demand. Also, testing followed by failure brings an acute sense of defeat, whereas failure while practising means merely the necessity to practise again.

Again, it helps the sufferer to understand that the symptoms of stress are part of life and that their exaggeration in his sensitized body is the illness, not simply their occurrence; that therefore cure lies not in their complete elimination, as he probably believes and hopes, but in their reduction to normal intensity.

Relapse

Even months after a patient is desensitized and thinks he is cured, the sudden return of his symptoms in an exaggerated way in response to stress can so shock the sufferer he may think he has "slipped right back." He should be taught to understand the traps memory can set and try to accept the setbacks it may bring, until he knows the way out of setbacks so well that he no longer fears the way in. Indeed the definition of recovery should include having setbacks and knowing how to cope with them, so that neither doctor nor patient becomes too discouraged by them.

In this short article I have not mentioned the complications sometimes associated with agoraphobia: indecision, suggestibility, loss of confidence, feelings of unreality, feeling of disintegration, obsession, and depression. These too may develop following a set, logical pattern and this, with treatment, is discussed in my books and recordings.

Finally, I stress that repetition of advice is the crux of treatment of the agoraphobic. He finds achievement difficult because he remembers past failures and how he felt then, so that when he thinks of facing similar experiences his reactions are automatically those of withdrawal, fear, and despair. With enough repetition of the right advice new association paths are established which ultimately replace the old automatic flashback reactions of panic and withdrawal when the patient is stressed. I call this right reaction-readiness and know of no better way of establishing it than by using gramophone

records and tape cassettes, which can not only be played immediately before the patient sets out to practise but also with cassettes while he is out.

Results

In 1970-1, questionnaires were filled in by 528 agoraphobic people in Great Britain and Ireland whom I had treated for periods varying from a few months to six years using the method outlined above, without any personal contact. Of these, 60% had been agoraphobic for 10 years or more and 27% for 20 years or more, so that most could be classed as chronic agoraphobics. For their present illness 65% had had treatment from one or more psychiatrists and 30% from their general practitioner alone. Previous treatment had included almost every known orthodox method. This group offered a challenge to treatment without the personal supervision of a doctor.

Of the patients aged 14-29, the results were satisfactory or good in 73%; of those aged 30-39 similar good results were found in 67%, and in those aged 40-49 in 55%. Of the older and therefore more difficult group aged 50-74, good progress was made by 49%. As so many of these people were chronically ill (only 27 had been ill for less than 3 years) the chances of spontaneous recovery irrespective of treatment were negligible.

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General Practice Observed

Comparative Study of District and Community Hospitals

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Summary

Opinions conflict on whether there is a place in the Health Service for general practitioner (community) hospitals in which the patients' treatment is mainly the responsibility of their family doctors. The authors therefore analysed a sample

of the patients admitted in the course of a year to a group of two general district hospitals with a comparable sample of the patients admitted to a general practitioner hospital. The aim was to analyse the type of care provided in the general practitioner hospital, to assess whether it was appropriate for the type of cases treated, and to decide whether the patients would have been better off in the district general hospital (and vice versa). The main conclusions are that a district hospital is best for serious illnesses needing skilled decisions and assessments but that most of the work of these hospitals is not of this kind and a community hospital staffed by general practitioners offers many advantages to patients—provided the work being done is constantly under critical assessment. The authors plead for special refresher courses under the N.H.S. for general practitioners working in community hospitals.

Tamworth, Staffs

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Introduction

General practitioner hospitals have been criticized as being expensive and tending to produce a service to satisfy general practitioners and patients "in a manner unrelated to the requirements of modern medicine or the community concerned."¹ Many consultants, on the other hand, tend to assume that all patients in hospital need direct consultant care, and junior hospital medical staff tend to interpret all needs in terms of medical needs.

Torrance *et al.*² and Loudon³ argued that many acute medical cases could be treated by general practitioners in a general practitioner hospital. The Oxford Regional Hospital Board¹ believed that the three fundamental aims in bringing general practitioners into hospital work should be to improve patient care, to make the best use of medical manpower, and to unify medical effort.

It seemed to us that these differing opinions indicated a need for a critical analysis of the type of care given in general practitioner hospital units and of the selection of cases admitted to them. We therefore decided to examine the work of a hospital in which the clinical responsibility lay largely with the patients' own family doctors (what is now referred to as a community hospital) and to compare it with the work of a district general hospital.

Hospitals and Methods

The hospitals chosen for the study were the Tamworth General Hospital and two general hospitals in Nuneaton, the George Eliot and the Manor Hospitals.

