BUSINESS MANAGER IN GENERAL PRACTICE

Function and training

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IN LATE 1945 I FOUND MYSELF in the position of being forced through the retirement of my senior partner by reason of coronary artery disease to take over within six weeks a large practice centred on Milnthorpe, where there was an assistant. I had to buy a large house, a well-equipped and rambling surgery with a large stock of drugs, while two leasehold surgeries, and an assistant, were also included. My partner had four-fifths share, and I one-fifth which I had acquired in 1939. The practice income was £10,000 in 1939 and only slightly less in 1945. My financial commitments were such that they make the moans of present-day practitioners seem laughable. My assets were a loyal, hard-working and medically-qualified wife, considerable stamina, a näive ignorance of finance, and an equally näive belief, which turned out quite practically, that God helps those who help themselves. The assets did not include cash, but did take into account an overdraft which even before acquiring the practice seemed large. By one means and another to my eternal surprise the financing was, with the material aid of a very good friend and a bank manager, to both of whom I am ever grateful, finally arranged. Two partners were taken in, and even before this another friend, who during the war had been engaged as financial secretary in an enterprise with an astonishing annual turnover, offered his services as secretary.

In 1946, of course, the main source of income was private practice, and one was in the difficult position of taking over on the first of January but receiving no income until after the bills went out, a suitcase full, in early—very early—April. Expenses, secretary, dispensers (2), two assistants (the partners in their probation year), drugs, motoring, heat, light, telephone, etc., of course all happily presented themselves at frighteningly regular intervals. Perhaps the general madness of the year was summed up on Christmas Day—appropriately enough for this surrealist time—when a buff-coloured envelope arrived, on top of a mound of Christmas cards, overstamped on one side " Post early for Xmas " and on the other " Blood donors urgently needed ". It contained a surtax demand. A cheque was sent on a piece of balloon cloth (a relic of my wartime service) so that it would bounce quietly, and was wrapped round an artificial eye-tooth, provided by my dentist, to signify that they had got my lot. Surprisingly the cheque was honoured. My two assistants then became partners—and God bless them, paid their dues, and we gradually got on to an even keel. Through the entire period of probable disaster, our secretary

was a tower of strength. I have never yet discovered all the ruses he used to keep the wolves from the door, but keep them out he did.

On joining us he knew nothing, and I little more of practice organization, so the only thing to do was to organize ourselves. We always have done a great deal of dispensing, and we were quick to realize the economies that a sensibly employed personal pharmacopoeia could effect, while we bought in bulk from the most advantageous source we could find. Even then, and of course so much more so when the National Health Service came into being in 1948, was it forced on our notice that many substantial payments in general practice were only effected if—as in the forces, one claimed from the proper authority at the proper time. Thus:

(1) All fee-charged services were immediately entered and constantly reviewed.
(2) All cards were dealt with immediately—details entered, the cards forwarded to the National Health Service office weekly.
(3) All claims; midwifery, mileage, drugs, immunizations, insurance examinations were meticulously cared for, and entered at the proper time. These matters amount to a large proportion of National Health Service income, much of which can be lost if not efficiently dealt with.
(4) All income tax matters were gone through with the finest of tooth-combs. Any legal options were used, maximal allowances for telephone, motoring, wife's allowance, periodicals, rooms in house (all surgeries are lock-ups), maids' allowance, car-washing, professional subscriptions were negotiated by the secretary and the accountant—another tower of strength—with the inspector of taxes. A considerable saving of tax could then—but not so much now—be effected by judiciously dealing with bad debt. Repairs and renewals, obsolescence of equipment—we have always put a sum aside each year for this—and stationery are accounts which more than repay care in their management.

As the practice grew, new partners came in. During their assistantship it is legally possible to effect considerable tax relief by carefully considering how they are paid. Each man was given an assistant's agreement which also set out the agreement for the proposed partnership. Twice we bought houses for assistants which they later took over. In 1956 we bought, and, with a group practice loan converted to a first-class surgery for four, a house well-sited in Carnforth. We had rebuilt and refurnished the Milnthorpe surgery (for three) in 1952-54, financed by myself.

Gradually the secretary became encyclopaedic in his knowledge of all things in any way financial to do with the health service. He had always been a most efficient book-keeper, and now has all the regulations at his finger-tips. He has a good working knowledge of drugs, and has always been keen to see that the man on weekend duty has not absent-mindedly 'lost' two or three pounds worth of antibiotics, prescription charges he chases like a ferret, and with the few bad payers he is both persevering and versatile. While we have a typist and a dispenser receptionist, each of the three takes a turn at dispensing, takes messages, arranging all appointments both at hospital and in the practice. They have been trained to use a diathermy machine, to do simple urinalysis and minor pathological tests. Co-ordinating the district nurses, arranging for x-ray services, hospital cars are all part of their normal job.

