about administration and finance are reached.

When preparing this report we felt that the different emphasis placed on patient care, education and research by different postgraduate hospitals, dictated largely by the needs of their different specialties, precluded the

formation of a definitive solution to the problem of their future relationship to the health service. Instead, we have examined what we believe will be the likely consequence of adopting one or other of a number of possible solutions.

The way in which postgraduate hospitals are administered and the amount of money devoted to their activities in the future will be easier to specify when these matters have been examined.

After 25 years, the need for reform in our health service became manifest and reorganisation is to be welcomed. Nevertheless, the understandable desire to remove anomalies, the real need to fill the gaps in health care provision to some sections of the community, and the determination to ensure greater uniformity in the provision of facilities and manpower may prove to be antipathetic to those very qualities which have resulted in the present-day excellence of British medicine. The postgraduate hospitals and their teaching institutes represent, at least as much as any other institutions, the epitome of such excellence. Moreover, it must be remembered by those who will be responsible for the ultimate decisions for the future of the postgraduate hospitals that they were not created as the result of administrative considerations but because men and women of vision perceived a demonstrable need for progress in teaching and research in particular specialties, without which little progress in medicine could have been achieved.

Terms of reference

1 To examine and analyse data relevant to the function of the specialist postgraduate hospitals in London. In particular to collect a sample of data, over a period of three months, for both inpatients and outpatients and investigate

a the source of patient referrals to the postgraduate hospitals and the nature of the diseases dealt with

b the geographic pattern of their patients' dispersions

c the general pattern and interrelation between inpatient and outpatient activity

d the pattern of consultant and junior medical staffing.

2 To examine the general pattern of sources from which postgraduate students are drawn, both from within the UK and from overseas.

3 To study any general information on the location, organisation and relationship of the specialist postgraduate hospitals with other parts of the health service. This will include discussions with relevant branches of the service and individual institutions.

4 To include in the study some consideration of

a the nursing arrangements of the postgraduate hospitals

b the 'back-up' services such as biochemistry, distinguishing between those for which the hospitals are too small for efficiency and those which are so specialised as to be unobtainable elsewhere.

Summary of conclusions and recommendations

1 It is vital to ensure that the aims and balance of specialist postgraduate medicine, particularly research and teaching, are in accordance with the aims of the new services.

2 To sustain the high quality of health care in the future, the organisation of medical research, education and special services must be clearly defined.

3 We **recommend** that research and teaching in the specialist areas of medicine are reviewed at national level and that priorities, effort and finance are given full and careful consideration.

4 There are no special advantages to be gained by geographically separating undergraduate and postgraduate teaching. The linking of some undergraduate and postgraduate hospitals, as proposed by Todd[19], may however lead to operating economies.

5 Economies of scale should be secondary to the provision of a suitably stimulating environment in which research and teaching take place.

6 The arrangements for administration of combined undergraduate and postgraduate academic facilities need to be resolved. In particular, working relationships between undergraduate and postgraduate deans should be decided as a matter of some urgency.

7 The London specialist postgraduate hospitals and their institutes must now review their teaching role. In particular, we **recommend** that the Council for Postgraduate Medical Education and the British Postgraduate Medical Federation define how, specifically, the London postgraduate institutes and provincial postgraduate centres can coordinate their activities to derive the maximum benefit from the resources now available.

8 We **recommend** that detailed data on student origins, including the previous place of employment, sponsorship, and subsequent place of employment, should be collected by the BPMF. The feasibility of collecting data retrospectively should also be examined.

9 The recommendations of the Briggs report[18] relating to post-registration training of nurses will influence the special nursing courses run by the specialist postgraduate hospitals; the whole question of nurse training by these hospitals must therefore be kept under review.

10 Researchers and specialists in training should be insulated from the pressures of routine service work, but they must not be isolated.

11 We **recommend** that the specialist postgraduate hospitals, in addition to developing their existing links, should keep directly in contact with the full range of service activities by broadening their working links with other medical institutions and general hospitals in the United Kingdom.

12 The specialist postgraduate hospitals should regard the operation of information services as an essential part of their national role. We **recommend** that the hospitals and institutes examine with the Department of Health and Social Security how comprehensive specialist information on national morbidity might be brought together and used more effectively.

13 In the reorganised National Health Service the board of governors of each specialist postgraduate hospital has to establish a working relationship for service purposes with the area health authority (teaching) in which the hospital is situated.

14 It would be wrong to settle the future administration of the postgraduate specialist hospitals on the basis of ad hoc working relationships developed for service purposes in 1974.

15 Some hospitals will be rebuilt in different AHA(T)s from those in which they are presently located. The boards of governors will need to initiate discussions with the appropriate AHA(T)s to decide a satisfactory basis for coordinating their longer term service functions.

16 In the reorganised health service it will be necessary to maintain close coordination between all stages of medical, dental and nurse education. We **recommend** the creation of a Joint Academic Board for London which will plan and advise on the coordination of quality in these matters.

17 The University of London and DHSS must continue

to promote high quality research and teaching at postgraduate level, and an appropriate method of directing funds to the specialist postgraduate hospitals and institutes must be more firmly established.

18 The greater emphasis on research, teaching and special services in the specialist postgraduate hospitals is reflected in the higher running costs on a per bed basis. A new approach to assessing running costs should be sought which is more in keeping with the nature of the work undertaken.

19 It is neither practical nor desirable to recommend a definitive solution to the long term administration of the specialist postgraduate hospitals at the present time. They should, however, have formal representation on the planning authorities in the reorganised health service.

20 There are a number of administrative arrangements that could be adopted. None is ideal, all have shortcomings and the ultimate arrangements may be quite different from those discussed. We strongly urge open and objective debate so that attention is concentrated on those factors which will preserve the strength and overcome shortcomings in the work undertaken by the specialist postgraduate hospitals and institutes.

Abbreviations

AHA	Area Health Authority
AHA(T)	Area Health Authority (Teaching)
BPMF	British Postgraduate Medical Federation
CNMC	Central Nursing and Midwifery Council for Great Britain
CPME	Council for Postgraduate Medical Education in England and Wales
DES	Department of Education and Science
DHSS	Department of Health and Social Security
DMT	District Management Team
GLC	Greater London Council
HAA	Hospital Activity Analysis
HIPE	Hospital Inpatient Enquiry
HMC	Hospital Medical College
HMS	Hospital Medical School
HSM	Hospital School of Medicine
JBCNS	Joint Board of Clinical Nursing Studies
MoH	Ministry of Health
MRC	Medical Research Council
NHS	National Health Service
PGH	Postgraduate Hospital
RHA	Regional Health Authority
RHB	Regional Hospital Board
RPMS	Royal Postgraduate Medical School
SEN	State Enrolled Nurse
SRN	State Registered Nurse
UCH	University College Hospital
UGC	University Grants Committee
UGH	Undergraduate Hospital

I THE PAST AND PRESENT

1 Postgraduate specialisation

Emergence of Specialisation

The specialist postgraduate hospitals occupy a special place in the National Health Service, being concerned with the training of teachers and consultants, the ongoing education of specialists and general practitioners and the conduct of research in particular areas of medicine. Most of the hospitals were established in the nineteenth century when specialisation was in its infancy and most clinicians were either general physicians or surgeons. The hospitals were established largely by the efforts of small groups of doctors or by a pioneering individual, and supported by finance from benevolent sources. These hospitals were unique and in addition to providing treatment and care for particular groups of people or particular diseases, they were engaged, almost from their inception, in clinical teaching and research.

In 1898 the London Postgraduate Association was formed.[3] The members were the undergraduate medical schools (with the exception of the Royal Free) and four specialist hospitals (Brompton, Great Ormond Street, Moorfields, and Queen Square), together with the London School of Tropical Medicine. This Association broke up in 1913 owing to the desire of several schools to accept graduates on their own conditions.

In parallel with the emergence of specialist training and services, further education was available to students of the various (undergraduate) medical schools. A focal point was the Medical Graduates College and Polyclinic, established in 1899. The formation, in 1918, of the Fellowship of Medicine and Postgraduate Medical Association set up the first collective arrangements for organising students to attend 'courses of instruction on the clinical practice at a number of general and special hospitals'.

The emergence of such a body at that time was remarkable, but there was no collective attempt to define curricula or standards, particularly in relation to the specialist hospitals. These particular hospitals have continued to enjoy a very large measure of independence up to the present time. Specific reference to the specialist postgraduate hospitals is conspicuous by its absence in the reports and studies on postgraduate education and research which have been prepared since the turn of the century.

Athlone Report[10]

In 1921 the Ministry of Health appointed a committee under the chairmanship of the Earl of Athlone 'to investigate the needs of medical practitioners and other graduates for further education in London'.

This committee made a wide-ranging examination of the nature and extent of demand for postgraduate instruction. The committee gave considerable emphasis to the importance of supporting instruction by adequate resources for clinical practice and went to some lengths to show that 38,000 beds were available in London to satisfy general and specialist postgraduate students' needs (see Table 1).

The main recommendation was

> '. . . the institution of a post-graduate medical school which should be attached to a large and well-equipped hospital. The School should be the centre of a great teaching organisation, in which the special Hospitals of London, the Poor Law Infirmaries, and the Medical Schools with their

TABLE 1 SUMMARY OF HOSPITALS AND BEDS IN LONDON IN 1921

Hospitals	Number	Numbers of Beds
Undergraduate teaching	12	5 301
General hospitals	24	2 771
Poor Law infirmaries	29	17 247
***Special hospitals**	63	4 413
Fever hospitals	12	6 664
Smallpox hospitals	4	2 090
Total	**144**	**38 486**

*specialist postgraduate hospitals

Source: Athlone report[10]

clinical units and research departments would all find their place. As an integral part of the organisation there should be a bureau or central office established under a wisely appointed committee of management to co-ordinate the whole system and with the central office we would wish to see included a library, hostel, and everything necessary to afford full facilities for social intercourse . . .'

The committee went on to recommend that

'The great special hospitals would be closely associated with the central hospital under the administrative arrangements which we describe later, and their post-graduate courses would be organised in connection with the programme of work at the centre. The departments of the undergraduate schools would be regarded as "special hospitals" for the purpose of our system.

'The provision for dental training would be made at the Royal Dental Hospital, and at existing dental departments attached to the general hospitals with teaching schools.'

The report also recommended a 'bureau be established centrally' to administer student applications and course curricula. This was not to materialise until the formation of the British Postgraduate Medical Federation in 1945.

Greenwood Committee[11]

In 1925, the Ministry of Health appointed a postgraduate education committee 'to draw up a practical scheme of postgraduate medical education centred in London'. The aim was to find a way of implementing the Athlone recommendations, particularly in respect of the 'central school'. The committee's recommendation led to the establishment of the British Postgraduate Hospital and Medical School* at Hammersmith Hospital in 1931.

A Dogma

The Greenwood report included the statement:

'The Committee are unable to recommend as practicable a scheme for the conversion of an existing hospital which has a Medical School into the British Postgraduate Hospital and Medical School, because it is an essential condition of effective postgraduate teaching in medicine that postgraduate and undergraduate students should not be taught in the same Medical School . . .'

The basis for this statement is obscure but nevertheless it has been subsequently used, and misused, in discussion on postgraduate training. Todd made specific reference to this dogma of separatism and dismissed it as undesirable.[19] However, it is still being discussed as a fundamental reason for the postgraduate hospitals remaining independent.

A sharp distinction needs to be drawn between two issues:

the justification for separation between postgraduate and undergraduate training

the possible loss of identity and effectiveness of a small specialist hospital when merged with a larger general hospital.

With regard to the first point the Athlone report[10] had said:

'The practitioner wishes to have in concise and concentrated form very much the kind of instruction the undergraduate is given at the bedside; he does not want to listen to theoretical lectures though he would welcome the opportunity of attending a well arranged demonstration. Further he dislikes receiving his instruction in the presence of undergraduates. This is natural enough, and we are convinced that any post-graduate instruction, whether of this particular kind or any other, must be organised quite separately from undergraduate work. By this we mean that at the least it must be given at a different time if not at a different place. Even from the undergraduate point of view there are serious disadvantages in the presence of postgraduates at the same demonstration.'

It would be difficult to find anyone, in any subject, faculty or university who would not support this statement today. However, it cannot be interpreted as a universal recipe for geographic separation of postgraduate and undergraduate work and the resulting need to duplicate common, expensive resources.

The second point will be covered in later chapters.

Goodenough Committee[8]

A committee, under the chairmanship of Sir William Goodenough, was set up in 1942 with terms of reference:

'Having regard to the statement made by the Minister of Health in the House of Commons on 9th October 1941, indicating the Government's post-war hospital policy, to enquire into the organisation of Medical Schools, particularly in regard to facilities for clinical teaching and research, and make recommendations.'

The report and recommendations are of considerable importance. Matters of principle, organisation and responsibility were dealt with in a clear and concise manner, ideal arrangements (or long-term aims) were distinguished from matters of immediate, practical consequence.

*Now renamed Royal Postgraduate Medical School.

Many of the matters dealt with in the summary of the Goodenough report are still relevant and we will refer to specific points throughout this report.

The recommendations of the Goodenough committee on postgraduate education in London are of immediate relevance in this chapter. There was reference to the lack of progress in establishing links between the British Postgraduate Hospital and Medical School and the special hospitals (as recommended originally by Athlone). The report also stated:

> 'Ideally, the British Postgraduate Medical School should be an integral part of a post-graduate hospital centre, situated in the inner area of London and consisting of a general hospital together with a number of separate institutes for each of the principal branches of medicine.
>
> 'The obstacles to the achievement of this ideal in the near future seem insuperable. Nevertheless, on a long view, it is desirable that the hospital authority for London should make the ideal one of its guides in the preparation and carrying out of its plan under the national health service.'

Other recommendations were implemented, particularly the setting up of a 'series of institutes in each of the principal subjects, each of the institutes being based on a leading special hospital' and a 'federal organisation' embracing these teaching facilities. The BPMF was set up in 1945 and the various institutes were established over the next few years (see Table 2).

TABLE 2 DATES OF FORMATION AND RECOGNITION OF THE INSTITUTES

Postgraduate Institute	Date of Recognition by Ministry of Health	Date of Recognition by London University	Associated Hospital Group
Laryngology and Otology	1948	1949	Royal National Throat, Nose and Ear
Psychiatry	1948	1949	Bethlem Royal and Maudsley
Ophthalmology	1948	1949	Moorfields Eye
Child Health	1948	1949	Hospitals for Sick Children
Obstetrics and Gynaecology	1948	1949	Queen Charlotte's Maternity
Neurology	1948	1950	National Hospitals for Nervous Diseases
Orthopaedics	1948	1951	Royal National Orthopaedic
Dental Surgery	1948	1951	Eastman Dental
Cancer Research	1951	1951	Royal Marsden
Cardiology*	1948	1954	National Heart†
Diseases of the Chest*	1948	1955	Hospital for Diseases of the Chest†
Basic Medical Sciences	?	1957	—
Urology	1948	1957	St Peter's Hospitals
Dermatology	1948	1959	St John's Hospital for Diseases of the Skin

* These two institutes have now amalgamated to become the Cardiothoracic Institute.

† These two hospitals have now amalgamated to become the National Heart and Chest Hospitals.

Pickering Report[13]

In 1960 a study group was set up by the Minister of Health to review the position of the specialist postgraduate hospitals. Their findings were announced in a statement to the House of Commons in June 1961 and in essence proposed to group the hospitals in two centres, one in Holborn and one in South Kensington (see Table 3). At the same time the Minister announced that a committee would be set up, 'To consider in principle and advise on the advantages which can be secured from the proposed grouping of postgraduate institutes and hospitals, and their joint use of facilities'.

The committee, with Sir George Pickering as chairman, dealt with a number of important issues, some of which are relevant to this present study. The committee identified and commented on a number of issues of practical importance such as laboratory and support services, libraries and animal houses. Some arrangements were suggested which could preserve essential advantages while removing many of the disadvantages. The chief obstacle was identified as geography and, in particular, the location of Hammersmith Hospital in relation to the other postgraduate hospitals. The setting up of two groups of hospitals was a compromise solution which had some advantages but the committee considered that there were significant shortcomings in South Kensington and Holborn. The various difficulties and possible solutions were discussed over the following few years but the proposals were left in abeyance and subsequently overtaken by the broader deliberations of the Royal Commission on Medical Education.

TABLE 3 GROUPING OF SPECIALIST POSTGRADUATE HOSPITALS PROPOSED BY THE MINISTRY OF HEALTH IN 1961

Hospitals*	Proposed Group
National Hospitals for Nervous Diseases	Holborn
Hospitals for Sick Children	
Royal National Throat, Nose and Ear Hospital	
Eastman Dental Hospital	
Moorfields Eye Hospital	
Brompton Hospital	South Kensington
Royal Marsden Hospital	
St Peter's Hospitals	
St John's Hospital for Diseases of the Skin	
St Mark's Hospital	
National Heart Hospital	
Royal National Orthopaedic Hospital	to be considered
Queen Charlotte's Maternity Hospital	to remain separate from groups
Bethlem Royal and Maudsley Hospitals	

* and their institutes

Source: Pickering report[13]

Todd Report[19]

The Royal Commission on Medical Education, under the chairmanship of Lord Todd, made a number of recommendations which were to have a significant impact on the future organisation of medical education and the associated hospital facilities for clinical teaching in London. Since the publication of the report in 1968 there has been continuous discussion between the University of London, the undergraduate medical schools and the Department of Health and Social Security. More recently, these discussions have included the institutes and the specialist postgraduate hospitals.

The present relationship of the medical schools and postgraduate medical institutes with the University of London is shown in Appendix 4. We also show diagrammatically the links and associations which have been proposed and are still receiving active attention. Parallel action is planned by DHSS for the merging or association of hospitals for the provision of clinical teaching facilities. As the recommendations of Todd are still actively receiving attention and are so far-reaching, we have devoted Chapter 6 to further discussion of some salient points.

Murray Report[2]

The final report of a Committee of Enquiry into the Governance of the University of London, under the chairmanship of Lord Murray, was published in 1973. This report differs from those so far discussed in that it was only indirectly concerned with the organisation of medical education as one faculty of the University. However, the report discusses the future of postgraduate medical institutes and the BPMF. It recommended that the Royal Postgraduate Medical School should become an independent school of the University. It also suggested that the BPMF should be dissolved when the

various institutes become associated with undergraduate medical schools. The particular remarks made in the report were:

> 'The future of the Federation is essentially linked with its present responsibility for co-ordinating the activities of the Institutes and distributing among them the block grant it receives from the Court of the University. As and when the Institutes become integrated with general medical Schools, they will drop out of the Federation which will no longer have any responsibility for their academic development or their financing. But the process of integration, involving in many cases the physical transfer and rebuilding of Institutes and their associated specialist hospitals, will take many years to complete, and during this period there will be a continuing function which the Federation, with its store of experience and expertise, is particularly well equipped to carry out. We see no grounds, therefore, for suggesting the immediate dissolution of the Federation. The general picture, as we see it, is one of the gradual phasing out over a period and the eventual disappearance of the financial function of the Federation which, as we have indicated, is in our view the only justification for its existence as an independent School of the University. It will be for the University during this period to work out alternative arrangements for fulfilling the other functions which are at present carried out by the Federation.'

This is a very over-simplified view of the actual position. It assumes that the only important function of the BPMF is to act as a convenient channel for allocating the block grant to the institutes. This is a serious censure of the activities of the BPMF and should have been supported by more detailed discussion. In particular, the last sentence of the statement dismisses the primary functions of the BPMF, as laid down in the Royal Charter, as 'other functions'.*

The Murray report also assumed that all the institutes would be quickly absorbed into a working association with undergraduate medical schools. This is very optimistic and the position as we see it is that three institutes and hospitals may be rebuilt and merged by 1980, three others by 1990 and possibly five will not link at all with undergraduate medical schools and hospitals. The Principal of the University of London stated in April 1973 that there is every reason for continuing the Federation for the foreseeable future (see Appendix 5).

Summary

The specialist postgraduate hospitals were set up in an ad hoc way to fill a need at a time when specialist clinical facilities were first emerging. Since 1920 several committees have recommended formalising the organisation and administration of these hospitals and institutes. Some recommendations have been implemented, in particular, the setting up of the Royal Postgraduate Medical School at Hammersmith Hospital, and the formation of the postgraduate institutes and BPMF.

There was no compelling reason to implement the more general recommendations on regrouping and relocation. However, many of the institutes and specialist postgraduate hospitals must be rebuilt and this may well lead to more positive action over the next decade.

*See page 28

2 Functions and services

What Do They Do?

The role of the specialist postgraduate hospitals in London was explicitly defined in the Goodenough report[8] in 1944, but that was largely dictated by the world standing of Britain at that time as the centre of an empire. More recently, the Pickering report[13] (1962) drew a distinction between the specialist hospitals and the special service units which have been set up within general hospitals. However, Pickering did not define the present functions or future role of the London specialist postgraduate hospitals. The most useful approach for us is to examine what they do, how they have measured up to their responsibilities, and to record the views of other parts of the health services on the achievements of the postgraduate hospitals.

Many people have defined the functions of these hospitals and institutes as research, teaching and service, in that order. Others have said, specialist care of patients, education and research, in that order. There is also a lesser body of opinion that takes the view that the institutes and hospitals are quite distinct, the former doing research and teaching, the latter providing a service to patients on whom some teaching may take place.

Who Does What?

The institutes have a responsibility for setting curricula and generally maintaining high academic standards in the education of students. The hospitals treat patients referred to them from a variety of sources – general practitioners, undergraduate hospitals, and district general hospitals. The institutes, with the exception of the Institute of Cancer Research, receive their main finance from the University Grants Committee and the hospitals from the Department of Health and Social Security (see Chapter 4).

This is as far as the distinction can be drawn and for all functional purposes the institute and hospital operate as a joint enterprise. We have illustrated the main overlap of activities in Figure 1.

Research

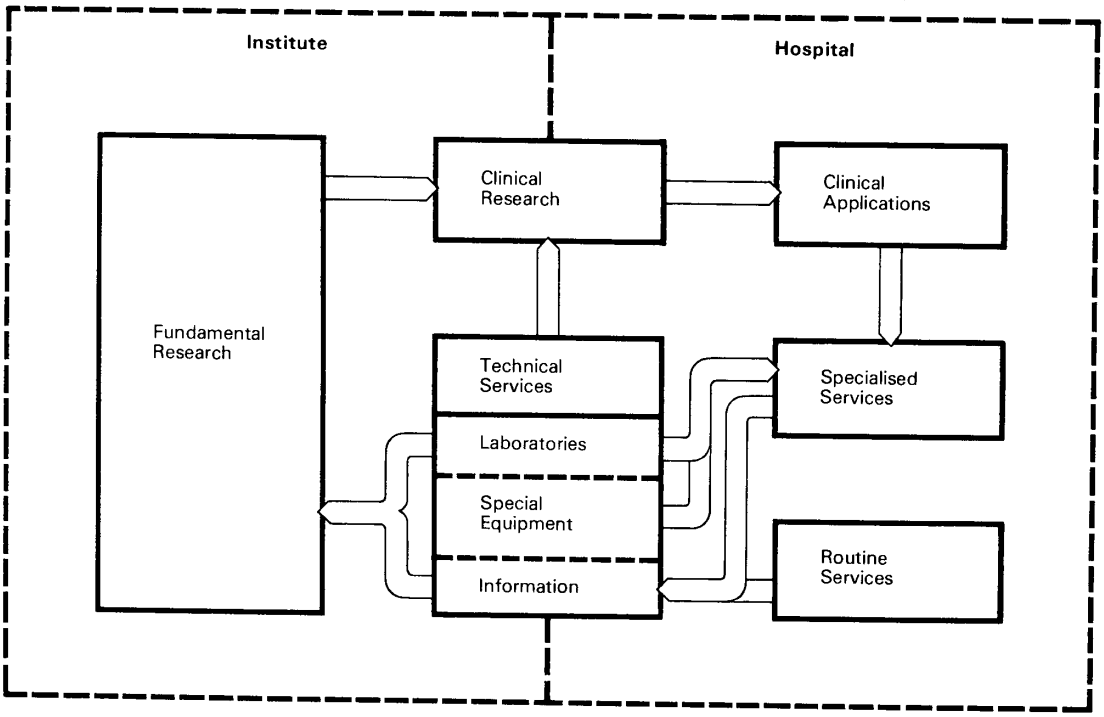
An important function in the specialist postgraduate hospitals and institutes is to conduct research into matters relating to a particular specialist branch of medicine. It may be of a fundamental nature concerning the furtherance of knowledge of the functioning of an organ or part of the body; it may also be of a more practical nature, such as the detection of a clinical condition or the development and evaluation of a surgical method. Fundamental research is usually initiated by staff with an interest in research and teaching. Because it often tends to be of an academic nature, it is frequently initiated by staff of the institute. However, fundamental research draws heavily upon resources provided by the hospital. In particular, it places heavy demands on resources such as medical records, pharmacy and laboratories. This work often leads on directly to clinical investigations and the development of treatment techniques. There is usually no identifiable point where academic study ends and treatment of patients begins, and there are many instances where a particular piece of work leads to the provision of a specialist service but continues to be monitored by the originating team for many years.

Clinical research is of a more practical nature from the outset and may be initiated by staff of the institute or the hospital. This type of work utilises the resources of the hospital and invariably involves patients at an early stage. Clinical research varies widely in its nature and objectives, and is certainly not the exclusive preserve of the specialist postgraduate hospitals; much valuable work is being done in undergraduate hospitals and special units in district general hospitals. Nevertheless, the essential difference lies in a clearly identifiable and continuing commitment to particular areas of research by the postgraduate institutes and hospitals.

It has been put to us on many occasions that the quality of research is dictated by the enthusiasm, commitment and competence of researchers and not by the place itself. This we fully accept but with an ever-increasing dependence on expensive equipment and support services, it is necessary to concentrate effort and thus avoid duplication of facilities.

During our discussion we encountered some criticism of the specialist postgraduate hospitals and institutes in respect of research. A particularly important aspect was a failure by some hospitals and institutes to be

FIGURE 1 OPERATIONAL LINKS BETWEEN INSTITUTES AND HOSPITALS



outward-looking and seek contact with other researchers and other branches of the health service elsewhere in the country. We raised some specific points in this respect in the hospitals and institutes concerned but were not fully satisfied by the replies. There are substantial overlaps in the subjects and work undertaken by different institutes and hospitals and, in some cases, there is no direct communication between their respective staff.

Despite this criticism there is a consensus view that the postgraduate hospitals and institutes should lead research in their specialty and act as a reference centre for clinical methods.

Teaching

Over a hundred years ago there were references in medical journals to the benefits to be gained by qualified clinicians attending instruction given in conjunction with patient treatment in the specialist postgraduate hospitals.[30]

The introduction of uniform standards and formal courses did not however occur until the formation of the British Postgraduate Medical Federation and the institutes in 1948.

The Royal Charter of the BPMF[3] lays an obligation on the Federation and upon the institutes to provide

- new and extended facilities for the training of consultants and specialists
- advanced instruction for medical practitioners
- refresher courses for medical practitioners.

In practice, the educational function has been wide-ranging and included various combinations of

- teaching future teachers (for example, the training of senior staff to a level where they can lead a professional unit)
- training consultants (including specialist training of registrars and senior registrars)
- refresher courses for consultants (national and international)
- seminars for general practitioners
- training courses for specialist nursing diplomas
- training support staff for laboratories, radiography, radiotherapy and other service departments.

It ought to be remembered that as a result of the postgraduate training of medical and nursing students from overseas, the reputation of British medicine abroad has been greatly enhanced.

A detailed review of the more recent discussions and formulation of policy on postgraduate medical education has been given by Revans and McLachlan.[26] That report summarised the developments that led to the foundation of the Central Committee on Postgraduate Medical Education.* The Council, jointly with the regional hospital boards, became responsible for advising on the provision and running of postgraduate training centres.

Until the early 1960s the London postgraduate hospitals were the main centres of further education and training. Since then, there has been a substantial increase in the resources devoted to postgraduate medical education. The CPME has supported a rapid expansion in the number of postgraduate medical centres throughout the country and its success can be gauged from Table 4, which shows that the total number of centres is now over 200 and a further 65 are scheduled. There has also been a corresponding increase in the number of qualified doctors attending lectures and short courses since 1960. It is too early to identify any pattern of activity or judge the forward trend in postgraduate education. But it is to be expected that the availability of these new resources may have an influence on the number and type of student courses at the London specialist hospitals.

