MEDICAL PRACTICE

General Practice Observed

General-practitioner Ward in a District General Hospital

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Summary

A general-practitioner ward, made available at the local hospital, was used by 34 of 64 local practitioners offered contracts by the regional board. Four of the five doctors in our practice took up contracts, and we were responsible for 119 admissions (100 patients) in one year. Had the general-practitioner ward not been available 73 hospital admissions would have been needed; in 27 cases care at home would have been the alternative, while the remaining 19 patients could have been seen as outpatients. Only seven consultant opinions were sought during the year.

Introduction

The establishment of the National Health Service in 1948 produced many changes, not least of which was a rigid tripartite structure which barred the general practitioner from what had been one of his major fields of activity—the hospital. In many areas general-practitioner cottage hospitals survived, but following a trend towards centralization and a belief that they were uneconomic some were closed and their beds transferred to the district general hospitals. This move further reduced the numbers of general practitioners who had access to hospital beds.

The Porritt Committee¹ recognized that “the link between the General Practitioner and his patient should remain intact whenever possible, and he should be encouraged to look after his own patients in hospital whenever he can do so efficiently . . . they must have access to some of their patients admitted to local

hospitals and retain continued responsibility for their care.” This view was also held in the *Third Report of Joint Discussions on the Family Doctor Service*,² which made specific mention of the arrangements for general-practitioner beds in the East Birmingham Hospital and the Queen Elizabeth Hospital at Welwyn. The general-practitioner ward in the East Birmingham Hospital, the first such ward in a district general hospital, was fully described by Wilkinson.³ The importance to general practitioners of access to hospital beds was stressed in a report of the South-East Faculty of the Royal College of General Practitioners,⁴ and London⁵ commented on the value of such units to the district hospital in the reduction of hospital work load.

Despite the Platt report⁶ and the findings of the Porritt Committee,¹ which advocated the development of general-practitioner hospital beds, the number of such beds has remained stationary over the past 15 years. General-practitioner beds represent 3% of all non-maternity beds (excluding psychiatric beds), and of these only 1% are situated in a consultant hospital.⁷ There is therefore a real need for practitioners using such beds to analyse and document their experience of them, and by doing so to encourage further development in this field. This paper reports on the use made of a general-practitioner ward in a district general hospital by a group of four doctors over a period of one year.

Hospital and General-practitioner Ward

Bangour General Hospital serves a catchment population of about 150,000 drawn from West Lothian and part of Midlothian. The general-practitioner ward was opened on 1 November 1970 and contains 10 female and eight male beds in the same ward but separated by a day-room. All general practitioners in the hospital area were invited to use the ward, and of the 64 practitioners contacted 34 signed contracts with the regional hospital board. The appointment is subject to Section 10(a) of the Terms and Conditions of Service for Hospital Medical and Dental Staff, and remuneration is from a staff fund described in these

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regulations. An honorary contract is issued annually by the hospital board of management to all practitioners who wish to use the unit. A small management committee has been established comprising the principal medical advisor to the Livingston Medical Services and the principal nursing officer of Bangour General Hospital, and three practitioners are elected annually by the holders of honorary contracts. Practitioners using the ward, in common with all general practitioners in the hospital area, have access to the laboratory and x-ray departments of the hospital and the consultant staff are available for opinion and advice.

Admission of a patient to the ward is by arrangement with the ward sister, and before admission the patient's next of kin signs an undertaking that the patient will be taken home when he is fit for discharge. Patients are limited to a stay not exceeding four weeks, but in special cases, and with the consent of the hospital authorities, this can be extended. No restriction is made on the type of illness managed, but patients under the age of 12 years are not admitted to the ward.

The Practice

The Craigshill Health Centre group in Livingston New Town has a total patient list of 8,250, and five practitioners work from this centre. Four of us regularly admit patients to the general-practitioner ward, and this paper refers to our use of the unit. The unique appointment of doctors in Livingston to a general practice list of 1,500 patients together with a five-session medical assistant grading in a hospital specialty was described by Duncan. This continuous involvement both in general practice and in hospital made it natural for us to extend our interest to the general-practitioner ward and may have influenced both the number and types of patients we have admitted. One of us (A) has a hospital appointment in general medicine, one (B) in psychiatry, and two (C and D) have appointments in paediatrics.

