Organising a Practice

Partnership of 10 doctors

JANE RICHARDS

In the mid-1960s Exeter City Council decided to build a health centre. The health committee chose to build the first health centre in the St Thomas area of the city, on the west side of the River Exe. There were five practices: one single-handed and the rest groups of two and three doctors. The doctors in three practices were already combining for weekend duty and had worked together for years; these doctors were interested in going into a health centre. Initially we thought that it would be better if we owned any health centre that was built and then offered accommodation to the local authority doctors and nurses who also wanted to work there. This we soon realised was impossible, as the City Council informed us that they would not give planning permission for a private venture, and even if we could raise the money and find an appropriate site we would get no further. We therefore agreed as a group of practices to go into a City Council-owned health centre—for as the saying is, "If you can't beat them, join them,"—and we thought that the improved facilities of a health centre would be an advantage to our patients, who might otherwise change to other doctors who were willing to practise there.

At the time we had not combined to form a single large practice, but as planning for the health centre progressed we thought that we needed to present a common front to the authorities and that staff who would be working at close quarters in one reception area should be employed by the same partnership and subject to the same conditions of service. We thought similarly that our own relationships would be better if we worked together, and so we consulted our lawyers and accountants, who all agreed that such an arrangement was both financially feasible and to our advantage so far as our partnership agreements were concerned.

Ten partners

We are now a partnership of 10 doctors working from the health centre in St Thomas. There are eight men and two women and one partner is a trainee, so we usually also have a trainee. We cover an area consisting of St Thomas and much of the city of Exeter to the east of the river as well as several villages around, especially on the west side of the city. Five of us qualify for rural practice payments. We have 10 consulting rooms at the health centre and three branch surgeries: a large well-staffed one at the student health centre on the University of Exeter campus and two small ones—in a private house in a village and in a purpose-built caravan in a residential caravan village that is inhabited largely by retired people.

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Because we are a large group we can provide almost continuous medical cover at the health centre during the day and yet allow ourselves to do outside sessions in subjects of interest to them without having to be on-call for the practice at the same time. We have several sessions in anaesthetics, obstetrics, and rheumatology, and also provide out-of-hours cover for a local long-stay geriatric hospital. We also look after a Guide Dogs for the Blind training centre, provide primary care for the resident hospital nurses and occupational health care for the employees of Debenhams. There is a danger of taking on more than we can cope with, especially when enthusiasm runs high as it did when the partnership was young. We are now more cautious of overcommitting ourselves.

Organisation

Originally three practices, we have continued to organise ourselves loosely in three groups—two groups of three doctors and one of four doctors—so that patients may be familiar with fewer partners, and our reception staff may also work for and know better the needs of a limited group of doctors. When the practice started we were all about the same age so we decided not to have a hierarchical partnership but take it in turns yearly to be chairman of the practice with responsibility for calling practice meetings and organising various administrative activities. Apart from this, certain administrative tasks such as the holiday rota, paying the bills and distributing our monthly cheques, and ordering supplies and equipment for the treatment room are permanently the responsibility of other partners. The chairman takes minutes of meetings and leaves with sub-committees that deal with staff employment and relations, structural alterations, and any locum cover required. In the year after the term of office is over the chairman is entitled to an extra six weeks' leave—an arrangement that has been accepted by the Devon Family Practitioner Committee. Meetings are held intermittently rather than regularly and are called when there is business to be done. Staff do not attend our meetings, which take place at lunchtime or in the evenings, but trainees are invited to come if they wish. We hold no formal clinical meetings, but ad hoc discussions often take place at coffee time and there is plenty of clinical stimulation. We have no practice policies for treatment.

Surgeries

We run a full appointment system, apart from the "extras" sessions about which I will say more below. There is an appointment book for each of the three groups, and although patients may see any partner if they expressly wish, when an appointment with their own doctor is unavailable they are first offered one with a doctor of the same group. About four years ago one partner did a study of the overall number of appointments

that we needed to provide for an average of four consultations per patient on the total list a year, and the surgeries were extended to accommodate the larger number needed. Despite this reorganisation there are always some patients towards the end of the day who think that they cannot wait for the next available appointment either with their own doctor or with another partner or who have genuine emergencies, and for these "extras" the doctors who are on duty overnight provide a daily mopping-up service in the late afternoon and evening. These patients are not given an appointment but are told that they will have to wait until the next day. At times—not necessarily in winter—this extra surgery is as large as 30 or 40 patients. Certain patients never manage to make an appointment and always attend this session whatever their problem. There seems to be no solution for this particular group, and they are seen by all 10 partners at one time or another, getting less than satisfactory care because of the pressure in such sessions and the lack of continuity. Such patients are very difficult to help or to discipline in a large group practice.