TABLE 4 GROWTH OF POSTGRADUATE MEDICAL CENTRES IN ENGLAND AND WALES

Year	Centres Opened	Total Centres in England
Pre-1960	–	16
1960	2	18
1961	1	19
1962	4	23
1963	9	32
1964	13	45
1965	13	58
1966	27	85
1967	20	105
1968	24	129
1969	24	153
1970	16	169
1971	14	183
1972	19	203
1973	20	222*

* A further 65 are scheduled.

*Now renamed the Council for Postgraduate Medical Education in England and Wales.

In view of the magnitude and nature of the recent expansion in facilities there is a need to examine how the institutes and regional centres can coordinate or even integrate their activities. An explicit definition of the roles, responsibilities and methods of working together is needed if maximum benefit is to be derived from the resources now available for postgraduate medical education.

Service

The service activities of the London specialist postgraduate hospitals are distinguished by three main factors.

1 In general, the patients are drawn (or more precisely, referred) from a much wider catchment area than is the case in district general or undergraduate teaching hospitals.

2 In a number of cases the mix of outpatient and inpatient activity is quite different from that in non-specialist hospitals.

3 Most of the hospitals do not accept casualty patients.

It is important in any discussion on the future administration of these hospitals to define more objectively the number of patients and their origins. The Hospital Inpatient Enquiry (HIPE)[6] provides one useful source of information, but does not cover the Eastman Dental and Maudsley hospitals; furthermore, HIPE data are confined to inpatients. As part of this study, it was therefore necessary to mount a survey of patients' origins to supplement the existing data. A brief summary of the scope of the survey is given in Appendix 6 together with an analysis of the patient data.

The characteristics of the catchment areas of these hospitals have an important bearing on the way in which the hospitals coordinate their service work with the district management teams and area health authorities. The nature of the catchment areas will also have some influence on the longer term planning and administration. These issues are discussed in Chapter 5.

In many instances the specialist postgraduate hospitals provide treatment for particularly difficult clinical conditions or unusual diseases of which only a few cases occur annually. The particular value of concentrating such work is that:

any special equipment, drugs or after-care facilities can be provided in the most economic way

highly specialised laboratory and diagnostic services can be concentrated

experience in treatment can be accumulated more rapidly, and comparison of methods can be evaluated under controlled conditions

consultation can take place between medical staff and their colleagues with knowledge and experience of different branches of their specialty.

The whole question of concentration and provision of very specialised services has been under discussion by the Joint Working Group of the Metropolitan Joint Consultative Committee since 1967, and significant progress has been made in quantifying the needs and deployment of particular services.

There is still a substantial amount of work to be done and this important forum continues to function as the London Coordinating Committee since the reorganisation of the health services.

The provision of highly specialised services in relatively small independent units can have attendant problems. The clinical work frequently requires special support services such as blood banks, radiology, laboratory services, as well as more general medicine expertise. High levels of nursing dependence of patients frequently call for cover from agency nurses. Catering, porterage and office services are becoming increasingly difficult to sustain at the required level for effective operation. The Pickering report[13] identified a number of important services required by the hospitals and institutes that could be provided more efficiently from a common source, and these influenced the recommendation to bring the postgraduate hospitals together in two centres.

However, all these points relating to service overlook the three basic features that make the specialist postgraduate hospitals important to advances in medical research and specialist care:

1 They have continuing commitment to carry out work in their particular specialty.

2 It follows that the full range of resources can be devoted to diagnosis, cure and care of acute and ambulatory patients solely in that specialty.

3 The support services, in particular, are geared to needs peculiar to the specialty, for example, neurological x-ray services, ophthalmic pathology or paediatric haematology, which are vital for both service and research purposes.

Whilst there is a need to give attention to the provision of general support services in the best way and to achieve economies of scale wherever practical, these matters should be secondary to the preservation of the features mentioned above.

Mix of Functions

The balance and emphasis given to each function by the different specialties vary widely and must reflect, to some extent, the present importance of the specialty in terms of community health. It is not, therefore, possible to make a detailed objective comparison of the activities of the institutes and hospitals.

In Chapter 4 we compare the levels of expenditure for research and hospital services over the period 1962 to 1967. In Appendix 2 we give a brief account of the work of each hospital, including, where appropriate, the number of consultants trained in recent years and some indication of research activities.

As Others See Them

In a set of multifarious activities such as those carried out by the specialist postgraduate hospitals, it is difficult to identify specifically a role and to assess whether it has been fulfilled. The general criterion seems to be that they are expected to lead in their specialty. Some do indeed lead in certain branches of research, others lead in teaching, whilst others lead in specialist services. It would, however, be totally inappropriate for them to have a monopoly of front-running on all aspects, all the time. Any judgement is therefore relative. The London undergraduate hospitals made some strong general criticisms of the postgraduate hospitals and institutes. This is perhaps understandable because there are significant overlaps in patient catchment areas, in research activities and staff appointments. The specialist departments in the undergraduate hospitals have the advantage of a full range of support services immediately available and many people cannot conceive of working in a specialist environment which does not have on-the-spot general support.

The Pickering report[13] devoted a whole section to the penalties of isolation and noted that many major advances in the specialties in the last 25 years did not come from the specialist postgraduate hospitals. This criticism has been voiced to us on many occasions but it apparently overlooks an important but related factor.

Most of the people making major advances received their specialist training at the specialist postgraduate hospitals, and their subsequent achievements must be a reflection of the quality of training given in these hospitals and institutes. It must also be remembered that many researchers have linked appointments and in many cases they continue work started during their period of specialist training at these hospitals.

Many people commented on the narrow range of more acute cases dealt with by the specialist postgraduate hospitals. There are strong feelings that this must inhibit a fully-rounded training. Furthermore, dealing with a narrow range of cases must have some influence on the breadth and character of the research programme. Pickering noted that:

> 'While a special hospital provides the richest collection of certain kinds of cases and of expertise over a limited range, the canvas tends to be incomplete. Certain types of case are lacking and only to be encountered in general hospitals admitting the acute sick. The specialist becomes intensely aware that developments are taking place in understanding the wider implication of the diseases with which he is concerned while he remains out of touch with them.'

The former metropolitan regional hospital boards expressed some concern at the lack of general participation of the specialist postgraduate hospitals in registrar rotation schemes. The RHBs regarded this as a valuable two-way flow, its advantages being:

Staff from specialist postgraduate hospitals have the opportunity to see a wider spectrum of cases in their particular field and get a proper perspective on the occurrence of general and more difficult cases.

The registrars help in the processes of disseminating new techniques, methods and thinking to their colleagues in district general hospitals.

The RHBs also expressed disappointment at the lack of response of the specialist postgraduate hospitals, in the past, to invitations to participate in the planning and provision of specialist services. This situation has been partly improved through the efforts of the London Coordinating Committee.

3 Staffing

Teaching

During our discussions at specialist postgraduate hospitals and institutes we often heard it said that one of their vitally important functions is the teaching of teachers. Not only is the continuing medical education of general practitioners and specialists of concern, but also the training of consultants who will, in turn, become the teachers of others. This is said to be a major reason for the existence of the specialist postgraduate hospitals. The organisational machinery for achieving this objective has been discussed in some detail in the Todd report[19] and there is little that we can usefully add to what was said there.

We do not, however, entirely share the view of the Todd commission (paragraph 515) that what has been referred to as 'geographically full-time' services of the consultant teachers, would be entirely beneficial. The attraction of the idea that a consultant should spend more of his time at the teaching hospital at which he received his appointment, is obvious; more patients could be seen, the need for separate office and staff facilities avoided, and a great deal of travelling time could be eliminated. Nevertheless, we believe it is important to emphasise the vital need for consultant teachers to spend a proportion of their time at postgraduate medical centres associated with district general hospitals in Greater London and the nearby provinces, and, of course, at the hospitals of their linked appointment. Thus, a consultant at a specialist postgraduate hospital will have a linked appointment at, say, an undergraduate hospital and give lectures at postgraduate centres elsewhere. We urge, therefore, that whatever formula is devised for the division of time between the needs of NHS and private patient care on the one hand and teaching on the other, takes full account of the necessity for the personal dissemination of knowledge and skill. We did not accept as valid the argument, often encountered, that the communication of knowledge through the publication of medical papers is, by itself, an adequate means of imparting information or educating others in some aspect of a specialty. Much more convincing was the argument that the best way to disseminate knowledge and expertise is to teach teachers.

Postgraduate Medical and Dental Students

Some limited data are available on the origins of students attending courses at the postgraduate institutes. These data mainly cover country of origin and type of course (full-time, part-time, occasional). However, our enquiries revealed that the data for the United Kingdom could not be usefully broken down to indicate the number of students coming from the various regions. Furthermore, no consistent data were available on the subsequent place of employment of those attending formal training courses.

Table 5 shows the numbers of UK and overseas students attending the postgraduate institutes for the years 1967–72.

TABLE 5 NUMBERS OF POSTGRADUATE STUDENTS FROM 1967 to 1972

Year	Postgraduates Enrolled for Courses		
	UK	Overseas	Total
1967-68	1671	1972	3643
1968-69	1983	2092	4075
1969-70	2260	2204	4464
1970-71	1923	2488	4411
1971-72	2194	2578	4772

Source: Compiled from annual reports of the British Postgraduate Medical Federation

TABLE 6 DISTRIBUTION OF POSTGRADUATE STUDENTS IN 1971-72

Institute	UK	Overseas	Total
Basic Medical Sciences	129	273	402
Cancer Research	94	70	164
Cardiology	221	166	387
Child Health	87	155	242
Dental Surgery	183	135	318
Dermatology	22	28	50
Diseases of Chest	62	51	113
Laryngology and Otology	109	103	212
Neurology	31	145	176
Obstetrics and Gynaecology	76	186	262
Ophthalmology	98	152	250
Orthopaedics	136	88	224
Psychiatry	290	191	481
Urology	124	133	257
RPMS*	532	702	1234
Totals	**2194**	**2578**	**4772**

* Royal Postgraduate Medical School

Source: Annual report of the British Postgraduate Medical Federation

Table 6 shows the distribution of students between the institutes for 1971–72.

In Chapter 2 we recommend a review of the general education role of the institutes in view of the growth in provincial postgraduate education centres. To do this it will be essential to base any review on data concerning the origins of students in the UK and the types of course attended at the postgraduate institutes. We recommend that data on the previous place of employment, sponsorship, subsequent place of appointment and other relevant information, should be collected by the BPMF. The feasibility of collecting such data retrospectively should also be examined.

Nurses

Nurses form the major proportion of staff in hospitals generally, and because the continuing supply of high quality nursing staff presents peculiar problems for specialist postgraduate hospitals, it is necessary to devote some space to consideration of these matters. The Briggs report[18] dealt very fully with a whole range of nursing matters, but there are a number of important points which we feel need particular emphasis.

If teaching and research are to continue in specialist postgraduate hospitals, the administrative machinery providing clinical facilities for diagnosis, treatment and rehabilitation of patients must be such that nurses will want to work in the setting. If not, there will be three consequences.

1 The work of specialist postgraduate hospitals will cease altogether or diminish in quality and quantity. The same would also be true of the associated institutes since teaching and research cannot take place without patients.

2 Specialist nurses who are often teachers, administrators or ward sisters will be lost to the nursing service as a whole.

3 National and international prestige will be lost.

It must also be borne in mind that nurses in postgraduate hospitals are frequently used as 'consultants' in their own right by the locality, the region, the country as a whole and by countries overseas. This consultancy may take the form of advice when new specialist departments are to be set up or part of a general education programme sponsored, perhaps, by the World Health Organisation, the Royal College of Nursing, the Department of Health and Social Security, or the International Council of Nurses when referring visitors on fellowship courses.

It has been said in the Briggs report and elsewhere that postgraduate nurse training courses are often designed to fill the recruitment needs of the specialist postgraduate hospitals. In Greater London, 29.7 per cent of the nursing staff in acute general hospitals and 47.5 per cent in teaching hospitals are student nurses, compared with 26.1 per cent for the country as a whole (Briggs: paragraph 471).

There are many reasons why the number of nurses in training in specialist postgraduate hospitals is a very high proportion of the total in those hospitals, and why full-time staff are difficult to recruit. Three of the most important are:

1 The hospitals are too small to provide an acceptable career structure for highly qualified nurses who might otherwise wish to stay.

2 Accommodation in London for nurses is generally limited and unsatisfactory.

3 The total number of student nurses in training is relatively small compared with those in training at undergraduate hospitals (see Table 7). Of the former, between 30 and 50 per cent may be from Commonwealth or foreign countries. The majority of these students return to their country of origin on the completion of their courses.

The nurses in training at the specialist postgraduate hospitals have usually already received their general nursing training and they can be used to augment the service needs of the hospitals. However, because of the usually short duration of specialist nursing courses, the number of nurses available for hospital service needs is sometimes temporarily below the number required. In this situation agency nurses are used.

A further point about which we can find no reference to any discussion concerns the staffing problems which are almost certain to be encountered as a result of implementation of recommendations for geographic and administrative linking of a number of postgraduate with certain undergraduate hospitals.

For example, at the time of writing discussions are taking place for a possible move of St Peter's Hospitals, with the Institute of Urology, to The London Hospital. Moreover, it has been proposed that as many as 200 urological beds will be allocated at The London Hospital. Because the turnover of staff nurses at St Peter's is high, and because its specialty requires both male and female nurses, we believe the adequate provision of the required nursing staff for urology at The London Hospital will continue to be a serious problem.

Nurses in Research

Nurses are being increasingly called upon to play their part as members of multidisciplinary research teams, either by collecting data and observations or by contributing ideas. For example, it is unthinkable that the development of a new bed particularly suited for burns patients could have been achieved without detailed advice from nurses. There are, of course, very many other examples and the process is continuous.

An awareness that nurses have an important part to play

in research and, indeed, that there is a national need for their contribution, is indicated by the increasing amount of money devoted to research into nursing. The Briggs report touches on this subject in paragraphs 370–5.

The current move to establish university chairs in nursing again points to an acknowledgement that many nursing functions are becoming highly specialised. However, the specialist postgraduate hospitals are, and are likely to remain, centres where research into nursing techniques will be carried out.

We hope due weight will be given to this important topic during relocation discussions.

Agency Nurses

The difficulties encountered by the London teaching hospitals in general, and specialist postgraduate hospitals in particular, in obtaining and keeping the nursing staff they require have been dwelt upon because they help to explain the rise in the use of agency nurses.

Table 7 compares, as a percentage, the agency nurses and midwives in all NHS hospitals in England and Wales with the total in undergraduate and postgraduate hospitals.

TABLE 7 ANALYSIS OF NURSING STAFF AND NURSES IN TRAINING IN ENGLAND AND WALES AND IN LONDON TEACHING HOSPITALS

	1968			1969			1970		
	All Hospitals	London UGHs	London PGHs	All Hospitals	London UGHs	London PGHs	All Hospitals	London UGHs	London PGHs
Total Nurses	253 599	12 494	3 810	258 432	13 929	4 130	264 258	13 913	4 045
Student Nurses (pre-registration)	49 346	5 928	882	46 046	5 849	981	42 683	5 285	868
Student Nurses (post-registration)	3 747	176	137	3 776	196	126	3 959	229	106
Pupil Nurses	17 539	489	123	18 862	754	127	19 487	839	110
Enrolled Nurses	31 857	632	466	40 261	991	531	41 610	1 138	541
Agency Nurses	—	—	—	1 779	525	389	2 357	711	507
Percentage of Total Nurses	—	—	—	0.69	3.77	9.42	0.89	5.11	12.53

	1971			1972		
	All Hospitals	London UGHs	London PGHs	All Hospitals	London UGHs	London PGHs
Total Nurses	281 740	13 837	4 212	297 376	14 331	4 367
Student Nurses (pre-registration)	43 018	5 241	887	44 608	5 235	881
Student Nurses (post-registration)	3 990	197	164	3 950	160	134
Pupil Nurses	21 771	731	143	23 670	736	156
Enrolled Nurses	44 160	1 240	602	49 967	1 497	732
Agency Nurses	2 887	911	459	3 009	953	519
Percentage of Total Nurses	1.02	6.58	10.90	1.01	6.60	11.88

Note: Figures include both full-time and part-time nurses and midwives.

Figures do not include the numbers of nurses taking diploma courses at London postgraduate hospitals or those outposted to other hospitals.

Figures for the numbers of agency nurses not available before 1969.

Source: Department of Health and Social Security

The percentage of 11.88 of agency nurses in postgraduate hospitals for the year 1972 is, we believe, a matter for concern particularly as it is apparent that the London postgraduate hospitals could not survive without their employment.

Recognition of the need to ensure a uniformly acceptable standard of quality amongst nurses employed in teaching hospitals prompted the Teaching Hospitals Association to study the question of establishing its own limited agency. The agency is now formed and, at the time of writing, planning to begin operating this year. We recognise that there will always be a need for nurses which probably could not be filled except through agencies. Despite this we believe that it is a matter of some urgency that ways and means are intensively sought to make conditions for nurses in teaching hospitals such that enough full-time staff will be attracted to work there, and so obviate the need for all but a marginal number of agency nurses.

Briggs Report[18]

The Committee on Nursing, led by Professor Asa Briggs, whose report was published in 1972, had simple terms of reference.

> 'To review the role of the nurse and the midwife in the hospital and the community and the education and training for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service.'

The main effects of implementing the recommendations of the Briggs report which are relevant to specialist postgraduate hospitals are likely to be:

1 Specialist postgraduate hospitals will inevitably have to link their schools of nursing with colleges which will incorporate other nursing schools. So far, no one has explored the possibility of links between the schools of advanced nursing and the institutes training doctors.

2 Pre-certificate courses needing psychiatric or child health modules will devolve upon certain hospitals (Maudsley and Bethlem Royal and the Hospitals for Sick Children); these hospitals already have training registers which would be discontinued.

Further, it is doubtful whether the schools of nursing of specialist postgraduate hospitals would be able to supply enough clinical experience for pre-certificate as well as post-certificate courses.

3 The needs of service and education will be separated and this, as much as any other factor, highlights the necessity for obtaining the right administrative structure for specialist postgraduate hospitals to give real identity to specialist nurses.

4 Post-certificate courses would still come within the aegis of the specialist postgraduate hospitals but would only be satisfactory if adequately trained nurses were available to care for patients.

5 A greater supply of nurses for full-time employment in specialist postgraduate hospitals will be brought about by improvements in the conditions of service.

6 Nurses with appropriate training and qualifications will be available to support the emphasis on community care in the reorganised health service.

7 The establishment of a Central Nursing and Midwifery Council for Great Britain will survey, coordinate and plan the strategy of post-registration specialised education.

In this context it should be said that the true position of nurse training in specialist postgraduate hospitals is partially obscured by the lack of an overall plan for post-certificate courses in the clinical specialties. In particular, the Briggs report had this to say:

> 'Large numbers of senior nurses in hospitals have by now taken post-basic training courses, but the provision of specialised post-certificate clinical courses in the hospital service is geographically patchy and is frequently related very directly to the need for local recruitment rather than to provision of sound educational programmes.' (paragraph 232)

Earlier recognition of this situation led to the establishment of the Joint Board of Clinical Nursing Studies in 1966 to advise on the post-certificate training needs of nurses and midwives in the hospital service, and to coordinate and supervise the courses provided as a result of such advice. We hope that, though the Briggs recommendation for a CNMC may be implemented, the JBCNS will be preserved and given 'teeth' to enable it to ensure that the content and quality of post-certificate training for nurses and midwives is improved and made consistent throughout the country.

Although there is still much to be done, a number of course syllabuses have been prepared and approved while others are either in course of preparation or about to be set up (see Table 8 overleaf).

Support Staff

The specialist postgraduate hospitals, with their associated institutes, rely heavily on the complementary services and support of further groups of staff which can be divided roughly into three categories.

Paramedical Staff, including biologists, biochemists pharmacists, laboratory technicians, radiographers, physiotherapists, dieticians, orthoptists, chiropodists. The routine clinical work of the hospitals, as well as the research work of the institutes, makes calls on services largely supplied by paramedical staff.

Non-medical Staff, comprising administrators, medical records officers, ward clerks, caterers, launderers, porters, engineers and so on. The largest of the postgraduate

TABLE 8 POST-CERTIFICATE TRAINING COURSES FOR NURSES IN 1973

Subject	Syllabuses prepared for	Number of course	Date approved
General intensive care	SRNs	100	October 1972
	SENs	115	March 1973
Renal care	SRNs	136	January 1973
	SENs	142	July 1973
Coronary care	SRNs	124	January 1973
	SENs	131	July 1973
Venereal and other sexually transmitted diseases	SRNs SENs	275	October 1972
Operating theatre nursing	SRNs	176	March 1973
	SENs	188	July 1973
Geriatric nursing	SRNs SENs	296	January 1973
Behaviour modification in mental handicap	SRNs	700	March 1973
Child and adolescent psychiatric training	SRNs	600	May 1973

PANELS SITTING

Subject	Syllabuses in preparation for	Number of course	Date approved
Special and intensive nursing care of the newborn	SRNs preparing to take charge of a unit	400	January 1973
	nurses working as part of the team in the unit	401	July 1973
Accident and emergency nursing	SRNs (completed) SENs	198	July 1973
Psychiatry	advanced psychiatric nursing		July 1973
Community psychiatric nursing			
Stoma care	for experienced SRNs		July 1973
Control of infection	for experienced SRNs		
Nursing care of the dying			

PANELS TO BE SET UP

Radiotherapy and oncology
Neurology and neurosurgery
Cardiothoracic

Source: Joint Board of Clinical Nursing Studies

institutes also employ considerable numbers of highly qualified staff in non-medical disciplines, who undertake important research work. These include physicists and chemists.

Present and future recruitment of the required numbers of suitably qualified staff in these categories is not helped by the continued uncertainty about the future of specialist postgraduate hospitals. Even in more stable times, the relatively small size of these hospitals and institutes offers less inducement to those seeking a career structure than perhaps that more obviously available in a large undergraduate or district general hospital.

It must not be forgotten that not only do doctors, dentists and nurses receive specialist training at postgraduate hospitals, but many paramedical staff also gain experience and receive post-qualification training in their disciplines. The special requirements, for example, of radiography of the brain and of cardiac catheterisation entail the use of skills and techniques which as yet can be acquired at only a limited number of centres. Because postgraduate hospitals will (it is hoped) always be at the forefront in the discovery and development of advances in patient care, it is to be expected that paramedical staff, as well as doctors, dentists and nurses, will benefit from association with these institutions.

Social Workers will be increasingly required to follow up the care provided by hospitals to patients after they have returned either to their homes or to specialised institutions of one sort or another. Also, social workers are required for support for some types of domiciliary patient; for example, long-term patients with orthopaedic, psychiatric, paraplegic or spastic disorders. There are many other such conditions which require the services of specialist social workers to complement the work of specialist doctors and nurses.

The specialist postgraduate hospitals themselves employ many social workers and some patients make heavy demands upon their services, often with corresponding burdens upon the social services of the area from which they come. This may be caused by the complexity of their medical conditions.

It is often not appreciated that the work of social workers forms a vital part of the activities of the specialist postgraduate hospitals. As an explanation we believe we can do no better than to quote an extract from a letter to the DHSS from Miss Isabel Menzies, a consultant at the Tavistock Institute of Human Relations, concerning social work at the Royal National Orthopaedic Hospital.

> 'To describe briefly the social work needs of these children and their families: the basic concern for the children if the risk of permanent damage is to be avoided or reduced, is to maintain adequate contact with their homes and families, in particular with their mothers.
>
> 'This is especially difficult in the case of children making long and repeated stays since the hospitalised child's needs come increasingly in conflict with the maintenance of an adequate family setting for the rest of the family. The situation is often exacerbated by the child's home being at a long distance from the hospital. Social work help has proved highly desirable and effective in helping families achieve a good resolution of these conflicts for all concerned; for example, in understanding the issues, effectively planning optimum visiting arrangements, learning how to mobilise other resources to help, and so on. Many families also need help in coping with the effects of the absence of the child, in keeping a place open in the family for his return and in managing effectively his return and the problems of his illness or disability. This is the more important since quite a number of the families show signs of social and psychiatric disturbance sometimes as a reaction to the child's illness or disability and his treatment.
>
> 'Such circumstances make great demands on social work services, requiring both a high level of skill and a detailed knowledge and understanding of the illnesses and disabilities and of their psychosocial effects that can only come from long and close experience of them. It is important that the social worker be an integral and constantly present member of the team working with children and parents, particularly medical and nursing staffs, if the total care for the patient and family is to be effectively integrated.'

Conclusion

Advances in specialist branches of medicine and surgery demand a corresponding increase of knowledge and skills by all types of staff, be they doctors, dentists, nurses, technical and social workers. This means that conditions, largely influenced by the future pattern of administration in the specialist postgraduate hospitals and institutes where many students in these disciplines train and work, must be such that they will be encouraged to seek their training and perhaps subsequent employment at these hospitals.

Once again, it will be seen that decisions for the future administration of the London postgraduate specialist hospitals must take full account of these issues.

4 Financing

Background

In discussing the existing basis for the financial support of specialist postgraduate hospitals and their associated institutes, it will be helpful to review briefly the circumstances which gave rise to the present system of support.

Agreement was reached in the early 1940s between the Ministry of Health and the University of London that postgraduate institutes should be formed in a number of medical specialties and that each institute should be incorporated under the Companies Act, independently of the specialist hospitals, but associated within the British Postgraduate Medical Federation which had been formed in 1945. The executive committee, on behalf of the governing body of the University, stipulated certain requirements which must be met by an institute before it would be formally recognised by the University.

The institute must show that it was providing postgraduate education of suitable academic standard.

It must accept postgraduate students only.

It must provide suitable accommodation such as lecture room, library, refectory and common room for the students, and laboratories in association with the hospital wards for the study of patients and their diseases, and for research.

The specialist hospitals were designated as teaching hospitals under the National Health Act of 1947 and each controlled by a separate board of governors. They were made directly responsible to the MoH from which they would receive grants for hospital maintenance and capital expenditure.

However, the grants for maintenance and capital expenditure for the institutes would come from the University Grants Committee, via the University and the BPMF.

Capital Expenditure

As far as capital expenditure on buildings is concerned the above division of responsibility between the Department of Health and Social Security and the UGC is basically the situation which still obtains today.

Capital expenditure on equipment if required for purely hospital needs is financed by the DHSS, but where such equipment is required for teaching or research purposes, the expenditure will be supported from any one, or a combination of sources such as

Medical Research Council (research grants)

Foundations (such as Nuffield, Wellcome, Wolfson and Ford)

the hospital's own endowment funds

charitable trusts (for example, Brain Research Trust and Cancer Research Campaign)

various public appeals

industrial and commercial organisations

University Grants Committee.

Operating Costs

The costs associated with the day-to-day provision of medical care within the specialist postgraduate hospitals are paid for directly by the DHSS, the method of allocation being on the same general basis as other hospitals, that is, the operating costs for the immediate past year are subject to weighting to allow for inflation and any forecast and approved increase in activity.

Whilst this method of allocation has obvious demerits, it nevertheless forms a consistent basis for allocation which applies also to undergraduate teaching as well as non-teaching hospitals throughout the country.

A particular difficulty arises when considering the division of responsibility for cost between the postgraduate hospital and its institute. For example, it is often impossible to decide accurately what proportion of an incurred cost is attributable to patient care – and so, by definition, to the hospital – and what proportion to research and education. It often happens that a research worker in receipt of a grant may use hospital facilities such as porters, nurses and equipment.

Similarly, the hospital will require the services of the researcher and teacher from time to time. Indeed, it would be impracticable to attempt to define just how much of a consultant's time is spread between the needs of patient care, teaching and research, or between hospital and institute activities.

Finance, then, is required to support the three vital activities of hospital and institute; namely, patient care, postgraduate medical education, and research. The main sources of finance for each of these activities are now discussed in more detail.

Patient Care

The DHSS meets by far the largest proportion of the day-to-day cost of patient care. In the case of specialist postgraduate hospitals, the money is provided directly by the DHSS and is administered by the boards of governors of the hospitals.

Attention has often been drawn to the significant difference between the operating cost per bed in a specialist postgraduate hospital and in an undergraduate hospital. Moreover, we understand that the difference has been a source of concern to the various authorities (DHSS, the former regional hospital boards and boards of governors). Some people have sought to attribute the higher cost per bed, at least in part, to the overheads associated with a small hospital (economies of scale).

It is evident, however, that there are three important factors which influence the cost of running the London postgraduate hospitals.

1 The level of outpatient activity compared with inpatient load is relatively higher in some postgraduate hospitals than in others (undergraduate teaching or district general) (see Table 9).

