The general practitioner and the hospital*

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THE medical problems of a community must always be considered in relation to the nature of the locality. Differences in geographical and social environment ensure that our hospitals are diversely varied; they come in all shapes, grades and sizes—as do general practices and general practitioners.

In considering the hospital's place in general practice it is natural to think primarily of the inpatients in our own, personal, neighbourhood, friendly-corner hospital. But there are outpatients as well as inpatients, specialised hospitals (paediatric, psychiatric, infectious disease, or chronic sick) and specialised areas in general hospitals. Happily, there are also cottage or general practitioner hospitals.

The subject of the general practitioner and the hospital is particularly important now and reflects especially the profession's great concern to achieve unity—without uniformity. Catch phrases are common. " Integration is strength," " hybrid vigour is a reality," " isolation is intellectual death," or " togetherness is fun." Such phrases may be eloquent and true but they express only principle and motive. Where are the plans? This is why new experiments are so important. If we light a small candle to guide the profession, the ultimate beneficiary will be the patient.

Medical vision may be impaired in its range and clarity by the printed images and dreams of other people. We struggle in a flow of published good intentions—white papers, green ones, blue ones, this report, that exhortation, a trumpet blast from here, or a breath of fresh air from there. Some of these publications have been excellent: however there is much chaff and little good grain. Although we suffer from the planners' apostolic eruditions, this year in Scotland there was a Caledonian type miracle. The Scottish Home and Health Department published *Doctors in an Integrated Health Service*,[1] which should become a vade-mecum for general practitioners. I can only describe this as a nosegay of other men's flowers. Its message is familiar but clearer, more coherent and more exhilarating than ever before. Simply and convincingly the authors demonstrate how vital is the integration or unification of our profession—and of doctors with all the other caring professions. The future shape of general practice in the United Kingdom within an integrated system of health care is clearly displayed. This lucid declaration of principles should act as a stimulus to the planners. In the creation of plans and experiments, we all have a responsibility.

Method

Our practice had already achieved some integration through district nurse and health visitor attachments. However, in Edinburgh in 1968, the Western General Hospital originated an attachment scheme for five Edinburgh general practitioners. Five consultants in charge of acute medical beds undertook the experiment of adding a general practitioner to their hospital teams. This was something unprecedented in Scotland and their flexible attitudes showed that the National Health Service is still a continuing experiment.

Objectives

Before beginning work on a twice-weekly sessional basis I presented my consultant

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colleague with a list of objectives which we might study together. In view of the difficulty of assessment, some academic shape and purpose seemed necessary.

TABLE I
OBJECTIVES IN GENERAL PRACTITIONER ATTACHMENT

1. To bring knowledge of community facilities into the hospital.
2. To improve the care of patients by injecting a leavening of general medical expertise into a specialised area of experience.
3. To educate the general practitioner in medicine.
4. To improve the general practitioner's understanding of the hospital practice of medicine, its organisation and procedure.
5. To bridge the gap between hospital and community medicine and promote exchange of knowledge and ideas.
6. To improve patient turnover and the rehabilitation of those discharged from hospital.
7. To ask the questions:
   (a) Is treatment possible outside the hospital?
   (b) Is investigation possible as an outpatient?
   (c) Is the patient in hospital for social reasons?
   (d) Is the patient fit for discharge to the community?
   (e) What convalescent procedures are indicated before the patient returns to work?
8. To study prescribing costs in both work areas.
9. To improve two-way communication between hospital and general practitioner.
10. To educate students and nurses.
11. To improve the quality of inter-speciality consultation.

Difficulties

Certain adverse factors should be stated which influenced the experiment:

1. Hospital routines are, understandably, uncompromisingly rigid. If the mechanisms are adjusted to allow a general practitioner to become involved at times convenient to him, a chain reaction arises which affects the routines of others—whether consultants, nurses or ancillaries. There is no slack to take up and flexibility will have to be developed.

