PRACTICE OBSERVED

Organising a Practice

Two's company

DONALD THOMSON

Why do two people elect to practise in partnership? It is not simply that their area houses between four and five thousand people. A two-man practice works quite differently from a single-handed one. The least traumatic way of forming such a unit is by joining two neighbouring single-handed practices and to work them as one. That is what we did. Gradually the good points of each half of the new practice can be assimilated by the whole. Ten years ago we had two small practices based on separate villages, with branch surgeries and message drops, and covered one another for emergency back-up, minor partner duty, and illness. The doctors' Charter had provided the means to reorganise and for the last decade we have had a two-man practice, based on the largest village with a population of about 4000.

Why bother? Well, it was thought by the Department of Health, possibly with more conviction than evidence, that group practices were "better" than single-handed ones. Pressure was exerted on single practices to amalgamate. Loans were made available for new premises only to groups, and the payment of group practice allowances increased the income. In 1971 this allowance was almost sufficient to pay for the construction of new premises, and the small print stated that in rural areas a group practice could consist of only two doctors. There were other less tangible reasons. One needs somebody to compare notes with—a partner whom one sees frequently helps enormously this way. Somehow, too, it seems easier to make big decisions about property, recruiting staff, and taking on new commitments when the advantages and disadvantages can be discussed easily with someone who has to share the commitment. It is easier to take on a trainee. Trainers bring all sorts of interesting ideas into a practice, but should have access to the

experience of more than one trainer if possible. The question of off duty becomes much simpler. An uninterrupted half day and weekend off certainly makes me feel much more efficient. Outside the practice the opportunity to influence local medical events is greater when there is a formulated practice policy, and this is much easier for two than one. In a dispensing practice it is possible to keep the stock at a more economical level—two doctors do not need twice as much on the dispensary shelves.

Decisions

There are definite differences in the way two-man and one-man practices work. The principle is one of trust and responsibility for the welfare of patients is shared, and one has to be able to sense how one's partner will look at a problem. This implies that potential partners must have similar outlooks. The single-handed doctor must make his own decisions and live with the results. The common fund of knowledge, more than just the contents of the practice library, is one of the most reassuring aspects.

Money is always a potential cause of friction. Some single-handed doctors have a separate practice account, but there is a great temptation to simplify everything by running all the household and practice affairs together. This does not work very well in a single-handed practice and is impossible in a group practice. It therefore becomes necessary when forming a partnership to formalise finances and decide what sort of things are legitimate practice expenses. It is possible to arrange things so that medical apparatus, cars, and postgraduate meetings are paid through the practice but debited to the individual's practice expenses. This way neither partner feels he is subsidising the other. It must be decided right at the beginning how the income is to be divided. We have always been equal, other than a fair and equal division of asking for trouble. One has heard horrendous stories of partners writing into the agreement that, for instance, all police work is excluded, then expecting cover

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Innovations in Wales: Clwyd

Day hospital care by general practitioners in a cottage/community hospital

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According to Brocklehurst,¹ "a day hospital is a building to which patients may come or be brought in the morning, where they may spend several hours in therapeutic activity, and whence they return subsequently on the same day to their own homes." Since Cosin² described a day hospital in a geriatric unit in 1954 much more day care in hospitals has taken place. The Department of Health and Social Security³ recognised that the day hospital was important for providing health care for elderly patients, recommending that units should be sited adjacent to inpatient wards and supervised by a consultant in geriatric medicine. In 1974 the DHSS published a document⁴ on the development of "community" hospitals, which envisaged that one of the roles would be to provide day care for the elderly, but there was no guidance on whether they should be supervised by general practitioners or by consultants in geriatric medicine. Day hospitals for the elderly in Britain seem to be supervised by consultants in geriatric medicine with varying degrees of help from general practitioners.⁵

A general practitioner day hospital at Chirk is the first of four day hospitals to be established in community hospitals in Clwyd over the next three years. Because of all of them will be staffed and supervised by general practitioners, the health authority is concerned with how well they function, especially as doubt has been cast on this type of supervision.⁶

Chirk day hospital

A purpose-built day hospital with 10 places was commissioned in 1979 when an existing cottage hospital was converted into a community hospital. The hospital will ultimately have 40 general practitioner medical beds (20 of them for "continuing care for elderly patients"), a general practitioner maternity unit of eight beds, a minor casualty unit, and a suite for consultant outpatient clinics. The hospital serves a rural catchment population of about 20,000, of whom 3000 (15%) are aged over 65. The community hospital is supported by a district general hospital about 10 miles away.

