"LONG LIVE THE SMALL ‘ACUTE’ HOSPITAL"

In

GLOBAL SERVICE

OF

REMOTE AND/ OR RURAL COMMUNITIES

A POST MORTEM?

Surgery already lost to 10 local hospitals in N. I.
Insufficient trolleys in bigger hospitals to receive the overflow?

‘LONG LIVE THE SMALL HOSPITAL’

The title taken from an article
written by Rex Lawrie FRCS,

Published by
John Robb FRCS, FRCS(I) (ad eundum), LLD (Hons)

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This pamphlet is a revised edition of papers circulated to the New Ireland Group, the Viking Surgeons and the many other people campaigning in Northern Ireland to have their traditional acute

FOREWORD

Although this booklet has been written as a result of experience as a Viking Surgeon it is also a reflection of the actions proposed in the New Ireland Group's 'Communitarian Manifesto, published in 2003 (see especially, page 58 Section VI. 'REMEDY'). The Aims and Role of the Group will be circulated with the booklet.

COMMUNITY RELATIONS

Good Community Relations underlie the breaking down of social barriers whatever their origin: sectarian, ethnic, social class, colour etc. This is a global issue yet it is an issue particularly germaine to areas like Northern Ireland where divisions have been particularly deep and where the 'gulf of unreality'[1] between people has been expanded by the bad blood of violence.

Nowhere are these barriers more likely to soften than as a result of the shared experience in the ward of a local hospital and that is one reason why we would appeal for support to have this pamphlet published.

ACKNOWLEDGEMENT

As author I am indebted to members of the following groups with which I have had association for their help in stimulating the thinking, discussion and debate around local Community Health and the role of the local community Acute Hospitals in conjunction with a need to explore current democratic practice in sustaining this valuable social resource.

New Ireland Group, The Viking Surgeons, The New Hospital Campaign Group, The Northern Neighourhood Health Action Zone (N.N.H.A.Z.) which, in Co. Antrim, provides support and encouragement to local communities deemed to be suffering from social deprivation; The Glebeside Community Association (Ballymoney) gained greatly from the support which it has received from HAZ and I gained much from my association with both of these groups.

‘LONG LIVE THE SMALL HOSPITAL’

OBITUARY TRIBUTE

TO

THE LATE RONNIE CUMMING FRCS.

This pamphlet is dedicated to the memory of the life of the late Ronald (Ronnie) Cumming FRCS, founder member along with Martin Crossfill FRCS of the Viking Surgeons.
The ‘Vikings’ were inaugurated in 1973.

Ronnie served the Shetland Islands from the hospital in Lerwick as a single-handed multi-purpose surgeon for over 30 years. Early on he became acutely aware of the need to share experience and learn from others, to integrate in order to perpetuate the collective well being of rural and/or remote communities. He realised that surgeons working in isolation — and there were a lot of them back then — would become dated in their practice to the detriment of the patients entrusted to them. He also realised that the simple solution, so easy yet so facile, was, for central academic medical and surgical departments and senior administrators to bring about the down-grading of the smaller acute hospitals as the prelude to having them closed. For the sake of the morale and well-being of the rural and/or remote communities concerned he believed passionately that such a policy had to be stubbornly resisted and, wherever it existed, changed, so that the acute local services to which the people were accustomed, would be preserved, developed and improved without loss of an institution which gave confidence to the local community served by it.

Ronnie believed that standards could only be maintained by establishing two way communication and exchange with the specialist services which were developing rapidly within the Health Service..

He gave a lead with his co-founders for a three-sided annual Viking conference which would be convened primarily to learn about advances in surgical practice and thinking yet which would also include a cultural programme to keep us grounded in the localities in which we were operating. He also believed that the social aspect of such meetings was important in establishing friendship and sustaining communication.

Meetings have now been held in Iceland, Shetland, Orkney, Faraoes, Lewis, Skye, Isle of Man, Penzance, Wick, Golspie, Elgin, Oban, Fortwilliam, Coleraine and Ballymoney and contacts have been made with the surgical unit in Kirkenes at Norway's North Cape and also with Derby in the Northern Territories of Australia.

Perhaps this booklet may help to raise awareness about the hopes and fears, which many share yet few articulate, of a less centralist, less imperialist domination of local community life. Communities will not survive if subjected to fragmentation of their services be it through the loss of small schools, small businesses or small acute hospitals.

As far as good community relations are concerned, the small local hospital, dealing with local A & E as well as the more chronic presentations of pathology in the locality, is a great leveler as well as a means of breaking down ethnic, social and sectarian barriers which separate us from each other.

Ronnie Cumming played a vital and integral role in the community which he served probably best exemplified by being chosen to be a member of the annual UP Helly Aa event in Shetland.

Much of the thought for action which is herein published has been written with the commitment of the late Ronnie Cumming in mind. Ronnie worked extremely hard to provide a surgical service for the people of Shetland. He enjoyed life to the full and was always at the centre of the social activity at our annual meetings. We shall miss him

terribly at our meetings in future.

This short tribute, however, would be incomplete if it did not include an expression of gratitude to his wife, Norma, who stood by him through all the ups and downs of the long distance surgical runner. It is an opportunity to register our thanks and to tender our sympathy to her at this time of bereavement and it is to be hoped that she will feel free to join us at our annual meetings on all future occasions.

Malt whisky will never taste the same again.

John Robb, Convenor of the Viking Surgeons (1987)
Founder & Consensor, The New Ireland Group.(1981‡)

VIKING SURGEONS:

SURGERY in CO. TYRONE, Gone!
and
MID-ULSTER and CO. MONAGHAN under threat!

AND NOW,

DAISY HILL, NEWRY, a city hospital under threat, and what about the acute services in the hospital of the other new city of LISBURN?

Will Acute surgery also come under threat in the Causeway Hospital, COLERAINE?

ELIMINATION OF ACUTE UNITS AND HOSPITALS FROM THE RURAL

AND/OR REMOTE COMMUNITIES: SOME OBSERVATIONS

by John Robb, MB., FRCS, FRCSI (ad eundum). LLD. (hon)

STARTING WITH CONCLUSIONS:

Health: defined as 'a state of well-being' by The New Ireland Group and in the 1970s by its predecessor, The New Ireland Movement

Centralisation: "The present-day centralisation of all forms of life of the mind is a monstrosity amounting to spiritual murder"
Alexander Solzhenitsyn: 'Letters to the Soviet Leaders': (1974) page 38

The Establishment: "The medical establishment has become a major threat to health"[1]
Ivan Illich: 'Medical Nemesis' or 'The Expropriation of Health'
Also, David Horobin : Illich's chief critic; in his book, 'Medical

1 Limits to Medicine/ Medical Nemesis: The Expropriation of Health: Ivan Illich: Marion Boyers: PART I. Clinical Iatrogenesis: page 1.:line 1.(1976).
2 Medical Hubris: A Reply to Ivan Illich: David F. Horrobin: Churchill Livingstone: (1978) Chapt. 11: pages 86, 91 (bottom para)., 97 (mid 2nd. Para).

Hubris'[2]

HOLD ON OR CLAIM BACK: IT CAN BE DONE

SECTION I
The Achilles Heel

Introduction:
The incredible decision to leave County Tyrone, Mid-Ulster and County Monaghan without their traditional locally developed acute hospital units flies in the face of the definition of 'Health' as a 'state of well-being'.

In recent times, the perfectly reasonable and natural desire of local people to retain what their forbears had created and sustained for them is dismissed by statements such as – *"We can't afford a hospital at every cross-roads, you know!"* The use of that kind of oblique innuendo questions not only the integrity of those who are protesting about a step by step downgrading leading ultimately to loss of yet another local community institution, in this case the local acute hospital with its surgical, medical, obstetrical and gynaecological units; it also suggests a loss of integrity among those who have to resort to such emotive obfuscation.

No-one associated with a campaign to keep a local hospital operating its acute services has ever, as far as I am aware, said or implied any such thing. Yet, from time to time, we hear about the 'hospital at every cross-roads argument', made by those whose agenda encourages the removal of small hospitals serving rural and /or remote local communities and rarely as a result of working in one of these hospitals or of living in the service of such a community.

Achilles Heel:
For almost sixty years, the Achilles Heel of the Acute Hospital service in rural and /or remotely located communities has lain in the provision of a satisfactory surgical service. To a considerable degree

this vulnerability has resulted from a desire at the centre of the Health establishments to hold a disproportionate amount of power and control. There is a belief abroad that professional excellence may only be found and maintained in large centrally located hospitals. Such a viewpoint is frequently held by persons who may well have little or no serious experience of working in those hospitals and units which they desire to close; furthermore, they do not usually have any direct accountability to those who will be most affected by their decisions, the local providers and the local users. The closure of small peripherally based institutions may also be attractive to some professionals as a means of obtaining a larger slice of the available financial cake for the larger centrally placed institutions in our regional cities.

It seems reasonable to conclude that justification of the prevailing centralising philosophy is, indeed, pursued by administrators, professionals and others who hold a disproportionate amount of power and control without commensurate accountability to those providers and users who are affected by their decisions. It adds insult to injury when it is so commonly implied that professional excellence may only be found and maintained in large centrally based hospitals: that excellence cannot be found elsewhere!
Such an attitude is particularly strange when we consider that the selection of medical students for university entrance, their undergraduate education and their **basic** post-graduate training in 'General' Surgery is, for all practical purposes, much the same whether they end up as consultants in a large Teaching hospital or in a small peripheral hospital located in a rural and /or remote community

Capacity and Limitation:
Rex Lawrie FRCS, long time consultant surgeon in Guys' Hospital, London, was to write in the prestigious Annals of the Royal College of Surgeons of England that only 10-15% of all acute cases presenting at the doors of the small Acute hospitals should require transfer to super-specialist units elsewhere. His article written

some time ago, is entitled, *'Long live the small hospital'*. It need hardly be added that when a patient falls into the very seriously ill category of the 10-15%, s/he should be transferred without any delay. Part of work practice in the peripheral hospital service is the ability to acknowledge what is beyond personal and hospital capacity and to recognise limitations (see p. 34).

Funding, Training and Practice:
Is it right therefore to discriminate disproportionately, in terms of personnel and resources, in favour of the Big and the Central at the expense of the Small and Peripheral? The latter may make greater – certainly quite different - demand on the personal as well as the professional resources of the surgeon.
In any case, the so called 'General' surgeon in a Teaching Hospital has a significantly different practice compared to the 'General' surgeon working in a small local hospital. *The question therefore arises as to whether the training is appropriately different?*

Community Surgery: the surgery of the Commonplace:
Not surprisingly, the title, 'General' in an era of super-specialisation downgrades the expertise of those surgeons so labelled, be they working centrally or 'locally'. As more and more so called 'General' surgeons working in the Central Hospitals are opting for expertise in one of the specialities and as the economic base of a Health Service could not sustain the staff and equipment for the development of such specialised interests in every small hospital, we argue that there should be a new title given to the practice of surgery in the smaller acute hospitals which serve rural and/ or remotely placed communities and that such an appropriate title should encourage a special training programme in its wake.

Nowadays, there are excellent training programmes for Cardiac, Thoracic, Hepato-biliary, Orthopaedic, Colo-Rectal, Plastic, Urological surgery and so on; so too, we would argue that there should be a programme of training devised to meet the special requirements of surgeons wishing to be appointed to small acute hospitals so that they may meet the expectation of the 85-90% of

surgical problems presenting at the doorstep of the hospital. **'Community Surgery' or 'Surgery of the Commonplace' may seem appropriate titles for such a new 'specialty'.**

Resources and Priorities:

Back in the 1980s attention was drawn to the population figures of the 1981 census in which, in round figures, the population of Belfast was recorded as ~320,000 and that of the Northern Health and Social Services' Board Area as ~379,000. Even making allowance for the referral of 10-15% of patients from the rest of any given region it was always suspected that the regional cities throughout the United Kingdom and Ireland received a disproportionate funding pro-rata of the total population. In Northern Ireland, for instance, of the 15% of acute surgical problems requiring reference for treatment not available locally, we should expect the Area (Intermediate) Hospitals to filter off say 5% leaving only 10% of total referrals from that area to end up in Belfast.

When studying discrepancy in funding application on population pro-rata basis, account must obviously be taken of the greater cost of super-specialist treatment and care. Against that, however, we should weigh in the balance the need to create greater *social health* in terms of well-being by encouraging de-centralising in all forms of activity, delivery of a Health Service being no exception. When people work in smaller institutions there is greater scope through leadership, to encourage co-operation and to relate more positively to the relevant local community. It becomes much easier to introduce and sustain flexibility in the solution of logistical and other problems.

Centralists may well retort by refuting Rex Lawrie's figures on the grounds that the centres can show that more than 15% of acute surgical problems are being referred to them and, further, that the respective cities have grown in population since Mr. Lawrie made his appeal public. This is certainly the case in Belfast since the declaration of the ceasefires (1994) followed by the Good Friday Agreement

(1998), the Saint Andrew's Agreement (2006) and now in anticipation of regional government.

