The vital role of the cottage-community hospital

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SUMMARY. The history of general-practitioner hospitals is reviewed and a case made for their retention and extension. Among the advantages they provide are: a local service for patients, less expensive hospital care than is possible in a district general hospital, less travelling expenses for patients, valuable postgraduate education for doctors, and improvement of general-practitioner morale.

Introduction

IN RECENT years small hospitals under the control of general practitioners have been eclipsed by the major hospital programme for the development of district general hospitals. But is it not of considerable importance that they should be allowed to emerge again under a new name and with an extended role to play in health care in the UK?

Under their new name of community hospitals, cottage hospitals will lose some functions and gain and extend others, thus becoming not only a base for community care services but also filling the gap between the district general hospital and the need for less specialized services.

The name 'community hospital' was first suggested in April 1968 by the Oxford Regional Hospital Board, and subsequently the functions of the small hospital of the future were formulated.

> "The ideal model of a community hospital is seen to comprise a health centre with accommodation for general practitioners, their staff, local health authority services, consultant clinics, and certain diagnostic services; day treatment facilities and inpatient accommodation" (Oxford Regional Hospital Board, 1965).

This arrangement, it is hoped, will allow integration at a community level of all the appropriate services needed for a defined population.

The problem of centralization as against decentralization of certain elements of the hospital service has been a matter for continuing discussion. It has been well demonstrated that large impersonal district general hospitals with a high degree of specialization have been developed at the expense of the smaller, familiar local units. As a result, the total well-being of each patient, both physically and emotionally, has not always been borne in mind (St Thomas Health District, 1976). This discussion has stimulated considerable research about decentralizing some services within the NHS. It is argued with good reason that if a general practitioner has suitable treatment facilities he and his team can provide local care for many patients as an alternative to district general hospital care, with several advantages to the patient and the community as a whole.

Development of cottage hospitals

It is essential to know something about the past in order to understand the present and alternatives for the future. Professor McKeown has said that "without historical perspective medical science and service will continue to drift" and that ". . . a rational approach to present and future hospital developments is hardly possible without historical research" (Loudon, 1973).

The first cottage hospital was established in Cranleigh in 1858 by Dr Albert Napper who had a clear concept in mind. He meant literally a cottage with an optimum number of six beds "identical to the homes from which the patients were drawn, differing only in cleanliness, warmth, proper hygiene, and absence of overcrowding" (Loudon, 1973). These hospitals were to serve rural areas from where it was difficult or impossible to transport the sick to the nearest infirmary in a large town. They represented the majority of voluntary hospitals of that time.

The idea was popular and within seven years 16 cottage hospitals had been built, conforming to the criteria of Napper (Abel-Smith, 1964). By 1895 the number had increased to over 600 in Britain (Oxford Hospital Regional Board, 1965). They proved to be a great boon, not only to the local community but also to

the general practitioners serving them. The general practitioners' status was raised considerably through performing some operations and by the retention of the clinical care of their patients after admission to hospital. Thus, as the consultants became more and more associated with hospital care, there was nevertheless one type of hospital which would always be undisputed general-practitioner territory—the cottage hospital.

With time, the original concept was forgotten and the term 'cottage hospital' has come to include any small hospital with between six and 40 beds in which general practitioners have day-to-day control. By 1934 there were 600 cottage hospitals containing about 10,000 beds (Loudon, 1973). Many have been unable to keep pace with the developments in medical equipment and skill, affected by rising expenditure rather than falling income.

Under the supervision of general practitioners, cottage hospitals were essentially part of the community medical services. However, they were incorporated into the hospital network when the NHS was formed in 1948. Some cottage hospitals were closed down but a majority have remained because their attempted closure often produced powerful local political opposition.

Cottage hospitals after the NHS

About 350 cottage hospitals have survived, mostly dating from before 1948 (Loudon, 1973). They vary in size, architecture, and usefulness. In spite of their rural origin, they are not confined solely to rural areas. Their present siting is based on local history so that the highest concentration is in one small area in the suburbs of London, to the west and south (Figure 1).

In the main, cottage hospitals have remained isolated from the mainstream of hospital care (Rue and Golding, 1968) so that they appear to be the poor relation of the big hospitals. While some serve small communities and the few associated general practitioners satisfactorily, the role of many is not so clearly defined. In fact, if present population patterns were to be re-examined, communities possessing cottage hospitals today would not necessarily be those with the highest priority for the establishment of local inpatient facilities. Thus it may be said that there is a tendency for some cottage hospitals to produce a service to satisfy general practitioners and patients in a manner which is to some extent unrelated to the requirements of modern medicine or the community concerned.

