Middle Articles

GENERAL PRACTICE OBSERVED

Organization and Management of Health Centres*

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British Medical Journal, 1970, **2**, 353–356

Introduction

Every year more doctors are joining together in group practice or moving into health centres. In its forthcoming report on *Primary Medical Care* the B.M.A.'s Planning Unit says:

> "If we are clear about the work which the primary care team must perform, the design and structure of the building should be such as to facilitate the work. It would seem a truism to say that in the planning of new buildings or the conversion of old ones the people who are going to use them and the architects concerned with their construction must work together."

This may be a truism, but behind it lies the danger that neither doctors nor architects know what is needed. Hence the proposed building must be planned to house all the various personnel and equipment necessary for the total care of the whole patient within the community, together with the additional function as a teaching centre which it may well have to assume in a few years' time.

A health centre is not just a building intended to house a group of general practitioners with or without attached paramedical staff. In concept it is far more than this. It is basically intended as a centre designed and built so that the total needs of the patients can be anticipated, organized, and carried through from the cradle to the grave and from the stage of prevention to that of aftercare and terminal care. It is intended primarily for the patient, yet if it is successfully designed it can give infinite satisfaction and fulfilment to the doctors and their colleagues in allied professions who work in it.

My comments are not based on any one particular health centre I have seen, but rather on looking at many of them in the mass and making general notes. Nearly all these come within the category of health centres, Mark I.

Facilities

On the assumption that an ideal siting has been chosen, the immediate need is for adequate directions for finding the centre. Patients should not have to search for their family doctor. Parking space for cars and prams is also a priority. One centre of 12 doctors I saw had 28 car spaces. This was entirely inadequate; for the cars of the doctors, nurses, health visitors, and other staff alone took up practically all this space. Undoubtedly the smaller centres have great advantages over the larger from the point of view of reception and waiting areas. In the large centres (of over, say, four doctors) patients tend—or can tend—to get lost, and the doctors seem too far away. I hope that this is a false impression, but it is one that is difficult to disregard.

If a partnership moves from one set of premises to another with an attached staff and an organization that are known to their patients, only the premises are changed—and these almost certainly for the better. There is therefore little that is new to which the patients have to accustom themselves. If, on the other hand, three, four, or more partnerships join together to work in one new centre with at least some new staff, and a new and untried organization to which no one is accustomed, it is the patient who suffers most. For this reason it seems to me vital that in this latter situation doctors, attached nurses, the medical officer of health, the clerk to the executive council, and any others who are to be concerned in the organization of a new centre should meet on several occasions before they actually move in. For a week or so after the centre is ready to receive patients it should remain closed so that the prepared organization can be given several trial runs and any defects ironed out. In more than one centre I have visited I questioned how the organization had been built up, since there seemed to have been quite a degree of "hit and miss" about it. I also wondered whether all the staff working in such a centre (including the doctors) were well informed about the organization as a whole, and how much of the experimental phase had rubbed off on, or worse still upset, the patients.

Size and Atmosphere

Everyone moving into a health centre is new to it, yet it is essential to preserve the family-doctor atmosphere, so that the patient *appears* still to be in direct contact with the doctor. Certainly, in the smaller centres this atmosphere is more noticeable than in the larger ones. For this reason, serious thought may have to be given to dividing a large centre into two or three small self-contained units.

Noise

The preservation of quiet is a very important aspect in trying to create the ideal atmosphere. I was particularly impressed by one centre in which telephone bells had been replaced by buzzers, and the doctors called their patients by means of a vacuum switch. This switch operated a light against the doctor's name on the receptionist's desk, and she was then able to call the next patient in *by name* (both she and the doctor having copies of his appointment lists). These two devices, together with a carpeted floor, produced a quiet atmosphere, which was both striking to the visitor and reassuring to the patient.

The next need is to reduce the superficial hustle and bustle of staff and patients. The organization should be such that nurses, secretaries, and receptionists can do their work effectively with the minimum of movement. There should be easy communication between all departments, either by

* Based on Memorandum on Organization and Management of Health Centres.

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intercom or by telephone. Patients, even those visiting for the first time, should have clear directions where to go to see the doctor, to make an appointment, or to register; in this connexion, the British Rail method of using different coloured lights for different purposes is a good one. In addition, patients should be given a pamphlet telling them who the various people are who run the centre, and giving details of its organization, times of doctors' appointment sessions, etc. An appointment card should also be handed to each patient, giving the time of the first or next appointment and indicating how and where to report.

