Health centre practice

With special reference to administration, medical records and research

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A HEALTH centre should combine all three branches of the health service. Usually the hospital service is scantily represented, so that the centre has general practitioner and local authority sections. Exceptions are Hythe, Stranraer and Witney, which have large hospital components. It is generally thought that the more the general-practitioner and local authority sections are interwoven the more successful the health centre. The discipline of the two sections is different and most centres show a division which may be structural or merely functional.

The attachment of local authority nurses to general practitioners is helping to integrate the services and this integration is increased when general practitioners hold their own well-baby clinics or school childrens' clinics (as at Hythe). Quite often, however, the 'clinics' are attended by doctors working on a part-time sessional basis for the local authority and they are 'programmed' to appear at the health centre between certain hours. These doctors are not interested in the organization of the centre and rarely meet the general practitioners working in it.

Integration

Integration may be helped by sharing some of the clerical and secretarial staff between the sections; by the interest of the responsible medical officer of health; by a combined staff room; by a suitable running committee; but chiefly by having a good administrator. I will deal with these points in turn.

Sharing clerical and secretarial staff

Staff taken over on the opening day should become local authority employees if previously employed by the general practitioners. Any new staff will also be employed either full or part-time by the local authority. The audio or shorthand-typists, telephonists and junior clerks will have duties for both 'sections'. The receptionists will be responsible to the general practitioners and there should be one senior receptionist to two doctors. Junior receptionists and clerical staff should have mixed duties between the sections.

The interest of the responsible medical officer of health

Many 'Section 21' health centres have been built and organized through the initiative of the county medical officer of health. Leaders in this field have been Dr R. W. Elliott in the West Riding of Yorkshire, Dr I. A. MacDougall in Hampshire, Dr Warin in Oxford, Professor Wofinden in Bristol, Dr J. B. Lyons in Devonshire, the late Dr A. R. Margetts in Nottinghamshire and his successor Dr H. I. Lockett. Leadership is also required when the centre has been finished and is working—this may come from the county health department, from the medical officer of health, his deputy or administrative assistant.

In Hythe we were shown round by the county medical officer, in Bristol by the administrative assistant, in Peterlee and Cleckheaton by divisional medical officers and

in Scotland by senior medical officers from the Home and Health Department. Quite apart from the paper authority and great interest shown by the local authority or Department offices, one of the doctors of the local authority working in the centre should take a major interest in its integration and running, and he should serve on the house committee. The general practitioner must learn to trust the medical officer of health and rely on him to organize the preventive health care of the patients attending the centre.

A combined staff room will serve as a meeting place for the staff and help in integration. It was Ministry of Health policy that there should be one room for both sexes and all grades of staff from doctors to clerks. We are not convinced that this is correct in large centres where a separate medical staff room may be better used. The position of the staff room in a central area of the building with a kitchen incorporated, or next door, is all important. We were particularly impressed by the staff rooms at Nechells Green and Hythe in these respects. Our Mansfield staff room is on the first floor which means that the general practitioners working on the ground floor do not use the room much.

A house committee or running committee should represent all users of the health centre. The members will be the county medical officer or his deputy, the clerk to the executive council or his deputy, at least one doctor from each practice in the centre and the administrative officer of the centre. Other persons who may be represented either by a member of the committee or an observer are the local authority medical officers working in the centre, the nursing staff and the receptionist and clerical staff. In some centres *all* the doctors are on the running committee but we have solved this difficulty in Mansfield by having a separate staff committee composed of all the general practitioners and nobody else.

These committees should meet at regular intervals, say monthly, in the early stages; later on it may be found that quarterly meetings are sufficient. After a year's work in Mansfield both committees now meet at six-monthly intervals.

Administration

'Section 21' health centres are owned by the county or county borough councils. The Department of Home and Health in Scotland is directly responsible for many of the Scottish centres. There are several independently owned centres such as Darbishire House, owned by Manchester University, and Witney, owned by Nuffield Provincial Hospitals Trust. Whoever owns the centre, and however small it may be, someone must be in charge of its day-to-day running. If the centre caters for more than 15,000 to 20,000 people the administrator's appointment should be full-time. The nature of the appointment will also depend upon the services provided, especially whether there is a large hospital component. There are more women administrators than men, probably because it is thought that 'you can get a better woman for the money available'.

