General practitioners and hospitals

THE 11th Conference of the World Organization of National Colleges, Academies, and Academic Institutions of General Practitioners/Family Physicians (WONCA) in June included a number of presentations on the role of the general practitioner in hospital medicine and obstetrics and a workshop and debate entitled 'Stretching primary care' which brought together a large group of general practitioners from all over the world. Most participants clearly did not regard primary care as synonymous with ambulatory care and saw an important role for primary care physicians in the inpatient care of selected patients. Access to inpatient facilities varies from country to country; in many European countries general practitioners are entirely excluded from hospitals, while in others, such as the United Kingdom and Finland, general practitioners make a significant contribution to the care of patients in hospital. In North America, Australia and New Zealand general practitioner hospitals flourish in rural areas and general practitioners without these facilities frequently seek them. The Royal Australian College of General Practitioners is funding a study into the possible development of general practitioner hospitals, and a number of research projects in Canada and the USA are evaluating general practitioner obstetrics. In the Middle East, Africa and Asia different systems of care make direct comparisons difficult, but there is evidence there too that general practitioner inpatient work is regarded as an appropriate activity. The three main issues emerging from the deliberations of the conference concerned the clinical contribution general practitioner hospitals and general practitioners working in hospital are able to make, whether such work really is an appropriate part of primary care and ways that general practitioner hospitals can be integrated into overall planning for health care. In the wake of the UK Government's Green Paper on primary care,[1] examination of these questions is timely.

There can be no argument about the value of work done in general practitioner hospitals and the major contribution to local health care that a flourishing unit makes. Cavenagh first documented this and since his study[2] a number of other reports have added detail to the overall picture of medical, surgical, casualty and outpatient services provided in these hospitals.[3-7] This issue of the *Journal* carries a review of 30 years of casualty and surgical services in Perthshire, which further emphasizes the amount and variety of work done in general practitioner units.[8] General practitioner obstetrics, although currently more contentious, has a clearly-defined place in the provision of maternity services, offering distinct and measurable benefits for selected mothers.[9,10] Other aspects of the work of general practitioner units include day hospital facilities[11] and terminal care.[12] Successful general practitioner hospitals have such characteristics as favourable demographic features, local enthusiasm, high quality nursing, an effective administrative structure and agreed and appropriate policies for clinical practice.

In this country, general practitioner hospitals are usually low-technology units in which general practitioners are responsible for admission and discharge of patients, but visiting specialists provide outpatient clinics and are available for consultation. Surgery is generally performed by hospital doctors but general practitioners often provide an anaesthetic service. Obstetrics in these hospitals is usually confined to general practitioners. General practitioners may also have access to beds in district hospitals, on general practitioner wards, where admitting rights are retained and the level of technology (and often nursing cover) is lower than in consultant wards.

At the WONCA debate it was suggested that such activities were inappropriate for general practitioners — they blur the definition of our specialty and reduce our credibility, they make us less available to our patients, they offer a ready escape from the isolation of primary care into the traditional safety of the hospital environment and they diminish our ability to act as our patients' advocates in the secondary care setting. These views may be shared by other general practitioners; questionnaire surveys of general practitioners' interest in the development of general practitioner units usually reveal that about half are interested and half are not,[13] and although we do not know much about the differences of attitude between these groups, constraints of time and perceptions of role may be important. However, almost one-fifth of all general practitioners in the United Kingdom are involved in general practitioner hospitals, with a further substantial number working in general practice wards and obstetric units, despite there being little financial incentive for doing any of this 'extra' work. Far from detracting from a rounded commitment to patient care or undermining the essential nature of general practice, work in general practitioner hospitals enhances patient care and enriches medical life.

