

General Practice

TOWARDS BETTER GENERAL PRACTICE

A PRELIMINARY SURVEY AND SOME SUGGESTIONS

BY

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The present and future roles of the general practitioner are subjects of much discussion. While it is accepted that the G.P. has a vital place in the medical teams it is also realized that improvements in standards and conditions are necessary if he is to perform his functions effectively.

As a preliminary to any drastic changes that may well affect the future course and pattern of general practice over the next generation or two it is very necessary to know more about what actually goes on in general practice. What are the G.P.'s own views on the aims and objectives of general practice at present and on his possible roles in the future? How is he organizing his work now to meet these needs? What types of premises is he working in and how suitable are they? These questions must be answered before we can plan for the future.

The information required is not available. The reports of Collings (1950), Hadfield (1953), and Taylor (1954) were valuable and their findings are still quoted and applied to-day, but they were all carried out more than 10 years ago and their recommendations may no longer be valid. The Cohen Report (1954) reviewed the whole field of general practice, and among its many useful suggestions was the idea of group practice loans. The great success of this scheme was acknowledged by the Royal Commission on Doctors' and Dentists' Remuneration, and these loans are now being financed directly by the Treasury, but the policy behind these loans is not based on any factual information or assessment of any later benefits and improvements. A study into the "functions and design of general practice" is required along the lines of the classical work carried out by the Nuffield Provincial Hospitals Trust (1955) on hospitals.

We report here our findings of a preliminary survey of 33 general practices, carried out chiefly to test methods and to see what information could be obtained simply, quickly, and cheaply.

Our aims were: (1) to meet the G.P. and discuss his work and future, (2) to learn of the organization of his practice, (3) to make a measured survey of the practice premises, and (4) to prepare plans for a more detailed and extensive study covering the whole country.

Methods

Thirty-three practices were visited by appointment between September and December, 1961. The selection was based simply on an acquaintance with the doctor. Admittedly this was a biased sample loaded with "good general practitioners," but we were more concerned with testing our methods than with obtaining a truly

representative picture. We hope this will be achieved in a more extensive study. To facilitate travel all the practices were within 50 miles of London. There were four rural practices, one in a new town, nine in the London metropolitan region, and 19 in residential suburbs. Of these, 14 were group practices with central premises, 12 were partnerships with more than one set of premises, and 7 were single-handed.

The visiting team consisted of a general practitioner and an architect. A prepared form was followed in the interview. The doctor questioned the general practitioner while the architect carried out a fully measured survey of the premises. It was found that about one hour, or slightly longer in group practices, was sufficient to obtain all the information sought.

We made no attempt to assess quality or to examine clinical methods, but studies similar to those of Osler Peterson *et al.* (1956) are obviously necessary if we are to achieve improvements in general practice.

Results

Although no definite conclusions can be drawn from these results they do, nevertheless, indicate the type of information that can be obtained. We experienced no difficulties in arranging suitable appointments and received the greatest co-operation from all the family doctors whom we met. All were keenly interested in the aims of the survey and its ultimate objectives.

The General Practitioner

From our meetings we were able to build up a composite picture of the G.P.s whom we met. All were intense individualists jealous of their independence and aware that their own personalities and attitudes were of the greatest importance in their work. Professional isolation was commonly mentioned, leading on the one hand to curiosity concerning how their practices compared with the average and on the other hand to diffidence about their own premises. There was considerable resignation towards the present situation in general practice and cynicism about past leadership. Paradoxically, these sentiments were associated with high morale and a belief that the N.H.S. has been a pronounced success. There were very few useful or original ideas about the future.

Doctor-patient relationships appeared excellent. We found many indications of mutual respect and understanding. All doctors denied any suggestion of abuse of the N.H.S. by their patients. Relations between the G.P. and hospitals and consultants were good—28 out of the 33 expressed great satisfaction with their local services. Domiciliary consultations were often used, particularly to have an E.C.G. done. The relations with the local health authorities were not as good. Just over one-half expressed satisfaction and there was a general indifference towards them.

When asked, nearly all said that they felt they worked hard, but only a minority (14) were in favour of reducing the present maximum size of list, 3,500.

In only 15 of the 33 practices were there any private patients. Most of the doctors expressed a dislike for private practice and there were no regrets at its continuing decline.

