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The hospitals we need

The district general hospital, once the star of the DHSS planning department, has been waning in official popularity for the last ten years. The early vision of every NHS district having one or more hospitals of 600-800 beds has been abandoned—largely because it is clear to all concerned that there is no chance of enough of them being built while current financial policies remain in force. Instead the planners have begun to talk of community hospitals and more recently nucleus hospitals, claiming that a combination of these could provide just as good a service. At the height of enthusiasm for the district hospital plan a start was made on closing the old, small, and scattered buildings throughout the country. Closures were often delayed by vociferous local opposition, however, and today almost half our non-psychiatric beds are still in hospitals with fewer than 250 beds. Many of these buildings are now seen to have a future as community hospitals, if the new philosophy endures: but in fact the total halt on new building projects imposed by the DHSS has frozen their transition into immobility.

Is this latest switch in policy justified? Or is it yet another example of that most damaging feature of DHSS planning, its total commitment to the latest theory? Only too often we have seen policies formulated and applied nationally without any trial or assessment, so that when second thoughts have led to changes the whole cumbersome structure has had to be put into reverse to lumber off in a different direction. Is this the latest example?

One region which has carried out some hard research is Oxford, where the university's Health Services Evaluation Group has recently assessed the cost-effectiveness of community hospitals. In Oxford these units have inpatient beds under the control of general practitioners, with consultant collaboration; a health centre on the same site; specialist clinics held by visiting consultants; and day ward facilities. Patients include those needing inpatient care before convalescence after an operation at the district hospital, acute medical cases needing continuous nursing care, medical patients transferred from elsewhere, holiday admissions, and patients needing terminal care.

The Oxford team's analysis of the cost-effectiveness of two of these small units has shown some of their advantages but has also destroyed several widely held beliefs. The capital cost of converting our existing cottage hospitals into community hospitals would be small—far smaller than building

new district general hospitals or extending old ones. Necessarily, however, the type of treatment that could be offered in the converted accommodation would be limited. When it came to assessing the cost of treatment the report was less encouraging. Use of a community hospital for the post-operative care of surgical patients proved more expensive than keeping them in the district hospital (transfer costs were an important factor unless the period of care required was very long). Nursing costs (always high in small units) meant that acute medical cases, too, could be treated more cheaply in the DGH than the community hospital. These cost differences could be eliminated by operating the community hospital with a lower nursing complement; but that would lead, almost inevitably, to a lower quality of care.

The report accepts that this analysis could not take account of the potential qualitative benefits of community hospitals: the friendly, unstressed atmosphere; the proximity to the patient's home; staffing by local people; and supervision by the patient's own general practitioner. These, it suggests, are features likely to be preferred by the elderly. Younger patients might prefer the bustle of a busy ward in a district hospital, the sense of anonymity from being treated by staff unknown previously, and the greater confidence in the facilities for dealing with emergencies or complications.

The report has killed a myth: that community hospitals offer a cheaper alternative to the facilities offered by a district hospital. Without doubt community hospitals could offer a service. Some patients could be treated there instead of at the district hospital, and, though the cost might be slightly greater, both patients and staff might well be more content. Many of the beds in such a hospital, however, might become filled by patients who would have otherwise been nursed at home, far more cheaply and almost as effectively. Community hospitals may be desirable, but they may prove an extravagance and not an economy. If that assessment is correct the planners will have to think yet again. The attraction of the community/nucleus hospital scheme lay, no doubt, in its cheapness in terms of capital costs. If, however, the running costs would be higher and the quality of care provided possibly lower than those of the district hospitals, such attractions would be illusory. The unfortunate fact of life is that replacement of an old, worn-out hospital by a new one inevitably leads to higher costs, for the new structure allows and encourages a higher standard of nursing care and medical treatment. Cheap

answers to problems of hospital building may prove second-rate solutions.

Yet we still have too little evidence on which to base decisions. The Oxford report drew its data from two tiny units. Surely the reasonable conclusion is that we do not yet know the best compromise between costs, medical efficiency, and what the patient wants. That being so, the planners might consider a more flexible approach. Why not offer a choice to one or two regions to act as pilot schemes based on one or other philosophy? Comparative trials have proved invaluable in clinical medicine; they may have a place in administration too.

¹ Rickards, J A, *Cost-effectiveness Analysis of the Oxford Community Hospital*. Oxford, Department of the Regius Professor of Medicine, 1976.

