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PRACTICE OBSERVED

Organising a Practice

Changes in general practice: do patients benefit?

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General practice has gradually changed over the past 20 years from being a mainly "cottage industry" of isolated doctors working from their own homes—usually with the help of family workers only (the doctor's wife)—into a network of small-scale organisations. The place of work has been separated from the place of residence. Independent groups of general practitioners have increased in size and have incorporated more and more employees who are engaged in both administrative and paramedical tasks.

Increasing the size of practices has been encouraged by professional medical organisations and by the Government. After pressure from the BMA direct financial incentives for group practice were provided in the Doctor's Charter in 1966. In the late 1960s and early 1970s the concept of health centres was supported first by the Government and later by the BMA. Recently the emphasis has changed again to encourage doctors to form large group practices rather than to move into health centres. The underlying assumption of these intentional, policy-directed changes in the organisation of general practice has been that they are beneficial to both doctors and patients.[1] Table I shows the growth of partnerships of varying sizes. By 1977, 17% of all general practitioners worked from health centres. We examine the effects that these changes in the structure of general practice have had on patients by discussing two critical topics: (a) the accessibility of the general practitioner to patients, and (b) the nature of the care provided, particularly the quality of the doctor-patient relationship.

We interviewed 1038 adults in Surrey and south-west London at home in late 1977.[2] Our sample allowed us to compare different types of organisation in general practice because it automatically gave a representative cross-section of patients who were registered with different types of practices. To simplify, we grouped these types of practices into single-handed doctors; small partnerships of two or three doctors; large groups of four or more doctors; and health centres, where the doctor worked mainly from a health centre but may not have been in a partnership. We found no statistically significant associations between patients attending different types of practices and age, social class, sex, or educational attainment. Therefore, direct comparisons may be made between the attitudes of patients who attended each of the four types of practices without controlling for sociodemographic characteristics.

TABLE I—*Changes in the size of partnerships**

Type of practice	Percentage of general practitioners			
	1951	1961	1971	1977
Single-handed practices	43	28	20	16
Two partners	38	34	24	20
Three partners	13	21	25	24
Four partners	5	11	17	19
Five partners	1	4	8	12
Six or more partners	—	2	6	9
	100	100	100	100
Total No of unrestricted principals		18 905	19 374	20 796

*Source: Department of Health and Social Security. *Health and personal social services statistics for England, 1978.* London: HMSO, 1980.

Accessibility

Changes in the organisation of general practice bring with them other changes that influence how accessible doctors are to their patients, such as a greater distance between the home and the surgery, altered surgery hours, greater use of appointment systems, and the behaviour of receptionists.

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DISTANCE

As the number of doctors in a practice increases so does the average distance that patients have to travel to their doctors' surgeries. Half of our sample of patients lived within half a mile of the surgery, but though this was true for 63% who were registered with single-handed doctors only 41% who attended large group practices or health centres lived that close. Crude distance, however, is less useful a measure of access than time spent travelling, which is related to possession of a car. Car ownership is strongly associated with both social class and age. Therefore those who are most adversely affected by having to travel further because practices are concentrated in groups are people from the lower social classes and elderly people.

SURGERY HOURS

In large group practices, and especially in health centres, each general practitioner has less autonomy to decide the hours he or she wishes to work and probably does not need to hold late surgery hours to compete successfully with other general practitioners for patients. When a group practice is a monopoly, as in small towns, general practitioners may have less incentive to be accessible to gain or retain patients. We found a strong association between the type of practice and the time evening surgery closed. Evening surgery finished by 6 pm for less than a quarter of patients who were registered with small partnerships or single-handed doctors, but this was the case for 45% of patients attending large groups and for two-thirds of patients attending health centres. Lack of access to a general practitioner in the evening creates difficulties for people who work all day, but for others this may be compensated for in large group practices and health centres because a doctor is usually available all day and may be seen at any time if necessary.

APPOINTMENT SYSTEMS

Large practices use appointment systems to a greater extent than small groups or single-handed doctors and the appointment systems restrict access for patients for several reasons.[3] What is important, however, is our finding that in practices with appointment systems the more complex the organisation in the practice the more difficulty patients had in getting an appointment to see their own doctor. Table II shows that the greatest problems were in large group practices. We suggest that smaller practices (of one to three doctors) are organised in a less bureaucratic way and are therefore more likely to operate appointment systems with the flexibility that is necessary to enable patients who wish to see a doctor that day to do so.

