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The executive partner

OVER the past two decades general practice has increased in size and complexity. Practices have larger lists, more staff, a greater number of partners, costlier premises, an increasing range of clinical services, growing computerization and as a result a turnover in the hundreds of thousands of pounds is commonplace.[1-7] The need has never been greater for practices to be administered and managed effectively and efficiently. This is reflected in the number of practices which are now employing practice administrators or managers. Yet having employed a practice administrator to cope with the regular running of the practice, the problem which remains for the partners is the need to manage the practice overall, including effective management of the administrator. Ultimately this responsibility rests with the partnership. The question that as yet seems unanswered is: how is that responsibility to be realized?

General practitioners have little management education as medical students or as trainees and hardly any continuing education in the subject. On the basis of my experience of visits to practices it is apparent that many general practitioners lack expertise in organizational management, that is planning, policy making, strategic decision making, the management of change, performance review, teamwork and innovation.[8-13] This is reflected in a tendency toward crisis management; poor accounting and ledgering systems; ill-managed meetings; inadequate administration and information systems; a lack of time management; weak staff management, including their development and training; and an absence of team leadership and motivation. The result is that general practitioners often feel both insecure and ill-equipped to undertake their managerial responsibility for an enterprise on the scale of contemporary practice.

One long-term solution would be to provide extensive management education and training for undergraduates, trainees and established general practitioners. In the interim, however, there are structural approaches to the management responsibility of the partnership which have historical precedents in practice; the role of senior partner is the traditional one; collective or *laissez faire* management is another; more prevalent is shared or lateral management, in which partners, often in rotation, take on different management tasks within the practice: staffing, buildings, finance, and so on. Each of these approaches has drawbacks. The traditional senior partner may retain too much personal control and may stifle initiatives by other partners. Collective management may appear democratic but may result in poor coordination and incompetence. Finally, shared management may be characterized by procrastination.[14,15] However, there is an alternative structural approach derived from industry and small business which promises to overcome some of these drawbacks.

The post of practice administrator is the equivalent in business of office administrator, personnel officer and company secretary combined. In a small company these posts are overseen by the managing director; in general practice the equivalent would be an executive partner. The role of such a position would be to develop and realize partnership policy through innovation, strategic decision making and the management of change. In addition the executive partner would oversee the administration and finances of the practice. As with any other high level management post the executive partner would represent the practice in negotiations with outside agencies, monitor the quality of services provided and promote teamwork throughout the organization. Finally, the executive partner would produce regular practice reports[8] as part of the process by which the partnership both evaluates progress and formulates future policy. Together the practice administrator and executive partner would constitute the management team. The circumstances of each practice will determine the relationship between management team and partnership, but it should include regular dialogue and the encouragement of other partners to take on specific management tasks.

Clearly no structural approach to management by a partnership will preclude the vagaries and interpersonal rivalries of partners and staff in a practice. For this reason the person occupying the role of executive partner should be an established principal whose credibility is based on commitment to, and personal standing in, the practice. In addition he or she should have demonstrated both an interest in tackling organizational problems and certain natural qualities of leadership, communication and decision making, which might in time be supplemented by appropriate management training. The partnership would vest powers over organizational matters in the executive partner, contractually if necessary. Time and possibly additional income would be attached to the post in order to provide status, incentive and opportunity to manage effectively.

As proposed the post is a powerful one. However, ultimate control must rest with the partnership, through regular assessment and a contractual capacity to override or even replace the executive partner. A limited number of agreed goals for the executive partner would help the partnership assess the quality of the individual and the usefulness of the post to the practice.

In the long run, however, if we are to understand and improve practice management then we must study the organization of practice as extensively as its clinical aspects. This will require methodologies[16] little used at present by medical research. Areas requiring study by such methods might include the process of policy and decision making, the management of change, innovation in practice, organizational performance review and fiscal control methods. If general practice is to meet both present and future demands then it must recognize its current managerial weaknesses, take note of the need for organizational innovation and research, and acknowledge the contribution management education and training has to the general practitioner's future role.

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Physiotherapy in the community

WITHIN the National Health Service most patients still receive physiotherapy in hospital departments, despite the considerable developments which have taken place in the community over the past 10 years. Although in 1984 80% of district physiotherapists in England and Wales reported having some community involvement,[1] many of the schemes were small and restricted. Some district physiotherapists only saw certain patient groups such as children or the elderly while others were limited to those with specific diagnoses such as stroke or multiple sclerosis. Geographical limitations were also imposed and patients were only accepted from within a specified area. However, 90% of all physiotherapists working in the NHS do not undertake any work in the community and therefore only a small proportion of patients in the country have access to community physiotherapy services.

In contrast to this picture of poor provision, a few health districts have reported community services with no restrictions or limitations — most patients attending for physiotherapy have the opportunity to be seen in the hospital or in the community, whichever is considered to be the most appropriate. From the work in these districts it appears that there are many people who, for different reasons, can benefit from community physiotherapy.

It is generally recognized that for frail elderly patients the long and often tiring journey to hospital for therapy may undo any beneficial effects,[2] but there are others for whom the hospital-based service is also inappropriate. Patients who have difficulty in maintaining independence at home and who are referred for problems of mobility may well benefit if the problems can be assessed by the therapist in the home, rather than trying to recreate the home situation in a hospital department. Visits from the physiotherapist to severely disabled adults or children who are cared for at home will involve all the carers in the home programme: their problems as well as those of the patient can then be considered in a practical way. Patients with acute exacerbations of chronic respiratory problems are another group who may benefit from physiotherapy at home. When there is a community physiotherapist in the primary health care team, admission to hospital with the attendant risks of secondary infections may often be avoided. In addition, patients who have had orthopaedic surgery can return home more quickly if physiotherapy supervision is available in the community.

New developments are always assumed to cost more but there is little evidence that community physiotherapy services, if well organized, cost more than hospital services, and they may well prove to be more cost effective.[3-5] Seeing some patients without delay where the problems are actually occurring may in the long run cost less than the traditional hospital visits three times a week for six weeks.

Physiotherapists in some parts of the county see patients in health centres and at general practice premises, mainly for the treatment of soft tissue injuries and conditions. Advice and treatment without delay may prevent the development of longer term disabilities and facilitate an early return to work for the patients.[6]

It is essential, with the present emphasis on care in the community, that physiotherapy services are made available when they are needed. In the early 1970s pressure from those working in primary health care for physiotherapy to be made available to patients outside the hospital first started the movement of physiotherapy into the community.[7] If all patients are to have