PRACTICE OBSERVED

After Acheson . . .

Constructing a primary care unit: the dream

IAN KEY

The Acheson report[1] of May 1981 confirmed the longstanding rumours about the poor quality of premises, access, and communication in general practice in inner London and that many elderly single handed doctors practised there. In their recommendations Acheson and his colleagues suggested that doctors should be encouraged to work in groups and with attached community (district) nurses, health visitors, and midwives in well designed premises, thus forming what I call a "primary care unit."

I had been aware for some time of the problems of providing primary care in inner London and was looking for a single handed practice to take over and convert into a primary care unit as quickly as possible. The practice would have to be large enough to support financially two doctors from the outset, and their appointments to the practice would have to be according to the regulations for providing general medical services. Premises would need to be large enough to accommodate the attached staff and have sufficient consulting rooms for three doctors to use simultaneously, as I hoped that the practice would become a training one. The whole concept was in the nature of an experiment.

Finding the practice

In the *BMJ* of 25 April 1981 there was an advertisement for a practice vacancy in an "open" area 10 miles south east of Charing Cross station. The single handed general practitioner was retiring on 30 September 1981. His list size was stated to be 3489 patients, and he owned the surgery premises. I already knew a young doctor who was about to complete his vocational training and wished to work in partnership with me. We discussed the vacancy and visited the practice in early May 1981. We agreed that it would support two doctors if it was run as a primary care unit, and the surgery building, although very dilapidated, was in the right place and could be modified to provide satisfactory premises. We would purchase the premises with a loan from the General Practice Finance Corporation, or another source, and modify them so that they would be accepted under the cost:rent scheme.

We decided to apply jointly for the vacancy. Competitive interviews were held at the offices of the family practitioner committee in June 1981, and we were offered the vacancy by the Medical Practices Committee but were informed that the offer was subject to appeal from unsuccessful candidates and that therefore we should not enter into any firm financial commitments.

We visited the practice again in July 1981 to discuss with the retiring general practitioner arrangements to take over the practice and purchase the premises. We were told, however, that an appeal had been lodged by one of the unsuccessful candidates, and in the meantime the General Practice Finance Corporation's interest rate had risen from 16% to 18%. Because of the uncertainties of both getting the job and financing the purchase we both thought that we should consider other practice vacancies. Sadly, my prospective partner accepted a vacancy in another practice, withdrawing his application.

The Secretary of State rejected the appeal in mid August, and the Medical Practices Committee confirmed that they were willing for me to take over the practice single handed. I accepted the offer on the understanding that I could take in a partner as soon as I wished, and that my suggestions for modifying the premises and creating a primary care unit would be supported by the family practitioner committee. I then negotiated with the retiring doctor for the purchase of the premises with vacant possession. The General Practice Finance Corporation was prepared to make a loan, and so the solicitors set to work on the conveyancing of the property. On 30 September 1981 the retiring doctor departed and I took over the practice.

Sidcup, Kent
IAN KEY, MB, BS, general practitioner

What I found

The surgery premises consisted of two ground floor rooms in a large, detached Victorian house. One of the rooms was used as a waiting room reception area, in which the patients' medical records were kept. A door led directly from this into the consulting room. The retiring doctor had held surgeries lasting one and a half hours, for which no appointment was needed, each weekday morning and on four evenings a week. He employed during surgery hours a part time receptionist who extracted and filed the patients' medical records when they were required and answered the telephone. She sat in the waiting room surrounded by the medical records. Outside surgery hours the premises were closed to patients, and a telephone answering service was used so that the doctor could be found if urgently required.

FIG 1—Before: rear of surgery October 1981

He made no claims for items of service payments and ran no antenatal clinics, well baby clinics, or well women or screening clinics. He communicated with his attached district nurse and health visitor almost always by telephone and during surgery hours. He seemed to be able to see at least 15 patients, and often 20, in an hour. He was well liked by his patients and was a popular local figure.

And so I took over the practice with these existing arrangements on 1 October 1981 and intended to convert it into a primary care unit. This required changes in the administration and the running of the practice and radical alterations to the premises.