TABLE 9 POSTGRADUATE HOSPITAL PATIENTS AND EXPENDITURE FOR YEAR ENDED 31 MARCH 1972

Hospital*	Numbers of Occupied Beds	Inpatient Cases	Outpatient† Attendances	Total Inpatient Expenditure	Total Outpatient Expenditure	Total Hospital Expenditure	Expenditure Per Occupied Bed Per Week
				£	£	£	£
St John's	45	766	58 626	196 164	259 974	**456 138**	
Sick Children	478	14 568	131 410	3 451 851	947 644	**4 399 495**	
Royal National Throat, Nose and Ear	140	9 385	93 588	871 810	394 055	**1 265 865**	
Moorfields Eye	214	9 116	272 586	1 273 993	908 382	**2 182 375**	
National (Queen Square)	251	4 786	48 384	207 512	523 206	**2 598 718**	
Bethlem Royal and Maudsley	349	2 045	65 739	1 736 588	567 477	**2 304 065**	
National Heart and Chest	480	10 899	78 008	3 370 139	475 400	**3 845 539**	
Royal National Orthopaedic	274	4 398	44 372	1 542 524	448 315	**1 990 839**	
St Peter's	106	5 918	18 621	871 149	251 982	**1 123 131**	
Royal Marsden	236	6 656	75 363	1 715 133	729 950	**2 445 083**	
Queen Charlotte's	229	10 129	72 663	1 183 530	355 210	**1 538 740**	
All postgraduate hospitals	**2 802**	**78 666**	**959 360**	**18 288 393**	**5 861 595**	**24 149 988**	**125.51**
All undergraduate hospitals	**11 464**	**345 977**	**4 501 457**	**62 248 972**	**21 127 750**	**83 376 722**	**104.42**

* Figures for the Eastman Dental Hospital are not available as inpatients are included with Royal Free Hospital.

† Includes new patients.

Source: DHSS Summary of Teaching Hospital Costs Vol 2

2 At some hospitals there are special and often extremely costly facilities and equipment required to support the special services being given to patients. In some cases equipment used for routine services is required in greater quantity than in other hospitals (for example, x-ray or laboratory tests).

3 Although the general costs of research are met from other sources, the cost of supporting a patient for study and teaching is borne directly by the hospitals as a service commitment. In some cases the patient remains in hospital longer than normal for observation or so that the effects of advanced clinical treatment or drug trials can be assessed. Indeed, there are cases where patients enter hospital specifically because they have agreed to participate in a research project.

The relatively high cost of maintaining the London specialist hospitals can be considered in a truer perspective if it is remembered that these hospitals represent places of last resort to which some patients are referred when diagnosis or treatment has been unsuccessful elsewhere. Also, many patients are suffering from unusual or complicated conditions and often require more detailed diagnostic investigations and treatment, and this is inevitably reflected in the running costs of the hospital.

Hospital Endowment Funds may be used for a variety of capital and revenue expenditure purposes in addition to those items funded by the DHSS.

'Soft Money' is the term used to describe sums of money, often considerable, donated by a grateful patient perhaps, to the hospital. It also includes grants from research councils, foundations and industry but is not used for operational purposes.

Postgraduate Medical Education

University Grants Committee The Department of Education and Science makes many millions of pounds of public money available annually to the UGC which is concerned with the financial support of higher education generally, not only in the metropolitan area but elsewhere within the UK.

The grant for medical education in Greater London is provided on a quinquennial basis by the UGC to the University of London, which, in turn, funds the BPMF as a school of the University. Individual grants are then made to those institutes which are members of the Federation.*

The grants are used to support the salaries of teachers including lecturers, senior lecturers, readers and professors in medical subjects, and to finance the buildings and facilities required for the teaching of postgraduate students. This scale of University grants and the rate at which they have increased over the past five years are indicated in Table 10 and Figure 2.

Foundations and Trusts Invaluable help is given to the institutes by organisations such as the Wolfson Foundation, Nuffield Provincial Hospitals Trust, Beecham Trust, Wellcome Trust, King Edward's Hospital Fund for London and many more, who provide support for medical education. This is often in the form of endowments for libraries and lecture theatres, but they also endow professorial chairs in branches of medicine with all that implies in terms of support facilities and continuing costs of salaries.

Endowment Funds Donations from individuals and legacies form an important source of funds to some hospitals. These funds are not uniform between specialist hospitals nor do they approach the level of endowment enjoyed by many of the London undergraduate hospitals.

The range of income from the investment of bequests and endowments varies from a few thousand pounds to as much as £300 000 per year. In the main, the specialties of cancer research, child health, psychiatry, neurology, opthalmology and cardiology have been the most fortunate in respect of endowment funds. These endowment funds are administered by the boards of governors on behalf of the hospitals, but in many cases the money is allocated for facilities or projects initiated by the institutes.

Nurse Training Funds Although most aspects of nursing are paid for by the DHSS through hospital revenue, the salaries of nurses concerned with education are paid by nurse training committees established by the General Nursing Council and now administered by the regional health authorities.

Research

Medical Research Council There are, as yet, no really objective and consistent criteria upon which applications for research grants are judged. However, the content of the proposed work in particular and, to a lesser extent, the reputation of the applicant are the factors which most influence the decision to grant funds.

Whether or not a piece of proposed research is likely to meet a national need is not a factor high on the list of MRC criteria, nor need it be since the MRC has adopted a policy for establishing units to fill particular research needs, perhaps not appropriate to institutes and medical schools and which are not otherwise being met. Instances of such units include the clinical genetics unit at the Royal Postgraduate Medical School and the gastroenterology unit at the Central Middlesex Hospital. In all there are some 75 of these units directly supported by the MRC, although the epidemiology and medical care unit at Northwick Park Hospital is jointly supported by the MRC and DHSS. The MRC is concerned with three types of categories of research grant.

*The Institute of Cancer Research, although a member of BPMF, does not receive UGC grants at present.

FIGURE 2 UNIVERSITY GRANTS TO INSTITUTES FOR THE YEARS 1967-68 to 1971-72

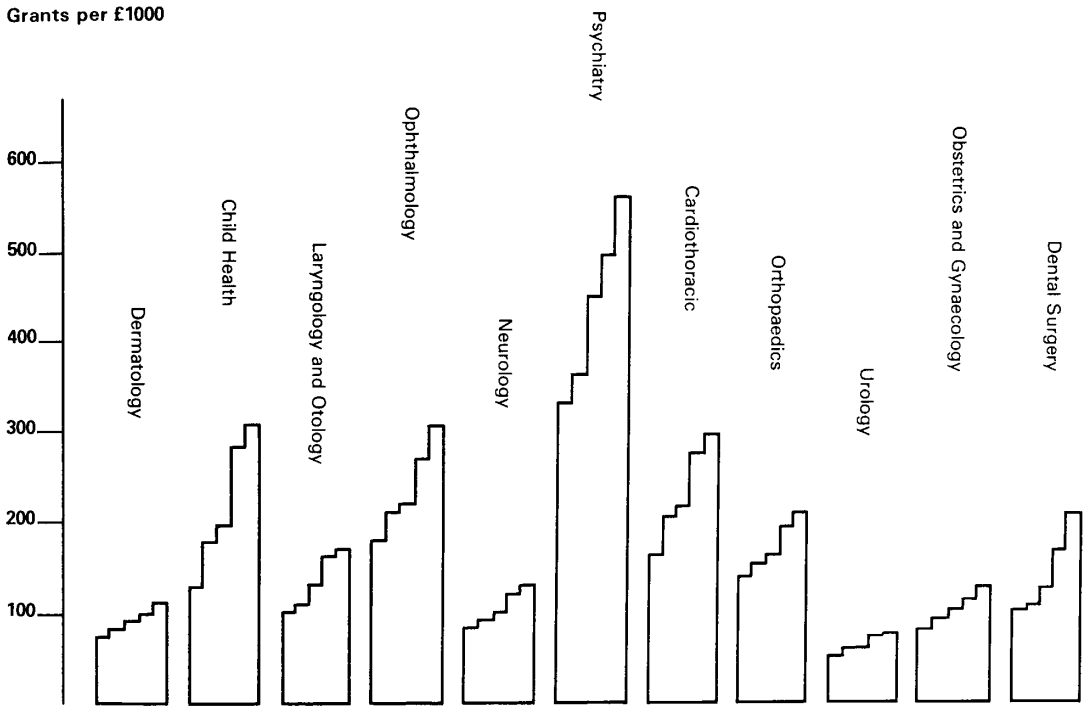


TABLE 10 UNIVERSITY GRANTS TO POSTGRADUATE INSTITUTES FOR THE YEARS 1967-68 to 1971-72

Institute	1967-68 £	1968-69 £	1969-70 £	1970-71 £	1971-72 £
Dermatology	76 000	86 817	91 156	107 075	118 404
Child Health	122 808	172 135	191 441	286 258	310 613
Laryngology	99 070	115 542	132 669	164 092	171 078
Ophthalmology	187 910	215 096	219 696	273 169	302 022
Neurology	87 392	94 201	103 171	126 906	172 671
Psychiatry	334 153	375 902	443 732	493 592	553 180
Cardiothoracic	159 396	211 085	215 064	267 095	292 143
Orthopaedic	140 278	152 916	159 882	195 902	214 364
Urology	53 037	55 495	58 010	71 603	74 080
Cancer Research	—	—	—	—	—
Obstetrics and Gynaecology	88 026	91 990	101 169	121 491	138 210
Dental Surgery	108 850	113 629	131 265	178 918	209 580
Totals	**1 456 920**	**1 629 313**	**1 847 255**	**2 286 101**	**2 556 345**

Note: Grants made to Royal Postgraduate Medical School and the Institute of Basic Medical Sciences have been omitted.

The figures for the Institutes of Cardiology and Diseases of the Chest have been combined as the Cardiothoracic Institute.

Source: British Postgraduate Medical Federation

Block Grants are for the support of on-going work of outstanding importance which is usually very expensive to conduct in terms of skills and equipment. An example is cancer research, and the Institute for Cancer Research receives an MRC block grant exceeding £250,000 annually.

Project Grants are for the support of research projects of up to three years' duration, but in exceptional circumstances this may be extended by up to six months.

These grants are designed to assist the young and aspiring research worker to start in research and they are thus instrumental in encouraging the vitally necessary supply of research workers in the various specialties so that the impetus for progress in medicine is not lost.

Applications for grants are made to the MRC through the head of department concerned at the institute or, in the case of an undergraduate teaching hospital, through the medical school.

The applications, which are scored for merit on the basis of content only, are considered by one of the MRC's research committees which comprise experts from a wide variety of medical and scientific disciplines.

Progress reports are required by the MRC at the half-way stage in the project. This is the only system of monitoring.

Programme Grants are normally for five years but the period can be extended. They are for research programmes rather than for single or individual projects. Unlike the procedure for determining project grants, programme grants are subject to scrutiny by the research board of the MRC which is composed of members with all-round experience and skills.

The MRC desires, but does not insist, that the results of the research it supports be published and it further believes that publication is the best return it can expect from its investment. The question of cost effectiveness of medical research, like other research, is a matter which has been discussed at length but never satisfactorily resolved. Indeed, it would be a brave man

FIGURE 3 RESEARCH GRANTS (OTHER THAN UNIVERSITY) TO INSTITUTES FOR THE YEARS 1967-68 to 1971-72

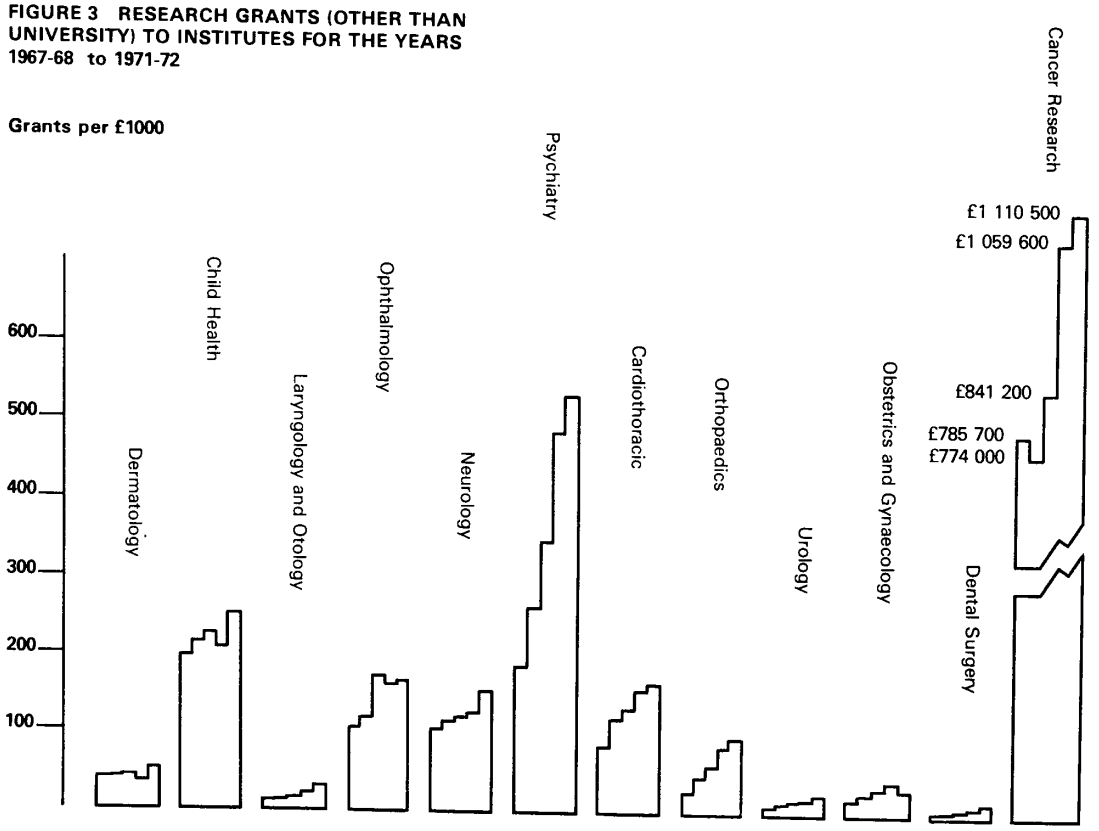


TABLE 11 COMPARATIVE SOURCES OF GRANTS TO POSTGRADUATE INSTITUTES FOR THE YEARS 1967-68 to 1971-72

Institute	Source	1967/68	1968/69	1969/70	1970/71	1971/72
Dermatology	MRC	17 807	8 147	15 767	10 779	21 785
	DHSS	—	—	—	—	—
	Other	26 159	35 391	31 903	23 408	27 814
Child Health	MRC	37 731	33 241	50 789	44 750	59 518
	DHSS	—	—	—	9 295	20 603
	Other	158 542	183 667	172 092	147 676	170 118
Laryngology and Otology	MRC	3 213	6 946	7 993	8 826	3 626
	DHSS	—	—	—	—	—
	Other	9 076	9 274	17 371	19 778	26 304
Ophthalmology	MRC	11 707	13 595	19 742	24 397	49 305
	DHSS	356	498	528	526	418
	Other	86 458	111 525	151 909	140 279	117 961
Neurology	MRC	55 932	52 133	62 524	76 085	95 748
	DHSS	7 123	6 659	2 458	1 924	890
	Other	44 516	54 891	51 003	42 460	52 320
Psychiatry	MRC	24 390	36 076	74 483	148 909	144 111
	DHSS	20 870	31 054	31 748	63 854	104 115
	Other	175 304	184 128	224 680	259 934	272 545
Cardiothoracic	MRC	8 160	13 327	27 914	35 001	26 751
	DHSS	—	—	—	—	—
	Other	70 460	109 422	104 433	130 015	139 460
Orthopaedic	MRC	6 633	9 287	1 729	4 096	3 407
	DHSS	—	—	5 318	10 434	11 626
	Other	26 921	40 811	61 652	76 858	86 384
Urology	MRC	4 819	9 287	4 403	4 474	4 858
	DHSS	9 073	8 099	8 256	18 925	17 198
	Other	9 318	11 228	13 240	15 172	20 427
Cancer Research	MRC	461 384	491 159	531 027	675 389	759 966
	DHSS	—	—	1 753	2 189	4 361
	Other	324 335	282 800	308 404	382 024	346 142
Obstetrics and Gynaecology	MRC	7 422	4 156	6 570	9 239	5 198
	DHSS	5 489	5 685	8 549	8 330	7 148
	Other	4 036	10 076	22 715	22 594	19 567
Dental Surgery	MRC	—	—	170	—	—
	DHSS	312	1 237	1 400	1 702	4 075
	Other	3 212	3 876	3 214	6 044	4 023

Notes: Figures for the Institutes of Cardiology and Diseases of the Chest have been combined as these two institutes were joined in 1972 under the new name of the Cardiothoracic Institute.

Sources of finance under 'Other' comprise other government departments, public appeals, trusts, industrial and commercial organisations.

Source: British Postgraduate Medical Federation

who would be prepared to quantify in any meaningful way the return from a financial outlay in research.

The importance of MRC grants can be assessed from the fact that in 1972 some 36 per cent of the financial value of all applications had been supported. Table 11 shows the relative importance of MRC grants to each of the postgraduate institutes.

The DHSS sponsors some research projects at postgraduate institutes and the money will often be supplied, either as a designated part of the hospital revenue or as locally organised research. However, the amounts are relatively small compared with MRC grants. Again, Table 11 illustrates this. See also Figure 3.

Foundations, Trusts and Endowments The proportion of money from these sources devoted to research is often much larger than that given for educational purposes.

Public Appeals and Charities Many millions of pounds are raised annually from public subscription, notably, through the Cancer Research Campaign, Brain Research Trust, Leukaemia Research Fund and the Arthritis and Rheumatism Research Council. There are many more. The institutes themselves are often instrumental in stimulating important fund-raising activities.

Industry and Commerce Industrial and commercial organisations contribute handsomely to special medical research.

5 National Health Service reorganisation

Unification of Services

In his foreword to the White Paper on NHS reorganisation[17], the then Secretary of State paid tribute to the achievements of the NHS since its inception and acknowledged the work of men and women throughout the service. However, he also said,

> 'But at the same time I have come to recognise, as many others have, that while this good work will continue, nothing like its full potential can be realised without changes in the administrative organisation of the service.
>
> 'Hence this White Paper. It is about administration, not about treatment and care.'

It was recognised that there were gaps in the health services, not only for the more obvious sectors of society – the elderly, the disabled and the mentally ill – but even for acute illness where we achieve less than we should considering the amount of resources devoted to health care.

The purpose of closing these gaps and achieving better coordination between hospital, general practitioner and local authority services, provided much of the impetus for reorganisation. At the same time reorganisation provided the opportunity to obtain a unification of health services under a single chain of authority. The reorganisation took effect on 1 April 1974.

TABLE 12 DISTRIBUTION OF POSTGRADUATE HOSPITAL GROUPS IN FORMER REGIONAL HOSPITAL BOARDS AND NEW REGIONAL HEALTH AUTHORITIES IN LONDON

RHA	Postgraduate Hospitals	Metropolitan RHB
North East Thames	Queen Elizabeth (Sick Children)	North East
	Nervous Diseases	North West
	Sick Children	
	Eastman Dental	
	Royal National Throat, Nose and Ear	
	Moorfields Eye	
North West Thames	St Peter's	
	St John's	
	Royal Orthopaedic	
	Hammersmith	
	Brompton	South West
	Royal Marsden	
	Queen Charlotte's	
South West Thames	Royal Marsden (Sutton)	
South East Thames	Bethlem Royal and Maudsley	South East

New Structure in Greater London

For health care purposes, Greater London is divided into four regional health authorities, the geographic boundaries of which differ in some minor ways from those of the former metropolitan regional hospital boards. However, these changes have a significant effect on the distribution of the postgraduate hospitals, as Table 12 shows.

The tasks of the RHAs include strategic planning, coordination and supervision of some specialised services including a blood transfusion service and the sponsorship of some research projects of which one is to be regional epidemiological studies.

Within the four regions there are 16 area health authorities (Table 13). The AHA is responsible for providing comprehensive health services for the population within its boundaries. It is to plan and develop services in consultation with local authorities and with the RHA.

Where an AHA contains substantial facilities for medical and dental teaching (that is, undergraduate hospitals and medical schools of the University), they are called 'teaching areas' or AHA(T)s.

Each AHA or AHA(T) has one or more 'districts', again based on geographic localities. The district forms the lowest unified operating unit of the health service. The district management team (DMT) coordinates the work of the hospital, community, local authority and

TABLE 13 DISTRIBUTION OF POSTGRADUATE HOSPITALS IN AREA HEALTH AUTHORITIES

RHA	AHA	Borough	Main Postgraduate Hospital	Institute	Postgraduate Hospital*
North East Thames	City and East London	City Hackney Newham Tower Hamlets			London Chest Queen Elizabeth
	Redbridge and Waltham Forest	Redbridge Waltham Forest			
	Barking and Havering	Barking Havering			
	Camden and Islington	Camden Islington	 Nervous Diseases Sick Children Eastman Dental Royal National Throat, Nose and Ear Moorfields Eye	(Urology) Neurology Child Health Dental Surgery Laryngology and Otology Ophthalmology	Shaftesbury St Paul's
	Enfield and Haringey	Enfield Haringey			
North West Thames	Barnet	Barnet			National (Finchley)
	Kensington and Chelsea and Westminster	Kensington and Chelsea Westminster	Royal Marsden Royal Orthopaedic Brompton St Philip's, St Peter's St John's	Cancer Research Orthopaedics Cardiothoracic Dermatology (Obstetrics, Gynaecology)	 Royal National Throat, Nose and Ear National (Maida Vale) Chelsea (Queen Charlotte's)
	Hillingdon	Hillingdon			
	Brent and Harrow	Brent Harrow		Orthopaedics (Stanmore)	Royal Orthopaedic (Stanmore)
	Ealing, Hammersmith and Hounslow	Ealing Hammersmith Hounslow	Queen Charlotte's Hammersmith	Royal Postgraduate Medical School	
South West Thames	Kingston and Richmond	Kingston Richmond			
	Merton, Sutton and Wandsworth	Sutton Merton Wandsworth			Royal Marsden (Sutton)
	Croydon	Croydon			Bethlem Royal
South East Thames	Lambeth, Southwark and Lewisham	Lambeth Lewisham Southwark	Maudsley	Psychiatry	
	Bromley	Bromley			
	Greenwich and Bexley	Bexley Greenwich			

* Branches of postgraduate hospitals are only shown where they are located in a different AHA from main hospital.

general practitioner services to provide all health care to its community. However, the patient is not constrained by the geographic boundaries of areas and districts but may cross boundaries to obtain the services he requires.

The undergraduate teaching hospitals provide substantial district hospital services and are included in the new administrative arrangements. However, the special character of these hospitals in providing medical education and in research has had to be allowed for in the arrangement for allocating finance. The additional finance required by the undergraduate hospitals is received by the RHA in its allocation and contains a specific and identified allowance for teaching and research.

Reorganisation and the Specialist Postgraduate Hospitals

The administrative relationship of the specialist postgraduate hospitals in London to the reorganised health service presents a much more difficult problem. A few of the hospitals have well-defined local catchment areas from which their patients are drawn. But these catchment areas are not well matched to the AHA in which the hospitals are located. The other specialist postgraduate hospitals tend to draw their patients from Greater London as a whole as well as a significant number from other parts of the country (see Appendix 6).

We think it is to be regretted that the essential differences between undergraduate teaching hospitals and the single specialty postgraduate hospitals were not recognised in the White Paper[17] and that it was planned for the latter to be administered eventually by AHA(T)s. Paragraph 185 (f) is worth quoting in full:

> 'It is an accepted aim that each postgraduate teaching hospital should become closely associated with other hospitals and health services in its vicinity. But until this association is close enough to make it desirable for the postgraduate hospital to be administered by the AHA(T), the Secretary of State will, after consultation with the London University, continue its Board of Governors in being for an appropriate transitional period. During this transitional period, the Board will continue to be appointed as at present, except that the members now nominated by the Regional Hospital Board will be nominated by the regional health authority. The Board will have a direct relationship with and will get its money from the Central Department.'

The moratorium, then, during which the specialist postgraduate hospitals continue their present administrative and financial arrangements, permits time for the DHSS to assess the problems presented by the inclusion of the undergraduate hospitals in the reorganisation.

Effects of Delay

Nevertheless, the effects of the interregnum for the specialist postgraduate hospitals cannot be expected to be entirely beneficial. In particular, we draw attention to four aspects which might give rise to difficulties:

1 staff interchanges between specialist postgraduate hospitals and other parts of the health service for both service and training purposes (this affects doctors and nurses and other categories of staff)

2 staff retention because of uncertainty about their future career prospects

3 staff recruitment because of future uncertainty

4 exclusion of the specialist postgraduate hospitals from planning of services by RHAs.

Uncertainty about the future of the specialist postgraduate hospitals is also bad for the health service as a whole. The new statutory bodies, RHAs and AHAs, are charged with the responsibility for planning, but are largely dependent on the teaching hospitals for the continuing supply of one of their most important resources – staff.

These factors are important and operational considerations will make it necessary to define the future relationships of the specialist postgraduate hospitals. However, it is equally important to ensure that the future administrative arrangements are based upon a proper definition of the role of these hospitals and we discuss this in detail in Chapters 8 and 9.

Geographic Considerations

The future location of the specialist postgraduate hospitals being discussed as a result of the Todd report[19], is also of particular relevance to the specialist service policies of the regions, areas and districts in London.

In the particular case of the twelve postgraduate hospitals, Table 13 indicates that five are in the Camden and Islington AHA(T) and five are in the Kensington and Chelsea and Westminster AHA(T); thus, ten of the twelve are located in two areas. Moreover, the proposed relocation still leaves five in the latter AHA(T), although the number of areas containing postgraduate hospitals rises from the present four to six (see Table 14).

The geographic distribution is not likely then to be substantially better as a result of the Todd recommendations; especially as these are largely in favour of linking the hospitals and their institutes with undergraduate teaching complexes which are themselves sited most unfavourably from almost all points of view.*

*This matter was discussed at some length in an unpublished paper, *A Study of Boundaries for Health Care in Greater London*, Teaching Hospitals Association, 1972.

TABLE 14 EFFECT OF REBUILDING PLANS ON DISTRIBUTION OF POSTGRADUATE HOSPITAL GROUPS IN AREA HEALTH AUTHORITIES

AHA	Postgraduate Hospital Group		Undergraduate Hospital	Area Coordination	Regional Coordination
	Present	Proposed			
City and East London	—	Moorfields Eye	Royal Hospital of St Bartholomew	With Camden and Islington *and* Kensington and Chelsea and Westminster	
		St Peter's St Paul's St Philip's	The London		
Camden and Islington	Nervous Diseases	Nervous Diseases	Royal Free University College		Between North East Thames *and* North West Thames
	Sick Children	Sick Children		Long term with City and East London	
	Moorfields Eye Eastman Dental Royal National Throat, Nose and Ear			With City and East London *and* Kensington and Chelsea and Westminster	
Kensington and Chelsea and Westminster	Royal Orthopaedic St John's	Royal Orthopaedic St John's Royal National Throat, Nose and Ear	Middlesex	With Camden and Islington	Between North West Thames *and* North East Thames
		Eastman Dental	St Mary's		
	Brompton Royal Marsden St Peter's	Brompton	Westminster (St George's)	With City and East London and possibly Merton, Sutton and Wandsworth	
Ealing, Hammersmith and Hounslow	Queen Charlotte's	Queen Charlotte's	King Edward* Memorial	—	—
	Hammersmith	Hammersmith	Charing Cross		
Merton, Sutton and Wandsworth	—	(Royal Marsden)	St George's	Possibly with Kensington and Chelsea and Westminster	Possibly between South West Thames *and* North West Thames
Lambeth, Southwark and Lewisham	Maudsley	Maudsley	King's College Guy's	—	—
			St Thomas'		

* district general hospital

Indeed, as long ago as 1902 the *Daily Mail* published a map showing the location of the undergraduate hospitals and referred to their congestion as a reason for relocation. Since that time little has been done and the map would appear very much the same today.

While it has been agreed that St John's Hospital for Diseases of the Skin, and the Institute of Dermatology should be rebuilt at or near the Middlesex Hospital, and that St Peter's Hospitals and the Institute of Urology should be rebuilt within the precincts of The London Hospital, decisions about the future locations of some of the other hospitals are less certain.

In any case, rebuilding at the new locations could take up to 15 years, and it is important, therefore, that an interim policy is established without delay so that the various areas can work out some arrangements with the particular specialist hospitals.

The complexity of the AHA-postgraduate hospital coordination is shown in Table 14 but an additional factor is the widely different timescale for the relocations. The fundamental question is, with which AHA(T) should a postgraduate hospital coordinate its service work: the one in which it is presently located or the one in which it will ultimately be located?

