Health centres and the family doctor*

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WE are accustomed to think of Dr Will Pickles in terms of his 50 years' work at Aysgarth in Wensleydale, as a devoted family doctor setting a pattern of skilful and continuous medical care in one community for half a century. However, we also remember that his book *Epidemiology in Country Practice* made a real addition to medical knowledge and that his reputation was such that he was asked to lecture in the United States, Australia and South Africa, and that his advice was sought and valued by many important organisations. All this was evidence of an active and enquiring mind motivated as much by his concern for his patients as people, as by scientific and intellectual curiosity.

Pickles was interested in all aspects of medicine—including health centres. In Professor John Pemberton's biography we can read how, in a lecture to the Yorkshire Society of Medical Officers of Health given in 1944, stressing the need for systematic research on farmer's lung, he said " As I am a great believer in health centres in country towns as centres for research I recommend this subject to a group of doctors working in one of them in the future."

Again, in a paper read at the Annual General Meeting of the British Medical Association in 1948 "Many of us have dreams about health centres and if they are to become more than 'airy nothings' I can see in them a very close link between the general practitioner and the public health service".

We can be confident that Pickles saw health centres not only as a base for the scientific research which was for him a compelling interest, but also as a means of constantly improving and extending the range of the continuous individual medical care which was the real substance of his 50 years at Aysgarth.

For many years after that annual meeting in 1948, health centres remained to a great extent 'airy nothings'; but the last few years have seen what has been called the health centre explosion and developments in this field are now going forward so quickly, that it is important to look carefully at the opportunities which are occurring and at the problems and difficulties which accompany them.

Health centre development

Figure 1 shows the total number of statutory health centres in the United Kingdom during the years 1948 to 1970. It will be noticed how few centres there were in the years 1948 to 1963. Of the 26 in existence by 1963 some were new and experimental centres, such as Sighthill and Woodberry Down, some were based on hospitals, such as at Stranraer, and a number were clinics and dispensaries which had been taken over in 1948 and had little or no provision for general practitioners.

In the years following 1967 the picture is very different. The total number of centres has multiplied fivefold in less than five years, and there is every indication that development will go on at this rate.

Figure 2 compares the situation at the end of 1970 with that which will exist at the end of 1972. It shows the proportions of general practitioners as a percentage practising from health centres in England, Wales, Scotland, and Northern Ireland.

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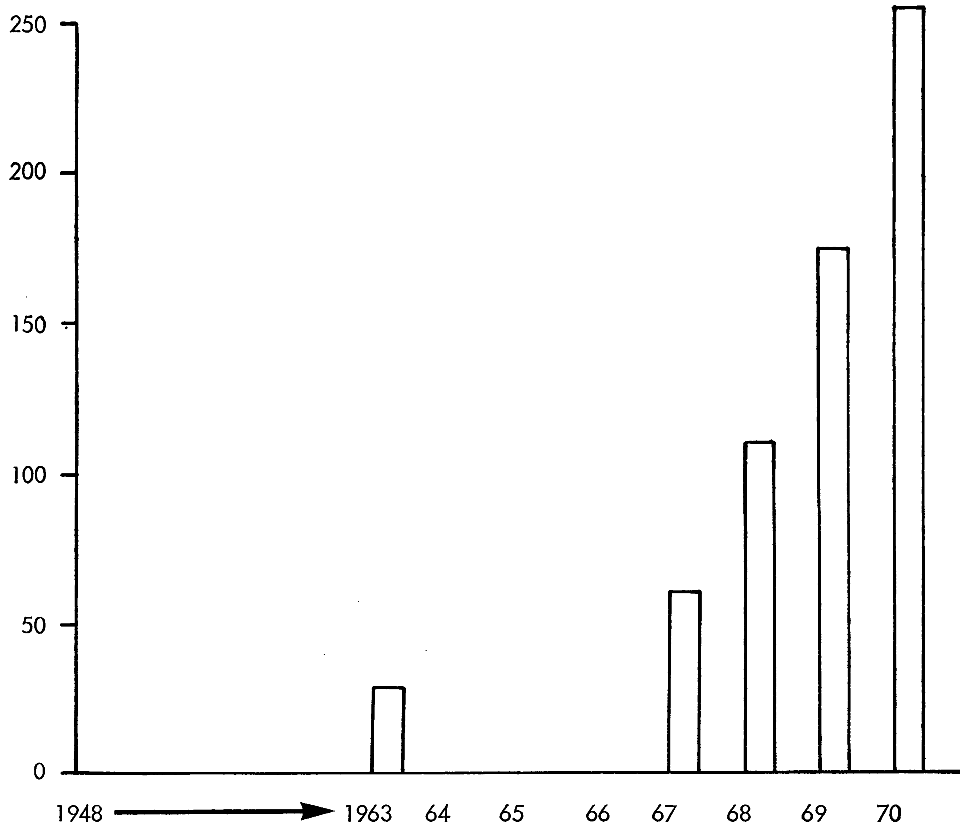