Administrative changes

Fortunately, the part time receptionist was happy to continue working in the practice. She seemed to know every patient very well indeed. I used the same waiting and reception area and consulting room, and as the rest of the building was now empty I used two rooms downstairs, one as an office and one as a store. My family and I decided to live on the first floor while we looked for our own accommodation in the district.

Within a week I had met the attached district nurse, the attached health visitor, and the nursing officer in charge of the community nursing services. They were pleased that rooms would be made available on the premises for the district nurse, the midwife, and the health visitor. Within three weeks I had appointed a second part time receptionist, and thereafter the surgery premises were open from 8 30 am to 6 30 pm. A further full time receptionist was employed from the beginning of January 1982, so that for most of the day two receptionists were on duty. This was necessary because of the increasing amount of clerical work, in part due to the growing number of items of service that required claiming, and in part due to the paper work required in refitting the premises.

At the end of November 1981 a weekly antenatal clinic was started in the one consulting room and in January a well baby clinic with the attached health visitor and community nurse in attendance. The district nurse was already seeing patients in the consulting room on three mornings a week after my morning surgery. A well women clinic was started in February. In December 1981 a full appointment system for surgery attendances had started. The patients were told of this when they attended the surgery and could make repeat appointments. It is remarkable how quickly the message spread among the patients in the practice, and almost every patient expressed satisfaction with the new system. It is interesting that in the week beginning 4 June 1982, 225 patients attended the surgery, only four of whom came without appointments, and only one did not know about the appointment system.

FIG 2—After: rear of surgery June 1982.

Before I took this practice on I had started looking for a partner to replace the doctor who had withdrawn by contacting the vocational training schemes in the surrounding districts. Furthermore, the Personal Service Bureau of the BMA prepared a clear job description of the vacancy I was offering and through this advertisement over 40 applicants wrote to me. I shortlisted 10 to whom I gave full details of the proposed financial arrangements—the successful applicant would be a shareholding partner after a very short time to assess mutual compatibility, and there would be a guaranteed minimum income, though this was likely to be exceeded by the agreed share of the profits. No capital would be required immediately.

Of the 10 doctors shortlisted, three withdrew their applications after I had given them further details. Over the next two months seven doctors came to see me, three of whom withdrew their applications. From the remaining four I chose a doctor who was 31, had completed his vocational training at the end of 1980, and had been a principal in a group practice for a short while. This doctor accepted the offer of partnership on 21 December 1981 and joined me on 1 February 1982, when he was also accepted on the medical list of the family practitioner committee.

From the day the partnership started we ran consecutive surgeries—that is, one of us from 9 to 10 30 in the morning and the other from 10 30 to 12 00, and in the afternoons from 3 45 to 5 00 and from 5 00 to 6 30—using the one and only consulting room, and we awaited the arrival of the builders with mounting excitement.

This is the first of three articles.

Reference

[1] London Health Planning Consortium Study Group. *Primary health care in inner London*. London: London Health Planning Consortium, 1981. (Acheson report.)

The GP and the Medical Student

Students from the Royal Free

N F ANDRAWIS

We accepted with interest an invitation in 1976 to a meeting at the Royal Free Hospital to discuss forming a group of teachers with other general practitioners from local and distant practices. The group would liaise with the academic department of community medicine at the Royal Free Medical School to organise teaching courses in general practice for undergraduate students. Students from the first, fourth, and fifth years were allocated to practices that were willing to teach them.

We are a group practice of three partners in north-west London, and we teach first and fourth year students: fifth year students are allocated to general practitioners outside London, all over England, for a two-week residential course with their tutor.

First-year students

First-year students are given a very brief introduction to general practice in an afternoon and evening. We always introduce the students to all members of the practice who are present. The senior receptionist explains how our appointments system, filing system, and the visits and messages book work. The students accompany their tutors on home visits, after which they sit with the tutors for the evening surgery. Discussion with the first-year student is aimed at clarifying the doctor:patient relationship, the general practitioner's relationship with his hospital colleagues, and the patient/hospital interface. It also includes organisation, social aspects of disease in general, patient education, and the patient in particular. Clinical matters are not discussed; the student taking little part in the clinical examination.