A further complication arises where a hospital has two or more branches which are located in different geographical and administrative areas. For example, the Royal National Orthopaedic Hospital is divided between Great Portland Street, London W1 and Stanmore. The Royal Marsden is in a similar situation with an establishment in the Fulham Road and one at Sutton. The arrangements for administering the 'outpost' branches of specialist postgraduate hospitals have not, as far as we are aware, been specified for England and Wales.

It is necessary for all concerned to have precise details as soon as possible of the intended method of administration of 'outpost' hospitals. Particular questions are:

1 Who will assume responsibility for a hospital which lies in one AHA but has its 'parent' hospital in another?

2 How will a hospital be financed that has establishments in different areas and perhaps in different regions?

3 Is there an explicit policy for research and teaching, particularly where they cross RHA boundaries?

4 What will be the function of the London Coordinating Committee? Will it also cover research and teaching?

The answers to these and many related questions are urgently required so that other dependent decisions can be made, for it is vital that decisions about the future of the specialist postgraduate hospitals and institutes are based on the needs of medicine now and in the future, rather than on a requirement to fit into a pattern for the sake of administrative convenience.

6 The Todd report

The Discussion of Postgraduate Education

In April 1968 the Royal Commission on Medical Education produced a report[19] on the state of medical education in Britain and made recommendations for the future which would, if implemented, have far-reaching effects. The main emphasis of the report is, naturally enough, with undergraduate medical education since the foundations of medical education are laid at the undergraduate stage. Nevertheless, the Todd report devoted some space to discussion of the present and future needs of postgraduate education and made a number of proposals for the geographic and administrative linking of the specialist postgraduate hospitals and associated institutes with certain undergraduate hospitals and medical schools (see Appendices 4 and 5).

Essential Differences Between Undergraduate and Postgraduate Work

We do not believe, however, that the Todd report gave sufficient recognition to the essential differences between the medical education of medical students and registered medical practitioners. The medical education of undergraduates takes place in hospitals which provide a full range of clinical services, usually to a definable geographic area or district. From the aspect of service commitment, therefore, the undergraduate hospitals are recognisably similar to district general hospitals. Moreover, it is important that they should be, since the education of medical and nursing students has to be undertaken in a service environment and is best done where a full range of clinical cases is likely to be encountered.

On the other hand, the educational needs of many postgraduate students are quite different. The environment in which they work is one of specialisation. The hospitals concerned do not usually provide a full range of clinical services and, as indicated in the previous chapter and in Appendix 6, the catchment areas from which patients are drawn vary significantly between the different hospitals.

Because of the specialist nature of the postgraduate hospital there is a continuing commitment to research in the associated institute which is not present in anything approaching the same extent in the medical school of the undergraduate hospital.

We think the definition of the functions of the postgraduate hospitals and institutes which we discussed in Chapter 2 is worth repeating:

patient care

medical education of specialists, the training of teachers and the further education of consultants

medical research.

It should again be emphasised that these aspects of the work of specialist postgraduate hospitals are indivisible, the last two arising from the needs of the first.

However, it must be remembered that the Todd report was produced during the time before the government of the day had issued the first Green Paper on health service reorganisation, and at a time when there were only the most tentative ideas about the form this would take. The Todd recommendations, particularly those concerned with the merging or linking of some postgraduate and undergraduate hospitals, were made at a time when the medical climate in Britain was different from that of today. Indeed, it is impossible for us to resist the temptation to question whether the Todd commission would have reached the same conclusions if its report had appeared five years later.

We have no doubt that these proposals were designed with economies of scale very much in mind and that, as a result, the specialist postgraduate hospitals in particular would become more cost-effective. We are satisfied that in some cases these objectives might well be achieved, especially through the sharing of certain hospital facilities such as some laboratory services, engineering and maintenance, laundry, catering and administration. Furthermore, the linked hospitals themselves would probably benefit from the association and we certainly do not share the unqualified view contained in the Greenwood report[11] that undergraduate and postgraduate teaching cannot properly be undertaken in the same environment. Whilst recognising the different

needs of both types of medical education, we think there is at the same time much to be gained from the presence of both undergraduate and postgraduate students in the same academic atmosphere. However, what is a lot less certain is the optimum size of unit to sustain academic quality whilst overcoming economic and 'domestic' difficulties. Pickering[13] quite rightly drew attention to the likelihood of intellectual isolation in a small separate institute, and it is also widely accepted that the financial overheads involved in running a small establishment are disproportionately high. Large units have the advantage of economies of scale but can lead to staff and students breaking into small groups to avoid the anonymity of large numbers, with the attendant danger of self-imposed intellectual isolation. The current reappraisal of large comprehensive schools is a pointer that there may be an upper limit to the size of academic units if quality and harmony are to be maintained. Optimum size in this respect is subjective and may be influenced by factors which are different in the case of secondary schools or undergraduate and postgraduate departments of universities. However, it seems appropriate to draw attention to the need to reflect on these matters before financial and building commitments make the mergers and associations an irreversible process.

A Postgraduate Complex

The recommendations of the Todd report include, for example, that the Royal National Orthopaedic Hospitals, St John's Hospital, and the Royal National Throat, Nose and Ear Hospital should become associated with the Middlesex and St Mary's teaching group, but rebuilt at, or near, the Middlesex Hospital, the Eastman Dental Hospital being more closely associated with St Mary's Hospital. If these recommendations are implemented, we foresee difficulties in academic administration which we have nowhere seen discussed. In particular, how will these combined facilities be run?

The teaching and research of each of the individual institutes have evolved to meet the needs of their particular specialties, as have the medical schools, and the respective deans have an obligation to meet their own programmes of work and to plan for future needs. To achieve this they must be able to exercise a measure of administrative and financial autonomy. The particular points which need to be clarified are:

What will be the relationship and responsibilities of the deans of paired undergraduate medical schools?

What will be the administrative and academic relationship between undergraduate and postgraduate deans?

Another aspect of these proposed associations which has not to our knowledge been discussed, but which we think should be the subject of close investigation, concerns their possible effects on the undergraduate hospital itself. The often expressed fears of the specialist postgraduate hospitals is that association will in time cause them to be swallowed up and that they will lose their separate identities to become just another department in the undergraduate hospitals. Is it not likely that the host undergraduate hospital may change its own character as a result of such associations? In the case of the Middlesex Hospital, which may become closely associated with three specialist postgraduate hospitals, the effects are likely to be far-reaching. In terms of size (bed numbers), the combined numbers of beds for the three specialist postgraduate hospital groups is some 60 per cent of the total bed complement of the Middlesex group. Moreover, because the Middlesex Hospital itself does not have a local patient catchment area of any significance, we believe that the associations proposed could lead to the Middlesex becoming a postgraduate medical centre of the type proposed in the Pickering report in 1962.[13]

Cost and Timing of Relocation

A further matter relevant to the discussion of the redisposition of the specialist postgraduate hospitals and, again, one about which we are unaware that serious consideration has been given, concerns the cost and timescale of the proposed relocations.

Table 15 summarises what, as far as we can discover, will be the likely cost of rebuilding the hospitals, based on 1973 prices, and the estimated year of completion in each case. From this it will be seen that the first of the proposed relocations (St John's Hospital) is not expected to be completed before 1981, and the Royal National Throat, Nose and Ear Hospital not until 1990.

We have not been able to obtain cost estimates for all the proposed relocations but we believe the total capital programme, allowing for inflation at the current rate and for the value of the vacated sites, is unlikely to cost less than £70 million and could well reach £100 million.

We fully recognise the need for rehousing some of the specialist postgraduate hospitals whose present accommodation is inadequate and otherwise unsatisfactory; for example, the urological specialty hospitals of the St Peter's group are particularly badly off for satisfactory accommodation. We are, however, far from convinced that, even if rebuilding is required to bring the hospital and its institute together, the relocation ought in every case to be with undergraduate teaching hospitals.

Apart from any benefits resulting from economies of scale (which may or may not be achieved) and the sake of administrative tidiness, there seems little case for the inclusion of the following hospitals with undergraduate hospitals, and their institutes with medical schools:

Bethlem Royal and Maudsley

National Hospitals for Nervous Diseases

Hospitals for Sick Children

Moorfields Eye

Cardiothoracic Centre (Fulham Road)

Royal Marsden.

Conclusion

Whilst in many respects the Todd report will be used as a definitive source book for a long time to come, some of its recommendations need reconsidering in the light of changing conditions in medicine and the reorganisation of the NHS. However, although the recommendations for resiting the specialist postgraduate hospitals and institutes may, at the time, have appeared the best solution, we cannot now endorse all the recommended moves, and we would exclude the hospitals listed above, together with their associated institutes.

TABLE 15 SUMMARY OF COST ESTIMATES AND TIMESCALES FOR REBUILDING

Postgraduate Hospital and Institute	Proposed Place of Rebuilding	Estimated Cost of Rebuilding (1973 Prices) £ Million	Value of Present Site (1973 Prices) £ Million	Expected Year of Completion (Earliest)
National Hospital for Nervous Diseases *and* Institute of Neurology The Hospital for Sick Children *and* Institute of Child-Health	on present site	22.5	–	1988
St Peter's Hospitals *and* Institute of Urology	The London Hospital	5.0	4.0	1981
Moorfields Eye Hospital *and* Institute of Ophthalmology	Royal Hospital of St Bartholomew	6.0	–	Institute 1978/9 Hospital 1986
St Marks *and* Department of Gastroenterology		–	–	–
St John's *and* Institute of Dermatology	Middlesex	2.0	–	1981
Royal Orthopaedic *and* Institute of Orthopaedics		2.6	–	1985
Royal National Throat, Nose and Ear *and* Institute of Laryngology and Otology	(not settled)	15	3.5	1985/90
Eastman Dental *and* Institute of Dental Surgery	St Mary's	3.5	–	1976
Brompton *and* Cardiothoracic Institute	Brompton	15	–	1981/82
Royal Marsden *and* Institute of Cancer Research	Sutton	Institute 5.5	–	–
Queen Charlotte's *and* Institute of Obstetrics and Gynaecology	King Edward Memorial		–	

II COMMENTARY ON THE FUTURE

7 Aims of the health service

Any realistic discussion of the future role of the specialist postgraduate hospitals in the reorganised health service must take account of the aims of that service.

High Standards

The British medical, dental and nursing professions have a world-wide reputation and undoubtedly share leadership in clinical advances with the USA and other major western countries. Britain also enjoys a high standard of health care and has a system of delivering it to the community which must rank, even before reorganisation, as one of the best in the world. Moreover, although there are admitted gaps in our system of delivering health care, it nevertheless has the virtue of attempting to maintain high standards which are consistent throughout the country. This was highlighted by a recent comparison of the British and American systems by Russell Nelson.[28] In particular, he said,

> 'The American and British systems of health care are substantially different. Yours has stabilised in twenty-five years and is so thoroughly accepted that you can contemplate the significant reorganisation and integration of 1974. Ours continues to be muddled, fractionated, uneven in availability and quality, primarily free-enterprise and astonishingly expensive. But we are moving into the common ground – we have declared health care to be a right for all citizens on an equal basis, and we are now developing the means to secure this.'

Redistribution of Resources

The reorganisation of the health services is about administration, but its purpose is to improve the arrangements for delivering a wide range of services to the community. Another important aim is to correct some imbalances in the allocation of resources. The then Secretary of State in his foreword to the White Paper[17] drew attention to this point.

> 'Everyone is aware of gaps in our health services. Even for acute illness, where we provide at least as good a service for our whole population as any country in the world, there are some respects in which we achieve less than we could. On the non-acute side the services for the elderly, for the disabled, and for the mentally ill and the mentally handicapped have failed to attract the attention and indeed the resources which they need – and all the more credit to the staff who have toiled so tirelessly for their patients despite the difficulties . . .
>
> 'Real needs must therefore be identified, and decisions must be taken and periodically reviewed, as to the order of priorities among them. Plans must be worked out to meet these needs and management and drive must be continually applied to put the plans into action, assess their effectiveness and modify them as needs change or as ways are found to make the plans more effective.'

These are very laudable aims but will require considerable finance as well as effort to bring to fruition. The reorganisation has not been supported by an injection of capital funds nor was there a short-term boost in revenue expenditure.*

The imbalances in the services are to be remedied by a redistribution of resources; resources which are already acknowledged to be overstretched. In short, this aim can only be achieved by cutting expenditure in some areas to provide finance for other services. Industrial, commercial and political action over the last 25 years shows quite clearly that, in times of financial stringency or when redistribution is necessary, the most vulnerable areas are research and training. The danger which faces the health service during the next few years is the temptation to meet the short-term aims of service at the expense of support for activities that will ensure a continuing high standard of service in the longer term. The high standard of health care emanates from British excellence in medicine which, if once lost, will be difficult and very costly to recover. This needs particular mention because neither the White Paper nor the Act[16] make explicit reference to the support of research and training as a national commitment. Current spending on research and training must be regarded as an investment in the quality of tomorrow's services and it would be disastrous if these resources were diverted to meet shortcomings in the present services.

*Other than normal increases to cover general inflation.

Responsibility for Planning

The identification of priorities and provision of resources in the longer term are to be part of the planning process. The regional health authorities are responsible for strategic planning but the scope and nature of this function has not been defined. It undoubtedly covers the planning and provision of services, but the power (authority and responsibility) of the RHAs in respect of research and training remains obscure.

The London Coordinating Committee has an important role in drawing together the activities of the four regions covering London and the Home Counties. However, we can find no general provision in the new structure for coordinating the planning activities of all the regions into a more comprehensive national plan. The question must be asked: who will give direction and finance to major areas of investigation?

The crucial issue is whether our future services will be planned, or evolve. It is often not appreciated that there is a significant difference between developing a plan to meet a particular goal and planning services to meet needs which evolve. It is not very appropriate to set precise goals in medicine. An objective such as 'finding a cure for cancer' is much less precise and has no definable endpoint as other projects such as 'putting a man on the moon' or developing Concorde or digging the Channel Tunnel. Broad objectives may be set in medicine, but the subsequent planning and investment must be adjusted as work progresses. However, this is not, as some would believe, a good reason for an entirely ad hoc approach to medical research and the development of services.

The White Paper makes specific mention that future plans must be effective in providing the services patients need; medical and nursing services at home, treatment and care in hospital for the acute sick as well as for the chronically ill.

There seems to be a need for simultaneous attention to planning and allocation of resources by specialty and between research, training and service.

The Todd report[19] is a basis for national planning of medical education; it identifies future needs, and resources (buildings and staff) are now being reorganised to meet those needs. It is already evident that the Todd recommendations require adaptation to meet changing circumstances and the need for periodic review requires explicit recognition.

Lord Rothschild, as head of the Central Policy Review Staff, set up by the government of the day in 1971, examined government control and investment in research and made particular recommendations for future control of research council funds.[15] Two important points affect medical research. First, the Medical Research Council's funds, voted through the Department of Education and Science, should be reduced and reallocated through the Department of Health and Social Security. This would give the DHSS greater control over funding of research as part of a total responsibility for health matters. Second, the Rothschild report endorsed the principle that applied research and development must be done on a customer-contractor basis.

Many people find these changes abhorrent because they are a move towards 'directed' research.* Others, however, accept the need for a better balance between research funds allocated to specific areas of specialisation and funds available for supporting 'bright ideas'.

The machinery for translating the Rothschild principles into an effective and equitable distribution of research funds between the specialties is as yet undefined.

Specialisation

The allocation of resources between specialties and between research, teaching and service is an issue of direct relevance to the organisation, size and work of the specialist postgraduate hospitals.

Assuming that the points discussed earlier in this chapter are overcome, there still remains the crucial question of how research and training funds should be divided between the specialties. In our discussion with various representatives of the health services we have asked four fundamental questions.

1 Do we need centres of excellence?

2 Which specialist areas are of primary importance?

3 Have some specialist postgraduate hospitals and institutes outlived their usefulness?

4 Are there some new identifiable groupings of specialisation?

These are matters which require full and careful deliberation and we were disturbed by what we considered were the relatively superficial responses when we posed these questions. For example, views on the future of the specialist postgraduate hospitals ranged from 'maintaining the status quo' to 'abolishing these anachronisms'. A general view implicit during our discussions is that any serious review of functions and effort in specialist activities would automatically result in a cut in finance. This is not, however, borne out in the one specialty (cancer), which has been subjected to overall national review.[14]

*That is, a programme of work is laid down and funded and researchers choose a part of that programme.

It would be inappropriate to assume that the grouping of specialty work is correct for future needs or that the balance of effort and finance reflects the present or future needs of the community; particularly in view of the deficiencies in services discussed in the White Paper which were mentioned earlier in this chapter. From our discussion we drew together a general list of specialty divisions. The subjects listed as fundamental specialties are currently researched as topics related to a number of specialties.

Fundamental Specialties

immunology
cell chemistry
genetics
psychology

Clinical Specialties

cardiothoracic*
orthopaedics*
dentistry*
ophthalmology*
cancer*
neurology*
urology and nephrology*
dermatology*
gynaecology and obstetrics*
laryngology and otology*
gastroenterology (new professorial unit)
general surgery*
general medicine*
tropical medicine (outside BPMF)*

Community Specialties

child health*
psychiatry*
geriatrics
general practice
venereology

Service Specialties

bio-medical engineering
radiology and nuclear medicine
pathology
anaesthetics

All the subjects listed are receiving research support, but obviously all do not justify the same level of support. From our enquiries it is evident that there is no sound basis for deciding the relative priorities. Effort and finance are decided in an ad hoc way without recourse to data or consideration of the need of other specialties. We are confident that this list will provoke wide disagreement in the medical profession on two scores. First, which subjects are to be separately identified as specialist? And second, which are of primary importance, particularly from the research and training standpoint?

*Specialties represented by separate postgraduate hospitals and institutes.

The important issues which need debate can be summarised.

1 What is the most appropriate grouping of topics for the future?

2 What is the relative importance of these specialties at present and in the foreseeable future?

3 How much effort and finance are required?

4 How does 3 compare with the present position?

5 How should the necessary resources be deployed; for example, is there a need for a focal point such as a centre of excellence?

We recommend that these questions be studied by an appropriate group representing the specialist interests, the specialist postgraduate hospitals and institutes, the DHSS and the DES.

Such a study would, in our opinion, ensure that the aims and balance of specialist work, and particularly research and training, are wholly in accord with the aims of the reorganised health service.

8 Objectives of the postgraduate hospitals

In the preceding chapter we discussed some of the broader issues concerning medical specialisation and the continuing needs of the health service. It is also necessary for us to comment on the more practical issues which automatically follow and have a particular significance for the specialist postgraduate hospitals and institutes.

The three main functions of these organisations will continue – patient care, teaching and research. The particular objectives in each function need to be examined and redefined in the light of the many recent and impending changes in organisation and policy – Todd [19], Rothschild[15], Briggs[18], and health service reorganisation.[17]

Research

Fundamental and clinical research will continue to be funded by the Medical Research Council but with more direction from the Department of Health and Social Security than hitherto. Researchers will also continue to attract funds from private or charitable sources. If the Rothschild principles and the regional health authorities exert their expected influences, it seems likely that research funds, designated for problems of national or regional importance, will be available. There are two important aspects which need examination.

First, the purpose and allocation of 'locally organised research funds' should be reaffirmed as a source of finance for aspiring researchers. The Goodenough report[8] observed in 1944

> 'A graduate who shows promise of developing into a successful research worker should have opportunities of learning the methods of putting ideas to the test and should be given reasonable facilities to do some research work on his own.'

The regional hospital boards did a great deal to ensure that this concept was realised in practice. However, Sir Thomas Lewis's observations, contained in the Goodenough report, are still true today.

> 'Many men who start to do research will not succeed, others will succeed in a measure which does not justify their continuing. Thus, for some years it may not be clear whether a particular man is best adapted to research, to teaching, or to practice. Thus, it is very important that the system should be flexible, so that he may come to follow his proved rather than suspected aptitudes.'

We believe it is incumbent on the RHAs, institutes and medical schools jointly to develop a policy for funding and reviewing work by young researchers.

The second issue is the need for an effective balance in the deployment of research activities; over-concentration may be harmful by obscuring channels of investigation whilst wide dispersion leads to a lack of contact and stimulation amongst researchers. The Coordinating Committee for Cancer Research, commenting on the Zuckerman Report[14], said

> 'The committee agrees that "money alone will not buy the new galvanizing ideas that are needed". Such ideas spring from original minds, but these minds need to have had appropriate training and a suitable environment in which to develop. Moreover, new ideas are produced against a background of accumulating basic knowledge which, at the present time, is coming from a wide spectrum of activities spanning the whole field of biomedical research.
>
> 'There is no evidence that, nationally, Britain is short of intellectual potential; there are, however, inadequate opportunities to enable this potential to be brought to bear, and money is a limiting factor in providing these. If, therefore, it is desired to enlarge and accelerate the cancer research effort already going on in Britain it is necessary to plan ahead for a long-term effort in terms of establishing more training and career posts for cancer research workers, providing new and better facilities for them and ensuring, as the committee has already emphasized that their work is carried on in close association with the main stream of other biomedical research.'[25]

These principles are equally apposite for other branches of medical research. Centres of excellence have an important role to play in creating a stimulating environment for research. They should provide

continuity of knowledge and factual information. A future objective must be to act as the hub of research and focal point of communication between other groups of researchers.

Teaching

In our first chapter we drew attention to the rapid growth in postgraduate training centres and the need to coordinate their activities with the work of the institutes. The special postgraduate hospitals and institutes must review their role in general postgraduate teaching.

In parallel, there is the prospect of a number of specialist postgraduate hospitals and institutes being physically and administratively associated with undergraduate facilities, and the possibility of fragmentation in postgraduate education is greater than hitherto. Certain essential and related functions will need positive attention. These include:

the monitoring of curricula and maintenance of exemplary and consistent standards of training in the institutes

the coordination of postgraduate training in the London undergraduate hospitals with that in the specialist postgraduate hospitals

the coordination, and where appropriate, integration of London and provincial postgraduate activities

the implementation of policy and general administration for overseas postgraduate students.

These are all-important activities which require continuing attention and can be most effectively carried out by a federated group. They should therefore be considered as the essential future functions of the British Postgraduate Medical Federation.

The implementation of the recommendations in the Briggs report[18] will have a significant impact on post-registration as well as pre-registration training of nurses. It is too early to identify how these proposals will influence special nursing courses but the specialist postgraduate hospitals may well need to review their role in the training of nurses.

Service

The functions of research, teaching and service are, we repeat, inseparable. It seems appropriate, therefore, that postgraduate students should continue to have full access to a specialist hospital located adjacent, or very close, to the institute. These hospitals provide only a small part of the service facilities for the particular specialty. The full advantages of special services for some patients and thorough training of specialist clinicians can best be achieved in an environment which is insulated from the heavy pressures of a full service commitment. A measure of protection, or insulation, should be afforded the specialist postgraduate hospitals, as well as other special service units in undergraduate and district general hospitals. We stress *insulation* and not *isolation* from service pressures. In return for this insulation of their working environment, researchers, teachers and students should expose themselves periodically to the broader range of service activities. The working links with specialist departments of undergraduate hospitals should be maintained, but there is a need for the specialist postgraduate hospitals in London to foster closer working links with specialist hospitals and departments in other parts of the country as well as to maintain contact with researchers abroad.

Information Services

The specialist postgraduate hospitals should regard information services as an essential part of their national role. There would be considerable value to be gained from a thorough factual appraisal of the national morbidity and mortality in each specialist branch of medicine; in particular, to quantify the incidence of different diseases or conditions and to establish patterns of age and geographic distribution. The incidence of serious or difficult conditions in relation to general morbidity would seem of particular value to the postgraduate hospitals. There are existing sets of records for particular subjects or groups such as cancer, blindness, mental handicap, and bone tumours, but not all of these are comprehensive enough to serve the general needs of the postgraduate hospitals or of the reorganised health service.

Two important exceptions are the Psychiatric Case Registers and the Cancer Registers. The specialist postgraduate hospitals concerned take an active part in maintaining the registers and derive considerable benefit from these data. It is not practical or appropriate to operate registers for all diseases, neither has it been practical to utilise the existing sources of general morbidity data such as SH3[5] and HIPE returns[6] as these are not suitable for specialist epidemiology studies. However, the introduction of the Hospital Activity Analysis (HAA)[20] on a national basis provides the opportunity to give this matter serious study. The setting up and operation of a broad based information service would enable the specialist postgraduate hospitals to make an important contribution to national planning of services. We see comprehensive specialist data on morbidity and mortality being used in a number of ways.

1 providing guidance to the DHSS on the national development of specialist resources

2 contributing to regional planning activities

3 providing guidance to the institutes on present and possible future levels of specialist training

4 providing guidance on the balance of research effort in different aspects of a specialist field, as well as assisting in the identification of new areas of work

5 providing sound factual backing to support applications for research funds.

We recommend, therefore, that the specialist postgraduate hospitals and institutes examine how comprehensive specialist information on national morbidity might be obtained and used. In particular, to examine with the DHSS the use of HAA and other relevant sources of information.

General Objectives

Far-reaching organisational changes are being implemented which will affect the research, teaching and service activities of the specialist postgraduate hospitals and institutes. These may result in some change in emphasis and responsibility for postgraduate work. The short-term objectives of the specialist postgraduate hospitals should be to take an active part in setting up and sustaining a dialogue with the newly constructed policy-making and administrative units. The aim should be to identify explicitly their future role in the reorganised health service. The longer term objective must be to give greater emphasis to coordination of training and service with national activities.

9 Organisation and finance

Administration

In the new administrative structure of the health services the specialist postgraduate hospitals are in a unique position. They are the only hospitals to retain the former administrative and managerial arrangements. One point which was not fully appreciated in all our discussions and which therefore needs emphasis is that although the specialist postgraduate hospitals are outside the new administration, they continue to be a part of the National Health Service, financed by and responsible to the Department of Health and Social Security. The ultimate aim, outlined in the White Paper[17], is for the specialist postgraduate hospitals to come under the general administration of the area health authorities (teaching) in which they are located. This will, however, have to be carefully phased with the implementation of the relocation and development of academic links emanating from the Todd report[19]. The administrative arrangements for these hospitals will therefore need to be kept under review over the next few years. In this chapter we highlight and comment on some particular points which will have a bearing on the ultimate arrangements for administration and finance.

Future Organisation

The Goodenough report[8] drew attention to the importance of a stable working environment for advancing scientific and medical investigation, and in particular said

> 'A community that wishes to promote research must do two things. First and foremost it must find and train the men who have the ability and impulse for scientific enquiry. Second it must create the most favourable conditions for their work and give them the tools they need.'

This seems to us to provide a succinct guide for the future organisation and administration of the specialist postgraduate hospitals as well as other research facilities in the health service. In Chapters 7 and 8 we drew attention to the need for defining aims and objectives in relation to research and teaching and, particularly, what and how the specialist postgraduate hospitals are required to contribute to overall developments. The detail will take some time to work out and will be influenced by both the reorganisation of the health service and the simultaneous implementation of recommendations emanating from the Todd report. In these circumstances the present and future position of the specialist postgraduate hospitals and institutes is characterised by uncertainty, and this naturally leads to apprehension and opposition to the proposed changes among those most closely involved.

Donald Shon, speaking about change in organisations in the Reith Lectures in 1970, said

> 'The system as a whole has the property of resistance to change. Sometimes we talk about this property as though it were inertia: that's a metaphor drawn from physics and refers to the property of an object to tend to remain where it is unless there's a force exerted upon it. But it is a rather passive metaphor and I propose instead that organisations are dynamically conservative: that is to say, they fight like mad to remain the same . . . It helps, I think, to refer again to the concept of uncertainty because the threat of change is unpredictable in its effects. It plunges individuals into an uncertainty that's more intolerable than any damage to vested interests. And in many ways the function of dynamic conservatism is to protect against that uncertainty.'[29]

The most pressing need in future discussions on the specialist postgraduate hospitals and institutes must be to remove the uncertainty which is bound to affect staffing and commitment to longer term projects, by resolving some of the outstanding matters concerning broad administration as well as operational aspects. We think the future organisation of the specialist postgraduate hospitals can be considered in two ways,

operational, that is, their working relationships and responsibilities locally in London,

constitutional, that is, their broader role and position in the NHS structure.

Operational Relationships

In the reorganised NHS, working relationships need to be fostered between the specialist postgraduate hospitals and the area health authority, and appropriate district management team, in whose territory they are situated.

These relationships need to reflect both the requirements of the area for services in the particular specialty and the catchment area of the hospital. The relationships seem destined to be fairly complex, and the extent to which the specialist postgraduate hospitals provide a local service in the AHA in which each will be located will vary from one specialty to another. The extent of the variations can be seen from the patient origin survey carried out as part of our study (see Appendix 6).