The physical layout of the day hospital is shown in the figure. The unit has a full-time nursing sister, two part-time State-registered nurses, two part-time nursing auxiliaries, a part-time physiotherapist, a part-time occupational therapist, a social worker, and a home-help supervisor visit occasionally. Staff of the community hospital provide secretarial help on the basis of one session a week.

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POLICY

The patient's own general practitioner is responsible for admission, clinical management, and discharge from the day hospital. This applies in all circumstances, including those when an assessment has been carried out at a home visit by a consultant in geriatric medicine and when admission is requested after inpatient care in a specialist unit. A form to request admission gives clinical and social details, including the reason for admission and expected treatment in the unit. This form is com-

pleted by the referring general practitioner and is sent to the sister in charge of the unit. It is designed so that it becomes the first page of the patient's medical case notes, thus avoiding a special visit by the doctor to write up the history and treatment when the patient first attends.

A general practitioner on the staff of the hospital acts as clinical co-ordinator in the day hospital. His duties are mainly administrative and supportive to the nursing and other therapeutic staff. Regular interdisciplinary meetings are held each month to review and discuss each patient's progress. They are attended by the staff of the day hospital, the clinical co-ordinator, and the patient's own general practitioner.

During the first 12 months (May 1979 to April 1980) 55 new patients were admitted to the day hospital. Fifty-two were referred directly from their own home by their general practitioners, and three were accepted from inpatient wards in the district general hospital. Stroke (28 patients) and chronic joint disease (17 patients) were the most common reasons for admission. Over the 12 months there were 2247 attendances, the

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while this is being done. Decisions must be made about seniority payments, remuneration from clinical assistants, legacies, and fringe items like lecture fees. Our policy has been to exclude the last two because we both felt this to be fair. A partnership will be safe if each partner is prepared to give up his or her £500 a year more than he does himself and not worry. The relation between the partners has to be decided early. One member of a two-man practice was heard to remark that though he had taken a partner he still kept 51% of the votes. This may work with some combinations of personalities but we feel that the African tribal government custom is better. With this method partners meet in an convivial atmosphere as possible and just talk until a consensus view emerges. Sometimes it is not possible for both partners to agree. At one time we felt differently about pertussis immunisation and had to tell patients that we had different opinions. Major policy decisions have to be unanimous, but by discussing these we have found little difficulty. However these decisions are made, two partners must be a lot less casual than two individuals.

Much has been written about partnership deeds. The making of this deed concentrates the mind wonderfully. Early in the partnership both doctors must discuss what they feel to be the essential contents. It is an opportunity to express fears and guard against exploitation, to express the intention of a fair division of labour and reward. It is also a chance to write intentions of how the practice will develop. The very act of writing in the arrangements for taking sabbaticals make it more likely that this will be done. One can write in the obligation to keep a reliable and comfortable car on the road, and to keep good records. Many partners would no doubt be happy to wait for several years to have hip surgery performed, while their colleagues did the work; others might consider writing into the deed an obligation to secure private insurance. Arrangements need to be made about retiring. Some partnership agreements make retirement at age 65 obligatory. Others make this a condition only if the partner is found unfit to practise by a physician or psychiatrist. Whatever is decided about all these details, the final deed must be prepared by a solicitor. It should ideally be brought out once a year to be shown to the trainee but used to settle the ultimate disputes.