Figure 1

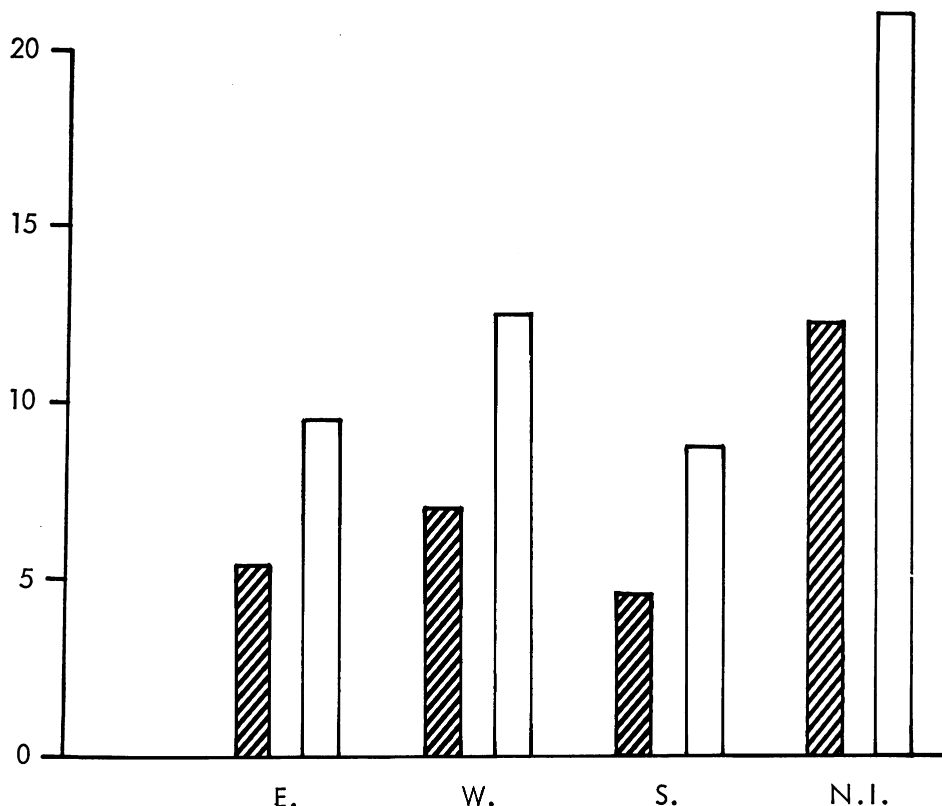
It will be seen that in each case the numbers in these two years will have approximately doubled. We know from the numbers of new centres that are being planned, or are being built, that developments will certainly go on at this speed for a number of years.

In Northern Ireland, for example, we know that by 1975 well over 50 per cent of family doctors will be practising from health centres. Preliminary discussions have already taken place which will involve a further 20 per cent, so that in the foreseeable future at least 70 per cent of Northern Ireland general practitioners will be working in health centres.

