My recent experience has shown that many patients who would previously have been admitted to hospital can, in fact, be treated at home with great success.

It is vital to think of mental illnesses rather than mental illness, since the needs of patients suffering from different types of psychiatric illness are widely different. For example, a patient with a phobic anxiety state—whose problem is that she cannot enter shops, travel by bus, and so forth—will clearly benefit from a type of treatment which can be given to her in her own home, whereas a wife with a puerperal psychosis may need admission to hospital to remove her from the stressful environment which will interfere with her rapid recovery. So we can consider the subject of early discharge from the standpoint of the patient, relatives, general practitioner, and nursing services.

The patients' expectations on admission to hospital affect the use that they make of the hospital admission, and their expectation that their stay will be brief will not lead to their feeling rejected or under-treated. Relatives, equally, often feel that there is some relationship between the time a patient spends in hospital and what can be achieved. Carefully planned active treatment with the elimination of unnecessary delays in organization and investigations can lead to very rapid treatment and early discharge.

General practitioners often regard patients who have been referred to psychiatrists (and particularly patients who have been admitted to hospital for treatment) as no longer their concern, and here too the reasons behind an early discharge policy will have to be explained to family doctors.

Liaison among all the services involved in the management of the patients is vital. Active transfer of information about the patient's state, treatment, and follow-up must be available to the general practitioner before the patient is discharged. In view of the delays which frequently occur in the postal service, a telephone call may be more appropriate. Active support systems—for example, community psychiatric nurses, psychiatric social workers, and health visitors—will need to be primed and involved in the therapeutic regimen. Access to early readmission if treatment is not progressing satisfactorily will encourage both doctors and nurses to accept patient's discharge from hospital before treatment has been completed. Education of the general practitioners to expect patients to return to their care before treatment has been completed is also important, as is the continuity of therapy.

Investment in Support Services

It is important that the money which would have been spent on hospital beds is invested in support services, both nursing and medical, while employers may have to be more flexible in accepting that patients will return to work on a part-time basis.

My own discharge policy takes account of the fact that the community and the patients can tolerate a particular level of symptoms before requiring admission to hospital. Equally I think that the patient can be discharged from hospital before total recovery has taken place, provided that his symptoms have been adequately reduced. The community can cope with early discharge provided adequate support is mobilized, provided there is adequate transfer of information from hospital to general practitioner, and provided that support in the patient's home is available. The success of an early discharge policy depends on a rapid feed-back of information about the patient's state and also on setting up an early warning system to prevent the possibility of relapse.

Early discharge from hospital may not necessarily be to the patient's home. Group homes and halfway houses, where they exist, sometimes provide a suitable stepping stone between hospital and home. Day hospitals, which provide an effective mixture of social support and active psychiatric treatment, again provide an interim stage between inpatient treatment and full discharge. Though the formal organizations may not be able to provide adequate befriending, in addition to their suicide prevention work, the Samaritans also accept referrals to provide support to lonely isolated people. Nevertheless, the relatives must not be over-stressed and other voluntary organizations—for example, the National Schizophrenia Fellowship—should be brought in to help them cope with the burden of patients with chronic mental illness.

Early discharge of patients suffering from affective illness or from phobic disorders is unlikely to result in the patient wandering away from home or hostel. Nevertheless, patients suffering from schizophrenia frequently wander away from home or from treatment, and present legislation makes it difficult to enforce outpatient care. Thus, if a pattern of care for schizophrenia swings away from inpatient care

—and indeed there are many arguments in favour of this—I believe that it will be necessary to introduce legislation to enforce attendance at an outpatient clinic, just as present legislation enforces admission to hospital for treatment.

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Do Doctors Need to See Everybody?

R. H. Hardy

The answer to this question is an emphatic "No." One feature that general practice and the hospital accident service have in common is the increase in demand for medical services. It is difficult to measure this in the former, but some of my own figures for a regional hospital illustrate it well for the latter. Between 1965 and 1973 first attendances in the Hereford Accident Department rose from 6,900 to 16,600 annually, an overall increase of 250%. In the same period the population concerned rose from 138,250 to 140,700—an increase of about 1.8%. Analysis of these figures has shown no identifiable cause for the rise—such as an increase in industrial or road traffic accidents, or increased summer holiday invasion—and they must represent a true increase in demand. My own experience in general practice also supports this conclusion. These figures are from an area where there is a tradition of responsible general practice of a high quality and our relations with the family doctors are good. To some extent, therefore, our accident department can largely select and control its own work load, which is essential for effective running with limited staff and premises. Nevertheless, there is always a residuum of patients who have to be seen by the accident service, who are left largely unaided by the reorganized general practitioner service and increasingly busy practitioners of sophisticated hospital medicine.

Those working in accident departments recognize that there is a steady influx of ludicrously trivial injuries—tiny scratches, bruises, and disabilities which need nothing but to be ignored or at most treated with the simplest domestic remedies. Add to these the attention-seeking, the litigious, and the manipulators who want their spoilt child brought to heel or their spouse punished, and the department is faced with a sizeable overload which distracts medical care from where it is needed. The result is an erosion of the quality and extent of medical care; a fall in the quality of the doctor-patient relationship; the erection of doctor/patient barriers (with all the apparatus of appointments and receptionists so sadly familiar in general practice); and a decay of medical responsibility.

As a profession doctors have some responsibility for this state of affairs, with its former emphasis on "see your doctor early," "come to the hospital at the time of injury," and so forth. But the trend has gone too far, and must be reversed—but how? Propaganda has spent its force. Expansion of medical services to meet an unlimited expansion of demand is neither economically acceptable, nor socially beneficial. Regulations and penalties can be enforced only in an authoritarian society. Probably the only practical remedy lies in a fee-for-item-of-service system to rebuild a sense of social and personal responsibility. Having rejoiced in the provision of a free National Health Service, I find this a deplorable but inescapable conclusion. Alternatively, could medical care be extracted from the political muddle which besets it and handed over to some independent corporation which can allow commonsense to direct its distribution? Certainly the problem has somehow to be solved if a general deterioration is not to become the rule.

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