

A STUDY OF PURPOSE BUILT GROUP PRACTICE PREMISES*

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IT IS doubtful if ideal premises could be defined which would act as an acceptable pattern for all group practices, because general practice is still such a personal form of medicine that it varies with the personalities of the doctors and the patients and the localities of the different practices.

The site

Though doctors may well have little freedom of choice in the matter of site for new surgery premises, if possible this should be level, to avoid patients having to go up and down steps, but where steps are necessary there should also be an alternative ramp, with good handrails to both steps and ramp. It may also be impossible to choose a quiet site. Where this is impossible, allowance must be made in planning for insulating the building against noise, as well as against weather, and dirt as in an industrial area. This can all be done but it must be planned from the beginning.

The site may dictate the size of the building, and where space is limited this can be met by staggering surgery times and thereby making a more economical use of the building, which can then be much smaller. The disadvantage of this is that the doctors in the group meet less often.

Caretakers. One of the next problems is whether the surgery premises should be lock-up premises, closed at night, or whether accommodation should be built for caretakers. With increasing use of the telephone by the public, telephone watch can be mounted on the practice from other buildings than the surgery premises, and lock-up surgeries no longer carry the stigma they used to in the past. Accommodation for caretakers is expensive, but if adequate rent is shown in the practice accounts, this should ease the financial burden, and there is no doubt that caretakers contribute enormously to the

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amenity and save the doctors' wives from burdensome ties.

Parking. Whereas car parking space must be allowed for doctors' cars, it should not be necessary for the doctor to supply parking space for patients' cars. If parking space is provided at all, it should be commensurate with the size of the waiting room, and not with the number of patients in the practice. On the other hand, pram shelters or cycle shelters are desirable.

Entrance. This should be generous, to prevent patients from forming a queue which will keep the door open, and it is advisable to have a large air-locked porch to conserve the heat in the building. Many doctors think it desirable to have a separate exit, to prevent congestion, but where they do this it is best that the patients should pass close to the reception desk again on their way out. The exit should also be air-locked.

The building

Lavatories. Many doctors have placed lavatories immediately inside the entrance. This has created problems, because they tend to become public lavatories for people who are not patients, and this leads to pilfering of toilet rolls, towels, soap, etc., to such an extent that in many cases doctors have had to put locks on the lavatories, and patients have to get the key from the reception desk. It is preferable to have the lavatories further inside the reception area. It is desirable to have separate lavatories for staff and patients, and if it is a large practice, then two lavatories for patients. All should have wash basins.

Reception. The reception desk should be obvious on entry, but not too near the door, as again this leads to congestion in the doorway. Many doctors have left the reception desk open to the waiting area. This has advantages and disadvantages. Where there is a call system by buzzers, bells or electric lights or signs, operated from the doctors' consulting rooms, it is better that the receptionist should be able to supervise this, as many patients do not respond to it and some, though responding, are apt—in spite of all the guide signs, such as lights, outside the doctor's door—occasionally to walk into the wrong consulting room, where there may be a patient already. In fact, where these call systems operate, they should operate in the receptionist's office, rather than in the waiting room, and the receptionist will then tell the patient what to do.

The disadvantages of having the reception desk open to the waiting area are that many receptionists find it difficult to work while they are exposed to patients, who may keep on asking why they have not been seen, etc. Telephone conversations carried on in the reception office can be overheard in the waiting room. Similarly, conversations between the secretary and the doctor, or between

patients and the receptionist, all of which may be of a confidential nature, are clearly audible in the waiting room. Where it is necessary to have the receptionist operating the call system, most of these difficulties could be overcome by having an enclosed waiting room with a window opening from the reception desk into the waiting room, which could be opened when the receptionist needs to speak to patients in the waiting room, but would otherwise be kept closed.

I prefer the patients being in a closed waiting room, which has one door near the reception desk and another door or doors near the consulting rooms, as I like to fetch my patients personally from the waiting room.

Waiting room. Whatever call system is used, it is advisable to have the exit from the waiting room near to the consulting rooms, but it is undesirable to have patients waiting near to the consulting room doors, since it is almost impossible to make a door so sound proof that a patient cannot hear what is going on inside, if he is sitting just outside. This is another reason for having an enclosed waiting room.

