A cottage hospital study

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I AM A FAMILY DOCTOR who did not emigrate. As such, I read articles and papers from time to time by those who have taken this step, reporting on the professional paradise which exists in other parts of the world, and expressing the reasons for dissatisfaction with medicine as practised under the N.H.S. in the United Kingdom. In general, the commonest reason given for seeking pastures new is the lack of time and facilities to practise medicine as taught in the medical school. In many parts of the country it is difficult to be any thing other than a cipher. However, within the health service conditions conducive to the best type of medicine do exist, and this paper is an account of a brief study of some of them.

In February 1966, there appeared an article in the *British Medical Journal* headed, "General practice observed. The future of the rural cottage hospital". This was an excerpt from the 1965 annual report of the Oxford Regional Hospital Board and gave an account of the work done in a cottage hospital of 31 beds. McGregor (1964) has reported on the "Hospitalization and specialist needs of a general practice", with reference to the functioning of a cottage hospital of 30 beds in Hawick, southern Scotland.

It has always seemed to me that the principle of the cottage hospital was something of great merit, and also of great potential for the future of general practice, so I arranged to spend two weeks in the early summer of 1967 looking at rural cottage hospitals in various parts of Scotland and speaking to members of their staffs. I myself work in a similar unit of 20 beds and the comparison with other units was stimulating and of considerable educational value.

The report of the Joint Working Party on the Medical Staffing Structure in the Hospital Services (the Platt report), published as a Government white paper in 1961, indicated that the place of the general practitioner in the hospital was acknowledged, and further ways of using his services were suggested. The report also indicated that general practitioners will continue to be employed in cottage hospitals with responsibility for their own cases. In his "Plea for general-practitioner beds", 1965, Marsh makes a reasoned case for the provision of beds where the family doctor can be in charge of his own patients. Marsh's case is supported by the findings of Winch and Wykeham Balm who surveyed the percentage of general hospital admissions which could competently be cared for by their own doctors, given hospital facilities.

From a professional point of view, the access to a hospital where the general practitioner can treat his own patients is of great value, if not essential. He maintains full responsibility for the investigation, therapy and outcome. Consultant opinion becomes, in fact, opinion and there is no takeover of the patient with subsequent loss of interest to the family doctor. Clearly, there must be full access to all laboratory facilities. In this area these do exist.

The hospital* in which I work is situated in a small country town of 6,000 people with the surrounding area devoted to agriculture, a small amount of light industry and coal mining. The patients admitted are general medical and maternity. The decision on admission is solely that of the family doctor, and he is not expected, nor is he willing, to accept convalescent patients from other hospitals without very compelling reason. The bed occupancy of the hospital is over 100 per cent all the year round, and there always seems to be an acutely-ill patient requiring admission. There are no long-term beds in the hospital. The average inpatient stay is 14 to 15 days. Any investigation necessary can be made and the co-operation of the ancillary services is speedy and willingly given. Results from laboratory samples taken in the morning are often telephoned to the hospital by lunch time, and this although the laboratories are over 30 miles distant. There is a portable x-ray unit in the hospital on which chest and bone films are taken, and once per week a radiographer visits the hospital. The films are reported the same day by the visiting radiologist. Contrast x-rays are done in the major unit 30 miles away, where requests for IVPs, barium x-rays, etc., are carried out with only a few days' waiting. There

*Davidson Cottage Hospital, Girvan.

is an excellent liaison with the consultants in the various specialities and they will visit the hospital on request. There is an electrocardiograph, the use of which is invaluable. Two consultant outpatient clinics are held, namely dermatology and ear, nose and throat, on two days each per month. The admission of acute medical cases to consultant units is uncommon and only occurs where constant specialist care is required or where emergency blood transfusion or constant laboratory control of parenteral therapy is necessary.

The outpatient department is always busy. It deals with all the casualty work of the district, and all sorts of minor surgery is done in conditions offering cleanliness and adequate staff. The nursing is of a high order and although often under-staffed there is adequate cover at all times.

The question of maternity beds in such a unit is controversial. It is accepted that patients with a high risk should be delivered in the major maternity unit and this is the policy adopted in this area. Only those patients who are likely to have uncomplicated labours are admitted. The nearest consultant-staffed maternity unit is 40 miles distant and the obstetric 'flying squad' takes over one hour to reach us. Inevitably there are occasions when it is impossible to get the potentially abnormal confinement to the major unit in time, and it is on occasions such as these that the happy relationship with our obstetric colleagues is manifested. The family doctors using the hospital to provide antenatal care in the hospital and a well-woman cervical smear service has been in existence since 1962.

