A general-practitioner ward in a new district general hospital

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SUMMARY. So far there are relatively few general-practitioner wards in district general hospitals in the National Health Service. The work of one such general-practitioner ward at Queen Mary's Hospital, Sidcup, is described and the advantages of this system of care for patients and doctors discussed.

Introduction

Although the British general practitioner has long been associated with cottage hospitals, his links with district hospitals have under the tripartite structure of the National Health Service been much less close. But the isolated position of general practice is changing.

In 1968, Wilkinson described the first ward in the bounds of a district general hospital for the exclusive use of general practitioners. This was a former tuberculosis ward in a Birmingham hospital which was adapted to provide 12 beds for family doctors. Thirty eight general practitioners used the ward during the first year, and 208 patients were admitted for investigation and treatment.

Jeffs (1973) from South-east London has for more than 12 years used beds in Hither Green Hospital. A single bed in each of the four wards is reserved for the use of general practitioners and Jeffs is enthusiastic about the improved contact with the hospital since his scheme started.

Barber and his colleagues (1972) reported on a general-practitioner ward in Bangour District Hospital in Livingston New Town. They describe the admissions to the 18-bedded ward for a year when 255 patients were admitted.

In Farnham, Surrey, Clarke and Mulholland (1973) studied all the admissions to hospitals in the group during a period of 13 weeks, and found that 31·5 per cent of these were cared for by general practitioners.

There has long been a close relationship between the general practitioners and consultants in Basingstoke. The district hospital has a department of general practice which organises an active vocational training scheme. Family doctors have since October 1974 used their own 16-bedded section of the medical floor of the new district general hospital and for four years before this they had used beds in the consultant ward.

In Sidcup, 12 miles from the centre of London, general practitioners had for many years been fortunate enough to work in two community hospitals. Sidcup Cottage Hospital stands in the centre of Sidcup, and Cray Valley Hospital is about a mile away to the south between Sidcup and Orpington. These hospitals between them provided more than 30 beds and patients admitted to them were under the sole care of their family doctors, who could if they wished ask for a consultant opinion from Queen Mary's Hospital, the district general hospital which was situated between the two small units.

The old Queen Mary's, which consisted of a complex of prefabricated single storey buildings in which Sir Harold Gillies had carried out his pioneering work in plastic surgery during the First World War, was at last replaced by a completely new hospital in 1974. From early in its planning stages general practitioners had been actively campaigning for the provision of a ward for their use and when the two cottage hospitals closed,

patients were transferred to a 29-bedded unit identical in design to the wards used by the consultants. This consisted of four bays of six beds, and five single rooms linked with a central nurses' station.

The general-practice ward in Queen Mary's began to admit patients in September 1974. This paper describes the ward's first year of work.

Planning and ward procedure

The general-practice ward is managed by two committees. First of these is the ward staff committee to which every doctor using the ward belongs. Naturally this is too unwieldy a body to deal with all the problems which arise and a small executive committee of seven members meets more often and reports back to the larger group at the latter's six monthly meetings.

Medical staff

General practitioners working in the cottage hospitals held contracts with the hospital authority and these were continued when the new ward opened. Many other doctors applied to join the staff and now more than 60 are entitled to use the ward.

Despite the large number of doctors on the ward staff committee only 28 used the ward in the first year and several of these admitted only one or two patients during the whole period. Eight of the staff were between them responsible for 72 per cent of the admissions and with one exception all these doctors belonged to group practices. Proximity to the hospital was obviously one of the most important considerations in its use by family doctors, and those on the periphery of its catchment area rarely found it convenient for their patients.

Each member of the medical staff serves on an emergency rota for a week. When on duty he is expected to visit the ward at least once, or to ask one of his partners to do so for him. In fact the personal cover provided by the doctors of patients in the ward is nearly always adequate for their care, but it helps the nursing staff to have someone they can consult if they have difficulty in contacting a particular practitioner.

The hospital cardiac arrest team has agreed to be on call for emergencies in the general-practitioner ward. It is considered to be the duty of the doctor to inform the nursing staff if he considers that his patient should not be resuscitated in the event of future collapse. " Striving officiously to keep alive " has no part in the treatment of many patients admitted to this ward with terminal illness.

Admissions and bed occupancy

During its first year of operation 237 patients were admitted to the general-practice ward. Of these 32 were subsequently re-admitted during the same period and three were admitted for a third stay, making a total of 272 admissions in all.

Bed occupancy varied from a figure as low as 48 per cent in the first month to a peak of 84 per cent in March 1975. It dropped during June and July to 61 per cent and 59 per cent and rose again with holiday admissions in August to 79 per cent. It has rarely dropped below that figure during the last six months, showing that the ward continues to be busy up to the time of compiling this report.

Age of patients

The ages of the 237 patients are shown in table 1. The average age of patients admitted to the ward was 75·1 years. In the medical wards this figure was 63 and in the geriatric long-stay wards it was 81·6. The oldest of our patients was 103 and the youngest 19; 37·6 per cent were older than 80 and only 8·4 per cent were under the age of 60.

TABLE 1
AGE OF PATIENTS ADMITTED

15–24	*25–34*	*35–44*	*45–54*	*55–64*	*65–74*	*75–84*	*85–94*	*95 and over*
1	1	1	10	35	54	84	43	8

Length of stay

Length of stay correlated with age is shown in table 2. The average length of stay was 29·3 days, considerably longer than that of patients in the medical wards (16 days), but the problems dealt with were, of course, different.

