Health centres and excellent medicine—a patient survey

D. G. MILLAR, M.A., B.Sc., D.P.S.
Assistant Curate, Pershore Abbey, Worcestershire

The results presented in this paper are from data collected during a placement at Worcester Health Centre while studying for the Diploma in Pastoral Studies at Birmingham University.

The health centre—the first to be built in the traditional cathedral city of Worcester—is sited close to the city centre in what is at present a redevelopment area. The building houses a large reception area, 12 consulting rooms, a treatment room, a doctors' common room and accommodation for health visitors. It opened in November, 1970, when it was occupied by two practices—practice A and practice B—which had previously been next-door neighbuors in city centre premises. While sharing the facilities of the centre the two practices continued to operate quite independently, each practice having its own receptionist staff.

Practice A

The larger practice A had been formed by an amalgamation, some two years before moving into the centre, of two smaller practices, and at the time of the survey was made up of six male general practitioners. An appointment system was operated and patients were free to make make an appointment with any doctor of their choice. Home visits were done on an area basis to avoid the duplication of journeys; the day's visits were divided into roughly equal groups, each doctor receiving a number of visits within a certain sector of the city. Contact with the chronic sick in the form of regular visiting had been stopped.

Practice B

Practice B was much more traditional in its methods of operation. Composed of two male partners, who had been together for many years, each docto raccepted a personal responsibility for his patients. Night calls and weekend duty were shared on a rota basis, as in practice A, but that apart, no interchange of patients took place. Patients made an appointment with their own doctor and those patients requiring a home visit were seen by their own doctor. The chronic sick on the practice list continued to be visited regularly.

The two practices thus presented a degree of contrast in their working. It is not a contrast arising from very different doctor patient ratios; practice A with six doctors had at the time of the survey, about 14,100 patients; practice B with two doctors had about 4,500. The contrast is directly related to the relative size of medical team and patient list of the two practices. However, alongside and underlying this factor of size are two more fundamental factors. The first is differing views as to what is a reasonable work load. The second is differing views as to the extent to which it is considered desirable to modify traditional modes of general practice in order to be able to offer 'excellent medicine' in the framework of today. Lambourne (1971) discusses the excellence of medical care relative to its content.

To ask what makes for excellent medicine in a health centre is a more important question than to ask whether health centres are a good idea. The building of a health centre does not automatically imply a particular stereotyped form of medical care. Three main problem areas may be identified.

1. *Specialization by the medical members of a health-centre team.* A degree of specialization by general practitioners clearly offers a considerable potential benefit both in terms of job satisfaction and medical care. It can however only be excellent medicine if serious attention is given to the problem of deciding who in the first place funnels the patient to whom.

In practice A the development of particular interests was encouraged but specialization had not reached a stage where it affected the structure of medical care to any great extent. The health centre did not thus present an opportunity for studying this problem.

2. *The relationship between medical and other members of a health-centre team.* In general the majority of doctors welcome the extended role which can be given to the nursing profession in a health centre. On the other hand, a considerable proportion of doctors feel more ambiguous about the extension in role and status of social workers. Nonetheless the extent to which there is effective professional co-operation between general practitioners and social workers is a key factor in the structure of medical care. Whether, for instance, doctors should continue to visit regularly the chronic sick must be seen in this context.

Worcester Health Centre provided, as yet, no illustration of a radically new measure of co-operation in this sphere and thus did not provide a good enough basis for a useful investigation into this problem.

3. *The relationship between general practitioner and patient.* That the establishment of a good relationship between patient and doctor is of importance for the practice of excellent medicine is above the level of controversy.

However, the traditional and exclusive one doctor–patient relationship is not *a priori* the only sufficiently good model. Indeed the traditional model has, of course, already been widely modified. First by the growth of highly specialized hospital medicine and secondly by the grouping of doctors for night and weekend duty.

The important question is how far and in what respect can the traditional model be further modified in general practice and remain a sufficient relationship for the practice of excellent medicine. This is a factor of considerable relevance when considering one or both of the other changes in general practice considered i.e. specialization and a fuller integration of medical care with non-medical and para-medical professional workers.

At Worcester Health Centre this factor could be studied in relative isolation. Co-existing in the same setting, the major difference between practice A and practice B was the relative lack of conservatism of the former in their attitude to the doctor–patient relationship.