Since 1960, in an attempt to streamline the medical care offered in the UK, the Government has sponsored a number of blueprints on the subject. In 1962 the Ministry of Health published *A Hospital Plan for England and Wales* which proposed that the bulk of hospital care should be concentrated in large, centralized district general hospitals which were to offer a wide range of facilities required for the diagnosis and treatment of inpatients. Some of the district general

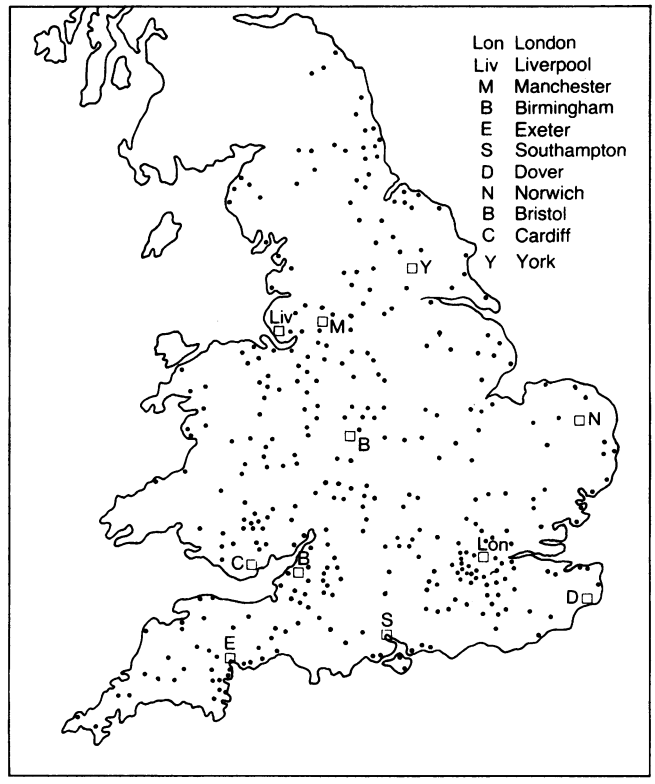

Figure 1. *General-practitioner hospitals in England and Wales. Each dot represents one general-practitioner hospital (total of about 400).*

hospitals were to be larger than others, depending upon local circumstances, but few were to offer less than 300 beds. The report stated:

> "The district general hospital offers the most practicable method of the full range of hospital facilities at the disposal of patients and this consideration far outweighs the disadvantages of longer travel for some patients and their visitors."

Under the Hospital Plan, as the district general hospitals developed, a large number of small hospitals would no longer be required. The Bonham Carter Report on the functions of the district general hospital also implied the closure of nearly all small hospitals (DHSS Welsh Office, 1969). Both these reports failed to acknowledge that the closure of the small hospital would be most felt by the rural practitioner, who would have to travel much further if he was to maintain his interest in hospital medicine.

The Gillie Report (Ministry of Health, 1963), *The Field of Work of the Family Doctor,* stressed the importance of the provision of hospital beds under the control of the general practitioner. By having hospital beds for the admission of cases which could not be treated at home, the range and standard of the general practitioner's work were increased. However, circumstances obviously required that the beds must not be too far away from the general-practice centre. The Gillie Report went so far as to suggest that the cottage hospital might become the premises for a combined

group practice and local health authority service. The report also recognized the need for the establishment of peripheral clinics where consultation could be undertaken by visiting consultants without the use of the full resources of a district general hospital.

The Platt Report (Ministry of Health and Department of Health for Scotland, 1961), *Medical Staffing Structure in the Hospital Service,* thought that general practitioners should continue to work in cottage hospitals, thereby maintaining responsibility for their own patients with advice available, as required, from visiting consultants. The Porritt Committee which published *A Review of the Medical Services in Great Britain* (Medical Services Review Committee, 1962) also made several references to the importance of cottage hospitals, particularly within the context of the organization of general practice. It took the view that general practitioners should be encouraged to look after their own patients in hospital and that the smaller hospitals should not be closed simply because of administrative convenience or temporary staff shortages. However, the Porritt Committee acknowledged that general-practitioner maternity units should be sited close to consultant-staffed district general hospitals in view of the findings published in the Cranbrook Report (Ministry of Health, 1959) on obstetric care. The Committee agreed that small hospitals staffed by general practitioners with visiting consultants should help to bring the two sections of the medical profession together, to the advantage of both patients and doctors alike. The only reason for the closure of small hospitals was economy.