Finances

Partners have to decide how to divide the work load, and any decision cannot be final. New, interesting work becomes available, partners develop new interests, and the quantity of work done has to be assessed. Sometimes work becomes important, and it is necessary to apply for work outside the practice to increase income. If this is done by one partner the other has to do extra work to cover. Partners differ in their

practical interests, and provided both are working to the same degree of effort it seems best not to duplicate jobs. It is better if one partner does the books and controls the finances; the alternative tends to be a muddle. It is unwise to subcontract the book-keeping. Tighter control is usually achieved when it is realised that the doctors' income is directly related to the efficiency of the system. Both partners must understand how the practice finances work, and both must agree on major items of expenditure. A useful disciplinary measure is to require two signatures on cheques over a certain amount. We do a variety of clinics, as do most partnerships, such as well-baby and developmental, antenatal, allergy, and—highlight of the month—a wart clinic. Usually we see our own patients, but one of us does the intrauterine contraceptive device insertions and a session of "odd jobs" at the cottage hospital, plus a couple of assisting sessions a month. This we feel makes up for doing less of the book-keeping. The important thing is that both must feel it is a fair division. Some partnerships insist that except in emergency all patients are seen only by their own doctor. We like to give patients some choice and some of them on one list see the other doctor. This is a policy which must be decided by each practice—there is no right or wrong way.

Generating ideas

One aspect of administration deserves special mention. We have found it helpful to set aside a half hour every week for discussion of small points that do not merit an evening's discussion. All sorts of ideas are generated at this time, and afterwards we have a further meeting to include all the staff—nurses, trainee, and anyone associated with the practice who wishes to contribute. The meetings started as a safety valve but now generate useful ideas.

Change in a partnership is always a time of stress. One partner will eventually retire and will have to be replaced. New men bring new ideas. The premises will be found to be too cramped or in the wrong place. Partnership loans may have to be arranged. A group practice loan can be obtained if all else fails. More staff may be required, and care is needed in selecting people who will fit in with both partners. A change in partnership may cause the resignation of staff if personality differences are too great. The senior partner may be asked for his opinion about potential incoming partners, but the final decision must rest with the remaining partner who has to work with the new doctor.

So what happens at the end of 10 years? What about a third partner? What about reducing the work load? It is very difficult to contract, so the partnership of two becomes three. A whole new set of considerations apply, and that is quite another story.

here are doing well, including the officers operated on, Lieutenants Hill and Hanson. Captain Lovegrove and Morris, and Major Hay, 92nd, are all improving. Two deaths, however, have occurred among the men after secondary operations. Dysentery and diarrhoea, and rheumatism, are the chief diseases, and respectively in the order named, which affect the present field-force. To-day, there are 31 cases of dysentery, 25 of diarrhoea, 18 of age, and 12 of rheumatism, in a total sick-list of 130 out of 3,284 men. But there is no sign of enteric fever yet, although we have now stationary for nearly a month, and the camps are beginning to wear a well-worn aspect. The sanitary condition is maintained satisfactory, however, in spite of the usual difficulties attending the sanitation of camps in the field. Assistant Commissioner-General Young has arrived as Commissioner for the Society for National Aid to the Wounded, and he is empowered to supply all the extra medical comforts and delicacies for the sick and wounded, which are not allowed by the administrative officers of the Army Medical Depot. (British Medical Journal, 1881.)

ONE HUNDRED YEARS AGO A correspondent writes: Two further convoys of movable wounded have been sent down to embark for England. The necessary medical boards on these cases are held locally, previously to their departure, which saves delay and trouble at Harburg. Of the seven dangerously injured who were left at Mount Prospect, five have been brought in most comfortably and effectively by the bearer company, who carried the men on stretchers the entire journey, twenty miles, without a fault. It is satisfactory to see such efficiency displayed by the stretcher-bearers under Surgeon-Major Johnston. There are now but three bad cases at Mount Prospect, one of which is that of Major Singleton of the 52nd, whose thigh was amputated at length as a secondary operation for gunshot-wound of the knee-joint, which injury did well at first, but latterly, some constitutional disturbance having set in, the leg was removed, and the case is not reported as very favourable so far. There is a rumour of the existence of enteric fever having been noticed at Mount Prospect, and if so, it will be well to break up the encampment there. The wounded

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TABLE 1—Age and sex of patients

	64	65-74	75-84	85+	All ages
Men	4	2	18	4	28
Women	4	2	18	4	28
Total	8	4	36	8	56

Note: The ratio of 2:1 between men and women in the over-75 year age group reflects the sex-ratio of the population of the hospital as a whole.