Visits

The practice covers a large part of Exeter, and we are trying to rationalise the practice area. All of us have patients who are reluctant to ask to find another doctor when they have moved to another part of the city and are still willing to travel to us to attend the surgery. The difficulty in agreeing a policy in a matter such as this is one major disadvantage of a practice of our size, and compromises are hard to reach. Each doctor visits his or her own patients, even if more than one partner is visiting a certain area of the city. Village calls are often grouped together if the partners concerned so wish, and the calls for an absent partner are shared out among the members of the partner's smaller group.

Staff

A clerk/receptionist deals with the repeat prescriptions and the various secretarial needs of each group of doctors and comes to know many of the patients concerned. One or two receptionists on the desk deal with each appointment book and are responsible for extracting the notes for these surgeries. The advantage of a large number of office staff is that each can have a defined area of work, but we insist that they all take over each other's jobs, apart from the typing, when necessary.

With over 25 000 patients attending the health centre we are able to justify full-time staffing of our treatment room with our own employed nurses from 9 am to 6 pm Monday to Friday and on Saturday mornings. We have three State-registered nurses, two in the morning and one in the afternoon. They help us to do minor operations, assist with the insertion of intrauterine contraceptive devices, and deal with quite a lot of the trauma. They also do routine dressings and injections. There is open access to the treatment room without an appointment, but there are often long queues. We also, of course, have a large complement of attached staff with whom we have a very good relationship, and they gain by working as a group rather than in isolation.

Off duty

One advantage of being a large practice is that we are our own deputising service, and we are backed up by the availability of the patients' records and a familiarity with many of the people we visit. We have an excellent off-duty schedule, working only one night a week each in pairs; some prefer to work "both on" each week, others alternate weeks solely, depending on telephone cover and family arrangements. There is a rota for Saturday morning surgery when four partners provide an emergency-only service. The weekend rota is one in 10 from 12 midday Saturday to 8.45 am Monday. Again, some partners split the duty and others work right through. It can be very busy with up to 20 calls a day including midwifery, but we know many of the patients, so we are often able to give telephone advice when a doctor in a deputising service would have to call.

Records

On moving into the health centre we ran all the notes together, male and female, A-Z. We did not realise what a problem we had given ourselves with the ever-expanding records of about 25 000 patients in one filing system, and this is something with which we are still struggling. The notes take up an enormous amount of space and names are frequently duplicated. Improving the standard of the records for this number of patients is a daunting task, which we are slowly tackling with the help of extra staff.

Conclusion

Despite being such a large group it is perfectly possible for us to practise personal medicine and evolve and adapt to new concepts of general practice. As doctors none of us is alike, nor do we all agree with each other on many matters of clinical practice or organisation—it is not necessary. Practice decisions are often compromises and sometimes have to be by majority vote, but we all value the many-faceted interactions among ourselves, both personal and professional, and I am sure they are to our patients' advantage.

Clinical Curio: low back pain in children

Low back pain is an uncommon complaint in children. It is therefore extraordinary that in two weeks we have had three cases severe enough to admit to hospital. Two of these have just been confirmed as being due to Ewing's sarcoma. Medical statistics quote the annual incidence of Ewing's sarcoma to be 0.5 per 100 000 population. A GP will therefore probably go through a lifetime without seeing one case. The chance of two cases in a practice of 9000 patients presenting in the same two weeks is infinitesimal.

After six months as a trainee, I was just beginning to think that rare things occur rarely. Now I am not so sure.—NATALA DWYER, trainee in general practice, Epsom, Surrey.

We will be pleased to consider for publication other interesting clinical observations from general practice.—Ed. BMJ.

Joint Working Party on training for obstetrics and gynaecology: recommendations

A Joint Working Party was established in July 1980 by the councils of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners "to consider training in obstetrics and gynaecology for general practice, having regard to undergraduate education and training; and to make recommendations." It met 13 times after the first meeting in September 1980. We publish the summary of the recommendations from the full report, *Training for Obstetrics and Gynaecology for General Practitioners*, which is available from both colleges.

Summary of recommendations

Obstetric care in general practice

1. The functional integration of all maternity services within districts should be vigorously pursued so that there is joint agreement between all the professionals concerned on the policies for clinical practice, audit, and continuing education.
2. General practitioners with recognised training in obstetrics should be given every assistance to have facilities within or adjacent to consultant units where they can deliver their selected patients. All consultant units should provide such facilities either within their unit or as part of a functionally integrated general practitioner unit.
3. Consultants, general practitioners, and midwives together with other health professionals should ensure that these facilities are made available.