Method

The survey was carried out in the form of a questionnaire for the patients.

The questionnaire was designed to take account of the fact that the doctor–patient relationship does not begin and end at the consulting room door. The ramifications of the relationship extend to influence the whole approach of patient to doctor e.g. attitudes of receptionist staff. The opportunity was also taken of examining some of the more technical difficulties which may impede the patient's approach to the doctor e.g. telephone arrangements.

The survey

The survey was carried out by me on a sample of patients waiting in the reception area during morning and afternoon surgery on the Fridays of March, 1971. The sample was collected at random, although not in any rigorous sense. All the following questions were not answered by all patients, percentages have been calculated on replies rather than numbers of patients.

TABLE I

PATIENTS SEEN

	Practice A		*Practice B*		*Both*	
	Number	%	*Number*	%	*Number*	%
Patients on list	14,100	(*100*)	4,500	(*100*)	18,600	(*100*)
Patients interviewed*	60	(*0·42*)	15	(*0·33*)	75	(*0·4*)
Male–female ratio of patients interviewed						
MALE	22	(*37*)	6	(*40*)	28	(*37*)
FEMALE	38	(*63*)	9	(*60*)	47	(*63*)
	60	(*100*)	15	(*100*)	75	(*100*)

*Five more patients were approached and declined and have not been included.

	Number	%	Number	%	Number	%
Age of patients interviewed						
Below 20 years	4	(7)	0	(0)	4	(6)
20–29	18	(32)	2	(12)	20	(28)
30–39	11	(20)	4	(27)	15	(21)
40–49	9	(16)	4	(27)	13	(18)
50–59	7	(12)	1	(7)	8	(11)
60–69	7	(13)	4	(27)	11	(16)
70–	0	(0)	0	(0)	0	(0)
	56	(100)	15	(100)	71	(100)

1 *Method of making appointments*

Did you make your appointment

	PRACTICE A		PRACTICE B	
	Number	%	Number	%
(a) By calling at the health centre in person?	17	(28)	1	(6)
(b) In person, immediately following a previous appointment?	5	(8)	4	(27)
(c) Through a third party?	1	(2)	0	(0)
(d) By telephone?	37	(62)	10	(67)
	60	(100)	15	(100)

Many more patients from practice B make another appointment on their way out from a consultation. That this reflects different styles of work was confirmed by informal conversation with the doctors of the two practices. In practice A the tendency is for the patient to be told by the doctor to come back if he feels the prescribed treatment is not effective. The tendency in practice B is for patients to be told to come back in x days time to see how matters are progressing.

Responsibility for deciding whether medical attention is necessary is thus shifted considerably towards the patient in practice A.

2 *Number of telephone calls*

If you made your appointment by telephone, how many calls did you have to make before getting through to the receptionist?

	PRACTICE A		PRACTICE B	
	Number	%	Number	%
One call	23	(62)	9	(94)
Two calls	7	(19)	1	(6)
Three calls	3	(8)	0	(0)
More than three calls	4	(11)	0	(0)
	37	(100)	10	(100)

Practice A issues a card to its patients giving two telephone numbers for 'appointments only' plus two other numbers for 'calls other than appointments' (including emergencies).

Practice B also issues a card to its patients giving one telephone number for 'appointments only' plus one other number for 'all other messages' (including requests for home visits). The answers given to this question reflect:

(a) The considerably larger appointment telephone to patient list ratio of practice B (1:4,500) as compared to that of practice A (1:7,050)

(b) The fact that a large proportion of practice A patients have only taken note of one appointment telephone number—(question three)

(c) The fact that a proportion of practice B patients use the non-appointment phone to make an appointment—see below (question three)

Factors (b) and (c) complicate matters but perhaps one may conclude that if a practice wishes its patients to have a 90 per cent chance of making an appointment by telephone at the first attempt then it must allow for an appointment telephone to patient list ratio of about 1:6,000. Practice A probably needs another line.

3 *Patients' knowledge of telephone lines available*

How many telephone numbers are available for you to ring to make an appointment?

