The general practitioner and the hospital*

Basingstoke

FOR the last 18 years I have been closely associated with a cottage hospital and general-practitioner maternity unit. The interest they give to the family doctor and the confidence he can instil into his own patients must not be lost sight of in the changing pattern of practice. The closed door of the district and teaching hospital to all who are not on the consultant staff is a tragedy of the growth of the Health Service.

This dichotomy between hospital and community practice has deep-seated roots in their different disciplines and methods. We must not underestimate these since they produce professional tension and sometimes antagonisms and may become more marked as technological complexity increases—the stronghold of the consultant cannot be stormed by the mass of general practitioners, we must have a plan of integration that will be to the benefit of patient, consultant and general practitioner, and we shall have to work hard to have this plan accepted and even harder to make it work.

In Britain, to quote the Report and Recommendations of a Ministry of Health Interview Board on discussion in N. America with British Trained Doctors (1968), the National Health Service has inspired "an incisive separation . . . between hospital and general practice." This is not a plea to return to the 'good old days'—but rather an attempt to put in perspective the various possibilities for a better continuity of care of the patient and a closer relationship between general practitioner and hospital practice.

The cottage hospitals have strong local support and tap the part-time staff in areas which would often be denied to the larger units.

They are criticized and closed for the following reasons: (1) that they are uneconomic, and that (2) they function in professional isolation without full or up-to-date diagnostic aids, thus offering a second-class service.

I am aware that certain of these hospitals are costly because bed occupancy is low, but this often reflects the consultant attitude, the consultant in his wisdom, often seeing a patient at the request of the general practitioner, will transfer him to a district hospital, not necessarily for further diagnostic procedures—these can often be covered by the parent hospital, even at a distance, but to halve the responsibility and bring the house officer in as the doctor with initial responsibility. This attitude is born of misunderstanding and can be overcome by closer general-practitioner–specialist co-operation.

Such hospitals need not be uneconomic compared to the larger unit as experience in New Zealand shows. Bed occupancy and maintenance costs by size of institution in that country show that although the unit of less than 50 beds has an occupancy rate of 70.5 per cent compared with about 85 per cent in the larger unit, the corrected cost per actual bed is about the same (Hospital Statistics of New Zealand (1964) Wellington).

These cottage hospitals and general-practitioner maternity units offer the easiest method of integration where the general practitioner can exercise his skills with clinical freedom, and where the patient finds the benefit of a personal physician who cares for the

*Read during a postgraduate course in Southampton on 3 November 1968.

J. roy. Coll. gen. PRACTIT, 1969, 17, 335
family and knows its problems. Many patients prefer this to the larger, more impersonal unit. There are stronger arguments in favour of their retention than their abolition, even though it may be considered unfashionable to suggest this at the present time. But we should consider more closely and with open minds the integration of the community doctor into the district and teaching hospitals—even the highly specialized units may well benefit from a closer association with the general practitioner.

Let us suppose that the aim of all medical care is to meet the health needs of the individual. To most people the transition from 'person' to 'patient' is enough without the sometimes necessary divorce from their natural habitat into the inpatient world of the hospital. The continuing care by a personal physician can often allay their fears and encourage their convalescence, and yet in Britain the patient is largely deprived of this contact, for although failures of technical competence are sometimes the failures of general practice, it is the failures in communication that are the characteristics of hospital care.

Even the referral to the outpatient department can mean disruption of work, endless follow-up and frequent change of physician (how often a junior sees the follow-up). Is this a legacy from the old pre-NHS voluntary hospital outpatient department? Does the outpatient department exist for diagnosis or for treatment and follow-up? Surely it is a primary function of the community doctor to treat and follow-up his patient after the diagnostic aids have been used and the results assessed. Of all outpatient attendances in Britain in 1966, 75 per cent were for 'follow-up' (Ministry of Health Report 1966).

Cammoch and Lee (1966) commented that: 'The hospitals are building up an increasing load of patients whose diseases they are treating concurrently with their own doctor'. I am sure we can all think of cases we have seen this week where this is happening.