TABLE II—*Appointment systems: ease with which a patient could see own doctor the same day according to type of practice*

	Type of practice				Total %
	Single-handed doctor	2 or 3 partners	4 or more partners	Health centre	
Very easy (%)	36	14	6	11	11
Fairly easy (%)	22	34	29	30	30
Fairly difficult (%)	39	21	30	25	26
Very difficult (%)	3	24	24	23	23
Impossible (%)	—	8	11	11	9
	100 (n = 36)	100 (n = 189)	100 (n = 223)	100 (n = 224)	100 (n = 672) p < 0·001*

The percentages in these tables have been rounded and therefore do not necessarily add up to 100%.
*Significance levels are intended only as a guide, since they were calculated on the assumption of a simple random sample, but the actual sample design was based on interviewing in 50 wards.

RECEPTIONISTS

The receptionist is now the intermediary through whom virtually all contacts with general practitioners are made. She controls scheduling procedures, which in practice means she controls access to the doctor by booking appointments, dealing with requests for home visits, and putting people through to speak to the doctor on the telephone, etc. The behaviour of receptionists is likely to vary with the size of the practice, since as organisations become more complex there is a tendency to formalise rules. Consequently, we suggest that receptionists in large group practices and health centres are more likely to act by the "rule book" than with the flexibility that is necessary in general practice. In addition, in large practices it may be less easy for the receptionist to check with a doctor each time she has a query or a "difficult" patient on the telephone.

One way that the receptionist influences access is by handling requests for home visits. In our study a higher percentage of patients and their children who attended health centres compared to other types of practices had been asked by the receptionist to come to the surgery on one or more occasion when they had requested a home visit (table III). (This does not necessarily mean that requests for home visits were refused, but that the receptionist encouraged the patient to attend the surgery.) Receptionists also control access by putting patients through to speak to the doctor on the telephone. Fourteen per cent of patients who attended health centres said that they had tried to speak to a doctor on the phone and were unable to do so compared with 6% of patients who attended other types of practices.

TABLE III—*Percentage of patients who were asked to come to the surgery by the receptionist when a home visit was requested on one or more occasion*

	Type of practice				Total %
	Single-handed doctor	2 or 3 partners	4 or more partners	Health centre	
For a child under 16 years	29 (n = 17)	41 (n = 81)	54 (n = 74)	63 (n = 67)	50 (n = 239) p < 0·05
For self (adult)	16 (n = 51)	15 (n = 182)	17 (n = 162)	26 (n = 155)	19 (n = 550) Not significant

We analysed patients' experiences of receptionists by combining the responses to four questions—did the patient ever have to insist when talking to the receptionist? Was the receptionist always courteous? Did she ever "talk down" to them? Was she thought to be more of a help or a barrier between them and the doctor? Criticism of receptionists increased directly with the complexity of the organisation. At least one critical comment was made by 25% of patients attending single-handed doctors, by 34% attending small partnerships, by 40% attending large groups, and by 45% attending health centres[2] (table IV).

We suggest that the complexity and greater differentiation of tasks in health centres, and to a lesser extent in large group practices, means that receptionists use more formal rules than are necessary in smaller practices. Rationalisation and efficiency become more important as practices become more complex. The result is reduced accessibility to general practitioners.

TABLE IV—*Attitudes of patients towards receptionists according to type of practice*

Number of negative responses about receptionists	Type of practice				Total %
	Single-handed doctor	2 or 3 partners	4 or more partners	Health centre	
None	75	66	60	55	61
One or two	16	26	28	26	26
Three or four	9	8	12	20	13
	100% (n = 67)	100% (n = 238)	100% (n = 234)	100% (n = 234)	100% (n = 773) p < 0·01

Nature of care

Since the late 1960s there have been debates about whether or not general practice is a specialty within medicine.[4 5] This has now become widely accepted because of the uniqueness of general practice in treating the whole patient and in taking into account psychological and social factors that may influence how symptoms present and the condition itself. Yet, parallel to this emphasis on the personal, supportive, and relational aspects of care is a pull in the opposite direction which is associated with the growing dependence on technology that is evident in all spheres of medicine, including general practice. Clearly, good care by general practitioners depends on both treatment that is technically competent and the personal and supportive aspects of the doctor's behaviour.

