BOOK AND VIDEO REVIEW

THE COTTAGE HOSPITALS 1859–1990
Arrival, survival and revival
Meyrick Emrys-Roberts
Tern Publications, Motcombe, Dorset (1991)
234 pages. Price £8.95

By the 1860s the British medical profession was settling into its division between hospital based consultant/specialists and general practitioners who were excluded from the hospitals. To paraphrase Rosemary Stevens: through the development of the principle of referral the general practitioners kept their patients but the consultants got the hospitals. It is true that in the nineteenth century the division was still blurred. Many provincial hospitals had local general practitioners as their honorary consultants, and all consultants, even the most eminent in London, undertook what was in effect general practice among the well-to-do. Nevertheless, when Albert Napper opened the first cottage hospital in Cranley in 1859, his concept was entirely original. It was not the first small hospital, nor the first to be staffed by general practitioners, but Napper created a model that was much more successful than anyone could have dreamed.

His purpose was strictly utilitarian. In many villages such as Cranley, the nearest hospital was 20 or more miles away. Even if transport could be found — and that alone was an immense problem — having arrived, the patient would be treated by strangers and might well die far from family and friends. It was a frightening prospect. Therefore, the cottage hospitals were built explicitly as a warm, clean idealized version of the farm labourer's cottage in order to reassure patients. Here the sick could be treated in a friendly atmosphere by their familiar family doctor, and it was one of the cardinal principles that all local general practitioners had the right to admit their patients and attend them in the local cottage hospital.

From 1860 cottage hospitals sprang up like mushrooms. Hundreds were built, many in suburbs and market towns as well as in villages. As they evolved they were turned into miniature versions of Guy's, St Thomas's, or wherever their local general practitioners had been trained. Soon they were far removed from the labourer's cottage. Some contained casualty departments, wards, operating theatres, labour wards, and even, in Moreton-in-Marsh for instance, quite sophisticated x-ray departments. General practitioners valued the greater scope of care provided by a cottage hospital. Patients valued the continuity of care provided on their own home territory. There is no doubt that from the time they were founded to the present day they have, with very few exceptions, been highly valued by the community they serve.

By the early years of this century the clinical emphasis was often far more on surgery and obstetrics than medicine. Consultants, seeing this through jaundiced eyes, openly expressed the fear that general practitioners with minimal surgical experience were fond of undertaking surgical operations requiring maximum surgical skill. I knew indirectly of one general practitioner, pre-1950, who submitted his mildly complicated maternity cases to a caesarean section at the slightest excuse; and of another, pre-1938, who loved to do mastectomies in the cottage hospital for 'chronic mastitis'; he said it prevented cancer. On the other hand there were many who knew their limitations, kept within them, and were excellent general practitioner surgeons. In certain quarters, however, cottage hospitals got a bad name. By the time the National Health Service was introduced most hospital consultants had little use for cottage hospitals, seeing them both as an irrelevance and a waste of scarce resources. They might all have disappeared, but hospital consultants, plagued by bed shortages, saw them as convenient places for convalescent patients and long-stay clinically uninteresting problems; empire-building geriatricians with their legacy of workhouse hospitals saw them as ripe for takeover; wrongly as it happens; and politicians knew better than to risk the wrath of the voters, particularly in the rural south where they were clustered, by sanctioning their closure. I recall that a minister of health, having checked no one else was within earshot, whispered to me that no Conservative minister who valued his parliamentary seat would dare to close the cottage hospitals.

Their revival came as a result of two events in the late 1960s and early 1970s. First, an Oxford initiative — the concept of the community hospital — for which most credit is due to Dr Rosemary Rue and Professor A E Bennett, and the resultant success of the Wallingford project. Secondly, the foundation of the Association of General Practitioner Hospitals in which the author of this book played a central role. But for these developments the general practitioner hospitals could well have disappeared. Some were, in fact, closed, but in general they have not only survived the present economic climate, they seem to be undergoing a revival.

About 20 years ago, I met the author on several occasions. We had a shared interest in both the revival of the cottage/general practitioner/community hospital and in the history of the subject. He already had an encyclopaedic knowledge of cottage hospitals, and appeared to have visited most of them personally. He told me of his plan to write a history of cottage hospitals. As the years passed, I feared he had given up the idea, and I am delighted my fears were unfounded. His book was worth waiting for. It is a fine and notable contribution to the history of medicine, authoritative and delightfully written. He has read widely, and assembled his material so admirably, that it may be difficult for anyone who has not attempted to deal with such diverse and scattered sources to appreciate the depth of his knowledge and his skill as a writer. It is the mark of good scholarship in history that the product is so clear, well arranged, and easy to read that the author makes it look easy when it is nothing of the sort. In this respect the author has succeed-

ed admirably. It is an inexpensive book, well illustrated and well-produced which I recommend without reservation to anyone interested in the present and past of the general practitioner hospitals and indeed the development of general practice in this country.