Clearly, developments on this scale will have profound repercussions on the pattern and quality of medical care for many years to come. A situation of such rapid change offers exciting opportunities; but there are also risks where so much is comparatively new and untried. It is my purpose to look briefly at both these aspects.

Historical background

In order to understand this rapid change in the pattern of general practice in the United Kingdom, it is essential to look briefly at developments which have been taking place since 1945. Many of these have been seen in other countries too, and I will refer only to changes in the United Kingdom.



PROPORTIONS OF GENERAL PRACTITIONERS (percent)
PRACTISING FROM HEALTH CENTRES IN ENGLAND, WALES
SCOTLAND AND NORTHERN IRELAND
END OF 1970 COMPARED WITH END OF 1972 (EXPECTED)

Figure 2

One of the most significant has been the steady increase in the number of partnerships and groups, and the increase in the numbers of comparatively large groups of general practitioners working together.

The size and numbers of partnerships over the years 1952 to 1969 are shown in Figure 3. It can be seen that the number of single-handed doctors has dropped from 43 per cent to 21 per cent, and that the number of two-man partnerships has decreased from 33 per cent to 25 per cent of the total numbers of doctors. By contrast, partnerships of five or more now form 11 per cent of the total and have increased fourfold during this period.

In parallel with the formation of larger partnerships and groups of general practitioners there was an increasing understanding of the importance of two other aspects of practice organisation; the first was how valuable it was for general practitioners to have efficient secretaries and receptionists and, if possible, the help of trained nurses. The second, that good buildings from which to conduct the work of general practice could add greatly to the efficiency of the family doctor and to his professional satisfaction.

A third factor is perhaps the most significant of all; that is the realisation that

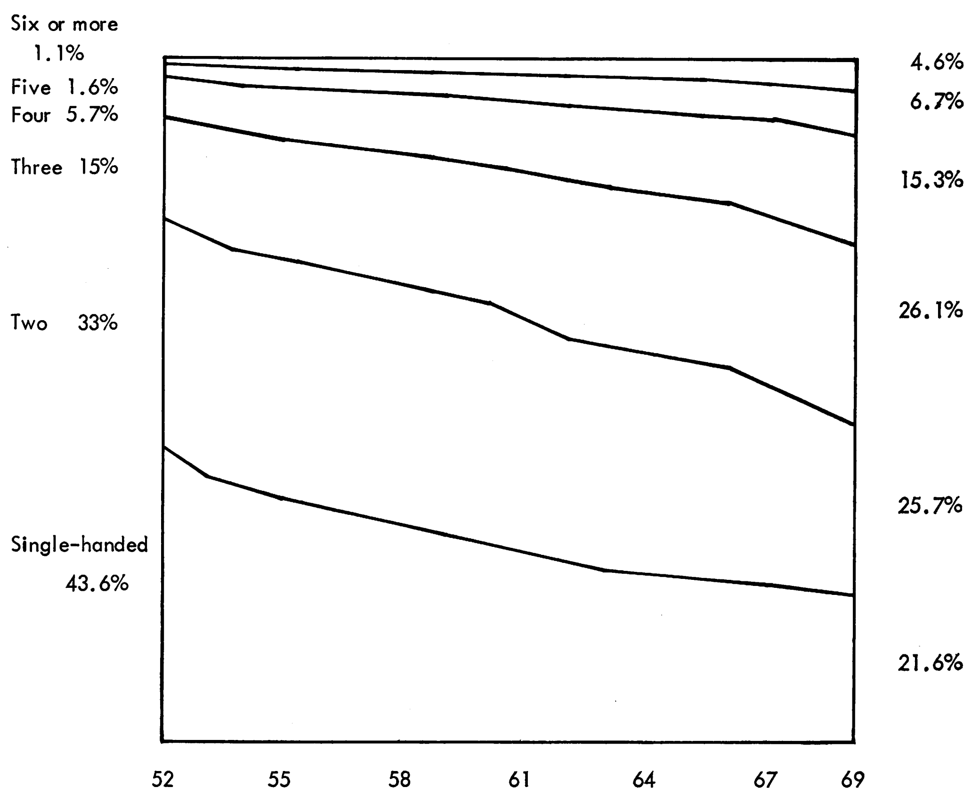


Figure 3

proper medical care cannot be provided by one section of the profession working in isolation from the others. Recent years have seen rapid developments in co-operation between family doctors and health authority staff, in particular with health visitors, district nurses, midwives and also to some degree with social workers.

