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Editorial

Regional thoracic medical centres

The basic hospital medical services in the United Kingdom are centred on district general hospitals. The reasons for not providing a particular facility in every district hospital are several. The demand for that facility may be relatively infrequent or the provision of it would entail either a major capital outlay in equipment and accommodation or large revenue consequences in terms of trained staff. The leaders of each specialty must determine which facilities should be available in every district hospital and which should be provided in only one or two centres in each region.

There are, however, reasons other than economic for the creation of regional specialist centres. Those specialties that do not require expensive or massive equipment and a great amount of space tend to become dispersed among several different hospitals and are thus denied the opportunity of creating a centre of excellence. In this respect, thoracic medicine is at a disadvantage in comparison, for example, with cardiology. The cardiologists recognise two types of specialist: the general physician with an interest in cardiology based in the district general hospital (type B) and the full time cardiologist based in a regional cardiac centre where the more expensive resources are contained (type A). The latter is enabled to build a centre of excellence in his specialty not just by virtue of the equipment and space available to him but because the centre can attract laboratory, nursing, and other ancillary staff who specialise in cardiology.

There are few thoracic medical centres of this kind and most of those that do exist have been superimposed on a tuberculosis sanatorium or a cardiothoracic surgical unit. Those in the former group are under threat on the spurious grounds that tuberculosis—their original raison d'être—is no longer a problem. The thoracic medical centres in the latter group are liable to suffer from the increasing demands for cardiac surgery and for the cardiac medical back up that this surgery requires.

It should be recognised that there are certain essential thoracic medical facilities that cannot be made available in every district hospital but must be provided for every region; a list of these has been drawn up and approved by the Council of the BTS and it is published on p 496. In some regions these facilities—if available at all—are scattered around several district hospitals, where the chest physicians may already have a major commitment to general medicine. There is a case for trying to concentrate certain special functions alongside thoracic surgery in one centre large enough to justify the appointment of full time chest physicians as well as pathologists, radiologists, physiotherapists, and other technical staff who specialise in thoracic diseases. Studies in Britain and elsewhere have already shown that patients with cystic fibrosis supervised at a major centre fare better than those attending local clinics, and the same may well be true for more common diseases such as lung cancer. But, quite apart from these immediate clinical advantages, there is also a greater opportunity for postgraduate education, research, and advancement of the specialty in centres where experts from different disciplines share a common interest in thoracic diseases. Centres of this kind are not just an economic necessity to avoid duplication of equipment or staff; they are needed for the welfare of our patients and for the future of our specialty.

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