These general practitioners struck us as being eminently practical men interested in their patients as individuals each with his own personal problems. Discussions turned much more often to psychiatric and social difficulties than to academic matters.

Practice Organization

In contrast to the individuality of the G.P.s there was an extraordinary similarity about their methods of organization. Hours of work and number of services for each patient were virtually identical in all the practices. The traditional evening surgery, unknown in most other countries, resulted in all the doctors having a 10- to 12-hour day, which must be a source of much unnecessary fatigue.

Access was available to some diagnostic facilities in 30 of practices. Pathological facilities on the whole were good but radiological facilities were often restricted. A desire was expressed for direct access to a diagnostic E.C.G. service.

In 26 of the practices some kind of a receptionist was employed, but in only 19 instances was she a secretary-typist who could deal with letters and book-keeping. Nurses were employed in only seven of the practices, and a health visitor, midwife, or district nurse regularly attended clinics in 10.

Special clinics for children, inoculations, and "antenatals" were held in 20 of the practices.

One-third (11) of the doctors lived on the practice premises. Only 14 of the 33 felt that their professional work interfered with their home life in anything more than a minor degree.

A rota scheme for emergency calls was being worked between local doctors in 28 of the practices. Night calls which got the doctor out of bed were infrequent, averaging no more than two a month.

Appointment systems were being used by one-third of the practices, a further one-third were in favour of an appointment system but were not using it, and the remaining one-third were against the idea. When the latter two groups were asked, "How long should a patient wait?" the majority thought 20 minutes a reasonable minimum waiting-time.

Premises

Consulting-rooms.—The sizes varied considerably from over 500 sq. ft. (46.5 sq. m.) in one case to several less than 70 sq. ft. (6.5 sq. m.)—the maximum for habitable rooms under by-laws. Optimum areas based on practice numbers have been suggested by Taylor (1954) and by the Group Practice Loans Committee of the Ministry of Health (Cohen Report, 1954), but the number of variables involved is enormous. All but one of the consulting-rooms had a couch even when an examination-room was attached with its own couch. Logically there seemed no reason for this duplication.

Examination-rooms.—An examination-room in addition to the consulting-room was present in one-half of the practices, and altogether 24 doctors were in favour of having one. The examination-rooms we saw had a number of defects. Most had no wash-basin; many were very small, often no bigger than the couch plus a small gangway; heating was usually intermittent and not always efficient; ventilation standards were often poor and in many cases no ventilation at all was provided. Natural lighting, so necessary for clinical examination, was also either absent altogether or deficient; and sound-insulation difficulties were often experienced because of the direct communication with the consulting-room.

Waiting-rooms.—Those using an appointment system found that it was possible to predict fairly accurately the optimum size and seating capacity. Taylor (1954) suggested 5 seats per 1,000 patients and the Group Practice Loans Committee 7. The practices we saw did not support such simple formulae because the number and effect of the variables are unknown. The waiting-rooms were generally large and cheerless, with seats around the walls. Only rarely were they broken up into a number of flexible smaller and more intimate spaces. In the practices visited a lavatory for the patients was provided in 15, a lavatory with a wash-basin in 10, and no such provisions at all in 8.

Secretary's Room.—In the larger practices the secretary's office was the hub of the organization, but in less than half was it considered satisfactory. Usually her comfort and efficiency were severely limited by makeshift accommodation.

Nurse's Room.—Only two practices provided a well-equipped nurse's room. Trained nurses were not commonly employed (7 out of 33), and most of their tasks were not commensurate with their experience.

Commendable findings included the high standards of cleanliness and the good condition of the interior decorations (31 practices) and the large proportion (26 practices) with accent on impending conversions.

Less satisfactory findings were: (1) Complete unsuitability of the premises in 20 practices by reason of insufficient space, natural light, or lack of ventilation; poor state of repair; non-compliance with by-laws; or lack of scope for adapting the premises. (2) Poor conversions in 14 practices (some of these are included in the 20 above); poorly shaped rooms with unusable and wasted space; corridors unnecessarily provided when simple rearrangements would have been less wasteful. Insufficient attention had been paid in some cases to planning for sound-insulation, and as a result attempts were made to correct these defects by expensive and usually ineffective remedies. There was considerable evidence of the use of unsuitable materials and shoddy workmanship. (3) In some of the newer purpose-built premises there was evidence of lack of research at the planning stage as indicated by some very extravagant space standards.