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
One	23	(*38*)	8	(*53*)
Two	25	(*42*)	4	(*27*)
Three	1	(*2*)	0	(*0*)
More than three	0	(*0*)	0	(*0*)
Have no idea	11	(*18*)	3	(*20*)
	60	(*100*)	15	(*100*)

The large number of patients from practice B who suggested there were two numbers for appointments is explained by the fact that practice B receptionists will accept appointment bookings made on the non-appointment phone. Practice A receptionists are rigidly uncooperative in this respect for reasons of internal administration and to prevent the blocking of the 'emergency' phone numbers.

It can be seen that almost half of the patient sample from practice A had only taken note of one appointment telephone number. It would probably prove considerably more satisfactory if more sophisticated telephone apparatus with interconnecting lines could be installed to receive appointment calls—especially if a third line is to be introduced.

4 *Emergency calls*

If you or a member of your family are suddenly taken ill in the night and it seems to you sufficiently serious to call for a doctor do you

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
(a) Ring 999?	1	(*2*)	0	(*0*)
(b) Ring your doctor at his home number?	15	(*26*)	8	(*57*)
(c) Ring the health centre as for an appointment?	2	(*3*)	0	(*0*)
(d) Ring the health centre's emergency number?	40	(*69*)	6	(*43*)
	58	(*100*)	14	(*100*)

The cards which both practice A and practice B issue to patients make no direct reference to night calls. Both practices operate a rota system for night calls; patients dialling one of the emergency numbers are put through to the duty doctor.

Both practice B doctors report that it is very rare for them to receive a night call when not on duty. The extremely high percentage of practice B patients who stated that they would phone

their own doctor at his home is therefore a phantom figure. This might be explained by two factors.

(a) Practice B patients have a 50 per cent chance of getting their own doctor when dialling the emergency number. (The corresponding figure for practice A is 17 per cent).

(b) It can be speculated that the more traditional ethos of practice B would be more likely to leave patients with the impression that they would be able to reach their own doctor at most times.

5 *Delay before being seen*

How long was it between making your appointment and being seen by the doctor?

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
Waiting without appointment	12	(*20*)	0	(*0*)
Same day	11	(*18*)	3	(*20*)
One day's delay	14	(*23*)	3	(*20*)
Two day's delay	12	(*20*)	3	(*20*)
Three days' delay	4	(*7*)	0	(*0*)
More than three days	7	(*12*)	6	(*40*)
	60	(*100*)	15	(*100*)

The much higher proportion of practice B patients who see the doctor more than three days after making an appointment again reflects the working method of the practice i.e. the tendency for patients to arrange another appointment immediately after a consultation (question 1).

Practice A, on the other hand, has to cope with a much larger number of patients who want to see the doctor on the same day. One of the consequences of practice A's method of working is thus to create a higher proportion of patients who, for a mixture of physical and psychological reasons need a fairly immediate approach to the doctor. Practice A must, therefore, take care that the time barrier impeding a patient's approach does not rise above a tolerable limit.

Of the 12 practice A patients waiting to be fitted in without an appointment

(a) Four had not asked for a particular doctor.

(b) Eight had asked for a particular doctor; of whom four were waiting to be fitted in with the doctor of their choice and four were waiting to be fitted in with another doctor suggested by the receptionist.

(c) Ten were female (83 per cent)—a higher proportion of females than the total sample.

6 *Convenience of appointments*

Is your appointment with the doctor at a time which suits you well? All patients, except some of those who were waiting without an appointment, answered in the affirmative. A list of surgery times is shown in appendix 1.

7 *Choosing a special doctor*

When making your appointment did you ask for a particular doctor?

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
Yes	46	(*77*)	15	(*100*)
No	14	(*23*)	0	(*0*)
	60	(*100*)	15	(*100*)

Of the 14 practice A patients who had not asked for a particular doctor—

Four were waiting without an appointment.
Five made an appointment on the same day.
Two had made an appointment one day ago.
Two had made an appointment two days ago.
None had made an appointment three days ago.
One had made an appointment more than three days ago.

It is reasonable to assume that some of those waiting without an appointment and those with an appointment on the same day would have preferred a particular doctor but refrained from giving any preference in the hope of bettering their chances of an immediate approach to a doctor. The true percentage of practice A patients who had no preference whatsoever was probably no higher than 20 per cent.