TABLE 2—Use of domiciliary services at time of admission to day hospital

Type of service	Men	Women	Total (%)
Home help	4	2	6 (11%)
Home help and meals	4	2	6 (11%)
Home help and meals on wheels	4	2	6 (11%)
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Note: The district nursing service was the most commonly used of the statutory domiciliary support services at the time of admission.

TABLE 3—Care at home

	Men	Women	Total (%)
No. at home	4	2	6 (11%)
Spouse	12	10	22 (39%)
Daughter	1	4	5 (9%)
Other	1	4	5 (9%)
Total	18	30	48 (85%)

*Care a relative responsible for caring for the patient.

TABLE 4—Treatment programme in day hospital

	No. of patients (%)
Nursing care	55 (100%)
Physiotherapy	41 (75%)
Occupational therapy	41 (75%)
Speech therapy	41 (75%)
Drug administration	40 (74%)

frequency being 17 once a week, 36 twice a week, one three times a week, and one four times a week. The patients arrived about 9.30 am and left home at 3.30 pm. Twenty-five patients were discharged during the first 12 months; five died, four were admitted to an acute hospital, and 16 were discharged home. Tables 1-4 give details of the age and sex of the patients, community support, and the treatment prescribed.

ONE HUNDRED YEARS AGO All who have occasion to traverse the by-ways of London have been familiar with the danger of the game known as "tip-cat." It is a pastime fraught with the most serious possibilities of injury, not only to passers-by, but to the luckless urban playing, and to his or her companions. The small piece of wood struck recklessly may become a most formidable source of boomerang, returning in its orbit from the player's foot to the nose or eye. Accidents are continually occurring, and all who know the crowded by-ways and open spaces of our metropolis, can judge for themselves how little effort is made to suppress the nuisance; and yet, if the police chose to apply their powers, or if those greater departments who give the police life and motion would authorise such application, there is no reason why this nuisance should not be at once suppressed. In an Act as old as 1839, regulating the powers of the police in London, we have the following definition of an offence subjecting the perpetrator to immediate arrest, and a forty shillings fine: "Every person who shall fly any kite or play at any game to the annoyance of the inhabitants or passengers, or who shall make or use any side upon ice or snow in any street or thoroughfare, to the common danger of the passengers." This subsection of the Metropolitan Police Act is, however, though still in full force in the Statute-book,

Discussion

We have described how a general practitioner day hospital was set up to serve a rural community 10 miles from the nearest district general hospital. We acknowledge that the current thinking is that consultants in geriatric medicine should be in overall charge of day hospital care for the elderly, and that in the absence of such supervision inappropriate referrals may be made to such units. We argue, however, that the likelihood of this happening may be more than overcome by the advantages of continuity of care provided by the patient's own family doctor, and the "synergic" effect of professionals in different disciplines applying themselves to each patient's needs for rehabilitation. Although the number of patients in this preliminary study is small we think that it shows that a great extent the general practitioner day hospital can support a particular type of patient—namely, an elderly woman who has no "carer" to support her, who is incapacitated to varying degrees by either a stroke or arthritis, and who is probably attended by a district nurse immediately before admission. After each patient was admitted intensive efforts were made to try to improve the patient's ability to be relatively independent in the local community for as long as possible. The fact that 30 (55%) of the patients we studied were still attending the hospital at the end of the first 12 months indicates, we believe, that rehabilitation is often lengthy and that the day hospital may be a considerable source of social support to the patient. Chirk day hospital is being studied to try to measure differences, especially in outcome, between general practitioner controlled and consultant controlled day hospitals for elderly patients.

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practically regarded as an obsolete provision, like the old injunction to magistrates to bring up people guilty of witchcraft. The string of a kite coming across one's nose, or jerking off a hat, might be a serious inconvenience, especially if the kite-flyers became very numerous; but any annoyance in this respect against which the Legislature of 1839 could have dreamed of providing, is utterly trivial in comparison with the danger of losing one's eye when an involuntary participant in the game of "tip-cat." We can understand that a very natural disposition sometimes to its most remote corner. With the words of the Metropolitan Police Act before us, and evidence of the serious mischief resulting from the prevalence of this stupid pastime, no theory or philanthropy can acquit those who are responsible for good order in our streets of the most supine negligence. (British Medical Journal, 1881.)