Services had already proposed several amendments.

That control should be in the hands of the medical profession was the view of the negotiators, Dr Marks told the committee. Many of their amendments had been included but what was still in question was the division of responsibility between the professional advisory committee, which the code had recommended should be set up in each area where there was a service, and the family practitioner committee. The CAC had recommended that the PAC should be appointed by the LMC or approved by the LMC, and should not be a subcommittee of the FPC.

Dr Mervyn Goodman, a user of a service and member of an LMC advisory committee, echoed many speakers when he said that the standard of the service would clinch the whole matter. The requirement of a deputy specified "adequate previous experience in general practice (normally of not less than six months' duration)." This was where the crunch would come. General practice could collapse in some

urban areas if a deputising service did not operate. Dr Goodman suggested that six months in an accident and emergency department would be more appropriate experience.

RCGP PROPOSALS

The representative from the council of the RCGP, Dr C Waine, referred to some of the recommendations which the college had made. Deputies should be principals in general practice with a year's experience or they should be vocationally trained. If this requirement was not met a member of the practice covered by the service should be available to be consulted by telephone and to visit if necessary. All doctors in a service should have access to a member of the practice for which they were deputising. If these proposals had been accepted there would be no question of the care offered being adequate and all objections would go up in a puff of smoke.

The committee was in danger of becoming hypocritical, Dr Riddle (a user) declared. Any doctor could employ another to cover for him,

but as soon as a commercial enterprise was mentioned a holier than thou attitude set in. If rules became too rigid it might have a disadvantageous effect for all the individual arrangements that were made.

The code specified that "adequate provision must be made for the assessment of medical priority of calls within the control room, in consultation with a duty doctor." Dr Lambie pointed out that leaving in the words "within the control room" would set a dangerous precedent. It was only possible to have the duty doctor actually in the control room in the smaller services. The words were deleted. At the end of the debate, during which several further amendments were proposed, the committee approved the introduction of a code of practice with the following resolution: "That this committee believes it is essential for the standards of care provided by all medical deputising services to be beyond reproach. The committee fully supports the introduction of a code of practice subject to the primary responsibility for control of standards being vested in local professional committees."

TALKING POINT

Problems in the development of the community hospital concept

D P KERNICK, S DAVIES

The 1962 hospital plan¹ called for an integration and consolidation of hospital facilities into a central district general hospital and saw no case for retaining small hospitals in any but remote areas. It was soon obvious, however, that this plan was not strictly relevant, and that many patients in district general hospitals did not need access to their diagnostic and treatment facilities. Crombie and Cross² recognised the problem in 1959. They estimated that a quarter of patients in a Birmingham medical ward had no specialist diagnostic or therapeutic requirements. Since then other studies have confirmed this impression.^{3,4}

Until recently, general practice hospitals have developed without defined aims in the context of an overall health plan. The diversity of function and variety of approach of such hospitals was demonstrated by Emrys-Roberts,⁵ who toured 23 of the 400 or so general practice hospitals in England and Wales. With the exception of one or two, he found regional policy concerned entirely with the larger district hospitals.

The importance of general practice hospitals in the overall health care plan was acknowledged by the publication in 1974 of *Community hospitals, Their Role and Development in the NHS*.⁶ This laid down a firm framework in which they could develop. The formulation represented an entirely new philosophy from the 1962 hospital plan. The general practice hospital was now seen to be complementary to the district general hospital rather than filling the vacuum left by the centralisation of medical services.

Who should be treated?

One main problem is defining groups of patients who can be treated more effectively at the community hospital than at home or in a district general hospital. Some groups may be readily identified—for example, short-stay patients with terminal disease and family nursing relief. Other groups, such as acute medical admissions and postoperative transfers, are more difficult to define. Torrance⁴ considered 573 admissions to a district general hospital in the Dundee area. In only 33% of cases did general practitioner and consultant agree on the need for specialist care, while 24% of all cases were assessed by both parties to be within the competence of the general practitioner. There was disagreement on the correct course of action on the remaining patients.