If, however, it is correct that accelerating centripetal movement is to continue unchecked, should we not be asking if we are really creating a healthier society. Admittedly, the Health Service is only one part of this insidious process which leads inevitably to more and more local community fragmentation and to greater and greater likelihood of urban implosion: trolley waits and traffic log-jams; being symptomatic of the early stage of this.
Regarding the questioning of the Rex Lawrie assertion, we must ask **why,** if true, is it that central hospitals find themselves receiving more than the 10-15% of the acute cases presenting at the smaller acute hospitals and that, inter alia, is what this booklet sets out to do:-

To sum up so far:

• We need a transparently fair allocation of funds on a pro-rata basis taking into account the extra expenditure required to meet the challenges of super-specialist practice and we also need to factor in finance to ensure that social balance is maintained through an appropriate level of de-centralisation.[3]
• We need novel structures to engage clinical personnel, administration, key professional and Trade Union representatives and active user involvement, all coming together in open forum to determine priorities in relation to the funds available, to learn about the difficulties and to raise awareness concerning the problems involved in solving them. These matters will be dealt with in **Section VI.** (Page 61)
• We need to feel more confident that those who are making the decisions are likely to become much more accountable to those who are most directly affected by those decisions.

[3] See the formula on page 63

[4] Note, the recent appeal from Australia for trained doctors to practise in rural and/or remote districts to fill vacancies by Australian medical graduates who would prefer working in the cities

• We need a fresh appraisal of the way undergraduates are conditioned at university regarding their living in, and service to, Rural and / or Remotely located communities not only in Ireland and Britain but also elsewhere throughout the world where there is still a great need for appropriately trained doctors – surgeons in particular — competent in caring for the commonplace. They will need to have their clinical and practical skills well honed so that they may cope effectively. even if working under very basic conditions, in some small remotely situated hospital. [4]

• We need to consider yet again how post graduates are trained to meet the challenge of responding to the expectation of people who live in rural and/or remotely located communities in the U.K. and Ireland as well as elsewhere in Europe and in areas of the non-European world where an adequate and appropriate local acute surgical service is urgently required.

• Training and re-training on a sabbatical basis in conjunction with disciplined audit procedure and re-assessment of knowledge and skills should be part of on-going surgical and medical career experience.

Challenging the prescribed wisdom of the status quo:

During their undergraduate experience, intelligent school leavers with the best of G.S.E results or with high marks in the Irish Republic's Leaving Certificate or in the Scottish Highers may well enter Medical School with strong vocational motivation for medical, surgical, obstetrical hospital practice. Yet they are too readily conditioned, albeit inadvertently, into believing the fallacy that good practice – the practice of 'excellence' – may only be found in the units of large Teaching Hospitals. Thus the embryonic surgeon may lose vocational ambition to work in a small hospital in the service of rural and/or remote communities whether here or elsewhere in the world. In Northern Ireland, such outlook is aggravated when medical graduates, especially the more gifted ones, seem to believe that there is no worthwhile life-long work satisfaction to be had outside of Belfast! That is arrant nonsense.

Worse still, the trainee surgeon begins to lose what should be the prerogative of all intelligent young people – the desire and ability to challenge the 'prescribed wisdom' of the status quo. It is depressing that there is so little challenging open debate with expressed dissent by juniors to seniors about the politics, philosophy and ethics of medical practice, its organisation and its administration; the former feel so dependent on the latter for professional advancement that they tend to settle for silence rather than any hint of opposing dissent.

The few who still decide, willy-nilly, that they will apply for surgical posts in a rural and/or remotely located community are faced with two further very significant difficulties.

Training: How relevant? The litigation impediment:
Firstly, the trainee may have difficulty in finding a training programme specifically tailored to meet the challenge of surgical practice in the service of a rural and/or remotely located community; if those who are being trained for rural/remote community service as 'General Surgeons' have also been obliged to develop, in the context of current General Surgical training, a specialist interest in keeping with those other 'General Surgical' Trainees destined for City Hospital practice we should ask if, in the time available, a well developed special interest is to be achieved at the expense of practical competence in the overall generality of surgery required to meet the local people's expectation for the 85% of their acute hospital requirements.

It should of course be a practical choice made by the trainee who may feel that some specialty exposure is what he/she needs to equip him/herself to service a local community in which he/she hopes to work. Even so, it should not be under taken at the expense of the overall training requirement to meet the demands of the repertoire of surgery which rural and/or remote practice may demand.
Any change, however, has also to take cognisance of how ambitious

lawyers may operate to ensure that the 'non-expert' remains increasingly vulnerable to due legal process. This then becomes a political matter if a balance is to be achieved which will give 'peripheral' hospital practitioners the confidence to feel, that they are working on a level playing field as far as competence in relation to legality is concerned.

If the smaller peripheral hospital is to survive it must be able to meet the reasonable expectations of the public who present at its doors.

With today's emphasis on super-specialist practice and the legal implications which this has placed on the profession, not to mention the cost to the Health Service, it is simply not possible, without a huge transformation in attitude and organisation for today's trained 'general' surgeon to provide the overall local service which the public has been traditionally conditioned to expect. This should not, however, imply that we should not try nor should it suggest any denial of reference to super-specialists if and when the clinical problem demands such.

Obligatory Research:

Secondly, and even more frustrating for many trainees, most especially if they become genuinely interested in the challenge of surgery in rural and/or remotely located communities is the pressure they may be placed under to spend 2-3 years on a research project at the behest of the head of the local University surgical department. Too often the pressure to undertake such a research project becomes the means to enhancement of the reputation of the department by using the intelligent young trainee for this achievement. All too often the project does not stem from the trainee's own mind in choosing a particular problem about which s/he feels personally motivated.
The motivation of many trainees in undertaking this research period may very simply be the chalking up of a research degree on his/her Curriculum Vitae (C.V). Considerable sums of money will be involved and many animals may be used and die in the process.

This will be justified by the claim that it is a 'mind developing' process when the period might, with much greater benefit, have been spent on honing skills in practical surgery relevant to the type of post to which the trainee aspires.

Money, Time and Animal Suffering:

'Considerable sums of money will be involved and many animals may die in the process.' In one case, back in the late sixties, the researcher received £1,200 grant to undertake surgery on greyhounds to reduce an induced high pressure of blood passing to the liver in the portal venous system by way of simulating the effect of portal cirrhosis and then, later, in a further operation, dealing with the resulting rise in Portal Vein Blood pressure. Many of the dogs developed lethal diarrhoea and, quite frankly the researcher was disgusted by the obvious suffering which was being caused. Although the results led to a paper being read at the prestigious meeting of European Vascular surgeons in Warsaw (1970 or 1971) the work was not pursued to obtain the CV-enhancing post graduate degree! Indeed the so-called intellect-enhancing benefits of such research were more likely to come about through the writing of a number of political pamphlets dealing with the tortured state of Ireland at that time.

There are horses for courses and it is surely misplaced for career enhancing professors to ride on the back of post graduates who may have no laboratory training, let alone aptitude, for a research project which takes up so much time at a particularly significant juncture in their lives.

VIKING SURGEONS:

Elimination of acute units and hospitals from the Rural and/or Remote Communities both here and elsewhere

FURTHER OBSERVATIONS

SECTION, II

THE VIKING SURGEONS

Viking Surgeons:

Having been appointed consultant surgeon to a large Teaching hospital and subsequently to a small hospital in a rural community and having become a member of the Viking Surgeons in Scotland in 1978 it has been gratifying to observe how successful the 'Vikings' have been in raising awareness about the daunting surgical challenges facing surgeons working in the service of remotely located or otherwise rural communities. That the 'Vikings' have striven hard to play a positive role in the resolution of the difficulties should speak for itself.

Over the past 25 years membership of the Viking Surgeons has been drawn from North-West Iceland, Shetland, Orkney, Lewis and Harris, Uist, Isle of Mann, Portree on Skye, Gibraltar, Penzance, Wick, Golspie, Elgin, Oban, Fortwilliam, Coleraine and Ballymoney. Contact has also been made with Kirkenes on the North Cape of Norway and with Derby in Australia's Northern Territories.

These surgeons have a vocational commitment to serving rural and/or remotely located communities and so they have been struggling for change in surgical training and for greater intra-professional communication and sharing of experience.

At last they have succeeded in obtaining from the Royal Colleges of Surgeons in Edinburgh and Glasgow, acknowledgement of the special position which their practice should hold in relation both to the development of a change in undergraduate attitudes and in the post graduate training of so-called 'General' surgeons.

As a result there is a new feeling of confidence that students in Scotland will be encouraged increasingly to spend more time with expanding exposure to the clinical and social conditions of work in remote and/or rural communities and that post-graduate training for surgical practice in such communities will be more appropriate than it has been in recent times. This is in keeping with the Rural Community Development Movement which encourages community integration to replace the community fragmentation which has brought about the decline in rural community morale and esteem in recent years.

As already indicated, those who are appointed to large Teaching Hospitals and those who are appointed to smaller, peripheral hospitals have had similar undergraduate teaching, similar examinations and similar **basic** post graduate training. The basic preparation for appointment will thus be much the same yet one is destined for security and advanced technological support while the other faces uncertainty with the continual threat of down-grading of her/his post, inevitably resulting in de-skilling of his/her repertoire of surgery. **Over time this results in the erosion of valuable and hard- learned surgical skills which is bound to be at no little cost to the state.**

Source of undergraduate teaching and clinical experience:

As an aside, many students will testify to the valuable learning experience which they have when attached to the acute surgical unit of a small peripheral hospital located in a rural and/or remotely located community. They value in particular the closer contact with the patients and the exposure to a wider range of clinical problems, greater opportunity to gain experience and confidence in becoming proficient in the simple practical skills which they may need after

graduation when they are junior house officers. Additionally, they will have much greater opportunity to become more intimately involved with the consultant on a one-to-one basis in relation to patient management and treatment.

De-skilling; Erosion by stealth: and by statistic:

In the current rationalising process many consultant appointees to the smaller hospitals may gradually become de-skilled as their hospitals are subjected , firstly to erosion by stealth – one department this year, another next year, with the result that morale and confidence in hospital personnel and public alike are undermined.

Following erosion by stealth, comes erosion by statistic which, in this cybernetic era, takes little cognisance of the power associated with the position to select the parameters by which others, to whom the 'powerful' are not directly accountable, may be judged. Having selected the parameters which will **re-enforce** the judgement of 'failure' to achieve selected standards, the results when publicised serve to strengthen an induced public perception that citizens would be crazy to continue to attend let alone support their local hospital!!

As de-skilling proceeds and morale begin to plummet, even those members of the public who campaigned in support of their local hospital will, understandably, begin to vote with their feet and so the downhill slide to closure is accelerated. On the road to the point of closure many people will suffer: in particular, personnel and patients. In turn this affects the morale and well-being of the local community. 'Rationalisation', which may sound good in itself, becomes 'Centralisation' which may be counter-productive as it leads to all kinds of problems for human communication with the result that general efficiency may then be the major casualty. The cohesive integrity of yet more small local communities is fragmented, their sense of well-being undermined.

In this regard, and at the expense of repeating an oft quoted statement, it may be appropriate to remind ourselves of the conclusion of the outspoken and courageous Soviet dissident, the Nobel Laureate, Alexander Solzhenitsyn, who stated, in a letter written to the Soviet Leaders in the early 1970s, that **"the centralisation of all forms of life of the mind is a monstrosity amounting to spiritual murder".**

management, for a change, consider the possibility of rationalising towards the 'small' and peripheral? Must we for ever rationalise towards the big and the central?

Standards:

Whatever about these observations they must not be interpreted as suggesting that the public accept other than high standards of care, treatment and outcomes wherever they may be hospitalised.

However, unlike the Health Service in Scotland which has been influenced by the Scottish Viking Surgeons, it sometimes seems that there has been insufficient imagination elsewhere in how best to compensate for remoteness and/or small scale hospital enterprise through development in the use of tele-medicine, video-conferencing and other possibilities created by the new Information Technology. These adjuncts should be further expanded by the provision of more active *direct* communication between central specialised 'experts' and surgeons working to service rural and/or remote communities.

Thus, specialised centrally located working expertise should be persuaded or induced to make working visits to peripheral units on a regular basis. Likewise, consultant surgeons working in the periphery might be induced to travel to assist at particularly complicated procedures on any of the patients whom they have transferred to the central specialist unit. Instead of being de-skilled through down-grading we would have enhanced skilling through further exposure and experience. The capacity of personnel, individually, as well as that of their institutions, collectively, would over time be much enhanced.

The obligatory use of sabbatical leave periods for up-dating surgical practice and re-assessment should be mandatory.

'Long Live the Small Hospital':

Rex Lawrie, who worked throughout his career as a Consultant Surgeon in Guys' Teaching Hospital, London, gave this title to one of

his publications in the prestigious Annals of the Royal College of Surgeons, 'Long Live the Small Hospital'. In that he suggested that 85-90% of all hospitalised ill health could be treated in the small local acute hospital. He acknowledged that 10-15% of patients might need to be transferred, a number which would depend on **the capacity and limitation** of the hospital concerned depending upon whether these — *capacity and limitation* — were expanding or contracting locally.

Naturally, capacity and limitation are bound to vary over time (see page 34) and will depend on the development and sustaining of skills as well as on the quality of support and communication as already described. Neither are static entities. **Ongoing rigorous audit of results is vital.** Nevertheless, **local people** should be provided with opportunity for significant input into the selection of the parameters by which their local service is assessed. Decisions which may affect their health and well-being will surely be most realistically made as a result of an informed collective input into the decision-making process through discussion between representatives of user and provider, both professional and managerial.[1]

Health — a state of 'well-being':
As long ago as the 1970s, members of the present New Ireland Group who were then members of its predecessor, the New Ireland Movement, were defining 'Health' as a 'state of individual and collective community well-being', the opposite being the state of *'dis*-ease' of which there is no shortage in the over-centralised and increasingly complex society of today.