2. It is not enough to agree that the general practitioner has admitting rights. A foolproof communication system must be offered to ensure these rights.

3. Integration is a two-way process and the hospital must give as well as receive. Sadly, it has not yet been possible for any of the hospital staff to work in our practice headquarters. Nevertheless, those in hospitals must have working contacts in the community. Part-time hospital consultants, who practise the medicine of the market place are links with reality, for their whole-time brethren who, in an abnormal work situation, are often out of contact with ordinary human environment. We must continually try to bring the abilities of the hospital into the community.

4. When influenza comes, hospital contacts virtually cease. Other emergencies inhibit the liaison but their impact would be diminished by hospital support for the general practitioner—as opposed to the existing drain of energy from the community towards the hospital. It should be made possible for single-handed practitioners to hold part-time posts in acute hospitals.

5. General practitioners' work programmes are unpredictable and it is difficult always to fulfil fixed commitments.

6. One experiences on re-entry into the hospital atmosphere a barrier of expression, knowledge and attitudes. These are best met by frank acknowledgement that the barrier exists.

The value of this attachment is difficult to measure. The merits of its different aspects have been assessed only on the personal opinions of the two principals. It is only fair to comment that one independent observer from the Scottish Home and Health Department concluded that the general practitioner employed in an acute medical

unit contributed little to patient welfare—but of course this crystal has many other facets for examination. The linkage of disciplines is shown in table II.

TABLE II

ASPECTS OF GENERAL PRACTITIONER–HOSPITAL LINKAGE

EDUCATION and TEACHING
SERVICE and ADVICE
RECRUITMENT
JOINT RESEARCH

Discussion

Education and teaching (table III)

This two-way process is usually at a subliminal level except for the general practitioner. The general practitioners and the hospital doctors rapidly reached an under-

TABLE III

EDUCATION AND TEACHING

ATTACHED GENERAL PRACTITIONER	PARTNERS	HOSPITAL DOCTORS
MEDICAL STUDENTS	NURSES	ADMINISTRATORS

standing with one another; the 'them and us' thinking which produces a variety of antigen-antibody reactions was hardly apparent. It is questionable if my partners derived any benefit because it is unusual for practitioners to learn from other general practitioners. Is such a process *infra dig*?

The best method of teaching students was for the consultant and general practitioner to teach independently on the same patient. This technique produced a wealth of angles and ideas besides illustrating the difference in the attitudes of hospital and community doctors.

The principle of a study day with a set topic and a panel of invited speakers was found excellent for teaching nurses.

Service and advice (table IV)

Only a general practitioner can act as adviser in environmental medicine to the hospital. Similarly he has a role as adviser in community medical problems to the patient

TABLE IV

SERVICE AND ADVICE

ENVIRONMENTAL MEDICINE	COMMUNITY FACILITIES	MEDICINE of GENERAL PRACTICE
PRESCRIBING DISCERNMENT	INVESTIGATION TREATMENT COUNSEL	PROBLEM PATIENTS
OUTPATIENTS	CASUALTY OCCUPATIONAL MEDICINE	COMMUNICATION and RECORDS

in hospital. The general practitioner is by nature equipped to work in this way, being a specialist in human ecology.

Counselling patients who require explanations of motive, principle and procedure is another service commitment—there is an increasing need for a doctor who is prepared to sit down, discuss and listen.

The medicine of general practice includes the assessment of the entire individual in his total environment. The hackneyed phrase ' holistic medicine ' is adequate. Our type of medicine can materially assist the hospital patient, particularly in promoting symptomatic treatment before the diagnosis is established. We can bring a discernment in investigation and treatment and can improve the quality of inter-speciality consultation —the medical unit need not then call oculists to look at styes, psychiatrists for mild anxiety, and general surgeons for piles.