Bennett has reviewed the problem.⁷ He proposed controlled trials where care in the community hospital was compared with that of an existing alternative. Two main problems arise from this approach. Firstly, to enable two groups to be compared, an index of the "health status" of an individual has to be defined. This index must include dimensions of mortality, morbidity, overall cost, and satisfaction, not only of the patient and his family but also of the doctor and nursing team. Though an attempt can be made to measure morbidity, it is impossible to relate objective indices to such factors as patient and family satisfaction. The difficulties of cost analysis, even in a small unit, have been shown by the Oxford community hospital pro-

gramme.⁸ Given it were possible to ascribe values to the medical, social, psychological, and economic outcomes of alternatives of care, each value would have to be weighed before it could be integrated into an overall index of health status. Based on such a subjective analysis, any conclusion as to the optimum course of action would be highly speculative.

The second problem arises from the fact that, even if one type of care is shown to be favourable, the results will apply only to that context in which the trial was conducted. No two communities will be alike in their social, geographical, or economic makeup. At trial centres medical care will not be typical. Medical staff will be highly motivated, while, if a full evaluation of medical care is to be made, patients will receive greater attention both in and out of hospital.

General practitioner's role

An important factor in the development of the community hospital which has not been fully considered is the general practitioner's attitude. In a study by Evans and McEwan⁹ of the doctors who did not use a 12-bedded general practice hospital—about half of those eligible to do so—52% stated that they were too busy, and 24% thought that they were either too out of touch or not sufficiently interested in hospital work. Barber *et al*¹⁰ found that of the 64 doctors who were offered contracts in a general practice ward of the local general hospital only 34 accepted, 47% of

patients being admitted by four doctors in one practice.

In a more recent study, Davis *et al*¹¹ surveyed the attitude of every general practitioner whose principal contract was with the South Glamorgan Family Practitioner Committee. Replies were received from 67.4% of the 172 doctors who did not have access to a community hospital: 88% expressed an interest in working in a community hospital. There was a strong correlation between age and attitudes towards control of hospital beds and provision of emergency cover. There were no doctors under 40 who were not prepared to work in the community hospital, provided conditions of payment were satisfactory. Nine per cent of doctors between 40 and 60, and 40% of those over 60 were not prepared to work in the community hospital.

These studies show that general practitioners will differ widely in their attitude towards the use of hospital beds. This is confirmed by the experience at Barry Community Hospital¹²: when it opened in 1972, 14 of the 19 Barry general practitioners agreed to accept a contract and at present 13 doctors share 40 beds.

From August 1972 to September 1975 details of bed occupancy over periods of six months were obtained from hospital returns and hospital activity analyses. Table I shows the average number of patients admitted per general practitioner in each of the three Barry practices. Tables II and III show the number of inpatient days and average length of stay of patients admitted by each practitioner in a group practice of six doctors acting independently. Only five doctors are considered, as the sixth post was not occupied continuously. The results show that general practitioners vary in their use of hospital beds. The patients of doctors who use the hospital less tend to stay for longer periods, implying that general practitioners are differing in their approach towards the community hospital.

Conclusion

The two main problems in the development of the community hospital concept have been outlined. Firstly, because of the difficulties in

TABLE III—Average length of stay in days of patients admitted by each GP in one practice

Six-month period starting August 1972	General practitioner				
	1	2	3	4	5
1	10.4	14.1	15.8	9.8	9.9
2	13.7	16.8	16.2	17.0	11.6
3	12.7	12.0	14.5	13.6	15.0
4	11.5	21.8	27.0	19.2	15.7
5	20.9	19.4	17.1	18.4	27.0
6	16.6	22.3	17.6	16.1	21.6
Average length of stay	14.3	17.7	18.0	15.7	16.8

evaluating alternative courses of treatment, it is impossible to allocate a definitive role to the community hospital in the context of an overall health care plan. Secondly, the attitude of the general practitioner towards the new concept has not been fully considered.

It is not yet clear how hospital commitments to the community hospital may be integrated into the overall work load of the general practitioner, but a study at Oxford⁸ has shown that, though time spent in the hospital is partially offset by a reduction in other practice duties, leisure time is sacrificed to some extent. Davis *et al*¹¹ have shown that remuneration is also an important factor. Of the 88% of doctors who expressed an interest in community hospital work, 42% regarded adequate remuneration as a prerequisite.

The successful outcome of any programme depends on active participation of the general practitioner. Not all GPs wish to take part in the hospital care of their patients. Because of differences in professional background and approach, those who do will place differing emphasis on this aspect of patient care, and, with the proposed integration of half of the area geriatric beds into the community hospital, attitudes will diverge further.