One further observation: the effect of technological imperialism:
An increasing number of graduates seem most concerned about opportunity to use the latest gadget, (most especially if they have been trained to use it and have been persuaded that nothing else can

[1] Democratic Accountability in a District Health Service' : Pamphlet out of the New Ireland Group: (1992). See also Remedy Section VI p.61 of this booklet.
[2] Many years ago I received a telephone call from an elderly Presbyterian minister who had taken exception to my use of the word, 'best' during a radio interview. "Young man, you have yet to learn that 'the best' is but an illusion' 'Whoever uses it should always be asked about the basis on which s/he has made this conclusion. 'Appropriate ' would seem to be less presumptive and more relevant.

compete with such, described as to them as the 'best')[2]. This is understandable yet should we not be asking whether it is happening at the expense of how a caring and curing agenda might better relate to the social and human well-being of patient, patient's family and community as part of the therapeutic and healing process. The so-called 'best' may not be the most appropriate in the pertaining circumstances. Surely, the patient's overall *sense of well-being* should be a very significant consideration regarding the desired outcome. Excessive transportation becomes part of the problem, adding, as it does to stress, congestion, concern, pollution and confusion. Today, even an elderly patient may be obliged to travel a considerable distance to the latest gadget or to be seen by a distant super-specialist therapist who chooses to *control* all too exclusively the dispensing of some significantly publicised drug.

Localisation: transfer of the problem rather than the patient if more appropriate

Elderly people with fractures are frequently transported in a state of confusion many miles to a central location where, on a trolley for many hours and a delay of many more, they may become even more confused. Further, it is not unknown for a scheduled operation to be postponed leaving an elderly patient, who has been starving and not permitted to drink in preparation for expected surgery, high and dry, hoping against hope, that it will not be a case of 'third time lucky'!

Such occurrence is less likely to prevail in the smaller local hospital because of the much closer personal obligation placed upon medical and nursing staff to meet the expectation of the patient who may well be known to them personally or to their friends and associates. Part of a Community Surgeon's training curriculum should therefore involve indepth exposure to and supervised practical experience in the treatment of the common place in the acute conditions of *all* of the specialties with, in particular, special exposure to the up to date management of common fractures. This attitude to training also gives the trainee Community Surgeon personal acquaintance with significant consultants which may well be productive later on if s/he

is in need of informed back-up.

Cancellation of scheduled operations:
In recent times it seems that operating lists may be stopped by members of the theatre team indicating that there will not be time to complete the next case before the statutory quitting time. This may cause great embarrassment and irritation to the surgeon for it will have been s/he who has led the respective patient to believe that he/she would have their operation on the day in question.

When theatre personnel are intimately connected with the people living in the community which they are serving, they are likely to be much more loath to disappoint patients by indicating to a 'starved' patient the postponement of his/her operation, or worse still returning such patient in a distressed state to his/her ward bed. Thus, the onus for dealing with the disappointment of patient and patient's family should be placed on the person who is first to indicate the decision to have no further operating on a particular operating list. Unless the surgeon has determined the cancellation, s/he should be protected from this inhuman decision which may only risk his, and no-one else's, reputation being sullied by public tittle tattle.

Also, we learn of people who are dying from malignant disease being transferred in a debilitated state to a central oncologist for their chemo-therapy. If at all possible, such therapy should be managed locally with, if necessary, communication between the central expert and the local hospital unit. Such a policy is relevant also to sound practice in disciplines other than surgery.
Would it be too cynical to suggest that resistance to localisation of treatment may, in some measure, be related to anxiety about downturn in the recorded figures for treatment and follow-up which might reflect detrimentally on the on-going financing and prestige of the central unit in question?
Sadly, graduates, who during their training have become accustomed to ever more sophisticated and expensive technology and treatments,

[3] See An Taoiseach's proposal: Front page headline, Irish Times, Monday July 9th, 2007, "Ahern pledges £25 million per annum to nurture peace."

are less and less likely to apply for posts where, because of cost, such technology is not available even though the new communication technology may *allow the problem rather than the patient* to be transferred for assessment.

Potential of Community-oriented hospital training for work in the Underdeveloped world: an important opportunity for UK & Irish medical schools and post graduate surgical departments:[3]

Should our country still wish to be considered as an appropriate place to train surgeons, obstetricians, anaesthetists and physicians who may be returning to the less developed world or who, being born here, are nevertheless contemplating a life's work for the needy in some remote location, we should be thinking much more seriously about the treatment of the common-place and training young post-graduates accordingly.

By introducing the concept of the Local Community Surgeon with a specially relevant training to deal with the common-place – the Lawrie 85%--90%, Ireland and Britain could become a much more empathetic location for overseas graduates to receive a more relevantly focused training. This would inevitably enhance opportunity in many areas of activity for our respective people.

The recent appeal from Australia for doctors to take up posts in the outback exemplifies both need and opportunity.

Without question, opportunity for training to become a high powered super-specialist should continue provided the respective home country deems that it can sustain the super-specialty in question. More importantly, overseas graduates coming from the less developed world or any of our own nationals who intend to practise in remote locations in the more 'westernised' parts of the world, or elsewhere for that matter, would come to Ireland and Britain confident that they would receive a relevant practical training which would ensure competence to practise wherever.

In conclusion we need to consider:

i) The process of Undergraduate conditioning in medical schools – The term, 'centres of excellence' exposes an unacceptable assumption that excellence cannot exist outside of large hospitals under the powerful control of those with vested interest in centralisation. By centralising more and more work in these is it any surprise that we find increasing trolley waits, waiting times and waiting lists, never mind the frustrating clogging up of the approaches for transport to unreliable car parking space?

The increasing pressure on central units to expedite patients back home must be a factor which leads to some of the mishaps about which we read quite frequently.

The person carrying out the operation should be the person who takes responsibility for sorting out any complications arising from it. It is understandable if the vulnerable small acute hospitals do not react too enthusiastically when expected to deal with a post operative complication on a patient who was referred centrally in the first instance for his/her treatment.

ii) Flexibibility v Closed Shop rigidty:
A more ready utilisation of available talents would suggest the need to encourage an acceptable flexibility in hospital clinical practice.
For example, in small acute hospitals the consultant, on witnessing a queue of patients sitting outside the door of the Casualty (A & E), is less likely to exclaim petulantly, 'Where's the Houseman' and is much more likely to address the person at the head of the queue by asking, 'How may I help you?' and then set about dealing with the condition, however, simple it may be.
The House-officer on his/her procrastinated arrival, has only to observe a consultant undertaking a basic 'house officer' task because he /she did not respond to request quickly enough, to be placed under strong compunction not to repeat the experience. No need for any Holy smoke!

iii) That health is about much more than curing disease:
embracing as it should, the creation of individual and collective community well-being.
It seems ironic that at a time when there has been much talk about Holistic Medical care, students and post-graduates have been encouraged to become more and more super-specialised! We do need super specialists but we also need surgeons (and physicians) trained to deal with the Commonplace, the 85-90% , presenting at the 'local' hospital. Closed shop mentality is no longer confined to the Trade Union Movement where wisdom has, for some time, determined it to be outdated!

iv) The failure to provide surgeons trained appropriately to meet the needs of people living in remote and/or rural communities where an acute hospital already standing is acceptable to the people and, in particular, when it was the enterprise of their forbears which created it in the first place.

v) The description 'General' surgeon to be replaced by the title, 'Community' surgeon' trained to cope with 85-90% of the acute surgical needs of any particular community. This could be covered by a new concept, 'Surgery of the Commonplace.'

vi) the need world-wide for graduates trained specifically in the most appropriate generality of acute surgery to meet need all over the continent of Africa, in the remote territories of Australia, in the isolated communities of Scandanavia as well as in the remaining rural and/or remotely located communities of the United Kingdom, Ireland and elsewhere.

vii) The unacceptable and largely unnecessary transportation of the elderly and terminally ill for treatment centrally which could be provided at their nearest local acute hospital provided communications, both technological and direct are improved.

viii) The effect of closure of the smaller hospitals serving as an

integral part of remote and/or rural communities **on the morale and well-being of the local community** and also on the resulting trolley waits, waiting lists etc. in centrally-placed larger town and city hospitals.
What did the powers-that-be expect; what would a P.7 child expect whenever ten or so of the small acute hospitals in Northern Ireland were closed, other than a huge increase in work-load in the remaining hospitals to which people in the remote and/or rural communities would be referred? Trolley engineers must be having a boom time?!!

ix) Viking Surgeons and Co. Tyrone:
The Viking Surgeons will be appalled to learn that the great County of Tyrone in Ireland has lost the acute services of its two acute hospitals and this in spite of the people having supported them enthusiastically, with confidence and with loyalty over a number of generations.
At the risk of repeating what we, in the New Ireland Group, have observed on many occasions, it seems highly ironic that we have the technology which has delivered men to the moon and brought them safely back to Earth yet women may no longer have their babies delivered acceptably in Co. Tyrone!

The mooted removal of acute surgery from Lagan Valley Hospital, (Lisburn) should be the final wake-up call to the surgical units and their staff in the few small acute hospitals still remaining in the local service of our rural communities in Northern Ireland. If City status (newly-conferred on Lisburn and Newry) is dependent on an existing Acute Hospital within the boundary of the town being assessed, then these two towns managed the upgrade in their civic status in the nick of time!
The time-honoured hospital which served in each of them is in process of being threatened with downgrading by the designated removal of the A& E from Newry and Acute Surgery from Lisburn.

x) Immolation by fire of evidence based back-up!
Sadly, some time after retirement when the author of this booklet

went to write up his 20-year experience of work in a local community acute small hospital surgical unit he discovered that instructions had been given to orderlies to have the records, which were stored in the administrative department, removed. The order was executed by a decision to put them to the flame!!
It is therefore unfortunate that the valuable record of that experience cannot be added as an appendix to this booklet in support of the work done by Viking Surgeons and as clinical evidence to support the points under consideration.

xi) "Blow-up two of the three hospitals to which you are now attached"

Perhaps, the destruction of records was not the worst fate affecting hospital practice.

At his last ward round as a consultant in the city hospital unit in which he had been working as consultant for four-and-a-half years prior to moving to a small hospital serving a rural community, he was followed by two students, two junior House Officers, a Junior Surgical Trainee and a Senior Surgical Trainee. The workload of the 45 bedded unit was shared with two other Surgical consultants.
At his first ward round in the 45-bedded unit of the small acute hospital serving a rural community, he was followed by no students, no junior house officer, no junior trainee, no senior trainee though, on two half-day sessions each week, one did come as part of a shared arrangement with another hospital, eight miles away. He was also contracted to cover emergencies in that other hospital with outpatient duties in a third hospital sixteen miles away at the periphery of the large rural district.
The consultant in question wrote to the regional representatives of the General Medical Council (responsible for the accreditation of junior house officer posts) to indicate that he was grossly under-staffed and

* Prior to making the move from Teaching Hospital Consultant to Peripheral Hospital Consultant he had been organiser of surgical training in Northern Ireland over a 10 year period and had also been part of a University Sub-Committee set up to make recommendations for change in the medical undergraduate curriculim. Just because one works 50 miles from a Teaching Hospital it shouldn't be reason for thinking that interest and competence in teaching suddenly ceases.

that he required appropriate accreditation to enable him to make the case to his employer for clinical support and teaching opportunity in his work.*
To this plea he received the following reply:

"The only solution to your problem is to arrange to have two of the three hospitals to which you are now attached blown up or otherwise destroyed in order to force the people to accept centralisation of services".

This letter now resides in a Public Record Office. The group responsible for the accreditation did not visit the hospital for some years after the request!

xii) Professional imperialism and Bureaucratic Centralism, the unholy alliance:
If it is true that, in the past, there was a rule that G.A.A. (Gaelic Athletic Association) players for their county had to be born in it and had the Gaelic Athletic Association not changed this rule, the Sam Maguire Cup might never have arrived in County Tyrone! There are no longer any Acute hospital maternity units in Co. Tyrone!! Fortunately, however, the Gaelic Athletic Association has no such rule on its books today.

Great O'Neill, Earl of Tyrone, reflecting on this decision, would probably be turning in his grave into which he may have been expedited by the effect, following the consequences of his defeat at the battle of Kinsale, as a result of the imposition of a deceptive policy of 'Submit and Re-grant'. Little did he know that he was being deceived into submitting to a sovereign who was already dead!! Is it too late to hope that the South Tyrone and the Tyrone County Hospitals, having submitted, will later be re-granted their former functions?
Furthermore, it seems strange that a new city, Lisburn, may be destined to lose acute surgery from its hospital so soon after gaining city status. Surely the existence of an Acute Services Hospital would be one criteria on which elevation to City status would be made?!!

Keep agitating! Who knows; most change eventually goes round full circle.

Perhaps the people of Mid-Ulster will give a lead in their protest to keep their hospital (the first in Northern Ireland to have an Intensive Care Unit and the first also to introduce a concept of Progressive Patient Care).

