REPORT

The community hospital

A symposium was held on 24 May, 1973 at the Welsh National School of Medicine, arranged by Welsh Council, and chaired during its morning session by the President of the College, H.R.H. The Prince Philip, Duke of Edinburgh

Dr R. Harvard Davies

The opening paper by Dr R. Harvard Davis, Director of the General-Practice Unit of the Welsh National School of Medicine, defined the concept of the community hospital. The basic needs of the sick person were:

(1) Appropriate knowledge, skills and technology.
(2) Availability of this care.
(3) Personal comfort and familiar surroundings.

The district general hospital as a place in which the specialist services were brought together had, he believed, been over-emphasised without enough evaluation of efficiency and, in some cases, total disregard of needs of individual groups of patients. He instanced the findings of Crombie and Cross (1959) that up to 43 per cent of inpatients in a Birmingham hospital had not needed the diagnostic and therapeutic service provided there. Other studies had produced similar findings.

The community hospital would eventually be an extension of the primary care services, rather than a peripheral extension of the district general hospital, providing a service for those patients who cannot be managed at home and yet do not need the sophisticated facilities of a big hospital.

The community hospital would be staffed by general practitioners with the aid of specialist consultant staff, but no junior hospital staff. Suitable groups of patients were: some medical patients, early discharge surgical cases, terminal-care patients, those having day-care treatment, selected outpatients, long-stay geriatric, long-stay psychiatric, and obstetric patients.

The precise form would depend on the facilities in the area and in many instances community hospitals would be built beside health centres. The advantages might be great and the need for evaluation was urgent, as the new area health authorities would be in a better position to plan such developments—a pattern of progressive patient care in which each patient received the care appropriate to his needs at any particular point in time.

The President

Thanking him for his paper, the President agreed that it seemed the present unnecessary use of district general hospitals may be an important factor in the development of forms of intermediate care.

Dr A. E. Bennett

Dr A. E. Bennett, of the Health Services Evaluation Unit, University of Oxford, in considering the *Evaluation of the Community Hospital* started by referring to an approach in 1969 by the Oxford Regional Hospital Board to the Department of Health and Social Security with the proposal for a two-tier hospital structure which as previously said, was considered to be an extension of primary care, rather than a weakening of the specialist services. The community hospital was an attempt to provide appropriate care as close to the patient's home as possible. His team at Oxford was studying a pilot unit at the Peppard Hospital and a new hospital at Wallingford with two others being planned. They had received great support from the Department of Health and Social Security. He condemned subjective opinion in the assessment of health care and stressed the importance of properly conducted experimental studies with, if possible, random allocation of patients to treatment groups.

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Losses and gains with regard to 'health items' (mortality, disability), 'money items' (travelling time, work time) and 'other valued items' such as patient's satisfaction, or anxieties, recruitment and job satisfaction all had to be considered.

A study of admissions at the Peppard Hospital had shown that there were 128 direct admissions in 1970; of these 31 per cent were an alternative to admission to the district general hospital, four per cent an alternative to another type of hospital, and 34 per cent would otherwise have remained at home. Postoperative transfer accounted for 24 per cent. A study was proposed of the clinical outcome of patients randomly allocated to either the district general hospital or community hospital for their postoperative care. If it emerged from this, and other studies, that there was little difference in the clinical outcome between the two groups—the other considerations would be the deciding factors. The development of day-care in the community hospital was also an exciting challenge.

The President

Commenting on the morning session, H.R.H. The Duke of Edinburgh said he thought that both papers indicated the present situation was not entirely satisfactory. There was however, a danger of fragmentation of development of human communities by planners and he stressed the co-operative nature of the community. The 'total community aspect' must be considered, and all factors should relate to a community pattern of easily comprehensible size.

Dr I. S. L. Loudon

Opening the afternoon session, Dr I. S. L. Loudon, a general practitioner from Wantage, Oxford, looked at the contribution of the community and consultant hospitals to total inpatient care.

A survey he had carried out at the Radcliffe Infirmary on 602 admissions revealed that a third of the patients could have been cared for in other ways, either by early discharge from hospital, early discharge to a general-practitioner unit, or alternatively direct admission to a general-practitioner unit.

In another survey in Wantage, where there is a general-practitioner hospital of 21 beds, shared between two practices, factors underlying admission to either a general-practitioner hospital, or the United Oxford Hospitals had been examined. It appeared that selection had been based on diagnosis and age as independent factors, but not on social class. These admissions had been shown to have been real alternatives to admission to specialist beds.

The general-practitioner hospital admission was an extension of the scope of service the family doctor could give, but if the community-hospital concept was going to thrive it would be by mutual co-operation and respect between hospital specialists and general practitioners.

Dr S. Davies

Dr S. Davies, general practitioner from Barry, Glamorgan, gave an account of the work and development of the community hospital in his town.

The hospital, a 40-bed former accident hospital had been threatened with closure and with it the x-ray, diagnostic, physiotherapy and other facilities. To prevent this the Barry practitioners had 'taken it over', but he went on to pay tribute to the very good co-operation from the local consultants, who were always prepared to see patients in the wards for a further opinion.

Fifty doctors had contracts with the hospital board, and admitting rights, but arrangements were flexible, friendly and often co-ordinated by the senior nursing staff.

Cases thought suitable for admission were acute medical (within the capability of the doctor and hospital facilities), predischarge postoperative surgery (with drains *in situ* and still needing considerable nursing care), short-stay geriatric, acute episodes of chronic illness, transfers from acute hospital for holiday relief, selected terminal care, mentally ill and handicapped patients requiring support (rather than intensive psychiatric treatment).