Given the clinical contribution and evident enthusiasm of large numbers of general practitioners working in hospitals it is difficult to understand why general practitioner hospitals remain peripheral to most regional planning policies (although at least one health region has now formalized its support for their inclusion in strategic planning[14]). This results in the units being vulnerable to closure, as it is much easier to close down a small unit, with an easily-defined revenue saving, than to prune staff or facilities in larger hospitals.[15] A number of studies have sought to demonstrate that this strategy is uneconomical; at the time of Cavenagh's survey it was estimated that inpatient costs in general practitioner hospitals were about 60% of those in general hospitals, although other studies have not given clear enough answers on relative costs to be persuasive to regional planners. However, in our health system in which innovation and experiment are rarely encouraged and where evaluation is frequently opportunistic, there is little information for planners seeking to develop a suitable balance between high- and low-technology facilities. In Finland, where general practitioner hospitals are part of overall planning, there is such evidence, from a detailed study by Kekki on the relationships between resource allocation to primary and secondary care inpatient facilities, showing for example that by increasing the number of general practitioner beds, the requirement for central hospital beds and the overall length of stay in them is reduced.[16] A recent study in the Oxford region has shown that for certain groups of patients bed use in district hospitals is halved when general practitioners have access to beds in community hospitals.[17] These findings are intimately connected with an awareness of the proportion of patients admitted to district hospitals who could be appropriately looked after in general practitioner units — estimates range from 20% to 60% of medical admissions.[18,19] At a time of shrinking resources there is an urgent need to investigate the most appropriate balance between peripheral and central inpatient facilities to enable the development of general practitioner hospital beds to be planned.

If general practitioner hospitals are to find a real place in planning they will have to submit to a level of scrutiny and analysis

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to which the district general hospital model has never been subjected. The Green Paper[1] stated its support for general practitioner hospitals if they can be shown to be cost-effective; this has to be a research priority, alongside clarification of their potential clinical role and a willingness on the part of planners to follow through the consequences of such research.

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The specialist contribution to the care of the terminally ill patient: support or substitution?

THE provision of terminal care in the community today is one of the most difficult subjects to discuss. It may be worthwhile to look at the origins of the hospice movement and the reasons for the foundation of the various cancer help organizations. His Royal Highness, the Prince of Wales, has described Dame Cicely Saunders as the 'Mother Superior of the hospice movement' and undoubtedly she was a pioneer who has done a great deal to promote good terminal care. She herself said that the hospice movement was developed to look after both people dying from cancer and the smaller group of patients suffering from advanced multiple sclerosis. However, the picture is now very different. Many hospices have as their main aim the care of people 'until the time is right for them to come to the hospice' and have created home care services linked to the hospice. A multi-million pound movement has grown from a foundation concerned with the pain control of patients dying from cancer.

The Registrar General's figures indicate that on average a general practitioner is involved with the death at home from malignancy of fewer than two patients a year with another four of his patients dying from cancer in hospital. Even if all of the general practitioner's patients dying of cancer did so at home this would still make up a very small part of his work.

Home care services have been established on the assumption that most patients would prefer to die at home and the only reason they do not do so is that there is not enough help available. Now that these services exist they should be used as a resource in the community. However, some thought needs to be given to their activities in order to maximize the advantages and minimize the disadvantages.

Any seriously ill patient who wishes to remain at home has both emotional and physical needs. In the National Health Service, the general practitioner is well-established as the choreographer of patient care. This role is crucial when considering the home care of the terminally ill. The first decision that must be made is whether the patient can stay at home. Is there enough physical professional support to back up the emotional support that the home environment is said to provide? The general practitioner's knowledge of local services is invaluable in making that decision. He will know the range of nursing, social and voluntary services available in the area.

In many parts of the country the general practitioner now has access to a community terminal care team. Like any other resource, these home care services need to be evaluated. Unfortunately, services for the terminally ill have mushroomed in a disorganized fashion based on demand and not on need. Teams range from home care services of long-established hospices providing 24-hour, seven-days-a-week multiprofessional cover to isolated nurses acting in an 'advisory capacity' with no back-up resources.

Audrey Ward, in the report for the Nuffield Foundation,[1] looked at the effect of home care services on home deaths as a percentage of total deaths three years before and three years after a home care service was established. No dramatic impact from the intervention of a specialist team was observed.

It is important that the home care teams be given clear objectives so that they can be readily assessed. It is also important that the members of the teams are part of the caring network and liaise effectively with their primary and secondary health care colleagues. Every patient who is dying and wishes to do so at home needs a medical assessment, a nursing assessment and a social work assessment. Thus it could be said that comprehensive care can only be provided if all three modalities are available 24 hours a day.

There is a danger that this concept of terminal care implies that such care can only be provided by an experienced specialist