If the wakening awareness of these surgical problems is to continue to develop in the Royal College of Surgeons in Edinburgh we trust that it will soon develop in the other Royal Colleges of Surgery, not least the one in Dublin, and that this awareness will also be embraced by the General Medical and Nursing Councils and by the University Medical Schools. If, in Northern Ireland, our well paid regional politicians had been doing the work expected by the people who elected them they should have been agitating to preserve what was once so acceptable in our rural communities. Perhaps it is no co-incidence that so many small hospitals were placed under the hammer at a time of political instability here. Now that a Regional Assembly has been constituted, local politicians should be canvassed, even harassed, and held accountable for decisions affecting the well-being of the smaller acute hospitals. It will not be good enough to respond that 'we – the politicians - cannot engage in further debate about what previous English consuls and pro-consuls have already determined.'

xiii) 10 years for the restoration:

Should the desired changes take root, it will take at least ten years for a new programme of surgical teaching and re-training to produce a fully trained cadre of Community Surgeons with back-up teams, trained to manage the commonplace surgical problems of a local community.

xiv) The people of County Tyrone must not therefore give up hope:

They should be persuaded to protest at the Royal Colleges and at the General Medical and Nursing Councils and at the Universities until they receive assurance that their challenge will be addressed and, once so assured, that in ten years time the operating suites and ward

4 Venture into the Interior: Laurens van der Post: Penguin Books Ltd: pub. by Hogarth Press (1964); page 213

SECTION III.

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RESPONSE

TO

INVITATION TO MAKE A SUBMISSION TO
THE ACUTE HOSPITAL REVIEW GROUP

CONSTITUTED BY
The Minister of Health (N.I.)

Bairbre de Bruin M.L.A.

Under the chairmanship

of

The Irish Senator

Dr. Maurice Hayes

On reading this publication, 'Long live the small hospital' (designed to serve remote and/or rural communities) it may be thought that there is too much repetition in the material. Although this may be distasteful to some readers and the self-plagiarism may upset others, the author of this publication offers no excuse for such repetition!

Repetition:
There may be no better justification for 'repetition' than that expressed by Abraham Colles, the second Professor of Surgery at the Royal College of Surgeons in Ireland..

'He (Colles) was on terms of close friendship with Daniel Ó Connell – the "Liberator" – and had similar political views on the 'Repeal of the Union'. A letter from Daniel O'Connell to Abraham Colles expressed justification of 'repetition' as can be read in Martin Fallon's biography of Colles (1773-1843). In this[1] he states:

"My dear Colles,
You see I have taken, or endeavoured to take, your hint. I did as well as I could, and according to my policy I will repeat the idea in many forms before I think I have fully complied with your suggestion. Sensitive men – and most men of talent are so – shrink from the repetition of the same thought. As far as the public are (is) concerned, it is a great mistake. **It is necessary to say the same thing one hundred times before the public *catch it.*** But then it becomes identified with the public mind – (or) so I delude myself……..

Very faithfully yours,

[1] Abraham Colles: Martin Fallon: William Heinemann Medical Books Ltd: page 191

Daniel Ó Connell"

21st August, 1840.

The following excerpt is taken from a covering letter which was written in response to the invitation to make a submission to the Acute Hospital Review Group. This has been amended slightly to allow for the change in context since it was first printed.

'I am thankful to the Acute Hospital Review Group for its invitation to defend the submission which I have made to it. This is an opportunity to share my experience of working in the acute service in Northern Ireland and elsewhere in both Teaching hospitals and Peripheral hospitals.
This experience may help to place the following observations in perspective.'

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Slide Presentation at meeting with Acute Hospital Review Group
With a series of slides I was able to indicate the professional experience from which my conclusions were made. The *breadth* of experience to be gained from working in less specialised hospitals was emphasised throughout my presentation.

1. **Slide 1** depicted a significant member of the personnel who was central to the splendid working morale of the Downe Hospital back in the 1950s and 1960s. Jimmy Kinsella was employed as an assistant boiler man, yet he was prepared to undertake any practical task of which he was capable and which was requested of him. He was regularly seen in the small town of Downpatrick on his way to place bets for staff in the local bookies! If Jimmy Kinsella had heard about the 'Closed Shop', he certainly worked as though he hadn't!

2. **The second slide** indicated the quite different terrain covered by a hospital in North Antrim and a hospital in West Belfast. This begged the question as to whether our plans and approaches were

sufficiently flexible to deal *appropriately* with the different requirements of different clinical and geographical environments.

3. **The third slide** demonstrated that even in a remote peripheral area, with the most basic communication technology, it is possible to sustain important communication through the use of telephone, fax, e-mail, radio and nowadays, telemedicine.

4. **A slide was then shown** to indicate that critical path analysis may be applied to the set of circumstances existing in rural hospital practice just as it is for the distinctly different set of circumstances existing under urban conditions. The example shown dealt with the management of major accidents and disasters.

5. **The following slide** then placed in table form, figures, which compared over the same period of six months, the work undertaken in a central unit and a peripheral unit in both of which the respective consultant had worked.

- As could be observed, the theatre sister in the peripheral theatre, with responsibility for two surgical units (one General Surgical and one Gynaecological and Obstetrical) was doing more than twice the work with less than half of the back-up of nursing and ancillary staff compared with her counterpart in the city hospital* unit which also had responsibility for the surgery of two surgical specialties.

- During the same period of six months, 180 surgical procedures requiring anaesthesia were performed in the peripheral operating theatre; 32 of these were classified as 'major' procedures, whereas, in the central unit 86 procedures were carried out per month and of these only 27 could be classified as 'major' procedures. The classification was made in accordance with the criteria then extant

* This was not the Belfast City Hospital.

in the 'International' Classification of Medical Procedures and conditions.

- When these comparisons were later presented at meetings, the inference stimulated little interest. It seemed as though those with the power and influence to control did not welcome the challenge which the figures were presenting!

- The slides in general emphasised the need for far greater flexibility if we are to use the talent and energies available to us with imagination,effectively and economically. We also believe that effectiveness is much enhanced by the closer human contact and co-operation which is more easily obtained in smaller institutions working within and for more closely relating small communities.

Flexibility:
There should be more flexibility within units and between units as well as within and between hospitals. Principles are surely more important than procedures made rigid by directives. No one can predict the medical/surgical effect of a Major Accident or, for that matter, what may be involved in the early acute management of Disaster or Confrontation Trauma; An appreciation of the implications of **capacity** on the one hand and of **limitation** on the other is surely essential in the management of such unpredictable events.

Capacity and Limitation are changing constantly and must thus defy any rigid assessment. Both invite constant re-evaluation. (Capacity is expanded by on-going development of talent, imaginative communication and the promotion of morale and self-confidence). What is most 'appropriate' in a particular circumstance is, on the whole, more significant than what is the 'latest', especially if the 'latest' is to be equated with the 'best'. We should at least know the parameters used in making the judgement and whether there was any

vested interest involved in choosing them.
The sabbatical as prelude to what one critic has called the obligatory, statutory 'M.O.T.' for all medical and surgical practitioners is becoming more and more essential for sound practice.

Plan origination:
In the process of re-evaluation of guidelines in response to the Accident, Disaster, Civil Disturbance situation the plans too often start with central demands for what is to be done augmented by central edict about what the periphery should not do, rather than starting with the capacity of the peripheral unit, then moving to that of the peripheral hospital as a whole, then to the overall resource of the particular district, then to that of the particular area and, finally, that of the region and the nation so that as much as possible may be achieved in as short a time as possible by those on the spot.
To emphasise the importance of having a flexible outlook, one has only to consider what could happen were a nuclear device to be exploded in a populated area. Even the region, perhaps the nation too, would have to respond outside of any regionally or nationally designed emergency disaster plan! Everyone medically qualified should have opportunity to be embraced by any 'plan' so that each person may use common sense in the liberation of the talents which are unique to them. Everyone involved should have opportunity to feel valued. After the particular event the community should gain a fresh esprit de corps which can only result in an overall rise in individual and collective self-confidence, leading to enhanced morale regarding the potential to face a similar event at some later date. There should be obligation on all similar units to attend a special seminar to learn about what went wrong as well as about the successes in the management of the particular event.

Contemporary Challenge: 'Community Surgery' to replace the concept of 'General Surgery'

[2] Insert formula later see Section VII, APPENDIX I, (page 65-73)

There is a need to start training for Community Surgery to replace General Surgery for reasons outlined on page 10. A formula has been devised for the financing of the acute hospital service, taking into account the population served, (10 – 15% of all hospitalised clinical problems will require to move in centralising "Specialist Direction"; however, the remaining 85 – 90% should not be subjected to colonisation unnecessarily by powerful centri-petal forces).[2]

This formula makes allowance for the special requirements of the centrally located hospitals; it also has a built-in factor in support of the appropriate local management of acute Health Care challenges. **Decentralisation** should be encouraged – "Centralism" is a major cause of *dis*-ease in our time.

The need for more flexibility suggests emphasis on the value of responding to 'difference' in place of an obsession with uniformity;

and also on concern for more 'closeness' in place of 'remoteness' in communication. **'Two-way' exchange** should replace the imposition of one-way systems of control. **The principle of Subsidiarity** suggests that the big and central should not take over from the small and peripheral what the latter can achieve working in the context of the resourcefulness and resources available in the local community.

A current axiom of Health Service Thinking:
'Reductionism reigns supreme'; much talent, therefore, lies dormant, undeveloped and frustrated.' 'All men and women different, each unique, all part of the same humanity'. How do we best find develop and liberate the talent that is unique to each'.

Yours sincerely, JOHN ROBB

End of covering letter.

A PERSONAL SUBMISSION

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TO

THE ACUTE HOSPITAL REVIEW GROUP

It was difficult to determine how best to comment on the issues highlighted in the letter of invitation to address the Acute Hospital Review Group; much seemed to depend on the parameters within which the Review Group had to operate. *As I have now been retired for some fourteen (at the time of the review eight) years, my observations may be dated. Nevertheless, in making them, I would like to think that they may stimulate other ideas perhaps more currently relevant. Before launching into this formidable task, I therefore feel it is appropriate to give you a synopsis of my experience within the Health Service of Northern Ireland and elsewhere. You may then understand better from where I am coming.*

Experience:

Professional experience in small/large hospitals, teaching/non-teaching, at home and abroad – Northern Ireland, Africa, North America and London.

In Northern Ireland, six months or more in units of the Royal Victoria Hospital, The Royal Belfast Hospital for Sick Children, the Regional Plastic and Burns surgical service, the Throne Hospital (Plastic Surgery), Mid Ulster Hospital (Magherafelt), Downe Hospital, Coleraine Hospital, Route Hospital (Ballymoney). Shorter experience of working in the Tyrone County Hospital (Omagh), the South Tyrone Hospital (Dungannon), the Erne Hospital (Enniskillen) and Dalriada Hospital (Ballycastle). Regular clinics on Rathlin Island.

United Kingdom:
Each year, as a member of the Viking Surgeons, I visit a surgical unit in a remote/or rural part of Scotland or elsewhere, eg Shetland, Orkneys, Lewis and Harris, Faroes, Iceland, Isle of Man, Penzance, Fort William, Oban, Elgin, Wick etc.
Member of the Association of Surgeons of Great Britain and Ireland

UK consultant: R.V.H., Belfast (1968-1973); Route Hosp., Ballymoney (1973-1992) with attachments to Coleraine Hospital and outpatient and minor operation commitment to Dalriada Hospital, Ballycastle, and to Rathlin island.

Overseas:
Senior Medical Officer (Sen. Registrar status) in the Fracture Department of the King Edward VIIIth (non-European) Teaching Hospital in Durban and in Orthopaedic and A & E surgery in Baragwanath (non-European) Teaching Hospital on the outskirts of Johannesburg serving Soweto township. (1966-1967): To its five surgical units, Baragwanath admitted in 1966-1967 approximately 1500 stabbed chests,1000 stabbed necks and 1200 stabbed abdomens.

[a] a book written to assist students to undertake effective Clinical Examinations in the small acute Community hospital, the Route Hospital –Ballymoney, Co. Antrim.
[3] A list of surgical conditions which the student must see/ should see/ may see before Final M.B.
[4] post graduate. Procedures to be observed/to be assisted at/to be undertaken independently
[b] A philosophy for the small acute hospital

Observation of the work undertaken by Anthony Barker, FRCS in the Charles Johnson Mission Hospital, Nqutu, Natal.
Short-term consultant post in Harare (non-European) Teaching Hospital at the height of the civil war in Zimbabwe.

Academic:
Fellow of the Royal College of Surgeons of England; ad eundum Fellow of the Royal College of Surgeons in Ireland.
Tour of medical centres U.S.A. and Canada to study and report on surgical under-graduate teaching and post-graduate surgical training. Hon. Doctor of Law, T.C.D. Editor on behalf of Junior Hospital Staff (Northern Ireland) of specialty reports on training and living condition needs as presented by a revival of Junior Hospital Staff Group (N.I.) to the Medical Education and Research Committee of the Northern Ireland Hospitals Authority (1963) and to the Junior Hospital Staff Group of theBritish Medical Association in London.