IRVINE LOUDON
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UNDERSTANDING BACK TROUBLE

E Rudinger (series ed)
Consumers' Association, London (1991)
151 pages. Price £8.95

It is a pleasure to read a book that allows the reader to do exactly what the title suggests. Fifty million working days are lost annually in the United Kingdom as a result of back trouble and there are a multitude of explanations and remedies for this almost universal problem. Thus, in a sea of confusion for the sufferer, and sometimes for the doctor, *Understanding back trouble* provides a rock of clarity and simplicity.

Doctors increasingly supplement verbal advice with leaflets, but a book for every patient with back pain would clearly be excessive. However, for those with chronic back pain, who have to learn to live with it, this book is an excellent supplement to good medical advice. This view was confirmed for me by one such patient to whom I loaned the book.

Each chapter is self-contained so the book can readily be dipped into. The last two chapters, 'Taking care of your back' and 'Exercise', are excellent, as is the check list of preventive advice. With the current emphasis on prevention, this book is in keeping with the aims of the general practitioner contract and should certainly be bought by every practice.

R M MILNE

CONCERNING THE CARERS

Occupational health for health care workers
J A Lunn and H A Waldron
Butterworth Heinemann, London (1991)
155 pages. Price £12.50

This is a short medical textbook in the traditional style containing the accumulated wisdom of two senior doctors. The introduction notes that the National Health Service has a very poor history of caring for its employees and the authors have set out to redress the balance. Much of the text, such as the section on prevention of accidents, is very helpful although the absence of references and a didactic style 'based on a wide range of experience and more than 20 years practice' is better suited to the non-medical reader.

A major deficiency is in the section on stress. Much stress in junior doctors is induced by their conditions of work but the authors dismiss this as the 'unique experience of those early post qualification years'. Their view on health promotion in medical students is equally simple: 'Selection procedures must be adapted to ensure that those chosen are likely to be able to withstand the rigours of training and subsequent life as a doctor'. There is no hint that prevention might include changes to the medical environment or that doctors with personal experience of illness make an essential contribution to the welfare of patients. The telephone number of the National Counselling Service for Sick Doctors (071-580 3160) is a significant omission from the list of information sources.

CLIVE RICHARDS
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CELEBRATION

Margaret Spufford
Fontana, London (1989)
121 pages. Price £2.95

Celebration is more than one individual's story, it is a profound exploration of pain and suffering. Dr Margaret Spufford, a professional historian and Benedictine tertiary, has written a book which should be essential reading for anyone interested in medical ethics.

While coping with the pain of her own osteoporosis, Dr Spufford's infant daughter, Briget, was diagnosed as having cystinosis and given a poor prognosis: 'almost certain death at between the age of eight and fourteen years'. The book describes the problems of living at 'the frontiers of medical knowledge', and of creating a normal, secure, loving environment for the family.

Nurses, doctors, surgeons, au pairs and even a friendly bank manager, receive praise for their support. However, Dr Spufford comments on the difficulty health professionals have in imagining 'the depth of ignorance and shock they are dealing with in parents new to an experience which they themselves undergo all the time'. Six hourly blood tests taught Briget to learn to fear, a process Dr Spufford found almost unbearable to witness. However, her daughter's emotional normality was of the highest priority.

Having a child in hospital for a year puts physical and emotional strain on parents who 'no longer share the same world'. In addition, there is a lack of community care for the young chronically sick adult. 'One can create a universe for a small handicapped child but one cannot create one for an adolescent who has lost a peer group from the innate effects of the disease and too much isolating medical experience'.

With advances in medical technology and diminishing resources, doctors are increasingly faced with ethical dilemmas. This book gives a rare insight into the ethical dilemmas which patients share and from whom doctors can learn a great deal.

DAVID JEFFREY
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IT'S ABOUT TIME (video)

Lederle Pharmaceutical Company, Gosport (1991)
Free

It's about time begins with a caricature of an overworked doctor which is overwritten and overplayed. Interspersed with this are a series of views from 'talking head' experts who tell us how to organize ourselves.

This approach has little educational value as it stimulates little response in the viewer. If television is to reach its real and considerable potential for learning (and justify its considerable expense) then it must stimulate thought and promote discussion. This reaction should occur in the viewers who can then explore the principles illustrated by the videotape in terms of their own experience and circumstance. Factual information should be provided by the teacher who conducts the session or in written material supplied with the videotape.

A great deal has been written about time management in general practice. The 16 minutes needed to view this videotape would have been better spent reading some of this material, before a small group discussion.

ROBIN HULL
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