TABLE 2
LENGTH OF STAY BY AGE GROUPS

	Under 65	*65–74*	*Over 75*
0–7 days	14	12	28
8–14 days	12	26	38
15–28 days	19	17	57
1–3 months	5	7	24
More than 3 months	—	—	11

The shortest stay was less than a day because of death or immediate transfer to another ward. The longest stay was a woman with a psychogeriatric disorder who spent eight months in one of the cottage hospitals before the ward in the new hospital was opened. She remained for the whole of the first year in the ward and is still there at the time of writing—a total of more than two years.

Reasons for admission

Social admissions formed the largest group of patients. Sixty two (21·8 per cent) were admitted either to give their relatives a short holiday or because their home conditions were considered to be unsuitable for them to remain there. The other main conditions are listed below:

Social	62
Chest infections	36
Ischaemic heart disease	29
Malignant disease	18
Cerebrovascular accident	15

Other less common reasons for admission included the following conditions:

Multiple sclerosis	5
Varicose ulcer	5
Deep vein thrombosis	4
Depression	3
For barium enema	3
Pleural effusion (for tapping)	3
Peptic ulcer	2

Table 3 shows the main reasons for admission analysed by age:

TABLE 3
REASONS FOR ADMISSION BY AGE GROUPS

	Under 65	*65–74*	*Over 75*
Social	1	7	54
Ischaemic heart disease	9	6	14
Chest infections	6	17	13
Malignant disease	5	8	5
Cerebrovascular disease	2	2	11

Transfers

Fourteen patients were transferred to other wards or hospitals during the first year. The analysis of these can be seen below:

Fracture of femur	3
For total hip replacement	1
For hysterectomy	1
Medical transfers:	
(a) Myeloma	1
(b) Respiratory failure	1
Surgical transfers:	
(a) Obstruction	1
(b) Perforation	1
To long-stay geriatric care	1
To other hospitals:	
(a) For myelogram	1
(b) Overdose	1

Deaths

Forty seven of the 237 patients (19·8 per cent) admitted to the general-practice ward during the first year died in the ward.

Causes of death were as follows:

Bronchopneumonia	15
Coronary thrombosis and congestive cardiac failure	13
Cancers:	
Lung cancer	8
Breast cancer	2
Other cancers	3
Uraemia	3
Cerebrovascular accident	2
Pulmonary embolism	1

Discussion

Thompson (1974), who is well-known for his interest in the care of old people in the community, wrote in *Update* on the topic *The general practitioner in hospital—against*. He used as his text " no man can serve two masters." In fact using a general-practice ward is not a matter of serving the conflicting masters of hospital medicine and general practice. It provides facilities to enable the family doctor to improve his service to his patients. Thompson did admit that doctors in general-practice hospitals could claim to see their patients right through their illnesses, and this is surely the reason why the ward in Sidcup is so popular.

A survey by the Department of Health and Social Security and published in 1971 as a supplement to this *Journal* on the care by general practitioners of their patients in hospitals made several important discoveries. It found that " general practitioners who had beds were, without exception, convinced that the opportunity to tend their own patients in hospital was of great benefit to them and that the hospital was part of their lives." Furthermore, the survey deduced that the area in which general practitioners chose to live was greatly influenced by the availability of hospital beds and some said they would leave if the facilities were withdrawn.

Wilkinson (1968) was convinced that a unit of this type would " increase the attractiveness of general practice in this country."

The ward in Sidcup has a high bed occupancy comparable to that of community hospitals like Tamworth in Staffordshire. One of its most important uses is for rehabilitation after strokes, for it is possible to obtain the services of physiotherapists, occupational therapists, and speech therapists who are not as yet available in the district health care teams. Full investigation and treatment of any condition which the general practitioner considers to be within his capabilities can be undertaken in the ward.

The average age of patients in the general-practitioner ward compares with that described by Wood (1974) at Hawkhurst Cottage Hospital. Intractable social problems are wherever possible anticipated and the consultant geriatrician is asked to visit the patient in his or her home rather than after admission to the ward. But some elderly patients with acute medical conditions deteriorate both mentally and physically while in hospital. It then becomes impossible to discharge them and they have to await their turn for part three accommodation or a geriatric bed.

Jeffs (1973) at Hither Green Hospital do not admit social cases to their beds. Holiday admissions do, however, provide overworked relatives with a welcome rest. An incontinent and demented parent is a daunting responsibility and to admit such patients for a fortnight is a worthwhile use of the resources of the Health Service.

There is another aspect of general practice which has not yet been considered. The general-practitioner ward provides valuable opportunities for teaching and the patients with their various problems give excellent insight into the work of a family doctor. It is hoped to start a vocational training scheme at Sidcup in the near future, and the ward will play an important part in its effective operation.

Emrys-Roberts (1971), who has championed the cause of the cottage hospital, has pointed out that the closure of all 400 community hospitals in Britain would be disastrous for the National Health Service. It is not possible in sparsely populated areas to bring patients in from the periphery to a large central hospital and in these situations the community hospital has a vital role.

It may be that in the less remote parts of the country, the cottage hospitals will be forced to shut for economic reasons in the same way as Sidcup Cottage Hospital and Cray Valley Hospital. But it is hoped that new district general hospitals will be built in a less gloomy financial climate than at present and it is up to the family doctors in the areas concerned to ensure that each one contains a general-practitioner ward. Without their pressure, it will not happen.

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