Patients are informed by the receptionist that the student is present and asked whether they object to the student's presence at the consultation. Our initial fears of substantial patient objection never materialised. It was a pleasant surprise to find such a high degree of acceptability of students by our patients. In fact, to date only one patient, who had a psychosexual problem, understandably asked that the student should be excluded from the consultation. Perhaps introducing the student to the patient at the beginning of the consultation and the relaxed atmosphere of the private enclosure of our consulting room have helped to reassure the patient. We often have the feeling that the student is being welcomed on to the home ground of doctor and patient together.

Ratings for the visit to general practice, given by 79 first-year students from the Royal Free in 1981, were: no value 0; little value 2; some value 15; very valuable 62. This visit whets their appetites and reinforces the motivation to prepare for later work with patients during the medical course and beyond. This is, after all, the reason they are at medical school.

London NW2
N F ANDRAWIS, MB, BCH, general practitioner

Fourth-year students

The fourth-year students join the practice for four weeks, having done general surgery and general medicine. They will also have completed courses in some of the specialties, such as psychiatry, geriatrics, nephrology, orthopaedics, accident and emergency, and pathology. During their second preclinical year they will have studied some psychology and sociology. After having worked with patients and handled clinical material they are in a very good position to benefit from the course in general practice.

We contact the students by telephone before the month begins. When they arrive at the surgery our practice manager introduces them to our staff, and, as for the first-year students, gives them a detailed run-down of the organisation of the practice. This breaks the ice and helps to set the background to our work. This has always been a great success in establishing good relationships between students and staff. They are encouraged to feel that they are part of the fabric and furniture.

In this four-week course the student averages over two full weeks in the surgery. The rest of the time is spent at the medical school for lectures and seminars in epidemiology, sociology, and other subjects, or on visits to a medical rehabilitation centre and institutions concerned with occupational health. This gives both us and them a break.

At first the student sits in the consulting room with his tutor. After introductions the consultation is conducted by the tutor. The student is given a chance to ask questions at the end of the history-taking. The clinical examination is then done by the tutor, and the student allowed to watch. One gradually gets a fair idea of the abilities and standard of theory that the student has, and so patients are selected for the student to take a history and examine. The student's practical skills are assessed in such procedures as taking blood samples, ophthalmoscopy, otoscopy, taking swabs for cultures, urine testing, and so on. Their skills improve, and when standards are lacking attempts are made to point out difficulties and the student is encouraged to meet them. In the one-to-one student tutor relationship there is continuous appraisal of work, which is a strength in teaching.

During the second week students are expected to do a home visit to a chosen, chronically sick patient who presents a difficult or interesting social and medical problem. One and a half to two hours may be spent with the patient. The case is then presented to a group of four students and their tutors, one of whom hosts the meeting. The meetings take place over a lunch provided by the host in a most convivial atmosphere, either in his surgery or home. There are two of these lunchtime get-togethers in which each student presents a long case. Students are advised to give a brief outline: detail can be brought out in discussion at the end of the presentation. We have noted that most students find this a bit of an ordeal and are relieved when their presentations are over. But, having made their debut in case presentation in public, they seem to be pleased with their achievement, and there is a visible improvement in their self-confidence.

The practice get-togethers have pleased us considerably, as they have been a means of contacting other local general practitioners and visiting their surgeries, which we would not have done otherwise. Enthusiastic tutors need to restrain themselves in the discussion, otherwise the students may be left out, particularly the reticent ones. The host takes over as chairman of the meeting and needs to ensure that everyone gets a fair hearing. As time has gone by, the tutors' skills have improved in these matters. The commonest failing in this teaching exercise is that hot discussion is taken over by the tutors, who ought really to occupy a back seat and be a source of information at judicious times only.

Students are also given a chance to see the work of district nurse, health visitor, and social worker, and visits are arranged with them. As soon as possible, and according to the ability of the student, he or she is placed in the "hot seat"—encouraged to take the history, examine the patient, and finally present the case to the tutor, who in turn verifies the findings. This is the part that the students enjoy and appreciate most. They discuss the management with their tutor, and again we have noted the pleasure that our patients show at being the centre of so much consideration. We cannot remember a patient leaving the practice unhappy after this exercise, or having ever received a complaint: it is surprising how many ask after the student when they return to the surgery, even months later.