The three principal features in the data are

1 Eight of the postgraduate hospital groups have individual hospitals in more than one AHA(T) and the level of service to each AHA(T) is different. For example, The Hospital for Sick Children, Great Ormond Street draws 9 per cent, and the Queen Elizabeth Hospital 65 per cent, of inpatients from the AHA(T)s in which they are located.

2 The level of local service varies significantly from one specialty to another, 5 per cent to 65 per cent. Furthermore, there are differences in the volume of local inpatient and outpatient services.

3 In most cases the level of services provided to the rest of Greater London is higher than to the local boroughs constituting the AHA(T).

Two further points should be made on the need for caution in the use of these data:

The data indicate the level of specialist postgraduate hospital service and do not represent the needs of the various areas for specialist services.

The pattern of local services after relocation and rebuilding of some specialist postgraduate hospitals cannot be inferred from these data.

It was suggested in the course of our discussions that the working relationships developed between the individual specialist postgraduate hospitals and the AHA(T)s over the next few years would identify a mutually acceptable basis for the AHA(T)s to take over full administration of these hospitals. However, because of the variations in levels of service, briefly mentioned above, this would in our view be a rather ad hoc approach. Furthermore, in many cases the specialist postgraduate hospitals provide a significant volume of service outside London; and in addition to service to patients there is a heavy commitment to research and teaching activities. Whilst accepting the need for the long-term development of a sound operational relationship, we believe it would be wrong in principle to settle the overall future administration of the specialist postgraduate hospitals on the basis of working relationships developed for local service purposes in 1974 as a result of the NHS reorganisation.

Constitutional Position

Two aspects call for comment

autonomy and identity

finance and monitoring

Autonomy and Identity We have already endorsed the comments made in the Todd report that geographic separation between undergraduate and postgraduate teaching is not essential. We also accept that merging academic and clinical facilities may bring economies of scale by avoiding duplication of some common resources. However, the undergraduate and postgraduate hospitals have quite different objectives, as we said in Chapter 6, and there is a need for each to retain a measure of autonomy so that they can take policy decisions as well as discharge their day-to-day duties. The Todd report accepted that there should be little difficulty for the postgraduate hospitals and institutes in retaining their identity, but did not consider that any particular measures were necessary to ensure this. In particular, that report cited the successful administration of the Hospital for Tropical Diseases by University College Hospital for the past 25 years. However, these observations were made at a time when the administrative body responsible for teaching, the board of governors of UCH, was funded directly from the DHSS.

The position is now quite different and some specialist postgraduate hospitals are to become integral with undergraduate facilities, the latter providing domestic and medical support services. Furthermore, the 'parent' is itself to be administered by an AHA(T) whose primary role is the adequate provision of wide ranging services to the community in its territory. We feel, therefore, that less force can now be attached to the commentary in the Todd report on matters of administration and there is now less justification for the full integration of undergraduate and postgraduate hospital administration.

Policy, direction and maintenance of standards in research and postgraduate teaching generally, as well as within a particular specialty, should be agreed and implemented between bodies that have a primary responsibility for these matters and the necessary authority to take action. Equally, there is a need for the same freedom to be accorded undergraduate hospitals and medical schools and we discuss this matter further in the next chapter, in the context of a Joint Academic Board.

Finance and Monitoring In Chapter 4 we discussed at some length the financing of the specialist postgraduate hospitals and institutions. Here we make a few additional remarks about future policy.

The commentary in the Todd report relating to the administration of teaching hospitals by the former regional hospital boards specifically stated:

'. . . the new arrangements must provide adequate financial and administrative safeguards for the

maintenance and development of teaching and research . . .'

We understand that the University of London is now reviewing the procedure for financing the institutes through the British Postgraduate Medical Federation from the University Grants Committee's block grant. It is probable that for an initial period* the institutes will receive a designated grant allocated by the BPMF. This arrangement will subsequently be reviewed in the light of the association developed between the institutes and medical schools as well as the future of the BPMF.

The regional health authorities will receive a specifically identified allowance for teaching and researching in the financial allocation (in the first instance mainly for support of undergraduate facilities). They are also to set up committees to advise on (undergraduate) education and research.

We accept that these arrangements may provide the necessary short-term safeguards, but what of the longer term? It will be difficult enough to assess the conflicting claims of undergraduate and postgraduate teaching. The AHA(T)s and district management teams will be in a worse position because of mutual incompatibility between the funding of service and teaching functions. In the past, central and regional financial support of some projects was conditional upon the hospital group finding part of the finance from general funds. This we regard as bad in principle and hope that it will not be carried forward as a general approach in the reorganised service. Mixing the funding of broad based functions (research, teaching and special services) with routine local service will inevitably lead to the erosion of one whilst giving inadequate support to the other. Whilst we fully support the principle that expenditure on research and teaching must be justified, it would seem more equitable for service needs to be evaluated against service demands and the need for research facilities to be adjudged in relation to research resources.

If, therefore, the University and the health service are going to promote high quality research and teaching at postgraduate level, further attention should be given to the most effective way of funding these activities in the longer term.

A related matter is the procedures for monitoring the costs and progress of work. Because of the greater emphasis on research, the specialist postgraduate hospitals inevitably cost more to run per bed than other hospitals and they are often regarded as embarrassing luxuries which do not conform to the general administrative and financial norms of the hospital service.

*This will be five years from the time that an institute is rebuilt on the site of a medical school; that is, up to 1986 at least.

A fresh approach to monitoring the cost of running these hospitals is needed which is more in keeping with the services they perform and which should take account of factors, such as the following, which invalidate direct comparison with other hospitals.

A large proportion of patients have unusual diseases or conditions which may require a greater use of laboratory, x-ray and other services in diagnosis and treatment.

The balance between outpatient and inpatient loads is different from those of other hospitals.

As single specialty hospitals draw their patients from a wide catchment area, the use of resources cannot be compared to specialist departments in other hospitals where use of resources is closely related to local demography.

Research and teaching make demands on routine hospital administrative and domestic services; for example, medical records.

We are reluctant to talk in terms of the development of new 'norms' because of the wide variation in activities between the specialist postgraduate hospitals. Furthermore, a new approach to assessing running costs could be of immense value to the RHAs and AHAs generally for the operation of specialised service units (providing regional or national needs) and the support or research projects in other hospitals.

Technical monitoring is also of importance. An essential function of the Medical Research Council is to monitor the progress of work and the use of funds that have been allocated. This part of the process is distasteful to some researchers but we fully support the need to make researchers accountable. The basis for wider review of specialist research programmes as a whole requires further attention. In particular, the Coordinating Committee for Cancer Research said

'The Committee wishes to re-emphasise that any expenditure of funds on cancer research must continue to be the subject of the most stringent and uniform scientific scrutiny in order to ensure that the quality of work is maintained at the highest standard.'[25]

This is a principle which could, with caution, also be applied to other specialties. The specialist postgraduate hospitals with their associated institutes are regarded by many as centres of excellence. This carries with it a heavy responsibility: centres of excellence do not aim for high standards, they aim for the highest standards. The retention of a measure of autonomy in the new service and the assurance of financial support for research and teaching must therefore be accompanied by the most stringent but equitable system of monitoring.

10 Alternative administrative arrangements

Desirable though it may be, we believe it is not practical to try to find a definitive solution which would apply to all the hospitals concerned.

Instead, we think it is more useful to consider what will be the likely effects of adopting any one of a number of possible alternative arrangements. Although there are inevitably almost as many possible solutions as the number of opinions consulted, we have nevertheless confined our consideration to five.

1 Retaining the boards of governors

2 Full integration into an area health authority (teaching)

3 A single separate authority for the specialist postgraduate hospitals

4 Direct administration under the Department of Health and Social Security

5 Administration under a regional health authority

Each of these alternatives represents a possible solution which is radically different in type from any of the others. Each gives rise to particular problems concerned with financial, constitutional and administrative relationships between the specialist postgraduate hospitals and the statutory bodies of the health service; and each must have control machinery for day-to-day administration of the hospitals themselves.

Factors Affecting Decision

Before discussing these possible alternatives, it will be helpful to list some of the factors which must influence the ultimate decision.

1 There are twelve specialist postgraduate hospitals – or groups of hospitals – and twelve associated institutes.

2 These hospitals vary greatly in size in terms of inpatient and outpatient flow. For example, in 1971/72 St Peter's Hospitals had 5918 inpatients and 18,621 outpatients; whilst Moorfields Eye Hospital recorded 9116 inpatients and over a quarter of a million outpatients (see Table 9).

3 Discussions are currently taking place between certain of the hospitals and their institutes and a number of undergraduate hospitals and medical schools with the purpose of implementing the modified Todd proposals for linking the hospitals and the academic facilities.[19]

4 The specialist postgraduate hospitals vary from each other not only in size but also in the amount of emphasis each places on the functions of medical education, nurse training and research.

5 Some of the hospitals are to be rebuilt on, or adjacent to, the sites of undergraduate hospitals; they will share some of their facilities and will be administered as a single unit, through the area health authority (teaching) and district management team. However, if the clinical and academic independence of the specialist postgraduate hospitals is to be preserved, it will be necessary to provide machinery to achieve this.

6 The boards of governors of the specialist postgraduate hospitals are to be retained for the time being. This gives time for their future to be properly considered and enables the Secretary of State to assess the way in which the undergraduate hospitals fit into the reorganised health service before reaching a final decision on the administrative arrangements to be adopted in the long term for the specialist postgraduate hospitals.

We believe it is of the utmost importance that decisions concerning the future administrative arrangements for the specialist postgraduate hospitals should be resolved as soon as possible. The longer discussions are delayed, the more rigid will become the ground rules for the reorganised health service and, in particular, for its relationship with undergraduate teaching hospitals. These could more and more influence the final decision about the future of the specialist postgraduate hospitals.

In the light of these main considerations we now discuss the possible alternatives listed above.

Retaining the Boards of Governors

The National Health Service Reorganisation Act[16] makes provision for the boards of governors of the London specialist postgraduate hospitals to be retained for a limited period and, if necessary, for this method of administration to be continued into the longer term.

The concept of retaining the boards of governors as the permanent system of administration is particularly attractive because it does not involve change. The relationship of the hospitals to the DHSS would be the same as at present and their relationship to the RHAs would be similar to that to the former regional hospital boards. Furthermore, these hospitals would be assured of a large measure of autonomy and any question of losing their identity disappears.

The arrangements for direct funding from the DHSS would ensure that financing would be maintained on the present system for the foreseeable future and the fears about erosion of funds would be allayed. However, it must be remembered that the main channel for planning is now DHSS – RHA – AHA, the important focal point being the RHA. Future plans are likely to be based on resources under their control. It seems likely, therefore, that the future of some specialist postgraduate hospitals could be eroded by being largely discounted in plans for 10 – 15 years ahead. Plans will be supported by finance through the same channels, and RHAs and AHAs will have a significant influence on the expansion of existing specialist services and the introduction of new ones.

The possible isolation of the specialist postgraduate hospitals is to be counterbalanced in two ways. First, the RHAs nominate representatives to the boards of governors. Secondly, the hospitals participate in the work of the London Coordinating Committee, but this body is only advisory and has no power to fund new activities in the postgraduate hospitals.

Retaining the boards of governors as the permanent system of administration would mean that the hospitals would have a relationship to the mainstream of the health service which would be functional and not constitutional, that is, they would have no formal voice in AHA or RHA activities. The service links of the hospitals with the AHA(T)s would, in a number of cases, be fairly tenuous (see data in Appendix 6). The extent to which the hospitals would exert influence would depend on the extent to which they were needed by the AHA(T).

Staffing of the specialist postgraduate hospitals needs to be given some careful thought. Nurses, paramedical and administrative staff, particularly those of high calibre, may find it more attractive to work for the principal employing authorities where job opportunities, particularly for promotion, are greater. There could be a resulting cumulative attrition which, although slow, could have the most serious consequences for the future of the specialist postgraduate hospitals.

In the case of the hospitals that are to remain on their present sites, or are not forming close links with undergraduate hospitals, the boards of governors will probably work directly with the AHA(T). However, where the relocation results in a merging with the undergraduate facilities this contact is more likely to be with the district management team. It is difficult to conceive how the boards of governors can function effectively when the specialist postgraduate hospital is physically integrated with a larger unit, the latter probably providing the domestic and medical support services. In particular, the boards of governors of St John's and St Peter's hospital groups cannot maintain a viable and satisfactory function after relocation. Other hospitals may be in a similar position when the relocation plans are more advanced.

For this alternative solution to be viable it will be necessary to build into the planning cycle adequate arrangements for the voice of postgraduate medicine and teaching to be heard.

Because of the national as well as local commitments of the specialist postgraduate hospitals, we think there should be representation at DHSS, RHA and AHA levels.

Full Integration into an Area Health Authority (Teaching)

In Chapter 9 we indicated the specialist postgraduate hospitals' need to establish a working relationship with the AHA(T) in which they are located. Furthermore, it was indicated in the White Paper[17] that the ultimate aim is for the specialist postgraduate hospitals to integrate into the new structure under the direct administration of the appropriate AHA(T).

The specialist postgraduate hospitals, like the undergraduate, would lose their boards of governors and the hospitals themselves would probably be administered, for day-to-day purposes, by committees of management which would include the following officers

chief executive (house governor)
assistant chief executive (assistant house governor)
accounting officer (treasurer)
chairman, medical committee
dean of the institute
chief nursing officer

The initial relationship between the hospitals and the AHA(T)s is purely functional on the basis of service and the danger we foresee is that the AHA(T)s may apply their full administrative power, using the recent service activities of the specialist postgraduate hospitals as criteria for the future. This was discussed in Chapter 9.

The service requirements of individual areas may eventually lead to the AHA(T) exerting some pressure on the specialist postgraduate hospitals to accept a greater load of routine cases. This would be a reasonable expectation by an AHA in discharging its primary duties.

The present pattern of local service varies substantially between the hospitals. The main characteristics, in so far as any are identifiable, are:

Only two hospitals provide a significant inpatient service locally.

Several hospitals provide a local outpatient service.

These local service catchment areas do not always coincide with the AHA(T) in which the hospital will be located.

All hospitals provide a significant amount of service to London as a whole.

Whilst none of these points present insurmountable difficulties to administration by an AHA(T) there is a need to look at the hospitals individually when assessing local and national functions.

We said in Chapter 8 that specialist training and research require a measure of insulation from service pressures. Furthermore, if the specialist postgraduate hospitals are to maintain a national role they must work closely with service facilities in their particular specialty, for the country as a whole. The DHSS has wisely deferred a decision and only indicated integration into an AHA(T) as a broad aim. The points mentioned in the foregoing will need to be given careful assessment before a final decision is made. It should be noted, however, that there may well be particular difficulties in supervision by an administrative body whose primary concerns are, and quite rightly, essentially parochial.

A Single Separate Authority for the Specialist Postgraduate Hospitals

The concept of overall administration and financing by a separate authority was commended to us on a number of occasions. This could take three possible forms

single board of governors
postgraduate health authority
administration by the University of London

Single Board of Governors Again, as with full integration into an AHA(T), the specialist postgraduate hospitals themselves would each be directly controlled by what we have called committees of management instead of separate boards of governors for each hospital. However, all 12 specialist postgraduate hospital groups would be jointly administered by a single board of governors whose formal relationship to the DHSS would be similar to that which at present obtains for the individual boards.

However, the hospitals vary widely in size, in their emphasis on research and teaching and in the nature of the service they provide. It would be difficult for a board of governors to arbitrate between the, perhaps, conflicting demands of the hospitals and to give adequate representation to each, especially in relation to service activities. In other respects this arrangement would have the merits and disadvantages of retaining the individual boards of governors discussed earlier.

Postgraduate Health Authority Membership of such a body would be similar to that for an AHA(T) or a single board of governors. It would, however, have officers as well as members. Such a health authority would not be responsible for a geographic area but for a group of facilities. It would be partly in keeping with the general pattern of the health service structure and it would have an annual budget for distribution solely amongst the specialist postgraduate hospitals, thus safeguarding any erosion of finance by general service demands. However, there would be drawbacks, the principal ones being:

To be in keeping with the health service administration the postgraduate health authority should operate in conjunction with an RHA, but which one?

In many respects a PHA would duplicate the work of the London Coordinating Committee. A sensible alternative, therefore, is for the latter to be changed from an advisory body to one with authority.

For the concept to be valid in practice there should, perhaps, also be an undergraduate health authority and a provincial teaching health authority. This goes beyond the scope of the present study but might be examined at a later date in the context of a review of the administration of undergraduate teaching hospitals.

Administration by the University of London This administrative arrangement is widely adopted for teaching hospitals in other countries and has a particular attraction for the London specialist postgraduate hospitals. The University Senate, or some appointed board would, in effect, run the hospitals through their committees of management. A particular attraction seems to be that the hospital and associated institute would come under the same administrative authority and enable very close coordination between academic study and clinical practice. However, the present level of cooperation between institutes and hospitals could hardly be bettered as we have said in Chapter 2.

The University of London has a big commitment to medical education (see Figure 6 in Appendix 4) and any arrangement involving the University in hospital administration would probably have to cover undergraduate as well as postgraduate facilities. It

might be singularly unattractive to the University that they should be asked to administer only a small part of the hospital resources used in connection with medical education. The university would need to establish a constitutional relationship with the DHSS, the RHAs, and the AHAs and agree a functional relationship with the last two. This would be necessary before agreement could be reached about a satisfactory system of providing finance for the service activities of the hospitals.

There would also be difficulties for hospital staff who would not only be employed outside the main stream of the health service, they would in effect be employed by a separate authority, namely, the University. This itself might pose severe problems in career prospects and conditions of service for many categories of staff.

Other difficulties might arise in the provision of support services such as blood banks, ambulances and sterile supplies; this is all quite apart from any reluctance on the part of patients to go 'outside' the NHS for treatment.

Direct Administration Under the Department of Health and Social Security

In a sense this alternative is similar to the present arrangements except that the DHSS would assume direct administrative responsibility for the hospitals, the existing boards of governors having been dissolved.

The DHSS would act, in effect, as a joint board of governors for the 12 specialist postgraduate hospital groups and it would delegate the day-to-day running of hospitals to the committees of management already discussed. Such an arrangement would entail the DHSS taking on the planning and administrative functions which were previously the responsibility of the boards of governors.

The constitutional relationship between what would be the DHSS's own hospitals and the statutory authorities of RHA and AHA would be very difficult to define. Nor is it obvious how the DHSS's representatives for postgraduate affairs at RHA and AHA levels would be able to make their voices heard and to contribute to the overall health care scene, except from an unassailable position.

Assuming that these problems can be overcome, we find it difficult to reconcile the functions of the DHSS which we believe to be essentially planning and coordinating ones, with the close control of a number of smallish hospitals providing highly specialised services to a relatively small proportion of the total annual number of patients throughout the country.

Administration Under a Regional Health Authority

When discussing integration into an AHA(T), we said that the necessary parochial interests of those bodies might be at variance with the wider ranging activities of the specialist postgraduate hospitals. The RHAs also have parochial interests in that they have to consider first the requirements of their particular regions.

Again, as with integration into an AHA(T), the formal administrative relationship with the RHA would be very much the same, in that operational control of the hospitals would be delegated to a committee of management, and responsibility for finance, planning and coordinating would be assumed by the RHA.

There might, however, be some advantages from this arrangement as well as disadvantages associated with administration under bodies with particular geographical interests and responsibilities.

The particular advantages seem to be:

Administrative difficulties resulting from some hospital groups being split between different AHA(T)s would not occur. That is, there would be no need for extra-territorial management of postgraduate facilities.

Administration would be at one level below DHSS. The RHA would act in part as the board of governors but of course it also has other wider duties.

Fewer separate authorities would be involved than in integration into an AHA(T); four RHAs as opposed to four RHAs and six AHA(T)s.

The national interest of the specialist postgraduate hospitals and institutes might be more readily understood at regional than at area level.

There might well be less pressure to undertake service commitments to meet local needs. Also, the arrangement of service contact with hospitals further afield would be more easily arranged at regional level.

Summary of Alternatives

We have looked very briefly at each of five main possible ways in which the specialist postgraduate hospitals might be adminstered in future. Clearly, much thought and discussion must be devoted to expanding these possibilities and to finding others. What must be remembered, however, is that each of the hospitals is different from the others. Consequently, the administrative pattern which will suit one hospital, or group of hospitals, may be quite inappropriate for another so that the eventual decisions may be based on the adoption of a number of possible alternatives, rather than on one.

Nevertheless, as we believe it to be in the best interests of British medicine in general and the specialist postgraduate hospitals in particular that these hospitals should be part of the future medical scene, they should have a place within the reorganised health service rather than be affiliated to it by means of specially designed administrative arrangements.

Clearly, safeguards are required which will be effective in preserving those things that administrative and medical staff in specialist hospitals most fear they will lose by incorporation into the reorganised NHS. Some of these safeguards may be achieved through the functions of a Joint Academic Board, which we discuss below. Given these safeguards we believe that the specialist postgraduate hospitals could take their important and secure place in the new health service.

A Particular Requirement – A Joint Academic Board

Although we drew attention in Chapter 6 to the different requirements of undergraduate and postgraduate medical education, we also believe firmly that these are two sides of the same coin. This will be highlighted most strongly by the arrangements to link some postgraduate with undergraduate hospitals. The close physical proximity of the two stages of medical education can be mutually beneficial. At the same time they may be antipathetic to each other.

There is clearly a need, therefore, to encourage dialogue and mutual cooperation on the one hand and yet preserve the clinical and academic freedom of both on the other. Being convinced of this we came to the conclusion that these two fundamental requirements might best be met by the creation of a Joint Academic Board (see Figure 4).

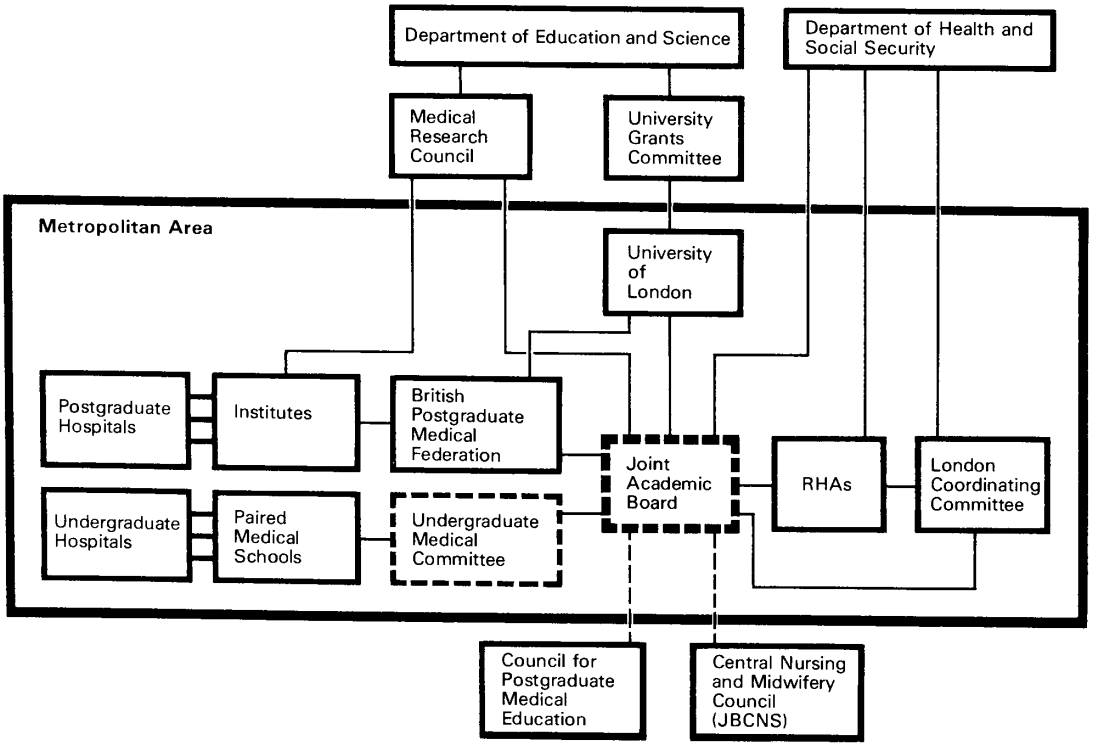
The purpose of the board would be to plan and ensure a level of quality, a sufficient quantity, and a proper balance of medical education in Greater London.

The board would be responsible to the University of London and have direct links with the DHSS. It would be an advisory body and it would be small; between eight and ten members. The board would represent the postgraduate institutes through the British Postgraduate Medical Federation and the paired medical schools through an undergraduate medical committee (to be created). The board would also work closely with the Council for Postgraduate Medical Education and the Central Nursing and Midwifery Council. Close cooperation would be necessary with the four RHAs from whom the board would receive advice and whom it would advise.

Much of the work of such a board has been covered by the Joint Working Group, now the London Coordinating Committee, concerned with a wide range of health care planning matters. However, we believe that the crucial need for close cooperation between many aspects of undergraduate and postgraduate medical education fully justifies the creation of a special board for this purpose.

Its existence would help to ensure adequate and appropriate allocation of finance, not only to institutes

FIGURE 4 POSSIBLE FUTURE ORGANISATIONAL STRUCTURE FOR MEDICAL EDUCATION AND RESEARCH IN GREATER LONDON



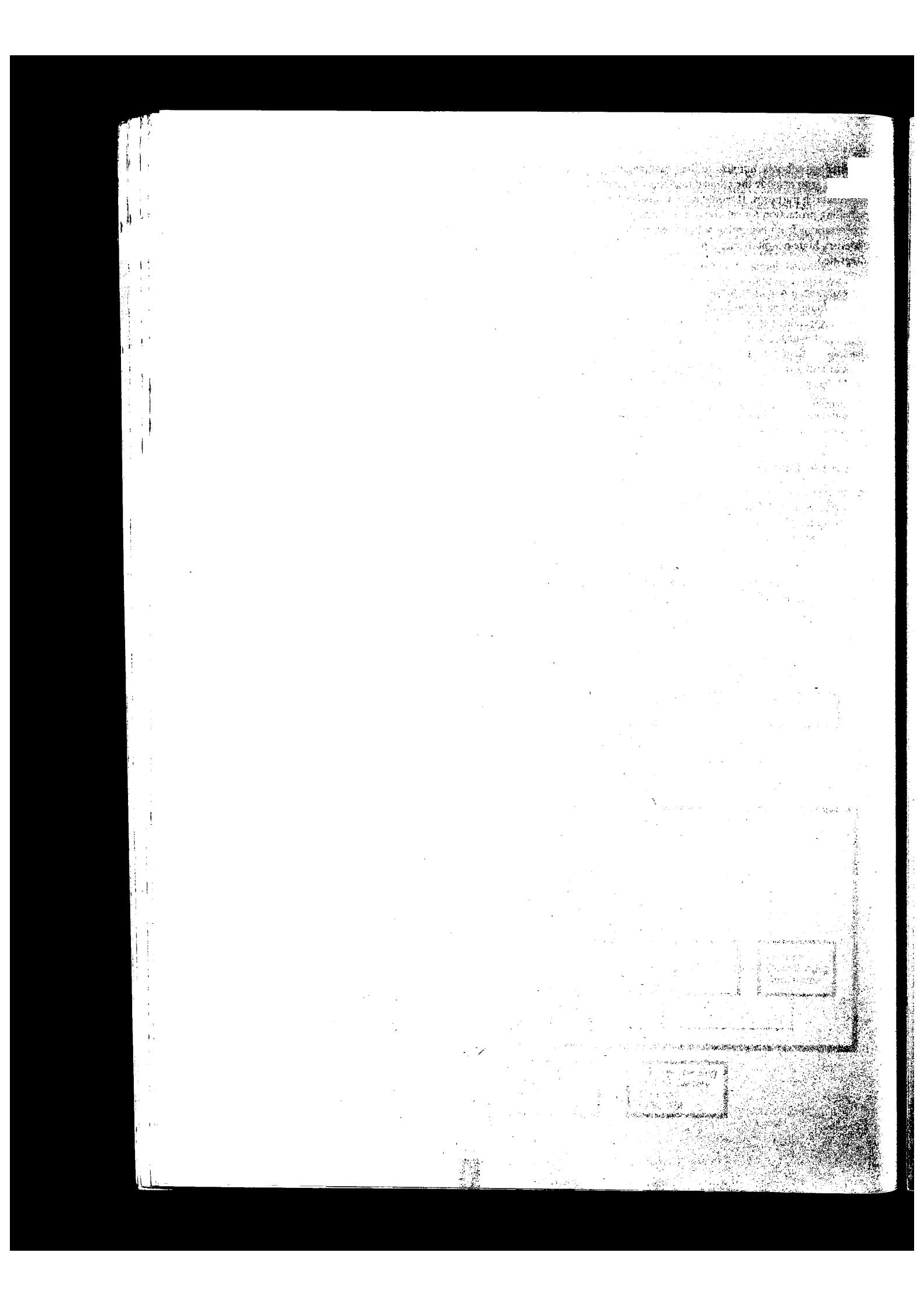
and medical schools, but also to their associated hospitals who provide the clinical facilities for teaching and research purposes. It would also be instrumental in providing protection for relatively small postgraduate organisations from becoming submerged by the larger undergraduate hospitals into which they may become integrated.

