Such promotions might draw the potential patient's attention to the personnel, the facilities and the levels of care, for example the immunization rate, of the practice. Any practice indulging in such competitive advertising would have to be careful to keep the content factual and avoid disparaging its neighbours. It is more likely that practices will follow the example of solicitors and advertise to raise the public's awareness of their existence, reserving the details for their practice leaflet. Specific groups, for example patients moving into the area, may well be targeted with a letter of introduction enclosing an informative practice leaflet.

The final type of advertisement that we are likely to encounter is one that has been allowable up to now but which has been largely ignored. If the political or societal climate requires it, general practitioners may wish to advertise through the Royal College of General Practitioners or the British Medical Association to promote the corporate image or view of the profession. If the current disputes with government are a guide, this form of advertising is likely to become a necessity.

Allowing general practitioners to advertise their services to their own and prospective patients will lead to better quality information being available to patients when making a choice of practice. Fears about the extensive use of the mass media beyond local newspapers will probably be unfounded. In the final analysis, it is likely that these proposals will offer benefits for patient choice which outweigh any theoretical detriment to the doctor–patient relationship.

MIKE PRINGLE

Senior lecturer in general practice, University of Nottingham

References

1. Department of Trade and Industry. *Review of restrictive trade practices policy: a consultative document (Cm 331).* London: HMSO, 1988.
2. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.
3. Monopolies and Mergers Commission. *Services of medical practitioners.* London: HMSO, 1989.
4. General Medical Council. *The services of medical practitioners and their advertisement.* London: GMC, 1988.
5. British Medical Association. *The British Medical Association's written evidence to the Monopolies and Mergers Commission.* London: BMA, 1988.
6. Royal College of General Practitioners. *Response to the Monopolies and Mergers Commission's inquiry into the services of medical practitioners and their advertisement.* London: RCGP, 1988.
7. Hart JT. Why family doctors should not advertise. *J R Coll Gen Pract* 1988; **38:** 559-562.
8. Marinker M. The referral system. *J R Coll Gen Pract* 1988; **38:** 487-490.

Community hospitals — time to come off the fence

THERE are approximately 403 000 staffed available hospital beds in the United Kingdom. Though it is impossible to be exact, current estimates indicate that just over 11 000 of these are under general practitioner control.[1-3] Unfortunately, many general practitioners see these beds as an embarrassment and an anachronistic remnant of a type of health care which is no longer relevant to current needs. Can they be persuaded that general practitioner beds are a vital resource within modern general practice which allow some doctors to provide a standard of care which would be impossible in their absence? Indeed could community hospitals be the basis for an extended form of general practice which might become a model for the 1990s and beyond?

For many years general practice has suffered from a failure to confront and acknowledge the implications of its diversity. We have assumed that as long as we all call ourselves general practitioners we somehow create a common job, with similar work and objectives. This may have some validity for the core of our work, the consultation, but it is far from being correct when one considers the wide variations in the types of practice in which we work.

A general practitioner in a large city is manifestly practising in a way which is different from that of a rural practitioner, with half the list size, who serves a 30-bed community hospital, an accident and emergency department and an obstetric unit. This is not to say that one type of practice is any better than the other — differences in the structure of practices should not be equated with differences in the quality of practice. However, the skills and attitudes required in one type of practice may be totally different from those required in another.

Viewed from overseas, general practice in the UK has become synonymous with primary care practised outside hospitals. General practitioners are seen as being involved in prevention, the initial diagnosis of acute illnesses and providing continuity of care for people with chronic disease. Our role as gatekeepers for specialist care is well established and the separation of primary and secondary care is entrenched in the National Health Service. This rigid separation of primary and secondary care is not a feature of health services in most other countries. Community hospitals provide an intermediate level of care and thus offer the prospect of bridging the widening gap between community based primary care and the increasingly specialized secondary care in large district general hospitals.

The current white paper, *Working for patients,*[4] suggests that large hospitals will tend to develop 'core functions', specialized areas of expertise which they can profitably promote at the expense of the less popular. Such developments can only further increase the need for low technology community hospitals where care, convalescence and respite can be provided for a wide variety of conditions.

The technical demands of medical specialization are such that it is questionable whether any general physicians will remain in hospital practice by the year 2000. This does not mean that we will not still require generalists in hospitals. The general practitioner of the future should not be afraid to re-establish his role as a generalist in hospital as well as in the community. Vocational training is now producing young doctors in general practice, willing and able to take on this role. Their ability to do so would be greatly augmented by the provision of an intermediate level of care in the form of community hospital beds under their control. Many medical problems do not require high technology or specialists for their effective treatment. Many can be appropriately dealt with in community hospitals with good nursing care, and access to haematology, biochemistry and radiology services. This type of care can be provided appropriately and completely by the interested family doctor. It should be

remembered that patients often prefer to be looked after near to their homes rather than in a remote distant general hospital.

Individual general practitioners have known this for many years but general practice as a whole has failed to do anything about it. Should we be allowing patients with problems that we can cope with, providing we have the facilities, to be looked after elsewhere?

Eighty per cent of general practitioners in this country do not have the opportunity to look after their own patients in hospital and many of them would voice considerable anxieties about taking on such work because of the time constraints created by their existing commitments. Are these fears about the time involved in caring for people in community hospitals justified? Looking after your own patients in hospital does take time and demands careful organization within the practice. However, most general practitioners work in partnerships where a rota of daily hospital ward rounds could, with the careful reassessment of priorities, be introduced into the practice routine.

