Health centres: Building on sand?*

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These views on health centres have arisen from architectural work in the past three years, from discussions with the potential users, from attempts to design centres and the discovery in conversation with fellow architects of considerable uneasiness.

The architects are uneasy lest the buildings they are designing prove unsuitable, both initially and in the long term, because there has been a lack of adequate information about what is to go on in them. As a one-time general practitioner myself, I fear that current designs may be fixing the future practitioners' working conditions in such a mould that we shall all wake up one day to find that the family doctor has vanished for ever.

One reason for the spread of this anxiety is the rate at which health centres are being planned. Until 1964 the numbers grew slowly—only 21 centres in the first 16 years of the National Health Service. Since then the acceleration has been rapid: 52 more centres appeared in the next four years, up to 1968, and now there are well over 200 in the pipeline, some partly built, some still only plans . . . and no sign of any slowing down in this building programme. Before the experience of the 1968 centres can be published, the working conditions of another 1,000 practitioners have already been determined.

If the subject were houses or schools this rate of building would please most people. Everyone knows what houses and schools are for, and any arguments over the plans would only be over details. But with health centres the situation is different. They seem to vary widely, though it is by no means certain that the patterns of health care they provide are equally varied. Experiment should be of great value, and if these variations have been studied it ought to be possible by now to see which of the earlier ideas has proved to be worthwhile and should be developed, and which should be dropped. Architects desperately need this information from the users of the buildings, but, apparently, it is not yet available.

The problem is most urgent in the context of the new towns, where the health services, like schools and fire stations, have to be ready as soon as the new housing is occupied. If the buildings are to go up in time the plans must be completed long before the appointment of the personnel to work in them. Already studies have been done for the centres to serve Thamesmead—the new town now taking shape on the marshes where Woolwich Arsenal once stood. Work is just starting on the centres for Milton Keynes, where the needs of a population of 250,000 must be met in what is now rural Buckinghamshire. The location of the centres and the form they take will influence the health care of a whole city, yet the people most concerned—those who will live and work there—can have no direct influence on the plans.

That is why the whole medical profession, whether it likes it or not, is involved. Anything doctors say in public—or in print—that seems relevant will be read by the architects and planners. Letters to journals can be particularly useful, since the response

*Based on a contribution to the N.Midlands Faculty symposium on health centres at Mansfield on 27 September 1969.

J. ROY. COLL. GEN. PRACTIT., 1970, 19, 12
in the next issue gives some indication whether or not the original views are widely accepted.

The most valuable views are not expressed in terms of buildings; indeed discussions about a building often obscure the original aims and intentions. A planner's first job, like a doctor's is to make a diagnosis, to discover what this person, or practice or town, really needs. No doctor thanks the patient who tells him "It's my heart", and no architect will thank the doctor who tells him "It's three consulting rooms we want". The architect needs to know exactly what his building's users are trying to do, be they doctors or nurses or secretary-receptionists, and why they are trying to do it and how they think it should be done. Only when that is clear can he bring his skills to bear to suggest what sort of accommodation would best enable them to do it.

The Royal College of General Practitioners has not been idle. It recently commissioned a series of studies of practice organization, allotting to each faculty some particular aspect. All its members in the North Midlands, for instance, have been asked to fill in a questionnaire about the diagnostic investigations they undertake on their own premises. Factual information of this sort about what doctors actually do is scarce and badly needed. The August issue of this Journal carried a report on how patients get to the surgery, suggesting that about 10 per cent of them will use a car even when the distance is less than a mile. This sort of data is needed to persuade a local council to provide an adequate car park even though it adds considerably to the cost of the centre. In the June issue of Update two Belfast professors showed that 85 per cent of their medical outpatients could have been dealt with perfectly well in a properly equipped health centre. That article encouraged those planners who are beginning to see the future division between hospital and community care as that between the bedfast and the ambulant patient, rather than between the consultant and the general practitioner. The implications there for hospital planning, as well as for health centres, are profound.

Unfortunately, architects are not as well trained as doctors in history taking. Even when the doctor is quite clear what he means the architect can be confused by the words used. When he talks of a 'clinic' does he mean only a consecutive series of appointments given to patients with the same condition? Or does he envisage as many patients as possible present at the same time, all benefitting busily from contact with each other in an atmosphere somewhere between that of a club and a cattle market? And when the doctor is not really sure what he means the architect can be completely lost. Some of the statements made about 'integration', for instance, between the three parts of the tripartite health service, have conveyed the impression that the mixture is much nearer to explosion.

Architects, asking questions about such things, have uncovered a good deal of woolly thinking. And when a question is asked in the planning stage of a particular centre there is no time to go back and consider the problem deeply. Decisions have to be made, and often then the best basis for the decision is the short-term economics of the case. That is one reason why cost appears as such a straitjacket. If there is no good evidence to support a case for a more expensive provision, then the cheapest version is all that the Ministry—quite rightly—will approve.

To focus attention on some of these issues, and perhaps stimulate the publication of other views in time to be of use to the next 100 health centres, I propose to consider a few of them briefly here.

The practitioner's consulting room is a good starting point. Naturally every doctor wants a room of his own. But when the duration of occupancy is studied it is clear that, on this basis, all the consulting rooms will stand empty for several hours each day while the 'owner' is out visiting patients in their homes. Surely when funds
are limited they could be used for better things than empty rooms... better ventilation in examination rooms perhaps?—or double glazing to the windows facing the road? If practitioners would allow their rooms to be used for limited periods by other people the total saving might meet such improved standards.