Tamworth General Hospital had 68 beds and a staff of 23 general practitioners together with visiting consultants. With three other hospitals between six and 15 miles (9.7-24 km) away it served a population of about 50,000. The day-to-day care of patients was carried out by their own doctor, but of the 23 general practitioners on the staff six were clinical assistants—four in anaesthetics, one in medical administration, and one in surgery. Consultant surgeons visited to do operations and other consultants were available for advice on request.

The two Nuneaton hospitals, 15 miles away from Tamworth, served a similar type of community and a population of about 60,000. They functioned as one unit with a total of 317 beds between them staffed by consultants and hospital junior staff working in firms in the traditional manner. There were no general practitioner beds.

Some comparative statistics for the three hospitals are shown in table I. Though the figures for the general practitioner hospital (Tamworth) compare favourably with those for the Nuneaton general hospitals the latter provide a 24-hour operating and emergency service, which add to their costs.

TABLE I—Comparisons of Bed Occupancy and Costs, Year Ended 31 March 1972

	Nuneaton Hospitals		Tamworth General Hospital
	George Eliot	Manor	
Staffed beds	202	115	68
Bed occupancy	84%	69%	73%
Average inpatient stay (days) ..	12.1	8.0	8.4
Cost per patient per week	£67.85	£74.39	£55.23
Cost per case	£116.99	£85.53	£66.03

DESIGN OF STUDY

The study was planned to examine mainly the following four aspects of the cases admitted to the hospitals: (1) the source and type of admission; (2) the main reason for the patient's

admission and the main treatment regimen while in hospital; (3) inpatient investigations carried out (as a guide to the quality of care); and (4) whether the type of hospital (that was, district or community) to which the patient was admitted was appropriate for the treatment needed.

The survey called for value judgements to be made on information in patients' case notes, and one among us (T.K.) acted as record assessor. His hospital and surgical experience was most valuable for this. He had some knowledge of all the hospitals but no working commitments to either the Nuneaton hospitals or Tamworth. Much of the factual information needed was obtained from the Birmingham Regional Hospital Board and additional information was coded in vacant boxes at the bottom of the record sheets on the advice of the Board's statistician. A simple numerical code was used.

The case records of the patients discharged from the hospitals during one week in every three weeks for a period of 12 months were examined. Since the Nuneaton hospitals had five times as many discharges as Tamworth hospital in the year the case records of only every fifth Nuneaton patient discharged were examined. The total number of case records examined was 908.

SOURCE AND TYPE OF ADMISSION

We classified the sources and types of admission into seven categories (table II). The assessor examined the case records of the 350 patients who had been directly admitted to hospital and of the 377 who had been admitted via outpatients and gave his opinion on whether their case was most suitable for admission to a community hospital (categories 2 and 4), or to a district hospital (categories 3 and 5). His allocation of the patients from each hospital to one or other of categories 2 to 5 are shown in table II.

TABLE II—Categories of Admission and Allocation of Patients to Categories

Category of Admission	Nuneaton	Tamworth	Total
1. Casualty	67 (16.3%)	71 (14.3%)	138
2. Direct: suitable for community hospital ..	41 (10%)	199 (40%)	240
3. Direct: suitable for district hospital ..	95 (23.1%)	15 (3%)	110
4. Outpatient: suitable for community hospital ..	153 (37.2%)	161 (32.4%)	314
5. Outpatient: suitable for district hospital ..	51 (12.4%)	12 (2.4%)	63
6. Social reasons	1 (0.2%)	2 (0.4%)	3
7. Transfer from other hospitals	3 (0.7%)	37 (7.4%)	40
Total	411 (100%)	497 (100%)	908

Direct admissions to Tamworth hospital were the responsibility of the admitting general practitioner. Almost all outpatients seen at Tamworth and subsequently admitted were put on the waiting list by the consultant concerned. High-risk cases and major surgical problems were put on a waiting list for a district hospital.

The number of patients admitted for social reasons (category 6) was surprisingly small, and seemingly doctors were reluctant to acknowledge what general practitioners know to be a common reason for hospital admission. The comparatively large number of patients admitted to Tamworth from other hospitals (category 7) represented those transferred from a district hospital at a preconvalescent stage of their illness. This was a useful function of a community hospital.

General practitioners with access to hospital beds are said to tend to use them uneconomically and to admit patients to hospital more readily than when only district hospital beds are available. But regional hospital board figures for 1970 showed that this was not the case in Tamworth. Hospital admissions for all purposes in Tamworth (population 42,000)

were 3,073 (about 70 per 1,000) and in Nuneaton (population 63,980) 5,203 (about 80 per 1,000). Furthermore, the number of admissions to the Tamworth General Hospital were half of the admissions for Tamworth borough.

