GROUP PRACTICE, ANCILLARY HELP AND PERSONAL MEDICINE

Ideas from Dutch general practice

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THE ADVANTAGES OF GROUP PRACTICE have appealed to an increasing number of general practitioners in Britain, and the trend is likely to be accelerated by the new incentives in the Review Body's recommendations.

In Holland, where single-handed practice is virtually universal, the formation of group practices is a current focus of interest. The Dutch Institute of General Practice, for instance, has plans for an experimental group practice at Utrecht; and in the same area well-attended meetings on the formation of groups have been held. At least 30 general practitioners there have indicated their readiness to involve their practices in group formation; and similar interest is being shown elsewhere in Holland.

Conversely group practice has lessons to be learned from the structure of Dutch single-handed practice.

The Dutch 'doctor's assistant'

About one-third of the single-handed men work with a purpose-trained 'doctor's assistant', who merits close attention. While we are used to thinking of ancillary help in terms of receptionists, nurses, typists or dispensers, the doctor's assistant is purpose-trained to fulfil, up to a point, all these roles. She occasionally, but not usually, has a nursing training. More often she takes a specific training for the work after leaving school, at the equivalent of our technical schools, the length of training varies from nine months to two years in different areas. This includes a period of in-service training in a doctor's surgery with a senior doctor's assistant for three months, or the equivalent on a part-time basis.

Her training covers typing, book-keeping and medical terminology; the care of medical records of all kinds; elementary pathology, such as urinalysis, ESR, and full blood counts, which she carries out in the surgery; elementary pharmacy; first aid nursing, and the sterilization of instruments. General practitioners vary in how much they train their medical assistants to take on, but some of them give injections, take venous blood, and dispense. Shorthand is not taught or expected; and omissions from the repertoire are ear syringing, immunization injections, sphygmomanometry and electrocardiography—though there is no clear reason why these should not be attempted.

The hours worked are commonly from 8.0 a.m. to 4.30 p.m. five days a week, and the pay the equivalent of £7 rising to £15 a week. But in

some practices the doctor's assistant becomes very much part of the practice and the family life, and she may switch to baby-minding or shopping for the doctor's wife. In one practice visited the doctor's assistant was making an important contribution to research work within the practice, and clearly enjoyed both the elastic duties and hours of work. She was not above preparing lunch, however, and clearing it up afterwards.

At his best, the single-handed general practitioner in Holland, with his purpose-trained doctor's assistant, presents an attractive method of practice with ancillary help. The doctor-patient relationship is extended to one helper only, and needs no protection; and for his patients, the doctor and his assistant, one or other or both, are his invariable first contact when in medical need. They are both likely to know a good deal about him. Personal medicine can thus hardly be escaped. In group practice it can be no less personal, but it has to be consciously striven for and protected. The formidable problems of communication in a group practice, as the number of ancillary helpers grows, barely exist for the single man and his assistant. The considerable time and effort spent in large groups on policy-making meetings are escaped, as is the daily drain on time and energy given to administration of the practice with a large staff. The personality problems and medicopolitical pressures of a group of partners and staff (inescapable in any human group where there is drive and progress) are disposed of. All this means more time and energy for clinical medicine and family life.

By virtue of the uninterrupted and continuing team-work on the practice population with one ancillary helper the Dutch general practitioner is in a position to train his assistant to take over a greater proportion of his work, judging her competence accurately as she proceeds, and to take on more difficult work, such as making extracts of patients' day-to-day records and reports for permanent summaries, or handling research material. But there are drawbacks which mirror the drawbacks of single-handed practice. It is impossible to replace this service during holidays and sickness, and difficult to find a replacement to do even the basic work, and hours of service are limited to what one person can provide in a day. Above all, if a practice sets its cap at developing its fullest potential, and expects an appointments system, an age-sex register, a morbidity register, and some active research, as well as a high clinical standard, the single assistant cannot cover the needs, however trained.

Advantages of group practice

Good group practice has solid advantages which are over-riding. It is true that for the single man professional isolation can be reduced by holding regular clinical meetings with neighbouring general practitioners in the evenings, as described by one Utrecht practitioner. But this is no substitute for the hour-to-hour contact with colleagues in a group, with its built-in mutual criticism and mutual help, and with its pooling of knowledge and ideas. Ideas and action are born of discussion, perhaps more often of scraps of discussion arising in the course of a busy day than of formal discussion at a meeting. Enthusiasm for progress is infectious.