Two Practices

The two case studies that follow are both of urban practices with a list of 6,000, but there the similarity

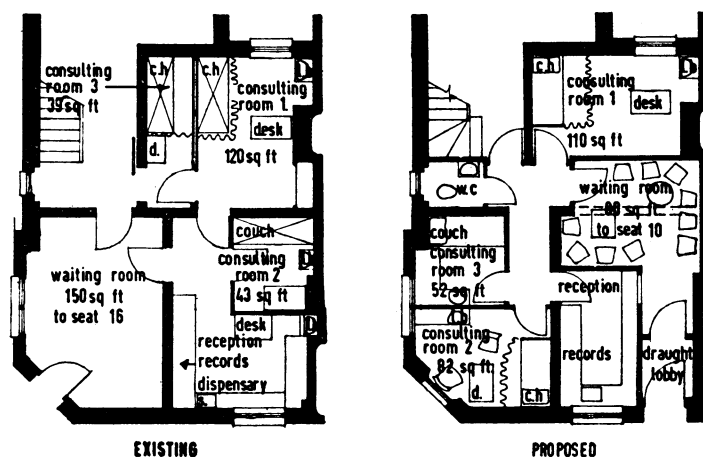


FIG. 1.—Existing and proposed features in Practice 1.

ends. The entire surgery premises of one could comfortably be accommodated in the waiting-room of the other. Case 1 is typical of much of the substandard accommodation that we saw, and was included above in the category of "unsuitable premises." Case 2 is an example of extravagant standards of space. In both premises, however, a high standard of medical care was achieved.

Case Study 1

Type of Practice.—Urban, of three doctors. List of 6,000 with small private practice. Husband-and-wife team living on premises. Help includes assistant and two part-time receptionists working in shifts. No appointment system. Premises built about 1900; two-story corner shop with yard. Residential accommodation on first floor and part ground floor. No expansion space.

Suggested Rearrangement.—In common with most practices it can be assumed that the private practice will diminish together with the need for a *substantial* dispensary. It can also be assumed that the introduction of an appointment system is essential in such small premises with a large list. The principal defect in the existing arrangement is the lack of natural lighting to the second and third consulting-rooms. On the other hand, the waiting-room occupies a corner position with light on two external walls. The suggested rearrangement shown involves repositioning the consulting-rooms on the external walls, leaving the waiting-room (occupied for short periods with an appointment system) internal. At the same time a better circulation is achieved, giving direct access to the two consulting-rooms and the third occasional consulting-room. A draught lobby and a patients' lavatory are also provided. The rooms generally are a better shape and size and the dispensary is separated from the office, giving more space for efficient record-keeping and allowing for the introduction of an appointment system. The accompanying Table gives a comparison between the existing and suggested arrangements.

Conclusions.—The only major structural work envisaged is the insertion of a beam between the present consulting-rooms 1 and 2 and the removal of the partition. The principal costs would be incurred in the services rearrangement—that is, plumbing, electrical, and gas. For the sake of economy new basins have either been replaced in the original positions or placed back-to-back. Detailed requirements of the finishes, equipment, and furnishing of the individual rooms are not part of the study and would be subject to discussion with the doctor and related to the total financial commitment.

Case Study 2

Type of Practice.—Industrial working-class area in central London. Group practice of five doctors working in two premises only one of which is considered here. Total list on both premises 11,200 plus 3,000 industrial patients. Size of list in practice under consideration was only 6,000. Help includes three part-time receptionists/secretaries, part-time nurse, and two midwives in occasional attendance. Premises were purpose-built in 1956 as part of local authority housing scheme, on a corner site adjoining flats. No yard or site for future expansion. Mostly single story with caretaker's flat on first floor.