But possibly the home visiting itself should be questioned. It is costly in medical man-hours, so, according to current arguments, it should be drastically reduced. The patients could be brought to the centre, by special transport if necessary. This would create a need for a larger car park, or for a larger waiting room—since the minibus would decant all its passengers at the same time, irrespective of their individual appointment times. Or home visits might be carried out by a nurse or social worker, as has long been the practice in the public health service. This would really alter the family doctor's rôle, for what claim would he then have to be any different from the hospital or clinic doctor who gets all his background information secondhand?

There seems a need for a more positive approach. What is the value of home visiting, to the doctor, or nurse, and to the patient? If this were clearer then architects could begin to find out how long each member of the team is likely to spend in the centre and away from it, and what facilities are needed for discussion between members of the team in the centre about those patients who never actually appear there. Is it not the surgery nurse who never works outside her treatment room who is the real anomaly in a domiciliary health team?

If doctors and nurses are to work more closely together—and this is, surely, one of the important facets of 'integration'—it may be that the nurses' specialist rôles need modification. In some areas planners are asked to provide separate spaces for health visitors, midwives and home nurses, while in others the nursing member of the team has become a single, multipurpose person. To an architect it seems obvious that a doctor would find it easier to work closely with one nurse than with parts of three, and that the nurse, giving more attention to fewer patients, would in her turn find it easier to cope with one or two doctors than with parts of half a dozen. The nurses' future rôles seem likely to change in any case, as domiciliary midwifery disappears in the towns and the separate specialty of social work encroaches on the sphere of the present health visitor. Recruitment must be difficult while the future is so bleak, but if the vision of the nursing member of the health-centre team could be given more substance, and suitable supplementary training be arranged, then this aspect of integration might come nearer to fruition.

General practitioners cannot abdicate all responsibility for the nursing organization. Only with their help will the medical officers of health and their chief nursing officers be able to see into the future of a service whose past was based on such very different premises. The good general practitioner can see how far the health visitor's present rôle overlaps his own, while the chief nursing officer sees more clearly the vital part she plays when the practitioner falls short. It would be tragic if members of the public health service persisted in supplementing poor general practice, thereby discouraging that evolution toward good general practice which is the very basis of the health centre idea.

How big a team can be expected to function efficiently and amicably and remain acceptable to its community? The Todd report recommends "at least a dozen" practitioners in a group practice, and for lack of any better guidance this is the gospel for new town planners among others. It so happens that a population of 30,000, which needs 10–15 practitioners, also needs one comprehensive school. So the school and health centre can share a site owned by the local authority and the bus routes can serve both. Is this tidy planning arrangement endorsed by those who will have to use the buildings? Do schools and health centres really make good neighbours? Can the occupants of existing large centres say whether such large groups of doctors and of
nurses tend to keep to their own professional cliques instead of mixing, and what happens to the visiting dentist, speech therapist or chiropodist, whose nomadic existence creates an even greater need to feel they belong to a multiprofessional team? If the smaller centres are better integrated there may be a very good case for them.

The patients’ views are difficult to ascertain. It is known that, in favourable circumstances, 30,000 people will accept the need to travel to a single centre. Not so many modern mums push prams after all: some have cars. But such a centre is inevitably quite a large building, full of the hum and bustle of telephones and arrivals on a scale four or five times that of the traditional doctor’s surgery. It is too big to offer privacy to the shy patient through its appointment system, yet not big enough to afford him the solace of anonymity. It is a council house of a provision, physically adequate no doubt, but still the sort of place a number of quite poor people might struggle to pay to avoid.

This basic issue of size arises again when the possibility of consultant outpatient sessions is investigated. Such sessions would probably be quite feasible in the large centres under discussion. The patients concerned would benefit, and it is pleasant to think that proximity would encourage valuable contact between the domiciliary and the hospital doctors. But 90 per cent of the illness seen by community-health teams does not concern hospital consultants. If the conditions suitable for 10 per cent are against the best interests of the great majority, surely it is time to stand out against administrative convenience and short term economy.

Such a stand cannot be made without a basis of factual information, and the issues raised here are only a few of those encountered in the planning of any health centre on which more facts are needed. Others range from the apparently straightforward matter of defining what equipment should be communally owned to the fundamental problem of whether the doctor should see all patients, referring some to ancillary team members, or a nurse or social worker be the person of first contact, passing on all who need more than her skill. With such matters still to be resolved on an ad hoc basis for each and every centre, it is small wonder—indeed it may be just as well—that the time likely to elapse from conception to occupation is at present nearly five years.

REFERENCES

The child with a cough

Mr D. J. Whitehouse, product manager of The Crookes Laboratories Limited has drawn our attention to a statement made by Dr R. P. C. Handfield-Jones in his article The child with a cough (J. roy. Coll. gen. Practit. 1969, 18, 22) that the contents of a Karvol capsule may be squeezed on to the pillow. In the experience of The Crookes Laboratories Limited it is more satisfactory to squeeze the Karvol on to a handkerchief or a piece of clean rag and to tuck this inside the childs night clothes. The warmth of the childs body vapourizes the essential oils which then have beneficial effects on the childs breathing.