There is now general agreement that the tripartite structure of the National Health Service has been an obstacle to this necessary co-operation. It is of interest to record that in spite of the difficulties of the administrative framework enthusiastic family doctors and medical officers of health and their staff have in many places combined to widen the scope and effectiveness of medical care in the community, within the present structure.

A great deal of progress has been made through the enthusiasm and initiative of general practitioners organising group practices and working from buildings either specially built or adapted for the purpose.

All over the country there are now very many such groups using all the generally accepted methods of providing a base for good clinical medicine: proper premises, supporting staff such as secretaries and receptionists, very often practice nurses, appointment systems, good records and practice registers. What is equally important, these doctors benefit by professional association—they work in a truly professional atmosphere, often consulting together, discussing each other's work, distributing praise and criticism, knowing that emergencies are adequately covered by group off-duty rota, able to get colleagues to cover absences for postgraduate study or sudden illness, and also for holiday periods.

Attached staff

I have referred to the increasing co-operation between general practice and public health authority staff. At 30 September, 1971, 13,325 general practitioners were working with full attachment schemes and nearly 3,000 within other schemes, that is a total of over 16,000 out of 23,000 general practitioners in England and Wales.

It is, of course, important not to be unrealistic as to what these statistics mean. It is difficult to teach old dogs new tricks; it is hard to change patterns of professional work that have been developed over five, 15, or even 30 years. This association between doctors and nurses in community care may mean anything from a perfunctory exchange of a few words once a week to the fullest co-operation, where each brings his or her complete professional training and experience to bear on problems of sickness and the maintenance of health to the full benefit of the patients of both. What is important today is that this new method of working is gaining momentum rapidly, and that for every doctor, nurse or health visitor who is sceptical of its value there are many others convinced that it is an essential development if patients are to receive the full benefit of medical progress.

The advantages of 'full attachment', i.e. where the health visitor or home nurse is involved with all the patients on the general practitioner's list and not restricted by a geographical area, over other forms of attachment are generally agreed. Many will now go further and say that there are even greater advantages where doctors, health visitors and nurses work from the same building, and that this applies to all the services provided by local health and welfare authorities.

Buildings

The problem of providing suitable buildings for the requirements of general practice alone, as now organised, is considerable, and when one includes accommodation for all the other people and services one wishes to see directly associated it becomes even greater. It appears that general practice now is in the same position as were the voluntary hospitals in the late 1940s—that is, that because of the increasing possibilities for medical care and the increasing expense of providing it further progress or, indeed, even the maintenance of present standards will be impossible without substantial aid from public funds in some form. This is one reason why current health centre developments are of such significance.

Government reports

The Dawson Report

In considering the origin of the idea of health centres reference is often made to the Dawson Report of 1920, or to give it its full title *The Interim Report on the Future Provision of Medical and Allied Services* from the Consultative Council of which Lord Dawson of Penn was Chairman.

This Report makes fascinating reading in the light of all that has happened since. Inevitably, after some 50 years, much of it has an old world sound; but much of it was prophetic, and some of it still highly relevant to the problems of today.

The health centres in the Dawson Report were, of course, much more allied to hospitals than to the contemporary idea of health centres. A so-called primary health centre was really a general-practitioner or cottage hospital, with a maternity unit, to be staffed by general practitioners who would often continue to have consulting rooms elsewhere. It was to be provided with x-rays and access to clinical pathology laboratories. The secondary health centres and teaching hospitals were seen as part of a hospital system providing all necessary specialist care.