Here then is a situation where there is academic stimulus and opportunity for the doctor to do medicine he wishes. From the patients' point of view, the hospital fills a great need. They have the advantage of the attention of their own doctor and the benefit if required of second opinion, and visiting from relatives is so much easier than in a hospital 30 or 40 miles away. The hospital is very much a part of the community and a feature of its life.

In visiting upwards of 25 other at least outwardly similar units throughout the country, I was in most instances impressed by the enthusiasm of the staffs for their own hospitals. There seems to me to be no doubt that the greater the facilities provided, the greater the interest and sense of belonging of the doctor. It may well be, however, that these facilities are provided because of the activity and enthusiasm of all or part of the staff. In some of the units there was an almost aggressive sense of pride in what was being done. In one place there was a health centre integrated with the hospital. Among the doctors in the practice was a general-practitioner surgeon and here there was a satisfying completeness in the care of the patient. Here, too, there was an infectious enthusiasm and a determination to guard their privileges. I was impressed in many areas that the greater the geographical isolation, the greater was the sense of initiative and the wider the range of work done.

Some of the hospitals seemed to be overloaded with long-term geriatric problems. In a small unit, even two or three beds so taken up make a considerable difference in the amount of acute work which can be undertaken. I feel that it is wrong to use cottage hospital acute beds in this way, and none of the members of staff to whom I spoke were happy about it. In this connection, too, I was disappointed to find in many areas that the autonomous role of the family doctor was being gradually taken over. There seemed to be a frequency of admission from other hospitals, often mandated from the group office, which to my mind was greatly lowering the status, theoretical and practical, of the hospital. It is my feeling that this sort of thing is the thin edge of a thick official wedge. It appeared to me that the more active and keen the unit, the more jealously were the admission privileges guarded.

There has been a trend in recent years to close down many small cottage hospitals. No doubt they have been sacrificed to the god of economic viability, so beloved by planners. Abel Smith and his colleagues (1964) discussing the reason for emigration comment: "So the role of the general practitioner in a country where the hospital and specialist services are organized as a separate service seems to be a major reason why doctors abandon or avoid entering general practice in Britain and go overseas". There is no doubt that to work in a cottage hospital is a privilege. In such circumstances general medical practice in this country can still be absorbing and testing and provide a satisfaction equal to or greater than that achieved in any other branch of medicine. It is still wholly possible to find in this country the professional conditions which are said to attract medical graduates overseas.

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A week with a general practitioner

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AS VARIETY IS SUCH A MAJOR factor in the student's life, it is only to be expected that the new system whereby students spend one week with a general practitioner, would be readily welcomed. I automatically took to the system in that I did not have to report for work until 10.30 a.m. instead of the usual 9 a.m. There could be no better gift than an extra 1½ hours rest to banish the proverbial Monday blues!

Nevertheless, having forgotten about time my foremost preoccupation was how much precious teaching I was missing at the clinics. This I suppose was not a very healthy attitude but little did I realize it could be so radically changed in the next few hours. After meeting the doctor who at once seemed to be very co-operative and willing to teach, I was introduced to his system of operation at the surgery. As I was allowed only one week to become acquainted with the system, the best way to derive the greatest benefit from my visit was by concentrating on a different aspect every day. On Monday I gleaned insight into the duties of the general practitioner with special emphasis on the doctor-patient relationship. It was most gratifying to find that the majority of the patients had no objection to my presence during their visits. I realized from observing them coming to and fro, that the most important task for the doctor was to gain the patient's confidence. Without this, successful rapport could not be established and the likelihood of efficient treatment would automatically be diminished. The best aid to diagnosis seemed to be a calm and sympathetic personality, a good deal of common sense and a sound knowledge of all aspects of medicine to add that essential element of confidence. Otherwise the doctor would find his patients informing him of diagnosis, treatment, etc. With the *Reader's Digest* knowledge of medicine, the lay public could easily come to regard the physician as a means of obtaining certificates, prescriptions, etc., and not as a person with healing powers —and general concern for the welfare of his patient. This deleterious attitude must be prevented at all costs.

So many patients, men and women, young and old, were seen on the first morning, that it was an obvious essential for the doctor to adapt himself to each different personality. In order to avoid an unnecessary sense of rush and bustle and to eliminate confusion, a breathing space of a few minutes between each patient is a great asset. The general practitioner can treat an illness not only in the light of the presenting signs and symptoms but also in the context of the patient's social and environmental conditions. This aspect is the general practitioner's prerogative and is in strong contrast to the patient–doctor relationship in hospital where the social factors influencing a disease are rarely unfolded. As a student's teaching is concentrated