The relationship between the family doctor and the hospital

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SUMMARY. From this paper based on the opinions of hospital patients, a representative group of Dutch family doctors and of specialists, as well as on the results of an investigation in three practices of the Nijmegen University Department of General Practice, two conclusions can be drawn.

(1) The family doctor can fulfil an important role for his patients in hospital. This role arises from his function as a doctor to the family and is complementary to the technical specialist's work in hospital. The family doctor can therefore bridge the gap between hospital and home and between the patient and his family.

(2) A strict referral and hospital admission policy by the family doctor has important consequences and gives him a key position in health care. He can promote the shift from hospital-centred care to domiciliary-centred care which is now generally considered to be necessary.

It seems likely that such a strict referral system means a better quality of medical care for patients.

This is a priority of the first order, greater than that of perfecting hospital medical care, which will require an ever-increasing effort and cost for a decreasing group of patients.

Introduction

There are two important problems both in Britain and in Holland in the relationship between the hospital and the family doctor. Firstly a gap has grown between the specialist and the family doctor on the one hand and the family doctor in the community on the other, leading to episodic, sometimes impersonal care for hospital patients (Lightwood, 1963; Smith, 1970).

The second problem in both countries is that many patients in hospital do not really need hospital treatment or specialist medical care.

Both these problems have been studied.

The hospital patient and the family doctor

As in Britain the Dutch family doctor has a key position in health care. Every patient has his personal doctor who tries to give continuous and personal care. Generally all the members of one family are on the list of the same family doctor. In Holland family doctors do not treat patients in the hospital as they still do in parts of Britain (Oddie, 1963; Keable-Elliott, 1964; Evans, 1971). In Holland small hospitals, where family doctors could admit patients have disappeared completely during the last 20 years.

The hospital patient is in a special situation, for instance he has feelings of uncertainty, intensified by a lack of information. In my opinion family doctors still have an important task in the hospital so I usually visit my hospital patients regularly. Some

family doctors also do this but others do not. Is it right that family doctors should systematically visit their patients in hospital? The Report of The King Edward Fund (1964) draws attention to the problem of the relationship between the family doctor, the specialist and the hospital patient, but this problem has rarely been investigated critically.

Method

First I selected 361 patients in four different hospitals. These hospitals varied in size and distribution in Holland and in degree of urbanisation.

Another inquiry was undertaken with 326 family doctors in Holland. This group appeared to be representative (assessed by several criteria) of the original unselected sample, which was itself taken at random from the register of all Dutch family doctors. In addition 80 family doctors, who sent patients regularly to the four survey hospitals, were contacted. A further inquiry included 62 specialists who were attached to the four survey hospitals.

I also investigated this problem in our own practice (5,457 patients in a rural area) which is a partnership of two family doctors who are attached for research and education to the Nijmegen University Department of General Practice. I collected information about the nature of visits to our patients in hospital, the communication with nurses and with the patients' families, over a period of one year.

Results

Hospital patients

Most of the hospital patients expected not only episodic attention from their family doctors, but also continuous, personal care for themselves and their families. They thought for example that the family doctor must give them information about their disease, listen to them, try to share their problem, and help them to make important decisions and to keep in touch with their families.

Compared with other workers in primary health care (social worker, priest, district nurse) their doctor's visit to hospital appeared to be greatly appreciated, especially by women, by patients with much hospital experience, and by patients with a lower level of education.

The family doctor appeared not to live up to these expectations because three quarters of the patients had not been visited by their general practitioner.

The patients' understanding of the disease and of the course of the treatment was slight especially in the elderly, the neuropsychiatric patient, and those with a lower level of education.

Family doctors

Of the family doctors, one third stated that they regularly visited their patients in hospital (three times a month or more), one third moderately (once or twice a month) and one third practically never.

The percentage of family doctors who regularly visit their patients decreased as a function of increasing loss of time in travelling to the hospital, distribution of patients over more than three hospitals, and of higher degrees of urbanisation. Lack of time was the most important reason given for not visiting patients. However, there are indications that other factors play a role, such as feelings of ambivalence and inadequacy towards the hospital specialist. There is a correlation between the frequency of hospital visits of general practitioners and the communication with specialists.