REASON FOR ADMISSION

The diagnosed illness may be only an approximate indicator of the reason for admission to hospital. For example, terminal care or nursing rather than the patient's carcinoma of the colon may be the main reason for his or her admission. Therefore, after consulting with the medical and senior nursing staff, our assessor decided what was the main reason in each case for the patient being in hospital (table III). The larger proportion of patients admitted to Tamworth hospital for therapy probably reflected continuity of care in that the general practitioner was reasonably certain of the diagnosis but thought the treatment would be better carried out in hospital. The larger number of patients admitted to Tamworth hospital for nursing probably included those admitted for social reasons and some of the preconvalescent patients transferred from other hospitals.

TABLE III—Main Reasons for Admission to Hospital

Main Reason for Admission	Nuneaton	Tamworth	Total
Therapy	88 (21.4%)	145 (29.2%)	233
Nursing	3 (0.7%)	41 (8.2%)	44
Investigation	69 (16.8%)	55 (11.1%)	124
Supervision and observation	69 (16.8%)	76 (15.3%)	145
Surgery	177 (43.1%)	162 (32.6%)	339
Terminal care	2 (0.5%)	13 (2.6%)	15
Transfers and others	1 (0.2%)	5 (1.0%)	6
Not known	2 (0.5%)	—	2
Total	411 (100%)	497 (100%)	908

As would be expected, the Nuneaton hospitals dealt with more major surgical cases and this accounted for the higher proportion of patients admitted for surgery. It also accounted for the lower costs at Tamworth hospital (table I) since there was no need for standby staff for lists consisting entirely of cold surgery cases.

The admission to Tamworth hospital of patients for terminal care seemed a proper use of general practitioner beds. District hospital beds for such patients are often unobtainable, even when the resources of the family are at breaking point. There were 28 deaths in Tamworth hospital and 17 in the Nuneaton hospitals. The Tamworth figures probably reflect the number of patients admitted for terminal care and elderly patients for acute conditions. The average age of the Tamworth patients was 46 compared with 38 for Nuneaton (table IV).

TABLE IV—Age Distribution of Patients

Age Group	Nuneaton	Tamworth	Total
—9	41 (10%)	62 (12.5%)	103
10–19	43 (10.5%)	40 (8%)	83
20–29	88 (21.4%)	43 (8.6%)	131
30–39	44 (10.7%)	63 (12.7%)	107
40–49	64 (15.6%)	52 (10.5%)	116
50–59	51 (12.4%)	62 (12.5%)	113
60–69	38 (9.2%)	70 (14.1%)	108
70–79	25 (6.1%)	68 (13.7%)	93
80–	17 (4.1%)	35 (7.1%)	52
Not known	—	2 (0.4%)	2
Total	411 (100%)	497 (100%)	908

INVESTIGATIONS

Taking the number of investigations done as a pointer to

the quality of hospital medical care, the greater number done at Nuneaton hospitals (table V) was as expected, since they catered for more seriously ill patients needing monitoring. Also junior hospital staff are apt to be somewhat prodigal in their use of radiological and laboratory facilities.

TABLE V—Number of Investigations Done

Investigation	Nuneaton (411 patients)	Tamworth (497 patients)	Total (908 patients)
Radiology	194	165	359
Bacteriology	113	79	192
Haematology	305	241	546
Biochemistry	127	59	186
Histology	45	14	59
Total	784	558	1,342

On the other hand, all Tamworth patients due to have an anaesthetic had a blood examination and a chest x-ray examination before admission. These are not recorded in the figures (table V), since the examinations were done elsewhere than at Tamworth hospital. Similarly the main pathological examinations and biochemical tests were done at a district laboratory.

The amount of consultation with consultants was considered an important factor in maintaining standards of care. Out of the 497 patients in Tamworth consultants co-operated with general practitioners in 262 cases among the following specialties: general surgery, 135; general medicine, 47; accidents and orthopaedics, 52; otorhinolaryngology, 10; gynaecology 17; dermatology, 1 (total 262). These numbers included patients first seen by consultants and assessed as suitable for admission to Tamworth hospital.

SUITABILITY OF HOSPITAL

Our assessor thought that the cases of 14 (2.8%) of the 497 patients in Tamworth hospital were suitable only for a district hospital (table VI). Thus of 2,500 patients admitted in a year about 70 would have been wrongly placed in a community hospital. On investigation, particular circumstances seemed to have precipitated the admission of these patients to Tamworth hospital—for example, a patient taken suddenly ill in the street and admitted as an emergency. There is an apparent discrepancy between the figures in tables II and VI; this is explained by the fact that the figures in table II (category 3 and 5) represent our assessor's opinion that these cases in Tamworth hospital were *generally* more suitable for a district hospital whereas the figures in table VI represent his views that the 14 Tamworth cases were suitable *only* for a district hospital. On the other hand, 287 (69.9%) of the 411 cases in the Nuneaton hospitals were suitable for a community hospital (table VI).