In a 'Section 21' health centre the local authority will employ the administrator and his salary will be controlled by the 'clerical grade' to which he is appointed. In my opinion it should be possible for the administrator's salary to reach £2,000 per annum in 1971 values. 'Health centre administrator' should be considered as a career and not as a step to something else or as a post for someone who has missed promotion in another field. It is a demanding post. The first requirement is a good educational background, the second is personality. Imperturbability, initiative and drive are all important. He or she must like people and have tact in dealing with doctors, nurses, clerical staff and patients. One health visitor administrator of a health centre told us that smoothing ruffled tempers, without taking sides in an argument, was most important. She naturally considered that only a woman could do this!

Choosing an administrator

There is no school for health centre administrators and so from whatever occupation the administrator is chosen he will have to receive some training after appointment. He or she may be recruited from the following posts:

1. *Experienced sisters and health visitors* are employed in Bristol, Birmingham and Sunderland. These people have mostly grown up with the centres and have reached their present ability by experience therein. Although nursing experience is an excellent background for the job there are other aspects of administration which will require extra training, preferably before starting in the centre.
2. *In Scotland* the policy is to select from the Home and Health Department a clerical officer who is skilled in administration and to send her to one of the active health centres for a short course of training before taking up her post in a new health centre. The disadvantage here is that the person chosen will not have had much medical background.
3. *A senior receptionist* employed by general practitioners will have many of the necessary qualifications. There may be some friction with nursing staff if she has not worked with nurses before, or if she tries to control them too closely. There may also be difficulty in taking over a receptionist of one practice, as the administrator, when there are doctors from several practices in the centre. Such a person would certainly require extra training in local authority administration. On the whole I would think that receptionists, unless they have exceptional experience and training, should become assistant administrators in large centres before being transferred to other centres as senior administrators.
4. Hospital administrators and medical records officers may be suitable for the job. They will have had contact with doctors, nurses and clerks though, possibly, not so much with the general public. Previous experience will serve as a useful contact between the hospital and general practitioners, but they will require further training in local authority administration and in the work of the general practitioner and his executive council. Only a large health centre will command a salary for its administrator high enough to attract a man away from the hospital administrative service. In Mansfield, we have made a very successful appointment from this source.
5. *A medical secretary* from any of the three branches of the health service might well make a good administrator if she is prepared to learn the work of the other branches. Willingness to learn, tact and initiative are the essential characteristics of the administrator whatever his or her other qualifications. Schools of technology are starting courses in medical secretaryship, and these will surely form part of the training of the future health centre administrator.

The duties of the administrator

The administrator will be employed by the owners of the health centre, usually the county or county borough council. He will also have responsibilities to the general practitioners and the hospital service, so part of his salary should come from these sources. In Mansfield the general practitioners are responsible for 50 per cent of the salary; part of this is reimbursed by the Department of Health and Social Security.

The *chief task* of the administrator is to make the centre run smoothly and effectively, and to show others that this is happening.

In order to do this—

1. He must establish an easy working relationship with each of his clerical staff: mutual trust is essential.
2. He must have an equally easy relationship with all the doctors, sisters, health visitors, and other people using the centre; he may have to act as a contact between them and county hall.

3. He must keep the centre accounts and petty cash.
4. He must arrange the duty rota of all clerical and reception staff, also arrange for the appointment and training of additional staff.
5. He will conduct people round the building when this is required.
6. He will act as secretary to the running committee or house committee, arranging the agenda and writing the minutes of their meetings. He may also be required to help the medical staff committee with its work.
7. He will be responsible for the caretaker of the building and, with him, make sure that the building is always clean, tidy and suitably heated.
8. He will organize any public or staff notices.
9. He will receive any complaints (or compliments) from the staff or patients and deal with them suitably.
10. He will be responsible for the ordering of all stock, stationery, etc. by requisitioning through county hall.
11. He may be responsible for ordering dressings and medical equipment, by arrangement with the sister in charge.
12. He will supervise any use of rooms on a rota basis, or any change in their use.
13. He will see that appointment books are well kept and medical records properly filed.
14. He will be responsible for the collection of any statistics of attendances or the keeping of any special records which the doctors may require. At Mansfield the age and sex register (kept on cards) is one of the administrator's special responsibilities.
15. He must submit returns to the county medical officer at intervals.
16. He must be willing to try new methods and to initiate improvements himself.