Great stress is laid on the part that should be played by general practitioners in preventive medicine: "Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in

close co-ordination". One is reminded again of Pickles' remark over 25 years later that he saw health centres as a close link between general practice and the public health services.

The Dawson Report says "The changes which we advise are rendered necessary because the organisation of medicine has become insufficient and because it fails to bring the advantages of medical knowledge adequately within reach of the people. The insufficiency of organisation has become more apparent with the growth of knowledge and with the increasing conviction that the best means of maintaining health and curing disease should be made available to all citizens".

In the years that followed the Dawson Report, while almost nothing appeared as bricks and mortar, the idea persisted and was often discussed—the words 'health centre' came into the language.

Medical Planning Commission

A Medical Planning Commission established by the British Medical Association in co-operation with the Royal Colleges in 1940 issued an interim report in 1942; this report stressed the importance of the family doctor as the normal medical attendant, and once again emphasised the need to integrate the preventive and personal health services. It saw the health centre as a convenient focal point for this co-operation. The report outlined a scheme for health centres as part of a regional comprehensive service; the building was to be provided by the regional authority and from it would work eight or ten general practitioners in urban areas or six or eight in mixed areas, midwives, health visitors and district nurses with clerical staff for record-keeping and secretarial work. There was to be a small theatre for minor surgery, a small x-ray department, and facilities for simple diagnostic investigations and clinical pathology.

Post-war problems

When the 1939–45 war had passed, and the period of reconstruction had begun, there were many who saw the health centre in some form as an important part of an adequate health service intended as the Dawson Report had said "To bring the advantages of medical knowledge adequately within reach of the people". When the National Health Service began in 1948 local health authorities were charged with the duty of providing, equipping, staffing and maintaining health centres.

However, the Chief Medical Officer's Report for 1948 refers to the unfavourable building position (war-time shortages and difficulties still prevailed). In the report for 1949, one reads that new centres were restricted to new housing estates with at least 10,000 people. As recently as 1961 there is reference to "Difficulties of an almost insuperable nature" in the establishment of health centres, of which only 15 new ones had by then been built.

That interesting and influential book *Good General Practice*, by Stephen Taylor, now Lord Taylor, published in 1954, was not optimistic about health centres and stressed the importance of group practice as the means of progress.

The Gillie Report

One of the most important reports on general practice appeared in 1963, on *The Field of Work of the Family Doctor*. It is known as the Gillie Report because the Chairman of the Committee was Dr (now Dame) Annis Gillie, a distinguished President of our College. Much of this report, now almost ten years old, is still highly relevant to the problems of general practice. Health centres are seen as only one among many ways of achieving progress; but the report is still a significant signpost to the health centre explosion; because all the developments which it saw as necessary and, indeed, inevitable in the work of the family doctor, in postgraduate education, in association with teaching, in research, in integration with the preventive services, in work in the obstetric and mental

health services, in association with hospital services and in practice organisation; are all almost impossible for isolated family doctors, and difficult even for well organised group practices. Some new structure and organisation was needed.

Other publications

The Royal College of General Practitioners, through the work of the practice organisation committee and in other ways, has made important contributions to developments both of group practice and of health centres. The publication of the *Design Guide for Medical Group Practice Centres* in 1967 was of great value in setting a pattern and starting systematic study; the College was also one of the sponsors of the General Practice Advisory Service where Dr George Adams and his colleagues have done such important work. The publication *Buildings for General Medical Practice* prepared by the General Practice Advisory Service and the *Design Guide for Health Centres* subsequently issued by the Department of Health and Social Security have consolidated a great deal of valuable and relevant knowledge.

The Harvard Davis Report

The most recent report on group practice organisation has come from the committee chaired by Dr R. Harvard Davis. This has assembled the evidence in detail, and as well as indicating many possible fields for future development has stressed the main thesis once again i.e. that proper medical care in the community now calls for, whenever possible, groups of doctors working together from suitable buildings, supported by trained staff, co-operating with other doctors, nurses and welfare services.