Inpatients too are often admitted for simple diagnostic tests, or even for social reasons. The highly specialized skills of the consultant should be safeguarded from being over-loaded by the patient who can quite easily and often more efficiently, and certainly less traumatically be cared for by his own general practitioner provided the diagnostic aids and beds are available to him. Crombie and Cross (1959) estimated that up to 43 per cent of patients admitted to a large Birmingham hospital did not need diagnostic or therapeutic services at specialist level. Similar figures were found in other parts of the country (1960, Barrow—25 per cent males and 40 per cent females).

The hospital staff required at sub-consultant level are in excess of future consultant appointments. Without hospital beds available to general practitioners is it any wonder that many emigrate after finishing their hospital appointments? It is a matter of some urgency that the family doctor should participate in the care of his own patients in hospital.

I hope I am beginning to show that the general practitioner with hospital beds would be a benefit both to the patient and the consultant, but how would this benefit the community doctor himself?

By the present segregation of care the general practitioners suffer both educationally and professionally. What better method of further education is there than that of following a patient throughout his illness, with constant contacts with hospital methods and with consultants—consultants who are specialists in their own field? Without integration into the district hospital this ideal state cannot be achieved.

Most general practitioners suffer from a lack of diagnostic needs, indeed it might be said that some of us forget how to investigate a patient thoroughly. Most nowadays have access to pathological investigations, but how many ask for latex tests and the transaminases in suspected rheumatoids and doubtful coronaries, and if these tests are asked for does the laboratory like accepting them from the general practitioner? How
many have open access to electrocardiography and if they have can they read the tracings? Radiology is now available to the majority and figures show that the negative findings from general-practitioner referrals are no greater than those from consultant referrals.

As a result of these shortcomings in general practice both standards and recruitment suffer. Given access to hospital beds the general practitioner stands to gain educationally; professionally, our standards should improve and the difficulty of obtaining assistants and partners should decrease.

I said earlier that the aim of medical care should be to meet the health needs of the individual—to achieve this, medical care must once again be seen as a unity. How can this be attained? Many will wonder how they can find time to care for their patients, even provided they have the ability, throughout an illness which requires hospital investigation and treatment? Apart from the cottage hospitals which exist as fully integral parts of general practice, the rest must be new. Extra work for the community doctor? Need this be the case? I contend that the advantages to be gained would be worth a little extra effort, but I very much doubt if extra time will be needed. I suggest that we could all do it within our present working week.

First it is necessary to extend the diagnostic services; in some areas they are moderately good, in others appalling. X-ray, pathology, diagnostic pathology and ECG are essential—medicine cannot be practised without these measurements. I have read that in Australia and New Zealand excellent 24-hour service is provided in these fields by independent contractors; x-ray films and reports are to hand with great rapidity. Those with cottage hospital facilities may have some of these advantages—but how many others could use them and speed up patient-time as a consequence. The National Health Service cannot afford to do less than the private contractor in other countries. I have already indicated that general practitioners do not abuse these services, yet the excuse of general-practitioner abuse is still heard.

The development of general-practitioner wards and beds is a most urgent issue. In my reading on this subject I have noticed a widespread desire amongst general practitioners for this improvement. In my own area the large majority of doctors, and I may here include most of the consultants, are in favour of general-practitioner beds; the consultants give at least lip service to the idea—but we have a cottage hospital and in the near future expect a new district hospital. It is the method of integration into this new hospital that interests my colleagues at present.

I am going to quote again from the Report of a Ministry of Health interview board with British-trained doctors in North America (1968): "The appreciation by the general practitioners of their ability to use the hospital and participate in the care of their patients there, cannot be exaggerated. Time and again doctors told us that they would be unwilling to return to general practice in Britain while opportunities to admit their patients to hospital and treat them there were not available." I hope that the Ministry read and digest their own reports, and I hope the regional boards do not ignore their own fact-finding exercises. Of 688 general practitioners in Wessex (Revans 1964) over 80 per cent thought that maternity and general beds should be available. In a similar survey in S.E. England (1963) of 138 doctors who did not have access to any beds, 111 wanted access to general beds; and of the 234 who did have access already, only 14 thought that loss of beds would not be detrimental to their practice. The Gillie Report (1963) states "the range and standard of the doctor’s work is increased when they have beds for the admission of illness."