Reception and Appointments

Ideally, there should be one receptionist for every two doctors. She should make appointments for the two doctors by telephone or at her desk. On duty during her doctors' appointment sessions, she would give a copy of her appointment list to the clerk in charge of the records before each session and in good time for her to be able to collect them from the records department and have them suitably arranged on the doctors' desks for the beginning of the session. At the end of the session the receptionist would collect them and return them to the records department for refiling. The only movement she would then require to make during the session would be to take into the doctor the records of any patients without appointments or emergency cases reporting during the session. She would call each patient *by name* when alerted by the doctor's light in her office. Her other duties should include responsibility for dealing with requests for new prescriptions and for handing them to her doctors, and for checking each day that the consulting-room desks are properly supplied with stationery and prescription and other forms in daily use. It is a good idea for all consulting-room desks to be similarly arranged, with a list of the contents of each drawer pasted on the side of it.

Another receptionist (possibly the senior one) should deal with new registrations and all matters of central office management, including central stock and storage, and ordering of the necessary forms from laboratories, hospitals, executive councils, etc. She might also oversee the records department and deal with the petty cash and postage. She would, in fact, be the senior secretary-receptionist, around whom the receptionists and the records and typing departments revolved.

Recording Visits

I am not sure of the ideal method for taking and recording visits. These could be the responsibility of the receptionists, each being responsible again for two doctors. Alternatively, they could be co-ordinated by the senior receptionist. Probably the latter arrangement is preferable since it will not always be possible for the doctor of the patient's choice to accept the call. Moreover, the system using the senior receptionist has the advantage of one person being responsible for ensuring that all visits are recorded, and it eliminates a multitude of telephone numbers.

Staff

There is an obvious need for additional or "floating" receptionists (who might well be students) who could help the doctors' receptionists during appointment sessions or known "heavy" hours on the telephone. My impression is that receptionists work an average of 38 hours per week (8.30 a.m. to 1 p.m. and 4 to 7 p.m.; 8.30 a.m. to 12 noon and 1 to 5 p.m.) and clearly if the two doctors for whom a receptionist is responsible have a half-day on the same day this enables her also to have free time on this day. Nevertheless, the organization should not be so rigid that receptionists are unprepared to take over from one another at certain times or to "double up" at others. The session between 8.30 and 10 a.m. and the hours during which appointment sessions are running comprise a particularly heavy workload, and during these hours secretaries and receptionists should be prepared to help each other.

Other members of the staff of a health centre include audiotypists, telephonists, and filing clerks, the numbers depending on the size of the centre and how many patients are served. I was impressed by those centres with a "manager" in overall charge of the centre and its activities. This man must be the diplomat par excellence; to understand and to deal with all the diversities of this job is a challenge to a superman. The wrong man could wreck the whole centre; on the other hand, the right man is an invaluable asset.

Interior Design

The more I have seen the more convinced I am that the large impersonal waiting area is to be avoided at all costs. Ideally each suite of consulting rooms should have its own waiting area, but if this is not possible the large waiting area should be broken up by means of the skilled use of chairs and tables to avoid the institutional and impassive appearance of the traditional hospital outpatient department. The floor should be carpeted in nylon and a variety of chairs provided; high and low, hard and soft. The need for privacy in the reception area must also be recognized. The doctor's consulting-room, together with his examination room, will be built to a standard size. I am not convinced that there is any disadvantage to this, though several factors must be borne in mind. To avoid the risk of losing his identity in the health centre, each doctor should have his own consulting-room, and there should be an *additional* room for the trainee assistant. Adequate sound-proofing must be ensured. Each doctor will arrange his room to suit his own personality and method of working. Nevertheless, some elements should be common to each room—such as a carpet and a shelf for books. The probable future teaching role of the general practitioner should be borne in mind. I saw two rooms of the same size in two health centres one of which had no room for a student, the second ample room. With the examination couch against the short wall and the doctor's desk parallel to it there was clear space for two additional chairs; with the desk parallel to the long wall there was room for only one extra chair. When the first doctor was asked if he had room for a student he said "yes," yet the second said "no."

The standard-sized examination room is too small. Space must be made available for an instrument tray and for the doctor to write his notes (both at the right height), and I was impressed by the switch in the room which the patient, when ready for examination, could press to activate a light in the consulting-room. An extractor fan in the examination room is another good idea.

Paramedical Staff

To run a health centre for the total care of the patient to which nurses, health visitors, midwives, and, where possible, social workers are either not attached or only partially attached is completely fatuous. In some cases district nurses have a room in the centre but phone in for calls; they rarely seem to meet the doctors with whom they are working. Alternatively, "practice nurses" may be employed, thus increasing the difficulties of two nurses looking after the same patient—one inside the centre and one outside. In some cases midwives are not attached but come to the centre for general-practitioner and local authority antenatal sessions. Local authority autonomy in this respect is a menace and it should not be left to local public health medical officers or family doctors to decide whether the attachment is feasible or not.

