General Practice Observed

The community hospital: a three-year study

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Summary

In a three-year period a community hospital of 40 beds discharged 2086 patients, their mean length of stay being 14.8 days. Some 68% of the patients treated were over 65, and 8.9% died in hospital. While the most common diagnosis on admission was disease of the respiratory tract, this does not indicate the actual cause of admission. For 142 patients from one practice this was acute illness in 44% of the cases, assessment in 20%, and a need for nursing care in 36%. If the community hospital had not been available about half these patients would have been admitted to the general hospital.

Introduction

The importance of general-practitioner hospitals in the overall health care plan was acknowledged in 1974, when the Department of Health and Social Security¹ laid down a firm framework in which general-practitioner hospitals could develop.

To evaluate performance and help in the future planning of such hospitals data on how they work must be available. This information is important in evaluating the relevance of operational criteria. To date, the only details available on a hospital run strictly along community hospital lines are from a small pilot study² carried out on 187 patients discharged from a hospital of 15 beds in one year. We have analysed 2086 discharges over three years from a community hospital of 40 beds.

Barry Community Hospital

Barry is a seaport and holiday resort with a population of about 40 000, although in the summer this may increase by as much as 25%. With the reorganisation of the hospital service the Barry Accident and Surgical Hospital was closed down, and on 13 August 1972 it was reopened as a community hospital. At that time 14 of the 19 general practitioners in Barry agreed to accept beds at the hospital, and currently 13 doctors share 40 beds. Bed allocation is run informally, being co-ordinated by the senior nursing officer, and this system works well. There are facilities for radiological investigation of inpatients and outpatients and also for patients of doctors who do not hold a contract at the hospital. Cholangiography and intravenous pyelography are performed, but barium studies are done at the district general

hospital. This outpatient facility provides a useful method of screening for fractures, although an accident service is not provided. Minor injuries, however, may be treated by general practitioners in a treatment room at the hospital.

Electrocardiograms are recorded by a visiting cardiographer and reported on by a consultant physician, while samples for pathological examination are collected daily and taken to the appropriate department of the district general hospital. Daily outpatient clinics of the district general hospital are held in a nearby annexe and visiting consultants are prepared to see any patient at the community hospital should a second opinion be needed.

Patients suitable for admission to the community hospital include: (a) medical cases admitted for social reasons and when relief to the domiciliary nursing service is needed; (b) predischARGE, postoperative surgical cases from most surgical departments; (c) selected short-stay geriatric patients; (d) patients with an acute episode of a chronic illness; (e) selected transfers from acute treatment departments; (f) holiday admissions; (g) selected terminal-care patients; and (h) mentally ill and handicapped patients needing community support rather than psychiatric or specialised treatment.

Children, grossly disturbed patients, inpatients needing the full facilities of an acute department, and maternity cases are not admitted.

Results

We studied the hospital's activities from 13 August 1972 to 12 August 1975 and report here the findings in each six-month period. Most of the data were taken from Hospital Activity Analysis. Bed occupancy, however, was derived from the hospital returns, and reasons for admission were evaluated from individual patients' notes.

During the three-year period 2086 patients were discharged. Some 68% of them were over 65 (table I). Their mean length of stay was 14.8 days (table II), 474 (22.7%) of them staying longer than the 21-day limit. In the first two years two patients stayed 123 days and 129 days, while 12 patients stayed between 50 and 100 days. Since the hospital opened, the half-yearly bed occupancy has risen from 70% to 85%.

Table III gives the sources of admission and disposal of patients on discharge. Altogether 1840 patients (88.2%) were admitted direct from home, the remainder being transferred from other hospitals; 1602 (76.8%) were discharged to their homes, 288 (13.8%) referred to other hospitals, and 10 (0.5%) discharged to convalescent or welfare accommodation. A total of 186 patients (8.9%) died.

TABLE I—Distribution of patients by age expressed as percentage of total discharges in each six-month period

Age (years)	Six-month period					
	1st	2nd	3rd	4th	5th	6th
<25	1.7	2.8	2.5	3.2	1.8	1.8
25-34	3.7	1.8	4.6	3.8	2.4	1.1
35-44	5.1	5.6	4.3	3.8	2.8	4.2
45-54	8.0	9.6	9.4	9.4	7.1	3.8
55-64	9.4	15.2	15.1	16.2	14.1	12.5
65-74	32.3	30.5	24.8	25.1	29.1	29.8
75-84	32.3	22.8	29.7	25.4	30.4	33.2
≥85	7.1	7.4	8.9	12.7	11.7	10.9
Not known	0	4.4	0	0.3	0.9	2.6
Total No of patients	372	394	390	339	326	265

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TABLE II—Distribution of lengths of stay expressed as percentage of total discharges in each six-month period