Author:
The Surgical Route,[a] The Clinical Route,[3] The Practical Route,[4] The Alternative Route. [b]
Paper on the Management of Trauma presented to the Abraham Colles Bicentenary meeting in Dublin and a paper on 'Flexibility in Surgical Training' presented to the bi-centenary meeting of the Royal College of Surgeons in Ireland.
Paper on Central spleno-vena caval and central spleno-renal vein shunts at European Vascular meeting, Warsaw.
Paper on casualties admitted to Belfast Hospitals as a result of Civil Disturbance Aug — Oct. 1969: British Journal of Surgery: 58; 6: 413 - 419.

Administrative:
Organiser of post-graduate training in surgery in Northern Ireland for approximately a decade.
Chairman of Junior Hospital Staff Group (N.I.).
Chairman North-Eastern sub-division of the B.M.A.

Editor: 'The New Irelander'

Research:

- Duodenal ulcers in children: Archives of Disease in Childhood (1972) 47; 688
- Work aborted for Mch. Thesis: Central splenic veno-caval and central spleno-renal vein anastomoses in treatment of surgically induced portal vein hypertension, as alleviation of haemorrhage in liver cirrhosis.

General Observations with regard to this Submission

1. Purpose:

The question must be asked as to how the purpose of under-graduate teaching and post-graduate training is determined. Do those who have the power to organise these aspects of a practising doctor's development have a recognisable philosophy? For example, how do they determine relevance of purpose in conjunction with the development of the trainee as a healthy, rounded person preparing her/him in a general manner to respond empathetically to the needs of his/her patient clientelle in the community. An army of referral agents at one end of the spectrum: super-specialists at the other end may not always give value for money when it comes to satisfying the overall human *let alone therapeutic* need of the client.

Managing priorities:

Put slightly differently, is there not danger of loss of balance between priorities decided by academic frontiersmen and priorities which might be better defined in regular open discussion and debate with the people (both clients and providers together) indicating honestly which resources are available and asking them — the people — to articulate their priorities in relation to the proportion of financial and other support available in their particular community. One thing is now certain and that is that we can no longer meet every demand of all the people. It would therefore seem wise to hand at least some of the responsibility for choice back to them so that decisions may be addressed collectively in community. Questions need to be asked about power and control and the relevance of empire building to the

delivery of the service in what has become a disease or *dis*-ease industry.

2. Dazzled by super-specialism?

In recent years much lip service has been paid to 'the holistic approach' in medical education yet we turn out more and more hospital doctors with dazzling fragments of specialised expertise who, outside of their particular 'dazzle', may be pretty ignorant – the cell separated out from the organ, the organ separated out from the body as a whole, the body separated from *being* in the context of family and community. Furthermore, many doctors don't seem to have the time or don't want to take the time to communicate adequately in both the clinical and personal sense with those who come to their surgeries or who call on them by telephone. Admittedly, the professions are, in the final analysis, only one part of a whole society and will, therefore, reflect the prevailing ethos of that society, in both its deficiency as well as in its attainment. It is unreasonable to expect them to be immune from any prevailing climate of social alienation, if such is the experience of the wider society in general.

Nevertheless, we should be asking if we are getting the right product for 5-6 years of under-graduate teaching plus a further ten years or so of post-graduate training. After all, we, the taxpayers, finance a large proportion of these years of teaching and training.

While reductionism does have a place in the scheme of things it seems, sadly, in today's disease-curing delivery systems, to have become an obsession and, in exercising such obsession, to have become synonymous with centralisation. We rarely, if ever, experience rationalisation in the direction of the Small, and the Peripheral. As such this shows little cognisance of the "intangible assets" described by E.F. Schumacher when he describes, in 'Small is Beautiful' 'Economics as though people mattered', the economy of

wellbeing.

3. The Common-Place.
Reductionism has also led to an increasing number of hierarchies. The closed shop of the health professionals today is not all that far removed from the closed shop which used to operate within the Trade Union Movement. In Africa, in those few places which have not yet been penetrated by latter day bureaucracy, there is a flexibility which out of necessity, encourages the release of talent, initiative and common sense to enable enormous amounts of **common-place** work to be carried out as effectively as possible in the context of the limited resources available. The downside is, as one might expect, that those whose illness requires highly complex and expensive treatment are denied it. Nothing is perfect, so let us seek social relevance alongside professional balance. Let us at least pride ourselves that the treatment of the Commonplace, in its particular social context, is as far beyond criticism as is humanely possible.

4. The muffled voices:
Where are the critical voices of the trainees and the students? Within such a short **space of time it is odd that young people who emerged from school with the highest A levels** seem unable or unwilling to engage in critical debate concerning the relevance of training and the relevance of exclusiveness in its use in the broad canvas of challenges which the Health Service presents.

Freedom of staff, especially juniors, to express dissent with any expectation of a constructive response seems woefully absent. Thus the 'establishment' may blunder on, unaware about any significant criticism from its troops; indeed it may even resent having to face up to the challenge of dialectical exchange. A healthy organisation should be continually seeking out points of view from personnel – all of them – and from its clients. Debate within our institutions is still in its infancy, yet it is urgently required to raise awareness as a means of promoting better feeling and more confidence in the delivery of what is appropriate in given circumstances.

5. Work in the smaller hospital: an undervalued and inadequately supported asset:

While the era of the small hospital would seem to be passing, highlighting some aspects of the work which was done in them may raise issues which could be debated with advantage. It had been hoped that the work of 20 years of surgical operations in Ballymoney could have been analysed for publication. Regrettably, the material which had been filed in theatre ledgers was burnt as a result of sloppy execution by those deciding to tidy up the attic room in which the records were stored. However, the overall record of practice over a short period is contained in the slides to which reference is made above (page 32). In these slides, which will be deposited in the P.R.O. (N.I.), practice in the smaller hospital is documented.

6. Junior Medical Staff:

Under the European Directive on legitimate hours of work, there is undoubtedly more officially designated off-time today than there was some years ago as far as junior medical staff in training are concerned. Even so, the question of on-call hours in continuity needs much stricter monitoring. Following recent enquiries it has been revealed that junior doctors, in order to accumulate a sequence of consecutive free nights off duty to add to a weekend or holiday, may, by judicious swapping, achieve this at the expense of working many more consecutive days and nights than is permitted by the directive. This practice is wrong, both with regard to the health of the junior doctor and also with regard to his/her judgement and effectiveness as far as patients are concerned. Overtime pay, board and accommodation conditions should be constantly under review and constantly up-graded. Many junior doctors forgo sleep and meals to keep the hospital service ticking over. Some of them are not paid for hours of work when there is disagreement between conflicting employment administrations. Some too, report that, when on call and obliged to sleep in hospital, the bed linen has not been changed following its use by the previous occupant!

Other trainees may be working in busy central city units where

consultants have a large commitment to private practice or to the law courts as expert witnesses. As a result, some trainees may have diminished contact with the person who is nominally meant to be training them! Still others find that even when the consultant is listed as *first* on call, there may be reluctance to call him/her and so the junior may feel under obligation to do extra cover so as not to compromise the relationship by calling the senior in.

In the bigger cities many consultants are permitted to have their home far from the relevant hospital. By contrast a consultant surgeon working in a small rural acute hospital has been known to say proudly that he could cross the road in his dressing gown at night and could go home for his lunch in his operating room dressing gown by day!-->a consultant led service!

With so much new legislation regarding the working hours of junior hospital doctors and with all the post-graduate talent which is available to medical practice there should be no excuse, in closely monitored working rotas, for anyone to work excessively long hours on the trot without rest and without being sustained, adequately by routine substantial snacks and breaks.
In response to the question to an enthusiastic trainee, 'What did you have for lunch today?' may come the response 'sandwiches on the hoof'. No break, little opportunity to socialise with other hospital personnel and little attempt to ensure that surgical trainees working to the limit of their energies shall be assured of a healthy food intake with time to digest it. This is a shocking indictment on administration and on senior members of the profession who, by their silence, only indicate an indifference to the state of health of junior staff on whom they are so reliant.

Junior trainees in the United Kingdom may well be appalled to learn – if they don't know it already - that the European Directive on Working hours has not yet been applied overall to the conditions of employment for junior hospital staff in the Republic of Ireland. It need hardly be added that this leads to unreasonable expectations by seniors of juniors where they may have their energy and stamina stretched at least to their elastic limits, if not beyond!

Some serious lateral thinking is required, however, to handle the dilemma presented by the Directive regarding its imposed reduction on training time especially in the area of practical surgical skills.

7. Stress and Anxiety:
It is time that the powers that be recognised the enormous stress that there is in surgery/obstetrics, anaesthetics and other disciplines when working at the frontier between life and death.

It is hard to imagine a surgeon going through her/his professional life without making some serious error of judgement which results in suffering for a patient and/or the patient's family yet there is no easily accessed means whereby, when something goes seriously wrong, the professional concerned may share his/her feelings of remorse, regret, guilt or whatever for what went wrong and for which s/he feels a personal responsibility. Unless the professional concerned has confidence in her/his ability to confront patient or relative directly to admit serious error, it will become bottled up inside causing symptoms of chronic anxiety or worse, an outcome not conducive to improving her/his practice thereafter. Are our professional and administrative leaders too proud, too embarrassed or too inadequate to introduce a counselling service to assist in the handling of these nightmares?

7. Research:
While not wishing to deny the value of well motivated, well directed medical research, it is long past time to ask why, when so many young doctors tell us that they would not do research if they did not feel that, *however irrelevant it may be to the post to which they aspire,* they must do it in order to fulfil the demand of the power brokers and members of interview panels.

Not everyone wants to be, or is suited to be, an academic and many feel that research years merely lengthen the time of apprenticeship for little or no direct return in contrast to the value of exposure to more relevant clinical and practical experience in the development of

professional skills. *It is surely time to look into this professional conundrum as there is a suspicion that it has as much to do with professorial prestige, status and the need to attract academic departmental grants as it has to do with meeting the needs of the trainee or of the service.*
The surgeon hoping to work in say, the Erne Hospital, Enniskillen, is more likely to arrive with a wider range of surgical skills if he or she sets aside three years to obtain these rather than spending the same three years undertaking a piece of esoteric research for a Ph.D. Yet s/he is probably more likely to impress the selection panel with the Ph.D. than s/he would be with documented evidence of extra relevant service experience.

Research is often justified by suggesting that it prepares the surgeon for a lifetime of enquiry. **How many of our consultants are actively and personally engaged in such throughout their time as a consultant??**

9. The Future: Retention of the Acute Hospital In Rural and/or Remotely Located Communities:

The prevailing ethos promoted by those with the power to control within the professions, combined with rising consumer expectation in front and increasing fear of litigation from behind, has led to the undermining of the function of, and confidence in, the smaller acute hospital. In the prevailing climate this trend is unlikely to be reversed and we should therefore look at any rationalising impulse in the context of minimising its effect on the well-being of Rural and/ or Remotely located communities. Organisations and individuals involved in the current upsurge of interest in Rural Community Development should be encouraged, by legitimate protest whenever necessary, to insist on the retention of local acute medical, surgical and obstetrical units.
Remove a functioning department from a hospital, remove a major service from a local district and you undermine morale and self-belief, be it within an institution or within a local community.

10. Rural and Remote Communities:

With the recently revived interest in the politics of Rural Community re-development in mind, academics from University Departments of Agriculture and experienced Rural Community Activists should be brought into the debate concerning the future of Acute hospital services as they impinge on the Rural community.
In this context it would be worth considering the involvement of Professor Alasdair Munroe of Inverness who has championed the cause of the Viking Surgeons within the structures of the Royal College of Surgeons in Edinburgh and the Association of Surgeons of Great Britain and Ireland. He is intimately acquainted with the Academic Department of Surgery in Aberdeen and has sound knowledge of the service to the Islands and Highlands. Likewise, communication should be developed with such as Dr. David Pate, working for many years in Derby in Australia's Northern Territories.

11. The Professional Class Conjunction:
It seems right to question how much time is taken out of their service contract by consultants in order to earn large fees in the law courts, never mind the time taken out of the N.H.S. by those consultants who work in private clinics.
One unfortunate spin-off of such private and litigation work is the need to have senior trainees available to cover the consultant's work whenever s/he is involved in legal or private work. While peripherally based consultants may also be involved in both private and legal work, they are unlikely to be in a position of comparable influence in the process of appointing trainees. Consequently, they are less likely to have the more confident and competent trainees appointed to their respective surgical teams. This may also have the effect of denying the peripheral consultant what he probably needs as much as anything else: contact with a younger professional who will share his/her more recently acquired, more up-to-date knowledge. Change in this respect may well have to wait until Community Surgery is recognised as a special interest in its own right.

12. Ward Meetings:

Much misunderstanding and poor morale might be obviated by regular, perhaps weekly, meetings. Operating under an agreed constitution and with standing orders indicating such as notice of agenda etc. Matters of importance to any member of the team, whether working with spanner or scalpel, brush or bandage, with trolley or in theatre, could be addressed. Such meetings should be minuted. Dissent in conscience and input from everyone should be encouraged by the chair.