It is evident that the demand exists, but there is an enormous gulf between request and realization. The present structure of the Health Service does not allow sufficient flexibility.
I hope I have shown that the need is for the general practitioner to have access to beds for the complete care of his own patients. This can only be achieved by a change in attitude at the top: A general-practitioner ward has been opened in Birmingham and it would seem that this is meeting some of the needs, but a method of payment for this work does not at present exist. I would be the last doctor to suggest a salaried service, I wish to remain an independent contractor, but it should be possible to have a system where salary for part of one's work existed alongside the present methods of payment for work in the community.

In the outpatient departments the general practitioner is already playing a part—but the present method of payment by way of clinical assistantships is plainly ludicrous. Some boards overcome the difficulty by paying for more sessions and so remunerating the doctor in a reasonable way. I should like to see these posts filled only as training posts for a limited time—as they were originally intended—and not, as I suspect now, used merely to fill gaps in the hospital service.

Admittedly the general practitioner has a large rôle to play in the outpatient department, both from the point of view of training and also of using his skills to the best advantage of his patients, but those skills should be recognized by reasonable remuneration. I should like to see a high degree of competition for these posts with payment to make it worth while applying.

A suggestion has been made that the general practitioner should become a member of a team in the hospital, viz: consultants, registrars, general practitioners and house officers. In this rôle the community doctor can play a very useful part; he can advise on domestic problems, liaise with his other general-practitioner colleagues regarding their patients under the consultants' care, and take charge of the preconvalescent cases under the consultants' care. The Platt Report envisaged permanent medical assistants recruited from general practice and the registrar grades. The A.R.M. at Eastbourne this year rejected this idea, and the suggestion that the hospitals could have cheap subconsultants was properly discredited by the young hospital doctors. There is a need for a reappraisal of this grade with particular reference to the general practitioner who wishes to become part of the consultant team.

**Conclusion**

There are a number of ways in which the general practitioner can take his place in the district hospital, to the advantage of patient, consultant and himself.

Of primary importance is the need for beds where he has complete clinical freedom; secondly he can be of great use in the outpatient department, and this department can be of use to him as a training ground. Thirdly he can be part of a team with defined responsibilities in the care of inpatients in a consultant unit.

Personally, I see the community doctor as the person in charge of the 45 per cent of beds required to accommodate those patients not requiring specialist care. I see him as the personal physician calling for aid from his consultant colleagues when necessary. I see the consultant using his time more efficiently as a highly competent specialist, both in hospital wards and in outpatients.

I am not altogether sure that a general-practitioner member of a consultant team is the only, or even the right answer, and I think this system may adversely affect the care available to the community.

In outpatient departments, the general practitioner has a rôle to play, when trained in his specialty by way of a clinical assistantship, but he should also have access to this department to treat his own patients.

**REFERENCES**


Quoted from Martin Luther and the Birth of Protestantism by James Atkinson. Pelican Books.

In 1510 A.D. Martin Luther made a journey to Rome. He was greatly impressed by hospitals he visited in Florence, not only for their godly and pastoral care of the sick, but for their standards of cleanliness and nursing. One is inclined to think that hygiene and nursing originated with Florence Nightingale but the following words speak for themselves:

The hospitals of the Italians are built like palaces, supplied with the best food and drink, and tended by diligent servants and skilful physicians. The painted bedsteads are covered with clean linen. When a patient is brought in, his clothes are taken off and given to a notary to keep honestly. Then they put a white bed-gown on him and lay him between the clean sheets of the beautifully painted bed, and two physicians are brought at once. Servants fetch food and drink in clean glass vessels, and do not touch the food even with a finger, but offer it to the patient on a tray. Honorable matrons, veiled, serve the poor all day long without making their names known, and at evening return home. . . . They also have foundling asylums, where children are well sheltered, and nourished and taught; they are all dressed in uniform and most paternally provided for.*

*Quoted by Preserved Smith, The Life and Letters of Martin Luther, Boston, 1911, pp. 17–18.