It is in view of this controversy over the future of cottage hospitals that detailed analysis of the work performed by such hospitals has been carried out. Thus the problem can be set in a true perspective, highlighting exactly the contribution of these hospitals in the hospital service.

In most cottage hospitals general operative surgery is no longer carried out although postoperative care of early discharge patients from district general hospitals is becoming more common. Most beds are used for medical admissions, acute or general, with few hospitals admitting children below the age of 12. However, at present there is unfortunately an increasing tendency to use the beds for long-term care of chronic illness with the general practitioner visiting only at infrequent intervals. Could this be the result of some sections of the community condemning general-practitioner beds as a second-class geriatric service?

Studies of the work done

The study at Frimley and Farnham in the use of general-practitioner beds showed that their main contribution was in the care of patients with diseases of the respiratory, circulatory, and nervous systems (Clarke and Mulholland, 1973). Cerebrovascular accidents formed the greater part of this latter group. In terminal care of malignant disease general practitioners made a considerable contribution to inpatient care. In this study although the general-practitioner patients were considerably older than those cared for by consultants, they stayed in hospital only just over two days longer than patients of consultants, but perhaps factors other than age account for this difference. The main conclusion of this study was that general practitioners played a large part in the hospital care of their patients in that part of England.

A similar study was carried out investigating the value of Chipping Norton Cottage Hospital which serves a community of 10,000 people, most of whom are 9 to 25 miles from a district general hospital (Oxford Regional Hospital Board, 1965). The spectrum of diseases within the hospital was similar to those in the Frimley and Farnham study, with the slightly higher admission rate compared with district general hospitals broadly being accounted for by patients with cardiovascular disease and elderly patients. The tendency today for more patients to be given terminal care in hospital was felt to be well met within the community by the familiar cottage hospital. The introduction of the transfer of postoperative cases from the district general hospital has provided an opportunity for maintaining a high use of the beds while at the same time relieving the pressure on the beds at the main acute hospital. This has therefore yielded both economic and social advantages with the relatives of local patients finding visiting much more convenient. Chipping Norton Cottage Hospital also offers some outpatient facilities which have been well used over the years, providing not only the opportunity for specialist clinics but also giving the general practitioners the opportunity of carrying out x-ray and pathological investigations, which are of great value in the maintenance of clinical skill. In short, "the evidence suggests that the cottage hospital of Chipping Norton renders a vital service to the community in terms of either inpatient or outpatient care." Although the cottage hospital would not claim to provide a comprehensive service for the community, its main usefulness lies in the fact that it can, with the co-operation of consultants, cater for a substantial proportion of the population, and this I feel is true of most cottage hospitals today.

Arrangements

The admission policy of cottage hospitals varies slightly from hospital to hospital. However, in general a patient is accepted for admission by the senior nurse in charge of the hospital after the patient has been discussed with the general practitioner. Thus the nursing staff are able to check that all patients are suitable for admission to such a unit.

The size and architecture of these hospitals varies depending upon the origin of the building. Most cottage hospitals have between 20 and 40 beds—it being considered that fewer beds are not viable in a time of economic stringency. The beds are usually allocated equally between two main wards, one female and one

male, with a small number of single rooms as well. There are also a number of utility and treatment rooms, in which some outpatient work may be undertaken. The range of diagnostic equipment is variable and often reflects the attitude of the governing health authority.

Cottage hospitals have undoubtedly served the community well in the past. Small hospitals may still have a vital role to play in our health service with the appropriate adaption to present-day medical practice and community requirements.

The contribution of general-practitioner beds to the NHS

The future of general-practitioner hospital beds has been questioned in recent years in an attempt to prune the NHS in a climate of ever-increasing economic stringency. However, various pieces of research have challenged the expediency of some aspects of the district general hospital concept serving a population of up to 300,000 as outlined in the Bonham Carter Report (DHSS Welsh Office, 1969).

