degrees of urgency and so on, and this requires some clinical understanding.

(e) If all staff have this wider knowledge the administrator, who should have an overall recognition of the working procedures of doctors and nurses, is able to deploy resources to meet varying demands. In fact most other countries already use medical secretaries and doctor's assistants in technical procedures. Urine testing, weighing, blood pressure and temperature recording, simple blood tests, preparing patients for examination, sterilizing, cleaning and checking instruments are all within the range of their competence.

Observations and recommendations

The scope of medical care is rapidly expanding. In order to permit the general practitioner to realize this full potential in the future we shall require a greater quantity and higher quality of administrative staff, and our recommendations are made in the light of what we regard as the future needs of group practice.

1. We cannot emphasize too strongly our belief in the importance of having a practice administrator in every group practice, whether designated as such, whilst also carrying out other duties in the practice, or with the sole duty of practice administrator, will depend on the size of the group. There is at the present time no source of trained experienced personnel to fill this rôle. A recent survey shows that less than 1 in 25 group practices have a member of staff designated as practice manager or administrator, recruited from various sources.
2. In the future it should be possible for an administrator to attain a properly recognized professional qualification and this we feel should be a long term object. For the present we believe it would be desirable to establish some training courses on a day release basis. These would run in parallel with planned visits and attachments to group practices already employing experienced practice administrators.

   We have already indicated some of the skills required and we would stress that the type of person needed should be mature and responsible and to this should be added training and practical experience.
3. The general staffing structure of group practices at a lower level will depend upon individual practice requirements. We see a need for an increasing number of staff per doctor. There are two possible ways of training these staffs; in-service training and specially-designed training courses. Both methods have their supporters, but we are agreed that there is an element of knowledge which is common to all practices and which can be well taught on a special course such as that designed by the Association of Medical Secretaries. There is also an element that can only be acquired by practical experience and this needs proper recognition.
4. There is need to accumulate, record and disseminate knowledge of administration in group practice. Doctors and their staff should be involved in this on a national and local basis.
5. Finally, the proper fulfilment of the functions of group practice requires efficient organization and adequate staff. It is often the absence of these that contributes to the deficiencies of many practices today.

Discussion

Dr M. Drury said that he had tried in his paper to categorize the principles of administration, the areas of responsibility, the skills needed, and many of the problems. He wished to go two steps further in the light of this paper and to ask, first, What was going on now in the sphere

of administration? and, secondly, What they ought to be doing in the future?

He reported on some preliminary figures analysed from a joint working party set up between this College and the Association of Medical Secretaries rather a long time ago, under the chairmanship of Dr Kuenssberg, where they had tried to look in detail at what was being done in the administrative field in a number of practices. One hundred and forty practices were taken which were regarded as having some system of administration. This was an entirely arbitrary method of deciding. It was known from papers they had written and from the fact that they employed large numbers of administrative staff that they were interested in this work. Between them they employed between 600 and 700 staff, and a series of questionnaires were sent out to all the members of the staff and to all the doctors involved.

One of the major problems had been the remarkable variations between the different practices, particularly in terminology. What was a secretary in general practice? What was a receptionist? This had produced great difficulties in an attempt to get a coherent analysis. Was there a relationship between the numbers of staff employed and the number of doctors in a group? Most people would say that there was, and the figures showed that the more doctors there were the more staff were employed, but one particularly significant point came out very clearly. This was that in practices of two or more doctors the average number of staff was pretty constant, but in single-handed practices the number of staff per doctor was significantly higher: in other words, it seemed to take more administrative staff to administer one man than it did a group; but above that, in groups of two to ten, while there was a tendency for the hours worked by staff to be lower, the ratio of staff to doctors was about constant; there did not seem to be any substantial saving in staff in the bigger group. The relationship was between the number of staff and the number of doctors, not the number of patients. The reason might well be a financial one; because the partial reimbursement of staff was based on the number of principals in the NHS, they were forced into a situation where the number of staff employed was limited by doctors. There might be a case for combining this with a system of looking at the average list size as well: a practice with three or four doctors looking after 2,000 patients each might get a certain reimbursement encouraging them to employ a certain number of staff but for a practice with the same number of doctors looking after 3,000 or 3,500 patients each there might be arguments in favour of a greater reimbursement as a greater incentive to the group to increase the number of staff.

Another result of this survey was that there did not seem to be any relationship whatsoever between the number of staff employed and the amount of work the doctor was able to do outside his practice. It might be thought that there ought to be, and that if this were not so there should be some relationship between the administrative staff employed and the degree of delegation of administrative work. The analysis of this was particularly difficult; it was found that in those practices which had a relatively small amount of staff in comparison with those with a relatively large amount of staff, the degree of delegation both in numbers and variety remained surprisingly constant. There was therefore something odd about the figures that came up out of this analysis—something that needed to be looked at—and if the figures were then broken down into greater detail the point sticking out like a sore thumb was that the degree of delegation done in most of these keen practice with a lot of administrative staff was really abysmal.