On the whole the ideas of the family doctors about their role in relation to their patients in hospital agreed with those of the patients. Just like the patients they thought

that the family doctor could help make important decisions, to inform the family, and to keep in touch with them to help the patient coming home after leaving hospital.

Only a small minority of family doctors wanted to treat the patients in hospital themselves.

Although half of the family doctors judged favourably their personal communication with specialists, on the other hand there was much criticism expressed about reports from specialists, particularly about the immediate information after patients' discharge from hospital.

The most important improvements proposed by the family doctors were:

(1) Sending a preliminary report of discharge,

(2) More intermediate information while the patient was still in hospital,

(3) More discussion about the procedure for discharge,

(4) The chance of attending staff meetings informally.

Several of these points were also stressed in The Report of the King Edward Hospital Fund.

Specialists

The ideas of the specialists about the role of the family doctor with hospital patients agreed with those of the family doctors themselves. The specialists underlined the instructive effect of the hospital visits more strongly than the family doctors. However, the specialist did not consider the family doctor had a responsibility for treatment. The specialist viewed communication with the family doctors less favourably than *vice versa*. Mutual communication seemed to be worse in urban areas.

The specialists reacted positively to most of the improvements in mutual communications proposed by the family doctors.

Our own practice

In our own practice I found that we were able to give advice and explanation to 22 per cent of our hospital patients. Sometimes they expressed feelings of loneliness and fear (28 per cent of hospital patients). We could help them in solving their problems, especially important decisions. It seemed desirable to be able to listen to problems and fears, just to know what hospital patients want to learn. One of the great problems in hospital is not only the lack of information but a wrong approach towards hospital patients by hospital workers. Many doctors are afraid of talking and listening to patients because of the risk of being confronted with their own feelings of anxiety and fear (Dumas, Anderson and Leonard, 1965; Menzies, 1960).

Our most important task was to act as a link between hospital, patient and family (25 per cent of patients, 50 per cent of the seriously ill). This task has several aspects. Firstly the knowledge of the family doctor of the possibilities of home care was important in making a better decision about timing the discharge. Secondly by means of our hospital visits we were able to support adequately the family of the hospital patient. Thirdly we could make preparations in the family before discharge. By this function we could partly bridge the gap between the hospital and home.

All these functions were fulfilled more often with more seriously ill patients and older people.

Intermediate and preliminary reports were seldom received by our practice. In nearly half of the patients we were not informed one week after discharge. We think that this report should reach the family doctor within one week as does the Report of King Edward Hospital Fund. If not, continuity of care is in danger.

Discussion

From this work we can conclude that Dutch family doctors can have an important task regarding their patients in hospital. The task arises from the role of doctor to the family and is complementary to the technical help from the specialist in the hospital.

The family doctor can bridge the gap between hospital and home in several ways. He can create continuity of care for his hospital patients. The task of the family doctor for these patients starts in his consulting room by instructing and preparing his patient before the admission occurs and by giving complete details to hospital doctors. Orientation of a small number of specialists and hospitals will lead to a better communication with the hospital.

Much more attention should be given to the elderly, seriously ill patients and problem patients who really are at risk.

The idea of the family doctor himself treating patients in hospital does not solve the problem of continuity of personal medical care; there is even the disadvantage that the family doctor may be too concerned with specialist technical knowledge and skills instead of concentrating on his own method of medical care.

Good hospital administration in serving the family doctor with notice of admissions discharges, and with death of patients in hospital is essential.

The importance of the family doctor in the quality of hospital medical care

In Holland, as elsewhere, another well-known specialist problem in health care is that many patients in hospitals do not really need to be there. Loudon (1972) showed that by attentive care one third of beds could be spared. Torrance *et al.* (1972) suggest that a quarter of the hospital admissions were not necessary. According to these statements probably too much money is spent on expensive hospital care and not enough on domiciliary care.