The community hospital is the first new concept for general-practitioner hospitals since Napper's in 1858. The concept was developed by the former Oxford Regional Hospital Board at the end of the 1960s in response to the problem of establishing district general hospitals in a rural area as suggested in the 1962 Hospital Plan (Ministry of Health, 1962). The Board therefore examined the possibilities of an alternative plan suitable for a predominantly rural area with a scattered population. A community hospital research programme was begun in 1969 centred on the former cottage hospital of Wallingford, a small market town between Reading and Oxford. A pilot trial was held at Peppard Cottage Hospital before this (Oddie *et al.*, 1971).

This potentially important concept in the organization of medical care in the NHS lacked official encouragement until quite recently. In 1974 the Department of Health and Social Security gave its first official recognition to the idea with the publication of a consultative paper on the role and development of community hospitals (DHSS Welsh Office, 1974), which it hoped would serve as a guide to the governing regional and area health authorities.

The 1962 Hospital Plan was drawn up to give the hospital service the necessary facilities for its most efficient functioning. It favoured the concentration of hospital care in district general hospitals situated near the centre of population of the area which they served. However, it recognized the need to retain some small hospitals and the importance of general-practitioner care. The report also acknowledged that the implementation of the programme would be determined by several factors, including financial limitations as well as the scarcity of doctors throughout the country as a whole.

Suggestions to reduce the shortage of hospital beds have always been seen in the context of reduced admission rates and an increase in the number of hospital beds. This is based upon the misconception that hospital care and consultant care are synonymous and, as a result, little thought has been given to the role of general-practitioner beds. Research has suggested that quite large proportions of patients in district general hospitals do not need the medical sophistication they provide (Loudon, 1970). Although this involves the contentious issue of clinical judgement, there is general acceptance that not all those in need of hospital care need district general hospital care (Ferguson and McPhail, 1954; Forsythe and Logan, 1960; Loudon, 1972; Smith *et al.*, 1973).

A saving of consultant beds could also be achieved through the transfer of surgical patients from district general hospitals for postoperative recovery before their discharge home, thus removing the financial burden on the district general hospitals to provide expensive diagnostic and treatment facilities. A substantial saving of consultant beds could therefore be made through an increase in the provision of general-practitioner care as an alternative to inpatient care in a teaching hospital. An editorial in the *Lancet* (1970) suggested that "these (general-practitioner) units might, by saving on the more expensive hospital beds, pay for themselves in no time." This may indeed be true if the comparison of 1976 costs holds today (Table 1). Similar figures have been produced in earlier studies showing that unit costs are lower for both inpatient and outpatient care (Graham and Gold, 1970; Loudon, 1970).

Some members of the medical profession have been denigrating the smaller hospitals (Loudon, 1973) and justifying their closure on the grounds that modern medicine is so complicated that only a large district hospital can provide proper treatment for anyone ill enough to need inpatient care. However, the premise on which this kind of statement is based is probably less than half true. Various recent surveys have shown that about 60 per cent of all hospital patients in hospital do not require the high-powered technology of the district general hospital (Kyle, 1971). For most inpatients, the diagnosis is straightforward and the treatment routine and well within the general practitioner's competence. Too many people forget that general practitioners were trained in large hospitals and spent on average one and a half to two years in responsible appointments there. Thus, the general practitioner, if he has the hospital facilities and particularly professional nursing and hospital beds at his disposal, can do a great deal to lighten the load on almost every department of the district general hospital.

Economics of outpatient care

A study of the economics of outpatient care published in 1971 challenged the Bonham Carter contention that outpatient clinics are best confined to the district general hospital (Gruer, 1971). The Office of Health Economics (1970) has suggested that "there is, in

Table 1. Comparative costs 1975/76: Radcliffe Infirmary, Oxford, and nine general-practitioner hospitals in Oxfordshire.

Hospital	Number of beds	Type of beds (acute/ maternity)	*Inpatient costs* Per IP week (£)	Per case (£)	*Outpatient costs* Per OP attendance (£)	Per new OP (£)
Radcliffe Infirmary	523		270.83	268.58	10.74	44.38
Abingdon	71	A + M	109.55	185.57	3.43	7.82
Brackley	12	A + M	139.09	147.14	3.10	5.09
Burford	9	A	123.20	360.00	2.01	8.20
Chipping Norton	37	A + M	104.37	219.39	6.51	15.26
Didcot	18	A	75.39	178.88	2.17	3.35
Thames	19	A	101.64	239.10	2.92	8.82
Wallingford Community	34	A + M	165.27	267.32	2.12	11.21
Wantage	31	A + M	69.58	149.65	1.72	2.90
Watlington	20	A	84.91	276.28	3.54	12.24