Detail Description and Criticism.—The principal defects were mostly recognized by the doctors and are as follows: (1) The extravagant heights and area of waiting-room and consulting-rooms. (2) The smallness of the reception office. (3) The provision of male and female lavatories for patients, with no separate lavatories for staff—in fact, one of these lavatories has now been set aside for staff, but it is inconveniently situated as it is in the patients' area. (4) The office is situated at one end of a long corridor in relation to the consulting-suites, and there is a lack of communication. (5) The covered entrance is unnecessarily large and very few prams are in fact parked outside. (6) Patients have to enter through three sets of double doors. (7) The waiting-room is virtually impossible to heat with the overhead

Existing and Proposed Features of Practice 1

Room	Proposed				Existing			
	Size	Area (sq. ft.)	Equipment	Comments	Size	Area (sq. ft.)	Equipment	Comments
Consulting-room 1	12' × 10'	120	Basin, couch, desk, 3 chairs, storage	Reasonable proportions, pleasant furnishings, well-equipped, newly decorated. Small corner window	13' × 8' 6"	110	As previous	Includes area of existing consulting-room 3
Consulting-room 2	7' 6" × 5' 9"	43	Basin, couch, desk all minimal sizes. 2 chairs. No storage	Internal, no windows, single glazed borrowed light with no sound-proofing to public corridor, fan ventilation, space under couch cluttered	9' × 10' max.	82	New equipment necessary, including storage and sterilizer	New room now has natural light and ventilation, privacy, and access to shared examination-room
Examination room/consulting-room 3	12' × 3' 3"	39	Couch, minimal desk, 2 chairs. N.B., less than 15" at side of couch for dressing	Recently partitioned off consulting-room 1. Expensive double glazed double door partition glazed above 3". No window, fan ventilation. Acts as corridor; patients must leave through residential part	7' × 7' 6"	52	As previous with addition of basin and dispensing equipment	Better size and proportion, natural light and ventilation, centrally situated between 2 consulting-rooms with direct access to waiting-room. No confusion in circulation. Smaller dispensary
Reception office	10' × 8'	80	Benches with sink, bottle shelves, records in wooden drawers, desk	Large proportion is dispensary for private patients. Cramped space for secretary. Some record drawers rather high and inaccessible. Fan exhaust from consulting-room 2	12' × 8'	96	Secretarial, records, basin	Single-purpose room with more space. Basin to take future nursing ancillary
Waiting-room	15' × 10'	150	16 chairs	Doctor is satisfied with space and number of seats. No patients' lavatory. No draught lobby. No hatch to receptionist	10' × 8'	80	10 seats	Less space required with appointment system. Artificial light and vent only, but considered satisfactory for short waiting-time. Draught lobby and hatch to receptionist provided. Patients' w.c. formed by turning bottom of staircase
Circulation incl. wall thicknesses		44	Shelf for immediate consultation record cards	No direct access to consulting-room 3 except through residential part		56	As before	Circulation improved. Area includes draught lobby
Totals ..		476				476		

* Partition cost about £200 and is not particularly soundproof, as air-space between glass is less than 3", causing internal reverberation and transmission instead of absorption of sound. Privacy between consulting-rooms is poor.

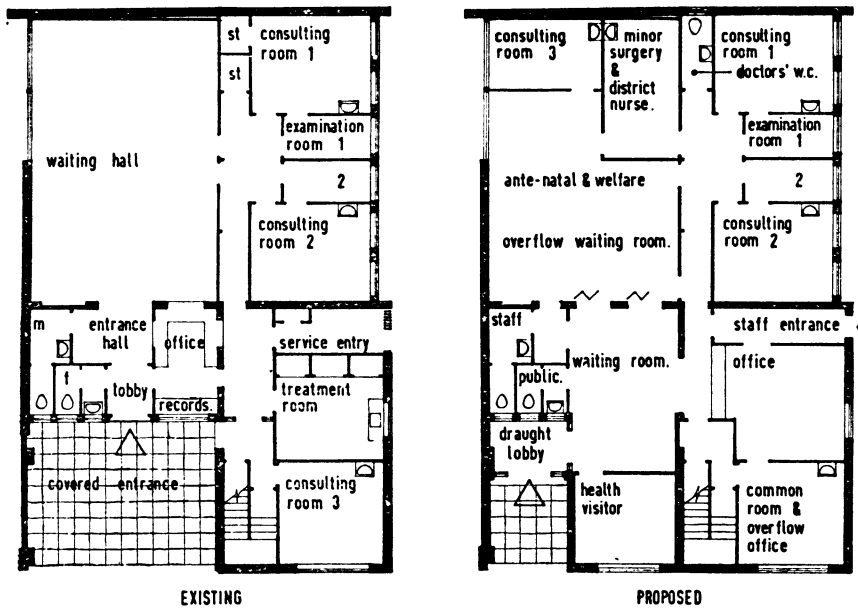


FIG. 2.—Existing and proposed features in Practice 2.

heaters provided, and its appearance, with chairs ranged round the perimeter walls and a vast empty central space, is depressing.

