General-practitioner hospital beds—a multi-ward system in action

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THE DESIRABILITY OF CLOSER INTEGRATION between general practice and the hospital service is becoming increasingly recognized[1] [2]. It is important that general practitioners should have the opportunity of admitting patients to hospital without relinquishing their supervision[3]. This not only ensures continuity of treatment but, as stressed in a recent report from the Royal College of General Practitioners[4], relieves some of the strain on hospital and specialist staff. The report suggested that 'experimental' family-practitioner wards should be set up as part of existing general hospitals. The operation of the first few wards to be thus set aside would provide pointers to determine the administrative and clinical difficulties involved.

The administration of a general-practitioner hospital bed unit at East Birmingham Hospital has been described recently.[5] The unit comprised an entire ward, divided into a male and a female section, each containing six beds. This article describes the experience of two general practitioners with another type of bed unit.

Hospital facilities

For the past five years this partnership has availed itself of the facilities offered by the Hither Green Hospital, London S.E.13, to all general practitioners in the Borough of Lewisham. One general-practitioner bed has been reserved in each of two male and two female wards, and up to the end of 1967 over 100 cases have been admitted by us under this scheme. We were in full charge of our patients, although consultant advice was available when necessary, and we were also given all laboratory and x-ray facilities, with access to physiotherapy and social welfare departments.

Selection of cases and admission of patients

We did not admit patients with social problems as, in our opinion, general-practitioner beds should not be blocked with long-standing cases of this type, but should be used primarily for investigation. The average length of stay was 21 days, although some patients who required surgery stayed in hospital for much longer, up to 95 days in one case (a 76-year-old man with carcinoma of the stomach). Eight male and four female patients were admitted on two separate occasions; thus for 91 patients (39 males and 52 females) there was a total of 103 admissions. The annual number of admissions rose from five in 1962 to 36 in 1966, and 25 in 1967. Only three deaths occurred in our cases during the whole of this period, proving the point that the beds were not used for geriatric cases admitted for social reasons. Patients ranged in age from 17 to 85 years, the majority being over 40 years old.

Cases admitted

There was a wide diversity of cases. Neurological disorders, and conditions of the alimentary tract were most frequent, with duodenal and gastric ulcers and anxiety states predominating. The following conditions were encountered:

Cardiovascular: Cerebral and coronary thrombosis; hypertension; thrombophlebitis; bradycardia; arteriosclerosis.

Metabolic: Achlorhydria; vitamin B_{12} deficiency; hypochromic anaemia; diabetes mellitus.

Respiratory: Bronchitis; pneumonia; pleurisy.

Malignant: Carcinoma of stomach, colon and bronchus.

Alimentary: Diverticulosis; duodenal and gastric ulcers; appendicitis; hydatid cyst of liver; cholecystitis; gastritis; abdominal pain; postoperative adhesions; intestinal colic; chronic constipation.

Neurological: Senile dementia; hemiplegia; epilepsy; trigeminal neuralgia; sarcoidosis; myalgia; hypochondriasis; anxiety or depressive states.

Skeletal: Cervical spondylosis.

Genito-urinary system: Urinary tract infection; pyelonephritis; suspect T.B. kidney.

Infections: Glandular fever; chest infection; pyrexia of unknown origin.

Discussion

The advantages of general-practitioner hospital beds have been stated eloquently else-

where[2 5]. We have been fortunate in having the opportunity over the past five years to avail ourselves of such a scheme. We have benefitted from the fact that one general-practitioner bed was available in each of four wards, in that we have come into contact with more consultants, registrars, house staff and sisters than would otherwise have been the case. Ensuing discussions have brought interesting cases to our attention, and have enabled us to keep our postgraduate education up to date. This is an important point in favour of the system described, for failure to recruit new general practitioners has been ascribed, at least in part, to the lack of opportunity to continue a scientific interest in medicine[3]. According to the Gillie Report[6], "A doctor's intellectual growth is based on continuous stimulus, enrichment and flexibility of mental activity, resulting from contact with colleagues in other spheres. Appreciation and application of development in medicine is then a natural process."

We have endeavoured to admit only medical cases, as social cases have, in our opinion, little or no place in the general-practitioner hospital bed scheme. We feel that the main object of the scheme is to have hospital beds available for those patients who, while not necessarily needing a consultant's care, would benefit from a short stay in hospital under the supervision of their own practitioner. The latter can perhaps more fully appreciate and understand the family background and its attendant problems, than can a houseman or registrar[2]. A striking example of the type of patient who benefits from this combination of hospital treatment and a friendly ear is provided by those patients with anxiety states arising from real or imaginary symptoms. We admitted 19 such cases for investigation and were able in every instance to prove conclusively—and convincingly—that the patient's fears were groundless.

The system is not only advantageous for the patient and in the interests of the general practitioner, but also reduces the cost to the National Health Service by eliminating the battery of diagnostic tests which support consultant beds, and which are not required for most cases admitted by general practitioners. In addition, it has been suggested that the resulting economy in the number of specialist house staff could be offset by an increase in the number of general practitioners[3].

Ideally, we would like another male and another female bed to be set aside for emergency admissions. An emergency has sometimes occurred when all four general-practitioner beds were occupied. The emergency case has therefore had to be admitted to a consultant bed, and we have thus had to relinquish the supervision of some of our more interesting cases. However, this is the only fault we have to find with the system; the success of the scheme at Hither Green Hospital will, we hope, encourage the governing bodies of other hospitals to set up similar units where possible. We have shown that the setting aside of an entire ward for this purpose is not mandatory; from our point of view the spreading of the unit over four different wards has much to commend it, in that it has broadened our medical horizons.

Summary

A general-practitioner hospital bed unit, comprising one bed in each of four different wards, is described. The advantages of such a scheme, in which the practitioner admits and supervises his own cases, can be shown to benefit patient, practitioner and National Health Service alike. The multi-ward system is felt to be of particular value to the general practitioner, providing as it does the opportunity to meet and exchange ideas with a large number of consultants and hospital staff, and to continue a scientific interest in medicine.

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