IMPRESSIONS OF GROUP PRACTICES

Group Practice, Health Centre, or Both?—Huntly and Hythe

[FROM A SPECIAL CORRESPONDENT]

Writing in 1959 in his book *The English Health Service*[1] Harry Eckstein observed that "both health centres and group practices on a large scale are conspicuous mainly for their non-existence." Six years later, however, probably over one-third of practices are in groups, yet there are fewer than three dozen health centres for the whole of Britain. Many writers have commented on the reasons for this discrepancy—including Eckstein himself—but one reason why the average doctor is indifferent to the arguments is that, however sincere the advocates of one form of practice or the other, almost none of them has personal experience of both. Thus when I heard of two groups of doctors with experience of both systems—at Huntly, in Aberdeenshire, and Hythe, in Hampshire—it seemed an ideal opportunity to try to arrive at some sort of conclusions.

Huntly

The group practice at Huntly, a town of 4,000 inhabitants which lies roughly midway between Aberdeen and Elgin, was started in 1960. It contains four doctors, one of whom has four S.H.M.O. sessions in surgery a week at the local 50-bedded general-practitioner hospital. Besides being responsible for the casualty sessions at the hospital, all the doctors do obstetrics, virtually all of the deliveries taking place in the 11-bedded general-practitioner maternity unit. In addition two doctors do anaesthetic sessions at the hospital. About half of the total list of 8,000 patients live outside the town, the area covered by the practice extending to about twelve miles in each direction. Though patients register with individual doctors, the practitioners try to pool their visits by area.

Until May this year the doctors practised in central premises in the town. Three years ago, however, they decided that these were getting too small to deal with the increasing work load, and after considering the alternatives of building their own new surgery or asking the Scottish Department of Home and Health for a health centre, they chose the latter. Detailed discussions on planning took place between the family doctors, the Department of Home and Health, and the local authorities, and building started in mid-1964. The centre was opened by Mrs. Judith Hart, Secretary of State for Scotland, in September this year.

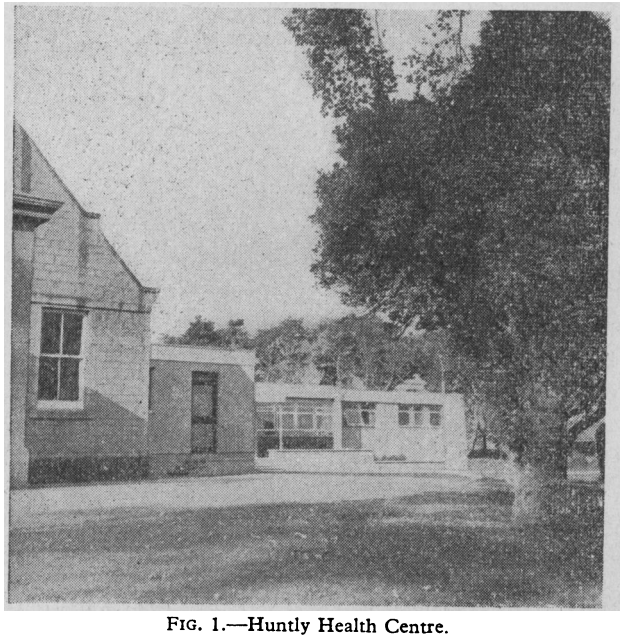

FIG. 1.—Huntly Health Centre.

The centre (see Figs. 1 and 2) is attached to the general-practitioner hospital and contains two consulting-rooms, a waiting-room, a minor operations theatre (which is equipped with modern anaesthetic machines incorporating rebreathing devices), plaster-room, a small pathology-room, and *x*-ray and physiotherapy departments. Consultants from the Aberdeen hospitals also use the consulting-rooms for holding sessions in the centre, informal contact between them and the family doctors being easy. The local general-practitioner surgeon holds a daily surgical clinic at the centre, and surgical patients are referred to him from neighbouring practices. He does a considerable amount of elective and emergency surgery in the well-equipped operating theatre in the hospital. There are several obvious advantages of this set-up. First, the Huntly centre and hospital together provide a comprehensive medical and surgical service. Second, the very difficult road conditions in winter make the arrangements highly satisfactory to doctors and patients alike, the latter being spared the tedious and often hazardous journey to Aberdeen. Third, the doctors are enabled to follow their patient's progress after surgical operations directly.