For example, it would be argued that if a specialist postgraduate hospital was in time to become merely just another specialist department in a major undergraduate hospital, this might be against the best interests of specialist patient care, teaching and research. The amount and level of activity of the affected specialties would decrease, so that before long gaps would appear in our ability to provide the best patient care for some clinical conditions. British medicine would then indeed be on a slippery slope.

The Final Decision

In this report we have attempted to draw attention to some of the many factors which will determine what sort of future place the London specialist postgraduate hospitals and institutes will have in British medicine. Many of our conclusions have been derived from subjective criteria because of the lack of availability of objective data. For this reason we have been unable to propose solutions which would, of necessity, have to be supported by numerical and definitive data.

Further, it seems likely that decisions ultimately made may be quite different from any of the alternatives we have discussed. What really matters, however, is that attention and discussion will be devoted to those factors which represent the strengths and shortcomings of the specialist postgraduate hospitals, and that, whatever future is decided for them, the former will be enhanced and the latter diminished. If this is achieved the continuance and growth of excellence in British medicine will be assured.



APPENDICES

Appendix 1

Organisations visited

British Postgraduate Medical Federation
Department of Health and Social Security
Joint Board of Clinical Nursing Studies
Joint Working Group of the Metropolitan Joint Consultative Committees
Medical Research Council
Nuffield Provincial Hospitals Trust
University Grants Committee
University of London

Bethlem Royal Hospital
Brompton Hospital
Chelsea Hospital for Women
Eastman Dental Hospital
Hammersmith Hospital
Hospital for Sick Children – Great Ormond Street
Maudsley Hospital
Moorfields Eye Hospital
National Hospitals for Nervous Diseases
Queen Charlotte's Maternity Hospital
Queen Elizabeth Hospital for Children
Royal Marsden Hospital
Royal National Orthopaedic Hospitals
Royal National Throat, Nose and Ear Hospital
St John's Hospital
St Peter's Hospital

North East Metropolitan Regional Hospital Board*
North West Metropolitan Regional Hospital Board*
South East Metropolitan Regional Hospital Board*
South West Metropolitan Regional Hospital Board*

Cardiothoracic Institute
Institute of Cancer Research
Institute of Child Health
Institute of Dental Surgery
Institute of Dermatology
Institute of Laryngology and Otology
Institute of Neurology
Institute of Obstetrics and Gynaecology
Institute of Ophthalmology
Institute of Orthopaedics
Institute of Psychiatry
Institute of Urology
Royal Postgraduate Medical School

Charing Cross Hospital
Guy's Hospital
King's College Hospital
Middlesex Hospital
Royal Free Hospital
Royal Hospital of St Bartholomew
St George's Hospital
St Mary's Hospital
St Thomas' Hospital
The London Hospital
University College Hospital
Westminster Hospital

Brook General Hospital, Woolwich
Exeter Postgraduate Medical Institute
Inner London Medical Committee
Kettering and District General Hospital
Public Health Laboratory Service Board
St Mary's Hospital, Colchester
Somerset Postgraduate Centre
Whipps Cross Hospital

*Now disbanded under the reorganisation of the National Health Service.

Appendix 2

Notes on the London specialist postgraduate hospitals and institutes

Because they are relatively small, these hospitals and institutes, we found, are not perhaps so well known outside the medical profession as are the larger and rightly famous undergraduate hospitals. We therefore felt it appropriate to include some brief commentaries on the hospitals and their associated institutes. The following notes cannot possibly do justice to the work of each hospital and its institute, but we hope that they will help to give some flavour to the often used but unqualified term, 'academic and clinical excellence'.

Bethlem Royal Hospital and Maudsley Hospital and Institute of Psychiatry

The joint hospital has a total of 510 beds, about half being used for general psychiatry and the other half for the specialist units, (for example, drug dependence, clinical research and treatment unit, and children's unit).

More than 2000 patients are admitted a year, and in the outpatient department at the Maudsley Hospital some 90 clinics a week are held, dealing with approximately 45,000 attendances a year. In addition there is a large day hospital and rehabilitation unit. Services are provided to other hospitals and institutions including prisons, remand homes, approved schools and child guidance clinics. The only 24-hour emergency clinic for psychiatric patients in London is in the joint hospital.

The joint hospital and its institute enjoy an international reputation and have an impressive list of achievements to their credit. Many techniques and treatments have been pioneered here, including the whole concept of voluntary treatment in the 1920s; the controlled trial of insulin therapy for schizophrenia (which led to its abandonment, thus saving thousands of patients from a potentially dangerous treatment); the surgical treatment of epilepsy; behaviour therapy for certain neurotic disorders; and the occupational rehabilitation of chronically handicapped patients.

Teaching, research and service are undertaken on a multidisciplinary basis which involves doctors, nurses, social workers, occupational therapists, psychologists and others.

One of the most important roles of the joint hospital and institute is the training of teachers in the various professions in this field. Some 18 registrars are appointed each year on a three-year rotating programme, and the majority become consultants when their training is completed. Many have left either to join or to establish academic units; and of the 22 chairs of psychiatry in the United Kingdom, 13 are occupied by people trained here. Some 20 to 30 doctors come annually from abroad for a two-year training programme, and most return to highly responsible positions in their own country.

The University of London has a large academic and clinical department of psychology in the institute, and considerable numbers of students are also taught by the school of nursing, and in the departments of social work and occupational therapy.

The total number of postgraduate students who received training at the hospital and in the institute in 1971/72 was 598, drawn from 56 different countries.

The school of nursing offers courses in post-registration training in mental nursing for trained general nurses and for nurses trained in the care of the mentally handicapped. There is also an experimental modular course in mental nursing, a mental nurse training course combined with a degree course in social sciences at Brunel University, a secondment course for nurses undertaking general nurse training, and inservice training for all nursing staff, including neurosurgical staff. Between them, these courses involve approximately 100 students annually, and a total nursing staff of approximately 450 nurses (full-time equivalents). Post-certificate courses in special and advanced aspects of psychiatric nursing are being developed, and such courses are contemplated in the near future in the fields of child and adolescent psychiatric nursing; behaviour modification in mental handicap; nurse therapists for special psychological techniques; advanced psychiatric nursing; and possibly neurosurgical and neurology nursing. The joint hospital is seen in the nursing field as developing into a major centre for training in advanced and specialised psychiatric nursing, and for psychiatric nursing research. Many senior nursing administrative and teaching posts in this and other

countries are held by nurses trained at the joint hospital.

In the field of research, contributions have been made to many aspects of general clinical psychiatry, child psychiatry, forensic psychiatry, drug addiction, the epidemiology of psychiatric disorders, and the development of a district psychiatric service; as well as to the fields of study in the basic science departments of the institute.

Eastman Dental Hospital and Institute of Dental Surgery

Like all other dental teaching hospitals, the Eastman Dental Hospital caters mainly for outpatients. The number of outpatient attendances is approximately 80,000 per annum; although a significant number of these patients come from the local district, referred patients are received from almost all parts of the country. Currently, the hospital has 13 departments, containing a total of 73 dental chairs.

There is a close integration of institute and hospital, most members of the hospital staff holding honorary appointments in the institute, and most of the staff of the institute having honorary contracts with the hospital. During the past ten years, the staff of the institute and hospital have contributed about 700 original papers and books. Significant contributions have included studies on various aspects of bone grafting, the use of the computer in histopathological diagnosis, developments in dental instrumentation and materials and the effects of these materials on the dental tissues, the effects of fluoride on dental caries, and the biological aspects of orthodontics.

A wide variety of postgraduate courses is provided, and each year includes courses in preparation for the Fellowship in Dental Surgery of the Royal College of Surgeons, for the Diploma in Orthodontics, and for the MSc degree of the University of London (six different MSc courses are available). In addition to these formal courses, each of which lasts for one calendar year, the institute and hospital provide a variety of other courses, including short courses in general dental anaesthesia and in various aspects of clinical dentistry. These short courses are mainly intended for general dental practitioners, but special courses are also held each year for dental officers of the armed forces, for the staff of the Dental Estimates Board, and for the regional dental officers of the DHSS.

On average, some 370 postgraduate students attend each year and these students come from almost all parts of the world. A large number of consultants have received at least part of their training at the Eastman; for example, the majority of consultants in orthodontics in the United Kingdom have attended courses at the hospital and institute. The dental schools in many countries regularly send their junior staff to the Eastman for further training and experience.

In addition to the postgraduate training of dental surgeons, the hospital has training programmes for dental technicians and for dental surgery assistants.

Hospitals for Sick Children and Institute of Child Health

The Hospitals for Sick Children comprise a group of three hospitals, with 349 beds at Great Ormond Street, London, 148 beds at the Queen Elizabeth Hospital for Sick Children, Hackney Road, E2, and 108 at the country branch at Tadworth Court, Surrey. With a total of 605 beds, the group is one of the largest of the specialist postgraduate hospitals and the largest paediatric teaching centre in the country.

The Hospitals for Sick Children, unlike other specialist postgraduate hospitals, are general hospitals catering for a special age group and, particularly Great Ormond Street, are special referral centres for the many complex disorders of childhood. It follows that the services required have to be related to the overall care of sick children from birth to adolescence, as well as providing highly specialised services for the investigation and treatment of a wide variety of disorders affecting different organ systems.

The hospitals and institute have achieved national and international fame in paediatrics and child health. Patients are admitted from all over the country, as well as from overseas; their clinical conditions are varied and often rare. For example, many children are born with defects which require corrective surgery, and in this respect Great Ormond Street has played a leading part in the development of cardiothoracic surgery in the infant and very young child; unquestionably one of the great achievements of modern surgery. Surgery for the newborn and the correction of defects affecting the palate, intestinal and genito-urinary tracts have also been developed. On the medical side, important advances have been made and pioneered in children with metabolic disorders, inborn errors of metabolism and renal disease, and the staff is taking part in a MRC trial in the treatment of leukaemia. These clinical skills must be supported by expertise in anaesthesia, radiology, all branches of pathology and other diagnostic services.

Queen Elizabeth Hospital in Hackney serves a large community in the East End of London and the majority of its patients come from that area and from the north east metropolitan region. It has a large outpatient department and is now expanding its services to the community and to the care and management of children with handicaps. Thus the functions of Queen Elizabeth Hospital are complementary to those of Great Ormond Street. The two hospitals, with the Institute of Child Health, provide outstanding facilities for the practice and study of all aspects of paediatrics.

The staff of the institute, together with the consultant staff of the hospitals, take part in postgraduate courses throughout the year on a wide variety of subjects concerned with paediatrics, the promotion of child health and the prevention of childhood disease. These are

attended by consultants, general practitioners, medical officers of health and many others in training. In addition, a special course is run for postgraduates from developing countries financed by UNICEF. The institute has undertaken to give selective training to undergraduates of the medical colleges of the Royal Hospital of St Bartholomew and The London Hospital. The research is varied and in the main related to those disorders for which children are admitted to the hospital. For example, the MRC's clinical genetic unit is one of the leading centres in the country for genetic counselling and research into genetic disorders, and the department of growth and development has made a special study of abnormal growth patterns and is the assessment centre for the MRC's clinical trial of human growth hormone. Other important problems being studied are disorders of fat metabolism and its possible long-term sequelae in relation to ischaemic heart disease; immuno-pathological disorders, developmental paediatrics and the causes of and methods of preventing infectious diseases contracted before and after birth.

The importance of the hospitals' nurse training activities can be appreciated from the following figures which show its contribution to the specialist training of children's nurses in the country at large.

	1970	1971	1972	Total
Hospitals for Sick Children's Nurse Training School	157	124	164	445
other children's nurse training schools	371	404	371	1146
percentage of national total	29.7	23.5	30.6	28

Moorfields Eye Hospital and Institute of Ophthalmology

The Moorfields group comprises three hospitals with a total of 350 beds. All the hospital buildings are in London and the largest, at City Road, has 214 beds. This famous specialist eye hospital is the largest in the world and is another postgraduate hospital with an international reputation, its patients coming from all parts of the United Kingdom and from overseas.

The hospital undertakes a very heavy outpatient load, mainly from the London area. The 322,000 outpatient attendances in 1972 are a measure of the amount of activity at the hospital. Research carried out at the institute and hospital has resulted in the prevention and, in some cases, elimination of blindness, as well as in the development of new and successful methods of treatment. The elimination of blindness in premature babies was a major advance in medicine. The treatment of trachoma, a disease affecting many millions of people in the world, is being steadily advanced by research projects in several countries under the direct guidance of the institute. Research on glaucoma and the development of new methods of early diagnosis, the use of lasers for surgical procedures, new operative techniques in corneal grafting, the pioneering development of electrodiagnostic methods, and the internationally acknowledged work on the treatment of malignant neoplasms are but a few examples of the research and development projects pioneered at Moorfields and the institute.

The institute is a World Health Organisation reference centre for ocular tumours and trachoma.

The consultant staff who have served the hospital over the years have been the leaders in the specialty.

The institute provides a wide range of training courses for students who come from many countries. Twenty-five courses for 633 students have been arranged, ranging from general practitioners, to advanced courses for consultants. Specialist eye hospitals in other countries have been established by consultants trained in the institute, including the New York Eye and Ear Infirmary and the Madras Eye Hospital. More recently the institutes of ophthalmology in Aligarh (India), Melbourne and Cairo have all been started with the help of the UK institute, and the academic chairs in those institutes have been staffed by men and women who have trained here. Since its foundation, Moorfields has had on its staff 12 Fellows of the Royal Society, and currently two members of the staff of the institute hold this high distinction.

There are at present 356 ophthalmic consultants in hospitals in England, of whom just over half received their training at Moorfields. More than 2100 contributions to journals and scientific books have been published by members of the staff in the last ten years.

The school of nursing provides some seven courses, including diploma courses, for staff nurses and student nurses, and a proficiency certificate for state enrolled nurses. The annual intake of pre- and post-certificate nursing students is about 160 with an additional 50 on secondment from other hospitals. The school trains approximately 90 per cent of all ophthalmic nurses in the United Kingdom.

National Heart and Chest Hospitals and Cardiothoracic Institute

The National Heart and Chest Hospitals comprise

Brompton Hospital, Fulham Road	353 beds
Brompton Hospital, Frimley	150 beds
London Chest Hospital, Bethnal Green	142 beds
National Heart Hospital, Westmorland Street, and Shaftesbury Avenue	99 beds

The Cardiothoracic Institute is associated with these hospitals. Its staff, numbering more than 150, undertake research and teaching associated with the heart and

lungs and the behaviour of these organs in health and disease. There is also an MRC unit adjacent to the Fulham Road branch of the institute.

A few examples of recent and current research are:

evaluation of artificial heart valves and original research into the use of homograft valves in heart surgery

assessment and development of cardiac pacemakers

treatment of pulmonary embolus by surgery and chemotherapy

applications of phonocardiography and echocardiography in cardiac diagnosis

investigation of immunological mechanisms in lung disease (for example, asthma, the farmer's lung group of diseases)

work on the bacteriology of chronic bronchitis which has provided the basis of standard antibiotic therapy

development of techniques for the study of lung function in the infant and young child.

In addition, senior members of staff are authors of many original and standard textbooks on such subjects as sarcoidosis, emphysema and cardiovascular pathology.

In the last ten years well over 200 consultants of thoracic medicine, cardiology and thoracic surgery were trained at the hospitals and now hold important posts throughout the United Kingdom and North America. In addition, postgraduate teaching programmes have been developed for general consultants, registrars and general practitioners. The institute enjoys an international reputation for teaching and research and is an important European centre for the dissemination of information in its specialties.

The hospitals provide a wide range of post-registration and post-enrolment nursing courses, ranging from the broadly based to the highly specialised and leading to appropriate certificates. Discussions are taking place with the Joint Board of Clinical Nursing Studies on the structure of a new course in cardiothoracic nursing. Individual arrangements are made for nurses from the United Kingdom and overseas to learn about particular aspects of cardiothoracic nursing as appropriate. At Brompton Hospital there is also a flourishing pupil nurse training school.

The postgraduate education of the paramedical professions, particularly those from overseas, plays an important part in the work of the hospitals. This education takes various forms and includes:

Physiotherapy There is an annual course of 60/70 members, mainly from the provinces and overseas. Additionally, an average of over 100 visitors a year come to the department at Brompton, mainly from overseas and particularly from North America. A standard textbook has been published in the last year.

Medical Laboratory Technology Large numbers of students, mostly from overseas, are seconded for experience. There are frequent courses and several textbooks and film strips have been produced.

Medical Social Work Apart from the ordinary teaching and lecturing programmes, three medical social workers from Brompton Hospital have had books published on their specialised work in the past decade.

National Hospitals for Nervous Diseases and Institute of Neurology

A group of three hospitals with a total bed complement of 358, of which 202 are at the hospital in Queen Square, Bloomsbury. There is also Maida Vale Hospital (84 beds), a branch hospital, and a rehabilitation unit at East Finchley (27 beds). The board of governors also administers the National Hospital-Chalfont Centre for Epilepsy at Chalfont St Peter, Buckinghamshire (45 beds) in association with the National Society for Epileptics. Recently, the board has assumed responsibility for administering the West End Hospital Speech Therapy Training School.

The hospitals enjoy a world reputation in neurological research and education. They have achieved many 'firsts' including the first successful operation for removing a spinal tumour and a cerebral tumour. This took place towards the end of the last century. More recently, research techniques have been pioneered for the examination of the peripheral nervous system and the use of computer analysis. The Institute of Neurology and the National Hospitals for Nervous Diseases did the pioneer work in neurochemistry which led to an understanding, for instance, of the abnormal biochemistry that causes Wilson's disease, a disease that was in any case originally described at the hospital in Queen Square. More recently the enlarged department of neurochemistry has been able to establish a neurochemical basis for dementia.

Much effort has been put into the diagnosis and understanding of multiple sclerosis and encouraging progress is being made. This is particularly so in the field of the experimental brain, of demyelinating lesions in animals, and in the use of evoked potentials in establishing a diagnostic test. The work carried out by a member of the institute's department of psychology in the study of the effects of brain damage on the cerebral cortex has received international recognition.

No fewer than 21 members of the staff have at one time or another been elected Fellows of the Royal Society.

There are about 120 neurological consultants in the

United Kingdom, of whom at least 94 have received all or most of their training at the institute and hospitals. There are six professors of neurology in the United Kingdom, all of whom received a major part of their training at the hospitals.

Further, the greater proportion of professors or consultants in neurology who now work abroad, received all or a considerable part of their training at Queen Square; more than at any other institute.

The school of nursing was the first to establish a truly postgraduate school. It is unique in that it attracts nurses particularly from the USA where the neurological units do not provide such training. The school provides a number of post-registration courses, and in common with other teaching hospitals, the number of applicants for nursing courses greatly exceeds the number which can be accepted.

Of the full-time nursing staff many are agency nurses. In some hospitals, agency nurses may provide a source of recruitment. It is a cause for concern that the hospital is so heavily dependent upon agency nurses and probably could not continue to function without them. However, there is also a wide use of agency nurses in the undergraduate teaching hospitals where they act sometimes as senior members of the nursing staff.

Queen Charlotte's and Chelsea Hospitals and Institute of Obstetrics and Gynaecology

Queen Charlotte's Maternity Hospital in Goldhawk Road, London, has 157 beds, and the Chelsea Hospital for Women, near the Fulham Road, SW3, has 126 beds.

Obstetrics entail a heavy local service commitment; virtually all outpatients become inpatients for delivery. Gynaecological patients tend to come from further away and mostly as inpatients.

The hospitals' laboratories provide national and international reference centres for pregnancy testing, smear tests, gynaecological pathology and virology.

The institute and hospitals are active in research concerned with bacteriology, biochemistry, haematology and immunology as they relate to conditions peculiar to women. The large department of pathology of the Royal Postgraduate Medical School also provides facilities for research as do the laboratories of the department of obstetrics and gynaecology at Hammersmith Hospital.

Like other specialist postgraduate hospitals and institutes, the Institute of Obstetrics and Gynaecology has been in the forefront as a centre for the medical education of registrars and senior registrars who in time become consultants, in turn teaching and working at hospitals throughout the country and abroad.

Courses are also provided for general practitioners with particular interest in the specialties.

In addition to the training of consultants and general practitioners, Queen Charlotte's and Chelsea hospitals are leaders in the training of midwives. This is an especially important aspect of the hospitals' work because of the increasing demand for midwives for community service.

Royal Marsden Hospital and Institute of Cancer Research

The Royal Marsden Hospital has major facilities in Fulham Road, London (209 beds) and in Sutton, Surrey (176 beds). Both deal with a wide spectrum of cancer patients with a major surgical effort centred in London. There are full diagnostic and radiotherapy facilities available at each.

The hospital together with the Institute of Cancer Research comprise the only comprehensive centre in Britain where work is devoted exclusively to cancer. Together they see as their primary role the advancement of diagnosis and treatment of malignant disease with the dissemination of improved techniques through teaching.

Since its foundation over a century ago, the hospital, latterly in association with the institute, has been in the vanguard of development in a number of clinical fields, notably radiotherapy, radiodiagnosis, surgery and, more recently, chemotherapy. The hospital and institute have established a national and international reputation which has led to the extensive referral of patients for diagnosis and treatment.

The Institute of Cancer Research has facilities in both parts of the hospital, and fundamental studies in chemistry, biology and physics are undertaken which relate to cancer. Through its academic departments of medicine, pathology, radiotherapy and social medicine, the institute is in a position to study in depth problems of human cancer. Considerable contributions have been made in the field of chemotherapy and immunotherapy, particularly in relation to the treatment of Hodgkin's disease and malignant lymphomas. A multidisciplinary unit involving institute staff and hospital clinical staff is investigating the problem of breast cancer.

The hospital's work is based on multidisciplinary units, each specialising in a particular tumour or group of tumours. This form of organisation provides the best basis for individual patient care, clinical research and postgraduate teaching, and the opportunity for close collaboration between clinicians and scientists working to a common objective.

The breadth of cancer facilities now developed by the hospital and institute can offer a comprehensive advisory service to a wide geographical area, and importance is attached to collaboration with other authorities in the evaluation and development of special services for the more effective dissemination of improved techniques. This detailed involvement in cancer services for the surrounding area is seen as a logical extension of the

hospital's and institute's national and international role, reflected by the establishment of a regional cancer service in collaboration with the former regional hospital board.

The successful nursing of patients with cancer requires expert knowledge and particular skills. As part of its postgraduate education programme, the hospital has, therefore, developed an active department of nursing studies which provides specialised training facilities in cancer nursing both for state registered and state enrolled nurses.

Royal National Orthopaedic Hospitals and Institute of Orthopaedics

The hospitals comprise two branches; one in Great Portland Street (88 beds) and a country hospital at Stanmore (308 beds). The institute has departments at Great Portland Street and Stanmore.

Although one of the principal orthopaedic service units in this country, the hospitals and institute have been moving towards a more specialist role, such as the diagnosis of bone tumours and their treatment by endoprosthetic replacement; spinal disorders, arthritis of the hip; bone and joint infections; paediatric orthopaedics; metabolic bone disease. These developments are supported by and allied to fundamental research. The problems of tissue reactions to implants; of wound healing; of immunological response to bone and cartilage transplants and infections; the characteristics and reactions of joint tissues; the epidemiology of the tumours; high and low air-loss beds; and orthopaedic appliances and surgical footwear, are amongst the main investigations from which much useful knowledge has already accrued.

Teaching is one of the main functions. The formal teaching schedule has been recently revised and reorganised to accommodate the interests of trainees in and around London as well as those of postgraduate students at the institute. Many undergraduate teaching and non-teaching hospitals participate in the first London multi-care training scheme. Since 1948 over 1200 orthopaedic surgeons from 80 countries have registered as postgraduate students and during the past ten years 65 consultant appointees have been trained.

Each department of the institute has its own programme of research activity and provides teaching in the relevant fields at both technical and professional levels. To support these clinical, teaching and research programmes, the institute has formed one of the most comprehensive libraries in diseases of the locomotor system and connective tissue disorders.

The school of nursing prepares pre-registration and pre-enrolment students for the Orthopaedic Nursing Certificate and the Diploma in Orthopaedic Nursing. Almost all students are from the United Kingdom. A shorter course is available to state registered nurses, many of whom attend from overseas. In addition to these nationally recognised courses, there is a continuous flow of nurses from other hospitals in the NHS and overseas who attend to extend their knowledge of orthopaedic nursing skills. This is considered a very important contribution. It is hoped that the hospital will become a centre for nurse research into mechanical aids to nursing.

Royal National Throat, Nose and Ear Hospital and Institute of Laryngology and Otology

The group of hospitals, in Gray's Inn Road WC1, and Golden Square W1, and residential units at Ealing W5, has some 230 beds in all.

This relatively small number of beds is no real indication of the level of activity; over 9000 inpatients and 25,000 new outpatients (90,000 attendances) are seen annually. This is the largest concentration of ENT patients in the world.

The hospital has been in the forefront of ENT developments in Europe for a century. Patients are drawn from all over the UK and overseas.

The medical staff consists of 45 consultants of various disciplines, including general medicine, neurology, neuro-otology, rhinitis, physical medicine, paediatrics, plastic surgery, psychiatry and radiotherapy.

The hospital has departments for radiology, audiology and speech therapy. Audiology for both children and adults is integrated in the Nuffield Hearing and Speech Centre which is part of the hospital in Gray's Inn Road. The adjacent hearing aid centre is the largest in the country, serving many hospitals in the London areas and issuing 3000 hearing aids a year. It also makes domiciliary visits to about 700 patients a year in homes and institutions. At Ealing there is a unit providing 45 residential courses a year for mothers in the management of their deaf children, and a further short-stay residential unit for children with hearing and other communication problems for investigation.

The institute takes advantage of the wealth of clinical material provided by the associated hospital. There is a three-year training programme for registrars and competition for this appears to be keen. The programme attracts candidates both from this country and overseas, particularly the English-speaking Commonwealth countries.

Four trainees leave the scheme each year, usually for further training posts in this country or abroad, and roughly 40 ENT consultants appointed during the last ten years received part or all of their training at this centre.

The institute also provides postgraduate courses in basic sciences, general otorhinolaryngology, general

practitioner refresher courses, and courses for medical officers of health, health visitors, audiology technicians and psychologists. Courses for advanced students, usually senior registrars or consultants, are run in aural surgery, head and neck surgery, and rhinoplasty, for which there is a waiting list of over one year.

The professorial units of surgery and pathology have active research programmes and it is intended that the audio-visual teaching facilities for all types of students shall be expanded. Since its inception in 1946, the institute has continued to grow and now occupies an established position in this country as the premier centre for postgraduate tuition in the specialty.

The school of nursing provides post-registration courses for SRNs and post-enrolment courses for SENs. Pupil nurses are attached for work on the children's wards, in their second year.

St John's Hospital for Diseases of the Skin and Institute of Dermatology

The hospital has an inpatient section at Homerton Grove (60 beds) and an outpatient department in Lisle Street, Leicester Square.

The total outpatient attendances are approximately 60,000 a year, a large proportion of which are referrals from other hospitals, particularly in the fields of histopathology, mycology, photobiology, contact dermatoses and genetics.

The departments and laboratories of the institute are divided between the two sections of the hospital in such a way that those research departments most closely linked with the outpatient service are at Lisle Street and those connected with the inpatient are at Homerton Grove.

Basic research is undertaken, particularly in the subjects mentioned above. Unique work on abnormal reactions of the skin of human beings is being done in the photobiology department. The department is also carrying out research into the effect of ultra-violet radiation in animals which has been related to skin cancer in humans.

The institute and hospital have taken part in the training of probably half the consultant dermatologists appointed in England and Wales each year over the last ten years. The only other professor of dermatology in England received his dermatological training at the institute and hospital.

In addition, the full-time senior registrar and registrar training posts provide a large proportion of the source of recruitment for consultant dermatologists throughout the country. In the last ten years, 43 doctors trained at St John's have achieved consultant status. Of these, 33 hold posts in British hospitals and the remaining ten practise overseas.