Basic medical education

4. The objectives of the Education Committee of the General Medical Council and our applications in appendix I should be achieved by all undergraduates.
5. There should be no further reduction in the time allotted in the undergraduate curriculum for obstetrics and gynaecology.
6. Undergraduate education is inadequate to meet the needs of general practitioners wishing to provide maternity services. We therefore recommend that all general practitioners wishing to provide such services should undergo a further period of training after qualification.

Vocational training

7. All trainees should achieve the educational objectives for antenatal and postnatal care and gynaecology, including family planning and gynaecological conditions, set out in appendices II and IV.
8. Trainees wishing to provide full care should, in addition, achieve the objectives set out in appendix III.

Achievement of vocational training objectives

9. For those general practitioners wishing to provide full care a period of six months' combined obstetric and gynaecological training in a post-graduate setting with two colleges should be the minimum requirement.
10. For those general practitioners wishing to provide shared care only a period of three months' combined obstetrics and gynaecology in a post-graduate setting with two colleges should be the minimum requirement.

Royal College of Obstetricians and Gynaecologists

Mr R M Ferron, chairman; Mr A F J Atkins; Professor R W Beard; Dr A D McIntosh; Mr K R Peel; Dr M P Roseacre; Dr J B Scrimgeour.

Royal College of General Practitioners

Dr M J V Bull, Professor V W M Drury, Dr J C Hasler, Dr M McKendrick, Dr Lotte T Newman, Dr J S Norrell.

11. Part-time training would be acceptable under the conditions set out in appendix V.
12. Those general practitioners wishing to provide full services who have only undertaken training suitable for shared care should undertake an additional minimum period of three months' resident obstetrics in a post recognised by the two colleges.
13. Experience in those aspects of obstetrics and gynaecology which are obtained more readily outside hospital experience should be provided in the training practice.
14. All trainees should be enabled to achieve the requirements for the Joint Certificate on Contraception.

Hospital posts and training practices

15. The two colleges should reconsider the criteria for approval of posts for vocational training.
16. The two colleges should continue joint visits to hospitals for educational approval of posts for vocational training.
17. All obstetric and combined obstetric and gynaecological senior house officer posts surplus to specialist training requirements should be regarded as potential vocational training posts for general practice.
18. Training practices should be organised so that they provide the necessary upstroke to hospital training outlined in appendix VII.
19. Regional postgraduate committees should examine any difficulties over the local provision of posts for vocational training.

Diploma of the Royal College of Obstetricians and Gynaecologists

20. Those general practitioners wishing to provide maternity services, particularly those intending to offer full care, should obtain the DBOG.

Continuing education

21. Facilities for continuing education should be regularly reviewed by the professionals providing maternity services so that they are designed to meet the needs of all concerned.
22. All general practitioners offering maternity services should take part in regular educational activities.
23. Those general practitioners providing full care who deliver less than 30 women in three years should undertake a practical refresher course.
24. Attendance at the delivery should be regarded as the normal practice for those general practitioners offering full care.

Organisation of maternity services

25. Maternity services liaison committees, representative of all those providing maternity services and with agreed terms of reference and constitution, should be established in all districts.
26. General practitioner obstetric beds should be organised to enable practitioners with locally arranged contracts to provide full care for selected patients.
27. There should be a two-tier obstetric list, one tier for full maternity services and the other for shared care only.

Final recommendation

28. The two colleges should review the requirements for training in obstetrics and gynaecology for women in labour after a period of five years.

Appendix I—Basic medical education

A doctor on qualification should:

1. have a basic knowledge of the principles of human reproduction and family planning
2. have a basic knowledge of the principles and practice of normal obstetrics, including antenatal and postnatal care and lactation
3. have had enough practical experience to be able to deliver a baby in an emergency and apply simple resuscitation to the newborn
4. be aware of the interrelationships between general disease and pregnancy
5. have a basic knowledge of important and common gynaecological conditions

6. be able to take a gynaecological history, conduct a pelvic examination, and take a cervical smear
7. understand the principles of psychosocial counselling
8. be able to recognise common obstetric and gynaecological emergencies requiring urgent intervention and be able to provide appropriate first aid measures
9. be aware of the emotional aspects of childbirth

Appendix II—Training objectives for shared antenatal and postnatal care

The doctor should:

1. appreciate the preventive role, and understand the significance of all routine procedures used in modern antenatal care
2. have a thorough understanding of the epidemiology of maternal and foetal morbidity and mortality
3. be able to undertake the initial management of common and life-threatening emergencies in early pregnancy
4. know when pregnant women require referral for specialist opinion or care and which are suitable for shared care or full care by the general practitioner
5. understand the principles of counselling women faced with possible or real problems of fetal malformation
6. know the methods by which congenital malformation of the foetus may be detected
7. be aware of the methods of and provision for education for pregnancy, childbirth, and care of the newborn
8. understand the importance of social and emotional factors in pregnancy and childbirth
9. understand his or her own role and that of different members of the health team in the field
10. understand the management of common conditions for which pregnant women are admitted to hospital—preterm labour, pre-eclampsia, multiple pregnancy, fetal growth retardation, antenatal haemorrhage, maternal disease, etc.
11. be able to recognise the signs and symptoms of onset of labour
12. understand the principles and methods of the current management of labour
13. understand the importance of accurate and detailed records in all aspects of obstetric care and recognize the value of such records in clinical audit
14. be able to carry out routine examination of the newborn infant
15. understand the normal development of the newborn
16. recognise common diseases arising in the newborn
17. recognise congenital abnormalities in the newborn
18. understand how breast-feeding is established and maintained
19. recognise and understand the management of physical and psychological problems of the mother in the postnatal period—postnatal depression, for example
20. understand the normal involutional processes in the postpartum period
21. understand the indications for maternal immunisation with anti-D and rubella vaccine and the importance of continuing their efficacy
22. be able to advise and provide suitable methods of family planning

Appendix III—Training objectives for intranatal care

For full care, in addition to the objectives in appendix II the doctor should:

1. understand the indications for the induction of labour
2. understand the physiology of uterine activity and the use of oxytocins to augment uterine action
3. know the principles and practice of continuous fetal heart rate and acid-base monitoring
4. recognise the abnormalities that may occur in labour necessitating referral to specialist—fetal distress, haemorrhage, delay in labour, abnormal presentation, etc.
5. be able to:
 - a) induce labour where appropriate;
 - b) provide obstetric analgesia and local anaesthesia including pudendal block;
 - c) carry out a low forceps delivery;
 - d) resuscitate a shocked mother;
 - e) resuscitate a shocked baby

6. understand the management of other abnormalities of labour—shoulder dystocia, breech, twins, etc.
7. be able to manage the third stage of labour including the immediate management of postpartum haemorrhage and retained placenta
8. be able to apply simple resuscitation to the newborn
9. be aware of special arrangements needed for home confinements
10. be able to communicate with women in labour so that they understand the procedures proposed for their own safety and that of their babies

Appendix IV—Training objectives for gynaecology including gynaecological conditions and family planning

The doctor should:

1. understand the role of the general practitioner in and techniques used from general practice (a) for health education and sex education in children, (b) for the management of common problems relating to menorrhagia—menorrhagia, dysmenorrhea, menorrhagia, polymenorrhea, premenstrual syndrome
2. be able to take a gynaecological history, carry out a full and appropriate examination, and conduct appropriate investigations on patients of all ages
3. understand the physical problems relating to congenital abnormalities of the female genital tract
4. be able to advise and provide suitable methods for family planning
5. understand the principles of counselling patients with psychological problems
6. be able to advise, investigate, and, where appropriate, refer patients with problems relating to infertility
7. be able to manage abortion in general practice, including emergency treatment, counselling, and aftercare
8. understand the management of common problems relating to menorrhagia—menorrhagia, dysmenorrhea, menorrhagia, polymenorrhea, premenstrual syndrome
9. understand the management of patients suffering from infection of the genital tract, including sexually transmitted diseases
10. know the steps required for the early diagnosis of neoplasia of the genital tract and the general practitioner's role in management
11. understand the physiology and management of the menopause
12. understand the management of stress incontinence and prolapse
13. be aware of ethical and legal aspects of gynaecological problems—abortion, age of consent, sexually transmitted disease, etc.
14. understand the role of other professionals in these fields

Appendix V—Part-time training

Part-time training is acceptable provided that:

1. it achieves the objectives for full-time training
2. it is of equivalent duration to full-time training
3. it is not less than half-time and is a consecutive unbroken period except for statutory annual and study leave
4. it is in posts highly recognised by the two colleges to ensure that they are adequate in educational content and do not diminish the experience of full-time trainees. The posts can then be selected by the regional postgraduate committee for vocational training

Appendix VII—Recommendations for training practices providing obstetric and gynaecological experience

1. The practice should provide for an adequate number of obstetric patients
2. The trainee or a partner should be on the obstetric list and actively practising obstetrics
3. The practice should hold a regular antenatal clinic
4. A community midwife and a health visitor should be attached to the practice
5. There should be family planning services provided by the practice
6. The experience and instruction offered should enable the trainee to meet the objectives for gynaecology, including gynaecological conditions and family planning listed in appendix IV
7. There should be a proper system of records, especially for maternity patients