A group of minds is more dynamic than a single one. With the speed of change accelerating both in the medical sciences and in social structure, these are the qualities we need in general practice.

The flexibility of a group in meeting the demands of sickness, holidays, and epidemics, and the sense of security that goes with it, are cardinal points in its favour, and go a long way to reducing the anxieties of the life. When the load becomes intolerable, there is always someone to help out; or perhaps equally important, someone equally over-burdened to grouse with. These rather intangible benefits of group practice are its main advantages. But there are others. Shared equipment is economical; for the same monetary contribution, a better standard can be reached. As a source of clinical material, the patient population of a group, by its size, provides more than a single practice. As a field for research it is similarly wider, and as an instrument for teaching and continuing education its advantages are obvious.

The best of both worlds?

To summarize, the Dutch general practitioner with his purpose-trained doctor's assistant enjoys the advantages of close team-work and continuity, denied to some extent to the British general practitioner working in the larger team of a group practice and sharing ancillary help; but is in turn denied the stimulus and security of working with colleagues. Neither of these factors should be under-estimated in planning the pattern of future general practice. Can we have the best of both worlds?

With some lightening of the British general practitioner's financial burdens, with the objective of making more ancillary help possible, there is little reason why each general practitioner should not in future work with his personal receptionist, on a one-to-one basis, within the structure of a group practice. With suitable basic training receptionists could be trained up to greater responsibilities according to need and capacity in each case. This need not interfere with the practice of sharing the premises, income and general policy of a group practice; indeed it would immediately enhance it by solving many of the problems of communication and training, which multiply as the number of persons in the ancillary 'pool' of a practice increases.

For the single-handed man the employment of a purpose-trained doctor's assistant would be a small step from employing a secretary-receptionist, and would lead to the development of a more comprehensive service. In either case, if a one-to-one ratio (general practitioner to ancillary help) were found insufficient, additional help could easily be added in a part-time capacity.

Proposed experiment

The general practitioner's basic needs are in three fields:

1. Secretary/receptionist/book-keeping.
2. Nursing and midwifery.
3. Medicosocial.

The mere aggregation of, say, five doctors, five nurse-midwives, five

secretary-receptionists and some form of medical social worker in one building is insufficient. The mechanics of communication, and the psychology of personal relationships when under the heavy stresses of practice life are more formidable than might be imagined by the inexperienced; and in addition, much time and energy can be mopped up by the detail of administration of the unit.

A solution may be to build five independent teams composed of general practitioner, one receptionist-secretary, and one nurse or nurse-midwife,* each responsible for its own population of patients and for the detail of day-to-day management. Separately filed case records would logically follow. The number of such teams would vary according to the size of the group, but they would need to be supported by a central telephone service for taking incoming messages to visit, and for surgery appointments. A system of this sort, though somewhat elaborated, is in fact used in the medical service of Messrs Phillips, Limited, of Eindhoven in Holland, where telephone messages and appointments are received centrally at the switch-board and distributed to each of the general practitioner's doctor's assistants.

This kind of arrangement should give easy and efficient team-work, and freedom for each general practitioner and his helpers to develop their service according to their personalities and bents, without interfering with the advantages of working with a group of colleagues. Income, expensive equipment, and major policy could still be shared, as could access to the group's medicosocial worker and health visitor, and the group's combined pool of clinical material for purposes of research and teaching.

The nurse in the team

In the team—general practitioner, secretary/receptionist, nurse—the work of the nurse is envisaged as being chiefly domiciliary, and covering not only what is now done by the district nurse, but also much of what the general practitioner now does himself. Nursing or technical procedures in the surgery could be undertaken either by the nurse in each team, or more probably, taken over by the secretary-receptionist, trained on the lines of the Dutch doctor's assistant.

It would not be difficult to mount such an experiment and obtain practical experience of it. It should free general practitioners' time to cover the expected increased load in coming years, and open the doors to the problems of presymptomatic screening, teaching, and research, which lie now beyond his grasp for lack of time and organization. A by-product would be the creation of a challenging and vastly more interesting career for the domiciliary nurse, for there is little doubt that she could take over much of the responsibility for domiciliary care, and some of the responsibility for domiciliary diagnosis, from her general practitioner.

*e.g. District nurse attached to the practice.