# COMMENTS ON THE ORGANISATION OF GROUP PRACTICE

## A Report of a Subcommittee of the Standing Medical Advisory Committee

## From the Council of the Royal College of General Practitioners

This Subcommittee of the Central Health Services Council was established in 1968 with a remit "to review the working and organisation of group practice, with particular reference to health centres, and to make recommendations". The committee had 15 members of whom six including the Chairman, were general practitioners. The Committee undertook no research of its own during its deliberation.

*Introduction*

This is an unexceptional report. Helpfully, it assumes that primary and continuing medical care will continue to be given in this country by the general practitioner. There are no new proposals. Rather, the report represents a consolidation and reaffirmation of published work and development already in progress in the field. The authors comment frequently on the relative paucity of hard data, as distinct from informed opinion on general practice. Curiously their list of references excludes many publications containing such material; indeed, more research has been done in the organisation of general practice than in any other branch of medicine.

## COLLEGE RECOMMENDATIONS

Before commenting in detail on the report the College makes the following recommendations:

### (A) Physical resources

(1) *Premises*

(a) The level of capital spending on premises in both the public and private sector needs to be increased.

(b) Existing premises really suitable for modification should be eligible for capital works under the improvement grant scheme at a time when new groups or partnerships are being formed.

(c) The arrangements for updating the *Design Guide* should be reconsidered, so that recent advances in technique and new requirements such as adequate space for teaching all members of the practice team, and undergraduates, can be made available to building authorities quickly.

(2) *Manpower*

The College encourages teamwork with other community-based professionals such as health visitors and nurses.

(a) Continuing effort must be made to secure more attachments of local authority nursing staff to general practice.

(b) Local authorities must be persuaded not to restrict their nursing staff pending the 1974 re-organisation. The College seeks assurances that nursing activities and levels of staffing will be appropriate for the needs of the community under the new administrative arrangements proposed.

(c) The training of community nurses and health visitors should be centred more in future on teaching general practices.

### (B) Relationships

(1) *With patients.* The College reaffirms that the main function of general practitioners is to provide primary, continuing and terminal care to individuals and families. The importance of stressing this personal relationship in the context of larger organisations cannot be over-emphasised.

(2) *With other health professionals.* Working together has created new problems as well as new opportunities. There is a need for more careful research into small group management in

the context of general practice, so that the interests of patients and the quality of their care is maintained at an optimum level.

(3) *With health service management.* The proposed role of the community physician in relation to general practice needs to be clarified. In particular, his possible responsibilities and authority, both clinical and management, need to be elucidated further.

(4) *With hospitals.*

(a) *Access to diagnostic and treatment facilities.* Although greatly improved recently, deficiencies remain. In particular, the right enjoyed by some practitioners of access to contrast media x-ray studies, ECG and physiotherapy should be extended to all.

(b) *Hospital beds.* The College reaffirms that practitioners should be able to look after their own patients, both obstetric and medical, in district general and cottage hospitals in appropriate circumstances. Such use assumes that practitioners are willing to meet the prevailing clinical standards of the hospital unit as a whole.

(c) *Contact with colleagues.* The importance of frequent contact with hospital colleagues is emphasised not just as a means of improving patient care through better consultations, but equally to promote mutual self-education.

### (C) Future studies

There is a need for a small committee to be formed with members representing patients, the Department of Health and Social Security, British Medical Association, and The Royal College of General Practitioners.

The committee should have a considerable degree of independence to consider priorities and areas for development in general practice, and should be able to commission fact-finding studies. Provided that it has the right type of lead and encouragement it could make a weighty contribution to the future of general practice and medical care.

## COMMENTS ON RECOMMENDATIONS AND CONCLUSIONS

*Chapter 1*

In defining the need for a generalist in our medical care system, the report (paras 19–29) is somewhat confusing. The economic advantage of a health service based on the general practitioner is restated, with the comment that such a policy "will free the highly paid staff and beds in hospitals for work which demands these skills and facilities". This section may disturb those practitioners who hold that general practice is as important a specialty as any other, and that it has a definable knowledge base and skills which the practitioner must possess to do his job properly.

*Chapter 2—Group practice*

The authors say that a 'basic unit' in the practice should be the doctor, nurse and supporting secretarial staff providing continuing care for a defined population (paras 27–28). It is suggested that each basic unit should normally relate to a constant patient population (para 40). Thus a number of basic units would be amalgamated to form a group practice.

The College is not persuaded that such a definition, with its implied rigidity, is necessary: even if it were, it is questionable whether the mix of personnel proposed is the right one. What is the evidence for this particular proposal?

