Communication and co-operation within the primary health team

A survey of ten large practices

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THE sweeping changes in the organization of primary medical care taking place in Britain are perhaps not fully appreciated by doctors. In 1967 the Annual Report of the Ministry of Health showed that nearly a half of all general practitioners were in partnerships of three or more. In 1964 only 3.4 per cent[1] of district nurses and health visitors were directly attached to practices, but by 1969 this had risen to 25 per cent[2] and the partial reimbursement scheme has encouraged most doctors to employ receptionist staff. All this has liberated doctors from non-medical tasks, has broken down professional isolation and has brought attached staff increased work-satisfaction.

These improvements have greatly enhanced the potential of general practice, but insufficient attention has been paid to Professor Butterfield's law[3]—"All fragmentations of responsibility carry attendant communication problems." Articles[4 5] have appeared on local authority attachment schemes, the work of secretarial staff and the most suitable premises, but little notice has been given to the problems of communication.

This present study is an attempt to discover how primary health teams work together and how far they have defined and answered problems of internal communications.

Method

Eleven large practices with attached local authority staff were chosen after discussion with fellow general practitioners. Each practice contained at least one partner who had published work from general practice, or had served on committees concerned with its improvement. The doctor was sent a letter explaining the purpose of the survey, and asked to complete a questionnaire, to be followed by a visit to view his premises and amplify matters by discussion. All of those approached agreed to help, several gave more than two hours of their time at interview and also let me interview their staff. Ten practices were visited: it was not possible to visit the last one in the time available.

The questionnaire covered a physical description of the premises, the number of patients and partners, the telephone arrangements, methods of calling patients and other communication systems. Details of appointment systems and any room sharing were noted. A section on the co-ordination of doctors was followed by methods of communication with patients. Questions were asked on the secretarial staff employed, their aids, organization and any voice they might have in the running of the practice. The duties and co-ordination of attached staff such as health visitors and district nurses were also studied.

Findings

The practices were all urban save one, ranging from Romford, Essex, to Winchester, and in size from 7,500 patients to 19,500 patients. Most had old converted buildings

but three had purpose built premises. All were growing in size, were in a state of evolutionary flux with many interesting experiments, and to this must be added a considerable variation between them in their working methods. (*See* table I).

TABLE I
PRACTICE POPULATION AND EMPLOYED STAFF

Patients	*Partners*	(*a*) *Secretarial staff*
1. 19,500	7	5 + 5 p.t. (7½)
2. 18,250	6	2 + 6 p.t. (5)
3. 16,000	6	2 + 8 p.t. (6)
4.(*b*) 16,000	6	7 p.t. (3½)
5.(*b*) 13,000	6	2 + 3 p.t. (3½)
6. 12,000	5	5 p.t. (2½)
7. 12,000	5	3 + 4 p.t. (5)
8. 11,500	6	3 + 5 p.t. (5½)
9. 8,000	2	1 + 2 p.t. (2)
10. 7,200	3	2 + 1 p.t. (2½)

(*a*) This column shows full and part-time staff. The figures in brackets show the full-time equivalents.
(*b*) Practices 4 and 5 employed their own surgery nurses.

Premises were generally too small, and where purpose built some years ago had allowed insufficient space for practice growth and an increase in the range of services offered. Five practices had a doctors' common room which was much appreciated, but only two had adequate libraries.

Most used a GPO 2+6, or larger switchboard for external and internal communication, or used a GPO house exchange system. Two had a Centrum loudspeaker system for talking to partners and reception staff. The patients were called personally by the doctors in seven practices, as this was felt to give a polite human touch, showed the doctor how matters stood in the waiting room and as one doctor said "The noise of a buzzer is an affront to human decency." The remainder had either buzzer or lighting systems in the waiting room or a buzzer to the receptionists.

Appointment systems were universal, ranging from five to ten minutes a patient, some being tailored to the doctor's speed, and others giving longer periods for antenatal examinations, cervical smears and special examinations when these were seen in an ordinary appointment session. All the doctors with five minute appointments ran late, which reduced the value of the system to the patient.

Co-ordination of doctors

In three practices the partners met each morning for coffee with the health visitor and district nurse for a clinical conference. Five other practices met for lunch once or twice weekly for administrative and clinical discussions, often inviting outside visitors such as hospital consultants, the medical officer of health or other field workers from the local authority.

