RAISING STANDARDS IN GENERAL PRACTICE

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The division between hospitals and general practitioners and the isolation of the general practitioner since the inception of the health service have been widely recognized and deplored.

Various solutions or partial solutions have been proposed and in some cases put into effect. These are admirable as far as they go but none seems to provide a generally applicable solution. I believe that if general practitioners were encouraged to visit their patients when in hospital and offered suitable payment most of the difficulties would be overcome.

Criticism of present arrangements

Clinical assistants. This can only be a partial solution. There seems to be a tendency for clinical assistants to see the patients of other general practitioners when the patients could just as well be seen by their own general practitioners.

General practitioner beds. The administrative and consultant objections to any great extension are probably insuperable.

Library and common room facilities. I find it difficult to believe that these will be used to any great extent unless the general practitioner is brought to the hospital for some other purpose.

The suggested scheme could of course work in conjunction with these and other arrangements.

Visiting patients in hospital at present

Some general practitioners do, of course, visit their patients in hospital but they are often regarded as oddities or interfering nuisances. Official recognition and payment would be necessary to stimulate a significant increase. Official encouragement is probably at least as important as payment.

The new scheme

Cost. Details of payment would have to be worked out. Mileage payments would be necessary. Payments would probably have to be kept outside the " Pool " system. Probably a large part of the cost or even the whole cost, could be saved by earlier discharge of patients (see below). The more a general practitioner visited in hospital the more he would be paid and the more he would tend to have his patients handed back to him by early discharge.

Responsibility for patient. This would in general remain with the

consultant. If the general practitioner was presented with anything new by the patient the general practitioner would leave a note for the houseman. The houseman should clearly understand that the responsibility was his and that he should consult his superiors if necessary, though in a court the general practitioner's evidence supporting the houseman would probably be of value.

Advantages to the general practitioner. Reduction of sense of isolation. Stimulus of medical discussion (there would no doubt be a healthy spirit of slightly antagonistic competition between general practitioner and houseman; of experience against academic knowledge).

Opportunity to see results of investigations and follow diagnosis step by step. Opportunity to see other interesting cases in the ward.

There seems little doubt that personal contact with hospital staff would greatly help mutual understanding. So much can be understood that cannot be verbalized and so much spoken that cannot be written.

The general practitioner would also improve his status in the eyes of the less intelligent patient. The opinion of a junior houseman is now sometimes preferred to that of an experienced general practitioner simply because the houseman is part of the hospital.

Adavantages to the patient. The patient would see a familiar face; someone whom he knew would continue to be responsible for his care after he left hospital. He would feel that the general practitioner had not lost contact with him.

The general practitioner would be able to reassure the patient that the hospital was doing the best that could be done and that the patient was not being used as a guinea pig. The general practitioner's loyalties would be about halfway between the hospital and the patient.

Attempted suicide cases might often be better handled by the general practitioner than by a strange psychiatrist and after the medical emergency was over the general practitioner could accept responsibility for care of the patient at home in suitable cases.

Advantages to the hospital. Houseman. It should be part of the houseman's duty to discuss the patients with the general practitioner. No doubt the houseman would gain considerably from this and would be less inclined to be averse to general practice and antagonistic to general practitioners.

Consultants. The consultants would be able to assess the capabilities of the general practitioner and discharge patients earlier than they would otherwise do. Perhaps too the general practitioner has something to offer in counteracting the often excessively academic and somewhat inhuman atmosphere of hospital medicine. He may

stress more the importance of unmeasurable morbidity and counteract the tendency to attach too much importance to mortality and gross morbidity statistics simply because they are measurable. His knowledge of the patient would be of some value in distinguishing organic from psychogenic illness.

Early discharge. At present many patients are kept in hospital far longer than they need be because liaison with general practitioners is poor. The savings in hospital costs could be enormous. It would mean more work for the general practitioner and this would have to be reflected in fairly generous payments for hospital visiting.

Difficulties. Cost—and the eternal " Pool " problem: more work for the general practitioner and more general practitioners needed: hospitals would have to notify general practitioners of admission from waiting list: partners would have to notify each other of emergency admissions.

Distance from hospital. (Country doctors could often fit in visits with business and shopping trips.)

Specialized hospitals and the emergency bed service in London would cause difficulty.

Wasting time of nursing staff. (Probably not serious as most general practitioners would not want to be waited on).

Some may object to this scheme on the grounds that the exclusion of general practitioners from hospital is having a desirable effect. In combination with free access for patients to the general practitioner and reduction of serious organic disease it is forcing the general practitioner to concentrate on neurosis and the social aspects of medicine. It seems likely that research into these problems will be one of the most important aspects of British medicine in the next 30 years.

However, if my scheme were put into effect the amount of hospital involvement would still be small and would not distract the general practitioner very much from the ever-presenting problems of neurosis.

If such a scheme were thought to be medically desirable it might be possible to run a pilot scheme (and, possibly, make a controlled comparison of the cost with existing arrangements). Further pressure to start the scheme would probably have to be through " political " channels and not the College.

Would those interested in the scheme write to me at **The Planks, Old Swindon, Wilts,** with ideas and criticisms?

Summary

A scheme is suggested to encourage general practitioners to visit patients in hospital. The pros and cons are discussed.