Some major pathological and radiological investigations are referred to Aberdeen, and there is a daily delivery service of specimens for investigation. The family doctors do not work an appointments system, though they have a rota for off-duty and holiday periods. The secretary and receptionist of the practice came from the original group-practice premises and are paid for by the doctors rather than by the Department of Home and Health. The yearly total rent of the accommodation is £235 and the services £240. The nursing staff attend to both hospital and general-practice patients as required, while the general-practice records are incorporated in the hospital records folder. There are no attachments of local authority ancillary workers to the practice, though the local authority is going to use the centre for holding a maternity and child welfare clinic on one afternoon a fortnight in the near future.

Hythe

The practice I visited at Hythe is based on two separate centres—the Hythe Health Centre and a group-practice surgery at Blackfield, five miles away. The health centre (Fig. 3), which was described in an earlier issue of the *B.M.J.* (3 July, p. 42), has been working since 1 May this year. It arose as a result of discussions among the family doctors themselves (who for a long time have run the minuscule Hythe Medical Society) and negotiations with Dr. I. A. MacDougall, the medical officer of health for Hampshire—a county which (20 November, p. 1234) has a long and distinguished record of co-operation between local authorities and general practitioners. In fact a health visitor has been helping one of the Hythe practices to run an infant clinic for 11 years, one of the partners claiming that this was the second such arrangement in Hampshire. A steering committee was formed from representatives of the hospital, family doctors, and local-authority services to plan the centre, and this has remained in existence to deal with any major problem that arises.

The health centre is attached to the general-practitioner hospital at Hythe; this has a total of 22 beds, of which half are used as a family-doctor maternity unit. The centre provides accommodation for three main types of services. First, there are three general-practitioner suites, each of which contains two consulting-rooms, two examination-rooms, and a waiting-room. The second type is a suite for out-patient and treatment sessions held by consultants in most specialties from hospitals in Southampton. The third type is used for local health and education authority services; this comprises a dental suite with two surgeries, a lecture hall, a clinic suite consisting of four rooms, and a health visitors' office. In addition there is a reception and records department, a laboratory, an *x*-ray department, and a common-room. The day-to-day running of the whole centre, including the equivalent of six whole-time secretaries, is in the hands of an administrative officer, who is paid partly by

the Hampshire County Council and partly by the Wessex Regional Hospital Board.

Three practices, containing 10 doctors in all, use the health centre and also man the casualty service in the hospital. Though the practices retain their separate identities, they all co-operate in the running of the centre. All are represented on the house committee, which includes the matron of the hospital and a representative of the local-authority service as well. Ancillary workers (health visitors, midwives, and district nurses) are attached to all three practices, and are paid for by the county authorities. Since most of these workers—doctors, ancillaries, and secretarial staff—meet in the common-room most mornings informal contact is easy. Another feature the doctors particularly singled out was the ease with which they could discuss a problem with an expert, such as a consultant or a child-guidance worker.