An *Update* editorial (1973) stated the same problem: " However, it is well to examine whether the specialisation and the development of specialists and superspecialists units has really made all that difference to the quality of health and to the outcome of treatment given in the hospitals. Available indices show only minimal improvements accompanied by increased discomfort and potential risks for the patients. There has also been a decline in the personal and family aspects of the care provided by these many membered units. One also wonders how many of the patients' diseases and problems really require such intensive specialisation."

Method

As a part of my study in our own practice I collected data about our patients in hospital (admission rate, diagnosis, specialty). Moreover, I linked some data of our morbidity patterns with the referrals to laboratories, x-ray departments and specialists; these came not only from our own practice but also from the two other practices attached to the Department of General Practice at Nijmegen University. The second practice has 3,900 patients in a town of 150,000 citizens, and the third practice has 3,000 patients in a small town.

Results

During the year of investigation the number of patients in hospital from our own practice was in all the age categories much lower than expected from the clinical morbidity figures in the Netherlands, namely 281 patients instead of an expected number of 511. From sick fund figures our lower hospital admission rate was constant over several years. The patients in hospital from our own practice differed markedly from the average rate in the Netherlands, owing to a marked selection, with relatively more patients having an inevitable indication for hospital e.g. appendicitis, neoplasms, myocardial infarction,

and cholelithiasis. As a consequence relatively more of our patients in the hospital were surgical patients, relatively few were medical patients and there were not many children (figure 1).

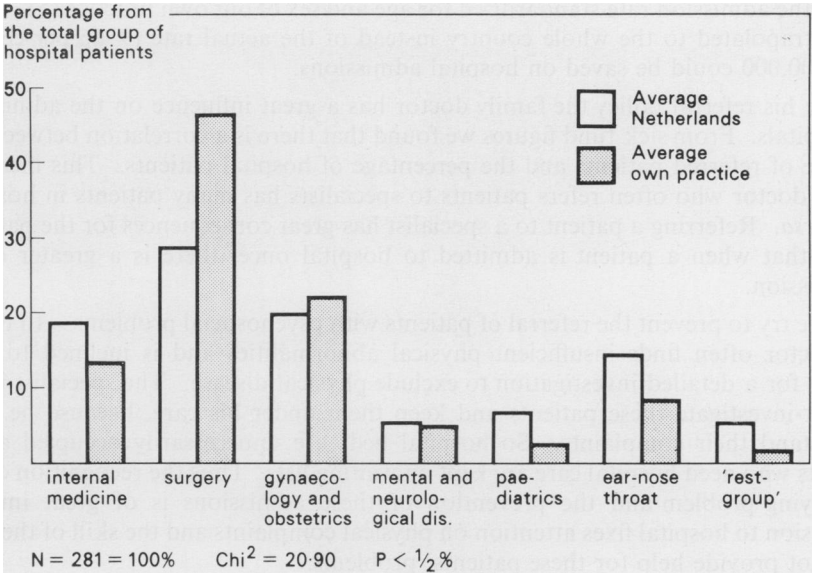

Figure 1

Moreover, the duration of stay in hospital of our patients was shorter than the average for the Netherlands (figure 2).

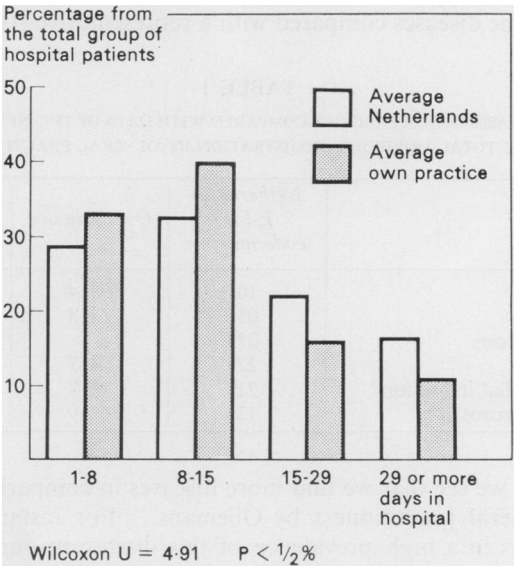

Figure 2

This could have been due to our selection of the patients we refer to specialists, to our better communication with the hospitals by our hospital visits, and also to hospital policy.

