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Notice

Requirements for thoracic medicine

In recent years there has been a steady reduction in the number of full time chest physicians except in teaching hospitals and regional centres. At the same time thoracic medicine has become an important subspeciality practised by appropriately trained general physicians based in district general hospitals.

In 1982 the Regional Representatives Subcommittee of the Council of the newly formed British Thoracic Society produced a statement of the current requirements for thoracic medicine in district general hospitals. This was later modified by the Standing Committee on Thoracic Medicine of the Royal College of Physicians. In 1983 the document was formally adopted by the British Thoracic Society and by the Royal College of Physicians. It is reproduced here to provide a convenient source of reference for those responsible for providing thoracic medical services in Britain, and for the interest of those with similar responsibilities abroad.

REQUIREMENTS FOR THORACIC MEDICINE: A DOCUMENT FOR THE GUIDANCE OF THOSE PLANNING THORACIC MEDICINE SERVICES OR CONSULTANT POSTS

Thoracic medicine will probably, like other specialties, be practised in two closely related types of unit. Large teaching centres may have two or more consultant physicians specialising almost exclusively in thoracic medicine, depending on the population served and the number of students. In addition, every district hospital of any appreciable size will have one or more physicians with a special interest in thoracic medicine. This document deals with the latter group in an attempt to define and quantify facilities that should be available to a general physician who is responsible for thoracic medicine in a district general hospital.

Inpatient facilities: requirements

1 Adequate beds for acutely ill patients with diseases of the chest, some or all in a district general hospital which is staffed and equipped for acute emergencies.
2 Ready access to an intensive care unit with facilities for artificial ventilation, with clinical charge of his or her patients. This would be in the same hospital as the ordinary inpatient facility.
3 Beds for the investigation of acute respiratory disorders, covered by resident house staff.
4 Access to a small number of beds suitable for the care of patients with infectious tuberculosis (NB very few such patients now remain in hospital for longer than six weeks).
5 Physiotherapists attending regularly and providing an out of hours service.
6 A 24 hour radiology service on site with facilities for tomography and screening when required.
7 Provision of spirometers, peak flow meters, and piped oxygen in the wards.
8 Equipment and facilities for fibreoptic bronchoscopy.
9 A formal link with a thoracic surgical unit and a radiotherapy department.
10 Ready access to nuclear medicine.
11 Twenty four hour availability of blood gas analysis.
12 Standard pathology services with cytology and routine clinical immunology.
13 Access to respiratory physiology laboratory, including facilities for spirometry, measurement of lung volumes and carbon monoxide transfer, and exercise testing.
14 Access to specialist respiratory physiology facilities with equipment for detailed investigation.
15 Access to facilities for exercise training and rehabilitation is desirable for the chronic respiratory sick.

Outpatient facilities: minimum requirements

1 Clinic, nursing staff, and satisfactory appointments system.
2 Nearby chest radiology without delays for patients.
3 Standard outpatient clinic equipment with the addition of spirometry, peak flow meters, facilities for skin allergy, tuberculin and Kveim testing and for skin biopsy and ECG.
4 Routine outpatient pathology services.
5 Ready access to respiratory physiology laboratory.
6 Access to non-invasive cardiological tests and echocardiography.
7 Access to nuclear medicine.
8 Day patient facilities.

Staffing: minimum requirements

1 One consultant with a substantial commitment to thoracic medicine per 150 000 population; at least one such consultant in each district general hospital.*
2 Sufficient junior staff support for inpatient care and facilities for their future training in the outpatient department.
3 A working association with other specialists in thoracic medicine and surgery.
4 Adequate cover for the speciality by experienced staff when consultants are absent.
5 Time available for investigation (physiology, bronchoscopy, etc).
6 Secretarial support.
7 Administrative support for the tracing and examination of tuberculosis contacts.
8 Physiological measurement technicians (at least one of senior grade) in the respiratory laboratory.
9 Session for research and travel to clinical meetings.

*This figure applies to 1982 but will need modification should junior staffing levels fall.