GENERAL PRACTITIONERS AND HOSPITAL BEDS IN THE UNITED KINGDOM

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Nearly everyone agrees that a general practitioner can help the hospital service most, in its staffing difficulties and shortage of beds, by treating his own patients well in their homes. Not all can be treated at home, however, and there are five questions about family doctors and hospital beds which must be answered soon if the proper role of the general practitioner in the health services of our country is to be recognized: (1) Should he treat any of his patients in hospital beds? (2) If so, can he be fully responsible for their care? (3) What part should he play in specialist teams in hospital? (4) How many beds does he need? (5) Where should they be situated—in general-practitioner hospitals, or in annexes or wards of general hospitals?

Sir George Schuster (1961), speaking to the General Practice Section of the Royal Society of Medicine, rightly stressed the importance of co-operation between family doctors and the hospital service. He invited comment from general practitioners on this subject, and one hopes that many will accept his invitation. Here I express my own views and offer them as a possible basis for further discussion.

Advances in medical knowledge have strained to the utmost the resources of general practitioners in this country, and the National Health Service has been criticized for not bringing the benefits of modern medicine sufficiently to patients in their homes. To keep the family doctor of to-day in touch with scientific methods is one of the main arguments in favour of bringing him into closer contact with hospital work. The weakest argument, with general practice already undermanned, is that he should return to the hospitals because they are now short-staffed and rely so heavily on junior doctors imported from abroad.

It is in providing continuity of care throughout many different illnesses that the work of a general practitioner differs fundamentally from that of a specialist; this is the overwhelming justification for his existence. The link between him and his patients should remain intact whenever possible, and everyone must agree wholeheartedly with the principle that he should be encouraged to look after his own patients wherever he can do this efficiently.

Should General Practitioners Treat any of Their Patients in Hospital Beds?

With the present widespread shortage of doctors some people consider that general practitioners are so busy that they have no time to treat anyone in hospital. Others who take the opposite view can show that many patients with simple and straightforward illnesses and minor accidents, which are within the province and competence of an experienced family doctor to treat, have to be admitted to hospital only because domiciliary treatment is difficult or impossible owing to unsuitable home surroundings. The many clinical conditions which are within the scope of general practice need not be

listed here; but one can safely say that the better-trained, more competent, and more experienced a general practitioner is the longer will be this list.

Apart from social and economic factors there are other important reasons why general practitioners should be allowed to admit some of their patients into hospitals under their own care. To follow up an illness closely in a hospital environment—even in a small hospital—and to be responsible for diagnosis and treatment there, is often of considerable educational value to a family doctor, however experienced he may be, and it reduces his feeling of isolation. More frequent contact with specialists helps to maintain his knowledge of scientific medicine, his enthusiasm and skill, and to keep him a sound up-to-date clinician. It may also stimulate him to develop a special interest—in internal medicine, obstetrics, minor surgery, accident surgery in peripheral casualty centres (Osmond-Clarke *et al.*, 1961), in rheumatology, paediatrics, geriatrics, etc.—so that he may support his colleagues in a group practice in these subjects or take his appropriate place in a specialist team. This interest, in its turn, may induce him to undertake clinical or social research, write a thesis, sit for a postgraduate degree or diploma, or help in teaching. Despite these points in favour of general practitioners having hospital beds and special interests, I must urge that these matters be approached with caution because they bristle with difficulties, some of which will be discussed later.

There are considerable advantages for a patient in remaining under his family doctor's continuing care when admitted to hospital and being nursed near where he lives and under better conditions than many homes allow. A change of doctors is avoided. Knowing the family background and home environment of his patient, the general practitioner will often be able to give better-informed and more personal attention than can a stranger. Sometimes it may be possible for the patient to be discharged from hospital sooner than expected because the family doctor knows just how much he can do for him at home.

Hospitals gain something, too, when family doctors visit them. It increases the nursing staff's understanding of the patients' and the doctors' problems, and often simplifies admission and discharge. The spheres of influence of general practitioners and consultants overlap; consultants appreciate closer liaison and co-operation with general practitioners, and many of them like to be asked to see patients in the smaller hospitals. General practitioners can help to staff hospitals and homes for the elderly, chronic sick, and convalescent, which is another aspect of this same problem.

On July 11 the Minister of Health said in Parliament:

"No one who has given attention to the problem of the future of general practice doubted that a close link between hospitals and general practitioners was integral to its solution." (Powell, 1961 (a).)

What better link can there be than for general practitioners to care for a larger proportion of their own patients in hospital? If family doctors of the future are to play their proper part in developing the general-practitioner aspects of the obstetric, geriatric, casualty, and other services, they must have entry into local hospitals and retain continuing responsibility for the care of some of their patients admitted there. The British Medical Association (1952, 1953, 1960, 1961) has

consistently pressed for more general-practitioner hospital beds; successive Ministers of Health have publicly announced support for the provision of these; and so have the Royal College of Obstetricians and Gynaecologists (1958), the College of General Practitioners (1956, 1960), the Scottish Health Services Council (1952), the Executive Councils' Association (1959), the Cohen Committee (1954), and the World Medical Association General Assembly (1949).