If the admission rate standardised for age and sex of our own practice (53·1 per cent) was extrapolated to the whole country instead of the actual rate (9·66 per cent) about £100,000,000 could be saved on hospital admissions.

By his referral policy the family doctor has a great influence on the admission rate to hospitals. From sick fund figures we found that there is a correlation between the percentage of referred patients and the percentage of hospital patients. This means that a family doctor who often refers patients to specialists has many patients in hospital and *vice versa*. Referring a patient to a specialist has great consequences for the patient. We found that when a patient is admitted to hospital once, there is a greater chance of readmission.

We try to prevent the referral of patients with psychosocial problems. In these cases the doctor often finds insufficient physical abnormalities and is inclined to refer the patient for a detailed investigation to exclude physical disease. The specialist is inclined to over-investigate these patients and keep them under his care, because he does not understand their complaints. So hospital beds are unnecessarily occupied and other patients who need hospital care are kept on waiting lists. Thus the recognition of the real underlying problem and the prevention of these admissions is of great importance. Admission to hospital fixes attention on physical complaints and the skill of the specialist does not provide help for these patients' problems.

The quality of health care

An important question is the quality of care. It is difficult to prove that our care is better or worse than the average. Some arguments are given below that perhaps in some ways it is at least not worse than the average.

(1) The registration of the morbidity pattern in general practice can give an indication of the attention of the family doctor into tracing diseases in his practice. In table 1 we give the prevalence of some diseases compared with a representative study in the Netherlands (Oliemans, 1969).

TABLE 1

PREVALENCE OF SOME DISEASES IN OUR PRACTICE COMPARED WITH DATA OF THE NETHERLANDS, IN PERCENTAGE OF THE TOTAL MORBIDITY REGISTRATION BY GENERAL PRACTITIONERS

	Netherlands E-list code number	*Own practice*	*Oliemans (1969)*
Obesity	101	*108·4*	*13·8*
Diabetes	091	*13·3*	*7·9*
Peptic ulcers	277, 278	*4·7*	*2·9*
Myocardial infarction	211	*8·7*	*4·2*
Psychoneurosis	135	*161·9*	*49·2*

From this table we see that we find more diseases in comparison with the data of a study of Dutch general practitioners by Oliemans. For instance we try to identify obesity which results in a high prevalence of this disease in our morbidity data. The high prevalence of emotional disturbances can be explained by the intensive training of both partners in psychiatry and in interviewing technique.

(2) Our death rate is lower than expected from the data of the Netherlands and for the age and sex register of our practice. During the year 1964 up to and including 1971,

198 patients died compared with an expected number of 253. So we conclude that our lower referral and rate of hospital admissions did not lead to a higher death rate.

(3) Comparison of our referral policy with the two other practices attached to the Nijmegen University gives some further information about our management.

TABLE 2

REFERRAL RATES IN THREE PRACTICES

	Own practice	*Practice* 2	*Practice* 3
Number of patients in 1971	5457	3984	3139
Total morbidity during 1971 per 1,000 patients	1990	1658	2302
Referral to X-ray departments and laboratory services (per 100 patients)	*13·7*	*4·2*	*1·3*
Referrals to consultants (per 100 patients) in the practice	*11·1*	*24·6*	*22·9*
Total of referrals	*24·8*	*28·8*	*24·2*
Hospital admissions per 100 patients in the practice in 1971	*4·5*	*6·7*	*8·7*

The total referrals do not differ much but we refer fewer patients to consultants and more for tests. Advanced diagnostic and therapeutic approaches by the family doctor can result in a lower referral to consultants and a lower admission rate.

(4) As our practice is attached to a university we have many knowledgeable visitors such as students or visiting doctors who can criticise our quality of medical care, so we have every incentive to be careful.

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