Source: Oxfordshire Area Health Authority (Teaching); Loudon, 1976.

economic terms, no justification for assuming that the patient's time is expendable and that he must always bear the inconvenience of seeking medical attention." Gruer came to the conclusion that nearly half the cases of outpatient treatment did not need the expensive and highly specialized diagnostic equipment of the district general hospital. She also costed patient travelling and consultant travelling time and was able to show that the cost of consultants travelling to peripheral clinics was invariably less than the cost to the community of outpatients travelling to centralized services. In terms of total travel cost, the arrangement of consultant outpatient clinics in a local general-practitioner hospital is thus the most convenient for patients and also the least expensive.

Staffing

Community hospitals, it is hoped, would also avoid the problems of staffing encountered by large district general hospitals. Whereas a district general hospital has to draw on a wide area for staff in order to employ a sufficient number, a community hospital can tap local resources, particularly married nurses with children who want to go back to nursing but cannot travel far. This has wider implications since it means that these hospitals are well placed for increasing their staff numbers in an emergency and for cover when staff are ill, drawing upon their local part-time staff. Also, these nurses are fully capable, having gained a depth of experience during the years before bringing up a family.

As part of a closely knit community, small local hospitals also seem to attract valuable voluntary help. This makes an immense contribution to the well-being of patients, particularly for long-stay patients, as well as helping to ensure that the trained nursing staff do not waste their time on less skilled ward activity, such as dealing with flowers (Oddie *et al.*, 1971).

The home affecting hospital admissions

The changing role of women in society is having repercussions upon the demands for hospital provision. Today, with most women of working age out at work, it is impossible for many elderly patients to be cared for at home. The breaking of family ties and the dispersal of the family have further contributed to the number of old people living alone, thus increasing the demand for hospital provision of good nursing care. Hence not all hospital admissions are based upon the clinical state of the patient— perhaps there is no able-bodied relative at home to maintain the care, or perhaps pressure from the relatives or patient himself may persuade the general practitioner to admit a patient.

In the course of his work, the general practitioner deals with a large number of patients who, for social reasons or through inadequate facilities, cannot be managed satisfactorily at home but would not normally justify admission to an acute hospital. However, inpatient treatment of these patients leads to a more rapid relief of disability, shortening of illness and earlier return to work. Wilkinson (1968) states that a large number of varicose ulcers were healed or generally relieved in his unit. General-practitioner beds also offer the valuable facility of good nursing care of patients of all ages with chronic disabilities while their families, who normally look after them, are on holiday or ill.

Satisfaction of patients

It is difficult to evaluate the effect upon patients of their removal from home surroundings and doctors and nurses whom they know to the more impersonal

atmosphere of a large hospital, but there is no doubt what the patient prefers. Indeed, satisfaction of patients with medical treatment has been found to be inversely related to the number of beds in a hospital. Cartwright (1964) showed that only three per cent of the patients in hospitals with fewer than 100 beds expressed any doubt about their medical care, as compared with 16 per cent of those in hospitals with 500 beds. A local hospital also poses no problems for visitors, since it avoids exhausting journeys. This is an increasingly important factor since the reliability and frequency of public transport services does not seem to be improving, and in many areas it is in fact deteriorating.

General-practitioner care also ensures a continuity of care to the benefit of both the patient and the doctor, and there are fewer problems of communication such as exist in large hospitals—"They never tell me anything when I visit him. I only ever see one of the little nurses." The patient's own doctor is in charge and the relatives know him and can talk to him, which contrasts markedly with the normal arrangement of continual changes in junior hospital staff in bigger hospitals. The value of the family doctor was summed up by Dr John Brown in 1858:

> "The familiar, kindly welcoming face which has presided through generations of births and deaths, the friend who hears about and keeps sacred deadly secrets which must be laid silently in the grave, and who knows the kind of stuff his flock is made of . . ."

Effect upon general practice

Finally, general-practitioner participation in hospital work could have a most beneficial effect on the status of general practice and future recruitment. At present few medical students start out intending to enter general practice and some drift into it. It is therefore most important to increase the attractiveness of general practice. It is interesting to note that according to a Royal College of General Practitioners' report (1968) the large majority of general-practitioners either had or wanted access to hospital beds. There was a minority of 18 per cent who did not want access and all except one of these was over 40 years of age.