13. Efficiency:
(reduced waiting times, decreasing length of waiting lists, satisfaction ratings etc.)

In *Small is Beautiful* the author, E. F. Schumacher referred to the intangible assets which we ignore at our peril: esprit de corps, morale, enthusiasm, communication which is for real and truly personal, genuine concern and so on. It becomes important to emphasise flexibility, vocation, liberation of the total talent of all personnel, most especially that of the professional trainee, with emphasis on the concept of the common-place and on common sense. Could there be a much more enlightened approach to error with a statutory drive to ameliorate the anxieties associated with a threatening, exploitive and adversarial legal system. An acceptable counselling service should be available for it would be nigh impossible to undertake surgical operations for say, forty years without making an error of judgement or technique.

14. Further Comment:
In its latter years the Route Hospital surgical unit in Ballymoney was undertaking a workload of approximately **4,000** surgical outpatient attendances per year, approximately **10,000–12,000** Casualty (A & E) attendances, **1,200-1,500** surgical procedures requiring anaesthesia, admitting around **1,200** patients each year and being on-call for the whole Coleraine district as well as North Antrim district every third day **(100,000 population in the winter, 200,000 in the summer).**

[5] The Greeks: by Anthony Andrewes: Hutchinson (1967): quoting Heroditus: p. 61.

The slides, which have been mentioned, show the ratio of work done to the number and grade of personnel appointed to sustain it. Let it be recalled that on taking up appointment the consultant had just vacated a centrally located city teaching hospital in which his ward staff included two students, two junior interns (house officers), one junior trainee and one senior trainee. By contrast he found himself in his new appointment managing the same number of surgical beds as well as being on call one day in three, covering two hospitals, eight miles apart and a weekly outpatient clinic in a third hospital, sixteen miles away. His back-up surgical staff was as follows: no students, no junior houseman, no junior trainee, the share of a senior trainee on two half days per week. In order to sustain the workload figures he had to work like the 'proverbial bat out of…you know where' if he was to justify his demand to the authorities for improvements.
Comparisons may be erroneous let alone odious; nevertheless, the workload figures given above suggest that a peripheral unit, if standards, morale and communication are sustained, has nothing to be ashamed of in comparison with more prestigious and better supported central units and may well surpass them in terms of appropriate effectiveness in relation to the needs of the people coming to it in the first instance. 'Excellence' may be experienced wherever appropriate training, energy, effectiveness, re-training, commitment and high morale exist. It should not be equated so exclusively with size and centre.

15. Justification for Institutional Democracy: see, 'Remedy': SECTION No VI: (page, 61).

In 1973 there were three consultant surgeons in the district, two with a 'full' commitment to one of the two Acute Hospitals (8 miles apart) and one with duties in each.
However, only two of these surgeons were prepared to undertake the responsibility of emergency night-time cover on a rota to serve the

[6] Dr. Wesley McGowan M.D., F.F.A.R.C.S.

district as a whole.

The 'night-time inactive' consultant was the 'senior' surgeon and was in declining health. He had simply decided that he would not be doing any more night-time cover which meant that he was leaving one colleague in each of the two hospitals to cover the district on a 24 hour Emergency Rota! No discussion; no request; merely the assumption that his two colleagues, being 'junior' would take it on the chin! Worse still, the local administration failed utterly to acknowledge the problem, let alone do anything about it.

While it is right to be willing to give support to an ageing colleague in failing health, it is surely not too much to expect the dilemma to be subject to open discussion. In the days of the Empire Class (?Caste) system, assumptions built into a covert code were the order of the day! That day has gone and we now know that Democracy was described by an historian of the ancient world as "Taking the people into partnership".[5]

16. Waiting times:

In order to make the point with regard to the propriety of smaller units operating in close association with a specific community the following example is given. This is taken from a leaflet with the title 'Routed' which was published, with its appropriate title, immediately before the Casualty department and Surgical unit was removed from the Route Hospital, Ballymoney, and transferred to Coleraine in 1992:-

"A recent survey of new patients attending the Casualty department (Route Hospital 1992) shows that the average waiting time, from arrival to attendance by a doctor, is six and a half minutes and the average time between arrival and designation is less than half an hour" ……."the proximity of the Casualty department (A & E), the Ward nursing station, the Concentrated Nursing Area, the Operating Theatres, the Theatre Recovery Room – which doubled as an emergency Intensive Care Unit (the I.C.U. was in Coleraine) and no!, over twenty years and despite negative predictions, no-one died in the ambulance en route – the proximity of these sections of a surgical unit may well have been unique"

17. Rapidity of Resuscitation:

Observation of the system at work led a distinguished anaesthetist,[6]

CENTRALISM: Terminal or Curable?

SECTION IV

Downside:

It has often been noted that people who attend rallies in support of the retention of traditional hospital services in their own locality demand that they be seen elsewhere whenever they require treatment for themselves! By and large this is the outcome of an insidious undermining of rural hospital performance by a centrally dominated health philosophy. Erosion by stealth – one department to-day, another tomorrow – and then the coup de grace – the mobilisation of statistics whereby the parameters used to determine performance may be selected by those with power to bring about a desired end result. The 'whole' is sacrificed on the altar of the selected part or parts.

Confronted as they are by notions of 'the best' which are promulgated by those with vested interest in defining what this is, the growth of centralism is slowly eroding the means of meeting even common-place needs locally: local staff commitment suffers, enthusiasm wanes and the local people begin to lose confidence.

Peripheral communities have also had to contend with a media which, by and large, is more easily accessible to those working in the centre than to those who would speak for the small and the peripheral and this despite the rapid advance in communication technology.

Faced, therefore, with changing expectations ahead, pursued by increasing litigation from behind, experiencing administrative suffocation and without adequate political or professional understanding and support, who can blame hard-working local community hospital personnel if morale begins to falter and service delivery suffers as a result. If, on top of all of this, there is lack of clarity with regard to direction and purpose, the kind of commitment

which is so necessary in caring for 'the sick' is bound to be undermined.

The Luke-warm Populist:
In the 1970s rural consultants in Northern Ireland, in spite of leadership by the late Dr. Anthony Pollock of Omagh, failed to come off professional pedestals in order to engage, as part of a regional rural hospital network, in *collective* institutional and *collective* co-operative community action with the people they were serving and with the other personnel with whom they worked. Hence, each rural acute hospital became vulnerable to being next in line for undermining as prelude to down-grading or closure. This reluctance of Health Service consultants working for Rural and/or Remote communities to challenge the medical establishment in a political and public manner and to do so with the support of a sound *collective* community base was, unfortunately, a sad reflection at that time of the reticence of the professional class and others – the residents of the leafy suburbs - to risk their fingers being muddied by association with a populist cause.

The idea of creating, let alone being involved in, a popular network of shared and similar enterprise in different communities and thus becoming a force for united rural action, for instance a march to the steps of the Royal Colleges to sit down on them, would have been - perhaps still is anathema to many of the members of my profession. Dialectical analysis followed by critical action seemed, in medical circles at least, to be 'beyond the Pale.' At public meetings organised as part of a campaign to save local acute hospitals, the consultants should be the first to be asked by the organisers if they are for or against the closure of the respective unit or hospital. Those who are in favour of such, could then be confronted by questions provoked by observations similar to those being advanced in this booklet!

Now, twenty years on, it is too late for most of the smaller acute hospitals. The acute services in those which remain will also go unless better researched and more appropriate arguments and actions are directed at the real sources of the problem — those who hold power without democratic accountability to those affected by their decisions — the academic super-specialist establishment, the Universities, the Royal Colleges and the Medical and Nursing Councils. Neither local public nor local professionals will win their case with 'shroud-waving' arguments which we hear all too

frequently. There are many more convincing arguments. Shroud waving should cease to be part of the argument.

Sadly, then, short of a revolution in social and political thought and action, the centralising trend is likely to continue and this in spite of the fact that alienating centralization has contributed so much to the social unrest associated with local community fragmentation on the one hand and increasing risk of urban implosion on the other. The effects of increasing population density, pollution and log-jam are there for all to see. The centre becomes clogged up. In hospital terms, waiting lists, waiting times and numbers of cancellations continue to rise.

The forces which move people out of community are, by and large, the same forces which serve the masters of centralism, forces which may so easily promote social alienation in one form or another.

Perhaps it is timely to remind ourselves that a community thrives on commitment; it is not so well served by commuters (or holiday homes for that matter!!).

Disease Industry: Institutional Imperialism:
As far as the practice of hospital medicine is concerned, undergraduate attitudes are formulated in the medical schools. As long as those responsible for imparting knowledge do so from an exclusively super-specialist, centralist point of view, the more likely is the student to inculcate the values of such.

The 'processing' of the post-graduate may only add to any alienation already developed during the pre-conditioning of the undergraduate.

[1] Anyone who worked in the Route Hospital operating theatre is unlikely to forget the experience of the 'Pleodor' X-Ray machine as it was trundled into the theatre to take the A-P (antero-posterior) X-Rays during operations to mend fractured necks of the femur. It had served this purpose within the living memory of all of the theatre staff ever since they had been appointed.

When one of the radiographers went for interview in a Belfast Teaching Hospital, she was asked what type of X-Ray equipment had been used during hip joint surgery in the Route Hospital. To this question she replied, 'To tell you the truth I don't know what you would call it for I've never seen the likes before or since'! I'm glad to add that her application was successful!

Equipment is judged by how it measures up to 'the latest' which in turn is too easily equated with 'the best'. Because it is so easy to label a therapeutic device as 'obsolete', what may be *appropriate* in terms of working life-span, function and value[1] may fail to satisfy the high-technology trainee who would prefer to use a gadget that will give enhanced status to his/her work and self-esteem. Technological imperialism becomes the reason whereby some hospitals, for instance, have been left without on-going, on-site appropriate radiological back-up.

On-going equipment crises, the lack of equitable staff back-up in terms of numbers and training, make it less and less likely that post-graduates in hospital medicine will anticipate satisfactory and happy practice outside of a city environment. In the prevailing social and professional climate, prestige, status and lucrative private practice are associated with the city and the country cousins are perceived as being in the halfpenny place.
In our market driven economy, where everything is so eagerly priced, the attractions of full-time rural community consultant commitment seem to have become less and less as time goes by. With so much loaded against them it is remarkable that some of our small acute rural hospitals still survive. Many years ago, (1970s) the New Ireland Movement began to think of Health in terms of the **State of Well-being.** We quickly discovered that we were not alone in this respect. So far, the urbanising effects of high technology consumer society do not seem to have delivered a consistent improvement in individual or collective well-being. It was no great surprise when Maeve-Ann Wren chose the title, 'An Unhealthy State', for the series of articles which she wrote in the Irish Times about the present Health Service in the Irish Republic.

Restoration:
If and when morale drops, performance and standards are bound to suffer; the very people who were prepared to fight for the retention of

traditional services in the community begin to lose confidence in what remains of those services and they too start to drift centrally. And so the central ego is further enhanced to the point where the centralist begins to believe his or her own myth – that s/he is better when in fact s/he is only different. Indeed, implicit in the populist phrase 'Centres of Excellence' is the arrogant assumption that excellence cannot exist anywhere outside of a centre!

The peripheral people have not the power, and the central ones are not yet prepared to yield enough of it, to ensure, through the imaginative use of modern Information and Communication technology, that objectives concerning need and priority, as determined by people where they live and where they work, may now be met in a quite different and more equitable manner than heretofore. Nevertheless, it is conceded that there has been advance in this regard in more recent times.

Before to-days centralism brings about its own implosion, we need a politic that will challenge and then change the direction in which technological centralism has taken us.

It is, perhaps, worth recalling, yet again, the words of the great soviet dissident, Alexander Solzhenitsyn,
"the centralisation of all forms of life of the mind is a monstrosity amounting to spiritual murder."

CONCLUSION

V

Health, as distinct from *dis*-ease, has for some time been described as a state of well-being. Those who use the economic argument to justify more and more rationalisation overlook the fact that there are intangible assets in an economy which we ignore at our peril. The only economy worth striving for is an economy of well-being. That being in short supply within the National Health Service, we could conclude that something may have gone radically wrong.

E.F. Schumacher (Small is Beautiful) highlighted the value of the intangible assets such as morale, esprit de corps, commitment, enthusiasm, centrality (as distinct from centralism), vocation, collective convergence and so on and these, he was at pains to point out, are related to the full development of the human potential in people as well rounded persons. **In turn he believed that such development also related to small scale and community rather than to size and centralism.** Health economists invariably place themselves in an uneasy position if the economy which they are promoting undermines the well-being which they are ostensibly trying to create.

In particular those concerned about health as a state of well-being should first and foremost investigate the degree of pathological stress to which young surgical and other trainees are subjected in fulfilling tasks imposed upon them. As far as a demanding period of research is concerned, such tasks may well be unrelated to the development of their desired surgical skills. This exemplifies but one of the extra pressures to expand C.Vs. to meet the demands of interview panels, all too often achieved at the unreasonable expense of any hope of having a balanced and healthy life style.
Are trainees to be exposed forever to time- and energy-consuming matters of questionable relevance in addition to the routine hard work and stressful clinical responsibility of their appointments? Are

trainees for ever to be denied the need, let alone the opportunity, to participate in structured and regular in-depth discussion with their senior colleagues and administrators about matters of concern to them. How many hospital administrators, during their training and learning years, would be prepared to work under life, death and career stress for anything like the number of consecutive hours carried out by junior surgical trainees on an average Friday to Monday take-in?