Length of stay in days	Six-month period					
	1st	2nd	3rd	4th	5th	6th
≤	9.0	6.7	6.7	6.5	7.4	4.5
2-6	16.6	19.9	22.0	15.3	18.4	13.2
7-13	30.8	28.7	29.4	29.1	29.8	26.0
14-20	23.1	26.4	22.9	24.2	18.1	29.4
21-28	18.6	11.7	11.0	15.2	12.6	15.8
>28	1.9	6.7	8.1	9.8	13.8	10.9
Total No of patients	372	394	390	339	326	265
Mean stay in days	12.2	13.0	13.3	15.6	17.2	17.2

TABLE III—Source of admission and disposal of patients expressed as percentage of total discharges in each six-month period

	Six-month period						Average
	1st	2nd	3rd	4th	5th	6th	
Source of admission:							
Direct from home	89.5	82.3	87.9	90.7	92.0	87.9	88.2
Transferred from hospital	10.5	17.7	12.1	9.3	8.0	12.1	11.8
Disposal of patients							
Home	78.6	77.6	77.0	77.2	69.0	81.5	76.8
Other hospitals	11.2	14.8	13.2	14.0	17.2	12.1	13.8
Convalescent or welfare homes	0.5	0	0.7	0.9	0.9	0	0.5
Died	9.7	7.6	9.1	7.9	12.9	6.4	8.9
Total No of patients	372	394	390	339	326	265	2086

During the first two years the most common diagnosis made was disease of the respiratory system (table IV); however, 43 patients were admitted with acute myocardial infarcts. Analysis of the reasons for admitting 142 patients from one practice in five months (table V) showed that 62 (44%) were admitted for an acute illness, 28 (20%) for assessment, and the remainder for nursing care.

TABLE IV—Diagnosis of patients discharged expressed as percentage of total discharges in each of the first four six-month periods

Diagnosis	Six-month period			
	1st	2nd	3rd	4th
Neoplasms	7.9	7.4	8.7	9.9
Diseases of:				
Cardiovascular system	19.9	21.0	20.1	19.0
Respiratory system	18.2	22.2	30.6	20.8
Central nervous system	12.9	8.5	9.6	7.6
Genitourinary system	4.0	4.0	4.7	5.5
Musculoskeletal soft tissue and skin	14.6	13.9	10.5	10.5
Gastrointestinal system	12.5	13.9	13.1	19.3
Haematological disease	3.6	2.0	1.7	2.9
Endocrine and metabolic disease	2.6	3.1	0.6	1.8
Miscellaneous diseases	3.3	4.5	0.8	2.6

TABLE V—Reasons for admitting 142 patients from one practice. Results expressed as percentages of patients

Reason for admission	Age in years			Total
	<45	45-64	≥65	
Acute illness	4.9	5.6	33.8	44.3
Family relief	0.7	0	11.3	12.0
Assessment	1.4	4.2	14.1	19.7
Chronic illness	0.7	2.1	5.6	8.4
Surgical transfer	1.4	2.8	3.5	7.7
Medical transfer	0	1.4	2.8	4.2
Terminal care	0	0	3.5	3.5

Of the 186 patients who died, 157 (84%) were aged 65 or over and had a mean length of stay of 10.8 days before death. The 29 patients aged under 65 had a mean length of stay of 10.5 days before death (table VI).

TABLE VI—Mortality and average length of stay before death in days expressed as percentage of total discharges in each six-month period

	Six-month period					
	1st	2nd	3rd	4th	5th	6th
Aged under 65	0.5	1.1	1.0	1.2	1.8	3.0
Average stay in days	5.5	7.5	15.4	4.5	10.3	19.6
Aged 65 and over	9.2	6.5	8.1	6.7	11.1	3.4
Average stay in days	6.9	8.2	14.2	10.0	12.7	12.7

Discussion

This study was carried out to evaluate the feasibility of maintaining a strict operational policy. The inpatient data from seven other general-practitioner hospitals have been reviewed, but comparison is difficult. Apart from the Oxford study² none of the hospitals conform strictly with the community hospital concept, while two—at Tamworth³ and Brecon⁴—undertake elective surgery.

In all cases most patients are admitted direct from home. At Barry an average of 88.2% of the patients were admitted direct from home during the three years, the remainder being admitted from the district general hospital for postoperative care or for medical care not available in a convalescent home. This proportion remained fairly constant over the period and was comparable to the 70% in the Oxford study and the 92% in the Tamworth general-practitioner hospital study. In Barry 68% of the patients admitted were over 65. In Oxford only 60% of the patients were over 60, and in the hospitals at Tamworth, Brecon, and Bangour⁵ 35%, 43%, and 43% of the patients respectively were over 60.

One criticism of general-practitioner hospitals has been that they tend to become long-stay geriatric units. In Barry a three-week limit was agreed, while at Oxford and Bangour the limit was four weeks. By adhering vigorously to these limits a rapid turnover may be achieved. At Bangour the mean length of stay was 6.3 days, while Oxford and Barry compared favourably with 15.3 and 14.7 days respectively. At Brecon, Crickhowell, and Birmingham⁷ the stays were 10, 13.4, and 16 days respectively. At Barry the mean length of stay rose slightly over the three-year period together with the number of patients who stayed above 21 days. In the first two years of operation 14 patients stayed longer than 50 days, owing mainly to failure of the social services to find adequate accommodation.