Attachments of paramedical staff are vital to the successful working of a health centre—in fact, without them one should stop talking about a health "centre." Similarly, open access to the laboratory and *x*-ray departments is imperative if total care is to be achieved, while a physiotherapy service is long overdue. It is a pity, too, that routine domiciliary consultations with hospital doctors in health centres seem to be too advanced a concept to be acceptable by the authorities. All those concerned with the organization of the centre—that is, with the care of the patients attending the centre—should be fully responsible for their share of the whole care of those same patients. They should know each other, each other's role in the centre, each other's rooms in the centre, and where the common room is. Possibly the district nurses working in and from the centre may use a rota system whereby one is on duty in the treatment room and another on her rounds. The former should be responsible not only for duties in the treatment room but also for ensuring that the consulting-rooms are properly equipped—to a standard pattern. Nurses, health visitors, and midwives should be attached to the centre rather than to individual doctors or partnerships working in the centre.

In one centre there seemed to be an ominous division between the various health and social security departments. The mental health officer had separate accommodation in the centre and worked from there outwards, being "in and out" from 8.30 a.m. to 4.30 p.m. He had an assistant based on the centre, and the relations with the doctors in the centre were no closer than with others outside. One building had thus two separate services dealing with the same patients but no "formal" association between the two.

I did not see a single centre to which home helps were attached. Yet with early discharge just around the corner, the wish of family doctors to treat their patients in the home, the high cost of the hospital bed, and the difficulty of attracting home helps to the National Health Service against the counter-attraction of better pay and shorter hours in other occupations, it is urgent that the status of the home help should be raised and that she too should be recognized as a member of the domiciliary team. Neither doctors nor nurses can cope with the patient in the home unless provision is made by day and often by night for the care of the home. Each health centre should have its known group of attached home helps working within the National Health Service.

Teaching Facilities

So far I have not found a health centre with accommodation for students or postgraduates under tuition. Mark II centres must either acknowledge Todd—with all its implications of teaching within general practice—or opt out of any teaching role from the very beginning. One consulting-room and at least two small rooms for individual study must be provided. The equipping of these rooms with desks and chairs, books, and audio-visual aids might be achieved through local effort—a good cause for appeal to patients and other well-wishers.

Ideally, the doctors' common room should be sited on the ground floor, and to ensure that it is used the obvious first rule should be that coffee and tea are served only in the common room. I am sorry to say that there is obviously a difference between a "common room" and a "staff room." Doctors enjoy a common room not only for drinking coffee but for talking shop. Thus a common room is very necessary, but so, for the sake of team-work, is a staff room. A common room *and* a staff room may be needed, for if one room has to serve both purposes it tends to remain empty.

Management

I am still unsure about the best way of running a centre, though possibly a committee consisting of representatives of all those who work there with an executive elected by the committee seems the best arrangement. The county medical officer of health should be a member of the committee, and I liked the notion of the clerk to the executive council in the chair, with the manager (or secretary-receptionist) as its secretary. A rotating chairmanship is another alternative. I am more concerned about the feeling I had that the larger centres were not all acting as one unit. My own experience shows that coffee or tea together can probably solve more problems more quickly than any official committee meeting. The more closely the various members of any centre know each other the fewer the problems. But this raises a number of questions. Should doctors continue to work within separate partnerships, each with its own agreement? Is there a danger of a large unit in with smaller ones tending to swamp the latter; or smaller units preferring to opt out of the concept of one overall organization? Either would be regrettable and to the detriment of the patient. From the patients' point of view doctors working in the centre should all appear to be working together as one unit. Time will show whether partnership agreements will become anachronistic, and neither this question nor the terms and conditions of service of doctors working in health centres should be allowed to intrude on to the patient in any way.

Patients' Records

Similar questions arise in connexion with patients' records. Should they be filed in partnership, against doctors' individual lists, open to all, closed to some, separated into doctors' notes and nurses' notes and health visitors' notes and social workers' notes—or all in one folder? I believe that, aside from the age-and-sex register and any other individual index, all the notes pertaining to one patient should be enclosed in one folder and filed within a general filing system. Any other method would increase the work-load of the filing clerks beyond the bounds of common sense. I know that health visitors may resist this—they point out that when patients move from area to area the health visitor's notes can follow them very much more quickly than the doctor's National Health Service notes. Considering the question of confidentiality, I believe that when all those concerned with the total care of the patient are working harmoniously together in one building there will be no difficulties over this, and I hope no secretive locking away of one aspect of patients' health separately from another. All the notes concerned with the health and social welfare of one individual should be together. Nevertheless, if even one of the units concerned operates from outside the building, or from an unapproachable part of the same building, this ideal is not possible.