The new health centres

What kind of buildings are now going up in such numbers, who are working in them, and what pattern of work is evolving?

In recent years I have had the good fortune to visit numbers of health centres in the United Kingdom, from Bristol to Huntly in Aberdeenshire, and at various times have seen 18 centres in England and seven in Scotland. I have also visited many group practices. I would like once again to thank all the doctors and other staff who have received me so hospitably on all these occasions and given valuable time to show me around and answer my questions.

We have now in Northern Ireland 29 health centres in operation from which 132 doctors out of a total of 750 general practitioners are practising. I have been closely associated, together with the family doctors, the medical officers of health and those in administration, including my own colleagues in the Northern Ireland General Health Services Board in the planning and building of all these except the first, and have frequent opportunities of seeing them in action. My comments are based on experience acquired in this way.

I have most experience of Northern Ireland, but what I have seen in England and Scotland suggests that health centre developments everywhere have much in common.

Problems of health centres

I want to consider some of the problems, as opposed to the many advantages, of health centre practice—problems which are often larger in the minds of those contemplating the change than in those who have experienced it. They might be summarized under one main heading—that where considerable numbers of doctors practise in groups from comparatively large and perhaps impersonal buildings, delegating part of their work to other professions, and with secretaries and receptionists who may form a barrier between them and their patients, the work of the family doctor may become impersonal and perhaps bureaucratic. This raises concern lest much of the quality and character of general practice in the best tradition will suffer. The first reaction of patients to the idea of a health centre is the feeling that they will have difficulty in seeing

their own doctor, and that in one telling phrase "the whole thing will be like a hospital outpatient department." It is sad to note in passing that this is meant as a major criticism.

The attitude of the family doctors and their determination to preserve the best in their existing methods of practice is, of course, the best safeguard against such a deterioration in standards. There are, however, a number of practical points about the design and staffing of health centres which can be stressed.

At the first point, where the patient talks to the receptionist, there must be reasonable privacy so that the patient can mention symptoms and names without being widely overheard. Equally, the receptionist should be able to talk on her extension telephone in confidence. This is an architectural problem—it certainly means that any seats for waiting patients must be far enough away from the reception desk or counter.

As far as staffing goes it is desirable, as far as possible, for the same receptionist to deal with the patients of the same doctors. This is usually easily arranged short of rigid divisions which make relief for off duty, holidays and sickness difficult.

Patients with appointments waiting to go to the consulting rooms should have suitably sited sub-waiting areas. In this way they leave the often busy main reception and waiting area for a quieter smaller one directly associated with the doctor they wish to see. The method of calling the patient to the consulting room is important. It should be clear to avoid confusion and it should be personal.

The use of examination rooms in association with consulting rooms, as well as having many recognised advantages from the doctor's point of view, adds to the privacy and comfort of the patient. Here he or she can undress and dress in privacy and without haste, knowing that the doctor can continue working in his consulting room.

Confidentiality and privacy should always be considered. They are of particular relevance in the design of treatment rooms and treatment areas, in centres where two or more nurses will be working at the same time. No family doctor would consider for a moment putting a curtain down the centre of his consulting room, and asking two patients one on each side of the curtain partially to undress and to discuss their symptoms with him. Yet this is still done in health centre treatment rooms. Quite clearly each patient here must be seen in a nurse's examination room, where undressing can be done in privacy and where essential discussions of symptoms and history cannot possibly be overheard. This means that a treatment area where two nurses are to work will consist of a suitably equipped working area, with an examination room for each nurse. One of these rooms should be of such a size that a couch can stand at the centre, easily accessible from the head and at both sides.

Other professions in health centres

Nurses

The nurses who work in treatment rooms in Northern Ireland health centres are all state registered nurses employed by the local health authority. In some of the centres, particularly the smaller ones, they may also do home nursing.