Our opinion is that the premises are soundly built if somewhat heavy-handed in appearance. There is an extreme contrast in the treatment of the waiting-room—with its exposed brick walls, open trusses and wood-wool slab ceiling and clerestory windows with a few overhead heaters—and the treatment of the remaining areas with underfloor central heating, wood-block floors, and polished hardwood door frames and skirtings. The pram park is enclosed on three sides, with external walls, and the cost of this area must have been almost as much per square foot as the rest of the building. Generally the premises are about twice as large as they need be.

Suggested Rearrangement.—The doctors are in favour of establishing an appointment system, thus making the large waiting-room even more superfluous. In these circumstances there is sufficient room available to experiment with a scheme of integration with the local health authorities. It is suggested that this group practice is important enough in its locality to act as a centre. The model for this exercise is the Nuffield Medical Centre in Harlow, which combines under one roof very successfully a group practice, an antenatal and infant welfare clinic, and a group dental practice. In this study the clinic only is added to the group practice by simple reorganization and by utilizing the existing waiting-room. The consulting-suites and doctors' common-room have all been retained in their entirety, the service entrance becomes a staff entrance and the treatment room is converted into the office—larger in area than the existing one. The space occupied by the existing office and entrance becomes the waiting area, which is shared with the clinic. While this area is small, the appointment system and the possibility of using the antenatal room as overflow waiting-space makes this a practical size. The treatment-room for minor surgery is repositioned and would be used by the district nurse. An additional staff lavatory, adjoining the consulting-rooms, is provided in place of deep cupboards. The covered pram park is enclosed to provide an office for the health visitors and to form a draught lobby entrance. Suspended ceiling in the waiting-room and top light and ventilation to the internal rooms complete the conversion.

Conclusions.—Both units are now of adequate size, better use is made of the space available, and the circulation in the group practice is improved. It would be improved still further if the common-room and consulting-room 1 were interchanged, but it would be rather expensive to provide a second examination-room. However, the suggested

rearrangement is flexible enough to permit possible reorganization in the future.

Discussion

This private survey was carried out because of our belief that there were urgent needs to look more closely at general practice with a view to improving conditions in the future. It is hoped a more detailed and extensive analytical study will follow.

The ideals of the Health Service are probably safe in the hands of the British general practitioners in spite of their past disillusionments, but their methods of working and their premises show evidence of uncritical acceptance of traditional patterns. This, coupled

with a lack of imaginative thinking about the future, highlights the needs for leadership from within the profession, based on adequate and continuing information and experiments.

Clinical methods were not part of our survey, but it is very important sometimes to look at the ways in which the G.P. is managing the common diseases and to assess the effectiveness of his therapies.

The functions and designs of G.P. premises must be studied in some detail. Is there a real need for an examination-room? and, if so, How can it be used most efficiently? What size and shape should the waiting-room be? and What will be the effects on it of an efficient appointment system? Research must be started and continued into the best ways to plan, organize, and build. Experiments will have to be undertaken to try out new ideas, such as omission of the evening surgery; the formal training of secretaries; more extensive and responsible use of nurses specially trained for general practice; provision of facilities for pre-symptomatic diagnosis; cheaper and more efficient building methods, including possible use of new architectural principles as evolved in the "clasp" system of school building; a national building programme in general practice, taking advantage of standardized bulk buying and possibly working in close liaison with the current plans for building hospitals; the special problems of building on restricted sites (which applies to many of our urban practices) and the possibilities of building G.P. premises on more than one level; the extension of the principle of reserving sites for general practice premises on all large-scale public and private housing projects.

As a result of such studies and experiments information will become available, and this must be used to help individual G.P.s. An "advisory service for general practice" must be developed. From it any general practitioner will be able to obtain expert advice on any problem connected with his practice. Ideally it will have to be a co-operative service from within the profession and sponsored by the College of General Practitioners, the British Medical Association, and other interested bodies.

Such a service will be quite useless unless at the same time we explore ways of helping G.P.s financially. The

average practitioner has not sufficient capital to undertake major reconstructions and alterations unaided. Consideration must be given to extending the Group Practice Loans Scheme to apply to all types of general practice. In addition the possibility of more generous tax-concessions for rebuilding, alterations, employment of ancillary staff, and provision of equipment must be studied. A ten-year plan for general practice is needed even more than in the hospital field.