One of the recognised advantages of practising in groups and health centres is that it is easier to purchase and use more complex equipment, such as electrocardiograms. Cartwright and Anderson found that as the number of partners grew in a practice the amount of diagnostic equipment definitely increased.[6] As for using technology, Mechanic showed that general practitioners practising in groups used more diagnostic tests,[7] and Williamson found that doctors practising in groups adopted new drugs more rapidly than single-handed doctors.[8] It is a moot point whether or not the greater emphasis on the technical aspects of care found among larger practices results in less personal care.

We did not investigate the clinical or technical quality of the care that patients received, but the study gave some insights into whether the type of practice was associated with the nature of care provided by general practitioners in terms of continuity of care, the personal relationship, ease of communication, and some aspects of treatment.

CONTINUITY OF CARE

Continuity of care is essential for a successful personal relationship between a doctor and patient. The alternative is a mechanistic view of the general practitioner's role, in which the care provided is assumed to be good irrespective of the identity of the doctor. As practices grow there is a greater possibility of giving fragmented care. In our sample over 90% of the patients thought of themselves as having one particular general practitioner. This did not vary directly with practice size, being very high for those who attended health centres (96%) and lowest for those who attended small partnerships (86%) (table V). This suggests that when there are two or three partners the care of patients is shared to the greatest extent.

Continuity of care may be more objectively measured by examining the proportion of respondents who saw their own doctors at their last surgery consultation. Eighty per cent of those who attended health centres and small partnerships saw their own doctor, but this fell to 69% among patients in large practices (table V). Therefore, the size of the practice affects continuity of care to some extent, but this effect is perhaps less than might have been expected.

PERSONAL RELATIONSHIP

It is difficult to measure how well the patient and the doctor know each other. As expected, patients who had been registered for a short time were less likely to think that their doctors would know them if they met on the street—only 40% of patients who had been registered for under two years compared with 85% registered for over 20 years. Patients registered with a single-handed doctor were more likely to think that their doctor would know them compared with those who attended health centres and larger group practices, even when the duration of registration was controlled. (There was no significant association between type of practice and duration of registration.) A related finding was that more people who attended health centres, and to a lesser extent large group practices, felt in awe of their doctor (table V). (Feeling in awe was unrelated to duration of time with a particular doctor.) These small but important trends suggest that patients may perceive a greater distance between themselves and their doctor in large group practices and health centres, possibly because of the larger scale of organisation.

TABLE V—*Nature of care given by type of practice*

	Type of practice				Total %
	Single-handed doctor	2 or 3 partners	4 or more partners	Health centre	
Continuity of care					
(a) % who do not have one doctor they think of as their own doctor	2 (120)	14 (293)	11 (277)	4 (249)	10 (939) p < 0·001
(b) % who did not see own doctor at last surgery visit	7 (107)	21 (277)	31 (233)	20 (208)	22 (825) p < 0·001
Personal relationship					
(c) % who do not think their doctor would know them if they met in the street	25 (120)	31 (324)	36 (276)	38 (256)	32 (976) p < 0·05
(d) % who feel in awe of their doctor	9 (118)	12 (321)	16 (274)	21 (253)	15 (966) p < 0·05
Ease of communication					
(e) % saying they could not talk easily to their GP	10 (120)	12 (324)	7 (279)	8 (252)	9 (975) Not significant
(f) % saying they do not get enough information	16 (119)	10 (316)	9 (275)	7 (255)	10 (965) p < 0·01
(g) % who do not always say everything they want to their doctor	27 (119)	18 (320)	18 (277)	18 (256)	19 (972) Not significant
Attitudes about treatment					
(h) % who say GP does not always examine when they think it is necessary	24 (110)	15 (301)	13 (257)	13 (240)	15 (908) Not significant
(i) % who wanted a different medicine from the one given by the GP	18 (120)	17 (324)	12 (278)	13 (256)	15 (978) Not significant

The numbers in parentheses are the number of patients.

EASE OF COMMUNICATION

Good communication is essential for any successful encounter between doctor and patient. Taking three aspects of communication, we found that there was, if anything, a *better* personal relationship between patients and their doctors as the complexity of the organisation increased. The differences were small but they were all in the same direction, with a higher proportion of people who attended health centres saying that they could talk easily to their general practitioner, that they could say all that they wanted to him or her, and that they obtained enough information (table V). This somewhat surprising finding implies that communication between patient and doctor is not affected by the bureaucracy of the organisation, and may in fact be improved in a more organised practice. Possible explanations include the fact that the general practitioner is more at ease because administrative tasks are organised by receptionists or practice managers and the doctor has more free time, since rotas are more often arranged for the group. Furthermore, the age and other characteristics of doctors who choose to work in a group or health centre may be responsible for some aspects of improved doctor-patient relations.