An example of what *can* be done has been given recently by Sir George Schuster (chairman of the Oxford Regional Hospital Board) (1961):

"Two things seem to me to be clearly right: that there should be a generous provision of general-practitioner maternity beds and that an adequate number of smaller hospitals served mainly by general practitioners should be retained in rural areas. In the Oxford region we have the lowest maternal mortality rate of any region and also what is, I believe, the highest proportion of general-practitioner maternity beds. Our forward planning proposals provide for 360 general-practitioner maternity beds as compared with 490 beds in specialist units. Our plans also provide for 329 general-practitioner acute and convalescent beds and 729 general-practitioner long-stay beds in smaller rural area hospitals. . . . We are contemplating the possibility of making an experiment with a general-practitioner ward in one of our main general hospitals."

Can General Practitioners Take Full Responsibility for Some of Their Patients in Hospital?

Medical schools teach students to treat patients in hospital. All doctors entering general practice in Great Britain now must have spent a year in pre-registration hospital appointments. Many have done further resident house appointments or have been registrars or senior hospital medical officers, and have gained postgraduate degrees and diplomas. There are now more than enough family doctors with the D.Obst.R.C.O.G. for the number of general-practitioner maternity beds. One-fifth of those now entering general practice have held a registrar's appointment, and it seems wasteful that their training and experience in hospital work should not be of continuing benefit to their own patients later. Family doctors already undertake full responsibility for treating their patients at home, and there can be no doubt that many of them are capable of taking equal responsibility for some of these same patients during short spells in hospital.

Attention has recently been focused on this matter by the publication of the report of the Joint Working Party of the Ministry of Health and of the Department of Health for Scotland on "Medical Staffing Structure in the Hospital Service" (under Sir Robert Platt's chairmanship). The first and main recommendation of that working party was:

"The staffing structure must be based upon consultants as being the only doctors in the Hospital Service who should take full personal responsibility for patients and the medical work required for them." (Platt *et al.*, 1961 (a).)

This is a very important point, because general-practitioner hospitals are within the hospital service and, as this recommendation reads and as it has been widely interpreted, its implementation would mean that no family doctor in Great Britain would any longer have ultimate responsibility for any patient in any hospital

bed. Many general practitioners would disagree most strongly with that. Members of the working party say earlier in their report, however,

"We visualize that general practitioners will continue to be employed at cottage hospitals in which they maintain responsibility for their own cases with advice available from consultants visiting regularly." (Platt *et al.*, 1961 (b).)

This apparent contradiction has now been resolved by personal communications with Sir Robert Platt and with members of his working party. I am assured that their main recommendation is meant to refer to doctors *exclusively* in the hospital service, and that they had no intention of interfering with the full responsibility of family doctors for patients in general-practitioner hospital beds. This is right. General-practitioner hospitals in country areas may be 20 or 30 miles away from the town where the nearest consultants work. A physician, surgeon, or obstetrician-gynaecologist may visit such a hospital regularly, but other consultants in 15 or more different specialties may occasionally have to be called in. It would be a waste of effort for them to visit the hospital regularly on the off-chance of finding a patient requiring their special skill, and it would be difficult for them, when they find one, to give him adequate personal supervision without transferring him to their own main hospital.

Consultants are too busy already to be asked to take full personal responsibility for patients admitted into small hospitals with straightforward complaints for which their special skills are not required—patients whom they may seldom, if ever, see. A general practitioner should always select his patients for admission to general-practitioner hospital beds and he should retain full clinical responsibility for their treatment. Should complications develop, or other difficulties arise which are beyond his scope, he should do just what he would were the patient at home—call in a consultant for another opinion or transfer the patient for specialist care elsewhere.

What Part Should General Practitioners Play in Specialist Teams in Hospital, Looking After the Patients of Other Doctors?

Another recommendation of the working party was that some general practitioners should be encouraged to work in hospitals, making

"a daily visit of two or three hours to supervise the work of the house officers, to see newly admitted cases with them, to undertake or supervise the performance of technical procedures in the wards, and in certain cases to perform operations and to undertake other responsible duties after consultation with the consultant in charge." (Platt *et al.*, 1961 (c).)

There were no general practitioners on the working party, though much evidence was obtained from general-practitioner organizations and individual family doctors, of whom I was one. We all know how anxious Sir Robert Platt is to help general practice, and how much he has done for it already; but the terms of reference of his working party were concerned with the medical staffing structure in the hospital service, and its report was written in the interests of hospital staffing, which explains why the emphasis was (quite reasonably) more on how general practitioners could help the hospitals than on how the hospitals could help them in looking

after their patients. In this present review, which is written in the interests of general practice, the bias is, I know, towards the other side.

From the hospital staffing point of view, the more family doctors who can be persuaded to work in hospital assistant grades, helping to care for the patients of other doctors, the better; that would certainly ease the staffing difficulty and perhaps help to solve the registrar problem. But many people who have the interests and future of general practice at heart, and those who appreciate the shortage of general practitioners, are unhappy about this recommendation of the working party.