There will inevitably be a great deal of frustration in the job, as he will receive so many different requests from the different people working in the centre. Even when agreement is reached, there will be delay before the officer concerned at county hall can achieve what is required. The administrator must be suitably housed in the centre in his own office, in a central part of the building.

In the larger centres, with twelve or more doctors, a sister-in-charge will be required in addition to the administrator. Her duties must be defined and she should have a separate office, leading from the treatment room. She will do some nursing duties and she will correlate the work of the other nurses, whether they be home-visiting sisters or part-time centre nurses. Although in smaller centres a sister could be in charge of general administration it would probably be preferable to keep nursing and administration separate. There are other centres where health visitors are in charge, and these centres are well looked after, but for larger centres an administrator should have specialized training in administration, rather than nursing.

Medical records and research in health centres

When we were planning the Mansfield Health Centre some of us hoped that an integration of general practitioner and local authority medical records could be achieved. There are considerable difficulties in this and so far very little has been done.

General-practitioner records are standardized throughout England and Wales and are passed on from one practitioner to the next through the executive councils. Each local authority has developed individual record cards for children, and keeps these until requested by a new local authority to forward them when the child moves. It would seem rational for the general practitioner to be the custodian of all records but some doctors do not keep satisfactory records and few do their own infant welfare work.

The general-practitioner records in all health centres are made on standard executive council forms EC 5, 6, 7 and 8. In the Edinburgh General Practice Teaching Centre an additional, specially-printed, large form was used for each patient. The medical record envelopes EC 5 and 6 (Scotland) were kept, and a summary of the patients' notes was sent

in these to the executive council when the patient left the care of Professor Scott and his colleagues. This scheme has great advantages for research but it is time-consuming. It is generally agreed that the present record card is too small and in many ways unsatisfactory.

The Department of Health and Social Security has no plans for changing general-practitioner records which have been in their present form since 1920, or before. This is not surprising, considering the cost of providing 50 million new records and cabinets in which to store them. The MRES (EC 5 and 6) are too flimsy to last for a patient's lifetime, as they are intended to do. The continuation cards are of poor quality and buff in colour, probably because this is cheaper than white, on which many of us would prefer to write. The size of MRES, 7 in. x 5 in., is the cause for most complaint because even when gussetted they do not allow easy filing of hospital reports which, unless trimmed, have to be folded several times. Standard size A5 paper, 5⅞ in. x 8¼ in., will fit into MRES with only one fold and size A6 will fit unfolded.

I would like to plead again for all hospital medical record departments to adopt these sizes only, and to use two sheets of A5 paper rather than one of double this size, *i.e.* A4: 11¾ in. x 8¼ in. Consultants will complain that it is the general-practitioner records which are at fault. This may be so, but we are in the hands of the Department of Health and Social Security, who do not intend to make a change. When area health boards are formed one of their early functions will have to be to sort out the differences between hospital and general-practitioner records. We cannot wait for the computer to solve all our difficulties. The doctor working in a health centre uses the MRES constantly.

The storage of records

In most health centres the advantages of lateral filing on shelves have been realized, though drawers or trays are still used in some. We have seen them kept in consulting rooms, or even in the corner of the waiting room.

Family folders

These were first used on an experimental basis by Professor Backett and Dr Maybin in Northern Ireland in 1956. Dr Kuenssberg has described the use of family filing in Edinburgh, and Dr A. J. Laidlaw has also described a folder to hold the MRES individually. Mr W. B. Fletcher, who was for a number of years the public health statistician and records officer in Professor Wofinden's department in Bristol, designed a family folder for use at St George Health Centre (before this opened in 1964).

The principle of this folder is that it should hold the MRES for all persons with the same surname living at the same address. If there are more than six such persons two folders should be used. The folder is 11 in. x 9 in. with a 3¼ in. deep pocket on each side. In one pocket are inserted the MRES in two piles, up to three in each, side by side. The reports and correspondence are removed from the MRES and placed in the opposite pocket. Each individual has his reports clipped together in chronological order with the most recent reports on top. This pocket will hold a sheet of paper up to 10 in. x 8 in. and so much trimming and folding is avoided.