Cases not considered suitable were children and grossly disturbed patients; also those requiring more intensive treatment, including some of the infectious diseases. A 21-day limit had been put on stay to prevent beds being blocked by chronic long-stay cases. This was flexible, but even in the elderly the average length of stay was only about 12 days.

The greater proportion of patients, 69 per cent, were, however, over 65 years and ten per cent under 45 years. Analysis of the results indicated that ten per cent died, eight per cent transferred to other hospitals, and the rest returned home. Only one third of those with neoplasms died in the hospital, and Dr Davies stressed the hospital was neither a geriatric nor cancer hospital, nor a terminal care unit. In the last six months at least 76 of those admitted for acute medical care would otherwise have required admission to a general hospital.

Dr Gareth Jones

Dr Gareth Jones, Senior Medical Officer, the Welsh Office, reviewed the administrators' view of the community hospital concept, and recalled the deliberations behind the current development of the district general hospital. The community-hospital concept had come from a slowly, perhaps reluctantly accepted realisation that the needs of close-knit populations, or communities required something more than super-specialist care. Continuous care throughout life was in the hands of the general practitioner whose skills, supported by inpatient beds, district nurses, health visitors and well-equipped practice premises, could, he thought, be put to far better use than previously had been the case.

He saw a particular advantage of the community hospital, in the favourable cost comparison between inpatient care in other forms of hospital. In Wales, he reminded the audience there were already a number of local hospitals, which might in many instances, by extension or adaptation be suited to fit them into the community health pattern, but the pattern must necessarily vary from area to area according to local considerations. He thought the general concept was that patients would be likely to be long-stay rather than short-stay but expressed horror at a recent leading article in *The Lancet* (1972) which suggested that many of the old asylums might continue as community hospitals to care for psycho-geriatric and "continuous accumulations of long-stay patients."

Early return to the community of most of the patients must be an avowed aim, which would depend on the co-operation of many disciplines.

Like previous speakers, he saw virtue in geographical relationship with both bigger acute hospitals on the one hand, and general practice on the other, and hoped that the 1974 reorganisation would greatly assist the co-ordination of care.

Discussion

Opening the discussion, a speaker from the floor asked whether present general-practitioner staffed cottage hospitals might profitably be converted to community hospitals. Dr Gareth Jones said each proposal would have to be considered entirely on its merits in the light of local circumstances and there could be no universal deal that every small hospital in England and Wales should become a community hospital.

From this there arose a lively and interesting discussion between members of the panel and audience as to the essential difference between the general-practitioner hospital and the community hospital. Dr Bennett said this could only be understood in an historical context. There had been three phases, the cottage hospital, the general-practitioner hospital, and now the community hospital.

The concept of the community hospital had arisen from discussions in Oxfordshire in about 1967 where there were many predominantly rural general-practitioner hospitals. He emphasised that the community hospital was a positive concept, and that the label 'community hospital' must not be stuck on every general-practitioner hospital, regardless of what it was doing. It was not a 'trendy' name for the existing cottage hospital—it involved the decision to admit definite categories of patients, linked with day-hospital care, outpatient clinics and preferably linked with health centres. It was for this reason that he himself had referred to the Wantage Hospital as a 'general-practitioner hospital' rather than community hospital.

This led to Dr S. Davies springing to his feet to plead for flexibility in the definition of categories of patients admitted—limited only by the skills of the doctors and services available.

Dr Bennett disagreed. There was much evidence of the reasons why the cottage hospital had fallen into disrepute—it had attempted to do too much and had become a mini general hospital working in isolation without the necessary degree of introspection.

Dr G. I. Watson, Deputy President of the College, criticised Dr Bennett's use of the phrase 'first-tier and second-tier hospitals' earlier in the day as he felt it had been used the wrong way round. Instead of talking about the role of the general practitioner in the hospital, we should be talking about the role of the hospital in general practice! A further important point was that young men having been trained in hospital and community medicine should *not* be cut off from hospital work.

Dr J. Gwyn Thomas, who said he had been born and now worked in the oldest cottage hospital in Wales, the 170-years-old Denbigh Infirmary, was very concerned to retain minor operating facilities and care of casualties. Dealing with a large rural area, this played a big part in his and his colleagues' present work. Blockage of beds by long-stay geriatric patients was a problem, and he pleaded for more help with the disposal of elderly patients, from the Social Services Departments.

After a Brecon doctor had supported the inclusion of a casualty service in the remit of the community hospital, the spontaneous applause from the audience indicated that many felt in agreement. Certainly the general feeling at the end of the day was that despite slight uncertainties as to its exact definitions the new concept seemed likely to offer a valuable extension to the primary-care services.

In winding up the afternoon session, the Chairman Dr David Coulter remarked that we live in exacting times. Many problems had been posed but workable answers would be coming in the not too distant future.

R. A. YORKE

REFERENCES

Crombie, D. L. & Cross, K. W. (1959). *Medical Press*, **242**, 316–322, 340–343.
The Lancet (1972). Editorial, **1**, 577–578.

FIRST-CONTACT DECISIONS IN GENERAL PRACTICE

A hospital nurse accompanied each of three members of a group practice on a total of 111 new house calls. Doctor and nurse individually made an assessment of the urgency of each case, choosing the course of action most appropriate in dealing with the patient's problem. The pattern of decisions made by the nurse did not differ significantly as a whole, either statistically or clinically, from that of any of the three doctors. There were nine cases where differences between the recommended actions might have had serious consequences for the patient, but these differences could have been removed by an instruction to the nurse based on the age of the patient and certain clinical features.

REFERENCE

Moore, M. F., Barber, J. H., Robinson, E. T. & Taylor, T. R. (1973). *Lancet*, **1**, 817–819. Authors' summary.