Recommendation 13 indicates that the optimum size of a group practice will be found to be five or six doctors with appropriate nurses and secretarial staff (paras 38–39). The authors may be right; here again, however, the recommendation is empirical and may be needlessly restrictive.

There is a suggestion in paragraph 41 (iii) that large group practice centres could accommodate a specialist in preventive medicine who would, amongst his other jobs, "take responsibility for promoting immunization schemes and health education and for the monitoring of morbidity and epidemiological work". The implications of such a suggestion will have to be thoroughly discussed. While the College would agree that the collection of data for audit is as essential in general practice as in any other specialty, the question as to whether the control of data collection should rest with practitioners or the health services administration is an important one. Doctors with experience of monitoring morbidity data have shown that the collection can be

done quite simply and effectively by the practice secretarial staff. The interpretation and subsequent action to be taken has then been a matter for practitioners themselves. The College is not satisfied on the evidence offered that Government (community physician) rather than voluntary control is necessary to improve standards of patient care.

Recommendation 15. The report suggests that the provision of pathology and radiology facilities cannot be justified in group practice premises (para 43). This statement again seems unreasonably dogmatic. Accepting that in most instances the thesis is correct, there are exceptional rural centres where the provision of an x-ray machine operated by the practice staff themselves can be used to screen for simple fractures.

Recommendation 18. Group practice will help to provide a higher quality service to the community, but may not enable doctors to care for more patients (paras 45–46). The authors set out their reasons for saying why they think the average list should not exceed 2,500 patients. The reasons are convincing, but again are delivered with a finality which the facts do not allow. The full implications of teamwork on the overall workload of a practice, and hence its manpower needs, are not clear at present.

*Chapter 3—The nursing staff in group practice*

The main recommendations are familiar, namely, that the several nursing tasks to be performed in a community setting call for several grades of nurse. They must be appropriately trained and have adequate accommodation and secretarial assistance within the practice.

Council strongly agrees with recommendation 21 that there is an urgent need to experiment with other methods in the deployment of nurses other than those currently employed.

Whilst we agree that in a group practice there are advantages in having a senior nurse in the practice responsible both to the practice doctors and the chief nursing officer of the area (para 67), it would be helpful to draw a distinction between the responsibility of this senior nurse for administrative and clinical tasks. When exchanging information about patient care, doctors and all nurses in a practice should be able to discuss matters freely.

We strongly support recommendation 25 that both the training of the health visitor and home nurse (sister) should include experience in selected group practices (para 70). The College would go further and suggest that all nurses preparing for the register should have more experience than they have done hitherto in the community.

The report does not mention the crucial question of the position of community nurses when the Health Service is re-organised. The immediate need to ensure that local authorities do not run down this service (which they are to lose) is not considered.

*Chapter 4—Social work in group practice*

No comment.

*Chapter 5—Secretarial staff of group practice*

This chapter is unremarkable. In many practices the recommendations have already been implemented.

Many practitioners disagree with the recommendation (para 90) that practice managers should be drawn from the ranks of receptionists who, it is suggested, are the senior career grade in practice. Many administrative secretaries or practice managers have a background which includes not only reception work, but secretarial, book and record keeping experience as well. The College would emphasise that the appointment of a practice manager should reflect the personal characteristics, experience and training of the individual; thus, several pathways might lead to this appointment.

*Chapter 6—Premises for group practice*

Here, the conclusions are unexceptional. There is now a large volume of published evidence to show that many general practice premises need modernising. Moreover, when new premises are built, their construction should be such that they allow not only for the housing of the present and envisaged staff complement of a group practice, but make allowance also for unforeseen developments.

The authors rightly draw attention (para 104) to the fact that many new health centres have been constructed on very traditional lines, and that there is thus a need to disseminate up to date information to building authorities more completely and quickly.

The document does not consider the kind of administrative and planning structure to be created within the new area health authorities to deal with health centres. Missing also are any practical indicators as to how that portion of the capital budget on health services expenditure earmarked for practice premises rather than hospitals is to be determined.

There is evidence that some converted premises are actually better than some purpose-built equivalents. It would be helpful to suggest the removal of the rule which at present prevents group practices in the stage of formation from attracting an improvement grant.

In para 110 the problem of rural areas is discussed. In addition to new buildings, it would be helpful if the Department would consider the adaptation of many cottage hospitals by the addition of practice consulting facilities.

*Chapter 7—Equipment, services and organisation*

Recommendation 54. Access to diagnostic facilities needs strongly emphasising. The report does not remind us that only 58 per cent of practitioners had access to contrast media x-rays in 1969.

The suggestion that a service for the transport of specimens (para 120) should be provided should be strongly pressed. The profession has been asking for such a service for years.

