General Practice Observed

Health Centre Design—A Criticism

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British Medical Journal, 1971, 2, 389–393

Introduction

It must be true of most new buildings that had they been designed with the hindsight of seeing them in use they would have been designed differently. To the layman in building

matters it seems obvious that the lessons of experience should be fed back to the appropriate design department in order to obtain a steady improvement in buildings of the same type. Yet the official guide for health centres¹ reproduces, with implicit approval, the plans of 19 health centres, built by 16 different local authorities, without any criticism of them or any report on how they have worked out in practice. As it happens, no hindsight is needed to see faults in all of them, nor is there need to ask how they are working to be sure that nearly all are wasting many manhours, including doctorhours, every day. The exceptions are those which have been designed in disregard of some of the specific advice given in the guide.

General Practitioners' Needs

Particular attention is said to have been given in the guide to the needs of general practitioners, and I shall concentrate on those needs.

Nearly all patients attending a health centre wish to see only their general practitioner, and most of them need either no treatment or treatment by way of a prescription. The design of health centres has been bedevilled by a half-baked unspoken theory that patients would be better treated by a committee of doctor, nurse, health visitor, and any consultant who happens to have dropped in. It is indeed helpful to have all these excellent people at hand for some patients, but they are a small proportion of the number seen. It would clearly be an impertinence that would be rightly resented to start investigating the home circumstances of a patient who simply needs treatment for a sore throat. It is therefore wrong to compromise with the general practice accommodation merely to meet the occasional case in which the "health team" may be required. The convenience of having the health visitor handy does not compensate for the disadvantage of making every patient who visits every doctor walk the additional corridor length of her room, as in the plan shown in Figure 1.

FIG. 1—Sketch plan of Ilkley Health Centre. Reproduced by permission of the Architect to the West Riding of Yorkshire County Council and Mr. Douglas Robinson, A.R.I.B.A., of J. B. Bailey & Son, Keighley.

FIG. 2—Flow pattern of patients' movements.

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FIG. 3—Room relationship diagram. Reproduced by permission of the Royal College of General Practitioners.

FIG. 4—Sketch plan of Frome Health Centre. Reproduced by permission of Mr. B. C. Adams, F.R.I.B.A., County Architect, Somerset.

FIG. 5—Unamended plan for Somers Town Health Centre, Portsmouth. Reproduced by permission of Portsmouth City Architect.

Most designers seem not to have appreciated the sheer numbers involved in general practice and the high rate of turnover. The pamphlet circulated privately to general practitioners by the pharmaceutical firm of Lloyd-Hamol Ltd., London, which has become the standard guide to general practice appointment systems, recommends up to 10 appointments an hour per doctor. In our practice we sometimes see 12 patients in an hour, and a doctor who does two sessions sees between 50 and 60 patients a day. Many of the consultations need be only brief—to obtain a certificate to go back to work or to be told the result of an x-ray examination—and it is in these that delay in getting in the next patient is especially irritating.

EFFICIENT MOVEMENT

Fig. 2 shows the flow pattern of movements of patients in practice premises. The critical movement for the efficiency of the building is from the waiting area to the consulting room, shown by the heavy arrow in the diagram. The dotted line represents the co-operation of the receptionist in this movement, as the guide advocates. An extra minute or so for the other movements adds to the time spent in the centre by the individual patient; but he is there only once in the day. On the other hand an extra minute in the time taken by the patient to travel from the waiting room to the consulting room time can add an hour to the doctor's day.

I think my diagram is superior to that given in *Design Guide for Medical Group Practice Centres*,² which is somewhat misleading since its "patient's basic route" shows only the inward flow and gives no indication that an equal number of patients are having to make their way out along routes which sometimes coincide with and sometimes differ from the inward ones (Fig. 3).

The designers of some of the centres whose plans are shown in the official guide cannot have been aware of the critical nature of the distance from waiting room to consulting room, or they would surely not have added gratuitously to it by introducing storerooms, lavatories, etc., along the route (Figs. 1 and 4).

Distance is vital, but there are two other factors in design which may speed the patient on the waiting room to consulting room path. One is clarity in direction signs, and the other elimination of opposing traffic. If the patient knows exactly the way he has to go he will obviously get to the end quicker. The chaos in the centre shown in Fig. 1 can be imagined when all five doctors ring for their next patient simultaneously and with the departure of their former patient. Five people floundering into lavatories and broom cupboards, while five others elbow their way out.