The investigation on the work of the practice nurse by the College with the support of the Department of Health and Social Security, the results of which were published as a *Report from General Practice* with *The Journal of the Royal College of General Practitioners* (1968), demonstrated clearly many important aspects of nursing work in general practice. In health centre treatment rooms the more common activities are found to consist of dealing with minor injuries, giving injections, taking specimens for laboratory investigations, such as blood and mid-stream urine, the treatment of gravitational ulcers, syringing ears, minor clinical pathological investigations, such as urine testing and the estimation of the blood sedimentation rate, pregnancy testing, and the taking of ECG tracings.

Taking the average for eight centres in Northern Ireland covering some 80,000 patients, it is found that 1,130 procedures of this type were carried out in one year for each 1,000 patients. The range was from 616 to 2,249 per 1,000 patients. It seems probable that with the present pattern of work one full-time treatment room nurse is required for every four doctors, or with our Northern Ireland average list size and pattern of work, one for each 8,000 patients.

It is clear that the nurses make a most important contribution to patient care, and that the work they do for the patients will leave the doctors more time to devote to purely medical matters and to such activities as postgraduate study and research.

District Midwives

The district midwives, of course, also work in the health centres. Where the doctors hold special antenatal clinics and this is increasingly the case, the midwives attend, prepare the patients for examination, and see them with the doctors. With the increasing number of confinements in hospital or in general-practitioner obstetric units, often associated with early discharge in suitable cases, this pattern of antenatal and postnatal care is of growing importance.

District Nurses

The district nurses can also be based on the health centre, where they will have an office, workroom and equipment store. In this way family doctor and district nurse can consult easily about patients. Arrangements of this kind can do much to widen the scope of home nursing care and to break down the barriers in communication between doctor and home nurse which in recent years have been found much more serious than was supposed.

Health Visitors

There is value in the arrangement where health visitors and doctors have common responsibility for the same group of patients. At present this would mean that one health visitor and two family doctors would work together, or larger numbers in the same ratio.

The importance of the health visitor's work in general practice is clearly linked to the increasing emphasis that is now placed on early diagnosis or, if possible, prevention of disease, on health education, and on screening programmes.

The health visitor can be much involved in all the following aspects of the family doctor's work—antenatal and postnatal care, cervical cytology and breast cancer screening; the management and care of infants and young children; screening for such defects as deafness, congenital dislocation of the hip, and phenylketonuria; the completion of full immunization programmes; as a link between hospital and practice in relation to hospital admissions; in many aspects of the care of the elderly; in looking after the mentally ill.

It is important to stress that the doctor's work is not made less by this association with the work of the health visitor, and may indeed be increased. The value of the arrangement lies in the stress it places on prevention, early diagnosis and health education, all leading to better patient care; where the arrangements work well, all those concerned feel that there is considerable satisfaction in doing important work of this kind.

Social Workers

Because social problems and medical problems are so often very closely linked there is a most important field for full co-operation between the doctor, the health visitor and the social worker. The types of problem which will fully involve all three cover a

wide range from such relatively straightforward matters as the provision of home helps and the arrangement of dietary supplements where necessary, to such complex problems as alcoholism, compulsive gambling, illegitimate pregnancy and problem families.

Recent years have seen a rapidly increasing appreciation of the relevance of social work in general practice. The medical diagnosis and treatment of chronic degenerative diseases in the elderly, for example, is recognised to be only the first step, and unless all the other problems that confront the patient are dealt with, medical treatment may well be wasted. Ferguson and his colleagues (1954), for example, reported nearly 20 years ago that one quarter of all patients discharged from hospital deteriorated seriously within three months, and they suggested that this was due as much to poor housing conditions and failure of after-care as to any progress of the pathological condition.