Would they be satisfied with "a couple of sandwiches on the hoof" in lieu of a decent meal and a rest break? What is the cadre of administrators doing to ensure that the European Directive on working hours is operating in spirit as well as by official regulation. Where is the Junior Staff Group protest[1] in all of this and does any consultant or administrator check up if trainees, for social reasons, are manipulating rotas by swaps of duty to satisfy the social rather than the workplace obligation or need for rest and balance in their lives. It's not good enough to shrug shoulders and say, 'that's their choice, let them get on with it'. Working hours are important to the health of trainees and other staff; they are also important to the effective treatment of the sick patient.

Ever since the mid-1970s, 'rationalisation' has become the catch-cry of Administration in general. Over the same period, personnel and people, as far as the National Health Service is concerned, have become aware of a decline in individual, institutional and collective community morale and well-being. This state of *dis*-ease goes hand in hand with worsening personal communication and, in many instances, with increasing feelings of alienation.

'Rationalisation' has become cheap speak for **'centralisation'** whereby the central, the powerful and the big are allowed and encouraged to colonise the weak, the small and the peripheral.
At the same time much lip-service has been paid to the **Principle of**

[1] The march of consultants and post graduates in Glasgow on Saturday, 17th. March, 2007, is a sign of hope that – at last – the profession has begun to realise the power of protest.

Subsidiarity which, crudely stated, urges that the large and the central should not do for the small and the peripheral that which the small and the peripheral may be able, albeit in a different context and with appropriate relevance, to do for themselves.

Regrettably, the present rationalising forces, responding as they do to the cult of size and centre rather than to the needs of scale and community, will continue unchecked until Health Service personnel and tax-paying people become more aware and more politically active regarding the issues surrounding control and accountability. A turning point may yet come through more imaginative use, on even wider scale than at present, of the new Communication Technology.
In the meantime, if it were possible to bring the relatively simple proposals outlined here[2] to fruition they could become a local exemplar in the exercise of a more people-focussed, democratically accountable, health-promoting process. Real dialogue based on a desire for consensus rather than on administrative and/or professional empire building and control might become more likely both within and between communities. For this to happen the central institutions of the state should be obliged, if necessary by protest, to respond positively and democratically to needs as defined by people where they live and where they work, albeit within a regional framework and responding to an overall regional strategy. Such could be validated by relevance where balance becomes more significant than control.
The centre could and should operate as a source of co-ordination rather than of control. It should be there to respond rather than to dictate.

Personal communication from Convenor of the Viking Surgeons following the Annual Meeting held in 1999 at Dr Gray's Hospital, Elgin, Morayshire.
"The presence of the President of the Glasgow College of Surgeons and the President Elect of The Association of Surgeons of Great Britain and Ireland was a coup for the Vikings.....Although

[2] See next section entitled, 'Remedy'

no solutions to all our problems were forthcoming, I have little doubt that two important components of the surgical establishment are now acutely aware of the threat of super-specialisation to smaller hospitals. The Glasgow president has promised to look critically at College accreditation of Senior House Officer posts and the President Elect of the Association of Surgeons is considering hosting an Autumn Association meeting in the year 2000 on the topic of the "smaller hospital".

Was this carried through?

The Viking Surgeons are independently minded surgeons working in isolation or in isolated communities mostly in island hospitals or with an island work commitment, e.g. Faroes, Iceland, Isle of Man, Lewis and Harris, Orkney, Shetland, etc. Meetings have also been held in Ballymoney, Coleraine, Fortwilliam, Golspie, Oban, Penzance, Wick as well as Elgin and other peripheral parts of Scotland.

Until the medical establishment can look at the local community scene with more concern for the commonplace in hospital patient management and how to prepare doctors to deal with such, competently and effectively to the satisfaction of people as part of a community, Ivan Illich's seminal statement that

"the medical establishment has become a major threat to health"

will continue to ring true even for his most outspoken critics, such as David Horobin.[3]

In Horrobin's book, 'Medical Hubris' – 'A Reply to Illich', he opens Chapter 11, 'Proposals for Change' as follows:-

'The medical establishment has become a major threat to health.' In spite of all my criticisms of his work, in spite of all his exaggerations and inaccuracies, I still feel that Illich's first sentence is right. He is wrong about the current seriousness of the threat; he is wrong in extrapolating so glibly to the whole world from the countries of his own experience, he is wrong in his estimate of the contributions medicine has made . But he is right in his assessment that things are

[3] Medical Hubris: (A Reply to Ivan Illich): J.S. Horrobin: Churchill Livingstone: (1978): p. 86.

beginning to go badly awry and that action is required if they are not to get very much worse in the near future."

That establishment should have been the primary target of community activists back in the seventies and eighties; it is now too late for many communities. The remainder, however, should keep Illich in mind and act accordingly.

Acknowledgement:
In conclusion we should congratulate the Scottish Royal Colleges of Surgery for their ability to respond to the campaign spearheaded by the Viking Surgeons. Attitudes are now changing and those of us who do not live in Scotland can only hope that the response of the Scottish Colleges regarding the training and vocation for work in the Acute Surgical Units of the smaller hospitals serving Rural and/or Remotely placed rural communities will, more and more, receive the support and encouragement for which they are yearning, be it in these islands, in the Australian Northern Territories, in the remote areas of Scandanavia or elsewhere.

SECTION VI. REMEDY.

REMEDY
Application of Communitarian Manifesto and Charter[1]
to
The Health Service[2]

With the urgent challenge of rural community regeneration very much in mind, pointers are here indicated as to how, within national and regional guidelines, the user and the provider (the public and health personnel) might become involved more actively and more constructively in the appraisal of the service and in the determination and provision of realistic priorities in relation to it.

The suggestions are taken from the New Ireland Group's Communitarian Manifesto, published 2003, with its contained Local Community Charter (pages 25-35) and should be applicable to the retention and good functioning of other small enterprise such as schools whenever such are under threat from centralism.

1. Users' Committees

The setting up of a patients', (clients'/users') committee in all health service institutions i.e. hospitals, residential homes, clinics, health centres, day centres, etc. Such committees would be elected annually and would each operate under a straightforward constitution with duly constituted standing orders. All identifiable users or, where more appropriate, close relatives by proxy, would be eligible to attend and to participate. Agendas should be circulated in advance and minutes taken for subsequent ratification or correction and should be indexed for easy reference.

2. Providers' Committees

The setting up of a personnel (providers) committee in all health

[1] Out of the past: A Divisive Democracy; Into the Future: A Citizen's Alternative: A Communitarian Manifesto: Coleraine Printing Co. (2003) see pages 25-35. (A New Ireland Group Pamphlet).

[2] See also the Pamphlet, Democratic Accountability in a District Health Service: First Edition, Green Cover, April 1992.
Second Edition, Orange Cover, Nov. 1992.

service institutions i.e. hospitals, residential homes, clinics, health centres, day centres, etc. Such committees would also be elected annually and would operate under a straightforward constitution with duly constituted standing orders. All personnel (whether using spanner or scalpel) on the pay-roll of the campus would be eligible to attend and to participate.
In addition to such general election, consideration should be given to the co-option, at appropriate meetings, into this committee of nominees of the Special Advisory Groups (see para. 6 below). Agendas should be circulated in advance and minutes taken for subsequent ratification or correction and should be indexed for reference.

3. Identification of Statutory Key Figures
In endeavouring to democratise the Service, key figures appointed in accordance with the policies of the state cannot, short of social revolution, be ignored and need to be included in the decision making process. These will include such as the Chairperson of Medical Staff, Chief Nursing Officer, the Senior Shop Steward/s, the Chief Executive Officer and so on.
Once the Tripartite Co-operative Cabinet (see, 4, below) has been constituted the ratified constitution should include means of determining the appropriate co-option of 'Key Figures'.

4. Tripartite Co-operative Cabinets
Following the election of the above committees the next step might be the setting up of Tripartite Co-operative Cabinets in each of the Health Service Institutions and that these would consist of equal numbers of nominees from the Users' Committee, the Providers' Committee and of those identified as the Statutory Key Figures as well as others co-opted from the Specialist Advisory Group (see para 6 below) for particular issues by agreement. Such Councils would be subjected to annual election and would operate under a straightforward constitution with duly drawn up standing orders Agendas should be circulated in advance and minutes taken for subsequent ratification or correction and should be indexed for easy

reference.

The objective would be to ensure better overall access to and more accountability in decision-making, leading, hopefully, to a more realistic expectation by the General public and more sensitive awareness by the professions as to problems and solutions.
If, for example, management is anticipating rendering personnel redundant this should be intimated well in advance of action so that those who feel vulnerable would have time to consider how best to cope with their future. At present, in the commercial and industrial spheres throughout Ireland, large scale redundancies are thrust suddenly on personnel, many of whom have given loyalty to their respective work place over many years. In all spheres of work, personnel should cease to be left in limbo without warning of how they may have to face up to redundancy coming at them out of the blue. 'Health' being defined as 'well-being', a Health Service should be giving a lead in this respect

5. Community Health Guilds,
The establishment of Local Community Health Guilds to meet at least bi-annually with the purpose of bringing together all of the voluntary and statutory agencies working in the locality in Health Promotion, Disease Prevention, Therapy and Care so that they may complement each other's work and, in time, link into a network of Health Guilds with other communities.

6. Special Advisory Groups,
Special Advisory Groups might be convened as follows:

i. Junior Medical Staff
ii. Nursing Staff
iii. Para-medical
iv. non-medical, non-nursing (all other personnel)
v Chaplains
vi. Social Workers
vii Voluntary Sector
viii Private Sector
ix. Local Councils
x. The local network of Community Associations

7. Local District/Community Health Council

This would be formed by delegates from the Tripartite Co-operative Cabinets, the Community Health Guilds and the Special Advisory Groups. This Council would be expected to meet in Convention at least once per year for a whole working day to discuss progress and policy etc. and to ensure that its deliberations were publicised.
Thus, the professions would become better informed and, more acutely aware while the public at large might become more conscious of the difficulties relating to the delivery of the kind of Health Service for which they yearn. These meetings would be conducted on an agenda created by submissions in advance from those eligible to attend. Well organised publicity should attend such cross fertilisation for discussion and debate involving the concerned public with the Health caring, Disease curing and Health Promoting personnel.

8. Regional Federation of the Local Rural Community Groups
Using such as news sheets, press releases, and media spokesmen as well as engaging politicians, Rural Community Hospitals and other Rural Health Institutions, through net-working, could start to create effective pressure to redress the worst aspects of present trends in rural community *dis*-ease and decline. Contact with such as the Viking Surgeons in Scotland and elsewhere should be encouraged.

APPENDIX I. (SECTION VII.)

FINANCING DE-CENTRALISATION

A.

The commentary in this section is based on the 'Lawrie' assertion that only 10-15% of all acute cases arriving at the doors of the small Acute Local Community Hospitals (A.L.C.Hs.) should need referral to more centrally , super-specialist hospitals for their management. From this assertion it has been suggested throughout the different sections of this booklet that this 15% should be amended to take account of 'Area' or Intermediate Hospitals offering some sub-super-speciality services. The latter would be expected to deal with 5% of referrals from the A.L.C.Hs. In those local communities which relate to such Area Hospitals, only 10% of overall referrals should need to reach the centrally located Regional super-specialists

Taking the 'Lawrie assertion (85-90%) into account **(see page 8)**, we would suggest that funding on a population pro-rata basis should reflect on the one hand, the extra resources required to sustain the centrally located super-specialist units serviced by expensive sophisticated super-technology (S) and, on the other, the incorporation of a Flexible factor (F) to sustain and encourage decentralization by maintaining small acute hospital service developed over generations in local rural and other remotely located communities. The argument justifying the continuation and, if necessary, the re-development of the latter is a central theme of this booklet.

B.

Derivation of formulae:

Let the population of the region = **R.**
Let the population of the city served by the Central specialist hospitals =**C.**
Let the population of the Regional area (R) be divided into those sectors which are separately administered. Taking Northern Ireland as it has been as the example,

Northern Area population =**An.** Any Northern Sector
Southern Area population =**As.** Any Southern Sector
Eastern Area population =**Ae.** Any Eastern Sector
Western Area population =**Aw.** Any Western Sector

} of any area under consideration elsewhere

Such sectors of a region may or may not boast an Intermediate ('Area') Hospital containing some specialist services
Within each sector/area there may still be Local Community Acute Hospitals which will serve the acute needs of the traditional local community population, = **(LCP).**

C.

In each region we anticipate three levels of hospital enterprise:

I.The Regional super-specialist hospitals:

Receiving 100% of the ordinary 'run of the mill' cases from the catchment population of the respective city's G.P.s

Plus,
15% of the cases presenting at the Local Community Hospitals in those areas which are not supported by an Intermediate Area Hospital (see below),
Plus
10% of cases presenting at the Local Community Acute Hospitals in those areas which are supported by an Intermediate Area Hospital with some specialist surgery. (see below)

II.The 'Area', Intermediate Hospitals

Surgeons appointed to these may have a well developed special interest in a particular sub specialty.

Receiving 100% of the ordinary 'run of the mill' cases from the catchment population of the GPs relating to the district concerned,
Plus,
5% of the cases beyond the capacity of the Local Acute Community Hospitals of the particular area.,

III. The Local Community Acute Hospitals:
Dealing with85% of acute surgery in its local catchment population

Examples of the above in Northern Ireland:

Northern Area (An):

- i). Recently built, **Antrim Hospital** which is receiving cases from the district previously served by Larne Hospital,

- from the Southern section and other sections of that previously served by the Waveney (Ballymena) hospital, but excluding those, which are referred to Causeway in the first instance.

