One practice's review of its use of a general practitioner hospital

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SUMMARY. For a period of six months a record was kept of every attendance at a general practitioner hospital by a patient from a four-partner practice with a list of 10,500 patients.

During the six-month period one in 17 of the practice population was x-rayed; one in 50 attended the physiotherapy department, and the rate for general practitioner surgery consultations was one per person.

I believe that in semi-rural North Yorkshire the general practitioner hospital has a continuing role to play and such a hospital can provide a better and more comprehensive service to patients, and give professional satisfaction and stimulation to the primary health care team.

Introduction

THE future of the general practitioner hospital and its possible transition to a community hospital is still under discussion. Some general practitioner hospitals have already closed (Humphreys, 1973) and probably more will do so, but little has been published on the work done in them. During the first few months of a trainee year in a mixed urban/rural practice in North Yorkshire, it became increasingly obvious that the local general practitioner hospital played an important part in the medical care of the area.

Aim

I wished to document the use made of this hospital by a four-doctor practice with a list size of 10,500 by means of a six-month prospective survey.

Method

Ripon and District Hospital is probably typical of many general practitioner hospitals. Twelve miles from the district general hospital, it has 40 general beds and, at present, 16 obstetric beds though this may shortly be reduced to 10. Plain and contrast radiography, physiotherapy, a 24-hour casualty service, and a geriatric day ward are available. There is an operating theatre and weekly or fortnightly lists are performed by the visiting ENT surgeon, general surgeon, and gynaecologist. Outpatient clinics are held by consultants in ENT, general surgery, gynaecology, obstetrics, psychiatry, paediatrics, ophthalmology, orthopaedics, geriatrics, and general medicine. Several other practices use the hospital which covers a total population of approximately 30,000.

A record was made of every attendance at the general practitioner hospital by a patient from the practice, whether it was for x-ray, physiotherapy, consultant clinic, casualty, or as an inpatient, over a six-month period from June to November 1977.

In the casualty department there was a set time for each practice in the town. Two general practitioners from the practice attending in rotation would see all the patients from their practice, as well as any emergencies or temporary patients from outside the area between 08.45 and 09.30 hours on weekdays, when the bulk of patients were seen. The casualty and outpatient department was staffed by one sister, one staff nurse, and one state enrolled nurse from 08.00 to 17.00 hours. After 09.30 the nursing staff would assess patients and call a doctor if necessary. Between 17.00 and 08.00 hours the sister in charge of the hospital wards would see casualties and again consult a doctor if necessary.

Admissions to the ward fell into those looked after solely by the general practitioner and those under shared general practitioner and consultant care. Inpatient facilities were used by general surgery, general medicine, ENT and gynaecology, the bulk of the general practitioner/consultant group being electively booked for surgery.

Results

Except where stated, the results refer to patients either permanently or temporarily registered with the practice.

There were 620 attendances for x-ray (308 male and 312 female), 61 for contrast media studies, 21 for

intravenous pyelograms, seven for cholecystograms, 20 for barium meals, and 13 for barium enemas. A consultant radiologist visited regularly to report films and perform the barium examinations.

Two hundred and thirteen patients attended physiotherapy for varying periods of treatment.

In the casualty department there were 3,940 attendances, of which 1,470 (37 per cent) were new attendances, and 2,470 were repeat or follow-up attendances.

A doctor saw all patients once and 46 per cent more than once. Two hundred and eleven patients were treated as temporary patients; that is, they were not registered with the practice.

In the maternity unit 31 patients were delivered, 11 patients were admitted for antenatal care, such as bed rest in toxaemia, and 24 women and babies received postnatal care in the unit after delivery at the district general hospital.

Of the 78 admissions under the sole care of the general practitioner 38 were male and 40 female. The average age was 64·4 years (range 1-96) and the average length of stay 17·7 days (range 1-220). Thirty-nine (50 per cent) were admitted purely for nursing or social reasons and of the total there were 11 deaths (14 per cent).

The general practitioner/consultant shared inpatient group totalled 108 patients (57 males and 51 females), of which 11 were transfers into the hospital from the district general hospital (after treatment). The average length of stay was 5·4 days (range 1-51) and the average age was 39·3 years (range 3-81; Table 1). The average length of time on waiting list for admission for all operations during this survey was 54·9 days (range 1-241).

About 25 to 30 patients a week attended the geriatric day hospital. Today the day hospital could probably handle more, but attendances were limited by the number of patients the ambulance service could deliver.

Three hundred and forty-four referrals were made to the outpatient clinics (152 male and 192 female). Six weeks after the close of the survey replies from referrals in the form of consultant letters had been received from 251 (72 per cent). Of the 93 outstanding referrals 44 (47 per cent) were awaiting ENT consultation. The average age of all referrals was 44·5 (range 1-95) and the average time between referral and consultant's reply (that is virtually the equivalent of the waiting time, but in effect a little longer as some consultants wrote their letters a few days after their outpatient clinic) was 40·3 days (range 1-134).