Dr Laidlaw has suggested that the folders be larger, so that A4 paper could be filed without folding. For this purpose the folder would have to be 12½ in. x 9 in., *i.e.* ¾ in. larger than the paper in each dimension. This is an ideal but with so many doctors having to file into small MRES it seems an unnecessary refinement at present, when every possible effort must be used to persuade hospitals to use smaller A5 paper.

These 'Fletcher' family folders are now used by seven doctors in Bristol, thirteen doctors in Mansfield, eleven doctors in Hythe, three doctors in Cantrill Farm, Liverpool, and two doctors in Langholm, Dumfriesshire. I have contacted all these 36 doctors,

and all approve of family folders, some of them enthusiastically. Some of the Mansfield doctors do not take full advantage of them in that they have not filed the reports separately from MRES in the opposite pocket of the folders. Others prefer to have the MRES removed from the folders by their receptionists prior to a consultation session.

The advantages of family folders are:

1. The family unit is rapidly visualized from the front of the folder.
2. The records of all members of the family are available when a consultation is turned into a 'family affair'. This can be abused but since we are family doctors we must expect to be asked for "something for Tommy while you are here doctor", and give in with grace if the request is reasonable.
3. Reports are much more easily filed in the larger area of the folder pocket.
4. Filing is easier and quicker.
5. The MRES are kept cleaner by being housed in folders.

Storage of family folders

The folders are filed laterally in large metal cabinets. These are 6 ft. high and 3 ft. wide, and have seven shelves. Each shelf will hold 150 folders, and so the cabinet will hold 1,050 folders. On average each folder contains two-and-a-half MRES and so the cabinet will hold 2,625 records. The cabinets are Railex and the present cost is about £50 each. In the Mansfield Centre we have a generous allowance of 18 cabinets for 35,000 patients. Some of us hoped that the family folder would be used to contain records of the patient other than those made by the general practitioner, especially those of the local authority welfare and school health services.

Local authority medical records

Each local authority has its own records, and every branch of each local authority has its own record. Records of immunization may be kept by the parent, the general practitioner, the local authority on its immunization card, its infant welfare card, its school record card and by the health visitor on her card. Surely there must be some way of simplifying all this.

The Society of Medical Officers of Health has produced a form ' MCW 46 (Rev)" which combines the clinic record for a child of 0–5 years with that of the health visitor. This record card measures 24 in. x 10 in. when unfolded and it is at least twice the necessary size for most children. Even so it does not contain a special list of systems, etc. for the neonatal examination. This card is used in Nottinghamshire, but the attempt to combine infant welfare clinic records with those of the health visitor has not so far been successfully used throughout the country.

The Ministry of Education has a record card, form 10M, which is used for all school children and unlike the form MCW 46 (Rev), is used throughout the country. Like the latter it is much too large, 16 in. x 10 in. unfolded. In the course of an average child's schooldays he is likely to be seen three times by the school medical officer compared with 40 times by his general practitioner. Another task for an area health board could be to devise a combined record for children from 0-15 years of age.

Attachment of health visitors to general practitioners

Those county medical officers who have been in the forefront in building health centres have favoured attachment of their nursing staff to general practitioners. Health visitors (and other nursing staff) should be attached before the health centres are opened. It will then follow that the general practitioners will conduct their own well-baby and immunization sessions as in Hythe, Oxford, Manchester and other health centres.

General practitioners may be financed for this work either on a sessional basis or by payment from the executive council for immunizations.

Records kept by general practitioners at well-baby clinics

The family doctor who is interested in continuous care of his child patients will wish to keep records of the work he does at these sessions. If he works on a sessional basis the county medical officer will expect a record on his form. Is it really necessary for these county council forms to be stored after the child has reached school age? It seems to me that they should be briefly summarized and a copy of this summary sent to the child's doctor to be kept in his medical record envelope.