Clinical Assistants

For the purpose of promoting his continuing education, and for stimulating, encouraging, and improving his work outside hospital, a general practitioner can work in a larger hospital for one or two sessions a week as a "clinical assistant" in the wards or out-patient clinics of a special department of his choice. Many family doctors who are seeking an extension of their interests or a wider selection of clinical cases than they see in their practices already do this; the hospitals in which they work often find their assistance invaluable, and the variety and scope of general practice are thus increased. A doctor who has developed and maintained such an interest in a special subject may do this part-time work in one department for several years as a member of a specialist team and under the supervision and clinical responsibility of a consultant; another may prefer to move round different specialties in rotation.

At present only a few specialist departments provide openings for clinical assistants; the range could be widely extended in those specialties in which this assistance is suitable, because nearly all additional experience can improve a doctor's quality. In the Birmingham area one general practitioner in four is already doing some such work in hospital, and in the Manchester area one in ten. Many more general practitioners would be only too glad to apply for these appointments if the duties, responsibilities, status, security of tenure, and remuneration were made attractive, and if a senior more responsible grade could be introduced for those with much experience, as the B.M.A. recommended in 1952 (b). The titles of these posts could be "clinical assistant" (as at present) and "senior clinical assistant," if the S.H.M.O. and equivalent grades are as unsatisfactory as many people, including the Platt Working Party, think. (Platt *et al.*, 1961 (d).)

Such senior clinical assistantships are likely, I believe, to be more valuable to suitably trained and experienced general practitioners than the "medical assistantships" with daily duties in hospitals suggested in the Platt Report. As a general rule, a family doctor should not be away from his practice for longer than one or two sessions a week, unless he or she has few patients or wishes to do what amounts to part-time work in some other branch of the profession. Some who have just joined or started a practice, some established practitioners who have plenty of partners, and some married women doctors may belong to this category. Family doctors may occasionally object to their colleagues holding appointments in specialist teams and seeing patients whom they have sent for a consultant's opinion;

although this feeling does sometimes exist, it has been found in practice that there is not much substance in it. Stephen Taylor (1954) wrote: "The clinical-assistant post is likely to be the key to the future work of the G.P. inside hospital."

There is a limited need for a stepping-stone from general practice to consulting work, and vice versa. A senior clinical assistantship in any subject would be as good as a medical assistantship for those who aim at leaving general practice altogether to become consultants or for consultants wishing to enter general practice. Such changes could easily be made by increasing or decreasing gradually the number of sessions in hospital. A few "general-practitioner consultants" already do four or more sessions a week; but this often means a limitation of their lists, and their numbers are dwindling.

The Personal Doctor

There are those who say that general practitioners must get back into hospitals at any cost and accept gratefully whatever work they are given. Others think that they could pay too high a price for this return, and that it would be a great mistake for them to give up too much of their precious time working in hospital assistant grades as "extra pairs of hands" or as "convenient sources of extra help" carrying out daily routine duties or supervising the work of others, merely because there is a shortage of proper hospital junior staff.

There is a limit to the time a family doctor can spend away from his own patients, however much he may be pursuing his continuing education—as a clinical assistant, in postgraduate courses, or when reading at home or in a medical library. In an emergency he would, of course, want to help his local hospital in every way. But ordinarily he should spend nearly all his time giving good and up-to-date care to his own patients; that is where he is needed most and wants most to help, and where he can always learn a great deal—a point not always appreciated. For many generations family doctors have done their best to give their patients this personal service and attention. It is a sad reflection on our modern medical system that the importance of this personal care, and of the personal doctor behind it, has recently had to be almost rediscovered and hailed as something new. Good general practitioners have known about it for a very long time, but they must be grateful to Dr. T. F. Fox (1960) for drawing attention to it so clearly once again.

The profession, the Ministry of Health, and those elsewhere who are responsible for implementing the Platt Report will no doubt consider carefully the effect of its recommendations not only on hospital staffing but also on general practice. One of the greatest needs to-day is for more general practitioners with smaller maximum lists (without reduction in pay) and with time and encouragement to treat patients really well. Rather than denude general practice still further by asking family doctors to disrupt their proper work for several hours a day to supervise house officers looking after other doctors' patients in hospitals, would it not be wiser to help them to do their own job better—shouldering their primary responsibility, which is to look after their *own* patients?

How Many Hospital Beds Do General Practitioners Need ?

At present, general practitioners in England and Wales are in charge, on average, of less than one hospital bed each, and this includes their maternity beds and private pay-beds (Ministry of Health, 1961). The number of general-practitioner beds is slightly larger than it was five years ago, but is still less than in 1948. There are those on the administrative and hospital side who think that even this small number is too large, and attempts have been made, some unfortunately successful, to reduce it still further. Other responsible people believe that family doctors should have more beds than this. Some already have them, to their great advantage, like many of their colleagues in Canada, the U.S.A., New Zealand, and Australia; but the distribution of general-practitioner beds in this country is very uneven. During recent trips abroad I have seen a large number of general practices, many of them closely connected with small hospitals: although the conditions under which those doctors work are often quite different from ours, my impression is that their clinical interest, enthusiasm, efficiency, and incentive to keep up to date are greatly enhanced by being able to treat some of their patients in hospital. In this way they accept and respond to the challenge of being given more clinical responsibility.