With such suitable incentives and aids for general practitioners to help themselves the future of general practice will be assured and rapid improvements should occur.

Summary

The present and future roles of the general practitioner are under much discussion. There is a general desire to help the G.P., but before such help can be usefully given it is necessary to have up-to-date factual information on the subject.

A survey has been carried out on 33 selected general practices, within 50 miles of London, to collect information on their organization and premises, and to obtain the general views from the individual doctors.

The visits were carried out by a general practitioner and an architect, and simple methods were employed. In the space of one hour much detailed information was obtained.

The general practitioners were all "good G.P.s." They were individualists jealous of their independence. Their morale was high but they complained of professional isolation and some dissatisfaction with the present situation. Doctor-patient relations were good and there was no abuse of the N.H.S. by their patients. Relations with hospitals were excellent: those with local health authorities were indifferent. Although all felt that they worked hard, less than half (14) considered that the size of the lists should be reduced. A decline in private practice was evident. Eighteen had no private patients, and the great majority expressed a dislike for private practice.

In contrast to the individuality of the G.P.s there was an extraordinary sameness in the organization of their practices. Premises were arranged in a similar fashion. Even the new purpose-built premises were inflexible with few thoughts for the future. Ancillary staff were not well accommodated. One-third of the doctors lived on the premises. There was only minor interference with home life. Night calls averaged only two a month and 28 of the 33 practices worked some rota scheme. Appointment systems were used in one-third of the practices. Those who did not have appointments considered a 20-minute wait by the patients a reasonable minimum. Half of the practices used an examination-room and two-thirds held special clinics for children, inoculations, and antenatal care.

There was a high standard of cleanliness and interior decoration, and in 26 of the practices there was evidence of recent or contemplated alterations. In spite of this 20 of the premises were regarded as unsuitable, and in 14 there was evidence of poor conversions. There is need for research into the optimum sizes and functions of the various rooms and into cheap and efficient building methods.

Examples are given of two practices that were visited, each of 6,000 patients. The faults in premises are noted and possible suggestions made to improve them.

We recommend that more extensive and detailed studies be carried out, that an advisory service be established to help G.P.s to replan and redevelop their practices, and that financial incentives and assistance be made available for this purpose.

We would like to thank the 33 general practitioners who so kindly and so willingly co-operated with us in this study.

REFERENCES

- Cohen Report (1954). Report of the Committee on General Practice within the National Health Service. H.M.S.O., London.
- Collings, J. S. (1950). *Lancet*, 1, 555.
- Hadfield, S. (1953). *Brit. med. J.*, 2, 683.
- Nuffield Provincial Hospitals Trust (1955). *Functions and Design of Hospitals*. Oxford Univ. Press, London.
- Peterson, O. L., Andrews, L. P., Spain, R. S., and Greenberg, B. G. (1956). *J. med. Educ.*, 31, 12, part 2.
- Taylor, S. J. L. (1954). *Good General Practice*. Oxford Univ. Press, London.

HOW GENERAL PRACTITIONERS USE OUT-PATIENT SERVICES IN TWO LONDON BOROUGHES

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Advice and care by senior consultant members of the medical profession have always been offered to out-patients by the London teaching hospitals. With the inception of the Health Act, however, institutions which had originated as fever hospitals or as a result of the Poor Laws came under the regional hospital boards, and, as newly constituted general hospitals, also became identified with a statutory obligation to provide consultant services. Thus a trend which had been developing during the pre-war years was officially accepted at a national level. The general practitioners in central London therefore found themselves in a position where they had a very wide choice of hospitals to which they could refer their patients for management as out-patients. It is the purpose of this paper to describe a survey of the use of out-patient facilities by general practitioners in two adjacent Metropolitan boroughs. In the area studied there are three teaching hospitals, and three hospitals under the control of the regional hospital board (R.H.B. hospitals *passim*); two of the latter have well-developed out-patient departments, while in a third only a few specialties are offered.

Method

At the beginning of 1962, when the survey was started, 77 general practitioners were holding more than two surgeries a week in the two boroughs. Over a four-months period 73 of them were interviewed by one of us (D.J.P.B.); four refused to co-operate, but they were all members of partnerships in which other members