TREATMENT

We could not hope in a survey of patients' views to measure the quality of treatment provided by general practitioners working in different types of practices. Two of our questions touched on this area, however. More patients who attended single-handed doctors said that their doctor did not always examine them when they thought it was necessary, and more said that they wanted a different medicine on some occasion from the one that they had been given by their doctor (table V). These findings are not statistically significant but suggest that single-handed doctors may fall down in these respects.

Discussion

A principle of social welfare is that equality of access to health facilities is a legitimate and laudable aim. Accessibility is particularly important because general practice is the entry point into the rest of the health care system, and, by definition, the need for medical care is often sudden in onset, requiring prompt attention. It is important to be aware of the actual and potential barriers to access that are consequent upon changing the structure of general practice. Our findings show that as general practice becomes more complex the barriers to access increase. These include distance from home to the surgery, curtailment of evening surgery hours, more rigid appointment systems, and receptionists who are often seen as a barrier between the patient and doctor. On the other hand, it is easier in large practices for the partners to cover for each other, so that access is improved in large practices both during the day, since there is more likely to be a doctor available at any time, and at night and weekends, when rota systems are more likely to be arranged.[9]

The barriers to access to general practitioners that accompany changes in organisation are likely to have more adverse effects on people in the lower social classes and on elderly people—for a number of reasons: since these two groups are less likely to have cars, they are more likely to be penalised by having to travel greater distances; they are also less likely to have telephones and thus experience more inconvenience in making appointments, in many cases having to make an extra journey to the surgery to make an appointment. Furthermore, there is substantial evidence that people from the lower social classes are less able to cope with the complexity of organisations and to "negotiate" to get an appointment, using the appropriate language and "persuasive appeals" that may be necessary when seeking urgent appointments or home visits through the receptionist,[10] and there is evidence of greater deference and diffidence among elderly people and people in the lower social classes.[11]

Our research and other studies[6 12] have found that the type of practice has only a marginal effect on the nature of care. Continuity of care is reduced somewhat, particularly in large group practices. Patients are less likely to know their doctors well and more likely to feel in awe of him or her in large groups and health centres. On other aspects relating to the nature of care the findings are not conclusive, but suggest that communication and possibly treatment is worse in single-handed practices and, if anything, best among large group practices and health centres. (Most of these effects are not statistically significant, but they are all in the same direction.) These associations are probably unrelated to how the practice is organised but are due to the types of doctors who go into each type of practice. This self-selection is illustrated by the fact that more doctors in group practices and health centres are members of the Royal College of General Practitioners and more are trainers.[6] Some would argue that such general practitioners are more likely to be concerned to provide good quality care, which they recognise as encompassing both interpersonal and technical skills.

Greater bureaucracy in general practice is likely to lead to each doctor having less control over his or her work environment, but this does not seem to affect the doctor's clinical autonomy. The more complex organisation may in fact facilitate having more equipment and ancillary and paramedical personnel, which, with the presence of other doctors, will allow general practitioners to provide the sort of care that they want to provide.

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Correction

Practice educational meetings: a new influence in general practice

In table III of this article by Dr B B Reiss *et al* two numbers were left out of the column Frequency: Never—Exploring doctor patient relationships: 4; Developments in other subjects: 6.

ONE HUNDRED YEARS AGO At this season of the year, tons of trash under the name of pork-sausages are thrown upon the market, and find a very ready sale; but, instead of being made wholly of pork, they are interspersed with the remnants of "block-ornaments"—no matter whether of beef, mutton, or veal—these latter being consigned to the sausage-mill when their appearance is no longer tempting enough to secure a purchaser. Any taint or unpleasant flavour is roughly disguised by the amount of seasoning used. In the raw state, they are not easily detected; but, on being cooked, they are readily distinguishable by their red and under-done appearance, as compared with that of the genuine porksausage, which presents, when cooked, an uniformly white colour throughout. Mouldy bread, tainted livers, and other equally dubious material, are common ingredients of cheap sausages. This, doubtless, accounts for some of the fatality from diarrhoea during the winter months. It is time that sausage and "polony" manufactories were under more rigid and systematic inspection; and that attaching to this food of the poor there should be a better guarantee of its wholesomeness. (*British Medical Journal*, 1881.)