antacids/alginates, histamine antagonists, and sucralfate. The new design of bougie was producing good results, half the patients not needing a further dilatation for 18 months.

Pancreatic cancer increasing

Dr Mitchell showed that the frequency of pancreatic cancer was increasing: the condition was now commoner than cancer of the stomach. Nevertheless, though modern methods such as computer tomography and endoscopic retrograde cholangiopancreatography were making the diagnosis more specific, patients still usually came to the clinic with advanced disease. The ideal test still had to be developed, and the best method of early diagnosis was a high index of suspicion in any patient with malaise and loss of weight.

Professor Losowsky discussed hepatitis problems and solutions, emphasising that persistent hepatitis B infection was associated with a considerably increased risk of hepatoma. Rarely remissions had occurred with treatment with interferon, but combinations of antiviral agents needed to be given. Thus, though the ultimate aim must be eradication of the infection, the short term one must be to prevent transmission. Patients known to be antigen positive must tell their doctor or dentist of this fact; conversely the general practitioner must give patients firm advice on lifestyle in simple lay language—yet a survey had shown that few did this. The current vaccine was expensive yet effective and boosters were required only occasionally.

Concluding, Sir Christopher Booth pointed to one outstanding achievement of the NHS: the striking improvement in hospital practice. Before 1947 the Pickles practice in Wensleydale had made it a rule never to send a patient to hospital—which was a virtual death sentence. The standard of the work at Scarborough, as well as the outstanding quality of the presentations that afternoon, showed how far standards had advanced in 40 years.

"Small is beautiful" in Whitby

CHRISTIANE HARRIS

In the 1960s emphasis was put on large district general hospitals and many small community hospitals were closed. Current thinking suggests that this may have been a mistake and that perhaps "small *is* beautiful" after all. The scientific session at Whitby Hospital on 25 June during the annual representative meeting, which was intended primarily for general practitioners, provided an opportunity to further the debate on the future of general practitioner beds and general practitioner or community hospitals.

It was probably unique to unite hospital, general practice, and community services in the same complex, Dr D R Lockstone said. He is a general practitioner in Whitby and he explained that the aims of the Whitby scheme (of hospital and health centre) had been to blur the edge between hospital and general practice and to improve the relationship between general practitioners and consultants. He and his colleagues were confident that these aims had been achieved. Whitby Hospital had received its first patients in 1977. The original estimate of the cost of building the hospital had been £1·5 million—the eventual cost was £3·5 million.

Fully integrated services

Dr Lockstone showed the visitors the range of services provided. The hospital has 30 general practitioner beds, 60 geriatric beds, and 10 maternity beds. The hospital services are fully integrated with a health centre comprising eight general practitioners, one trainee, a practice nurse, a practice manager and reception staff, and a dispensary. Together with a branch dispensing practice at Robin Hood's Bay the health centre caters for a population of 25 000 but in the peak holiday season—July to mid-September—the population almost doubles. This results in a high proportion of temporary residents—1346 out of a total of 35 227 consultations at Whitby last year.

The complex also houses the school medical services, a school dentist, chiropody, speech therapy, child guidance, and community paediatric services, as well as a large physiotherapy department, which serves inpatient, outpatient, and community needs and works closely with the occupational therapy department.

Barium studies and intravenous pyelography are performed routinely in the *x* ray department. A visiting radiographer from Scarborough District Hospital attends once a week to do ultrasound studies using Whitby's own small machine. All these facilities are available to general practitioners' patients as well as to hospital inpatients and outpatients. The films are usually interpreted by the referring doctor although the consultant radiologist comes from the district general hospital twice a week to review all new films.

The casualty department has a crash room and full facilities for resuscitation. Casualties are brought to Whitby, regardless of the severity of their injuries, if it is the nearest department to the accident, so the staff are often called on to give initial treatment to seriously injured patients before they are transferred either to Scarborough (21 miles) or, in the case of head injuries or burns, to the regional centre at Middlesbrough (26 miles). The general practitioners who are on call for the practice and the hospital are also responsible for the casualty department. They thus shoulder a great deal of responsibility but between them they possess a wide range of specialist qualifications and hold clinical assistantships in accident and emergency, ophthalmology, obstetrics, orthopaedics, and ear, nose and throat. The geriatric beds are under the care of two general practitioners from other practices. Visiting consultants hold outpatient clinics in most specialties.

There is a consultant maternity unit, but patients needing elective caesarean sections or those considered a high obstetric risk are transferred to Scarborough. Despite this careful selection the unit has nearly 250 deliveries a year, and three emergency caesarean sections were performed last year.

Having received such a positive view of a community hospital, more than one visitor must have asked himself why centres like Whitby were so few and far between. The afternoon's speakers tried to answer this question.

Essential to create a "living organism"

The unit general manager at Cheltenham General Hospital, Dr C D Shaw, said that attitudes towards community hospitals had varied during the past 25 years. People were now beginning to see

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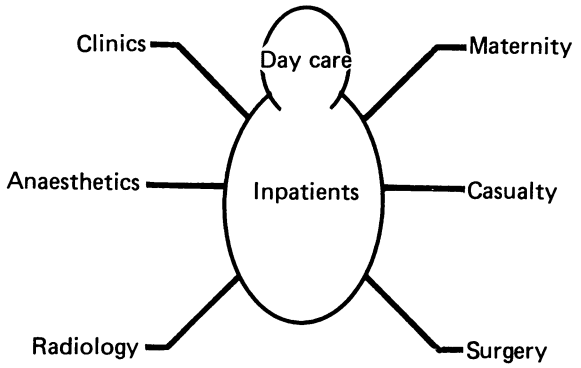
advantages in small, decentralised hospitals. It was appropriate that some definition of a general practitioner hospital should be attempted. Technically, the term applied only to those hospitals with more than half general practitioner beds but this definition would exclude a site like Whitby, which clearly had all the characteristics of a hospital where a general practitioner could treat his own patient under his own direct care in a hospital. In his view the advantages of a community/general practitioner hospital were the ease of access, the cheapness, and the general pressure to return to primary health care.