It was difficult from a self-recording questionnaire type of inquiry to pick out what the practitioner was failing to delegate. He could only pick out a few points which would illustrate these findings. For example, in less than half of these practices was there typing, shorthand-typing, copy typing, skill available. This was a surprising figure, and there were many other administrative tasks which ought reasonably to be done by administrative staff; receptionists, secretaries, book-keepers, sorters of mail, people making hospital appointments, abstracting records, looking after the doctors' equipment testing weighing machines, testing urine, weighing and measuring, etc. Many practices either did not delegate these duties at all, or delegated them very little.

Other factors were that it would appear to be much less efficient to employ part-time staff than full-time staff. Equivalent practices employing part-time staff seemed to need many more hours of staff than those employing full-time staff, but again it may have been simply a different degree of service that one kind of practice offered to their patients as against another.

Finally, the most depressing aspect of all was that in all these practices well under ten per cent of the staff had had any training whatsoever for the job they were doing. Looking at the

skills, only 12 per cent of the staff had any secretarial skills; only five per cent of the staff had any knowledge of book-keeping; and only 20 per cent were able to copy-type. This included the one-finger typing of addresses.

The conclusions to be drawn at this stage from this sort of analysis were quite inevitable. Until there was an adequate supply of good quality, trained, full-time staff, the doctor's work would continue to suffer and he would continue to grumble—and so would his wife.

What ought to be done about it? If we are to rationalize the system, I think we ought to define clearly what categories of staff are employed in practice, and here I take up Dr Reedy's point about job evaluation. Whatever classification is used it needs to be simple. There is a good case to be made out for three types of staff to be employed in practice and for their duties to be fairly clearly defined: receptionists, medical secretaries and practice administrators. Good quality staff are needed, and to get them reasonable economically competitive rates will have to be paid. The Guild of Medical Secretaries had provided advice on pay. Thirdly, the active support of doctors is needed in inititating courses and in supporting refresher courses for administrative staff. Finally, the skills required for practice administrators must be clearly defined.

A start has been made on this. Information was being collected from between 3,000 and 4,000 staff who were employed in hospitals and in general practice in administration rôles to try to find out what they believed were the skills needed by administrators. From there it was hoped to go on to the point of defining the knowledge and preparing to teach them, and providing pay scales. They were looking at the training received by the administrator in the hospital in order to see how it fitted with the training required for a practice administrator; if practice administrators were to be employed, they should come up through the ranks of their own staff. If we get into the situation of employing only outside staff who have no experience of the medical milieu and whose jobs previously have consisted entirely of administration in offices or factories, we shall do ourselves or our patients a disservice.

Dr J. S. Clark agreed with the three divisions of staffing mentioned by Dr Drury but remained unconvinced about the case for the practice administrator. "I think we tend to get rather carried away with this", he said, "and may well create a sort of bureaucratic paradise in which we shall lose all touch with family medicine as we knew it. One of the quickest ways of doing it is to instal in charge of our premises some highly efficient administrator from outside. My secretary is a crack secretary who has been with me now for seven years, since we first became interested in practice administration. We split the staffing into three areas: we have a separate secretarial area, a reception area and the nursing side of the practice and we have all three autonomous. We have made the secretary the focal point in the situation without her being a gauleiter. She takes the minutes at our practice conferences and hands on the appropriate information to the staff. She acts as a go-between with a foot in all camps. But she does not ruthlessly run the place, she runs it like an administrator but in a pleasant sort of way. I was told that she was an administrator and that I was playing with words. I went away and worried about it. Now a catastrophe has occurred and she is having a baby at Christmas! As her successor we got an ordinary secretary who copes with the situation and does the liason. She does not run it as a powerful administrator and the receptionists and the nurses stay happy. I do not think there is need to worry too much about the 'administrator".

Further discussion clearly showed that it was unnecessary to get bogged down in semantics: once there were two or three people involved in clerical-secretarial work somebody had to be in charge and decide, whether she was called administrator, clinic manager or chief secretary.

Secondly, the bigger the organization became, the greater was the need for management skills. It might be necessary to seek these skills outside because they were not available otherwise, but the job of an ancillary administrative worker in general practice was coming to be regarded more and more as a career job. Where was the cut-off line going to be? Why should not the more mature, more experienced, senior medical secretary, who had taken the time to go and acquire extra skills, be the obvious source for the recruitment of managers of larger groups and larger practices?

Nobody offered a definite cut off point, above which a full time administrator was required, although the general discussion appeared to favour the practices of six doctors and establishments with more than eight ancillary workers.