St John's provides the only postgraduate course in dermatological nursing through which approximately 35 nurses pass each year. In addition, ad hoc training is provided annually for about 40 to 50 nurses who come from other hospitals to gain experience before taking up more senior appointments in dermatological units.

St Peter's Hospitals and Institute of Urology

The four hospitals in the group are administered as a unit: they comprise St Peter's Hospital (41 beds), St Paul's Hospital (50 beds), St Philip's Hospital (26 beds) and the Shaftesbury Hospital (39 beds); 156 beds in all. The small number of beds in each hospital is a measure of the unsatisfactory accommodation with which the staff has had to contend for many years. It is for this reason that the hospitals and institute are likely to be rebuilt on a site at The London Hospital.

Although urology as a clinical specialty is widely practised in hospitals throughout the country, much of the pioneer work was done at the institute and the hospitals, and the consultants engaged in advanced work elsewhere received at least part of their training there.

Nephrology, the medical aspect of the treatment of renal disease, has also been intensively developed in the hospital. The guiding principle has been the team approach to the problems of the urinary tract by specialist physicians, surgeons, radiologists, pathologists and ancillary staff working together in a way which is seldom possible in a large general hospital. Notable among the work pioneered by the hospital and institute has been the development of many new operative techniques in relation to the kidney, the bladder, and in particular, to stricture of the urethra. Recent work has been particularly concerned with intracavitary chemotherapy of bladder tumours, preservation of kidney for transplantation by perfusion methods, and an exhaustive study of the problems and treatment of incontinence. On the medical side, investigatory work has been concerned not only with treatment of renal failure but of hypertension.

The hospital provides a reference centre both for renal dialysis, in which it has eight dialysis units, and for the control of incontinence.

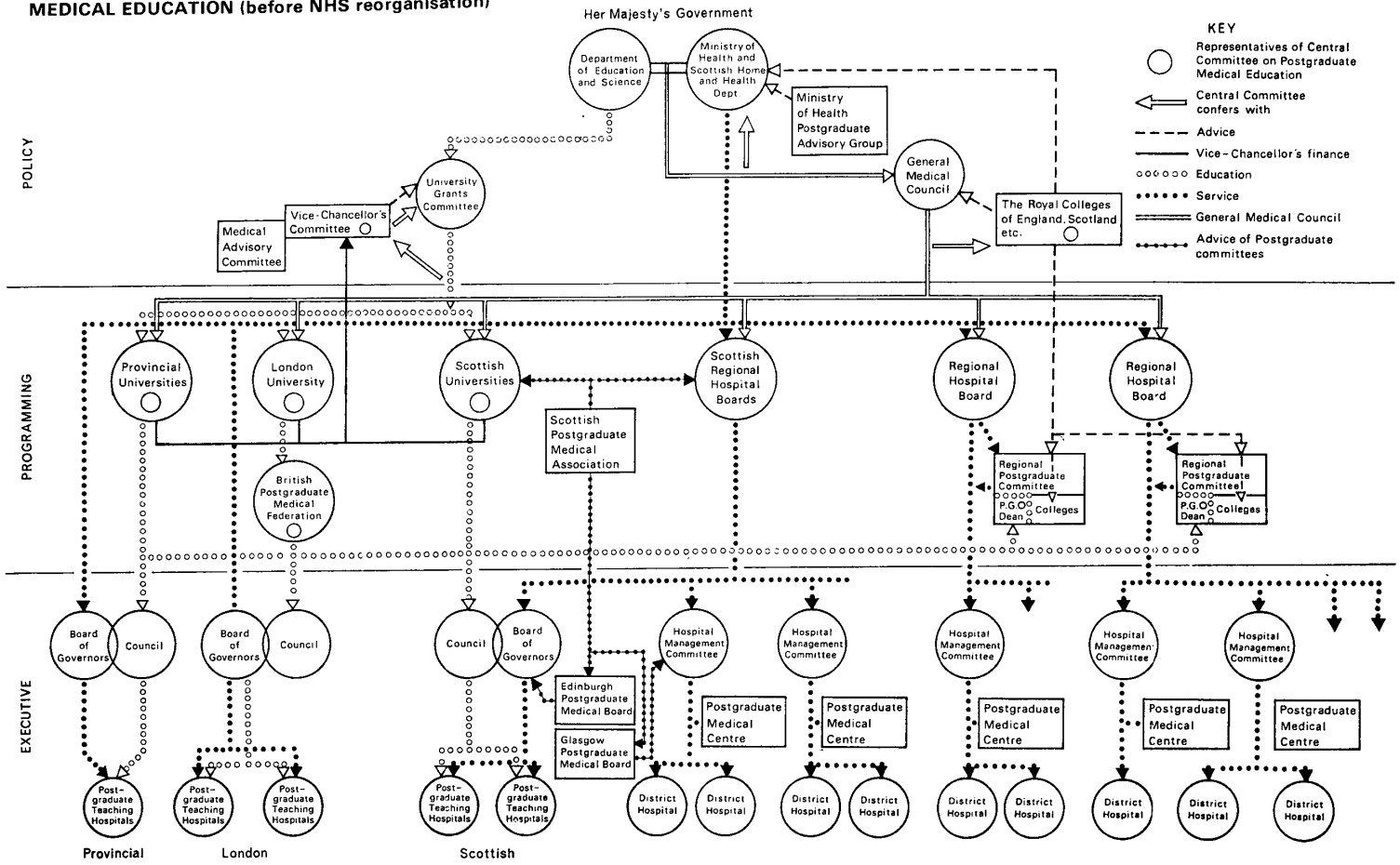
The institute provides a large number of lectures and courses in urological subjects.

The list of consultants trained in urology includes many famous names and in the last ten years 30 of the urological trainees have been appointed to consultant positions.

Not least among the hospital's departments, the school of nursing suffered considerable inconvenience from the poor accommodation until it was moved to the Shaftesbury Hospital where conditions are better.

The hospital fosters research in nursing because of the special care needed by many urological patients.

FIGURE 5 ORGANISATION OF POSTGRADUATE MEDICAL EDUCATION (before NHS reorganisation)



Source: *Postgraduate Medical Education—Retrospect and Prospect* by John Revans and Gordon McLachlan, 1967, reproduced by kind permission of the publisher, Nuffield Provincial Hospitals Trust.

Appendix 4

Academic relationships in London

Figure 6 shows the relationship of medical schools and postgraduate medical institutes to the University of London.

Figure 7 shows the proposed future arrangements including pairing of the medical schools and their links with multifaculty colleges. Also shown are the links proposed by the Todd and Murray reports[19,2] for the postgraduate institutes.

FIGURE 6 PRESENT LINKS BETWEEN UNIVERSITY AND MEDICAL SCHOOLS AND INSTITUTES

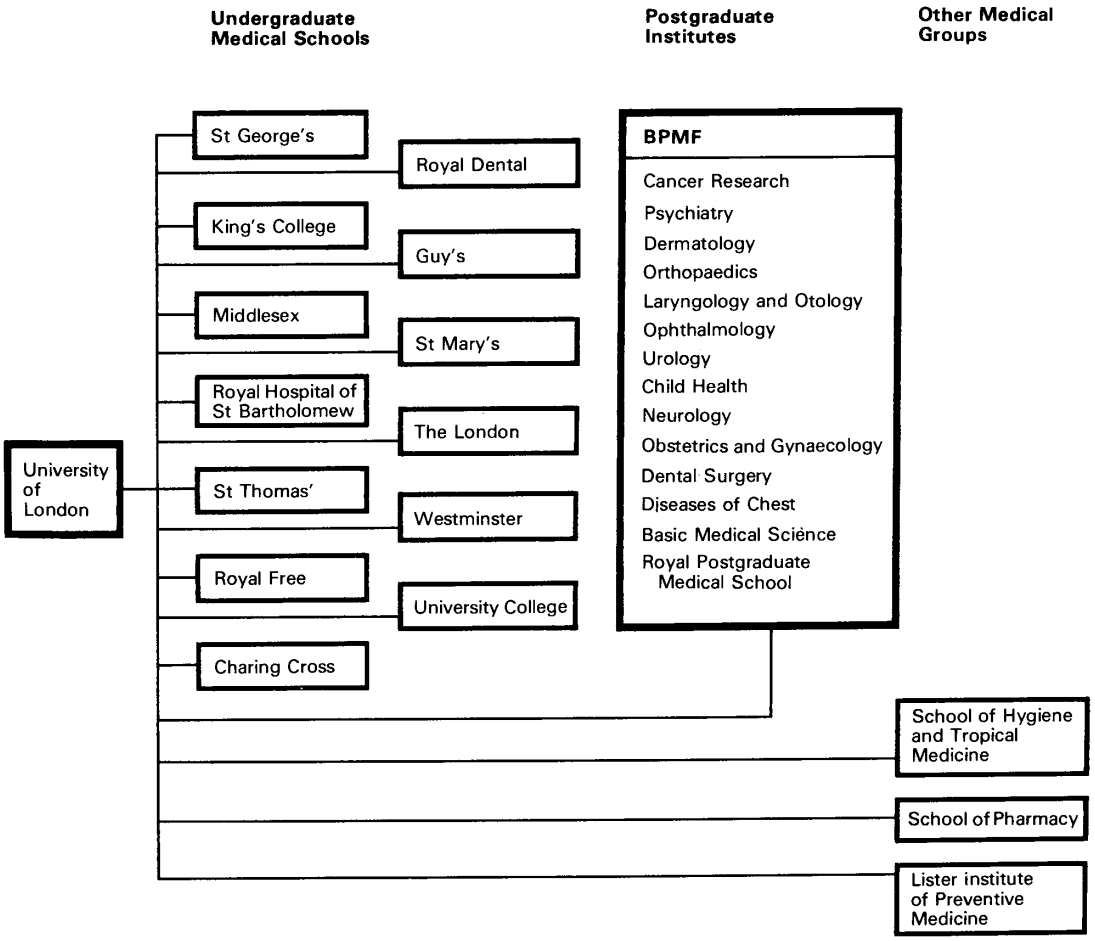
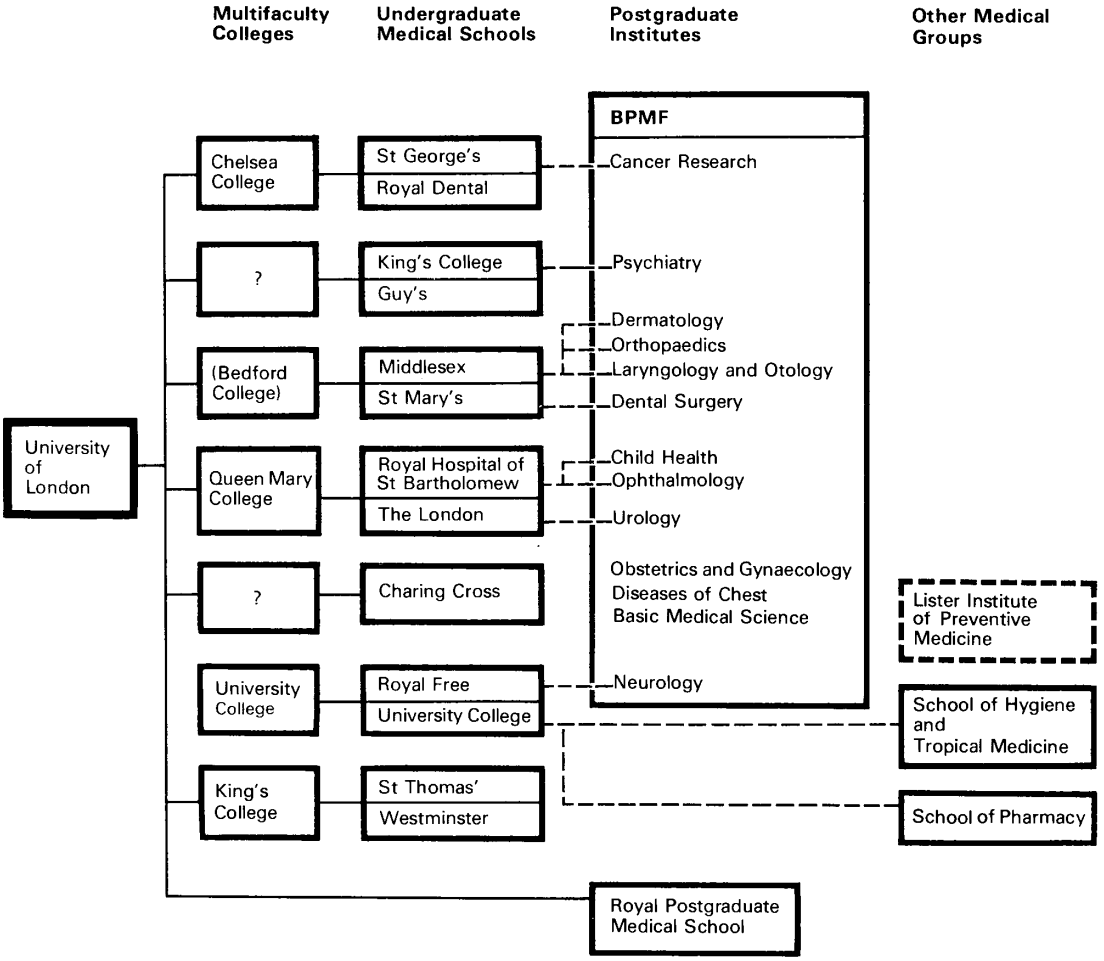


FIGURE 7 PROPOSED LINKS BETWEEN UNIVERSITY AND MEDICAL SCHOOLS AND INSTITUTES



Appendix 5

University of London

Position with Regard to the Implementation in London of the Recommendations of the Royal Commission on Medical Education

Note by the Principal *15 March 1973*

1 Undergraduate Medical Education

In August 1968 the University accepted one of the main theses of the Royal Commission 'that the future development of undergraduate medical education in London should be planned on the basis of larger units, comprising a smaller number of individual Schools' (SM 955 of October 1968).

Of the pairings suggested by the Royal Commission, four have been accepted and in two cases association with a multifaculty institution has proved feasible:

a The pre-clinical departments of St Bartholomew's HMC and The London HMC will become part of the enlarged biological sciences complex at Queen Mary College and land is being acquired for this purpose.

b University College HMS and the Royal Free HSM with an enlarged pre-clinical school at University College. No additional land is being acquired but the UGC have suggested a very substantial capital programme of redevelopment within the University College rectangle to provide the additional accommodation needed.

c The Middlesex HMS and St Mary's HMS. It has not yet been decided where the joint pre-clinical school shall be. Association with Bedford College is not feasible on any substantial scale.

d Guy's HMS and King's College HMS. Both have large dental schools. There is a serious problem here about the location of the joint pre-clinical school. No land is available at Guy's to expand its pre-clinical departments and King's College HMS has no pre-clinical school but wants one. This problem will become acute when the pre-clinical departments of King's College join in the Biomedical Centre on a site at St Thomas' Hospital since there will be no provision for the pre-clinical training of the medical and dental students of King's College HMS (see paragraph (iii) below).

The Report also recommended two further twinnings:

e Charing Cross HMS with Westminster MS

f St Thomas's HMS with St George's HMS

Neither of these twinnings materialised.

(i) Charing Cross HMS is to 'go it alone' at Fulham Palace Road where the medical school departments, pre-clinical as well as clinical, are physically an integral part of the big new hospital block.

(ii) St George's HMS is being rebuilt in conjunction with St George's Hospital on a site at Tooting with a pre-clinical school large enough to cater for the students of the Royal Dental Hospital of London School of Dental Surgery, the Royal Dental Hospital being already designated as part of the St George's Hospital group. An association is being developed with Chelsea College which is to move to a site about a mile away from the new St George's complex at Tooting.

(iii) A scheme known as the KTW project has been evolved for a biomedical centre which will comprise the biological and pre-clinical departments of King's College and the pre-clinical departments of St Thomas's HMS and will provide pre-clinical teaching facilities for St Thomas's HMS and Westminster MS. It now seems likely that the necessary site can be made available by St Thomas' Hospital and planning is actively proceeding. It was originally suggested that the Westminster Hospital should be rebuilt on the site of Queen Mary's Hospital, Roehampton, but the possibility of a rebuilding on a site at Croydon is now under consideration.

The extent to which the facilities for undergraduate education in London should be increased was finally settled by a statement issued jointly by the University and the UGC in January 1972. The final figure of the annual pre-clinical entry for London was fixed at 1200 divided as follows:

Charing Cross HMS	120
St George's HMS	150
St Bartholomew's HMC – The London HMC with Queen Mary College	200

University College HMS – Royal Free HSM with University College	200
St Thomas's HMS – Westminster MS with King's College	160
Guy's HMS – King's College HMS	195
The Middlesex HMS – St Mary's HMS	175
	1200

This in fact represents an increase of 285 in the pre-clinical entry. On the other hand, the creation of a clinical medical school at Cambridge and the expansion of the Oxford clinical school will by 1981 reduce the annual entry of students coming from these two universities for clinical training in London from nearly 300 to 60.

II Complications caused by the estimates made by the Department of Health and Social Security about the number of beds required in Inner London to satisfy service needs

The Department has put in hand a survey of the number of beds which will be required in 1981 and thereafter to satisfy service needs in the Inner London area. These surveys indicate that the number of beds required is likely to be substantially less (except for geriatrics and psychiatry) than the existing number, particularly in some of the specialties. The complexity of the problem is exemplified by the case of obstetrics. The Department came to the conclusion that only 350 obstetric beds would be required by 1981 in the boroughs of Hammersmith and of Kensington and Chelsea and of that part of the City of Westminster which is within the South West Metropolitan Regional Hospital Board, and asked the University how those beds should be allocated for teaching purposes. The University thought that in this area, in which were situated the undergraduate medical schools of Charing Cross, The Middlesex and St Mary's as well as the Institute of Obstetrics and Gynaecology based on (a) the Department of Obstetrics at the Royal Postgraduate Medical School and Hammersmith Hospital and (b) Queen Charlotte's Hospital, preference should be given to undergraduate teaching. Accordingly it took the view that 142 obstetric beds should be allocated to the twinned medical schools of The Middlesex and St Mary's and 90 to the new Charing Cross HMS, leaving 118 beds of which 70 were already in Hammersmith Hospital. The remaining 48 beds were not sufficient to operate a viable unit at Queen Charlotte's Hospital nor were 118 beds sufficient for the postgraduate teaching needs of the Institute of Obstetrics and Gynaecology. The problem was ultimately solved by a decision of the Department to rebuild Queen Charlotte's Hospital in the adjoining borough of Ealing.

There is a similar problem in ophthalmology.

The Department insists that the maximum number of ophthalmological beds which it is prepared to authorise in the Inner London area (including private beds and beds for referred cases) is 450 whereas the University's requirements are put at 486:

a For the Institute of Ophthalmology, St Bartholomew's HMC and The London HMC	250
b 44 beds for each of the other four paired medical schools	176
c 30 beds each for Charing Cross HMS and St George's HMS	60

In the case of three of the four paired medical schools referred to in (b) only one of the associated teaching hospitals will have ophthalmological beds though both will have ophthalmological outpatient departments.

III Postgraduate Medical Education

One of the main theses of the Royal Commission (paras 450–51) was that it is a mistake to separate undergraduate and postgraduate medical education. Accordingly, it recommended that the special hospitals should be rebuilt 'in close geographical proximity to the general teaching hospital groups (or possibly embedded within the structure of large general teaching hospitals)' and that the postgraduate institutes should be linked to and ultimately become part of the twinned undergraduate medical schools. Incidentally, this recommendation highlights one of the major differences between the Royal Commission's proposals for undergraduate medical schools and postgraduate institutes.

Though St Bartholomew's HMC and The London HMC are paired, there has never been any suggestion that St Bartholomew's Hospital and The London Hospital should be built on the same site; the integration, however, of the Institute of Ophthalmology with the twinned medical schools of St Bartholomew's and The London does involve the rebuilding of Moorfields Hospital as an integral part of either St Bartholomew's Hospital or The London Hospital. Hence the recommendations of the Royal Commission on postgraduate medical education could not be implemented unless the Department of Health was brought fully into the discussions alongside the University and the University Grants Committee.

After prolonged consultations the pattern which is emerging is as follows:

a Cases where it is uneconomic to move the specialist hospital and institute from their existing sites

(i) The National Hospitals for Nervous Diseases and the Institute of Neurology will remain in Queen Square and a large rebuilding programme has been agreed.

(ii) The Hospitals for Sick Children and the Institute of Child Health will remain on the adjoining site in

Great Ormond Street and Guildford Street and will share some facilities with the National Hospitals for Nervous Diseases and the Institute of Neurology. The other hospital designated as part of the Hospitals for Sick Children Group, namely the Queen Elizabeth Hospital, Hackney, remains part of the group but now houses a professorial paediatric unit serving both St Bartholomew's HMC and The London HMC.

(iii) The Institute of Psychiatry is associated with the Bethlem Royal and Maudsley Hospitals. The latter is situated on Denmark Hill opposite King's College Hospital and Medical School. The Maudsley Hospital and the Institute of Psychiatry will develop increasingly closer links with King's College Hospital and Medical School through the creation of chairs tenable jointly at both institutions but there will be no formal merger.

b Cases where rebuilding of specialist hospitals and institutes in close association with a general hospital and undergraduate medical school has been or is likely to be agreed

(i) The St Peter's Hospitals and the Institute of Urology will be rebuilt as part of The London Hospital and Medical College complex.

(ii) St John's Hospital for Diseases of the Skin (now temporarily located in the Eastern Fever Hospital) and the Institute of Dermatology will be rebuilt as part of The Middlesex Hospital and Medical School complex.

(iii) St Mark's Hospital for Diseases of the Rectum and Colon, which is designated as part of the Hammersmith Hospital Teaching Group despite being situated on the opposite side of London, will be rebuilt as part of an enlarged St Bartholomew's Hospital. An academic department of gastroenterology will be built at the Charterhouse Square site of St Bartholomew's HMC.

(iv) The Eastman Dental Hospital and the Institute of Dental Surgery will be rebuilt in association with the St Mary's Hospital and Medical School complex.

(v) Moorfields Hospital will be rebuilt as part of the enlarged St Bartholomew's Hospital and the Institute will be rehoused in Charterhouse Square in association with St Bartholomew's HMC.

(vi) The Royal National Throat, Nose and Ear Hospital and the Institute of Laryngology are likely to form part of The Middlesex Hospital and Medical School complex.

c Remaining cases

(i) The Boards of Governors of the Brompton Hospital and the National Heart Hospital were merged in April 1972 and the Committees of Management of the Institutes of Diseases of the Chest and Cardiology followed suit in August. The present plan is to build a 450 bed Cardiothoracic centre in or near the Fulham Road on which the combined institutes would be based.

(ii) The Royal Marsden Hospital and the Institute of Cancer Research are based in the Fulham Road with an outstation at Sutton. One possibility would be to develop the Hospital and Institute at Sutton perhaps in collaboration with the new St George's Hospital and Medical School at Tooting.

(iii) The Institute of Basic Medical Sciences has no hospital affiliation and will remain on its present site.

(iv) The Stanmore branch of the Royal National Orthopaedic Hospital and of the Institute of Orthopaedics will continue to function and it has been suggested that the town branches of both Hospital and Institute should be rebuilt as part of The Middlesex Hospital and Medical School complex.

IV The Future of the British Postgraduate Medical Federation

If the recommendations of the Royal Commission for postgraduate medical education in London had been practicable in all cases, then with the impending return of the Royal Postgraduate Medical School to its former status as a School of the University in receipt of grant directly from the Court, the raison d'être of the Federation as a body for allocating the portion of the University's block grant devolved to postgraduate medical education would have disappeared though the Federation has other important functions, which, if not discharged by it, would have to be entrusted to some other body or bodies. At least four postgraduate institutes, however, will not be merged into general medical schools and, moreover, even those institutes which are to be so merged are expected to have an initial period of at least five years during which their finances come by way of an earmarked grant. There is therefore every reason for continuing the Federation for the foreseeable future though at the same time dropping the adjective 'British' from its title and modifying its constitution as the Royal Commission on Medical Education recommended (para 452). The Murray Committee (paras 138–39) expressed the view that with the phasing out of this grant allocation function the British Postgraduate Medical Federation should eventually disappear and its two other major functions should be handed over to other bodies. These are:

a the organisation of postgraduate and post-experience medical education in the London area; and

b the provision of the advisory service for overseas medical students and practitioners.

No decision has yet been taken about these recommendations.

V The London School of Hygiene and Tropical Medicine

The Royal Commission recommended that as the London School of Hygiene and Tropical Medicine was

associated with the Hospital for Tropical Diseases which is under the Governors of University College Hospital, and as the School has an important part to play in postgraduate medical education, it should be associated with the University College HMS/Royal Free HSM pair. It is, however, actively examining several possible associations, including one with UCHMS/RFHSM, in the light of its plans for future academic development but a final decision has not yet been taken.

D W LOGAN
15 March 1973

Appendix 6

Patient origin survey

A special survey of patient data was carried out to establish a recent and comprehensive assessment of the origins of patients attending for both inpatient and outpatient treatment at the London specialist postgraduate hospitals. The data were collected from each of the postgraduate hospital groups for the three-month period January to March 1973. The first quarter of the year was chosen because it was felt to be more representative of hospital service activities than either of the two middle quarters which would include holiday periods for both patients and hospital staff. Further, although each of the hospitals had previously formed its own assessment of the dispersion of its patients and although 1971 HIPE data were available, these were felt to be insufficient and inconclusive.

HIPE data fell short in a number of ways. First, they dealt only with inpatients. Outpatients considerably outnumber inpatients in all but two hospitals (St Peter's group, and Royal National Orthopaedic, Great Portland Street), and therefore form a significant proportion of the hospital service load. Because of this, information concerning outpatient origins was deemed essential. Secondly, for HIPE collection purposes the term 'new' patient has a rather loose interpretation which permits over-weighting of certain patient categories; if a patient is admitted to hospital for tests, then released and subsequently readmitted for further treatment, he will be counted twice. This is useful when trying to ascertain bed usage, but not when attempting to discover the dispersion of patients, since a single patient may be counted more than once and so his home location given extra weight. Thirdly, more recent data than the HIPE data would have been desirable.

This survey could not hope to produce data as comprehensive as HIPE data because we could not collect and analyse the sheer volume of data in the time available. However, a three-month sample (25 per cent) was aimed for. This involved all new patients – new in the sense that they had either never visited the hospital before or not previously for their present debility. By this definition it was hoped to eliminate any double counting. Likewise, a patient was defined as an inpatient in two different ways:

if, during the three month survey period, he was at any time an outpatient and previously, or subsequently, became an inpatient (also during the survey period), or

if an inpatient only during the period.

Patients were defined as outpatients if they had not been admitted throughout the survey period. By this means it was hoped to avoid any double counting of patients both as new outpatients and as new inpatients during the three-month survey period.

Day patients were to be shown separately, as certain hospitals felt that these were a significant group; this has, however, been largely disproved by the survey, since the number of day patients was found to be negligible, with the single exception of the Royal National Orthopaedic Hospital (see Table 20).

The home location of patients was of primary interest. Tables 16, 17 and 18 show these locations and the individual hospitals separately, as well as hospital groups as a whole. As their locations were often far distant from each other, clarity would have been lost if the group only had been shown.

Table 16 compares the results of our data collection with the 1971 HIPE data, and in the main these are comparable. However, there seems to be a trend (see especially the Hospitals for Sick Children, Royal National Orthopaedic Hospital and National Hospitals for Nervous Diseases) for an increasing number of patients to come from Greater London than from the rest of the United Kingdom. This implies that the hospitals are serving the populations of a smaller, more compact, area than hitherto.

Table 17 shows both outpatient and inpatient percentages for the area health authority, for the Greater London Council areas and for the UK as a whole for each hospital and its group where applicable. From a comparison of the outpatient and inpatient data, it can be seen that outpatients are far less dispersed than inpatients for every hospital. The figures for the Royal National Orthopaedic Hospital show a slightly distorted picture because the Stanmore branch of the hospital is on the GLC border; approximately half of its immediate locality is outside not only the AHA but also the GLC, thus, although this hospital services its immediate locality to a greater extent (38 per cent of outpatients

from Hertfordshire) than many other hospitals, this is not shown by the presentation of the data. Likewise the National Chest Hospital at Frimley, situated on the Surrey-Hampshire border, draws 38 per cent of its patients from Surrey and Hampshire, and this reliance on the locality does not appear in the table. The same applies to the Sutton branch of the Royal Marsden Hospital which, being on the GLC-Surrey border, relies heavily on Surrey patients (26 per cent outpatients, 25 per cent inpatients).