For the future we must plan for the young men and women entering general practice. We do not know for certain how many of them will be willing to do some hospital work; but most of those in Great Britain will have been properly trained in hospitals, having done their full share of resident appointments. The Platt Report says:

"We consider that ideally new entrants to general practice should have spent at least two years in the Hospital Service after becoming fully registered. If this became the regular career pattern of British graduates, a substantial contribution would be made towards the provision of adequate staff between the provisionally registered houseman and the registrar." (Platt *et al.*, 1961 (e).)

With another year in pre-registration appointments this would mean *three* years in hospital after qualifying, which I believe might often be too long because these young doctors need considerable vocational training in general practice also. About two years in each post-graduate discipline—hospital and general practice—will probably prove to be the right training for good family doctors of the future. When starting in practice it is likely that nearly all of them would welcome the opportunity of treating some of their own patients in hospital and using the skills which they had been taught.

Methods of payment of family doctors working in general-practitioner hospitals and as clinical assistants in larger hospitals will need to be reviewed and adjusted. It is not satisfactory that their remuneration for this should be at the expense of the central pool, the money being automatically deducted from the total amount available for distribution as capitation fees or notional loadings. If general practitioners are to be encouraged to work more in hospitals this must be put right (Davies, 1961). The success of general-practitioner midwifery beds is due partly to the fact that general-practitioner midwifery is guaranteed a proper fee.

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Many older general practitioners in this country do not want hospital beds under present conditions of payment and would only half-heartedly support them even if they were supplied. Some of those who have them do not use them fully. If offered the use of such beds for their own patients many would say that they were too busy or that they did not want to change their ways or take on extra responsibilities—the capitation system of payment tends to encourage unloading of responsibility rather than taking on more. Some might think that they would need retraining in certain techniques. Some live and work too far away from any hospital. Others are in the happy position of being able to treat nearly all their patients quite adequately at home, except the few they send to hospital for full consultant care; they find domiciliary general practice under present conditions a full-time and satisfying job.

We are told that there is no need for an increase in the total number of hospital beds in our country. Better housing, more recruits to the home-help and home-nursing and other ancillary local health authorities' services, and improvements in modern drugs make possible more out-patient and domiciliary treatment each year (Forsyth and Logan, 1960; Crombie and Cross, 1959). This, together with reorganization of the mental health services and increasing care of the aged and chronic sick in hostels, should free many hospital beds before long. The suggestion has been made that in 15 or 20 years' time up to 50% of the present half-million hospital beds in the United Kingdom may not be needed (Holmes Sellors, 1961).

Before general practitioners can have more hospital beds several things will have to be done apart from improving their training in hospital, ensuring adequate consultant liaison and cover, and adjusting their method of payment: some reduction in the size of maximum lists, some reallocation of beds by hospital planning authorities, and much hospital adaptation or rebuilding will also be necessary. The total number of general-practitioner beds in future will depend on how rapidly these developments are pushed forward and how much money there is for them. Those family doctors who want hospital beds must not miss the chance which the promise of more money for hospital building now gives them to stake their claim for their legitimate needs. When there are enough general practitioners, the number of consultant hospital beds which are occupied by patients with conditions which are within the competence of family doctors to diagnose and treat correctly, but who cannot be looked after at home, will be a rough indication of the number of additional general-practitioner hospital beds that will still be needed.

Where Should General-practitioner Beds Be Situated ?

Country districts are best served by having their general-practitioner beds in general-practitioner hospitals. In urban areas it may be more convenient and cheaper for some of these beds to be in annexes of general hospitals or in general-practitioner wards within these hospitals. Patients whose medical expenses are covered by personal insurance or private fees will continue to be admitted into private hospitals or nursing-homes, into the private beds of small hospitals, or into the paying-patients' blocks of larger hospitals.

(1) General-practitioner Hospitals

"Cottage" hospitals and other general-practitioner hospitals in country towns have long been of great value, and they still are. Many of them have been well run and deservedly popular. The work done in them may sometimes have been poor, occasionally even bad, but for the most part it has been admirable and of more than adequate standard; some of it would not have been done at all, anywhere, had these smaller hospitals not existed. The convenience to patients, relatives, and to doctors of a hospital near by is obvious. A general practitioner can visit several patients in such a hospital far more quickly than he can travel round to see them in their homes. Patients appreciate the intimate familiar surroundings and other local advantages of these smaller hospitals, and the friendly co-operation between doctors often fostered within their walls.

There is need for a large-scale study of the present pattern of use of beds in general-practitioner hospitals and for carefully planned experiments, under proper conditions of payment, to predict their probable future value and to ensure that they are run economically. It has been said that the majority of patients admitted to general-practitioner hospital beds at present are either surgical or chronic cases, and that relatively little of the work done in them is of the kind usually thought about in the past. This may be so in some places, but it should certainly *not* be so because the wards of many larger hospitals contain patients whom general practitioners could easily diagnose and treat themselves, given the right training, the time, and proper conditions.