Advertisements in the *British Medical Journal* offering a vacancy in a practice which has access to beds in a cottage hospital always bring in a flood of answers (Evans, 1971). This is because it offers considerably more scope to the medical care undertaken as well as allowing the general practitioner to be in full clinical charge. It is perhaps not money alone that causes young doctors to leave the country for the USA or Canada. Perhaps it is the better, fuller medical life they find there, with hospital attachments and all the facilities that they need to practise good medicine.

The removal of the general practitioner from the hospital as a consequence of the regional spreading of consultant services has not helped him to keep in touch with technical advances which have been applied in the hospital and not in general practice (Forsythe and Logan, 1960). Thus a close link with a hospital would provide valuable postgraduate training and offer individuals the opportunity to practise their skills in specialties. A survey showed that about two thirds of doctors felt more contact with consultants and general practitioners could be a powerful stimulus to improve the standard of general-practitioner care (Loudon, 1972). Thus, if consultants come to advise on inpatient care, just as they come in many instances to take outpatient clinics, suspicions of low clinical standards would be removed and for general practitioners the consultants' visits would be a form of continuous postgraduate education. However, the operational policies of future community hospitals will need resolution at a local level. A problem arises from the day-to-day care resting with the general practitioner, while the specialist assessment may require consultant opinion. The continuing treatment and discharge will then depend upon good co-ordination so that the concept of 'shared care' becomes a reality.

When Humphreys (1973) reviewed the role of his local general-practitioner hospital in retrospect, he concluded, "since the local community (cottage) hospital closed, I am in no doubt that I was able to practise better medicine when it was open."

Conclusion

There are about 350 cottage hospitals in England and Wales, contributing a larger share of highly economic hospital care than is relaized; and as beds are an extremely expensive part of hospital resources, both in terms of finance and staffing, their efficient use must be one of the main aims of hospital management.

It is clearly uneconomic for expensive equipment and supporting facilities which are provided at district general hospitals to be duplicated elsewhere. However, there are a substantial number of patients who need hospital care that can and should be provided by their general practitioners. The majority of general practitioners in this country have no access to hospital beds, so that those of their patients who need hospital admission come under consultant care. This is a waste of specialist skill, time, and money. With lack of money nearly always blamed for the failing NHS, improved medical services will depend upon avoiding waste, particularly the waste of skill for which the NHS is renowned.

Contrary to Beveridge's projection, circumstances have conspired to increase the demand for hospital treatment. The increasing proportion of old people in the population has inevitably influenced the hospital load, especially since pneumonia has largely lost its hold, as more old people are afflicted with illnesses of long duration, notably cerebrovascular accidents and malignancy. There is little to be said for continuing to keep such patients in highly equipped wards when their main requirement is kindly nursing care.

The desirability of general practitioners having access to hospital beds in which they may care for some of their own patients has been a recurring theme in many reports since the inception of the NHS (Platt Report, 1961; Porritt Report, 1962; Gillie Report, 1963; Hospital Plan for England and Wales, 1962). The Brotherston Report (Scottish Home and Health Department, 1971) also recognized the great benefit to smaller communities of cottage hospitals staffed by general practitioners and suggested that it was desirable to consider how the means could be found to extend these to all general practitioners.

The concept of a community hospital should be the key to integration between specialist care provided by the hospital and primary care provided by general practitioners and the domiciliary team, because it attempts to integrate the three branches of the health service on one site (Wycherley, 1974). One of the major aims of the reorganization of the NHS was to bring health care closer to the needs of the community, and therefore community hospitals could undoubtedly play an important role in the future.

Provided general practitioners using community hospitals realize their own limitations and those of the hospital and are always ready to be critical of their work, patients in a community hospital would not seem to be at a disadvantage. Instead they benefit from the doctor's wider knowledge of the human needs of patient and family, as well as medical needs, so that closer attention may be given to the specific abilities needed by the patient in his particular home.

The community hospital concept avoids all the administrative difficulties usually thought to be associated with the introduction of the general practitioner into wards of the district general hospital. It also has the attractive virtue of being an economical way of providing medical care, and perhaps the removal of some of the load from the district general hospitals would allow them to be smaller than at first envisaged.