In outpatient departments there is much room for experiment and the shoe of the general practitioner is a snug fit for the foot of the Cinderella of casualty. There are other potential spheres of activity. For example, it is possible to make a significant contribution in the prescribing of medicines. In the proposed Occupational Health Service for hospital staff the Tunbridge committee report rightly states that general practitioners are indispensable. Additionally, in hospitals there exists a haunting awareness that communications and records are vital in the welfare of the organisation and patients. Doctors usually find them a most distasteful fact of life but there is endless scope for study and experiment.

Recruitment

This must surely be assisted by the fact that for all hospital staff the general practitioner is seen to exist and even to have a precinct of authority. General practice like

TABLE V
RECRUITMENT

	UNDERGRADUATES	
DOCTORS	VOCATIONAL TRAINING	NURSES

that old time religion, is caught through contact as much as taught. Assurance of continuing hospital relationships after entry into general practice will ensure a high quality of new recruit.

Joint research (table VI)

There are a hundred exciting possibilities here. Through my own attachment, a joint project has developed which has received initial financial support from the Royal College of General Practitioners and has now attracted the interest of another research

TABLE VI
JOINT RESEARCH

STUDIES IN PREVENTION (PRIMARY AND SECONDARY)
DELAY FACTORS IN DISEASE
STUDIES IN COMMUNICATIONS
IDENTIFICATION OF HIGH RISK PATIENTS IN PRACTICE
EARLY-WARNING SYMPTOMS

body. The scheme is an assessment of coronary risk factors in our patients and an evaluation of attempts to influence these factors. The hospital, the practice, the behavioural scientists, the social medicine department, the medical officer of health's department,

the nurses, the clinical chemists are all involved in a common endeavour which should have, through its hybrid skills, much merit and penetration. Equally important is the corporative influence of a shared interest on all the professions concerned. Joint research is the great integrator.

Conclusion

At present, having 2,500 beds in the community I have neither the time nor the ability to supplant the general physician in the acute hospital. However, when the ultra-specialist concept is fully implemented, as it must be in about 20 years, I know that the general practitioner will, *faute de mieux*, acquire the mantle of the hospital generalist.

Hospital medicine is an increasingly expensive brand of medicine. It is not only cheaper, but usually preferable, to care for the sick in the community. Admission to an acute hospital bed for investigation or for social reasons is common and must be regarded as an admission of failure on the part of the community services. The strength of British general practice may be gauged by its ability to keep people well and out of hospital so we must cherish and improve the ancillary caring professions. Let us continue to learn from the costly confused failures of the North American system.

In regard to acute hospital beds for general practitioners we must distinguish between *availability* and *responsibility*. *Availability* is essential to the general practitioner as one member of the hospital team, his use of his admission rights will be judged by his hospital colleagues. How totally illogical it is for the general practitioner *not* to follow his patient into his new ambience. However, we are not yet ready for the *responsibilities* of the general physician and the acute hospital bed should not become a success symbol or a spurious index of equality.

Looking ahead, prevention is much in the news these days: accident prevention, crime prevention, population prevention, and pollution prevention. But never do the treating doctors find glamour in disease prevention or control. Is this because we are reared in the study of disease, not of health? One can envisage a department of preventive medicine in every acute hospital and a general practitioner might do very well in the field of the preservation of health.

In the words of Francis Bacon: " They that reverence too much old things are but a scorn to the new ". But if resistance to change and to experiment is unpardonable then failure to unify the profession is a betrayal of the patient. We should be mindful of St. Augustine's plea for unity and integration—without uniformity. " Let the garment be of divers colours but let it be without seam."

REFERENCE

Scottish Home and Health Department (1971). *Doctors in an Integrated Health Service.* Edinburgh: H.M.S.O.

HOSPITAL COSTS

The national average cost of a hospital bed in England in 1970–61 was £66·70 per week. The cost per patient per week in the London teaching hospitals averaged £97·74.

The average increase in costs per inpatient per week increased by more than 20 per cent compared with 1969–70.