Livingston acquired its first inhabitants in 1966. At first they came from all parts of the country, but in the past three years the town has taken mainly the overspill from areas of Glasgow. The population is young, 40% being under the age of 15 years and 10% over the age of 45. Women in the child-bearing age group form 25% of the practice population. The medical problems of the community are therefore predominantly those of the young adult and child, with few cases of degenerative disorders. This has influenced the number and types of patients admitted to the general-practitioner ward during the year. The information presented was collected from ward and practice records. Additional information relating to the use made of outpatient consultations and admissions in general medicine for the same year was obtained from the computer-assisted record system in operation at Livingston. The Livingston record system was described by Gruer⁹ and Barber.¹⁰

Patients

From 1 November 1970 to 31 October 1971 there was a total of 255 admissions to the general-practitioner ward, of which 119 (46.6%) were patients admitted by us. The 119 admissions involved 100 patients, 12 having more than one admission in the year. A detailed breakdown of the patients admitted to the ward is given in Table I. The ages of the patients ranged from 14 to 84 years, with an average for all admissions of 47 years (see Chart).

TABLE I—Patients admitted to General-practitioner Ward

	Doctor				Total
	A	B	C	D	
Male	11	11	4	19	45
Female	15	21	19	19	74
Total	26	32	23	38	119

Age distribution of patients admitted to general-practitioner ward in Bangour General Hospital from 1 November 1970 to 31 October 1971.

The length of stay of patients in the ward ranged from one day to a stay of 43 days in one instance. Apart from three cases the limit of stay of 28 days was observed. The length of stay also varied with the type of admission, with a total of 1,334 patient-days for the 119 admissions. Admissions were categorized as acute, for investigation, and social. Acute illnesses were those which could not adequately be treated at home, and social admissions were generally of patients with minor or chronic illness who could have been treated at home had the domestic situation been suitable. Without the agreed limit of stay of four weeks social admissions could have blocked beds for long periods. In two instances patients admitted on social grounds were eventually transferred to other wards in the general hospital as discharge to their homes was not possible. Admissions for investigation were of a short-term nature and were arranged for complicated tests not readily carried out at home or in the health centre. In all there were 71 acute admissions, 19 social admissions, and 29 admissions for investigation. The average length of stay of the acute admissions was 11.6 days, for social admissions 20.1 days, and for those admitted for investigation 12.7 days.

It might be thought that all admissions to a general-practitioner ward would be from the patients' homes, but in certain selected cases patients were transferred from the general hospital to the general-practitioner ward before returning home. All admissions by doctors A and D were direct from the practice, and doctors B and C admitted patients from general medicine, gynaecology, ophthalmology, psychiatry, and plastic surgery in addition to practice patients. The ward also became a transit ward for some patients who were subsequently transferred to other hospital departments. The disposal of the 119 admissions is shown in Table II. Patients admitted were categorized into specialties, and the classification of the admissions is shown in Table II.

As mentioned above, practitioners using the general-practitioner ward have at their disposal all hospital facilities,

TABLE II—Disposal of Admissions from General-practitioner Ward

Home	100	Ophthalmology	1
General medicine	1	Psychiatry	2
Gynaecology	3	Died	2
Surgery	3	Still in ward on 31 Oct. 1971 ..	5
Geriatrics	2		

TABLE III—Classification of Illness by Specialty

Specialty	Doctor				Total
	A	B	C	D	
Medicine	19	17	19	28	83
Psychiatry	2	10	1	4	17
Geriatrics	3	4	1	2	10
Surgery			1	4	5
Gynaecology	2	1	1		4

including access to consultant opinion. In the present cases a registrar opinion was sought on two occasions and a consultant opinion on seven occasions. The consultants concerned were a gynaecologist, a physician, a surgeon, and a geriatrician, and the patients seen by the gynaecologist and the surgeon were subsequently transferred to their wards for specialist treatment. The action that would have been taken by us in the management of the 119 admissions had the general-practitioner ward not been available is shown in Table IV.

TABLE IV—Alternative Action to Admission to General-practitioner Ward

Medical admission	53	Gynaecological outpatient ..	0
Medical outpatient	13	Psychiatric admission	8
Surgical admission	7	Psychiatric outpatient	6
Surgical outpatient	0	Care at home	27
Gynaecological admission ..	5		

Discussion

Many reports have actively encouraged the provision of general-practitioner wards in district general hospitals, but apart from a few isolated instances of such wards being opened there has been little progress.^{1 2 6 11-13} Our findings confirm those of Marsh,¹⁴ who argued that many patients are admitted to hospital because there is no one to look after them at home, because they are old as well as ill, or because they require nursing care and supervision rather than the skills of a consultant team. Such patients benefit from the continuity of care and the known face of their general practitioner, while the practitioner himself benefits from involvement in hospital and from the professional contacts which thus result.