Community hospitals present considerable potential benefits in integrating hospital and community care with the consequent efficient use of appropriate resources. Direct contact between the general practitioner, ward staff and the primary care team, as well as improved general practitioner–consultant relationships, facilitates the provision of support services in the community for patients on discharge from hospital. Similarly the timing of admission to hospital of patients with a terminal illness can be best judged by those who are providing care at home.

Inevitably, general practitioners are distanced by time and geography from the teaching hospital structure. They tend to perceive hospital medicine as being associated with intensive investigative techniques and rare and unusual disease. This is hardly unexpected as their training tends to be based in the teaching hospital which has a vested interest in maintaining the high technology profile of medicine.

It has been shown, however, that at least 25% of patients in acute medical beds in district general hospitals could be managed in low technology community hospital beds.[5] This figure has been established for several years and has never been seriously challenged. We have watched passively as other disciplines have evolved to take over our patients' care, decreasing the quality of care that general practitioners can provide.

Working with inpatients requires skills in assessment, diagnosis and treatment. These are skills that all interested doctors should have. There is a need for a special knowledge of post-operative care and an understanding of the scope and availability of rehabilitation and the procedures involved.[6] The educational needs of general practitioners working in hospitals need to be more widely recognized both by departments of general practice and by the regional advisory structure. Every region should have an associate adviser with general practitioner community hospitals as part of his remit. The College and the Association of General Practitioner Hospitals in England and Scotland are currently producing a report which will emphasize this need for appropriate education and training. The report will also highlight the potential of the community hospital as an educational resource.

Through a lack of powerful political support the subject of community hospitals has remained very much on the periphery of the debate about how health care will be provided in the future. The current proposals on the future of the health service[4] challenge all our entrenched ideas on how we should care for our patients. 'Budget holding' and 'free market forces' should not obscure the fact that maintaining or improving the quality of care must be the basis for any proposed change. The potential for the highest possible quality of primary care is maximized where the general practitioner has access to his own community beds. Because only a minority of doctors are involved there is a credibility problem which is compounded by the lack of good data on the functions and costs of community hospitals. Descriptions of these units do exist, but in themselves they do not yet form a strong enough base on which the expansion of community hospitals can be built.[3] The type of work done in community hospitals often involves low technology care, primarily of the elderly. These patients are not subjected to the batteries of tests which allow hard data to be collected. Studies are needed which evaluate the care provided in hospital in qualitative as well as quantitative ways.

What of the future? At the spring meeting in 1985 the College passed a resolution supporting the concept of general practitioners looking after their own patients in hospital beds. Unfortunately the profession has not actively campaigned for the widespread availability of community beds. The Association of General Practitioner Hospitals and the College have sought to heighten public awareness about the role of general practitioners in hospital care. This process must continue.

None of this can take place without the changes outlined above and without fundamental changes in attitudes at all levels. Our patients wish and in many cases demand to have health services within their own localities, a fact that the current white paper[4] fails to appreciate. Part of such a service can be a community hospital. Of course there are major economic considerations and not every community would be suitable or even wish to have such a facility. However, if we are to achieve acceptance of the community hospital in the future health service of this country, it must be more widely accepted as a positive planning option rather than an anachronistic form of care which lies outwith the normal planning boundaries.

New community hospitals which were planned to meet their community's particular needs have been opened in many areas, for example, Lambeth, Whitby and Dunoon. In Lambeth the need was for a few inpatient beds and the hospital there was designed for rehabilitation in a deprived area. Such a hospital would not have been appropriate in Whitby where inpatient facilities and outpatient consultant facilities were needed as well as the ability to carry out minor surgery and obstetrics.[7] In Dunoon the withdrawal of consultant services has allowed a thriving 30-bed general practitioner unit to develop, running with a higher throughput than when under consultant control. Each example is different but each satisfies a local need through imaginative planning. Such examples are not mere expressions of fanciful planning eccentricity, they are modern practical expressions of appropriate cost-effective health care.

We must, as a profession, fundamentally reconsider our attitudes to intermediate care and the community hospital. If we do not it is unlikely that our patients or our successors will easily forgive us.

JAMES A. GRANT

General practitioner, Auchterarder, Perthshire

References

1. Chaplin NW (ed). *Hospital year book 1988*. London: Institute of Health Services Management, 1988.
2. Scottish Home and Health Department. *Scottish health service costs, year ended 31 March 1988*. Edinburgh: Common Services Agency of the Scottish Health Service, 1988.
3. Tucker HJ. *The role and function of community hospitals. Kings Fund project paper 70*. London: Kings Fund, 1987.
4. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555)*. London: HMSO, 1989.
5. Bennett AG. Evaluating the role of the community hospital. *Br Med Bull* 1974; **30**: 223-227.
6. Working party from the Thames Valley faculty of the Royal College of General Practitioners. Educational needs of doctors working in community hospitals. *J R Coll Gen Pract* 1976; **26**: 461-465.
7. Higgs R. Example of intermediate care — the new Lambeth community care centre. *Br Med J* 1985; **292**: 1395-1397.