General practitioner hospitals: coming or going?

Papers in the last four weeks’ issues of the BMJ raise again a question which has smouldered since the early 1960s. At that time the Department of Health’s policy favoured the elimination of small, peripheral hospitals and the concentration of acute services in large, central district general hospitals. Opinions on the place of general practitioner hospitals still differ, but these four papers show not only that they are still surviving but also that they can provide a real service to the community and to general hospitals—if they are effectively managed.

Firstly, North and others (21 April, p 1209) describe a pioneering 24 bed hospital in a deprived urban area. It has no outpatient or diagnostic facilities and no regular consultant visits but emphasises facilities for rehabilitation and maintenance of patients (especially the elderly) in the community. The authors estimate that almost half the patients would have occupied a bed in a district general hospital had the new hospital not been available, and half would have remained at home. Eighty five per cent were discharged home, mostly in less than one month.

Next, Johnson (28 April, p 1293) described surgical practice in a community hospital in Brecon. Though this hospital is atypical (in that nearly all the general practitioners have hospital specialist qualifications), he described a method of review which could be applied to community hospitals in general—and, implicitly, to major surgical units as well. Some 85% of all inpatient surgery on Brecon residents is performed in the community hospital; complication rates (such as wound infection and recurrence of hernia) are acceptable, and waiting lists are short. Even with anonymous questionnaires an opinion survey may be biased, but there is a clear message in the finding that of patients who had an operation in Brecon 96% said they preferred that to surgery in a district general hospital.

Last week (p 1366) Grant reported on the facilities and distribution of hospitals in Scotland staffed primarily by general practitioners. Most of these are more than 30 miles (48 km) from a district general hospital and have casualty and outpatient clinics. Intrapartum maternity beds are available in almost twice as many hospitals as surgical beds.

The final paper (p 1438) pursues this theme south of the border, with Cavenagh and others discussing the place of isolated general practitioner maternity units. In 131 units separate from consultant sites the “average” general practitioner has 10 deliveries a year and the “average” midwife has 20. Nearly 40% of units have no visiting consultant and 10% no flying squad cover. Perinatal mortality is predictably low, and the authors suggest that transfers in labour (8% of all bookings in the survey) are a better index of a unit’s success or failure: they reflect the adequacy of the selection process—which is “clearly capable of further refinement.”

These four papers support the view that general practitioners should care for their own patients in hospital, but among both patients and staff opinions differ on what constitutes a “good” service. Patients give priority to ease of access, comfort, and the reassurance of familiar surroundings; to obtain these they are often willing to forego the virtues (usually unmeasurable) of technical excellence. Indeed, much of the debate among clinicians concerns relative safety—especially of acute services such as maternity, surgery, and casualty. Some family doctors appreciate the continuity of care offered by general practitioner beds, and, especially as more principals are completing vocational training, enjoy the chance to use hospital based skills. Others see the commitment of time as disproportionate to the rewards and believe that hospital work detracts from their task as primary physicians.

As hospital consultants retire they are being replaced by a younger breed weaned on high technology, who may sometimes be less willing to work in peripheral hospitals. And as the workload increases in central hospitals time spent by consultants in travelling becomes increasingly a luxury—even if it is to a friendly little hospital. Health authorities also face a dilemma. The revenue costs of small hospitals are more easily identified than are those of individual units in general hospitals (without specialty costing), and the great temptation is to prune. Another response, however, may be to preserve small hospitals in order to transfer suitable patients to low technology, low cost care: that would make progress towards providing more care for more people in their own community.

Certainly general practitioner hospitals can reduce demands on district general hospitals, but they also generate demands from the community. Despite being cheaper in terms of unit costs, it is hard to show that they are more economical overall. Better use of them, however, may provide a realistic alternative to the development of expensive new district general hospitals, and districts are being asked by regions and by the DHSS to consider these possibilities.

Our four papers suggest that the effectiveness and efficiency of individual general practitioner hospitals depend largely on recognising the limitations of local facilities and staff, critical internal evaluation, cooperation with district general hospitals over planning and selection of cases, and a clearly defined place within the health district. Sadly, very little objective evidence, such as from clinical trials or cost benefit analysis, has been produced to help define that place.

Nevertheless, decisions must soon be made about the future of several hundred such hospitals in Britain. By the end of this summer each health authority should be finalising its strategic plans for the next 10 years. They should consider carefully the economic and clinical potential of general practitioner hospitals, given a clear purpose and clear management.

CHARLES D SHAW
Specialist in Community Medicine, Cheltenham and District Health Authority, Cheltenham GL50 2QN


Neuroleptic malignant syndrome

The neuroleptic malignant syndrome of Delay and Deniker is “the most serious but also the rarest and least known of the complications of neuroleptic chemotherapy”; its cardinal features are hyperpyrexia and rigidity. The syndrome was first described under the name syndrome malin in a French journal2; since then isolated reports have been made from many parts of the world3-7—but a review in 1980 of over 60 cases8 included only one from Britain.9 A recent report of a