PRACTICE OBSERVED

After Acheson...

Constructing a primary care unit: the work

IAN KEY

The house that I purchased from the retiring doctor was Victorian, detached, very dilapidated, on a main road, and had a large garden. On the ground floor there were four large rooms and an entrance hall. The first floor was similarly arranged, the hall being replaced by a bathroom, and there was a lavatory half way up the staircase. On the top floor there were two further rooms. From my visits to the practice before taking it over I realised that it could be altered to provide very satisfactory premises, and once the alterations had been completed the cost/rent scheme would operate. The "Red Book" states that "substantial attention must be given as is needed to make the completed premises the equivalent of separate purpose built premises in the view of the family practitioner committee after consultation with the Department's [of Health] Specialist Regional Medical Officer" (SSA Para 51.51) substantial alteration (for premises).

Design

The services of an architect would be essential for redesigning the premises, and fortunately an architect with whom I had worked before on surgery conversion was willing to act for me. He visited on my second day in the practice, and we worked out what would be required to provide satisfactory accommodation for a primary care unit, enabling three doctors to consult at once—a waiting area for up to 14 waiting patients, a reception area, a practice office, three consulting rooms, a treatment room, a patients' cloakroom, a pram park under cover, staff rest room with minor cooking facilities, a staff cloakroom, a common room, a room and office for health visitors, and storage rooms, and outside the building, car parking facilities on the site for both staff and patients. All the rooms should conform to the sizes recommended by the Department of Health.

We agreed that responsibility for the design should be

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

shared by the architect for the structural work and commissioning the builders, by my wife for the decor, and by me for the internal layout of the various rooms. We were to meet frequently during the planning and building, and each made valuable suggestions in the others' sphere. Our aim was to produce premises that were efficient, quiet, easily maintained, and not too formal. We decided that the clinical rooms should all be on the ground floor and that the first floor should be used for offices, study, and refreshment facilities. The design should allow for expansion by new building if that became necessary in later years.

Once the design drawings had been completed the people

FIG 1—Reception area

who were going to use the rooms were consulted about the internal arrangements. For example, the reception staff made many helpful suggestions about the reception hatch that divides the waiting area from the reception area, and about storing the patients' medical records. The builder also made many suggestions that were adopted, as did several of his work force. For example, the plumber advised on the siting of sink units, which in the original designs had been perhaps inappropriately placed. The patients were kept informed throughout the building of what was going on, and their comments were invited. They made it clear that they would be unhappy with a cold impersonal atmosphere, particularly in the waiting and reception area, where the receptionists' need for privacy had to be balanced with their need to be in close touch with the waiting patients.

Architect

By mid October 1981 the architect had produced a satisfactory design, which was submitted to the family practitioner committee for comment. The administrator of the family practitioner committee approved the design in principle, and thereafter the architect and I were in frequent communication. Early in November 1981 at a meeting on the premises of the regional medical officer, the architect, officers of the family practitioner committee, and me it was decided that the regional medical officer was likely to approve the design, and this was formally granted at the end of November.

The architect obtained the relevant local authority planning permission, and he discussed the proposals with the planning department to see if their approval was likely before submitting the plans. He also obtained the views of the fire control officer and the local building inspector and thus many delays were avoided. Once he knew that approval was likely he drew up a specification for the work and prepared working drawings, which he submitted to three builders that he had contacted who had an interest in carrying out the work. The architect showed them the building and site and asked them to tender by a specific date. The lowest tender being acceptable, the architect arranged for the building works contract to be signed by the builder, my partner, and me.

Once the building work was under way the architect visited the site regularly and often met the builder, my wife, and me to discuss problems or to consider any new suggestions that had been made. After these meetings he always drew up minutes, which were very useful. During the construction, when it became clear that more finance was available than we had planned on, he issued many variation orders. Stage payments during the work were requested by the builder, and the architect issued certificates stating that payments would be in order. Apart from designing the new premises, he was the link with the builder, particularly concerning arrangements for paying the builder, and when the work was completed he made a final inspection and agreed the final account with the builder.

Builder

The builder who was chosen to do the work had submitted the lowest tender, and it is interesting that this was 50% lower than that of his highest competitor. The specification for the work had included firm details of timing. It was emphasised that the practice would have to function during the building. We would try to avoid delaying the builder as much as possible, however, and we accepted that there would be times when the mains services, such as electricity and water, might be cut off.

The work on the ground floor was to be done in three phases. Phase 1—The office and store room were to be made suitable as a temporary waiting-reception and consulting room; they would require some redecoration. The estimated time for this work was three weeks.

Phase 2—When phase 1 was completed my partner and I

would move into the temporary consulting room and the builder would start construction of the new waiting and reception area, which would include the entrance hall and the new treatment room. The treatment room would be used initially as a consulting room during phase 3 of the work. The estimated time for this work was six weeks.

