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General practitioners' views on geriatric day hospital care

Sir,
Concerns have been expressed that most general practitioners remain unaware of the services and facilities provided by geriatric day hospitals,[1] and research has shown that general practitioners fail to distinguish between the therapeutic functions of geriatric day hospitals and the social care provided by day centres.[2] It has been argued, therefore, that general practitioners need to be made more aware of the different roles of day centres and day hospitals.[2] Donaldson has made the point that rehabilitation should be emphasized in geriatric day hospitals in order to meet their overriding objective which is to facilitate and prolong independent living for the elderly in the community.[3] We carried out a survey of general practitioners to ascertain their opinions about the relative importance of geriatric day hospital functions.

A nominal list of general practitioners provided by the Croydon family health services authority formed the study population. After two postings, 130 replies were received, giving a response rate of 79%. General practitioners were divided according to length of time in practice, and the number of practice partners. A group practice was defined as three or more partners. Approximately two-thirds of general practitioners were in a group practice, and 43% had been in practice for less than 10 years. There was no relationship between practice size and length of time in practice.

When asked to rank geriatric day hospital functions according to their relative importance, 54% of general practitioners ranked rehabilitation first (most important) and 37% ranked medical assessment first (Table 1). For social care 13% of general practitioners ranked it first, 26% second and 61% third. For nursing care 7% ranked it first, 23% second and 70% third. General practitioners who had been in practice less than 10 years ranked medical assessment as significantly less important than those in practice for more than 10 years (Table 1). Again 69% of general practitioners in practice less than 10 years ranked rehabilitation as most important compared with 42% of those in the 10 or more years group (Table 1). Analysis by size of practice showed no significant differences in perception of the relative importance of day hospital functions.

Table 1. General practitioners' views of relative importance of geriatric day hospital functions by length of time in practice.

	Percentage of GPs		
Rank order	0–9 yrs in practice ($n=56$)	10 or more yrs in practice ($n=74$)	All
Medical assessment/ treatment			
1[a]	*23*	*48*	*37*
2	*43*	*31*	*37*
3	*34*	*21*	*26*
Functional assessment/ rehabilitation			
1[a]	*69*	*42*	*54*
2[b]	*14*	*34*	*25*
3	*17*	*24*	*21*

[a]$P<0.01$. [b]$P<0.05$.
n = total number of respondents.

These findings suggest a significant change over the last decade with younger general practitioners having become more aware of the value of rehabilitation and apparently more reticent about the need for medical assessment as part of geriatric day hospital care. These changes may be due to the effect of vocational training, suggesting that trainee general practitioners are being taught the rationale for geriatric day hospital care. A surprising finding was that nursing care was identified as the least important function by 70% of general practitioners. A possible explanation is that more nursing tasks are being performed by practice or community nurses and so general practitioners see little need for nursing care in a geriatric day hospital.

Research in the 1970s showed no difference between patients attending day centres and those attending geriatric day hospitals,[4] suggesting that general practitioners inappropriately referred patients for social care. In this survey only 13% of general practitioners ranked social care as the most important function. This may indicate that general practitioners are better able to distinguish between the services provided in day centres and geriatric day hospitals. Concern that modern general practitioners will misuse day hospitals seems to be unfounded.

The overall impression created by this survey is that general practitioners want geriatric day hospitals that have a strong therapeutic input, dominated by functional assessment and rehabilitation.

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Continuing education for pharmacists and general practitioners

Sir,
The relationship between general practitioners and community pharmacists has come under increasing scrutiny in the past few years. In 1981 a joint working party of the British Medical Association and the Pharmaceutical Society of Great Britain

explored the difficult area of pharmacists giving advice to patients.[1] The Nuffield report on pharmacy, published in 1986,[2] stated that the pharmacist could exercise a more important role as a provider of information to the general practitioner. Most recently the government foresaw an extended use of the pharmacist's skills.[3] Yet even when the pharmacy is based in a health centre the relationship may not be entirely satisfactory. Harding and Taylor, in a study of 10 such health centres noted disparities between the two groups that were either the result of inadequate communication or indicated that neither group expected to have a major influence on the activities of the other.[4] Finally, the advent of PACT (prescribing analyses and costs) and of indicative prescribing awards for practices has heightened the awareness of many doctors of their need for better information.