An analysis of referrals to each clinic is shown with the effective waiting list time. This average figure includes referrals seen and those still waiting (Table 2).

To compare the work of the practice as a whole during the six-month period with that referred to the general practitioner hospital the following figures are of note: during regular surgery hours 10,438 patients were seen by doctors, while the practice nurse saw 1,500.

Table 1. Details of inpatient and outpatient care (percentages in brackets).

	Total	Male	Female	Average inpatient stay (days)	Average age (years)	Number over 75
Inpatients sole general practitioner care	78	38	40	17.7	64.4	33 *(42)*
Inpatients general practitioner/consultant care	108	57	51	5.4	39.3	4 *(3.7)*
Total inpatients	186	95	91	10.6	49.8	37 *(19.8)*
Outpatient referrals	344	152	192	0	44.5	44 *(12.7)*

Table 2. Details of inpatient and outpatient care by specialty.

	Shared inpatient care	Outpatient referrals seen	Outpatient referrals still waiting	Outpatient average waiting time (days)*
Surgery	57	55	23	59.4
ENT	15	12	44	103
Gynaecology	29	40	2	46.2
General medicine	9	22	0	26.2
Geriatrics	0	8	1	26.2
Psychiatry	0	9	0	22.9
Orthopaedics	0	33	14	47.6
Paediatrics	0	10	0	12.3
Ophthalmology	0	58	9	45.5
Obstetrics	0	5	0	6

*This figure includes those seen plus those still waiting.

Discussion

The discussion document on community hospitals (DHSS, 1974a) suggests that all operative surgical procedures, all contrast radiography, and most casualties are to be carried out or treated at the district general hospital. If this were carried through in Ripon it would mean considerable unwelcome changes for both patient and doctor.

It has been stated several times (DHSS, 1974a) that there are large groups of patients who are in need of hospital care but who do not need specialist care or facilities. If the 78 patients in this survey cared for solely by the general practitoner are considered, 50 per cent of them were admitted for purely nursing or social reasons, and required relatively long stays (17·7 days on average). If a general practitioner hospital is not available (Humphreys, 1973) these are the patients that will block district general hospital beds. A second group suited to care in the general practitioner hospital are the early convalescent patients who have recently had surgery or acute medical treatment. However, in Ripon this constituted only a very small group (11, excluding maternity).

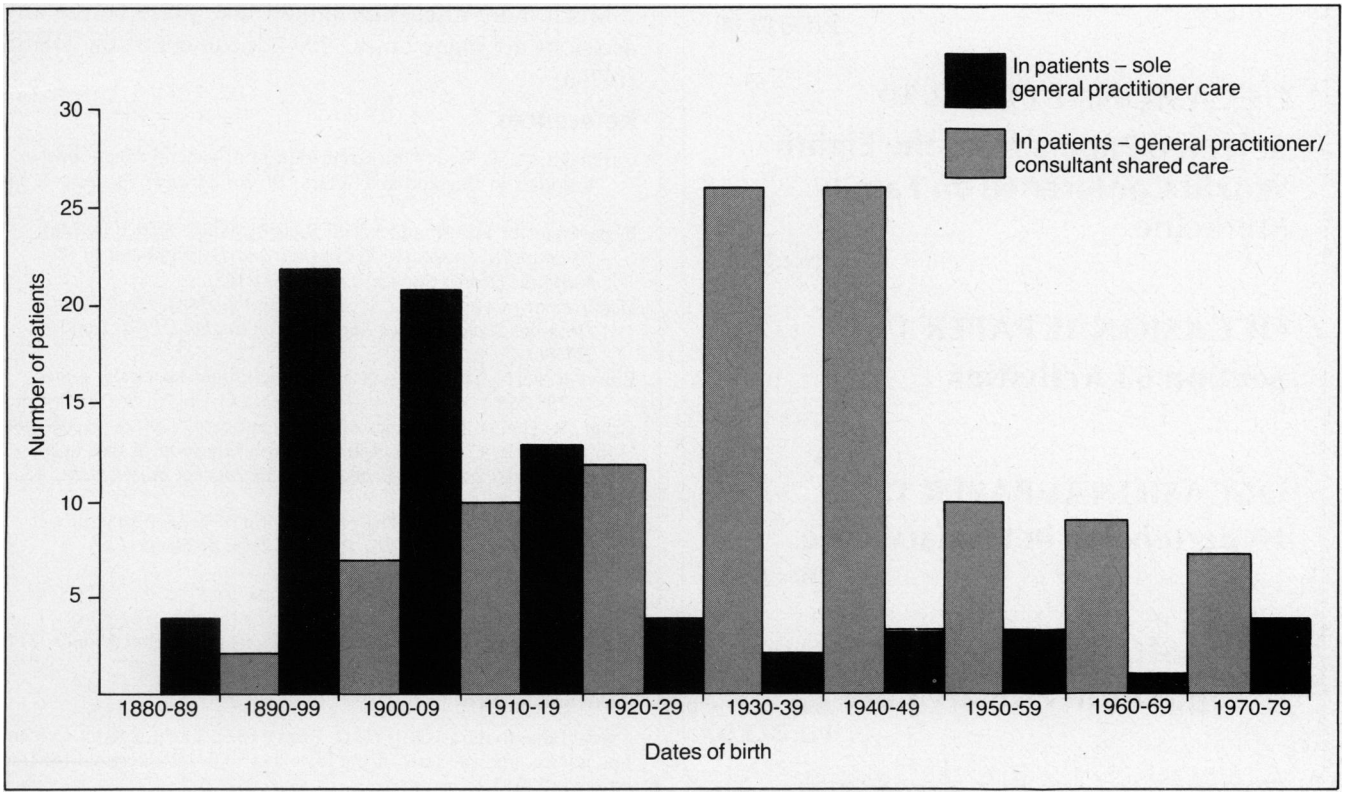
The seemingly high casualty attendance figures of about one in seven of the practice population attending during a six-month period (one in five in 12 months nationally; DHSS, 1974b) is interesting. A possible explanation may be the relative ease of access: with the decline of public transport in rural areas, patients sometimes find it difficult or inconvenient to attend the surgery at set appointment times, and they also have to cross the 'receptionist barrier'. In the casualty department these two restraints do not apply. The mere availability of casualty facilities possibly contributes to their over-use: patients attending for treatment of minor cuts, sprains, and bruises, if treatment had depended on a 12-mile journey, might well try home remedies first.