Lack of Unity

One cannot help being very anxious about the fact that the functions of health centres differ from area to area. No one seems to have defined what the total responsibility should be. This must be obvious from the "hit and miss" type of attachment schemes; moreover, the absence of any central recommendations relating to records is in itself unfortunate. There has been no attempt in most areas at screening or presymptomatic diagnosis. Some centres have no well-baby clinics; others are running antenatal clinics without midwife support. Some have no interviewing-rooms for health visitors. What sort of a "health centre" is it that will have a maternity and child welfare clinic working dead opposite it? Surely family-planning clinics should be a part of health centre activities? Should some patients go to local health

authority clinics and others to health centre clinics for cervical cytology? Should ambulance and British Red Cross services be drawn into health centres or separated from them? One could go on. Central direction is overdue. A waste of money and manpower is bad enough, dividing the patients' total care is worse.

So far I may have seemed to be guilty of emphasizing the mistakes and deficiencies of the health centres I have visited. This was not my intention; local authorities and family doctors initiating these centres have done so with the best of intentions and with all the available knowledge at their disposal. No one can work to a central plan, because one does not exist. Some centres are deficient in some aspects of care and strong in others. Facilities are available in some and absent in others. Thus different populations of patients have different qualities and degrees of care and this is quite improper.

Even though different areas may call for variations in siting and planning, these should be based on certain principles which are now clear: total care through total attachment; all activities designed to cover the whole care of the whole patient from the cradle to the grave attainable in the same centre, and not duplicated or triplicated in other buildings under the charge of other doctors and paramedical personnel. A centre represents the concentration or marriage of all those personnel and disciplines involved in the overall medical care of the population in its totality, from the stage of prevention of disease through to aftercare and follow-up.

OUTSIDE EUROPE

Medical Care in Australia

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British Medical Journal, 1970, **2**, 356–357

Australian medical care is organized differently from medical care in the United Kingdom. In Australia the patient pays his general practitioner. Should a second opinion be necessary the G.P. refers the patient to the specialist of his choice who will charge his fee. To cushion the financial blows the patient can join one of about 110 medical and hospital benefit societies. Only if he is a member of a benefit society will he be entitled to a Commonwealth subsidy towards his medical costs. The benefit society must add at least as much as the Commonwealth pays; the total rebate, however, is limited to 90% of the doctor's bill. Pensioners get free medical attention and drugs, the doctor being paid by the Government on presentation of a voucher signed by the patient.

Should the patient require admission to hospital financial hurdles are once again raised. Only those who can pass a means test can be public patients whose medical care and drugs are provided free. They still pay for their board and lodging. Those who do not take or fail to pass the means test pay their doctors, whom they have personally chosen, and also pay for their drugs and a higher rate for bed and food. These costs can be guarded against by insuring with a benefit society.

When the health benefits scheme, often known in Australia as the National Health Scheme, was introduced the gap between benefit and fee was modest. Steady inflation over the past 20 years, combined with the increasing complexity of medicine, has led to a constant rise in costs. The cost of running a general practice has been increasing at more than 3% per annum for at least the past five years. Doctors' fees have risen, but the take-home pay is unaltered, the increase in total income having been swallowed by extra costs. In effect this means a decrease in the doctors' purchasing power as the Federal Government admits to inflation of about 3% a year. The Government has not altered most of the subsidies during the past 10 years, though it has agreed to higher payments from benefit societies, which has meant higher premiums. By 1969, when benefits were averaging 50% or less of medical costs and were also failing to meet hospital accommodation costs by a large margin, it became obvious that an overhaul was necessary.

Policies of Political Parties

What should be done? The Liberal (Conservative) Government, backed by the Australian Medical Association (A.M.A.), praised the present voluntary system with its emphasis on self-help and its sturdy antisocialism. The Government blamed the doctors for raising their fees, conveniently overlooking the Government-inspired inflation that constantly raises wages and costs. The A.M.A. blamed the Government for failing to raise their contribution to the health scheme to meet rising costs.

The Labour opposition countered with a comprehensive plan for the rescue of hospital finances as well as the payment of medical fees. Public hospitals are financed by State Governments, whose financial responsibilities include hospitals, education, roads, public transport, cheap housing, urban renewal—in fact, everything except defence and foreign affairs. The States have been faced with rapidly rising essential expenditure, due to immigration and natural increase in the population, and a much less rapid rise in income. The Federal Government is the only collector of income tax, leaving the States without a tax whose return rises as the community's income rises. Grants to the States are increased each year, but often the increase is almost all conditional on the State Government spending an equal amount, or in education twice the amount, on specified projects. This system of matching grants bears heavily on the States, whose income is barely enough to maintain their inadequate services. Hospital buildings can often be constructed, but there is no money for extra running expenses, such as paying the honorary medical staff. The Labour party plan was for the Federal Government to accept the responsibility for hospital costs and at the same time pay those doctors who

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