Be that as it may, almost one quarter of the practice A sample did not ask for a particular doctor and this well illustrates the way in which the importance of personal continuity in medical care is played down by practice A. Stemming from the practice doctors, this viewpoint is reflected in the attitudes and actions of the receptionist staff who are quite ready to suggest an alternative doctor to a patient when they feel it convenient or necessary. That this attitude has reached down and influenced the patients is shown by the fact that even when a particular doctor has been asked for there is little visible resistance to seeing an alternative doctor.

An alternative doctor

The 46 practice A patients who had requested a particular doctor were asked whether the receptionist had suggested an alternative doctor for any reason.

Twelve replied "yes". Of these only one patient had insisted upon an appointment with the doctor of his first choice. The other 11 patients were seeing the alternative doctor which had been suggested by the receptionist.

These 11 were further asked which of the following statements best described their feelings about not seeing the doctor they had asked for—

I feel perfectly happy	one patient
I feel quite happy	six patients
I feel fairly happy	two patients
I feel not too happy	two patients
I feel definitely unhappy	no patients

The 'invisible' resistance to seeing an alternative doctor seems not to exceed greatly the 'visible' resistance.

When asked whether the receptionist had suggested an alternative doctor, as one might expect all practice B patients replied in the negative.

8 *Home visits by 'personal' doctor*

Suppose you or a member of your family fall ill. You are not dangerously ill but it is necessary for a doctor from this practice to visit you at home. Which best describes your feelings?

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
(a) I would very much hope to see the doctor whom I normally see at the health centre	20	(*35*)	13	(*86*)
(b) I think I would rather see a doctor whom I have met before than a stranger	1	(*2*)	1	(*7*)
(c) I honestly think that I would not mind which doctor called	35	(*60*)	1	(*7*)
(d) I would be quite pleased to get to know another doctor in the practice besides my usual one ..	2	(*3*)	0	(*0*)
	58	(*100*)	15	(*100*)

These are some of the most interesting figures revealed by the survey. The divergence between the two practices is extremely wide.

Although at least 77 per cent practice A patients continue to have a preference in respect of which doctor they see in the surgery, only 37 per cent think it of any real importance for a particular doctor to call when they require a home visit.

In complete contrast 93 per cent of practice B patients continue to feel it important to see a particular doctor when a home visit is needed.

We can conclude that where the one doctor–patient model is treated as of absolutely overriding importance in the running of general practice this state of affairs is perhaps more the product of a particular professional identity than it is the product of the real needs of the patient. In certain areas, such as home visits—'hard' cases aside—traditional expectations of the patient population would seem to be readily open to a considerable degree of modification.

Of the practice A sample 78 per cent had had at least one experience of a home visit before or after the practice moved to the health centre. The corresponding figure for practice B was 93 per cent.

9 *Personal doctor–patient relationship*

With modern medical techniques and advances do you think that the personal relationship between doctor and patient is

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
(a) Even more important than it ever was?	16	(*28*)	3	(*21*)
(b) Just as important?	38	(*66*)	11	(*79*)
(c) Not quite so important?	3	(*4*)	0	(*0*)
(d) Not so important?	1	(*2*)	0	(*0*)
	58	(*100*)	14	(*100*)

The patient was here asked not what is the case but what he felt ought to be the case. Ninety-four per cent of practice A patients and 100 per cent of practice B patients apparently felt that the personal relationship between doctor and patient is at least as important as it was.

10 *Change in doctor–patient relationship*

It has been said that the relationship between a doctor and his patient is not as personal as it was—once upon a time. Do you—

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
Agree	24	(*41*)	2	(*14*)
Disagree	34	(*59*)	12	(*86*)
	58	(*100*)	14	(*100*)

In answering this question patients were stating what in their experience was the case.

In practice B the gap between what patients seek and what they find is quite small. Eighty six per cent find that degree of relationship with the doctor which they believe to be important. In practice A the gap is wider. Although only six per cent feel that the personal relationship with the doctor is less important than it was, 41 per cent feel that the relationship which they experience is lacking in some way.

Summary

At Worcester Health Centre a patient survey was carried out to compare the workings of a large practice of six doctors (practice A) with a smaller practice of two doctors who continued to operate the traditional one doctor–patient model (practice B.)

Most of the practice B sample expressed contentment. Within certain limits, so also did the greater part of the sample from practice A.