Left atrial myxoma

Cardiac myxoma is one of those conditions whose rarity is matched only by the satisfaction of diagnosing and treating it. Occurring at any age but more often in women, such tumours, probably of mesenchymal origin, may be found in any chamber of the heart. Most commonly, however, they develop in the left atrium, where they usually arise from a pedicle on the atrial septum. Right atrial myxomas¹ are three to four times less common and ventricular ones even rarer. Necropsy evidence shows myxomas to constitute some half of all cardiac tumours.²⁻⁴ Macroscopically they may appear as either a firm globular or a soft polypoid mass, while microscopically there is endothelium covering an amorphous matrix containing malformed vessels, cords of vasoformative cells, and areas of necrosis and haemorrhage, together with a variable infiltrate of siderocytes, giant cells, lipophages, polymorphs, and lymphocytes.⁵

The clinical features of left atrial myxoma are protean and have been copiously described,⁶⁻¹⁰ but new modes of presentation continue to occur, and isolated case histories are still being published. A left atrial myxoma becomes manifest by causing obstruction to the mitral valve or the pulmonary veins (often with secondary pulmonary hypertension), by systemic emboli, or more mysteriously by constitutional effects such as loss of weight, fever, anaemia, raised sedimentation rate, or an increase in gammaglobulin production. One of the most useful clinical reviews was that of Goodwin,⁸ who collected details of 45 patients from the Hammersmith Hospital and members of the British Cardiac Society. In this series the commonest constitutional features were raised sedimentation rate and fever, while dyspnoea, pulmonary hypertension, and mitral murmurs were the commonest obstructive features.

When suspicion has been aroused the diagnosis must be confirmed by demonstrating a filling defect in the left atrium on angiography, first reported by Goldberg and colleagues in 1952.¹¹ The left atrium should be outlined by injecting contrast into the pulmonary artery, for transseptal catheterisation carries the risk of dislodging fragments of tumour.^{12 13} The advent of echocardiography, though not yet replacing angiography, has provided a safe, non-invasive method of investigation. Since the first report of its use in the diagnosis of an intra-atrial tumour¹⁴ improved techniques have established its value. In using the conventional approach the ultrasonic beam is directed posteriorly from the fourth left intercostal space while the operator searches for echoes beneath the anterior

mitral valve cusp during diastole. These will be evident only if the tumour or part of it slips through the mitral valve during diastole. In a more recently described modification¹⁵ the beam is directed inferiorly from the suprasternal notch to traverse the aortic arch, right pulmonary artery, and left atrium. Petsas and colleagues¹⁶ have shown the usefulness of this method in a report of three cases of left atrial myxoma in which the tumour appeared as a cloud of echoes in the cavity of the left atrium.

¹ Morrissey, J F, *et al*, *American Heart Journal*, 1963, **66**, 4.

² Yater, W M, *Archives of Internal Medicine*, 1931, **48**, 627.

³ Fawcett, R E M, and Ward, E M, *British Heart Journal*, 1939, **1**, 249.

⁴ Pritchard, R W, *Archives of Pathology*, 1951, **51**, 98.

⁵ Hudson, R E B, *Cardiovascular Pathology*, p 1565. London, Edward Arnold, 1965.

⁶ Campeau, L, and David, P, *Canadian Medical Association Journal*, 1960, **82**, 586.

⁷ Aldridge, H E, and Greenwood, W F, *British Heart Journal*, 1960, **22**, 189.

⁸ Goodwin, J F, *Lancet*, 1963, **1**, 464.

⁹ Greenwood, W F, *American Journal of Cardiology*, 1968, **21**, 367.

¹⁰ Peters, M N, *et al*, *Journal of the American Medical Association*, 1974, **230**, 695.

¹¹ Goldberg, H P, *et al*, *Circulation*, 1952, **6**, 762.

¹² Marpole, D G F, *et al*, *American Journal of Cardiology*, 1969, **23**, 597.

¹³ Pindyck, F, *et al*, *American Journal of Cardiology*, 1972, **30**, 569.

¹⁴ Effert, S, and Domanig, E, *German Medical Monthly*, 1959, **4**, 1.

¹⁵ Goldberg, B B, *Journal of the American Medical Association*, 1971, **215**, 245.

¹⁶ Petsas, A A, *et al*, *British Heart Journal*, 1976, **38**, 627.

Audit again

A new, and possibly useful, vocabulary is creeping into our jargon-ridden profession—peer review, utilisation review, activity analysis, medical audit. As Irving and Temple indicate on page 746, we are still largely at a loss to define these terms, either in a straightforward semantic way or in the effect they might have on human behaviour. Indeed, here lies the rub of the problem: if we are seized with the principle of self-examination as a good thing, how do we translate the idea into reality and how do we find out if it works? Furthermore, *Quis custodiet ipsos custodes*? How do we ensure that standards set and corrective action taken mirror the needs of the community and do not destroy personal endeavour? Could we not rely on the innate sensitivity of the profession to the need to maintain standards, rather than constantly thrust the minutiae of performance under the noses of those who are at the sharp end of clinical practice?

These, and many other questions, are prompted by Irving and Temple's review of medical audit in a surgical setting. They describe all the care, which Dudley has also noted,¹ needed to nurture the delicate plant of open self-criticism. They take us clearly and instructively up the familiar climb of gradual acceptance of non-threatening debate. They have reached a plateau from which it might be possible to attack the real problem of altering human attitudes. It is here that they are on less secure ground. Such evidence as there is (and admittedly it is scanty) does not suggest that isolated debate—however amusing, cathartic, and apparently educational—has direct effects on how things are done. Indeed, medical audit often has many of the characteristics of a ritual rather than an instructive or constructive exercise and may be received by medical staff with indifference.² To air problems is one thing; to change behaviour is another.

These criticisms apart, it may be argued that *information* means *control*: to know about the incidence of complications, to have comparative statistics on length of stay, will auto-