Dr Shaw went on to explain which factors were essential to ensure the viability of a community hospital (figure). The "body" was important but it was the "legs" which made it a "living organism."



Factors essential for the viability of a community hospital.

The problem was that there had been a tendency for health authorities to amputate selectively the legs until they were left with an organism which would not move at all—that is, a repository for patients with long term, chronic problems.

The major problem facing community hospitals, Dr Shaw said, was that the government did not have a consistent policy. Consultant beds were planned for while general practitioner beds seemed to be tolerated; there was a feeling that each general practitioner bed was competing with a consultant bed. So it was important to judge these beds in terms of their use rather than in terms of who cared for their occupants and to cultivate a flexible relation between general practitioners and consultants such as existed at Whitby.

Another problem was that a small hospital was always at risk when health authorities had to make cuts because the running costs were a discrete figure on the annual budget sheets and a closure was an easy way of making a substantial saving at a stroke rather than closing one or two wards at a district general hospital.

Community hospitals would survive, Dr Shaw told his audience, but only if general practitioners and consultants took the lead in supporting them.

Importance of job satisfaction

Dr R H Jones, a senior lecturer in primary medical care at the University of Southampton, had worked in a general practitioner hospital. He listed the advantages as follows: an improved relationship between primary and secondary care; an improved relationship between general practitioners and postgraduate education centres; continuity of care; improved relationship with lay and paramedical staff; and job satisfaction. Dr Lockstone confirmed the last advantage as being the single most important factor for the Whitby doctors.

How often do patients really need to be admitted to a district general hospital, Dr Jones asked. Studies in Oxford had suggested that 39-54% of acute medical patients were under general practitioner care and in Brecon the figure was as high as 71%. The indications were that 20-25% of all admissions to district general hospitals were for conditions that could be treated in the general practitioner hospital.

Many studies, he said, had concentrated on the hazards of admission to large hospitals and it seemed probable that the risks of iatrogenic disease could be less in a community hospital although there was little evidence for this view yet. A recently published survey of the community health programme in Oxfordshire had shown that one third of general practitioners had access to beds in general practitioner hospitals as well as in district general hospitals When these practices were compared with those without access it was found that the rate of use of acute medical and geriatric beds in district general hospitals in the former group was only half that of the latter and that total bed utilisation (acute medical and geriatric beds in general practitioner hospital and district general hospital combined) was slightly higher in the latter group.

The future for community/general practitioner hospitals throughout the country is hard to predict. What was clear was that a scheme such as the one at Whitby not only works but receives the full support of everyone associated with it. One of the Whitby general practitioners, Dr David Thomas, told us that if he should ever collapse and be in need of resuscitation he knew of no one he would rather have treat him than one of his colleagues at Whitby Hospital. What greater vote of confidence could the scheme possibly hope for?

Council meeting in Scarborough

The first council meeting of the 1986-7 session was held in Scarborough at the conclusion of the ARM. The chairman, Dr John Marks, welcomed the new members of council and thanked those members who were no longer on the council.

The following members were elected to the finance and general purposes committee: Dr W E Dixon, Dr J M Dunlop, Dr P F Kielty, Dr E B Lewis, Dr Caroline Marriott, Dr J A Riddell, Mr A P J Ross, and Dr M A Wilson.

Transmission of prescriptions to the PPA

The following guidance is intended for dispensing doctors for transmitting prescription forms to the Prescription Pricing Authority (PPA). It has been prepared by the rural practices subcommittee of the General Medical Services Committee and the PPA.

"(1) If there is more than one doctor in a practice all forms should be submitted in one parcel. However, if the doctors require individual payment the parcel should be subdivided into bundles relating to each doctor and the details recorded separately on a single parcel invoice.

"(2) Ideally, prescribers should use only their own prescription pads.

"(3) Form FP34D should be complete as required. Particular care should be taken in carrying out the appropriate deletion regarding VAT.

"(4) Each doctor's name and index number should be entered along with the number of forms and items.

"(5) All doctors' forms and the completed FP34D should then be parcelled up securely and posted to the PPA using the labels supplied by the family practitioner committee. 'Securely' is defined as tying the bundle firmly, placing it in a plastic bag, and either wrapping in strong paper or placing it in a suitably sized box.

"(6) The green address labels, obtainable from the family practitioner committee, should be used on the outside of the parcel.

"(7) A certificate of posting or recorded delivery is an extra security in the event of a query from the PPA regarding the non-arrival of the parcel."

Doctors in independent hospitals

Guidance for resident medical officers in private hospitals in the form of a model job description and a model contract is available to BMA members from the BMA secretariat and from regional offices. Details of the guidance were published on 24 May (p 1410). It was prepared by the independent medical practice subcommittee of the Central Committee for Hospital Medical Services and the Joint Consultants Committee and was agreed with the Association of Independent Hospitals and the Independent Hospitals Group.

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