Of the present 119 admissions to the general-practitioner ward 71 patients were admitted with acute illnesses, 29 for investigation, and 19 were admitted mainly for social reasons. The diagnoses of patients admitted under these three categories are listed in Table V.

TABLE V—Diagnoses of Patients admitted to General-practitioner Ward

Acute Illness:		Investigation:	
Chest infections	15	Hypertension	4
Psychiatric disorders ..	9	Dyspepsia	4
Cerebrovascular accident ..	8	Anxiety state	3
Drug overdosage	5	Headache	3
"Lumbago"	4	Vertigo	2
Anaemia	3	Recurrent urinary tract infection ..	2
Duodenal ulcer	3	Neurosyphilis	2
Pulmonary embolus	2	Weight loss	2
Jaundice	2	Carcinoma colon	2
Urinary tract infection ..	2	Obesity	1
Drug reaction (skin)	2	Anaemia	1
Congestive failure	2	Multiple sclerosis	1
Threatened abortion	1	Mild congestive cardiac failure ..	1
Postpartum bleed	1	Epilepsy	1
Cholecystitis	1		
Varicose ulceration	1	Social Reasons:	
Deep venous thrombosis ..	1	After cerebrovascular accident ..	6
Migraine	1	Geriatric care	3
Rheumatic fever	1	Depression	3
Glandular fever	1	Mild congestive cardiac failure ..	2
Acute gout	1	Varicose ulcer	2
Viral meningitis	1	Convalescence	2
Rheumatoid arthritis	1	Obesity	1
Hypertension	1		
Asthma	1		
Renal colic	1		

There was considerable variety in the types of conditions admitted, not only among "medical" conditions but also in the range of specialties. Patients with "gynaecological" diagnoses, such as threatened abortion and postpartum haemorrhage, were transferred to gynaecological wards on the day of admission, and their initial admission to the general-practitioner ward was due to a shortage of beds in the gynaecological ward at that time. One patient with jaundice was admitted as an acute case and after investigation was transferred as a case of obstructive jaundice to a surgical ward. Most of the patients with psychiatric disorders were admitted by Dr. B, who holds an appointment as a medical assistant in psychiatry. The admission of patients

with vague symptoms and a persistently high demand for medical attention was found to be of value, as they responded to removal from the home environment and full and careful assessment in hospital.

Several conditions normally found in the acute medical wards of a district hospital are not included in Table V. As a matter of policy we did not admit cases of possible myocardial infarction or haematemesis, as the presence of a full-time medical team was regarded as essential in the management of these conditions. The patients listed as admitted for investigation are representative of those who would otherwise have been sent to an outpatient clinic. One of the major advantages of this general-practitioner ward has been the ability to complete the investigation of such patients with a resultant greater selectivity in those referred for specialist opinion.

Widoger and Jeffs¹⁵ showed the same range of conditions admitted to their general-practitioner beds with the exception that they did not admit patients with social problems—"general practitioner beds should not be blocked with longstanding cases of this type, but should be used primarily for investigation."¹⁵ We cannot agree with their opinions. Social admissions accounted for 22% of all patients admitted to the Bangour general-practitioner ward, and with the exception of two whose stay in the ward was extended well beyond the agreed limit of four weeks all such patients were discharged home well within the time limit. Knowledge of the patients' home circumstances and of the back-up facilities available in the community may have allowed a shorter stay in hospital than would have resulted in a hospital ward where this information was not available.

The admission of 119 patients in the year under review resulted in a net saving to the hospital of 62 admissions and 19 outpatient referrals. It was not possible to obtain figures for the referral rates to general medicine for the year ending October 1970, although the impression is that referrals were more frequent before the general-practitioner ward was opened. During the year under review 14 referrals were made by the Craigshill group to consultants in general medicine—six as direct admissions and eight as referrals to outpatient clinics. Most of these referrals were from the one practitioner in the group who did not use the general-practitioner ward.

One of the most interesting facts to emerge from this study is that we, who represent 25% of the practitioners using the ward, admitted 46% of all patients treated during the first year. This ward is, however, still a novel feature, and the numbers of patients admitted and doctors using the ward may change during succeeding years. Several factors, however, have influenced the high usage rate of the ward by practitioners from Livingston New Town. Mention has been made of the dual appointment in practice and in hospital which is a part of the Livingston experiment. By virtue of this appointment we are in the general hospital each day and find it convenient to attend patients in the general-practitioner ward.