The size of the waiting room is not only to be equated with the size of the practice and the number of doctors consulting at any one time, but it is probably true to say it only needs to be half the size in a practice which works an appointment system that it would need to be in the same practice without an appointment system; and if the cost of building is taken into account, the saving on the size of the waiting room will contribute much to the cost of running an appointment system.

The most popular form of seating in waiting rooms appears to be the bench type, with plastic-covered sorbo or other sponge rubber seats. The commonest fault in these is where the seat is made horizontal and the back vertical, which is orthopaedically unsound and very uncomfortable. Both the seat and the back should slope slightly backwards. It is preferable there should be a gap between the bottom of the back rest and the back of the seat to prevent the collection of dirt. Some modern designs of separate chairs with plastic seats and backs and metal legs seem to be very good.

A very common problem in waiting rooms is the ventilation, and it calls for special thought in planning the heating. It might well merit special air conditioning. Waiting rooms very easily become stuffy with humidity and smell when there have been several patients waiting, and special ventilation by extraction fans may be necessary. Waiting rooms need to be warm at the beginning of a session, but they may quickly become over-heated, and therefore they will require a form of booster heating at the beginning which can soon be turned down or off. Under-floor storage as a sole means of heating

is not the ideal form for a waiting room.

Another point in favour of making the waiting room an enclosed space is that where it is a waiting area, it is commonly part of the communications system, and patients return through the waiting area from the consulting rooms on their way out. This is undesirable for many reasons, but particularly for the patient who may be distressed. For this reason also, it is in my opinion desirable to have at least two waiting rooms, one of which need not be very large, in which patients can wait who are distressed or who need isolating for other reasons. This second waiting room may serve other purposes, such as a doctors' common room after surgery is over.

Flooring. Plastic tiles seem to be the commonest form of flooring. If too light in colour the floor soon looks dirty, as the result of black marks from rubber or composition heels, or pock-marked from stilettoes. There are some armoured plastic tiles which do not mark so easily, but they are much more expensive. Terrazzo floors might well have a place at the entrance, where patients' feet are apt to be wet.

Office. There appears to be no commonly accepted best way of storing record cards. My own preference remains in favour of steel drawers in cabinets, and these must be fixed to the wall, to prevent them toppling forwards if two upper drawers are open at the same time. The bottom drawers are best used for long-term storage and not for record cards.

It is desirable for the office to be divided into two—the outer reception office, and the inner private office, where confidential telephone conversations or discussions between doctors and secretaries can take place without being audible to patients. A common fault in office planning is to make it too small.

Telephone systems. One good type of telephone installation seems to be the G.P.O. Transfer Telephone Service with PBX facilities. This is said to be cheap in operation and to have many advantages. Alternatively, the G.P.O. PABX 1, which is more expensive, seems to have added advantages, which many would feel to justify the extra cost.

Consulting rooms and examination rooms. These need to be considered together. When, in the absence of the promised health centres, general practitioners took the initiative and started grouping together and building group premises, examination rooms were thought to be one of the great advances. I am doubtful of their value.

Many reasons have been given for the construction of examination rooms. The commonest is that they save time, and the next is that they give privacy to the patients when dressing and undressing.

Another one is to keep the atmosphere distinct between the personal interview in the consulting room and the examination couch and instruments in a separate room, and lastly, to help the doctor break up an otherwise interminable interview with a limpet-like patient.

When considering all these points of view, it is necessary to bear in mind whether the consulting room itself contains a couch and whether the examination room contains a desk. If not, then the two rooms together only constitute one complete unit and it is extravagant of space. Moreover, if a patient goes into the examination room and gets undressed, and the next patient needs to be examined, there will be a temptation for the doctor not to examine the second patient when he should, because no couch is available. Another disadvantage of the double unit system is that, having taken the history of the first patient, the doctor then breaks off consideration of that patient and takes the history of a second, before going in to examine the first. I personally prefer to remain in contact with the problem until I have finished with it—in other words, to take the history and proceed to the examination without confusing the issue with another case history. Furthermore, by remaining in contact with the patient until the problem is solved, it gives the patient an opportunity to produce afterthoughts which are sometimes of vital importance. It may even be a question of the patient summoning up the courage to give the doctor some vital information he might otherwise have concealed. If it is a question of providing a patient with privacy, a wall and a door are very expensive substitutes for a curtain. It also leads to the production of two rooms, both of which are rather cramped unless there is to be an extravagant use of space.