A study, supported by funding from the Department of Health, was carried out to try to develop a programme of continuing education which would encourage interaction between general practitioners and community pharmacists at a local level. Initially a series of workshops was held with a selected group of nine doctors and seven pharmacists to identify those areas which the group felt had the most relevance to joint continuing education. These were:

— to seek agreement between local doctors and pharmacists about advice given by pharmacists to patients;

— to provide better information to doctors about the range, nature and cost of 'over the counter' preparations;

— to consider guidelines for doctors and pharmacists that would facilitate cross referral;

— to seek agreement from both groups about areas of self-help for patients;

— to explore the contribution pharmacists might make to developing practice or local formularies;

— to explore the contribution pharmacists might make to a doctor's analysis of PACT data.

The workshops explored these areas by means of case studies and home assignments and a course was then designed for three evenings at a postgraduate centre. An invitation to attend was sent to all 150 general practitioners and 130 community pharmacists in a single town in the West Midlands. The 50 places available were filled by pharmacists and doctors in a ratio of 2:1. The letters to general practitioners were dispatched later than those to the pharmacists and this might account for the different uptake of invitations.

The three evening programmes were centred around responding to symptoms, generic prescribing and disease prevention. These topics were sufficiently broad to allow for discussion of all six areas listed above. Short presentations were made at the beginning of each evening followed by small group discussion of these topics reinforced by background papers and case studies circulated before each meeting.

Evaluation was carried out using a post-course questionnaire and the observations of a trained sociologist sitting in with the groups and observing the interaction. Thirty nine questionnaires were completed. The venue and time were convenient for 34 responders and all liked the format of the programme. Topics which were not covered but which were thought to be important included the use of computers and the function of the Prescription Pricing Authority. All participants welcomed the contact and nine wished to have a longer programme.

A number of important subsidiary issues were observed during the small group discussions. Doctors and pharmacists perceived themselves as being of different status — the doctors were more assertive, spoke first and emphazized how the pharmacist could help the doctor rather than vice versa. The pharmacists were mainly on the defensive, particularly in relation to commercial aspects of their work. Doctors were troubled by the change of staff in pharmacies whereas pharmacists were troubled by their view of the relative inaccessibility of doctors and the doctors perceived tendency to prescribe too readily. Both groups had a poor understanding of each others training and competencies and felt that this type of joint educational exercise helped to increase this understanding. Finally, both groups felt they would be helped by the establishment of local protocols for managing certain common conditions.

If such courses are to be promoted elsewhere we believe their success will depend upon the participation of a general practice organizer and a local pharmacist organizer working closely together and supported by prepared course material.

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Educational initiatives for patients

Sir,

The early stages of the government's current review of the National Health Service introduced the concept of 'good practice'[1] which despite many efforts has never been adequately defined. A new contract for general practitioners has now been imposed and internal markets will operate in which funds follow patients in a commercial atmosphere aimed at reducing costs.[2,3] Regrettably few constructive alternative proposals were ever voiced from either the parliamentary opposition parties or the profession which could have brought about the implementation of a negotiated review of the NHS.

Great emphasis has been placed on 'quality of care' but it was never in doubt that the majority of professionals loyal to the NHS are true carers and therefore possibly poor businessmen. It is regrettable that in a demand led organization no attempt has been made to re-educate the consumer who ultimately must pay for the service. Some of us have invested many years of professional time educating our patients in the appropriateness of prescribing treatment, the use of primary and secondary services, and in encouraging them to take greater responsibility for their own health. If it is the consensus view of government and the professions that limited funds should be targeted in the most effective and clinically appropriate manner, then perhaps the energy expended resisting any change to the status quo could be more effectively employed in a joint educational exercise aimed at the consumer.

We cannot expect all our patients to make reasonable and appropriate demands upon the limited resources of the NHS but we could place greater emphasis on educational initiatives aimed at improving the use of restricted services to the benefit of the provider, the consumer and the treasury.

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