screens, or in examination rooms. This was an extremely difficult problem to probe, but, so far as it went, women were quite adamant that they preferred to be in a separate room when undressing and dressing, and that they took in "very little" or "half" of what the doctor told them if he stayed in the room and discussed their problem with them while they were on the couch. They were much happier if they got dressed and returned to the consulting room to continue the interview, so it would appear on aesthetic grounds that women should be given the privilege of undressing in an examination room. If this is accepted, it is wrong to have a desk or wash basin in the examination room, the doctor should leave the room directly he has finished his examination telling the patient to come back into his consulting room when she is ready. As it is just as difficult to sound-proof an examination room if it leads off a consulting room as it is to sound-proof a consulting room when it leads off a waiting room, the entrance to the examination room should be from a lobby common to both the consulting room and the examination room. If the examination couch is removed from the consulting room then a minimum of three examination rooms beween two consulting rooms are required. The maximum for general practice purposes is two to each consulting room.

Treatment rooms

The size and the design of treatment rooms is still experimental in so far that these are only a recent inovation in group practice, or perhaps, it would be more accurate to say that the activities within the treatment room have expanded considerably in the past few years. In the smaller group practices where there is not so much activity one single room is usually adequate, but in the larger group practices it is considered that there should be two rooms although they may by intercommunicating. One of these should be looked upon as a 'clean' room and the other as a 'dirty' room. In the 'clean' room minor operations, medical instrumentations etc. would normally be undertaken, whereas in the 'dirty' room the dressings of wounds and septic lesions, washing of ears, and maybe immunizations, would take place. With a nurse undertaking these duties as the doctors' deputy, there will be occasions when she wishes them to view her handiwork before continuing treatment. Under these circumstances, she is held up until the doctors can spare the time to see the patient, and it is for this reason that it is probably right to consider giving her separate examination rooms within her treatment room. I am glad to say that this type of design has recently been accepted by a seven-man practice in the north. I do not think that it is sufficient to give her only undressing cubicles as we are then ignoring the problem of sound-proofing that is just as important in her clinical work as it is in ours.

I think the problems associated with dispensing are already fully covered in the documents mentioned earlier, and likewise the requirements in respect of sound-proofing, furnishings, decorations, and the services generally.

Discussion

Dr A. K. Ross (*Newcastle-under-Lyme*) said that one of the difficulties of having a waiting area separate from the passage was that there was a delay in the time taken for the patient to reach the consulting room. In a large health centre, with a doorman at the door, etc., it would be necessary to provide motor scooters for the patients to reach the consulting room in a short period of time.

Dr Adams said that in the hospital field motor scooters were now provided, but not in this country. The centre should be so designed as to have the waiting room centrally, as in Dr Whitaker's practice. There could be a feed-out from the waiting room to the consulting rooms over a very short distance indeed. This was only a design problem. He had once taped a con-

sultation period to see what happened. He knew that at the end of it he had not a minute to spare—he had been busy throughout it—and although there were quite long gaps when he was not in contact with the patient, the pressure was there all the time. He believed this aspect was more a thought in the doctor's mind than a fact. An architect could easily design a building so that the time taken by a patient moving from the waiting to the consulting room was cut down to the absolute minimum.

Dr A. Whitaker (*Guildford*) urged that there should be no stinting in setting up a group practice. In his own case they were getting £200 a year for living in the building; it was costing them nothing. They had not set out to save money but to build something which was really going to function. He took issue with Dr Adams on examination rooms and always had done, believing them to be an extraordinary waste of money compared with a curtained corner. With the addition of a few feet one could have a completely separate consulting room. Having to send somebody down the corridor and go after them would not encourage him to make an examination! He recalled one woman who said 'I don't give a damn about taking off my clothes in front of you but what I won't do is stand with my stockings hanging down'!

Dr Freda Lucas was perturbed about the prognostications of the enormous size of future group practices. Many doctors were worried about this, and she was not a "voice crying in the wilderness". The personal factor, spoken of so feelingly earlier in the day, was more and more in danger of being eliminated with these larger and larger practices. They were all coming to see the value, under present conditions, of the small group practices, up to six or, in certain circumstances, up to 12 doctors, but the concept of the enormous super-clinic was a little alarming. She was hoping to work in a group practice shortly. The particular circumstances of the area made it suitable, almost necessary, but they were still trying to keep it small in order to give a more personal service.