Advances of medical knowledge in such areas as spina bifida, and the treatment of paraplegia, save lives but create serious problems of management and support. Then there is the whole general situation where people in trouble turn very often to the family doctor for help. It is traditional and respectable to do so, and they often know of no other source. Yet, though they present their problem as a medical one, the medical aspect may be only a small part of the situation. All this has been well shown by numbers of family doctors who have pioneered co-operation with social workers and welfare departments.

It is still a difficult field of co-operation. The organisation of social work and welfare services is complex, and provision throughout the country is uneven. The number of social workers is still too small for all that needs to be done, and the training of those available is variable. Yet the setting up of the new social service departments, and the increasing organisation of full professional training for social workers, means that an important and growing contribution to the care of patients in the widest sense will come from these sources. Family doctors have always recognised the duty of caring for the whole patient, and fully appreciate that in very many cases all the resources of welfare services as well as medical skill are essential if this is to be properly carried out. The support and co-operation of the social and welfare services will also leave family doctors more time and energy to deal with the more purely medical tasks for which they have been trained and equipped.

The health centre offers a good base for this important development. In all our health centres in Northern Ireland an interview room is now provided where a social worker can attend to see patients by arrangement. How often depends on local conditions. This offers an opportunity of bringing into personal contact doctors, social workers and health visitors who, of course, are often confronted with social problems, and in many cases already are the means of involving social work departments in patient care. In this way we will all have an opportunity of coming to understand the essential contribution which each profession makes to dealing with combinations of disease, disability, and social and environmental difficulties that so often present as one seemingly intractable problem.

Other services

It was originally considered that health centres should include all community health services, including, for example, general dental services (in addition to school and priority dental services), pharmaceutical services, and general eye services. In practice, the extent to which this is happening is limited. Of centres built or planned less than ten per cent include general dental services. Less than three per cent include pharmacies, and less than one per cent general ophthalmic services.

There is much to be said for including these services where possible. However, pharmacists, dentists and opticians all face considerable financial and administrative problems in relation to working from health centres under present arrangements. The

inclusion of general dental services on any realistic scale raises many difficulties in planning already complex buildings, and it has been suggested that the provision of special dental buildings in close association with health centres might solve this problem.

There are, of course, a number of extremely important aspects of health centre practice to which I have not even referred. What, for example, should be the relation between health centre and hospital? Is there a place for providing hospital services, such as outpatient services in health centres? What should be the arrangements for management? Is there an ideal size for the group of doctors who should work together in health centres? What additional accommodation for teaching is needed? How can the physical planning of health centres best be done to allow for developments and change in the pattern of community medical care that will take place in the next ten years? All these and many others need study and experiment.

Conclusion

I have given a brief survey of health centre development in recent years, and I have tried to show its inevitability, and to indicate some of the many possibilities it creates for improving standards of medical practice and extending the range of medical care. Looking at the increasing numbers of people involved in caring for the individual patient, and the increasing size of the buildings in which they work, many must feel that the tradition of continuing personal and individual care, which is the mark of the good family doctor, may be in danger. I do not think it is: but I think there are urgent tasks to be done.

The first relates to the physical design of health centres—and the family doctors who are to work in them should always be closely associated with the planning and design from the original concept to the final details. The personal privacy and dignity of the patient must be considered in every aspect of the design.

The second relates to the ideal of continuing personal care; all those working in health centres and the family doctors especially must devise a way of working which will combine all the benefits of professional association with the best tradition of continuing personal care and responsibility for the patient. This may often not be easy, but should be well within our competence provided the will is there.

I will end by quoting once more from John Pemberton—this time from an address given at the memorial service to William Pickles in Leeds in 1969. Speaking from his personal knowledge of Will Pickles, Professor Pemberton said "The art of medicine is difficult to define. I think it lies in the way a doctor greets his patients, the courtesy, tact and yet great thoroughness with which he elucidates a history, his gentle but careful and complete examination, the clear and sympathetic way in which he explains the situation to his patient and advises him, and his continuous and conscientious care, if necessary, right to the end. This was the way Will Pickles practised medicine."

This is the standard at which we should aim.

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