The main criticism of general-practitioner hospitals in the past has been that family doctors have sometimes treated unsuitable patients in them—patients (often surgical or orthopaedic) who should really have been under a specialist's care and perhaps should not have been kept in these hospitals at all. This difficulty, which has already greatly diminished, can be eliminated by improving the training of general practitioners, by increasing the time they spend in hospital before entering general practice, by ensuring frequent meetings and exchanges of views with consultants, and by encouraging regular postgraduate study.

Consultant Cover

In a large hospital, members of the staff are criticized and advised by their senior and junior colleagues, whether they like it or not, and their sins will usually find them out; but sometimes a family doctor can look after a difficult case in a quiet corner of a small general-practitioner hospital with no one to criticize him except the nurses, his patient, and the relatives. How can we get over this real difficulty and solve the delicate problem of adequate consultant cover or control? How can we safeguard patients when a doctor who knows that he should call in a consultant ignores his obligations, when consultants complain that they are called in too late and general practitioners grumble that consultants interfere? As in other branches of medicine, one must usually rely on the conscience of a well-trained doctor who has kept himself up to date.

Consultants might perhaps be asked to see (in an advisory rather than a supervisory capacity) every patient who has been in a general-practitioner hospital for more than a fortnight, the general practitioners themselves having full clinical responsibility for short-stay cases, calling in consultants when they wish. In

some hospitals the family doctors have already invited consultants to give them general supervision. The Royal College of Obstetricians and Gynaecologists has recently suggested that consultants might perhaps be given the power to "initiate a consultation" on patients who are not doing well; to do that they would have access to the notes but not to the bedside, and perhaps hear regularly through the matron about the progress of patients. This might be satisfactory for obstetrics, but many general practitioners might not altogether approve of it for other patients; it savours somewhat of "snooping." Another possibility is that senior consultant advisers in medicine, surgery, or obstetrics and gynaecology might be appointed yearly on a sessional basis (after nomination by the family doctors of the general-practitioner hospital) to hold regular out-patient clinics at the hospital so that they meet the general practitioners often and know them well, and second opinions can easily be sought.

For the smooth working of general-practitioner hospitals of the future, the fullest opportunities should be taken for close and friendly liaison between the doctors who work in them and their consultant colleagues. The general practitioners must arrange how best they can ensure adequate and efficient consultant cover. If these points are generally accepted by family doctors I believe that they will obtain the full support of most consultants in their campaign for more general-practitioner hospital beds.

General-practitioner Hospitals in Urban Areas

There are already a few general-practitioner hospitals in urban residential areas, and there is no medical reason why there should not be more in large towns and cities as well. Family doctors do much the same kind of clinical work wherever they practise; their patients suffer from much the same complaints, and there is no fundamental reason why those in the country and those in towns should be treated differently. Mr. R. Idris-Lewis (1961) has made an important observation about this:

"The majority of general-practitioner hospitals are descendants of the 300-or-so cottage hospitals built in the second half of the last century to serve the sick poor in isolated areas. But since then a most interesting historical fact has occurred unnoticed. In many small towns these small hospitals have become engulfed by the sea of urbanization, and modern communications have brought the big towns nearer. One might have expected the small hospitals to lose their value. Instead they have thrived, and are not only prized by the doctors who work in them, but greatly loved by the populations for whom they were built. Here, without tiresome duplications of doctors, they can be treated for a multitude of complaints in relative quiet and homeliness, close to their relations and friends, under the continuing care of the doctor they know."

Staffing of General-practitioner Hospitals

General-practitioner hospitals do not usually need resident house officers; family doctors probably do better managing the day-to-day treatment of their own patients there themselves, arranging a rota for casualty and other emergency work. Where possible such hospitals should have a small operating theatre, an x-ray department, a pathological laboratory, and perhaps an electrocardiograph, all under the supervision of a visiting specialist. The scope of the investigations carried out in these small special departments could be

roughly the same as those done in general-practitioner diagnostic units elsewhere (Hunt, 1951, 1955). Technicians should be on call but need not necessarily be full-time; complicated pathological investigations could often be done from a near-by general hospital if there was an efficient collecting service.

Major difficulties and restrictions at present are due to shortage of nurses and midwives, of domestic staff, ancillary staff such as radiologists and laboratory technicians, and of some apparatus and equipment. I foresee that what has been found recently in general-practitioner maternity units—the development of which is now being encouraged—will soon apply to other general-practitioner hospitals. Under a good matron staffing difficulties in these maternity units may not be so great as they are in the larger hospitals; many midwives prefer the somewhat freer social and medical life in the smaller hospitals, and more part-time use can be made of married nurses.