The guide¹ states: "Patients in the waiting area should normally be called forward by the receptionist when she receives a message from the doctor that he is ready for the next patient." It would be hopeless to put this into practice in the centre in Fig. 1, especially as the siting of the office gives the receptionist(s) no view along the corridor. This is another important design principle not touched on in the guide: the office must be sited to give the receptionists a commanding view, so that they know at once if anything has gone wrong, if a patient has collapsed, or been sick, or lost his way. However good the traffic system, there are always the blind, the deaf, and the confused who will fail to end up at their destination.

The writers of the guide, like some of the architects, have not made the transition in their minds from the leisurely Harley Street situation, where it is practicable for the receptionist to go in and say "The doctor will see you now, Sir" and escort him to the consulting room at a dignified pace, to the busy centre with a rapid turnover catering for many patients simultaneously. In that situation it is imperative to devise a system where the receptionist can set the patient on arrival on the path

to the correct consulting room when the time comes without any further intervention from her. With a properly designed building and intelligent seating, colouring, and signalling arrangements only one conversation between receptionist and patient is necessary—not two as the authors of the guide envisage.

Personal Experience

Notwithstanding the statement in the guide¹ that particular attention had been given to the needs of family doctors, and its warning that the plans illustrated "should not necessarily be used as model plans because health centre design is still evolving," the effect of the guide and its predecessor³ has been, in our experience, to freeze design at what has already been done and to cause resistance to the demands of general practitioners for what they need. Our own demands for a spread-out waiting area facing the row of consulting rooms and for a doctors' office were resisted on the ground that the Department of Health would not approve.

In our case there has never been a briefing stage at which we were able to tell the architects what we needed. The briefing had already been done by the health department of the local authority. A suggested plan was submitted to us, and we rejected it as quite hopeless. It was scrapped and an entirely new one produced (Fig. 5). We saw that it was at least much better than the first, and we accepted it. At that time none of us knew anything about the problem.

FIG. 6—Ground floor plan of Shoreham-by-Sea Health Centre. Reproduced by permission of the County Architect, West Sussex County Council.

Over the next year or two the impracticality of the general design began to dawn on us. The seven consulting suites were arranged in a line on one side of a corridor. On the opposite side was a large treatment room—unnecessarily large and unnecessarily close to the consulting rooms. The waiting area, with folding doors into the adjoining health education area, was at one end of the corridor which was invisible from the reception office.

WAITING AREA

We asked for a meeting of all interested parties with the architects. We knew that things had already gone too far for a major alteration to the plan of the whole building, and so we asked for only two changes—firstly, that the treatment room should be interchanged with the waiting area, to bring the latter close to and facing the line of consulting suites; and, secondly, for an office for the use of doctors only. Both requests were refused, the first on the ground that the waiting and health education areas were higher than the part of the building housing the consulting suites and the treatment room. We, the general practitioners, maintained that the plan would make it almost impossible to organize a free flow of patients and would force us to employ an unnecessarily large reception staff. They, the local authority health department and the architects, maintained that it was the only sort of plan the Department of Health and Social Security would tolerate, and produced the previous design guide to prove it.

To relieve the impasse it was suggested we should visit other centres to see how they were making the unworkable work. The newest and nearest centre (Fig. 6) was in a small town. We saw at once that it had not been built to the unworkable model but to a design rather better than we had been asking for, with a central waiting area spreading out to subsidiary waiting areas which faced two quite separate groups of consulting suites. In the light of this revelation, our architects relented and offered a compromise which we gratefully accepted (Fig. 7). It will not be as good as that shown in Fig. 6 or one of the other plans in the guide, but it is much better than what we were threatened with, and very much better than the plan in Fig. 1. A strip has been taken off the treatment room to provide a wide bay in the corridor opposite the consulting suites large enough to be used as a subsidiary waiting

area. It will then be possible to ignore the advice of the official guide that patients in the waiting area should normally be called forward by the receptionist when she receives a message from the doctor that he is ready for the next patient. It will be possible, as is done in the Shoreham centre, to place the waiting patient on a chair of the same colour as the doctor's door, so that he will know exactly where to go when the signal is given and his path will not interfere with the path taken by other patients coming and going.

DOCTORS' OFFICE

Our request for an office for the exclusive use of doctors was fiercely resisted by the representatives of the local authority, who could not think why we should want an office as well as exclusive use of our consulting suites (we had had to fight for that too: the health department had wanted the right to use our suites when we were not using them).

