Educational needs of doctors working in community hospitals

A REPORT PREPARED FOR THE EDUCATION COMMITTEE OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS BY A WORKING PARTY FROM THE THAMES VALLEY FACULTY

(1) Introduction

Some recent figures show that only 20 per cent of general practitioners have access to hospital beds other than for obstetric care. It is, therefore, likely that where new community hospitals are built, local general practitioners will have to broaden their range of responsibility, thus creating new educational requirements.

(2) Community hospitals

Community Hospital is the name used to describe small hospitals serving the non-specialist needs for treatment of local communities. They provide in-patient accommodation for selected groups of patients and rehabilitation sources for day patients. They should ideally be associated with health centres or group practice centres with accommodation for the primary health care team and visiting specialists, so creating a focal point for the community health-care services.

It is proposed that this type of hospital should have a limited and defined role which is complementary to the district general hospital. It would form a link in the chain of services for patients and help bridge the gap between community services and the specialist services based on a district general hospital.

Medical cover in community hospitals will be the responsibility of general practitioners. Flexibility in the deployment of nursing staff to meet patients' needs in the home or in the hospital requires unification of nursing management at community level. The strong emphasis placed on remedial therapy and rehabilitation clearly identifies the contribution of the physiotherapist and occupational therapist, who should similarly be able to serve the patient in home or hospital according to need.

Thus the concept is one of extended responsibility and capability of members of an enlarged community health care team. Local goodwill towards community hospitals can be expected to result in substantial community involvement.

In-patient care

Patients suitable for admission to a community hospital may be defined as those who, while requiring hospital care because they cannot be maintained at home, do not require the services of a district general hospital or of a specialist team. Such patients fall into the following groups:

(1) Acute medical cases admitted for professional nursing care or observation,

(2) Patients transferred from specialist departments for a further period of nursing care and medical supervision, e.g. early post-operative transfers for mobilisation and rehabilitation,

(3) Selected geriatric patients after assessment,

(4) Selected psychiatric patients after assessment,

(5) Selected physically and mentally handicapped patients requiring hospital care,

(6) ' Holiday ' or other ' social ' admissions,

(7) Terminal care patients.

Day treatment

Day-treatment services for patients are complementary to the hospital beds and apply especially to the following groups:

(1) Patients transferred from specialist in-patient or day-patient care for continuing supervision,

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(2) Patients admitted directly by the general practitioner for group assessment, treatment, and supervision,

(3) Patients admitted directly by the general practitioner who are not expected to gain substantial therapeutic benefit from day treatment, but where a pressing need for relief of the relatives makes this highly desirable,

(4) Patients attending for nursing treatments which would otherwise be undertaken less efficiently at home.

(3) Broad goals of learning

The learning requirements for the general practitioner in a community hospital fall into the following broad goals:

(a) The doctor needs to understand the organisational pattern in relation to definition, categories of patients, resources, and liaison with appropriate medical, nursing, paramedical, voluntary, and administrative services,

(b) The doctor needs to have a special knowledge of post-operative care,

(c) The doctor must be able to make adequate assessments and plans for treatment of patients, especially the elderly,

(d) The doctor must have a special knowledge of rehabilitation and basic procedures involved. He needs to understand the role of all the team members, especially the physiotherapist and occupational therapist.

(4) Content

(A) Organisation

The care of patients in the community hospital is based on the principle that the general practitioner retains responsibility for the treatment of his own patients; thus no one may be admitted, even temporarily, unless responsibility is accepted by a general practitioner. However, for such a system to function satisfactorily, and for the community hospital to function in a complementary mode to the district general hospital, an agreed ' code of practice ' is necessary which defines admission and discharge policies for in-patients and for attendance policies for day patients. To achieve this requires some understanding of how the system works, i.e.

(1) The role and composition of district medical committee and the local representative committee.

(2) The emerging role of the district community physician in:

(a) Maintaining a health profile of the population,

(b) Reviewing the provision of services to identify gaps in relation to need,

(c) Co-ordinating the work of health-care planning teams,

(d) Co-ordinating preventive services in the district,

(e) Advising his consultant and general-practitioner colleagues.