Special record forms for well-baby clinics have been developed by Dr John Fry and by Dr John Wright. The latter's 'Pre-school record' which is a most comprehensive document is obtainable from the Royal College of General Practitioners. Although an excellent record card and most educational it is only likely to be used by enthusiasts: I cannot see many general practitioners having the time or inclination to complete it.

Both these record forms are intended for combined use of general practitioner and health visitor.

Dr P. B. Bailey at Stockwood Health Centre, Bristol, has developed a much simpler document by over-printing on the back of forms EC 7A and 8A—the immunization card. In our practice three doctors do the well-baby work for six practitioners with the help of our attached health visitor. We have no special record forms but we have over-printed headings for the initial examination of infants on forms EC 7A and 8A. The same printing has been done on sticky labels which we attach to MCW 46 (Rev), used by the health visitor. We therefore make notes of the initial examination in duplicate; other notes we write on either our own cards or those of the health visitor (MCW 46 (Rev)). We may at some later date decide to over-print the lower part of the back of the EC 7A and 8A card with dates of important developmental landmarks.

Combination of general-practitioner and health-visitor records

This problem has not been solved, but certain principles should guide the integration of work in health centres.

1. The clerical work done by doctors and health visitors should, wherever possible, be delegated to the secretarial staff.
2. All notes made by general practitioners should be freely available to health visitors and vice versa.
3. Wherever possible notes should be made on one form only and the record of this should be stored in a convenient place.
4. The receptionists and secretarial staff should be responsible for getting out and re-filing records for health visitors as well as for general practitioners.
5. The confidentiality of records is important but it is not practicable to lock up all records in a large centre. One must rely upon the quality of the staff and depend upon them not to divulge information which they acquire at work.
6. All forms used should be simple to complete, and should avoid irrelevant spaces.
7. Wherever possible the forms should be issued centrally through the Department of Health and Social Security, via the executive council.
8. These forms should be filed in MRES but if too large for these they should fit into the present family folder.
9. All records should remain in the charge of the general practitioner and his staff until the patient transfers to another doctor.
10. It should no longer be necessary for the superintendent of health visitors to inspect records and no records need be returned to county hall.

A new record form will be necessary for general practitioners with attached health visitors. This should be a simple white card 7 in. x 4½ in. or at the largest a folded card

7 in. x 9 in. One of the difficulties in getting it adopted will be the conservatism of county health departments and of health visitors. General practitioners also are slow to change their methods. This record could also be used to record findings on school children up to 15 years of age and so replace form 10M of the Ministry of Education. It would be a great advantage for the future if the card could be designed in such a way that the information on it could be fed into a computer.

Personal record cards

These are at present only used to record immunizations, special therapy, important diseases such as diabetes, and for co-operation purposes in antenatal patients. Many BMA conferences have approved of personal cards for everyone and these would be valuable.

Special opportunities for record keeping in health centres

1. The provision of adequate secretarial and clerical staff, supervized by an administrator, should encourage good record keeping.
2. Working together in groups should emphasize the importance of general practitioners keeping records to assist their colleagues. Records of drugs prescribed are particularly important. There are several ways of making these clearly visible—by a separate drug record card, by writing them on the right hand side of the EC 7 and 8 as advocated by Walford (1962), or by writing the drugs in a different ink as is done by one of my partners.
3. The use of case summaries would be helpful; staff could be trained to keep these for us.
4. Records should be filed centrally so that they are easily accessible to all practitioners and health visitors. The records of different practices can be distinguished by colours.
5. Treatment records made by the nurse may also be kept in the centrally stored family folders or MRES.

I would make a strong plea for all doctors entering new health centres to consider the adoption of family folders from the time the centre opens. They will not be likely to get another opportunity to obtain new filing cabinets and the clerical work is much easier when there is the incentive of moving into new premises. All the general practitioners who have done this are pleased that they have done so.

Have health centres failed to set an example in general practitioner teaching and research?

Unless incentives to do otherwise are provided or unless there is exceptional leadership, general practitioners will continue to practice in the way they know. Good premises and adequate staff should act as an incentive but there is no extra time provided by new premises; with more people to talk to it is likely that the doctors will have less time for research or teaching than before. Something else must be provided,—an exceptional leader, (from any of the three branches of the health service), extra finance, or the provision of a research assistant. In the best health centres help has come from universities, Edinburgh and Manchester and, to a lesser extent, Bristol.