Table 18 shows the largest catchment borough for each hospital and compares this with local boroughs and AHA. This was considered necessary because of the impracticability of showing reliance of hospitals on the locality by only showing percentages for the AHA.

Many AHAs consist of very small populations; for example, Camden and Islington AHA contains only 5 per cent of the GLC population, Kensington and Chelsea and Westminster AHA, $5\frac{1}{2}$ per cent of the GLC population, as opposed to, say, Lambeth, Southwark and Lewisham AHA, which contains 11 per cent. Not only do they contain small populations but the AHAs also cover small areas in which the hospitals are not ideally situated to provide for their communities. Moorfields Eye Hospital provides a good example of poor coverage by the AHA. Both branches of the hospital are on the very boundary of Camden and Islington AHA (High Holborn on the Camden-Westminster border, and City Road on the Islington-Hackney border), thus its AHA does not provide for the immediate locality. The four so-called local boroughs have been arbitrarily chosen in an attempt to provide an immediate locality. This has not always been easy owing to the geographical location of the hospital combined with the pattern of London boroughs, the four most local ones not always being obvious. The Bethlem Royal and Maudsley hospitals which have been classed together as one hospital but which consist of two distinct units physically removed from each other, provided yet another type of problem. However, a general picture can be obtained from the use of even these not altogether satisfactory divisions.

Outpatients again appear to be more concentrated and locally oriented than inpatients, especially for the minor (as opposed to the main) branches in several groups (National, Maida Vale; Queen Elizabeth, Hackney Road; and Royal Orthopaedic, Stanmore).

As can be seen from the boroughs providing the largest patient loads, patients rarely cross the River Thames. Although Lambeth and/or Southwark could be defined as local boroughs for many of the hospitals situated in Westminster, South Camden, Islington or Hackney, it is not worth considering them as such because in central and east London, mobility across the river in a northerly direction for hospital purposes seems to be negligible. Further to the west this does not seem to apply. Wandsworth supplies many patients for the hospitals situated in Kensington and Chelsea and Hammersmith. Mobility seems to be easiest in a radial direction; this is illustrated very strongly by the identification of Barnet and Haringey as the highest catchment boroughs for the hospitals situated in South Camden, Islington and Westminster. Barnet and Haringey are both more distant than, for instance, Hackney, yet they provide a far greater number of patients.

The boroughs with the largest service loads for each hospital are listed in order of the highest patient catchment (see Table 19). They are in the main similar for both outpatients and inpatients, although with some change in their order of importance.

The general picture to be gained from Table 18 is that the hospitals situated in the South Camden, Islington and Westminster areas (the very central area), do not attract the bulk of their patients from the immediate locality but from the north to north-west section of the GLC. The other hospitals situated further from the central area rely more heavily on their locality. This is especially apparent for outpatients in hospitals to the east of London and near the perimeters of the GLC [remembering that the GLC percentage underestimates the reliance on locality of the Royal National Orthopaedic Hospital (Stanmore), and the Royal Marsden Hospital (Sutton)].

Table 19 gives a breakdown of the patients' route to each hospital. For both outpatients and inpatients, percentages are given for each type of emergency and referral, with subtotals for these two groups.

Status is also shown with headings NHS and Other, which comprises both private and overseas patients.

Few hospitals seem to accept emergency cases, the exceptions being the Bethlem Royal and Maudsley hospitals which run a 24-hour emergency service, the Eastman Dental Hospital and Moorfields Eye Hospital which have large casualty departments, the Royal Orthopaedic Hospital, Stanmore, and the Queen Elizabeth Hospital for Sick Children.

The majority of these emergency cases come directly to hospital without any intermediary medical contact. A high proportion of patients of the Eastman Dental and Moorfields Eye hospitals have nothing seriously wrong with them that could not be dealt with by their own dental practitioner or oculist, but either because they have not registered with a local practitioner, or because they have greater confidence in the hospital, they come to the hospital directly as 'emergencies'.

The largest number of patients for all the postgraduate teaching hospitals are referred by their own GPs. This applies to outpatients, inpatients relying to a greater extent on referral from other hospitals. The numbers of 'other' referrals are insignificant except in three cases, all of which are explicable. The Royal Orthopaedic Hospital, Stanmore, counts its 'other' referrals as patients who, before the survey period, had come to the

hospital as emergency cases and then progressed to outpatient or inpatient status during the survey period. Thus, their route to the hospital is unknown. The 'other' referrals of the London Chest Hospital were mostly referred by the local medical officer of health. The Bethlem Royal and Maudsley hospitals get some of their patients referred by such organisations as the Camberwell Reception Centre and these have been entered under the 'other' heading.

The Brompton and London Chest hospitals offer a variety of services to local GPs, such as ECG, x-ray, pathology laboratory, and respiratory examinations. The data for these have not been included in these tables, since the patients using these services are not classed as outpatients and would therefore distort the outpatient data. The Brompton Hospital dealt with 2699 cases, and the London Chest Hospital with 223. These, expressed as percentages, show:

Service	Brompton Hospital	London Chest Hospital
path lab	60	24
x-ray	27	12
ECG	13	45
respiratory	—	—
four local boroughs	90	44

The general pattern which has emerged from the survey is one of service for the GLC. Hospitals rely heavily on their immediate localities as catchment areas for patients. However, this applies to a lesser extent to hospitals located in the most central area of London, where there is a relatively sparse population. Movement across the river by patients is negligible from Westminster to the East End of London.

With the three exceptions already discussed, emergency work is insignificant, the vast majority of patients being referred by their GPs and other hospitals.

Outpatients and inpatients follow similar patterns but outpatients are less widely dispersed and rely less heavily on hospital and private referral.

Note: In the following tables area health authorities are referred to by numbers. Their full titles are:

1	City and East London AHA	North West Thames RHA
2	Redbridge and Waltham Forest AHA	
3	Barking and Havering AHA	
4	Camden and Islington AHA	
5	Enfield and Haringey AHA	
6	Barnet AHA	North East Thames RHA
7	Kensington and Chelsea and Westminster AHA	
8	Hillingdon AHA	
9	Brent and Harrow AHA	
10	Ealing, Hammersmith and Hounslow AHA	
11	Kingston and Richmond AHA	South West Thames RHA
12	Merton, Sutton and Wandsworth AHA	
13	Croydon AHA	
14	Lambeth, Southwark and Lewisham AHA	South East Thames RHA
15	Bromley AHA	
16	Greenwich and Bexley AHA	

TABLE 16 SUMMARY OF GEOGRAPHIC ORIGINS OF INPATIENTS COMPARED WITH HIPE DATA

Postgraduate Hospital Group	Hospital	Source of Inpatients (percentage) AHA	In AHA	Rest of GLC	Rest of UK	Total Patients
Bethlem Royal and Maudsley	—	14	45 *	34 *	19 *	**535**
Eastman Dental	—	4	11 *	78 *	11 *	**79**
Hospital for Sick Children	Great Ormond Street	4	9 (6)	46 (34)	38 (55)	**889**
	Queen Elizabeth	1	65 (68)	27 (17)	8 (9)	**591**
	Group	—	— —	38 (29)	12 (41)	**1480**
Moorfields Eye	City Road	4	7 *	55 *	35 *	**573**
	High Holborn	4	1 *	48 *	31 *	**78**
	Group	4	7 (11)	53 (49)	35 (34)	**651**
National Heart and Chest	Brompton	7	15 (19)	38 (38)	30 (31)	**574**
	London Chest	1	51 (47)	27 (33)	20 (18)	**311**
	Frimley	—	— *	44 *	56 *	**407**
	National Heart	7	8 (5)	39 (36)	49 (55)	**193**
	Group	—	— —	—	37 —	**1485**
National Hospitals for Nervous Diseases	Queen Square	4	5 (7)	50 (44)	38 (47)	**468**
	Maida Vale	7	5 (20)	66 (51)	26 (27)	**260**
	Group	—	— —	56 (45)	39 (43)	**728**
Queen Charlotte's	Queen Charlotte's	10	51 (66)	48 (24)	1 (6)	**999**
	Chelsea Hospital	7	24 (19)	56 (46)	18 (24)	**685**
	Group	—	— —	51 (33)	8 (13)	**1684**
Royal Marsden	Fulham Road	7	13 (12)	53 (58)	21 (24)	**167**
	Sutton	12	32 (30)	29 (31)	38 (34)	**171**
	Group	—	— —	41 (49)	30 (27)	**338**
Royal National Orthopaedic	Great Portland Street	7	4 (10)	65 (53)	29 (35)	**302**
	Stanmore	9	21 (17)	23 (19)	56 (57)	**84**
	Group	—	— —	56 (30)	34 (50)	**386**
Royal National Throat, Nose and Ear	Gray's Inn Road	4	6 *	77 *	16 *	**505**
	Golden Square	7	9 *	73 *	17 *	**276**
	Group	—	— —	75 *	16 *	**781**
St John's	—	7	8 (6)	67 (75)	25 (19)	**183**
St Peter's Hospitals	St Peter's	7	8 (5)	59 (57)	22 (35)	**120**
	St Paul's	4	4 (8)	61 (68)	24 (22)	**94**
	St Philip's	7	4 (7)	34 (47)	35 (46)	**51**
	Shaftesbury	4	7 (2)	43 (45)	48 (45)	**121**
	Group	—	— —	50 (57)	36 (34)	**386**

* No comparable HIPE data

Note: Figures in brackets are percentages taken from 1971 HIPE data.

TABLE 17 SUMMARY OF GEOGRAPHIC ORIGINS OF INPATIENTS AND OUTPATIENTS

Postgraduate Hospital Group	Hospital	Source of Patients (percentage) AHA	In AHA		In GLC		UK		Total Patients	
			OP	IP	OP	IP	OP	IP	OP	IP
Bethlem Royal and Maudsley	—	14	48	45	87	79	100	97	**872**	**535**
Eastman Dental	—	4	28	11	87	89	100	100	**1976**	**79**
Hospital for Sick Children	Great Ormond Street	4	14	9	78	55	100	93	**1187**	**889**
	Queen Elizabeth	1	74	65	98	92	100	100	**1327**	**591**
	Group	—	—	—	88	70	100	96	**2514**	**1480**
Moorfields Eye	City Road	4	16	7	82	62	100	97	**2861**	**573**
	High Holborn	4	13	1	81	49	100	80	**1374**	**78**
	Group	4	15	7	82	60	100	95	**4235**	**651**
National Heart and Chest	Brompton	7	24	15	82	53	99	83	**1019**	**574**
	London Chest	1	87	51	99	78	100	98	**1381**	**311**
	Frimley	—	0	0	0	44	100	100	**8**	**407**
	National Heart	7	19	8	72	47	98	96	**253**	**193**
	Group	—	—	—	90	55	99	92	**2661**	**1485**
National Hospitals for Nervous Diseases	Queen Square	4	6	5	71	55	100	93	**1018**	**468**
	Maida Vale	7	19	5	88	71	100	97	**298**	**260**
	Group	—	—	—	75	61	100	94	**1316**	**728**
Queen Charlotte's	Queen Charlotte's	10	—	51	—	99	—	100	—	**999**
	Chelsea Hospital	7	25	24	85	80	100	98	**802**	**685**
	Group	—	—	—	85	91	100	99	**802**	**1684**
Royal Marsden	Fulham Road	7	16	13	69	66	86	87	**1161**	**167**
	Sutton	12	37	32	61	61	96	99	**474**	**171**
	Group	—	—	—	67	63	89	93	**1635**	**338**
Royal National Orthopaedic	Great Portland Street	7	14	4	73	69	100	98	**242**	**302**
	Stanmore	9	33	21	60	44	100	100	**995**	**84**
	Group	—	—	—	63	64	100	98	**1237**	**386**
Royal National Throat, Nose and Ear	Gray's Inn Road	4	16	6	81	83	99	99	**996**	**505**
	Golden Square	7	16	9	86	82	99	99	**483**	**276**
	Group	—	—	—	83	83	99	99	**1479**	**781**
St John's	—	7	10	8	84	75	100	100	**3249**	**183**
St Peter's Hospitals	St Peter's	7	6	8	82	67	99	99	**150**	**120**
	St Paul's	4	9	4	78	65	100	89	**130**	**94**
	St Philip's	7	7	4	66	38	100	73	**53**	**51**
	Shaftesbury	4	5	7	81	50	100	98	**42**	**121**
	Group	—	—	—	78	57	98	93	**375**	**386**

Table 18 continued

Hospital	Four Boroughs to which Highest Volume of Service Given				Four Local Boroughs			AHA		
	Borough	OP%	Borough	IP%	Borough	OP%	IP%	Borough	OP%	IP%
Queen Charlotte's and Chelsea										
Queen Charlotte's	—	—	Ealing Hammersmith Hounslow Kensington and Chelsea	63	Kensington and Chelsea Hammersmith Wandsworth Ealing	—	52	Ealing Hammersmith Hounslow (10)	—	51
Chelsea	Kensington and Chelsea Hammersmith Wandsworth Hounslow	51	Kensington and Chelsea Hammersmith Wandsworth Ealing	44	as Queen Charlotte's	49	44	Kensington and Chelsea Westminster (7)	25	24
Royal Marsden										
Fulham Road	Kensington and Chelsea Hammersmith Wandsworth Westminster	31	Hammersmith Kensington and Chelsea Bromley Wandsworth	30	as Highest Service OP Borough	31	27	Kensington and Chelsea Westminster (7)	16	13
Sutton	Sutton Merton Kingston Croydon	45	Merton Kingston Wandsworth Sutton	43	as Highest Service OP Borough	45	39	Sutton Merton Wandsworth (12)	37	32

TABLE 18 SUMMARY OF SERVICE TO LONDON BOROUGHS

Hospital	Four Boroughs to which Highest Volume of Service Given				Four Local Boroughs			AHA		
	Borough	OP%	Borough	IP%	Borough	OP%	IP%	Borough	OP%	IP
Bethlem Royal and Maudsley	Southwark Lambeth Lewisham Bromley	54	Southwark Lambeth Westminster Lewisham	49	Southwark Lambeth Lewisham Croydon	53	48	Southwark Lambeth Lewisham (14)	48	
Eastman Dental	Islington Haringey Camden Enfield	47	Kensington and Chelsea Haringey Havering Islington	42	Islington Camden Haringey Hackney	46	26	Camden Islington (4)	28	
Hospital for Sick Children										
Great Ormond Street	Islington Barnet Haringey Enfield	27	Barnet Islington Camden Enfield	19	Camden Hackney Islington Westminster	19	13	Camden Islington (4)	14	
Queen Elizabeth	Hackney Tower Hamlets Islington Waltham Forest	84	Hackney Tower Hamlets Newham Islington	73	Camden Hackney Islington Tower Hamlets	78	64	City Hackney Tower Hamlets Newham (1)	74	
Moorfields Eye										
City Road	Islington Hackney Haringey Newham	34	Islington Hackney Haringey Newham	22	Islington Camden Westminster Hackney	25	16	Camden Islington (4)	16	
High Holborn	Camden Kensington and Chelsea Westminster Barnet	26	Westminster Kensington and Chelsea Wandsworth Brent	24	as City Road	21	10	as City Road	13	
National Heart and Chest										
Brompton	Kensington and Chelsea Wandsworth Hammersmith Westminster	44	Wandsworth Kensington and Chelsea Hammersmith Westminster	31	as Highest Service	44	31	Kensington and Chelsea Westminster (7)	24	
London Chest	Hackney Tower Hamlets Newham Redbridge	90	Hackney Tower Hamlets Newham Havering	57	Tower Hamlets Hackney Islington Newham	88	53	City Hackney Newham Tower Hamlets (1)	87	
National Heart	Westminster Barnet Brent Camden	28	Westminster Barnet Camden Haringey	19	Westminster Kensington and Chelsea Camden Lambeth	17	13	Kensington and Chelsea Westminster (7)	19	
National Hospitals for Nervous Diseases										
Queen Square	Enfield Barnet Ealing Camden	19	Barnet Hounslow Brent Richmond	14	Camden Islington Hackney Westminster	12	9	Camden Islington (4)	6	
Maida Vale	Brent Camden Westminster Barnet	55	Brent Ealing Barnet Richmond	32	Brent Camden Westminster Kensington and Chelsea	54	18	Kensington and Chelsea Westminster (7)	19	

continued overle

Table 18 continued

Hospital	Four Boroughs to which Highest Volume of Service Given				Four Local Boroughs			AHA	
	Borough	OP%	Borough	IP%	Borough	OP%	IP%	Borough	OP%
Queen Charlotte's and Chelsea									
Queen Charlotte's	—	—	Ealing Hammersmith Hounslow Kensington and Chelsea	63	Kensington and Chelsea Hammersmith Wandsworth Ealing	—	52	Ealing Hammersmith Hounslow (10)	—
Chelsea	Kensington and Chelsea Hammersmith Wandsworth Hounslow	51	Kensington and Chelsea Hammersmith Wandsworth Ealing	44	as Queen Charlotte's	49	44	Kensington and Chelsea Westminster (7)	25
Royal Marsden									
Fulham Road	Kensington and Chelsea Hammersmith Wandsworth Westminster	31	Hammersmith Kensington and Chelsea Bromley Wandsworth	30	as Highest Service OP Borough	31	27	Kensington and Chelsea Westminster (7)	16
Sutton	Sutton Merton Kingston Croydon	45	Merton Kingston Wandsworth Sutton	43	as Highest Service OP Borough	45	39	Sutton Merton Wandsworth (12)	37
Royal National Orthopaedic									
Great Portland Street	Westminster Barnet Haringey Camden	31	Camden Brent Barnet Haringey	24	Westminster Camden Brent Kensington and Chelsea	25	17	Kensington and Chelsea Westminster (7)	14
Stanmore	Harrow Barnet Brent Hillingdon	55	Harrow Barnet Brent Haringey	40	as Highest Service OP Boroughs	55	39	Brent Harrow (9)	33
Royal National Throat, Nose and Ear									
Gray's Inn Road	Haringey Islington Hackney Barnet	36	Haringey Islington Newham Hackney	16	Islington Westminster Camden Hackney	26	10	Camden Islington (4)	16
Golden Square	Westminster Harrow Ealing Brent	39	Harrow Ealing Westminster Brent	35	as Gray's Inn Road	16	12	Kensington and Chelsea Westminster (7)	16
St John's	Barnet Brent Westminster Ealing	24	Brent Haringey Kensington and Chelsea Barnet	21	Westminster Camden Islington Hackney	15	10	Kensington and Chelsea Westminster (7)	10
St Peter's									
St Peter's St Philip's	Brent Camden Lewisham Barnet	30	Barnet Brent Camden Westminster	16	Westminster Camden Islington Hackney	17	13	Kensington and Chelsea Westminster (7)	6
St Paul's Shaftesbury	Barnet Westminster Waltham Forest Islington	26	Brent Greenwich Westminster Islington	19	as St Peter's and St Philip's	17	12	Camden Islington (4)	8

Note: Figures in brackets refer to AHAs, see list page 88.

Table 18 continued

Hospital	Four Boroughs to which Highest Volume of Service Given				Four Local Boroughs			AHA	
	Borough	OP%	Borough	IP%	Borough	OP%	IP%	Borough	OP%
Queen Charlotte's and Chelsea									
Queen Charlotte's	—	—	Ealing Hammersmith Hounslow Kensington and Chelsea	63	Kensington and Chelsea Hammersmith Wandsworth Ealing	—	52	Ealing Hammersmith Hounslow (10)	—
Chelsea	Kensington and Chelsea Hammersmith Wandsworth Hounslow	51	Kensington and Chelsea Hammersmith Wandsworth Ealing	44	as Queen Charlotte's	49	44	Kensington and Chelsea Westminster (7)	25
Royal Marsden									
Fulham Road	Kensington and Chelsea Hammersmith Wandsworth Westminster	31	Hammersmith Kensington and Chelsea Bromley Wandsworth	30	as Highest Service OP Borough	31	27	Kensington and Chelsea Westminster (7)	16
Sutton	Sutton Merton Kingston Croydon	45	Merton Kingston Wandsworth Sutton	43	as Highest Service OP Borough	45	39	Sutton Merton Wandsworth (12)	37
Royal National Orthopaedic									
Great Portland Street	Westminster Barnet Haringey Camden	31	Camden Brent Barnet Haringey	24	Westminster Camden Brent Kensington and Chelsea	25	17	Kensington and Chelsea Westminster (7)	14
Stanmore	Harrow Barnet Brent Hillingdon	55	Harrow Barnet Brent Haringey	40	as Highest Service OP Boroughs	55	39	Brent Harrow (9)	33
Royal National Throat, Nose and Ear									
Gray's Inn Road	Haringey Islington Hackney Barnet	36	Haringey Islington Newham Hackney	16	Islington Westminster Camden Hackney	26	10	Camden Islington (4)	16
Golden Square	Westminster Harrow Ealing Brent	39	Harrow Ealing Westminster Brent	35	as Gray's Inn Road	16	12	Kensington and Chelsea Westminster (7)	16
St John's	Barnet Brent Westminster Ealing	24	Brent Haringey Kensington and Chelsea Barnet	21	Westminster Camden Islington Hackney	15	10	Kensington and Chelsea Westminster (7)	10
St Peter's									
St Peter's St Philip's	Brent Camden Lewisham Barnet	30	Barnet Brent Camden Westminster	16	Westminster Camden Islington Hackney	17	13	Kensington and Chelsea Westminster (7)	6
St Paul's Shaftesbury	Barnet Westminster Waltham Forest Islington	26	Brent Greenwich Westminster Islington	19	as St Peter's and St Philip's	17	12	Camden Islington (4)	8

Note: Figures in brackets refer to AHAs, see list on page 38

	Croydon		Sutton							
Royal National Orthopaedic										
Great Portland Street	Westminster Barnet Haringey Camden	31	Camden Brent Barnet Haringey	24	Westminster Camden Brent Kensington and Chelsea	25	17	Kensington and Chelsea Westminster (7)	14	4
Stanmore	Harrow Barnet Brent Hillingdon	55	Harrow Barnet Brent Haringey	40	as Highest Service OP Boroughs	55	39	Brent Harrow (9)	33	21
Royal National Throat, Nose and Ear										
Gray's Inn Road	Haringey Islington Hackney Barnet	36	Haringey Islington Newham Hackney	16	Islington Westminster Camden Hackney	26	10	Camden Islington (4)	16	6
Golden Square	Westminster Harrow Ealing Brent	39	Harrow Ealing Westminster Brent	35	as Gray's Inn Road	16	12	Kensington and Chelsea Westminster (7)	16	9
St John's	Barnet Brent Westminster Ealing	24	Brent Haringey Kensington and Chelsea Barnet	21	Westminster Camden Islington Hackney	15	10	Kensington and Chelsea Westminster (7)	10	8
St Peter's										
St Peter's St Philip's	Brent Camden Lewisham Barnet	30	Barnet Brent Camden Westminster	16	Westminster Camden Islington Hackney	17	13	Kensington and Chelsea Westminster (7)	6	7
St Paul's Shaftesbury	Barnet Westminster Waltham Forest Islington	26	Brent Greenwich Westminster Islington	19	as St Peter's and St Philip's	17	12	Camden Islington (4)	8	6

Note: Figures in brackets refer to AHAs, see list page 88.

TABLE 19 SUMMARY OF TYPES AND ORIGINS OF PATIENTS (PERCENTAGES)

Hospital		Emergency				Referred						Status	
		Home	GP	Other	**Total**	Hospital	GP	Private	Overseas	Other	**Total**	NHS	Other
Bethlem Royal and Maudsley	OP	12	14	6	**32**	12	38	—	—	18	**68**	100	—
	IP	10	10	5	**25**	33	15	—	3	24	**75**	95	5
Eastman Dental	OP	46	30	4	**80**	2	18	—	—	—	**20**	100	—
	IP	3	30	—	**33**	—	66	—	—	1	**67**	100	—
Hospital for Sick Children													
Great Ormond Street	OP	6	—	—	**6**	10	79	—	—	5	**94**	100	—
	IP	2	3	—	**5**	37	39	7	6	6	**95**	86	14
Queen Elizabeth	OP	30	4	9	**43**	2	55	—	—	—	**57**	100	—
	IP	19	2	1	**22**	16	62	—	—	—	**78**	100	—
Moorfields Eye													
City Road	OP	23	11	5	**39**	4	53	—	—	2	**59**	100	—
	IP	2	3	1	**6**	15	66	—	2	11	**94**	96	4
High Holborn	OP	48	10	3	**61**	6	29	—	—	3	**38**	99	1
	IP	—	1	—	**1**	2	24	50	21	1	**98**	29	71
National Heart and Chest													
Brompton	OP	—	—	—	—	15	78	—	2	5	**100**	99	1
	IP	—	—	—	—	14	53	6	17	10	**100**	78	22
London Chest	OP	—	—	—	—	20	46	—	—	34	**100**	100	—
	IP	—	—	—	—	49	49	1	—	—	**99**	97	2
National Heart	OP	—	—	—	—	11	85	—	1	3	**100**	98	2
	IP	—	9	1	**10**	52	32	2	2	1	**89**	96	4
Frimley	OP	—	—	—	—	—	100	—	—	—	**100**	100	—
	IP	—	13	—	**13**	87*	—	—	—	—	**87**	100	—
National Hospitals for Nervous Diseases													
Queen Square	OP	—	—	—	—	10	82	3	3	1	**99**	99	1
	IP	—	3	3	**6**	37	44	4	5	2	**92**	92	8
Maida Vale	OP	—	—	—	—	5	95	—	—	—	**100**	100	—
	IP	—	2	—	**2**	55	40	—	3	—	**98**	94	6
Queen Charlotte's and Chelsea													
Queen Charlotte's	OP	—	—	—	—	—	—	—	—	—	—	—	—
	IP	—	—	1	**1**	—	90	9	—	—	**99**	91	9
Chelsea	OP	—	—	—	—	6	90	—	—	3	**99**	100	—
	IP	—	1	—	**1**	10	72	13	—	4	**99**	85	15

continued overleaf

Table 19 continued

Hospital		Emergency				Referred						Status	
		Home	GP	Other	Total	Hospital	GP	Private	Overseas	Other	Total	NHS	Other
Royal Marsden													
Fulham Road	OP	—	—	—	—	26	52	6	11	5	**100**	70	30
	IP	—	—	—	—	38	44	4	11	3	**100**	78	22
Sutton	OP	—	—	—	—	45	46	1	2	5	**99**	92	8
	IP	—	—	—	—	42	41	2	2	12	**99**	93	7
Royal National Orthopaedic													
Great Portland Street	OP	—	—	—	—	13	86	—	—	—	**99**	100	—
	IP	1	—	—	**1**	19	70	6	3	1	**99**	90	10
Stanmore	OP	26	1	1	**28**	1	29	—	—	41	**71**	100	—
	IP	37	1	—	**38**	2	—	—	—	60	**62**	100	—
Royal National Throat, Nose and Ear													
Gray's Inn Road	OP	2	2	3	**7**	4	85	1	—	3	**93**	98	2
	IP	—	1	1	**2**	7	85	2	1	3	**98**	96	4
Golden Square	OP	8	4	2	**14**	2	82	—	1	—	**85**	98	2
	IP	2	1	2	5	17	69	9	—	—	**95**	88	12
St John's	OP	—	—	—	—	4	89	1	—	6	**100**	100	—
	IP	—	—	2	2	13	78	2	—	5	**98**	98	2
St Peter's Hospitals													
St Peter's	OP	—	2	—	**2**	5	90	1	1	1	98	98	2
	IP	—	2	—	**2**	17	78	1	1	1	**98**	98	2
St Paul's	OP	—	—	—	—	9	88	1	—	1	**99**	100	—
	IP	2	2	—	4	22	46	19	9	—	**96**	72	28
St Philip's	OP	—	—	—	—	30	57	2	4	7	**100**	91	9
	IP	—	2	—	**2**	47	25	4	20	2	**98**	73	27
Shaftesbury	OP	—	—	—	—	50	45	2	—	—	**99**	100	—
	IP	—	—	—	—	87	8	2	1	2	**100**	96	4

* Including 20 per cent from Brompton

TABLE 20 SUMMARY OF DAY PATIENTS AT FOUR HOSPITALS

Hospital	Patients	Four Local Boroughs	GLC	Emergency	Referred	
					Hospital	GP
Bethlem Royal and Maudsley	7	5	6	3	—	3
Hospital for Sick Children (Great Ormond St)	34	7	28	—	1	32
National Heart and Chest	6	—	—	—	—	—
Royal National Orthopaedic	52	13	42	—	7	36

Note: All figures are expressed as numbers, not as percentages.

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