There is a tendency for local health authority doctors to regard general practitioners as being like casualty officers, dealing only with acute cases which, like casualties, need dressings, injections, suturing, etc. (hence the prominence always given in plans to the treatment room) and that the treatment given then and there would be the end of the general practitioner's contact with that particular patient. In fact, the number of patients seen in general practice who need that kind of treatment is very small, and the number who need continuity of care by the same doctor is large. We need to discuss our patients with each other and with hospital doctors, and even occasionally with local health authority doctors, and these are confidential conversations, whether face to face or on the telephone. We are pleased to have a staff room where we can have the pleasure of the company of nurses and midwives as we drink our coffee, but we must have somewhere private for private conversations and the dictating of confidential letters.

The point was put to us that these things could be done in our consulting rooms. In our practice of four doctors we have two consulting rooms, and we shall have the same number in the health centre. While two doctors are consulting the others are doing home visits or office business of some sort. To take another consulting room, with its examination room, merely for what is essentially office work would surely be a misuse of space and equipment.

FIG. 7—Amended plan for Somers Town Health Centre, Portsmouth. Reproduced by permission of Portsmouth City Architect.

We won the argument. We have been given the room allocated to the administrative officer for the building. But on looking through the plans of various health centres I see that very few, if any, other groups of doctors have been so lucky, unless (which is quite likely) they too have been allocated a room intended as a store or office for some more privileged person, and which has remained as originally labelled on the plans so as not to displease the Department of Health and Social Security.

Another bad feature of plans such as those in Figs. 1 and 4 and our own unrevised plan (Fig. 5) is that some of the consulting suites are much more desirable than others. The doctor occupying the bottom left consulting room in the plan in Fig. 1, for example, might well have to wait twice as long for his patients as those who occupy the rooms at the top of the passage. This can give rise to bad feeling.

Conclusion

The decision to allow local authorities to plan, build, and own the health centres and then to let out rooms in them to general practitioners was political.⁴ It placed general practice in a position of inferiority. General practitioners have to ask the local authority for what they want. If central government built and owned the health centres, as it does the hospitals, the position would be reversed, to the obvious advantage of general practice.

General practice tends to attract to it men whose temperament allows them to work more or less anywhere. They pride themselves on not being fussy, and they tend to take little interest in matters of planning. No doubt this is in many respects a virtue. Nevertheless, a properly thought out building, really suited to the work they do, saves both their time and their tempers. The somewhat unimaginative, expandable design (Fig. 8) suggested in the *Design Guide for Medical*

FIG. 8—Unit plan for five to seven doctors. Reproduced by permission of the Royal College of General Practitioners.

Group Practice Centres,³ which is a centre only for general practice with no local authority services, has many of the faults that I have found with the health centres. We shall get really good buildings for general practice only if criticism is frank and made available to the designers of the future.

References

- ¹ Department of Health and Social Security, *Health Centres—A Design Guide*, 1970. London, H.M.S.O.
- ² National Building Agency and College of General Practitioners, *Design Guide for Medical Group Practice Centres*, 1967.
- ³ The General Practice Advisory Service, *Buildings for General Medical Practice*, 1967. London, H.M.S.O.
- ⁴ *National Health Service Act*, 1946. London, H.M.S.O.

Clinical Problems

Cigarette Dependence: II—Doctor's Role in Management*

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British Medical Journal, 1971, 2, 393–395

A dependence disorder, once contracted, is as difficult to control in a society as it is to treat in an individual. The fact that cigarette smoking is pursued despite considerable health and financial disincentives points to the strength of the dependence. The Royal College of Physicians has recommended¹ that doctors "should set an example by still greater abstinence from smoking and must take every opportunity to urge their patients not to smoke cigarettes." Many doctors

may wish to go further by helping the more dependent smokers among their patients to break the habit, and some may also see a role for themselves in the wider preventive field by assisting in the campaign to curb smoking.

Natural Discontinuance

Some 18% of smokers become ex-smokers.² This so-called natural discontinuance tends to occur after 30 and increases with age, especially after 60. However, the ex-smoker status is unstable. A majority of those who give up smoking do not find it difficult. In 1964 66% of a sample of adult ex-smokers said it was "not difficult at all," 20% found it "fairly difficult," and only 14% found it "very difficult." Surprisingly, as many as 56% of ex-smokers who had relapsed said that stopping had not been difficult at all.³

* Part I of the article was printed last week.