TABLE VI—Assessment of Suitability of Hospital for Case

	Nuneaton	Tamworth	Total
Case suitable for community hospital	287 (69.9%)	483 (97.2%)	770
Case suitable for district hospital	118 (28.7%)	14 (2.8%)	132
Not known	6 (1.4%)	—	6
Total	411 (100%)	497 (100%)	908

Analysis of the duration of stay of cases deemed suitable for a community hospital showed (table VII) that after two days it was much the same in the two hospitals. The figures for the first three days might be explained by the fact that day cases may have been easier to arrange in a community

TABLE VII—Duration of Stay in Days in Hospital of Cases Suitable for Community Hospital

	0	1	2	3	4	5	6	7-13	14-20	21-30	31-40	41-50	61-
Nuneaton . .	15	56	78	21	16	13	9	41	15	9	5	2	3
Tamworth . .	57	66	56	38	35	35	22	80	41	19	12	8	9
Total	72	122	134	59	51	48	31	121	56	28	17	10	12

hospital, which was closer to the patients' homes and contacts. An analysis of the duration of stay of all hernia cases (taken as typical of cold surgery) operated on in the two hospitals showed that in Nuneaton it was 5.6 days and in Tamworth 5.7.

The average waiting time for admission from the waiting list (all cases) was 26.5 weeks for the Nuneaton hospitals and 13.2 weeks for Tamworth hospital. Thus there was a shorter waiting time for the type of cases dealt with at Tamworth.

Discussion

The essential assessment to be made from this study is whether there is a place in the Health Service for community hospitals under the control of the patients' own doctors. If there is, much money could be saved by building lower-cost hospitals, less ambitious in design, and much more economic in staff.

Our findings, we think, indicate what is possible in a hospital that serves a community at an admittedly lower level than the traditional type of district hospital with its full range of hospital medical staff. On the other hand, Tamworth is not a true cottage hospital.⁴ But provided the general practitioners using a community hospital realize their own limitations and those of the hospital and are always ready to be critical of their work patients in a community hospital would not seem to be at a disadvantage.

The assessor's estimates (table II) of the suitability of the hospitals for the cases admitted indicate that both the general practitioners and the consultants were able to make reliable assessments about the type of patients to be treated in a community hospital. Whether the patients would have received better treatment in a district hospital is almost impossible to assess. They would certainly have had more investigations done on them and would have stayed in hospital a slightly shorter time. On the other hand, the cost of their treatment would have been more. The effect on patients of removal from home surroundings and doctors and nurses whom they know to the more impersonal atmosphere of a larger hospital is difficult to evaluate. There is little doubt, however, that for serious illness of any kind needing skilled decision and assessment a district hospital is the correct place. But our findings seem to show, and it is also the opinion of many professional workers, that most of the work done in a district general hospital is not in this category. We believe that the beds in a hospital catering for the community should be under the control of the local general practitioners—subject always to their work being under continuous critical assessment by their general practitioner and consultant colleagues.

Some suggest that when general practitioners have access to beds the level of illness at which patients are admitted is lower. We found that the hospital admission rate for the Tamworth area is lower than the average, and our impression is that discipline is generally imposed, especially by our nursing colleagues, if valuable beds are squandered needlessly. Nevertheless, when general practitioners are constantly visiting the wards beds can be used during slack times to relieve families under stress as a result of illness. This cannot be the case with a district hospital, where the diagnosis and clinical state of the patients must be the first consideration. One other aspect of the matter is important. The waiting time for most cases for admission to a community hospital is usually a few weeks, sometimes days, while for a district hospital it may be a matter of months or years.

General practitioners working in community hospitals do not qualify under the N.H.S. regulations for refresher course grants for their hospital work. We think refresher courses should be provided specifically for these doctors, and the standards should be higher than those of the usual refresher courses. The average graduate qualifying at a British university is a very skilled person. If he loses contact with hospital he can readily lose these skills and may be unprepared to accept hospital responsibility again. In the N.H.S. of the future, general practitioners should be given the opportunity to continue to care for their patients day-by-day in hospital either by the provision of special wards, by the upgrading of existing hospitals, or by the building of fairly standard type of medium-sized hospitals. We think that this study shows that such a practice is possible and desirable.

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