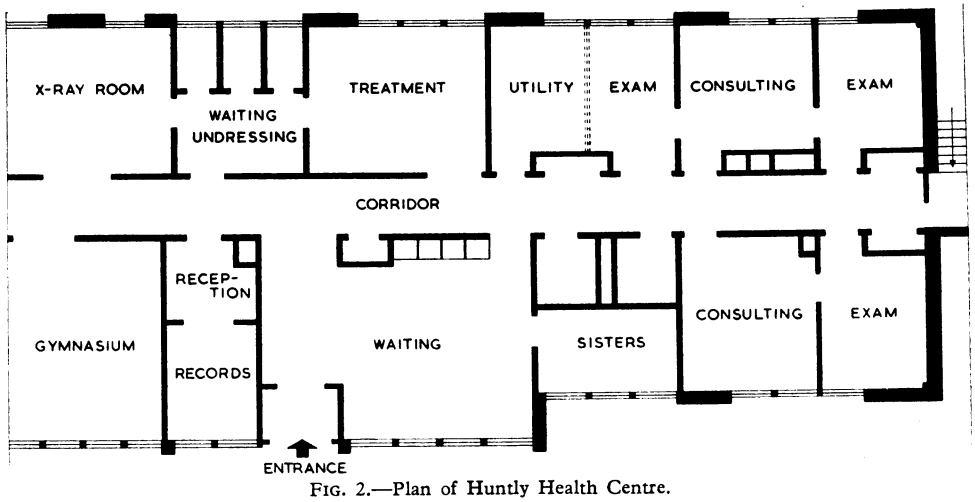

FIG. 2.—Plan of Huntly Health Centre.

As at Huntly, the centre at Hythe seems to have achieved one of the aims of the Dawson Report[2] and of the doctors themselves—namely, the integration of the general-practitioner, public-health, and hospital services. At £500 per practice, the rent (which includes all overheads) represents a total subsidy of £6,000 per year for the general-practitioner services by the local authority, a fact that has already aroused unfavourable comment.[3] For their part, however, the family doctors are helping the local authorities by undertaking without any fee the clinics normally undertaken by an assistant county medical officer—such as well-baby and immunization sessions. They are also responsible for the school medical service, though they are paid for this.

One of the three practices works exclusively in the Hythe Health Centre, while the other two (who have a total list of 24,000 patients) share a group-practice centre at Blackfield, five miles away. The latter was also opened this year and contains four consulting-rooms, together with reception-, treatment-, and waiting-rooms. As at Hythe, a full appointments system is in operation, and a private telephone line connects the centre with the health centre. The group-practice centre employs, and pays for, the equivalent of two whole-time secretaries. With the exception of one doctor, who works only at Hythe, all the doctors in both practices have sessions in both centres—and as at Edinburgh (27 November, p. 1300) they have not found this difficult for themselves or their patients.

First Impressions

Neither the doctors at Huntly nor those at Hythe thought there was any fundamental difference between working in a health centre or a group-practice centre. All had had a considerable say both in the design of the centres and in appointing the ancillary staff. Among the things they liked were the following: the opportunity of working in bright, modern purpose-built premises at a reasonable rent; the ready access to the opinions of colleagues, consultants, and specialist ancillary workers; and adequate help from secretaries and receptionists. Other gains were the radiological, laboratory, and treatment services. Thus *x*-ray equipment was installed at both centres, with consultant radiological cover, and at Huntly major investigations are often undertaken. Huntly had a daily delivery service of specimens to the pathology laboratory, at the hospital in Aberdeen, while at Hythe a consultant pathologist attended for one session a week, and a technician for another two; both centres had a minor operations theatre with provision for simple anaesthesia.

Principally among the things they disliked was the time taken in negotiations—over whether there should be a centre, over its design, over how the capital and running costs should be shared among the authorities concerned, and over the rents to be paid by the practices. Emphasizing this, one doctor at Hythe said, "It took