In a publication by the *British Medical Journal* in 1938 it was agreed that there was "a growing need for a more extensive provision of a type of hospital or accommodation in which the general practitioner can treat the cases falling within his sphere of competence" (Loudon, 1973). This suggestion was not controversial at the time and perhaps could be re-examined in the context of limited national resources. With enough general-practitioner hospital beds everyone would gain —the patient, general practice, the hospital service and, in financial terms, the NHS and the taxpayer.

References

Abel-Smith, B. (1964). *The Hospitals 1800-1948.* London: Heinemann.

Association of General Practitioner Hospitals (1977). *Cottage-Community.* Old Woking: Gresham Press.

Bennett, E. D. (Ed.) (1974). *Community Hospitals: Progress in Development and Evaluation.* Oxford: Oxford Regional Hospital Board.

Brown, J. (1862). In *Horae Subsecivae—Rab and His Friends and Other Works.* 12th edition. Edinburgh: D. Douglas.

Cartwright, A. (1964). *Human Relations and Hospital Care.* London: Routledge and Kegan Paul.

Clarke, M. & Mulholland, A. (1973). *Journal of the Royal College of General Practitioners,* **23**, 273-279.

Department of Health and Social Security Welsh Office (1974). *Community Hospitals: their Role and Development in the National Health Service.* London: DHSS.

Department of Health and Social Security Welsh Office (1969). *The Functions of the District General Hospital.* London: HMSO.

Evans, E. O. (1971). *Journal of the Royal College of General Practitioners,* **21**, 187-198.

Ferguson, T. & MacPhail, A. N. (1954). *Hospital and Community.* London: Oxford University Press.

Forsyth, G. & Logan, R. F. L. (1960). *The Demand for Medical Care.* London: Oxford University Press.

Graham, K. T. & Gold, M. (1970). *Notes on a Case for the Retention of Teddington Memorial Hospital.* Unpublished.

Gruer, R. (1971). *Lancet,* **i**, 390-394.

Humphreys, R. C. (1973). *British Medical Journal,* **4**, suppl., 19-22.

Kyle, D. (1971). *British Medical Journal,* **4**, 348-351.

Lancet (1970). Editorial, **i**, 1326.

Loudon, I. S. L. (1970). *The Demand for Hospital Care.* Oxford: United Oxford Hospitals.

Loudon, I. S. L. (1972). *Journal of the Royal College of General Practitioners,* **22**, 220-226.

Loudon, I. S. L. (1973). *General Practitioner Hospitals and the Relationship of General Practice to Hospital Medicine.* MD thesis. Oxford: University of Oxford.

Loudon, I. S. L. (1976). *British Medical Journal,* **2**, 1506.

Medical Services Review Committee (1962). *A Review of the Medical Services in Great Britain.* Porritt Report. London: HMSO.

Ministry of Health (1962). *A Hospital Plan for England and Wales.* London: HMSO.

Ministry of Health (1963). *The Field of Work of the Family Doctor.* Gillie Report (paras 172 and 173). London: HMSO.

Ministry of Health (1959). *Maternity Services.* Report of the Cranbrook Committee. London: HMSO.

Ministry of Health and Department of Health for Scotland (1961). *Medical Staffing Structure in the Hospital Service.* Platt Report. (paras 110-112 and 137-142). London: HMSO.

Oddie, J. A., Hasler, J. C., Vine, S. M. & Bennett, A. E. (1971). *Lancet,* **ii**, 308-310.

Office of Health Economics (1970). *Building for Health.* London: OHE.

Oxford Regional Hospital Board (1965). *The Work of a Cottage Hospital in a Rural Community.* Oxford: ORHB.

Royal College of General Practitioners (1968). *Reports from General Practice No. 8. General Practice in South-West England.* London: RCGP.

Rue, E. R. & Golding, D. K. (1968). *The General Practitioner and the Hospital Service in the 1970s.* Oxford: Oxford Regional Hospital Board.

St Thomas Health District (1976). *Community Health Council Annual Report 1975-76.* London: CHC.

Scottish Home and Health Department (1971). *Doctors in an Integrated Health Service.* Brotherston Report. Edinburgh: HMSO.

Smith, J. W., O'Donovan, J. B., Hoyle, G., Clegg, D. F. G. & Khalid, T. (1973). *British Medical Journal,* **2**, 471-474.

Wilkinson, B. R. (1968). *British Medical Journal,* **1**, 436-438.

Wycherley, G. J. (1974). *Health and Social Service Journal,* **84**, 926-927.

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