The Chairman recalled that the Cohen Committee in 1952 had recommended an optimum size of four. The Gillie Committee (of which he had been medical secretary) recommended in 1963 an optimum size of six. This was the direction in which things seemed to be moving.

Dr Adams said that the Todd Committee recently recommended an optimum size of ten. It was very difficult to visualize what numbers meant unless one happened to be mixed up with these things. There was, he maintained, no problem about being a personal doctor within any organization. It depended purely on the personality of the doctor. If he were prepared to personalize himself he would be a personal doctor.

He had noticed that as practices got bigger there was a much greater tendancy for the doctors to work as single-handed doctors, looking after their own lists and nobody else's. They had deputies for when they were away and were really single-handed doctors. This was the pattern that was developing, and they had retained the personal aspect even better than the three or four man groups, who tended to let the patient walk in and have him alloted to any one of the four.

Dr J. McGlone said that in Glasgow they were thinking much more in terms not of group practice but a fully-integrated system, including, if possible, elements of both the hospital and the local authority. They had in mind a minimum size of about ten. They were not worried about 20 or even 30 in one place, because it was felt that much more could be done in the way of services.

With regard to the personal doctor, a point stressed time and time again, he wondered how many patients really wanted this particular aspect. "We treasure this very much indeed", said Dr McGlone, "and get great satisfaction out of it, but, in all honesty, probably only 20 per cent of the patients make this an important issue. I agree that we should make it available to those people but it is not so important for the other 80 per cent."

The examination problem could be solved (as in his own case) by having twin consulting rooms. There should be nothing in the consulting room but the desk and examination couch. If there were anything else there, even a syringe, the doctor would always be tempted to do something himself instead of delegating it. The advantage of the twin consulting rooms was that while the patient was undressing there could be a patient in the second consulting room waiting to be seen. It saved time and space to have one central place for all treatment, and also there was a saving on equipment, because there was only one set to deal with the whole surgery.

Mrs E. H. Simmonds (*chairman, Health Visitors' Association*) said that with the advance

from four to six to ten general practitioners in practice together there were more and more requests for health visitors to be attached to them. Where on the plan were they going to be accommodated? Apart from an office, they needed an interviewing room. One of the speakers, dealing with the equipment aspect, had referred to a nurses' room but not to any facilities for the health visitor. Even in the urban areas there was a difficulty with public transport. Where there were eight doctors with a catchment area of, say, 25,000 population, were these patients going to come readily to see their general practitioners? This had to be kept in perspective.

Dr L. Newman said that in her practice there were sliding doors at one end of the examination room and at one end of the consulting room, and between them there was a sort of corridor with wash basins and urine testing facilities, so that the doctors could talk to the patients while they undressed, or shut them off and send students or nurses into them. In this way contact was not lost and time was not wasted. There was a health visitors room too. It was important to give all the health visitors and various social workers proper facilities.

Dr Adams said that this sounded an excellent plan. With regard to health visitors, the particular plan was only put up to show the heart of the administration and the reception and the appendage of the waiting room and was designed some 20 years ago. With the changing pattern of medicine and general practice there was no doubt that accommodation must be provided for local authority staff. In his own practice there were four health visitors and they had accommodation upstairs, with their own office, and could use any of the rooms for interviewing as long as they saw the practice administrator; in other words, they made the necessary arrangements through the central organization of the practice. They must be provided in any new building with space in which to work. Nurses needed a large treatment area.

Scope of ancillary (paramedical) staff in group practice

A preliminary report

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Aim of study. A suitable questionaire was devised and circulated in early September 1969 to volunteer group practices in the areas covered by the North-west and Merseyside Faculties of the Royal College of General Practitioners, designed to cover as many aspects of the work of the staff as possible and provide background information about the premises. We suggested that each of the seven sections could be completed by the appropriate member of staff, e.g. nurse, health visitor.

Analysis. Information was coded and punched on 4 × 80 column cards for subsequent analysis. 382 group practices agreed to participate. This paper is based on an analysis of the 278 (73 per cent) who have so far responded.

Results

The majority of practices (81 per cent) were 3 or 4 principal groupings. The average list size per principal was 2.572 (table I).

Types of staff (*see* table II)

Hours worked. The hours worked by various members of staff show wide variation in the practices studied. There does not appear to be a relationship between the clerical hours of work per week for each 1,000 patients and various factors such as total list size, number of principals, number of patients, per principal (tables III, IV, and V).