Doctors preferred to work as generalists, but there was a little specialization within

some partnerships, mainly limited to obstetrics, birth control, the interpretation of ECG's and developmental paediatrics. There was some internal referral where a partner had a hospital appointment in a speciality.

Administrative functions were totally assumed by one doctor in one practice, and he gave a morning a week to this. The most popular arrangement was for administration to be broken down into such categories as finance, staff, premises and equipment, and rota, and for each partner to be responsible for one or more function, even if he delegated it to the practice manager.

Joint consultations varied: five practices had a rate between one a day to three in a surgery, but five only consulted a colleague rarely, not more than once a week.

All practices had night rotas and some sharing of patients as perhaps a third of patients are indifferent to which doctor they see, and inevitably receptionists attempt to share appointments evenly. Three practices did not take the patients' notes out on visits, and more did not do so for night calls. Although doctors tried to see each disease episode through, and most recorded diagnosis, treatment and investigations, only one practice had an agreed method of note taking. Two practices used a form of signal tagging similar to the Royal College of General Practitioners' system, for special groups of patients.

The filing of general and administrative information was often haphazard and was infrequently consulted. The best systems were in suspended or box files maintained by the practice secretary who was also responsible for information retrieval. In one practice the burden of administration fell on one doctor, who had wallet files (PAYE, ancillary staff, premises, banking, etc.).

Communication with patients

Printed forms issued to patients included appointment cards, immunization schedules, and a form for obtaining a repeat prescription through the post. This showed the patients' name, the drug required and the quantity, and the date of issue. Another excellent card gave information on the running of the practice and how to obtain the services available. Two practices had no notice board in the waiting room, and most doctors believed that notices are rarely read.

In four practices doctors insisted on being given the medical records before being interrupted to speak on the telephone about a patient. Records are usually required as an *aide memoire*, and this step saves the doctor's time.

Six practices had age-sex registers, three using them for research, but only three were used in preventive medicine, to trace the young for immunization or the elderly for geriatric visiting by the health visitor, for a cervical smear service, for health education talks, and also for administrative purposes.

Children in Hampshire requiring immunization are called by computer. Elsewhere five practices pursued defaulters from immunization directly, while others did so when the patient reattended for illness. Antenatal defaulters were not pursued in three practices, despite health visitors being available.

Two practices offered health education talks to their patients, while a third, in a poor area of London, had tried an unsuccessful experiment.

No practice had any form of a "Friends of the practice" club, and this area of self-help may be worth exploring.

Secretarial staff

Staffing ratios varied greatly. In two practices of 12,000 patients, one had three full-time and four half-time employees, and the other had five half-time workers. Usually the work was broken into administrative and secretarial, reception and tele-

phone duties, and the tasks allotted to individuals. In one practice the manager was responsible for administration, typing, executive council forms and finance, while the other staff rotated weekly through reception, filing, telephone and 'runner' duties, in order to add variety to the work.

Generally, staff status was low by external criteria. Wages were relatively low in comparison with the local health authority scale, and because many of the buildings were old and adapted, the working conditions tended to be cramped. Only two practices offered a superannuation scheme and in one of these it was restricted to the practice manager, yet similar local authority staff have pension schemes. These problems were increasingly recognized, as some practices talked of instituting greater in-service training, of employing fully-trained medical secretaries, or were considering superannuation schemes. The loyalty and enthusiasm of the staff were most impressive.

Four practices held quarterly meetings with their employees for general discussion and suggestions, which certainly enhanced the team's co-operation, and clarified the receptionist's rôle in the team; while in the smaller practices there was a constant, closer, dialogue. One practice circulated memoranda of administrative changes.

Six practices used a large day book to record messages and requests for visits. Messages were marked when dealt with, and an indication was made to show which doctor had taken calls. Two further practices used separate pads or books, one for visits and the other for messages. Doctors in seven practices used the Burroughs Welcome visiting diary. Two practices timed all messages received. All these systems seemed equally satisfactory.

Hospital appointment letters were not sent through the post in all practices, yet they may be opened by the patient if handed to him, and this can have unfortunate consequences.

Local authority staff. (*See* table II).