The continuing contact with a hospital unit encourages the doctor to apply his skills in the management of his own patients, and he is continually kept aware of the treatment regimens and investigational procedures which are used in hospital medicine. In this respect it is the continual contact with a hospital rather than with a particular hospital specialty which is the important factor, as only Dr. B—the general-practitioner/psychiatrist of the group—has shown a specialty bias in his admissions. Apart from this there was no significant difference in the types or numbers of patients admitted by each of us. Practitioners who have been divorced from hospital medicine for many years may be reluctant to accept the responsibility for the management of patients in hospital, some may find it impossible to do so for geographical reasons, and some believe that if a patient requires hospital admission he therefore requires the attention of a specialist hospital team.

In the area served by the general-practitioner ward at Bangour Hospital the geographical factor has been one of the reasons why the ward is not more generally used; another is the novelty of general practitioners having inpatient facilities. In areas where

practitioners have been accustomed to the use of beds in cottage hospitals there is evidence that this facility is highly prized and that its removal would be strenuously resisted.⁴ The growth of vocational training schemes for general practice and the increasing spread of group practices and health centres will increase the demand for inpatient facilities, and to the doctor practising from a health centre with x-ray and physiotherapy equipment and with access to a hospital laboratory, a hospital bed will become a natural additional extension of the care which he can give to his patient. In Livingston, where all practitioners work from health centres and are continuing their contact with hospital, this demand has been concentrated and accelerated in relation to the rest of the general practitioners in the hospital area.

The nursing staff of the ward have proved to be both adaptable and helpful and have found little difficulty in dealing with practitioners who visit patients at varying times throughout the day. Nurses in this type of unit have increased responsibilities, but these have added to the satisfaction of their work and they have stated that they learn more about their patients, their domestic situation, and their future progress than they do when working in other hospital departments. Without question, we have found that the ability to look after our patients in hospital has added a much valued dimension to our work. With the

entry into practice of doctors more versed in the practice of hospital medicine, more will wish to apply the skills learnt during training and will find it frustrating to have to practise without the facilities to use this knowledge.

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Establishment and Use of a General Practitioner Medical Unit in a District General Hospital

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Summary

An analysis of the establishment and running of a general-practitioner medical unit in a district general hospital has shown that it fulfills a useful and positive role in the area health services and is well used. It shows that selectivity of admission can and does work and that the theoretical drawbacks to such a unit did not materialize in practice during the study.

Introduction

At this time of change in the organization of the National Health Service and in view of the emphasis on integration it seems important to consider all the ways in which general practitioners can work in hospital to provide the best service for patients in terms of quality of care and total National Health Service economics. One of the ways in which practitioners can work in hospital is outlined in this paper.

Objective and Organization

The objective was to set up a unit in the district hospital to which doctors in the area could admit patients solely under their own care and treat them with the support of the hospital's diagnostic and therapeutic facilities. This arrangement would simplify consultation between practitioners and consultants and enable the unit to take part in the postgraduate teaching arrangements in the district hospital. It seemed im-

portant that general practitioners be encouraged and given the opportunity to participate in postgraduate teaching.

ESTABLISHMENT OF UNIT

The unit was opened in November 1970 after two years of negotiation with the hospital staff, the hospital authorities, the local medical committee, and practitioners. It was possible to establish the unit without additional finance by redeployment of existing beds. Associated with the district hospital (Bangour General Hospital) are four peripheral units varying from 25 to 78 beds, formerly fever hospitals. These hospitals contained mainly long-stay geriatric patients, but also scattered throughout the four hospitals were 33 general-practitioner beds. These beds were used virtually as long-stay geriatric beds and not for short-stay, acute medicine, partly because of geography, partly because of inadequacy of supporting resources. It was agreed that the 33 beds in the peripheral hospitals be exchanged for an 18-bedded unit in the district hospital—eight male and 10 female beds sited in the same ward but separated by the bathrooms and dayroom. It was finally accepted that 18 "viable" beds would be of greater use than 33 "blocked" beds.

ADMINISTRATION

The board of management agreed that the day-to-day administration of the unit should be undertaken by the medical superintendent. (In Scotland the medical superintendent is a wholetime medical administrator based at hospital level and with no clinical duties.) A small management committee comprising the medical superintendent, the principal nursing officer, and three general-practitioner users was also established.

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