# *Editorial*

## COTTAGE HOSPITALS

Just one year ago in an editorial in this *Journal* we commented on the report of the Joint Working Party on the *Medical Staffing Structure in the Hospital Services*[1] (the Platt Report) which was published as a Government white paper. We noticed with pleasure that, although there were no general practitioner members on the Working Party, the place of the family doctor in the hospital was duly acknowledged and that further ways of using his services were suggested. We singled out for special notice the statement that the Working Party " . . . . visualize that general practitioners will continue to be employed at cottage hospitals in which they maintain responsibility for their own cases with advice available from consultants visiting regularly. We favour the continuation of experiments in the provision of general-practitioner wards in general hospitals ".[2]

Now, less than a year later, a further white paper, *A Hospital Plan for England and Wales*[3] has been published and is at present receiving the close study that it deserves. The plan is comprehensive and bold in its conception. No one will deny the need of some plan for the future. Bearing in mind the haphazard way in which our hospitals have grown up in the past, depending for their existence almost entirely on local initiative and the munificence of individuals, the wonder is that there is so uniform a spread of hospital services over the country. " Hospitals are for people " says the preface to the plan and in the past the people saw that they had their hospitals where they most needed them. Over the passage of the years the hospital often has become un-sited, in just the same way as its once impressive fabric has become old and worn, and its wards and corridors, so carefully planned according to the fashion of the day, have somehow shrunk into things depressingly small and dingy. Such is the effect of time.

By its very nature hospital planning must always follow in the waggon-train of progress. Even the newest designs may become antiquated almost before they are perfected. The fate of sanitoria

for consumption indicates how this can happen. They still exist for us to admire, but who now falls into a consumption? So, if we can find no further use for the sanitorium it will have to go. Many of the large prison-like buildings now called mental hospitals first started as lunatic asylums, and a change of name has not changed their character; likewise no amount of juggling with words can make a workhouse hospital any less a poor-house. It is time that many of these were destroyed. We are glad that this bold, new plan will replace as it unfolds so many of these monstrosities.

Amongst the varied edifices that have been erected for the treatment of the sick, the cottage hospital is unique. The first cottage hospital was established by Dr Albert Napper of Cranleigh in 1855.[4] In the following ten years, 17 more were built and after only 22 years the number had risen to 200. It is evident that the cottage hospital met an immediate need—a need that was recognized both by doctors and by the rural and small urban populations which they were intended to serve. As Dr John H. Hunt in a paper on " General Practitioners and Hospital Beds in the United Kingdom " wrote: " The work done in them may sometimes have been poor, occasionally even bad, but for the most part it has been admirable and of more than adequate standard; some of it would not have been done at all, anywhere, had these smaller hospitals not existed."[5] From the beginning they were run by the people themselves with the help of the family doctors, and soon the hospital became one of the established institutions of the district upon which much voluntary work and charity was lavished. To many people the thought of being without their own cottage hospital is sad in the extreme. Yet if the plan projected by the Ministry is not modified many will be closed within the next 15 years, and one of the hubs around which provincial life has for so long revolved will stop for ever. The planners' urge for tidyness will have been satisfied—but at how great a loss to the local amenities?

We are glad to note that the Royal College of Obstetricians and Gynaecologists in their " recommendations on the principles and organization of general-practitioner maternity units " recognize the need for small maternity units.

> " The size and site of each unit should be suited to its own local conditions, if the needs of the population are to be met. It must be within easy access of the family doctors using it, so as to enable them to attend their patients readily, and the relatives and friends to visit with the minimum of travelling. Small units situated at some distance from the main hospital are therefore, in certain areas, an essential feature of the maternity health service."[6]

" Hospitals are for people "—patients are people. We believe that patients like to be looked after by doctors of their own choice and, when in hospital, welcome continuing care from those whom

they know; in the local hospital many of the sisters and nurses are familiar to them, and the matron, by virtue of her office, is often a local dignitary.

Much has already been said and written about the loss that general practice will sustain if these small hospitals are closed. Dr H. L. Glyn Hughes from his experience both in country practice and hospital administration made a strong appeal in the correspondence columns of the *British Medical Journal* for the retention of at least some of these hospitals in certain areas.[7] Dr Lindsay Batten supporting him wrote " general practitioners who staff and ' run ' and work in a hospital can practise their profession with pride and satisfaction, knowing that they have what they must have if they are to serve their patients as they ought ".[8] In these words is the whole reason for these hospitals. Nearly all of them were founded during the last hundred years by general practitioners who needed them to treat with all the skills at their disposal the patients in their charge. The patients taken into these hospitals were poor and in need of social services which could not be provided elsewhere. The doctor did not receive nor expect payment for his services, but he did find reward in his hospital work in the increasing amount he was able to do for the sick in his area; and his meetings with other doctors on mutual ground to exchange views and share experience did much to improve the standard of medicine in rural England.

Hospital medicine has changed, but so has general medical practice, and to do his work well the modern general practitioner requires the use of hospital beds. Concurrently with changes in hospital medicine have come changes and improvements in the general-practitioner hospitals. No longer does the general-practitioner surgeon attempt difficult major surgery—this can now be better done in the larger unit well equipped for these techniques. No longer does he need beds for acute lobar pneumonia which, if seen early, can be treated at home with greater ease than influenza. Changing social circumstances and the advance of medical science have brought other needs. A visitor to the cottage hospital in any small town will find in its beds many short-term, geriatric cases—patients recovering from cerebral haemorrhage, coronary thrombosis and heart failure, and cancer patients recovering from the effects of radiotherapy. Younger patients may be recovering nearer home from surgery performed in the more distant larger hospitals, some may be under treatment for medical complaints such as gastric ulcer and anaemia; a few psychiatric casualties of modern civilization will be in the process of rehabilitation. Some may have been seen in consultation by a specialist, most will be in the sole care of their

family doctor and his partners. In the local hospital there may be found a small x-ray plant, a small laboratory, an electrocardiograph, and a physiotherapy department—all these bring techniques to the service of the people in effecting rapid diagnosis and efficient treatment. Consultants may pay regular visits and hold clinics at which they are able to discuss the patients they see with the patients' own doctor. There will be a casualty department at which a host of minor injuries will be adequately treated, often at times outside the ordinary consulting hours of the local doctors, to the great convenience of the patients.

The suggestion that the needs of the country doctors will be satisfied by the provision of general-practitioner beds or even special wings in the district hospitals is unrealistic. To be of any use the hospital must be near the practice area of the doctor, so that he may easily visit it whenever necessary.

*A Hospital Plan for England and Wales* was considered by College council at its last meeting and after a long debate it was decided that:

"In developing their plan for the hospital service in Great Britain and Northern Ireland, the Ministers concerned should provide an adequate number of general and maternity beds in suitably placed hospitals or wards, in which general practitioners can carry out the medical care and treatment of their own patients who do not require continuing supervision by consultants or specialists."

REFERENCES

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