- from cases from the district previously served by the old Antrim Hospital

- and from the 5% of cases from Whiteabbey Hospital which may be beyond its capacity yet which do not require to be referred to the Regional super-specialist centres in the Regional City..

[1] When the original decision was made by the board, it was stated that there would be two Acute Hospitals in the Northern Board's Area, the larger one in Antrim and the other in the Northern part of the Area, the exact location to be determined later (Northern Board minutev38/77, line 13). Regarding the latter, agreement became possible because of the magnanimity of the people of Ballymoney who were willing to accept the siteof the Causeway Hospitalon the edge of Coleraine

There is some doubt as to whether the Antrim Hospital was ever officially designated as the Area Hospital for the Northern Board's area.[1] This now seems irrelevant as it has for all practical purposes taken on the mantle of being so! –
Practically speaking, acting as an Area Hospital, it should also expect to receive
5% of cases referred centrally from Causeway
ii). Recently built Causeway hospital

Receiving 'Run of the mill'cases from the district previously served by the Roe Valley(Limavady) catchment between Limavady and Coleraine,
Plus,
'Run of the mill'cases from the district which had been traditionally referred to the old Coleraine Hospital,
Plus,
Cases previously received by the Route Hospital (Ballymoney) which served North Antrim,
Plus,
'Run of the mill' cases from the Northern section of the former Waveney (Ballymena) Hospital catchment

iii). Whiteabbey Hospital which receives cases referred by the G.Ps of the Whiteabbey district.
Cases beyond its capacity will be referred either to Antrim hospital(?5%) or to the Regional specialists in Belfast(10%)

iv). Mid Ulster Hospital (Magherafelt), a Northern Board Local Community Acute Hospital serving its traditional district less the

[2] Royal Victoria Hospital,, Belfast
[3] Belfast City Hospital,
[4] Musgrave Park Hospital

'Lawrie' 15% which should be referred centrally.

EASTERN AREA (Ae):
Regional services in R.V.H[2] .,B.C.H[3] .,Mater Infirmorum and M.P.H[4] with Plastic Surgery in the ULSTER HOSPITAL (Dundonald)

Receiving:100% of the ordinary 'run of the mill' cases from the catchment population of the GPs relating to the immediate population of the Regional city **(C).**
Plus,
15% of cases from all local acute hospital GP referals in the Region **(R)** which do not refer to an Intermediate (Area) hospital for particular specialist services,
Plus,
10% of cases from local acute hospitals which are able to hive off 5% of what they cannot manage to an Intermediate (Area) hospital

THE SOUTHERN AREA:
Acute Hospitals already closed: Armagh, Banbridge, the old Lurgan and Portadownand more recently, The South Tyrone Hospital (Dungannon)

i). Craigavon Area Hospital Receiving:

from the catchment populations of the above** former locally active acute service community hospitals.
Plus,
5% of centrally referred cases from Daisy Hill Hospital (Newry) now also said to be under threat of losing it's A & E Department (? The initial stage in 'erosion by stealth'??)

THE WESTERN AREA:
i). Altnagelvin Area Hospital:
Receiving
all 'run of the mill' cases from the communities which had in the past been serviced traditionally by Acute Hospitals in Derry City,

Plus,
All 'run of the mill' cases from the district served by the former Roe Valley Hospital excepting those cases from the district between Limavady and Coleraine which may now travel to Causeway (Coleraine) and by a proportion of the 'run of the mill' cases from the district formerly serviced by the Tyrone County Hospital.
Plus,
The 5% requiring specialty treatment who do not have to travel to Belfast for it. eg., from The Erne Hospital (Enniskillen)
And, by special cross boundary arrangement, with Altnaelvin Hospital, Derry from the Causeway Hospital catchment population (Fractures & Orthopaedics in particular)

D.

Regional Hospitals; Area Hospitals: Is their double/triple responsibility t a cause of current log jams in the service?

The Regional Hospitals, in addition to dealing with super speciality work must also deal with ordinary 'run of the mill' cases from the catchment areas of the GPs who refer into them. Together with the Intermediate (Area) hospitals they must also cope with the 'run of the mill' cases requiring referral to hospital from the former catchment districts of the Acute Hospitals already closed as well as the referred percentages from those Local Acute Community Hospital units which have thus far escaped closure: 15% where there is no intermediate Area hospital service and 10% from those where it is possible to have 5% dealt with in the Intermediate Area Hospital

E.

Conclusions:

i). not surprisingly, the closure of so many small hospitals has led to trolley and bed log jams in the bigger more 'centrally operating' hospitals

ii). a cadre of Community Acute Surgical consultants is urgently required to preserve any semblance of a Local Community Acute Hospital service in those localities where such had been built up over a number of generations.
Such a training programme, specifically tailored, might also be attractive to many of the aspiring indigenous trainees from the developing countries of the world.

iii. Like Local railways, there may come a day when the demise of the local acute service hospital is rued, especially by the increasing number of elderly patients and also because of ecological measures involving Carbon rationing for travel by both patient, friends and relatives, not to overlook accompanying Hospital personnel.

iv. The closed local hospitals should be preserved to allow for re opening rather than run the risk of being bargained off as a developers dream come true!

F.

THE FINANCING FORMULAE, Based on the 'Lawrie' assertions.

To recall the meaning of the 'letter' code.

S= a factor to be taken up centrally to take account of the cost of the superspecialist service required by 10--15% of the Regional (R) acutely ill population while 5% will be taken up by Intermediate ('Area') Hospitals where these are operating.

F= a flexble factor to encourage and sustain decentralization by maintaining the Small Local Acute Hospital Service where it has been developed over generations in local rural and other remotely located communities.

R= population of the region.

C= population of the city where the Central Super-Specialist Hospitals are located.

Let the Regional area, R, be divided into separately administered sectors, for example as it was in Northern Ireland:

An= Northern Area Population.
As= Southern Area Population.
Ae= Eastern Area Population.
Aw= Western Area Population.

Such sectors of a region may or may not boast the existence of an intermediate ('Area') hospital rendering some specialist services

L.C.P= Local Community Population.

In Northern Ireland, the Central Super-Specialist hospitals are situated, by and large, in the Regional City **(C)** which, in Northern Ireland, was in the Eastern Area **(Ae):** (see below:--'Application').

G.

APPLICATION of the FINANCING FORMULAE

(Northern Ireland as example):

Central Specialist Hospitals should receive on a population pro-rata basis,
100%C
+15% of the rest of the area in which they are located = **(Ae – C).**
+10% of the Northern Area **(An)** - Antrim assumed to have status of an 'Area' Hospital

+10% of the Southern Area **(As)**
+10% of the Western Area **(Aw)**
Plus the Specialist Factor **(S)**

=100%C +15%(Ae –C)) +10%(An +As + Aw) +S

The Intermediate ('Area') Hospitals should receive on a population pro-rata basis,

To account for **90% of** the 'run of the mill' cases traditionally referred to them by the GPs in their catchment district. The 'Lawrie' formula would suggest that 10% of referrals will be sent on to the Regional super-specialist City hospitals

+ 5% of referrals from the rest of the area requiring specialist attention.
+/- a Flexible Factor **(F).**

The small local acute service hospitals should receive on a population pro-rata basis,

To account for the 85% of the local community population requiring referral to an Acute Hospital. = **85%LCP (15% expected to move centrally)**

+the FLEXIBLE Factor **(F)** to promote decentralisation. This amount should be allocated per head of population in proportion to the total finance determined for the region for decentralization of the service. In other words the F factor for a particular Local Acute Community Hospital would be deduced by the fraction of local population over Regional population.

Local politicians, Local Community Activists and concerned groups such as members of ' The Rural Community Network' could decide

to come together to lobby for a decentralisation fund. This would be distributed as suggested in the above paragraph. Some consideration should be made as far as the Intermediate ('Area') acute hospitals are concerned.

The S factor should be allocated to the super-specialist hospitals in accordance with the number of cases referred to them for super-specialist attention per annum.

H.

Worked out allocation (N.I. as the example)
City share:=100%C +15%[(Ae –C)] +10%(An+As +Aw)+S

LCP share = 85%LCP +local share of Regional Flexible allowance for the promotion of decentralization =

$$85\%\ \text{LCP} + \frac{\text{LCP}}{\text{R}} \times \text{F}$$

I.

DETERMINATION OF PRIORITIES

Once figures have been given to these financial formulae, the Tri-partite cabinets, the Health Guild and the Community Health Council should be encouraged to come together to debate allocation in relation to priorities determined by the combination of user, provider and statutory officer input. (see Section VI –Remedy).

Different communities may well have different priorities and decisions relating to these differences should not be determined so exclusively by centrally located professionals and administrators.

J (1).

Comment:

Back in **1992**, the above formulae were used to demonstrate what seemed to be a fair means of allocating financial support to hospitals with different numbers of cases likely to be referred to and dealt by them . A comparison was then made to determine the financial distribution to Local Acute Community hospitals with that being distributed to the Central super-specialist hospitals. This was based on the 'Lawrie' assertion quoted above

Using the population figures available from the previous census it became clear that, on a pro-rata basis per head of population, Central hospitals were doing much better w.r.t. their financing.

Undoubtedly, the population figures for **1982** would have been seriously affected by the troubled state of Northern Ireland. Even so, we must ask, if the City population has increased by leaps and bounds since that time, whether this can be a good thing for the overall health of the people. Further, we should ask, if more than the Lawrie 15% is being referred centrally out of the local communities, why this may be so. This booklet suggests pointers to the answers to such questions.

Since **1992,** the date of the previous study, there has been a further dissemation of the small Local Acute Community Hospitals
with the not unpredictable consequence of increased trolley and bed demand centrally.

Ballycastle offer rebuffed!

It therefore seems relevant to recall that a brand new operating theatre suite lay vacant for years in Ballycastle's Dalriada hospital and was only used latterly as a matter of decentralising principle by the surgeon based in Ballymoney, (1973-1992), 16 miles away.

An offer:
At a time when concern was being expressed about the length of the Waiting List for minor and intermediate Plastic Surgery operations in Belfast it was suggested that these could be undertaken during the summer in Ballycastle by a competent senior trainee with consultant cover for post operative complications being provided by the Ballymoney consultant who, as part of his training , had spent approximately three years attached to Plastic Surgery units. Suitable accommodation would have been available for the Senior Trainee, his wife anf family so that, as a bonus, they could enjoy this well-loved summer seaside resort!

Two objections were raised:

i.) that consultant cover would be 16 miles away yet this distance could probably be driven as quickly in North Antrim as the drive across the city of Belfast from a consultant's home in the suburbs to the Plastic Surgery unit.

ii.) That the people of Belfast would not be prepared to travel to Ballycastle for treatment yet it was taken for granted that the people of Ballycastle were ever prepared to travel in the opposite direction to Belfast!

J (2).

POST OPERATIVE INFECTION:

Because of the author's belief in decentralization he must pose the question as to why we do not seem to have heard from the media of research being undertaken to compare rates and severity of infection between large centrally placed hospitals located in cities and small locally based Acute Community Hospitals located in rural and/ or other remote localities.

After resigning from a central Teaching Hospital to take up a consultant post in perhaps the smallest of the remaining 'surgical' hospitals in Northern Ireland, he gained the opinion that the risk of

POSTSCRIPT SECTION VIII
'Long Live the Small Hospital': a Summary:

The significance of the small acute hospital in a community which has had one as part of its experience for generations is explored in this booklet. The booklet deals with the need for change in medical school and post graduate training culture so that, in the context of the sophisticated technology now available, the need to be up to date is effectively managed without compromising local community well-being.
The Small Acute Hospital is an important resource in a small community for many reasons, not all of them to do with a traditional therapeutic service. The booklet, 'Long Live the Small Hospital' touches on a Health Philosophy suitable for the promotion of a new look Health Policy.

The work is based on four assertions:
I. A definition of Health,

II. The detrimental effect on society of an obsession with centralization,

III. The lack of open debate and discussion between personnel, clientele and statutory key figures obscured by, even suppressed by, Institutional (Professional) imperialism,

IV. The combination of Bureaucratic Centralism and Institutional Imperialism has had an inhibiting effect on the contribution to communication between the three legs of the Health Scene — personnel, clientele and representatives of the statutory appointments. There has not been a sufficiently dynamic structure to bring them all together for open and liberating discussion on a regular and frequent basis.

Health is defined as a State of Well-being – from which we might conclude that a healthy economy is the economy of well-being an economy which is dependent on much more than a *Health* Service.
Education should provide appropriate knowledge; *broadening experience* should raise awareness. Knowledge and awareness are the

pillars of informed debate.

Centralism: In a letter to the Soviet Leaders sent to them by the courageous dissident, Alexander Solzhenitsyn, (1972), he insists that **'The centralisation of all forms of life of the mind is a monstrosity amounting to spiritual murder'**

The Medical Profession has been promoting more and more centralisation and using 'rationalisation' as a euphemism to make it more palatable for the public. The booklet questions the belief that rationalisation must invariably take place in a centrally moving direction and that it cannot take place in the opposite direction .

Health is indeed a state of well being and Community Health should be an expression of local Community well-being.