The report suggests that the use of both pathological and radiological facilities by practitioners will increase in future. Thus, the authors say, provision should be made for this expansion in planning health services. We would agree with this view and have said so before. The key reason why this has not happened in the past is not stated in the document; planning diagnostic services, it appears, has been directed often towards the hospital inpatient and outpatient population rather than related to the morbidity generated by the total population of the community served by the hospital. When shortages have appeared, general practitioners have too often been the first to experience a restriction of service.

The report is lukewarm about the provision of transport to bring patients to group health centres (para 124). We hope the Department would now go beyond the continuation of experiments suggested by the authors. The present position, especially in rural areas, is demonstrably unsatisfactory without the need for further procrastination through experiment.

Management and organisation within group practices and health centres is emphasised in five paragraphs of the report (paras 125–129). The complicated problem of small group management, including audit, communications and personal relationships, is merely touched on. The question of leadership of a group is raised in paragraph 127.

We agree that the doctor must be responsible in all clinical matters but have reservations about the observation that some kind of hierarchical structure is required if group practice is to remain stable. Does this mean a hierarchy of doctors, or of doctors and other staff? Where does the community physician fit into this hierarchy? Further discussion of this point is necessary.

*Chapter 8—Records for group practice*

The College would strongly agree with recommendation 63 (paras 132–133 and 138) that the present National Health Service medical record is inadequate, and in need of revision. Moreover, this should include data recorded by all members of the practice team (recommendation 64).

It appears that an assumption has been made that the new record would be evolved from the present, perhaps along the lines of one of several experimental models in use. The problem orientated record or the problem orientated practice are not considered. The potential of these methods should be examined further.

*Chapter 9—Group practice and the community physician*

Council finds itself confused about the many roles of the community physician which appear in this document. However, it agrees that community physicians must have experience in general practice as part of their vocational training.

*Chapter 10—The relationship of group practice with other disciplines and professions*

No comment.

*Chapter 11—The relationship between the hospital and group practice*

We agree with the implied recommendation of the report (para 188) that cottage hospitals should be retained because they provide an important community service. The College emphasises the importance of retaining such hospitals.

The report really closes the door on the possibility of practitioners undertaking full clinical responsibility for their patients in general hospital beds (paras 196 and 199). The College questions the validity of the argument. Examples such as the East Birmingham Hospital Practitioner Unit show that it can be of value both to practitioners and patients. Further experience is needed before a definite statement of rejection can be considered.

The authors suggest that practitioners can make their most useful contribution to hospital work by "participating as members of the hospital team" (Recommendation 91). Presumably what this recommendation means is that the hospital service would prefer to accept practitioners working as clinical assistants. The College's view has been stated before on this issue. Where such appointments are likely to have some educational value to general practice they can be encouraged. On the other hand, it must be clearly stated that many such assistantships are purely 'pair of hands' jobs and have no relevance to the work of the general practitioner; th us they can only serve to dilute his experience and competence in his own specialty.

Concerning maternity beds, the College holds strongly that enough beds must be made available for general practitioners in district general hospitals.

The College would welcome further experimentation with the involvement of consultants in sessions held in group practice (para 206).

*Chapter 12—Role of the group practice in education*

The recommendations in this chapter are all in accord with College policy. We would emphasise particularly the importance of providing suitable accommodation now for teaching purposes in group practice premises (paras 221–222).

REFERENCE

*The Organisation of Group Practice* (1971). London: Her Majesty's Stationery Office.

## W.H.O. DEFINITIONS

The World Health Organisation expert committee on maternal and child health have previously defined low birth weight as 2,500g or less. More recently, the expert committee on the prevention of perinatal mortality and morbidity has agreed to define *pre-term* as 'before 37 weeks of gestational age (calculated from the first day of the last menstrual period), *term* as from 37 to before 42 weeks, and *post-term* as from 42 weeks.'

*World Health Organisation Technical Report Series* (1970). **457**, 20.

## SWING TO GENERAL PRACTICE

The *Canadian Family Physician* (1971) reports the officers of the Canadian College describing "a virtual revolution in medicine" and "a dramatic swinging of the pendulum away from the specialties and towards family medicine."

The evidence for this claim consists of a record number of 300 doctors enrolling in 1971 for the certification examinations of the College of Family Physicians of Canada.

In addition, there is evidence of "an impressive increase in the number of medical students choosing to make their career in family medicine. In 1965, about 30 per cent of all medical students elected to enter general practice. Today this percentage has perhaps doubled. Figures of 64 per cent in the University of Alberta, 68 per cent in the University of British Columbia and 73 per cent at Dalhousie have been reported. More than 100 students are taking residency training in Family Medicine at the present time."

*Canadian Family Physician.* (1971). **17**, April.