Other centres are being planned along experimental lines with a view to teaching and research, Thamesmead in association with Guy's Hospital, Livingston in association with Scottish Home and Health Department, and Aberdeen in association with the University. Undoubtedly others are developing along the same lines. Will area health boards and a unified service produce more forward-looking health centres? We hope so, but their success will depend on the staff working as a team with spirited leadership and upon the finance provided for teaching and research. Many of the existing centres

have the opportunity to become 'teaching practices'; let us hope they will do this and lead with a good standard of general practice.

Departments of general practice should be established in all medical schools and with these should be associated teaching health-centres with specially selected medical staff. These teaching centres could learn something from the experience of the established Section 21 health centres. Doctors working in the latter should be able to get help and advice from the departments of general practice.

Summary and conclusions

Integration in health centres is helped by the attachment of local authority nurses to general practitioners, by sharing clerical staff and by the interest of the responsible medical officer of health. Other important factors are the quality of the administrator and regular meetings of the running committees. The position and size of the staff room will determine the extent to which it is used.

Administrators may be chosen from the following:

1. Experienced sisters and health visitors.
2. Local authority clerks or Home and Health Department clerks in Scotland.
3. Senior receptionists.
4. Hospital administrators and medical records officers.
5. Medical secretaries from any branch of the health service.

The duties of an administrator are considered in detail. His post should be considered as a career; he should have special training, command a good salary and have his own office in the centre. In larger centres a sister-in-charge will be required in addition to the administrator.

Medical records in all health centres visited (except Edinburgh teaching practices) are kept on MRES and continuation cards—forms EC 5, 6, 7 and 8. The local authorities keep separate records and usually have record cards for the clinics in addition to those of the health visitor. A plea is made for hospital reports to be issued on paper which will fit into MRES, *i.e.* not larger than standard size A5.

There are advantages in lateral filing of records. Family folders designed by W. B. Fletcher for use in Bristol St George are described. Their method of use and storage and the advantages which they possess are detailed. Local authorities show no conformity with their records—the combined clinic and health visitor record card MCW 46 (Rev) is not extensively used. This and the school children's record card 10M are too large.

Health visitors should be attached to general practitioners before the centre is opened and they should conduct combined well-baby and immunization sessions. Different combined records are described, and some principles to be considered in the further development of combined records are enumerated.

Record-keeping in health centres should be of high quality because it is the chief method of communication about patients between members of the medical team. The records should be centrally stored and available to both doctors and nurses.

Opportunities for research in health centres are for the most part being neglected, exceptions to this are the teaching centres in Edinburgh and Darbishire House, Manchester.

In addition to good premises and adequate staff there are three other requirements for a health centre to fulfil its rôle in community health. These are leadership in the centre, trained research assistants and extra finance, provided from an outside source.

There are opportunities for present existing health centres to become teaching

practices. Teaching health centres with specially selected staff should be associated with departments of general practice in all university medical schools.

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INFLUENCE OF THE MIND UPON THE BODY

"As soon as the powers of nitrous oxide were discovered, Dr Beddoes at once concluded that it must necessarily be a specific for paralysis; a patient was selected for the trial, and the management of it was entrusted to Sir Humphrey Davy. Previous to the administration of the gas, he inserted a small pocket thermometer under the tongue of the patient, as he was accustomed to do upon such occassions, to ascertain the degree of animal temperature, with a view to future comparison. The paralytic man, wholly ignorant of the nature of the process to which he was to submit, but deeply impressed, from the representation of Dr Beddoes, with the certainty of its success, no sooner felt the thermometer under his tongue than he concluded the talisman was in full operation, and in a burst of enthusiasm declared that he already experienced the effect of its benign influence throughout his whole body; the opportunity was too tempting to be lost; Davy cast an intelligent glance at Coleridge, and desired his patient to renew his visit on the following day, when the same ceremony was performed, and repeated every succeeding day for a fortnight, the patient gradually improving during that period, when he was dismissed as cured, no other application having been used."

Thomas Joseph Pettigrew. *Superstitions connected with the history and practice of Medicine and Surgery*. 1844. London. Churchill. p. 146.