The result is that we are concerned with financial matters only by work-

ing for them, and dictating policy at minuted meetings—this is a useful idea in general practice where people always refuse to believe that certain items were ever discussed, let alone agreed. We have, in this rural area, only small lists, but the constant care in dealing with our finances means that we miss very little, if anything at all, of any rightful income, and achieve maximal tax relief. The time available for getting on with our real job is not only increased but made pleasanter by no thoughts of sordid book-keeping to be done. We have our surgery manned daily (except Thursday and Saturday till 5.45 p.m.) from 8 a.m. until the end of the evening surgery. The staff arrange their own holidays, sick leave, rotas, etc., and we have never been let down. The practice wives enjoy considerable freedom each day but have to share their husbands' weekend and night duties only.

At the end of each quarter (or monthly for the junior partners) each partner receives a cheque—tax paid by the firm—so that he has no worries about any business expenses. It is arranged that junior partners have some assistance with their motoring expenses, as this can be an inequitable burden. All telephone accounts for partners' homes are paid by the firm, and each has a private line from the central surgery which can be connected when a particular partner is on duty. All patients have a full list of partners' addresses, telephone numbers and practice information generally. These cards are given out to all new patients and were left in the waiting-room when we first used them.

When one hears so much of complaint from doctors about their lot, it is too easy for us to feel a little smug. We have been most fortunate in finding the right people of a loyalty which cannot be bought, who have a great sense of team work. Perhaps our geography, rural north-west, has been a blessing, but we believe that no group should be without a business secretary, who should be willing also to pitch in and do other jobs. This seems important when one considers training.

The modern tendency is all against the general in any walk of life and all for the specialist. If formal courses are to be arranged to train business secretaries it will be necessary to ensure that they are also capable of doing other duties. The business side alone is not whole-time unless the group is very large. Our secretary handles all the business for a National Health Service list of 14,000, still finds time to do a lot of other jobs (You want tickets for the Cup Final?) and works a 42-hour week with one late night when he takes over the evening surgery. The other point to be taken is that this is essentially a practical job, and some of the training time—perhaps two to three weeks—should be spent in such a practice as ours getting the feel of the matter at first hand before being decanted into a practice. Arrangements should be made for part-time training for people already in posts whose principals wish them to be upgraded.

And now a *cri-de-coeur*. We have for some time had a modest superannuation scheme for our staff. It seems that the service could not continue without the general practitioners' secretaries who contribute so much to good doctoring. Now that the state have—to us ironically enough, decided to provide a substantial portion of the salaries of our staff, they should go even further and make provision for their proper

superannuation. These people are just as integral a part of the service as any radiographer (soon to be married), hospital secretary, or any other normally superannuated medical ancillary, and it is a belated justice that must be done. None of our staff had any qualification for ancillary medical service in the way of formal training when they came to us. They each had intelligence, loyalty, willingness to work, and a sense of team work. None of these qualities can be taught, but if any training scheme is to avoid producing people all content to occupy their own clearly defined niche and be therefore useless in general practice, these qualities must be demonstrated in action.

CLINICAL NOTE

AN INTERESTING CASE OF CARDIOVASCULAR COLLAPSE

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A CASE IS DESCRIBED OF sudden collapse in a man of early middle age. On 6 December 1963 at about 2 p.m. Mr XY was seen as the result of an emergency call. He had been found collapsed on the kitchen floor by his wife and although conscious he was confused and unable to give any history.

Personal history. Mr XY was aged 46 and the owner of a village general stores. In addition he carried on his trade as a painter and decorator. He had led an active life but had been moderately overweight in recent years. Patient took an occasional pint of beer and smoked 20–30 cigarettes daily.

Family history. Father died at 70 after repeated attacks of coronary thrombosis and a history of angina for several years. Mother died at 42 of tuberculous meningitis. Brother, alive and well aged 50. Sisters, two alive and well, aged 49 and 44.

Previous history. Mr XY suffered malaria during the 1939–45 war. He had synovitis of the right knee in July 1948, and there was a further attack in 1960 and consultant's opinion was that there might be damage to the meniscus. In December 1960 the patient had an attack of upper retrosternal pain lasting for 30 hours, aggravated by deep breathing, but unaffected by exertion. Subsequently he complained of some vertigo, and a slight pain in the left breast. Examination showed a mild hypertension 170/95 and (?) faint apical and aortic systolic murmurs. At this