(3) Related role of area specialists in community medicine.

(4) The organisation and management of nursing and para-medical services.

(5) The relationship of ' sector ' management to district and area management.

The implementation of such a ' code of practice ' requires agreement on monitoring and control procedures. These should be self-imposed and can be considered as primarily educational.

They require understanding of:

(6) Source, meaning and fallacies of statistics, e.g. on bed use,

(7) Requirements and procedures for clinical and operational audit including problem-orientated medical record keeping.

(8) Concepts of effectiveness and efficiency in health care, the distribution of resources, and priority.

Increased community involvement in health services requires a change of attitude in the majority of health care professionals. For this to occur requires appreciation of:

(9) Composition and purpose of community health councils.

(10) The potential of voluntary services and problems in deployment of staff.

Personal reassurance of the general practitioners, nursing staff, and remedial staff employed in this new situation of extended capability and responsibility requires clear understanding of:

(11) Formal complaints procedures.

(*B*) *Postoperative care*

Every community hospital physician must be familiar with the principles of postoperative care followed at the local district general hospital. Specific needs include:

(1) General principles, e.g.

(a) Early mobilisation,

(b) Prevention of thromboembolism and its management, management of secondary haemorrhage,

(c) Bladder care (especially after pelvic surgery),

(2) Special aspects, e.g. stoma care and mobilisation procedures after orthopaedic surgery.

(*C*) *Management of the acute patient*

Experience shows that the majority of patients admitted by general practitioners to community hospitals will be elderly and many will suffer disabilities in more than one system, which will interact, one with another.

(1) *Assessment*

(a) Recognition of the disabilities which must be described in pathological, functional, and social terms.

(b) Present training and experience should enable the general practitioner to make an assessment of each system (cardiorespiratory, locomotor, haematological, biochemical/endocrine, iatrogenic), but in addition, he must understand the hazards involved in treating some of these patients. For example, hospital admission may itself cause a period of confusion and disorientation. At the same time, those hitherto supporting the patient at home may " close ranks " and not be willing to accept the planned return.

(2) *Establishment of goals*

Goals of treatment must be ambitious, yet realistic. The greatest need here is an acceptance and understanding of the multidisciplinary approach; the whole team may need to be involved at the assessment stage if a coherent treatment programme is to be prepared.

(3) *Planning a treatment programme*

As the leader of the team who will undertake the treatment programme, the doctor needs to be familiar with the contribution of the following:

Appropriate drug therapy and its hazards,
Physiotherapy,
Occupational therapy,
The services of the domiciliary occupational therapist,
The place of the day ward.

Perhaps only experience will teach what cannot be done!

(*D*) *Rehabilitation*

(1) Possibly, for the first time in his professional life, the doctor working in a community hospital is able to have total clinical responsibility for the rehabilitation of those patients, either in the wards or as suffering from many conditions, particularly locomotor and neurological outpatients. His previous training will have made him conservant with their natural history and drug therapy. It will not have taught him, however, how to plan and supervise a programme of rehabilitation.

(2) More specifically, he will need a working knowledge of various techniques and appreciate their place and the role of the therapist. He does not need to learn these skills himself, however except (b) below.

(a) *Physiotherapy*. When to use it, how to supervise and when to assess: traction, splinting, use of rest, massage, exercises, heat, wax treatment, short wave, faradism,

(b) *Local treatment of joints, tendons, ligaments and muscles*. Injections of local steroids and/or local anaesthetic, aspiration of joints,

(c) *Occupational therapy*. Assessment techniques, including daily living, therapeutic techniques, use of aids and adaptations for eating, dressing and in the home, use of diversional therapy,

(d) *Speech therapy*. Awareness of techniques, and regular assessment,

(e) *Appliances and aids*. Collars, footwear, calipers, support jackets, walking aids, special splints, types of major and minor adaptations in the home, at work and in any vehicle,

(f) *Industrial rehabilitation and work retraining*.

(3) It would be desirable for one general practitioner to develop more detailed knowledge of, and skills in rehabilitation so he may act as " resource man " for the others.