Cost of General-practitioner Hospitals

It is often said that beds in general-practitioner hospitals are less efficient and economical to run, and therefore relatively more expensive, than are those in general hospitals even though the former have no house officers. I doubt whether this need always be so for a well-run modern hospital of 30 or more beds. Smaller numbers (below 25) may be uneconomical, but they are essential in out-of-the-way places. Seasonal influences may affect the number of beds occupied in a general-practitioner hospital more than they do in general hospitals, so there should be no rigid allocation of beds though general practitioners must have priority. During healthy periods of the year some beds in general-practitioner hospitals can be used by consultants, as they often are now, as an overflow from the general hospitals. Any analysis of general-practitioner patients treated in these hospitals must take this into account.

It is hard for those who are not hospital administrators to appreciate the difficulties involved in all these staffing and costing problems. One sympathizes with those in charge, but we must decide how far administrative convenience and temporary staffing difficulties should be allowed to influence long-term planning or determine important future clinical policy. We are in danger of losing something of great value if we concentrate on huge "area" or "community" general hospitals and close down most of the small ones except in isolated places. Smaller general-practitioner hospitals are by no means always incompatible with efficiency and economy, and many of them are really needed.

(2) General-practitioner Annexes of General Hospitals

If it is accepted that the provision of general-practitioner beds is justified in rural areas there is no clinical reason why they should not be valuable in urban areas also. Some of these beds could be in self-contained annexes or wings of general hospitals, administered by the hospital service with the same safeguards as set out above; and there is much to be said for trying more experiments with these. When general practitioners admit their patients into such an annexe, co-operation and consultation with specialists should be even easier than it is in a separate general-practitioner hospital.

A difficult decision which will have to be made in large communities, such as industrial areas, will be

whether all or only a selected proportion of the doctors who may want these beds can have them. There will not be enough for all, and discrimination may give rise to jealousies and other complications. Under such conditions there must be selection of a kind at first—some method of election or appointment, perhaps like that before 1948, depending as far as possible on clinical ability and hospital experience.

Even in a rural area a general-practitioner annexe to a near-by larger hospital might sometimes be as useful as a separate general-practitioner hospital; one advantage over an independent cottage hospital would be that nursing, ancillary, and domestic staff could be under the parent hospital, which could also organize the catering.

(3) General-practitioner Wards in General Hospitals

As a committee of the British Medical Association has pointed out, we have seen the pendulum swing from the time when general practitioners founded and ran most of the hospitals in this country, and every member of their consulting staffs did some general practice, to the time not long ago when family doctors were almost completely excluded from many of our hospitals (except to see their patients as privileged visitors), and very few of the younger consultants had any first-hand knowledge of general practice. Many beds previously used by general practitioners, even in the smaller hospitals, had by then been taken over by consultants, and several executive council areas and at least one city with a million inhabitants had no general-practitioner beds left at all. (Executive Councils' Association, 1959.)

This divorce of general practitioners from hospitals has turned out to be wrong, particularly from the patient's point of view. The pendulum of opinion is swinging back, now, towards the middle position. The value of an extension of general practice into hospitals is once more being appreciated, and the useful work general practitioners can do in them, how much they can learn, and what they can teach students about domiciliary and social medicine is being reassessed.

The Platt Report favoured "the continuation of experiments in the provision of general-practitioner wards in general hospitals." (Platt *et al.*, 1961 (f).) The main advantage of having these within the precincts of general hospitals must be the close liaison possible there between family doctors and consultants. Once again difficulties might arise in deciding which doctors in a large town should use these wards, and which patients should be admitted. General practitioners themselves should control the admissions (ideally with the sympathetic collaboration of the hospital's administrative officer, chairman of the medical staff committee, senior resident medical officer, and the matron), allocate the beds fairly and ensure that they do not become a dumping-ground for elderly, chronic, or difficult patients whom consultants no longer want in their wards. One would have to guard against such beds becoming too easily the *end* of lines of investigation or treatment, instead of the *beginning*, where most of them should be. An increase in partnerships, or better still group practices, would make certain that practice work was not interrupted by the temporary absence of one partner. The hospital patients of a single-handed doctor who was away would usually be looked after by the colleague who stood in for him.

Good family doctors on the staff of a teaching hospital, perhaps looking after some of their own patients, would enable students to see something of the types of cases G.P.s have to treat, not all of which would be admitted in the ordinary way to a hospital attached to a medical school. They could see, too, the sort of co-operation that is needed between family doctors and specialists. Experienced general practitioners, while gaining much themselves, would have something of value to impart to students, junior medical staff, nurses, and consultants.

(4) General-practitioner Beds in Private Hospitals and Nursing-homes

In the reforming atmosphere after the second world war there were those who thought that private practice would soon disappear and that all private hospital beds would be taken over by the State. But the larger and more unwieldy an organization like the National Health Service becomes, and the more the responsibility for running it devolves on one man, or on one department dependent on the Treasury, the greater is the need for other experiments carried out by more flexible organizations and by private individuals. In his first major speech as Minister of Health, Mr. Enoch Powell said:

"The great machine is bound to have a one-track mind, to be cumbrous and unresponsive, to abhor variations, to be insensitive to the world around it. These disadvantages apply anywhere; but in the field of health and medical care they could be specially dangerous." (Executive Councils' Association, 1960.)