We have been impressed by the maturity of students, and the grasp they have of difficult social problems. The standard of behaviour and calibre of the students are a tribute to the students and to the selection committee at the Royal Free Medical School.

The assessment of students and the feedback to department and student is an essential part of this course. At the end of the month there is a lunch-time debriefing when the tutors meet. We take account of the student's performance in terms of the knowledge of clinical medicine; understanding the functions of practice staff and outside agencies; skill in examining patients and carrying out procedures; communicating with people; and managing problems. Attitudes towards staff, patients, tutor, and to the work in the practice are noted. The student also assesses the course and is asked to comment on its various components. They have consistently stated that time spent in the practice is most valuable, awarding it the highest grades.

There is no doubt that working in general practice is an essential part of the education for medical undergraduates. It may be the only chance that some of our future medical colleagues have to experience primary care and understand its nature. It is the only time during the whole medical course that the student has such a close relationship with a tutor on a one-to-one basis. This is of great benefit in the process of learning for the students and allows a teacher to get to know the student and recognise problems or help to develop latent abilities. Five years is a long time to spend in the hothouse of learning, especially in the important formative period of professional life.

We have nothing but encouragement for the hesitant, would-be tutor to try teaching medical students. The rewards may be poor financially, but teaching does enable the general practitioner to pass on his own special knowledge and skills and to provide a balance against the highly selected group of patients that the student sees in hospital, especially teaching hospitals.

SAGE ADVICE TO MEDICAL PRACTITIONERS Gentlemen, Grey hairs and bodily infirmities inform me that my professional career approaches its close. Having grown old in the service of the public, I have had opportunities of making many observations, although I have not in this respect made so good a use of my time as I now think I might have done. Nevertheless, many of my juniors do me the honour to profess a regard for my opinion on matters which relate to medical affairs, and more especially do they seem desirous of my advice as to the best method of obtaining and maintaining the good opinion of our worthy master—the public. My remarks have usually been simple and my words few, and if you think what I shall state worth printing in your useful Journal, I beg the honour of its insertion.

(1) Let all your professional exertions, if you wish to practise, tend to a practical end. The public want a man that can DO, not him that can merely speak or write. Aim at a practical character—keep your speculation to yourself, until the practical end can be made self-evident to the public.

(2) Keep your private studies or amusements in the background; never wish to be thought a great poet, a musician, a shot, or a card-player.

(3) Be not known as a great runner after new things; the public are afraid of experiments. Be not the first by whom the new are tried, nor vet the last to lay the old aside.

(4) Cultivate the benevolent feeling in a high degree; a kind-hearted man has a universal passport; be kind, open, and frank, but not LOQUACIOUS, and never take offence so as to show a mark of ruffled temper.

(5) Study what is your duty, and do it at all risks; ever let your motive be seen, for motive gives the character to the deed.

(6) Consider patronage the great instrument of success; consider every patient a patron; you may make him so. By looking beyond what you possess you lose your possession; what you have, nurse with tender care; from that will emanate all you can obtain; if your present patients be not your warm friends, you will long remain in *statu quo*—therefore, treat everyone, even the poorest gratuitous patient, with respect, but no one with familiarity.

(7) Attend to general knowledge, but do not let it appear to occupy much of your time.

(8) Let your literature shine in your language, not by classic flashes, but by steady clear and strong length of sound and cultivated sense; as you will avoid grammatical errors, so omit the use of one part of speech; the grammar of every medical man should be minus one part, that is, the interjection. This may be considered fastidious, but I have known that part of speech cost a physician more than a King's taxes; it pays a very heavy duty, and should not be kept but by those who can well afford it.

(9) Let the exterior, as relates to dress and manners, be such as a little observation will teach you; dress and address more frequently (*caeteris paribus*) make a practice, than scientific attainments. Excuse the style of an old man, who is Your very humble servant, A GENERAL PRACTITIONER London, 18th June, 1828. (*The London Medical and Surgical Journal* 1828;1:53-4.)