(E) The long-stay patient

(1) There will be some patients who are beyond rehabilitation, not terminally ill, and who need long-term medical and nursing care. The general practitioner must be able to identify chronically ill patients needing community hospital facilities. He must always remain aware of simple problems that may cause confusion and can easily be alleviated (e.g. constipation).

(2) Previous sections have emphasised the need for an awareness of disabilities, potential goals of treatment and the skills of the other members of the team, especially the physiotherapist and occupational therapist. This should enable the general practitioner to know when the stage has been reached that rehabilitation no longer has anything to offer. He will be advised by his specialist colleagues in geriatrics and rehabilitation.

(3) Consultation with the local geriatrician is essential before patients are admitted specifically for long-term care. The general practitioner must be aware of:

(a) The full range of domiciliary services,

(b) Nursing facilities in community hospitals, and

(c) Attitudes of relatives and friends.

(4) Patients may be admitted for planned long stay and subsequently improve. Formal reassessment at intervals is essential. Nursing staff and team members should be included in the decision-making process.

(5) Disturbed elderly patients are a group presenting particular problems in nursing care and ward morale. The general practitioner may need to increase his knowledge of drugs used in the management of these patients.

(F) Care of the dying

The nursing care available to the doctor in the community hospital will enable him to look after terminal patients whom he would previously have admitted to a specialist hospital. As a result, he will need to be aware of techniques for dealing with problems in the more ' complicated ' dying patient, especially: the relief of pain without narcosis, the relief of vomiting, fistula care, the use of diversionary occupational therapy, the support of the family of a patient in prolonged coma.

(5) Organisation of training

In each area an educational programme should be mounted to coincide with the opening of a community hospital. Such a programme will need to be locally oriented. In general, however, it should be possible for general practitioners and trainees to be attached for short intensive periods to an existing community hospital. During this time they should come to realise the role of the general practitioner within the community hospital team and his relationship with

the local specialist units. Every general practitioner should spend a few sessions in hospital departments of rehabilitation, and geriatrics. For a general practitioner who has a special interest in rehabilitation and who may act as resource man for other general practitioners a longer attachment to a rehabilitation unit will be necessary. He will need to pay visits to domiciliary occupational therapy departments, workshops, and specialised units demonstrating aids and equipment.

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Addendum

The members of the working party of the Thames Valley Faculty of the Royal College of General Practitioners were: Professor A. E. Bennett, Drs J. C. Hasler, M. Lee Jones, and T. I. Stewart.

ABORTION IN THE SOUTH-WEST THAMES REGION

A questionnaire was sent to general practitioners and had a 60 per cent response rate (although sent out in September with a four-week deadline). The doctors were asked, among other things, about the actions they had taken with regard to women requesting abortions during the three-month period before the questionnaire. They reported that 93 per cent of requests had been referred to either National Health Service or private sectors.

Difficulties in securing abortions in the National Health Service varied widely from district to district within the region. Although in all 40 per cent of general practitioners reported that they had difficulty in securing abortion under the National Health Service, this varied from only 12 per cent at one extreme to 76 per cent at the other. There was evidence that in districts where it was difficult to obtain an induced abortion, there was a somewhat higher incidence of other abortions or their sequelae. In some districts these two categories (induced and " spontaneous " abortions) made up as much as 25 per cent of the total gynaecological in-patient workload.

REFERENCE

Price, D. (1975). *South-west Thames Faculty Newsletter*, November 3.

FAMILY PLANNING AND ABORTION

One might suppose that the Abortion Act, 1967, would have enabled abortion to be done in Britain to the limited extent required by failure or non-usage of contraception. But the absence of facilities for contraceptive advice and supervision within the normal framework of the National Health Service means that those women aborted within the NHS are unable to receive adequate contraceptive counselling at the time of abortion—while in the private sector the woman is all too often aborted far from her normal place of residence, so that even if contraception is offered she may be unable to attend for supervision.

Only when the general practitioner is widely approached as the normal source of contraceptive advice, backed by his consultant colleagues when technical problems arise, will there be any real continuity of abortion and subsequent contraception.

REFERENCE

The Lancet (1972). Editorial, **2**, 749.