In his more recent Winchester Address he said:

"If anyone wishes to add . . . how important it is that there should always be a substantial amount both of research and of treatment which is not financed by the State and for which the Minister is not responsible, I should be the last person to argue against him." (Powell, 1961 (b).)

The British Medical Association has constantly recognized the importance of maintaining and encouraging the existence of private practice side by side with the National Health Service.

In this country, private hospitals are financed directly by patients or indirectly through non-profit-making contributory insurance schemes which shield their subscribers from heavy expenses arising from unexpected illness, accidents, or operations. Some of these schemes cover a person not only for specialist and hospital services but also for general-practitioner treatment.

A private hospital usually offers advantages to a patient which he may not always get in a State-financed hospital. He can often be admitted at once or on the day of his choice. He can generally have a private room. His family doctor can visit him regularly, prescribe some part of the treatment, and discuss freely with him his troubles and difficulties—providing a happy liaison between patient, consultants, and nursing staff. A patient can have the consultant of his or his doctor's choice; he can talk to him frequently, freely, and if necessary alone—a most important asset. Nursing may sometimes be more personal in a private hospital. Other less obvious advantages are that visitors can come and go easily; a telephone or a secretary by the patient's bedside may enable him to do some useful work; and the food may be better, with more choice and more attractively served. No one of these points taken alone is of paramount importance; but added together they

may mean a great deal to an ill patient, and are advantages for which many people are willing to pay, through insurance or otherwise.

Every patient who is admitted to a private hospital bed saves the National Health Service a considerable sum of money, and lessens the strain on N.H.S. doctors and hospitals. Many people in Great Britain who use the N.H.S. attend private doctors, too, for some of their medical care. Members of Parliament and Cabinet Ministers have sought medical advice outside the N.H.S. during the past ten years, and even Ministers of Health have been known to do so. Some firms insure their employees for private treatment to save time wasted in waiting for admission to hospital. Already one-quarter of the doctors resident and working in Great Britain have insured themselves and their families for treatment in private hospital beds. While appreciating the good points of the National Health Service, with the great benefits it has brought, we should not be ashamed of our privately financed medical care. We should accept it and improve it, and welcome it as a necessary and important adjunct to the health services. Hospital beds outside the N.H.S. will play in future an increasingly important part in it. With the recent rapid extension of private medical insurance their number and distribution should be re-examined: in some places they are not fully occupied; in others, more are needed.

Conclusions

The two main reasons for a family doctor to work in a hospital are (1) to give continuing personal care to some of his own patients admitted with conditions which he can properly treat himself and which do not need full consultant supervision; and (2) to promote his continuing education as a clinical assistant for one or two sessions a week, with or without a special interest, so that he may be a better doctor to his own patients. He can help the hospital service greatly in both these ways. With the present shortage of general practitioners, proposals that they should work in hospitals, on a large scale, for any other reasons than these should be examined extremely carefully.

Recent trends, and information from various sources, suggest that moves may be afoot to deprive general practitioners of the few hospital beds (apart from normal midwifery) for which they are still responsible, and to offer them a number of appointments in hospital assistant grades with *daily* routine duties caring for the patients of other doctors. In this review reasons are given for believing that general practice would be seriously handicapped by either of these measures.

It is now appreciated that the National Health Service was planned, its rules and regulations laid down, and its financial arrangements made before the proper role of the general practitioner was understood. A special committee of the Central Health Services Council has been set up recently to study the future scope of general practice, and the necessary adjustments in the organization and finance of general-practitioner hospital beds should be made as soon as possible. Family doctors with adequate experience should be encouraged to treat, in hospital, suitable patients from their own practices, with close and efficient consultant cover in an advisory rather than a supervisory capacity. The number of general-practitioner beds should be increased gradually wherever this is practicable—in general-practitioner

hospitals in rural districts (and in some urban areas), in annexes or wards of general hospitals in large towns and cities.

The hospital services are greatly helped, and the continuing education of general practitioners is advanced, when they work in wards or out-patient departments of larger hospitals as "clinical assistants" for not more than one or two sessions a week under the supervision of consultants. More of these appointments are needed. Senior and junior grades of clinical assistantships should be officially recognized and introduced into specialist teams with different rates of pay and differing degrees of responsibility. The senior grade should be long-term appointments, perhaps for several years, in which general practitioners with special interests and experience could play a really useful part in the work of hospitals, in a more important and responsible role than that of clinical assistants at present. The junior grade could be short-term appointments for those learning to develop special interests or striving to maintain their continuing education.

These measures should go far towards closing any "rifts" or "gaps," where they exist, between family doctors and consultants and between general practice and hospital work; and it should lead to better and much-needed integration, and happier co-operation, between these two great branches of our profession.