It is also interesting to note that during the six-month period one in 17 of the practice population received an x-ray, one in 50 attended the physiotherapy department, and the rate for general practitioner surgery consultations was one per person.

The two previously mentioned groups of sole general practitioner care and general practitioner/consultant care also divide themselves by age (Figure 1) and length of stay; the younger group, short-stay elective surgical procedure (D and C, hysterectomy, vasectomy, herniorrhaphy, tonsillectomy, and adenoidectomy) and the older longer-stay group (stroke, convalescence, rehabilitation, holiday admission, mild to severe dementia awaiting permanent placing, the elderly patient with congestive cardiac failure, and myocardial infarction or pneumonia).

To make comparisons between general practitioner hospitals is, as Emrys-Roberts (1971) has said, notoriously difficult as no two are the same. However, the figures for medical inpatient stay in Wantage of 18 days

Figure 1. *Comparison of inpatients under sole general practitioner care and shared general practitioner/consultant care by age.*



(Loudon, 1972) and in Hawkhurst of 20·6 (Wood, 1974) compare readily with the Ripon figure of 17·7.

The economic value of encouraging consultant outpatient clinics to be held in general practitioner hospitals has been shown convincingly by Gruer (1971); the undoubted additional advantages of convenience, less travelling, local nurses known to the patient, and increased general practitioner/consultant communication remain.

Cavenagh's (1978) recent survey of general practitioner hospitals shows well the significant contribution that they make to the hospital workload. He also gives the estimate that 20 district general hospitals would be needed to cope with the workload if all general practitioner hospitals were phased out.

Conclusion

From my experience in semi-rural North Yorkshire I have no doubt that the general practitioner hospital has a continuing role to play in the health care of the United Kingdom. I believe it can provide a better and more comprehensive service to the patient, professional satisfaction for the primary health care team and stimulation for general practitioner trainees. Furthermore, bearing in mind Rickard's (1976) study in Oxford, general practitioner hospitals may well prove to be the best value for money for the NHS.

Whilst the Department of Health and Social Security is planning for the future, rather than to decrease the number of general practitioner hospitals, it may be appropriate, certainly from the community's point of view, to consider extending them to places where they are not now common, including cities.

Much more discussion should take place before any decisions are made on the 1974 document of the DHSS (1974a).

References

Cavenagh, A. J. M. (1978). Contribution of general practitioner hospitals in England and Wales. *British Medical Journal,* **2,** 34-36.

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

Department of Health and Social Security (1974b). *Health and Personal Social Service Statistics for England 1974.* London: HMSO.

Emrys-Roberts, M. (1971). General-practitioner hospitals. *Lancet,* **2,** 755-756.

Gruer, R. (1971). Economics of outpatient care. *Lancet,* **1,** 390-394.

Humphreys, R. C. (1973). Retrospective evaluation of role of a community hospital. *British Medical Journal Supplement,* **4,** 19-22.

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

Rickard, J. H. (1976). *Cost-Effectiveness Analysis of the Oxford Community Hospital Programme.* University of Oxford.

Wood, C. R. (1974). Hawkhurst cottage hospital. *Practitioner,* **212,** 78-82.

Acknowledgement

I would like to thank Dr I. G. C. Brown for his help, encouragement, and advice, and the staff of the Ripon and District Hospital for their co-operation.