Although about 75 per cent of the practice A sample definitely chose to see a particular doctor when they visited the health centre, over 60 per cent said that they would not mind being visited by another doctor from the practice team if and when the need for a home visit arose. It thus seems that a rigorous application of the one doctor–patient model in general practice is more the product of a particular professional identity than the real needs of the patient. In the area of relationship patients would seem to be open to a considerable degree of change in modes of medical care.

However, a considerable proportion of the practice A sample harboured some ambivalent feelings in this matter of relationship, inasmuch as while over 90 per cent felt the personal relationship with the doctor to be at least as *important* as ever it was, about 40 per cent felt the relationship to be *not* as *personal* as it was.

How personal a patient feels his relationship to be, is likely to be influenced by the approach road to the consulting room door as well as by what goes on behind the door. The survey provides some evidence that in practice A the barriers which impeded a patient's approach were rather too high to be compatible with the method of working adopted by the practice doctors.

APPENDIX 1: Surgery hours at time of survey (weekdays)

PRACTICE A		Number of doctors usually on duty
09.00—10.30		5
11.30—12.30	(except Friday)	1
14.30—16.00	(Tuesday and Thursday only)	1
16.30—18.00	(Monday, Wednesday and Friday only)	5

plus antenatal clinics.

PRACTICE B	Number of doctors usually on duty
08.30—11.30	2
16.30—18.00	2

plus antenatal clinics.

APPENDIX 2: Travel

1. Taking both practices together 47 per cent of the patients interviewed came to the health centre in their own car and a further ten per cent came in someone else's car.

	Both practices	
	Number	%
Came in own car	35	(*47*)
Came by public transport and/or on foot	32	(*43*)
Came in someone else's car ..	7	(*10*)
	74	(*100*)

Local conditions affect any result of this kind. The position of the health centre in the middle of a redevelopment area, with as yet no public transport to the city centre, must increase the need for private transport. Even so, it is a considerably higher figure than that obtained by Ann Cartwright (1967)—who recorded that only 23 per cent of patients were in the habit of going to the doctor in private transport. It does suggest that those responsible for the future design of city centre health centres would be unwary if they presumed that less than 60 per cent of patients needed parking facilities.

2 Time taken to reach the health centre

	Both practices	
	Number	%
Less than 20 minutes	45	(*61*)
20–30 minutes	14	(*19*)
30 minutes or more	15	(*20*)
	74	(*100*)

3 Whether patient is combining his visit to the health centre with another activity e.g. shopping

	PRACTICE A		PRACTICE B	
	Number	%	*Number*	%
Yes	26	(*45*)	4	(*29*)
No	32	(*55*)	10	(*71*)
	58	(*100*)	14	(*100*)

The Nuffield Centre (University of Leeds) survey on Health Centres (1970) recorded that 30 per cent (sample of 50 patients) combined visits to health centres with another activity.

APPENDIX 3: Length of time allowed for appointments

Do you think that your doctor gives you

	BOTH PRACTICES COMBINED	
	Number	%
(a) Sufficient time? ..	60	(*85*)
(b) Barely enough time? ..	6	(*8*)
(c) Not enough time? ..	5	(*7*)
	71	(*100*)

Both practices run appointment systems and book in patients at five-minute intervals. Ann Cartwright (1967) recorded that 88 per cent of her random sample of 1,000 felt that their doctor was good about taking his time and not hurrying them.

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THE PATIENT'S POINT OF VIEW

Planned appointment preferences

A consecutive sample of 100 new and ongoing cases were analysed in relation to the following variables:

1. Social class
2. Number of children in the family
3. Presence of pre-school children
4. Mother working

Some of the findings are presented and discussed in this article. The most significant are that of the appointments kept, 29 per cent of new cases and 24 per cent of the ongoing cases felt inconvenienced, 30 per cent of the sample would prefer to be seen at the weekend, and, of the 30 per cent who wanted an evening appointment, these chose mainly weekdays. The main factors which influenced these choices were social class, mother working and father's availability.

It is apparent that there are definite preferences for days and times which are not always in keeping with agency practice. This has direct implications for the provision of social work help at least for the area studied and perhaps for social service departments in general.

REFERENCE

Baker, R. (1972). *The British Journal of Social Work*, **2**, 55.