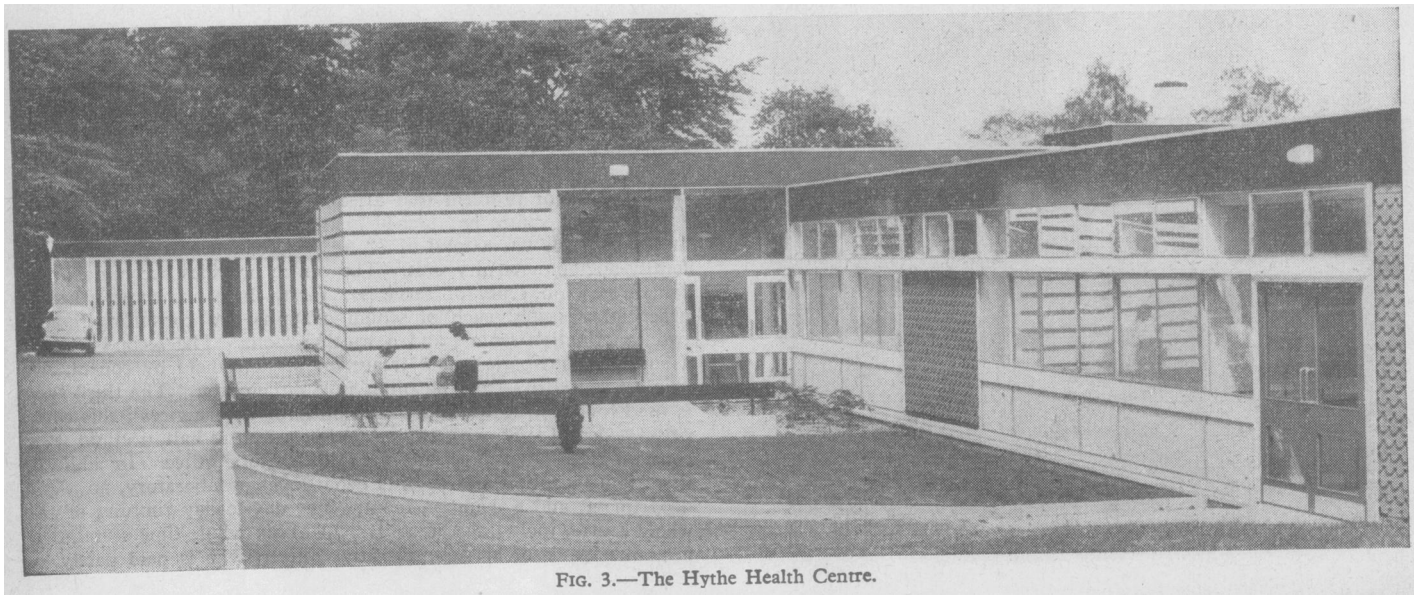

FIG. 3.—The Hythe Health Centre.

us all over five years from start to finish to get the centre built. When we decided to build the annexe to the house to make our own group-practice centre all the partners spent a couple of evenings together discussing what they wanted. We then drew out the plans ourselves and applied for a group-practice loan, which was readily granted. From plan to completion took only nine months." As with any new project other minor snags have inevitably arisen —such as, at Hythe, those resulting from the design of the buildings, or, at Huntly, what services are included in the rent—but the doctors thought that these could readily be sorted out by the house committees. " So why not a salaried service ? " I asked one doctor at Hythe. He was against this, even if the salary was a large one. A salary, he thought, would not necessarily be related to work load, and at present it was possible to keep the list to a reasonable size. Moreover, once general practitioners lost their independence authority was in a position to dictate—even though he admitted that where the nature of the work to be done was concerned this had not happened in the hospital service. But he emphasized that under the existing arrangements there were no restrictions of any kind.

Judgment of Paris

Hence we came back to the question at the beginning of this article, " Group practice, health centre, or both ? " With the limited number of health centres built any conclusions must be both tentative and personal. There are already enough health centres in existence, however, to disprove the contention that they must necessarily fetter the doctor's freedom to practise medicine in his own way. Moreover, many doctors are obviously happy working in modern premises in close contact with colleagues, supported by consultant, ancillary, and diagnostic aids. Some have also commented favourably on the way health centres may break down the present tripartite system of the Health Service. Many doctors, also, lacking capital, could never under the present system have provided such conditions for themselves. But, apart from close contact with consultants, almost all these things can be provided in a group-practice centre, even if the cost at present is extremely high.

Here I must state some personal conclusions, for what they are worth, emphasizing that they refer neither to Huntly nor to Hythe. Of the places I have visited where I would most like to work one was a health centre attached to a small hospital, the other a modern group practice with a hospital near by—and I could find little to choose between them. As elsewhere, much of their success seemed to owe a great deal to an " old-boy " net connecting family doctor to medical officer of health and consultant, and often arrangements that were unrecorded in any committee minutes had made all the difference between a practice that ran smoothly and one that did not. For doctors in a health centre this vital relationship might seem to be all too tenuous, depending as it does on rapport between persons who may move, retire, or die. Whereas in a doctor's own practice a change in relationships might be serious but not disastrous, some might think that the reverse would be true in health-centre practice. This conclusion could be called unfair when to-day many medical officers of health, by attachment of ancillary workers and other enlightened schemes, are showing their willingness to co-operate fully with general practitioners. On the other hand, one question that I heard asked remains unanswered, " Why if one county can attach 180 ancillaries to general practices cannot all do the same ? ", and one still meets family doctors who say that they have spent years trying unsuccessfully to persuade local medical authorities to assign them a district nurse or a midwife. Again, other doctors have told of matters agreed on in the planning of health centres that remained unprovided, without explanation, in the final building.