Where doctors desire to have separate examination rooms, I think it is essential that there should be a couch in the consulting room as well, and the entrance to the examination room must not be by a communicating door in the common wall between the two rooms. In no instance did I find one of these communicating doors which was in fact sound proof. Where such a door exists, a patient sitting on the examination couch, with nothing better to do than listen to the next consultation, can hear it! To get sound proofing it is necessary to go out of the consulting room into a passage and back into the examination room by a separate door.

Where examination rooms are required, I believe they should be fully equipped rooms, with couch and desk—i.e. a spare consulting room—the question arises of the proportion of these spare rooms that are required. When questioning three doctors who had just finished their morning surgery, each with a couch in his consulting room and an examination room for each doctor, I found that they had between them seen five patients in the three examination rooms,

and they assured me this was about the average. My conclusion was that I was in favour of having one spare consulting room, fully equipped, for every three doctors who were working simultaneously. Where this is done there is something to be said for all consulting rooms having an identical layout in a particular practice, and each doctor having his own drawer in the same position in each room to keep his own equipment in.

Equipment of consulting rooms. Built-in sink units, with drawers and cupboards and working top, such as are fitted to modern kitchens, and taking up the whole of one wall (probably under the window) look tidy and efficient and are cheap. It does away with the need for instrument trolleys and basins, which are more expensive. It also has the virtue of concealing the instruments until they are required. Separate electric or gas hot-water heaters for each consulting room seem to have advantages. Other items were separate weighing machines in each consulting room, and fixed over the couch were anglepoise lights and brackets for sphygmomanometers. Plugs for low voltage electricity distributed from a central transformer, for use with sigmoidoscopes, ophthalmoscopes, speculae and cautery seemed to be a good idea.

Treatment rooms. The need for treatment rooms is related to the nearness of the practice to a hospital which has an operating theatre, such as a cottage hospital, or to a general hospital with a casualty officer. Where these exist close to the practice premises, it is more appropriate for minor surgery to be done in the hospital.

Rooms for nurses. I was surprised not to find any rooms for nurses, health visitors and midwives working with the practices. My view of the logical development of general practice is that these rooms will be required in all group practices in the near future. If supplied by the general practitioners I believe in most instances the county health authority will pay rent for these rooms to accommodate the health visitors, midwives and nurses who are employed by the public health authority, but who should work from the general practitioners' surgery and so be in constant consultation with the general practitioners over the patients they are all looking after together. Their rooms should have couches and desks, like the other consulting rooms, in addition to cupboards or cabinets for storage of their own records. Thus they would be enabled to carry out minor treatments, injections, or collect specimens such as swabs or M.S.U.S, and cervical smears, or even do such tests as ECG.S and haemoglobins.

Heating. Under floor night storage heating has been installed in many of these practices and found to work well, but I met several doctors who felt it was desirable to have some sort of booster heating available, such as convectors or radiators, but it was once or twice

emphasized that this form of booster heating was better not fixed—it was preferable to have it on a lead so that it could be moved about the room. Oil and gas central heating was being used in some instances. Where night storage heating is used, it is essential to insulate the building to prevent loss of heat, and thermostatically controlled, ducted, filtered air is a practical proposition and I saw it working well.

Rent. I was surprised at how few doctors showed a realistic rent for the premises they have constructed, and I feel there is a case to be made out for groups of doctors who own group premises to form themselves into a property owning company, and let the practice pay the company a realistic rent which can then be shown for inclusion in the central pool. Failure on the part of doctors to do this is probably depriving the central pool of several millions a year.

Common rooms for doctors. The most vital part of a group practice is the opportunity that the doctors get to meet each other frequently to discuss professional problems, whether clinical medicine or practice organization, and anything which facilitates their meeting regularly and frequently is valuable. Consequently all group practices should have a room in which the doctors can meet every day. Some doctors have built a room which is kept solely for this purpose, but it would seem, with building costs as high as they are, that such a room might well be used during surgery time as a small second waiting room, as mentioned earlier, and then when surgery is over, any patients who are waiting for any reason (perhaps for letters or prescriptions) can wait in the main waiting room while the doctors meet in the small waiting room, which would be their common room. Here they could also meet the nurses, midwives, and health visitors who complete the general practice team.

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Volume 9/1965 will comprise Journals No. 48, 49 and 50 with supplements. Volume 10/1965 will comprise Journals Nos. 51, 52 and 53 with supplements.

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