REFERENCES

- British Medical Association (1952). Report of the Committee on *The Association of the General Practitioner and Hospital Work*, (a) p. 1-11, (b) p. 8.
- (1953). Report of the General Practice Review Committee, *Brit. med. J. Suppl.*, 2, 103.
- (1960). Report of the General Medical Services Committee to the Annual Conference of Local Medical Committees, Appendix C, pp. 31-40.
- (1961). General Practitioners and Hospital Staffing; comments sent to the Minister of Health by the General Medical Services Committee, *Brit. med. J. Suppl.*, 2, 131.
- Cohen, H., et al. (1954). Report of the Committee of the Central Health Services Council on *General Practice Within the National Health Service*, p. 41.
- College of General Practitioners (1956). Memorandum of the South-east England Faculty on *The Problems of the Relations of General Practitioners with the Hospitals in the United Kingdom*, p. 13.
- (1960). Evidence submitted to the Joint Working Party of the Ministry of Health and the Department of Health for Scotland on *Medical Staffing Structure in the Hospital Service*, p. 7.
- Crombie, D. L., and Cross, K. W. (1959). *Med. Press*, 242, 316.
- Davies, A. B. (1961). *Brit. med. J. Suppl.*, 2, 74.
- Executive Councils' Association (England) (1959). Memorandum on *The Provision of Additional Beds in Hospitals to Enable General Medical and Dental Practitioners to Retain Responsibility for the Treatment of Their Own Patients*, p. 7.
- (1960). Record of Proceedings at the 13th Annual Meeting (Llandudno), October 27, 1960, p. 113.
- Forsyth, G., and Logan, R. F. L. (1960). *The Demand for Medical Care*, p. 105. Oxford University Press for the Nuffield Provincial Hospitals Trust.
- Fox, T. F. (1960). *Lancet*, 1, 743.
- Hunt, J. H. (1951). "A Diagnostic Unit for Practitioners and its First Five Years' Work," *Brit. med. J.*, 2, 1575.
- (1955). *The Scope and Development of General Practice in Relation to Other Branches of Medicine*, *Lancet*, 2, 681.
- Idris-Lewis, R. (1961). *Pulse*, 2, No. 19, 1.
- Ministry of Health (1961). Report for the Year ended December 31, 1960, Part I, Appendix 3, pp. 176, 181.
- Osmond-Clarke, H., et al. (1961). Interim Report of the Accident Services Review Committee on *The Accident Services of Great Britain and Ireland*, p. 18.
- Platt, R., et al. (1961). Report of the Joint Working Party of the Ministry of Health and the Department of Health for Scotland on *Medical Staffing Structure of the Hospital Service*, H.M. Stationery Office, (a) p. 49, (b) p. 46, (c) p. 36, (d) p. 40, (e) p. 34, (f) p. 46.
- Powell, E. (1961). (a) *The Times*, July 12, p. 14. (b) *Brit. med. J.*, 1, 1479.
- Royal College of Obstetricians and Gynaecologists (1958). Evidence submitted to the Royal Commission on *Doctors' and Dentists' Remuneration* (Chairman, Sir Harry Pilkington), Appendix, p. 13.
- Schuster, G. (1961). *Practitioner*, 187, 92.
- Scottish Health Services Council of the Department of Health for Scotland (1952). Report on *The General Practitioner and the Hospital Service*, p. 21.
- Sellers, T. Holmes (1961). Paper read at the B.M.A. Annual Clinical Meeting at Canterbury in April, on *Future Developments in Hospital Planning and Design*. Not yet published.
- Taylor, S. J. L. (1954). *Good General Practice*, p. 350. Oxford University Press.
- World Medical Association General Assembly (1949). Quoted in the Report of the Hospitals Subcommittee of the General Medical Services Committee of the B.M.A., 1959, p. 5.

NEUROPATHY AFTER INTAKE OF THALIDOMIDE (DISTAVAL)

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There have been recent reports of cases of peripheral neuritis attributed to a toxic effect of thalidomide ("distaval") (Florence, 1960; Burley, 1961; and Kuenssberg et al., 1961). This paper is based on 13 patients who developed neurological disturbances while taking this drug as a hypnotic. The neuropathy is interesting, with some evidence that abnormalities are not confined to the peripheral nervous system.

Clinical Features

Details of the cases are shown in the Table. The ages of the patients ranged from 37 to 76 years. All had taken thalidomide regularly for 2 to 18 months before the onset of symptoms. In most cases the dose had been the usual one of 100 mg. each night, although a few had taken higher doses (up to 400 mg. nightly) and one had had only 50 mg. nightly.

The earliest symptoms were paraesthesiae and numbness in the feet followed by similar symptoms in the hands, usually a few months later. These disorders of sensation were the most prominent feature in all cases, and weakness of the limbs was a minor complaint in five and of major importance in only one. Seven patients complained of cramps in the legs as one of their most distressing symptoms.

All patients were carefully cross-examined for evidence of other neurotoxic exposure. Only one (Case 9) gave a history of excess alcohol consumption, after the onset of a depressive illness. He had taken a bottle of spirits daily for 16 months before the onset of symptoms. However, in this patient, many features, such as proximal weakness in the limbs, increased reflexes, and equivocal plantar responses, indicated that he was not suffering from an alcoholic peripheral neuritis. No other aetiological factors could be elicited from the history of the remaining patients.

Neurological examination showed altered superficial sensation of varying extent in the distal parts of the limbs in all patients. Eleven showed depression of all