The general practitioner is an independent contractor, and his attitude towards the community hospital is determined by his personal outlook and not the requirements of a national health plan. It has been argued that those practitioners who do not use the facilities of a community hospital available to them will lose patients to those who do. Apart from the obvious impracticability, the argument misses the essential point. Unless all general practitioners actively participate the concept will fail.

The community hospital has been heralded as an important development towards an integrated health service, providing economic, satisfactory care in local surroundings. The difficulty of evaluating optimum operational policies and the varying attitudes of general practitioners mean that there can be no national policy on community hospitals.

Each region must adopt its own approach within a general framework, taking into consideration local social, geographical, and medical factors. The importance of the community hospital exercise has been that it has identified the potential of general practice hospitals working within an integrated health care system. Even so, the contribution will be based on arbitrary decisions taken largely locally and influenced by local factors.

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References

- Ministry of Health, *Hospital Plan for England and Wales*. London, HMSO 1962.

- Crombie, D L, and Cross, K W, *Medical Press*, 1959, **242**, 316.
- Loudon, I S L, *Journal of the Royal College of General Practitioners*, 1972, **22**, 220.
- Torrance, N, *et al*, *Journal of the Royal College of General Practitioners*, 1972, **22**, 211.
- Emrys-Roberts, M, *Lancet*, 1971, **2**, 755.
- Department of Health and Social Security, *Community Hospitals, Their Role and Development in the National Health Service*. London, HMSO, 1974.
- Bennett, A E, *British Medical Bulletin*, 1974, **30**, 3.
- Rickard, J H, *Cost Effectiveness Analysis of the Oxford Community Hospital Programme*. Department of the Regius Professor of Medicine, University of Oxford, 1976.
- Evans, E O, and McEwan, E D, *British Medical Journal*, 1969, **1**, 172.
- Barber, J H, *et al*, *British Medical Journal*, 1972, **4**, 27.
- Davis, R H, Richards, R M, and Keble-Williams, G, *The Attitudes of General Practitioners Towards the Community Hospital*. General Practice Unit, Welsh National School of Medicine, Cardiff, 1977.
- Kernick, D P, and Davies, S E, *British Medical Journal*, 1976, **2**, 1243.

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In brief . . .

Tory plans for NHS

The Opposition spokesman on the social services, Mr Patrick Jenkin, told the Conservative Medical Society symposium on health care finance on 29 October that the NHS was not short of doctors, nurses, or hospital beds: it was short of money. Prescription charges had not been increased since 1972 and he did not think that people would object to increased charges if it meant an improved service with better facilities and shorter waiting lists. The Conservative Party hoped to be able to reduce direct taxation, so Mr Jenkin said it was reasonable for people to pay towards their keep when in hospital. Calling for a system of incentives to get much better use from the money being spent, he also argued that at least part of the cost of the NHS would be better transferred from general taxation to a specific health insurance contribution. This would give the Health Service greater independence from the Exchequer and would enable the public to see a closer connection between what they paid and what they got.

Reorganisation in Liverpool

Liverpool, with a population of 423 000, is to become the largest single district area. Since NHS reorganisation the Liverpool Area Health Authority has operated through two districts—Liverpool Central and Southern and Liverpool Eastern. The AHA asked for the change after discussions with local staff, professional interests, and community health councils. There will be no redundancies as the AHA has avoided filling vacancies for some months and further reductions will be by natural wastage. The AHA will consult with unions about the definition of posts which are new in content or will carry substantially increased responsibilities; staff with the necessary qualifications will then be invited to compete for them.

TABLE I—Average number of patients admitted per GP in each practice

Six-month period starting October 1972	Practice			Total number of patients admitted
	1	2	3	
1	14.8	6.5	21.4	302
2	13.5	6.0	23.6	365
3	13.9	5.4	19.3	394
4	10.5	4.3	16.1	322
5	10.4	4.8	19.1	321
6	8.7	5.1	17.1	277
Average	12.0	5.4	19.5	330.1

TABLE II—Number of inpatient days per GP in one practice

Six-month period starting October 1972	General practitioner				
	1	2	3	4	5
1	367	362	262	509	763
2	444	296	123	453	561
3	340	304	295	490	608
4	540	446	139	565	322
5	488	463	184	688	588
6	306	487	184	395	461
Average inpatient days	414	393	198	516	550