Unlike Scotland, where the statutory responsibility for providing health centres rests on the Department of Home and Health, in England and Wales this rests on the local authority. Many have criticized, rightly or wrongly, the National Health Service for introducing a third person—the State—in the doctor–patient relationship. In England and Wales the health centre introduces yet another person—the local authority—and for this reason, other things being equal, I think that most doctors will still choose to remain independent contractors and to practise at group-practice centres.

I wish to thank the doctors at Huntly and Hythe for their kindness and help in the preparation of this article.

REFERENCES

1 Eckstein, H., *The English Health Service*, 1959. Harvard University Press, Cambridge, Mass.
2 *Report of the Future Provision of Medical and Allied Services*, 1920. H.M. Stationery Office, London.
3 Barnett, N. S., *Brit. med. J.*, 1965, 2, 109.

Computers in Medicine

[FROM A SPECIAL CORRESPONDENT]

A discussion on the use of computers in medicine took place at the general meeting of members held at the Royal College of Physicians on 25 November.

Mr. D. ELLIS-JONES (Electronic Data Processing Division, Honeywell Controls Ltd.) said that his prescription for computers in medicine was to increase both the size and frequency of the dose. It was not necessary to learn all about computers, merely to come to terms with them ; they did not really compute, they compared. Mr. Ellis-Jones illustrated the forms of input media, such as punched and magnetic cards and tape. These would offer tremendous compression of data—for example, 28,000 characters would be printed on one small card. The memory part of the machine had its value in the phenomenal acceleration possible in data manipulation. Such data could be stored serially or in random order, for instantaneous retrieval. The output of the computer could be geared to any device suitable for displaying the information required.

Clinical Applications

Dr. P. CLIFFE (Westminster Hospital) was concerned with applying computers to clinical and experimental medicine. He was stimulated by the fact that qualitative observations were giving way to an increasing degree of clinical measurement. This itself was creating new problems of definition and analysis. In applying conditional probability to diagnosis, characters such as signs and symptoms must be independent and mutually exclusive. One must choose, for example, between recording cyanosis or clubbing but not both. This technique was only suitable for diagnoses for which the machine was set up. On the other hand, by applying numerical taxonomy, characters could be grouped together into clusters which revealed associations previously unrecognized and separated diseases which were not really associated. Thirdly, the statistical method of multivariate analysis not only grouped characters according to disease but worked out which characters would further aid their separation. Dr. Cliffe quoted instances in which these approaches had already been fruitful, but warned that " if you feed garbage in, you will get garbage out."

Dr. R. F. L. LOGAN (Manchester University) said that the factual data of hospital usage were not yet freely at our disposal, and that we had not seized the opportunity of building a bank of clinical experience on which all could draw. It had taken, he said, eight students three weeks to follow up 145 cases of gastrectomy. Particularly now that each patient was cared for by teams of doctors and survived one crisis to reach another, 5% being readmitted each year with a growing volume of clinical data, the old records system had broken down. The computer was coming to the rescue only just in time.

Uses in the Laboratory

Turning to the biochemical laboratory, Dr. A. J. BUCKLE (Guy's Hospital) discussed " unsolicited, valuable, laboratory information " which could ideally be gained from measuring 30 parameters simultaneously on one 10 ml. sample of blood. This, of course, required suitable methods of measurement of proved significance. He estimated that this approach could double the number of abnormal values found, and lead to significant improvement in diagnosis and treatment. A small study had shown that a mechanized approach could reduce the patient's stay in hospital by up to two days. Dr. Buckle