TABLE II

PRACTICE POPULATION AND LOCAL AUTHORITY STAFF

	Patients	*District nurses*	*Health visitors*	*Others*
1.	19,500	2	2	2 Midwives
2.	18,250	2 + 1 p.t.*	3	
3.	16,000	2	3	2 Nurse/midwives
4.	16,000	2	1	1 Midwife; 2 p.t. clinic nurses
5.	13,000	2	1	1 Nurse/midwife 1 Psychiatric social worker
6.	12,000	0	1½	1 Mental welfare officer p.t. 1 Geriatric visitor p.t.
7.	12,000	4	1	1 Bathing auxillary
8.	11,500	1	1½	1 Geriatric visitor session
9.	8,000	0	1	
10.(*a*)	7,200	2	1	1 Midwife p.t. 1 Nursing auxillary

*p.t. = part time

(*a*) This is a rural practice

Eight practices had district nurses attached: in five of these they worked both at the surgery (three having a treatment room) and on the district, and in two further practices the doctors employed their own nurses on the premises. In some practices it was impossible for the nurse to work at the same time as a doctor, as insufficient space led to sequential room-sharing. This made communication with the nurse less effective. One fortunate practice had four nurses and a bathing auxillary for 12,000 patients.

A nursing work sheet for the surgery was kept at one practice, showing the date, name of patient, age, diagnosis and treatment. In two others the nurse made entries on the medical record of the patient. Work undertaken included dressings, ear syringing, injections and immunizations, taking blood, sterilizing instruments, and taking ECG's. One practice used the nurse for certain follow-up visits in addition to the usual district work.

The medical officer of health usually gave a fairly free hand in the functioning of attached staff. This was not abused, and all were enthusiastic about the better liaison. Doctors could undertake care of illnesses formerly requiring admission to hospital, and nurses greatly appreciated the ready access to doctors and the patients' records. Messages were passed verbally or by a note to the nurse, and they saw the doctor daily to discuss problems. Some doctors were diffident about seeing the work record, but two practices reviewed this monthly with the nurse.

Health visitors were attached to all practices in a ratio varying from 1:4,000 to 1:16,000 patients, while most had one health visitor to about 8,000 patients—far too large a work load. Health visitors had initiated new ideas in all practices, and had enriched the practice work, especially as some doctors previously held rather vague ideas about their functions. All worked at the surgery while a doctor was on the premises, as well as working on the district, and liaison was close. Patients were mainly referred verbally and problems discussed daily. Special clinics were held in all practices for infant welfare and for expectant mothers: three practices also held developmental or toddlers' clinics. Some offered geriatric and dieting clinics in addition, but none as yet held discussion sessions for special groups such as engaged couples. In addition seven practices had consulting sessions for general referrals to the health visitor.

In four practices entries were made by the health visitor directly on the patients' medical records, and one had a child development card for joint use with the doctor.

Further local health authority staff included midwives or midwife-nurses in five practices; a psychiatric social worker and a mental welfare officer working part-time in two more practices, clinic nurses helping at antenatal and infant welfare clinics in two practices, a part-time geristric visitor at two practices, and a chiropodist visited one practice weekly.

Attached staff had access to all the facilities of the practice (records, telephone and typist if necessary) and were full members of the team. In some practices the local health authority either furnished the health visitors' room, provided other equipment or made some contribution to expenses.

Most doctors in the survey felt that four partners, with their staff and paramedical workers gave the optimum size for a team, to allow good internal relations, and for the patient to feel comfortably 'at home'.

Discussion

This survey showed that the general practitioner working as leader of the primary-care team has his rôle considerably enlarged. Professional isolation ends, and time is saved by delegating routine administrative tasks to clerical staff. The team can often investigate patients in greater depth, or offer them fuller aid, rather than refer them to hospital or other specialized agencies. Hospitals can return patients earlier, so in-

creasing their turnover and making better use of their specialized skills. Early return saves the patient much travelling time, ensures his care in familiar surroundings by those responsible for his long-term health, and in turn makes fuller use of the primary health services.

The team is a recent and evolving concept, and few have been trained as yet to work in such close co-operation. Frequent, leisurely meetings between the partners allow adequate time for discussion, and weekly working lunches afford a good opportunity for this in the larger practice. They should occasionally include the attached local authority workers and also guests from the neighbouring hospitals or the local health authority, so that mutual understanding is enhanced.