The most common diagnosis on admission was disease of the respiratory tract (table IV). The principal diagnosis, however, does not indicate the true reason for admission. Thus a patient with a malignancy may have been admitted for investigation, postoperative care, treatment of complications, or terminal care. Analysis of the reasons for admitting 142 patients from one practice showed that 62 (44%) were admitted for an acute illness, 28 (20%) for assessment, and the remainder for nursing care. This compares favourably with the Tamworth study, in which, with the exclusion of surgical patients, 43% were admitted for treatment and 16% for investigation. For the 142 patients at Barry the alternative arrangements that would have been made had there not been a community hospital were considered: 15% would have remained at home, 53% would have been acute medical admissions, 12% would have been admitted elsewhere, and 20% would have been referred to an outpatient clinic. At Oxford it was judged that 45% would have remained at home and 50% would have been admitted immediately to the district general hospital, while at Crickhowell the figures were 21% and 73% respectively. These differences emphasise the subjective nature of the evaluation of patients' requirements.

Bennett⁸ outlined the difficulties in allocating a patient correctly, and this is one of the major problems in using a community hospital. Nevertheless, one group that may be readily identified as suitable for community hospital care is terminal admissions. Isaacs *et al*⁹ defined a stage of "predeath

dependency" and identified a need for short-term terminal nursing. At Barry 8.9% of the patients died, the average length of stay before death being 10.6 days, while at Oxford 15.2% of the patients died with a mean stay of 15.4 days.

We have provided descriptive information on the running of a typical community hospital and shown that such a unit can be run effectively and within the constraints laid down by an operational policy whereby a high turnover is maintained. The major problem, however, is in identifying groups of patients who may be effectively treated in the community hospital. Certain groups may readily be identified as suitable for care, such as short-stay terminal patients and patients admitted for family nursing relief. Other groups, however, such as acute medical admissions and postoperative transfers are more difficult to define. Despite this problem, which may be only partially resolved by evidence derived from randomised controlled trials on the outcome of care, the community hospital adds a valuable dimension to primary care.

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Aspects of Student Health

Counselling and the student

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A counselling encounter

A new client. He sits hunched up in the waiting area pretending to read the *Guardian*, but the restless eyes betray his fear and apprehension. "You must be John." He jumps up at this and manages a frail smile. It is impossible to know whether he is pleased to be addressed by his first name or whether he is suspicious and on guard. I think he is pleased, but I cannot be sure and as the door closes behind us it is my turn to feel apprehensive. Every counselling encounter is a risk, and although this is my ninth year as a counsellor the risk does not diminish.

Gradually he reveals himself. This is not the first university he has attended. He graduated at Oxford last year and now he is here to do postgraduate work—something to do with the nineteenth century novel. His smile, I notice, is automatic and is always accompanied by a frown. The frown looks real. He talks with a degree of fluency, but I sense that we are moving beyond the bit he has rehearsed. He cannot settle down here, he says. He likes Norwich, but the university buildings he describes as oppressive and impersonal. He finds it difficult even to open a book, and he has already lost interest in his research subject. Last week his girlfriend of two years' standing wrote a "let's just be friends" letter. The misery flows out of

him, and the smile gives way to a trembling of the lips that heralds the approach of tears.

As I touch him gently on the hand he enters fully into his own well of anguish and sobs convulsively. I hold him and ask if he wants me to do that. He indicates that he does, and I feel myself relax as I encourage and accept his tears. Later he tells me that he has not wept for 10 years and never before in the presence of a man. He is 23. When the weeping stops he goes on to describe the pointlessness of his existence and the punishing conscientiousness that had driven him to his Oxford first and enabled him to cock a snook at those who for three years had excluded him from the sanctuary of their intimacies. He talks of his relations with Ruth, a "kind of narcotic" under whose influence his sense of existential absurdity was temporarily dimmed. The words tumble out of him and he quotes Sartre, Nietzsche, Camus, and others with the angry relish of one who is determined to own and cultivate an inescapable despair. He is ashamed now of the tears, and obliquely he directs his hostility at me and challenges me to say something. I wonder at the punishment he has inflicted on himself for so long and at the powerful battalion of famous supporters he has recruited to help him in his cruel task. I ask him gently why he does not leave the university tomorrow or perhaps today. It is one of those frightful moments when I feel the tension in my chest, and I know that John's world and mine are no longer divorced.

Students' concerns

John's complex anguish incorporates many of the common strands that bring students to a counsellor's door. He is at odds with the academic process itself, and yet it is on the academic altar that he has made so many sacrifices in the past. He cannot

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