Greater use could be made of joint consultations within the practice. These give the patient the advantage of another opinion, and the partners have the benefit of observing and discussing interesting histories and physical signs. Failure to take medical records on visits may leave the doctor without important information when confronted by a seriously-ill patient. He may also forget to make a subsequent clinical note.

Clear and accurate medical records are vital for communications within the team, and are not merely an individual *aide mémoire*; but they were not always adequate. A convention of record keeping is useful, starting with a summary of the patient's past, family and social history. Each disease episode should be separated by a space, the diagnosis clearly shown, and the notes should be fixed in chronological order. Special cards could be introduced to note repeat prescriptions for the chronic sick, blood pressure readings in hypertensives, and for weight charts, so that the disease record appears uncluttered. It is often useful for the health visitor to write in the patient's notes, but where she did this on the same card as the doctor the notes became confused and difficult to follow. Therefore, paramedical staff should also use a separate card within the medical record envelope. The Department of Health and Social Security could introduce a white continuation card to serve these various purposes. An orderly arrangement of this nature saves time when reading, eases communication and aids clear thought.

The age-sex register is an important tool in preventive medicine, but was used for this in only three practices. It is expensive to prepare and maintain, and it is also costly to send for patients. The executive council should pay directly for the preparation of a register, or perhaps maintain a central computerized service, which could also send for those patients required for preventive programmes.

Two complementary problems were the difficulty in getting some patients from the lower end of the social scale to attend preventive medicine routines, and the failure of some health visitors to pursue antenatal defaulters. These patients are often more at risk, and special effort is required both in explanation to the patient and in the diligent pursuit of defaulters.

"Neither the technical nor the humanitarian aspects of medicine can function properly without adequate communication"[7]. The aims of earlier diagnosis and preventive care may fail unless the patient feels welcome, and is so eased in his relationship with the team that he can readily communicate his problems. The responsibility of maintaining the lines of communication within the primary care team rests firmly with the general practitioner. This study suggests that many practices have not fully thought out the various communication problems. There is a need both for further studies of this subject, and of education through discussion.

Health centres accommodating ten or more doctors are being built or planned, although most of the doctors interviewed felt that four is the best size for a team. Sociological and other studies of this problem should be made, and perhaps such large buildings should contain clearly-defined separate teams. There will not then be

the risk of the patient feeling his personal doctor is sheltered behind a large, unapproachable and impersonal bureaucracy (a not infrequent criticism of hospital outpatient departments).

Finally, co-operation within the team will improve as future members (practitioners, health visitors, district nurses and medical secretaries) learn more of each others work during their training, through joint discussion and visits to large practices.

Summary

Ten large practice teams were studied to assess their working methods and co-ordination. The employment of staff and attachment of local health authority personnel raised problems of internal communication. How far these were recognized and tackled is discussed. The extent of the problem is not yet fully realized, and needs further exploration.

Ackowledgements

It is a great pleasure to thank those doctors who generously gave so much of their time while participating in the survey. My thanks go also to Drs John Fry, E.V. Kuenssberg, Peter Draper, Professor Margot Jeffreys and Dr J. E. Struthers (Department of Health) for their planning advice. The secretaries of the Health Visitors' Association, the Queen's Institute of District Nursing and the Association of Medical Secretaries were most helpful. The Middlesex Executive Council kindly duplicated the questionnaire and typed the manuscript. Finally, I wish to thank my partners Drs Rhoda Law, Peter Brent and Derek Coffman for their encouragement.

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Study of childhood urinary tract infection in general practice. N. C. MOND, M.R.C.S., L.R.C.P., M.R.C.G.P., R. N. GRUNEBERG, M.B., M.R.C.Path. and JEAN M. SMELLIE, B.M., M.R.C.P., D.C.H. *British Medical Journal.* 1970. **1,** 602.

Mid-stream urine specimens were collected from 426 children under 13 in a London general practice (97 per cent of the total in this age group). Five children were found to have significant bacteriuria, all under five-years old. Five other children in the practice were known to have urinary infections. Eight of these ten were investigated radiologically and in five cases radiological abnormalities of the urinary tract were discovered.