Phase 3—We would now move into the new rooms, thus clearing the path for the construction of the three new consulting rooms. The estimated time for this work was five weeks. Work on the first floor and all outside work was to be done at the builder's convenience. I was living on the first floor at the time and said that I would vacate the accommodation as soon as the builder wished.

Work started on 24 February 1982 with the preparation of the two temporary rooms; these in fact proved to be a substantial improvement on what we had been using hitherto.

FIG 2—Waiting room

Phase 2 began on 8 March and was completed by 2 May 1982. The builder had started work on the first floor at the end of March, when I moved out. All branches of the building trade were concerned, often working concurrently, and seldom were there fewer than four workmen on the site. A very happy level of cooperation was achieved between the working side of the practice and the builder and his work force. Patients' acceptance of the inevitable minor inconveniences to them was helped by being able to see the work in progress and by knowing that the improvements would be largely for their benefit. The builder kept to his timetable, although work beyond that originally specified increased the time required by about two weeks. Phase 3 of the work was completed by 19 June 1982, and the practice was able to take over the whole building.

This is the second of three articles.

AVERSION THERAPY IN 1837. A native of Norway, aged forty, who had from his youth been accustomed to drink-drinking, was attacked with delirium tremens. His medical attendant, to cure him of his dangerous propensity, prescribed the daily use of a mixture of two drachms of sulphuric acid and twenty-four ounces of whiskey. The result was remarkable: in three months' time he got such a dislike to all kinds of spirituous liquors, that he could not bear to swallow a drop of anything stronger than beer. The dose of the above mixture taken was four wine-glasses daily, and the cure had been of a year's standing at the time of the communication of the case. (*British and Foreign Medical Review* 1837, 3:231.)

General Practice in the Year 2000

General practice in full bloom

ALASTAIR G DONALD

"The Royal Banquet, held in the Guildhall, to mark the dawn of a new millennium was a glittering and impressive occasion. Her Majesty The Queen, recovered from her recent indisposition, paid fulsome tribute to the place of medicine in our society, with particular reference to general practice. The president of the Royal College of General Practitioners and the chairman of the General Medical Services Committee were accorded places of honour and sat on either side of the Archbishop of Canterbury. The discerning spectator observed that both ladies were wearing dresses of similar shades but of contrasting design—a fact that was disguised, however, by the gift of the chairman of the GMSC which, in the tradition of that office, was substantial, and contrasting with the slender stature of the president of the RCGP, befitting perhaps such a staunch protagonist of preventive medicine. In a provocative article under the heading "Were these Freudian slips?" the medical weekly *Palladium*, suggested that the crimson gowns worn by these distinguished medical ladies were in fact metaphorical red rag. The bulls were not identified."

A Hundred Years On, RCGP Press, 2005

A review of British general practice in the year 2005 is entirely appropriate since the year 1965 was an annus mirabilis which changed the course of primary care in Britain for a generation. The happy congruence of the planets that brought together an enlightened Labour Party Minister of Health, Kenneth Robinson, and a brilliant medical politician, James Cameron, produced a charter in that year that was to lift British general practice from its "cottage industry" (image to a position befitting one of a great profession. Then, in the same year, responding to earlier stimuli from Lord Cohen and Dame Annis Gillie, the Royal College of General Practitioners produced its first report from general practice, *Special Vocational Training for General Practice*, which set the pattern on which the whole structure of postgraduate medical education for general practice was subsequently based. These twin pillars of structure and of process had offered British general practice a unique opportunity to arrest the decline that followed the introduction of the National Health Service and to redress the failure of British general practitioners a century earlier to establish for themselves a position in medical society comparable to the narrower specialty disciplines.

The year 2000 was not itself remarkable for any particular innovation but was a standpoint to review the changes in British general practice that stemmed from that remarkable period in the mid-1960s. The year 1982 had provided a further educational landmark with the introduction of mandatory vocational training under the National Health Service Act of 1977, but it was not until 1990 that the full impact of two documents produced in

Edinburgh EH8 6AE

ALASTAIR G DONALD, FRCS, FRCP, regional adviser in general practice, south east Scotland, and chairman, Joint Committee on Postgraduate Training for General Practice

the late 1960s was fully felt. The statement on basic medical education by the General Medical Council in 1967 had declared that the aim of undergraduate medical education was no longer to produce a "safe" doctor, but rather a "basic" doctor, who required specialist vocational training at postgraduate level. The Royal Commission on Medical Education in 1968 (Todd report) set the pattern for that postgraduate structure by proposing three years of "general professional training" for all doctors before proceeding to more specialised "further professional training", but these recommendations were never implemented. Twenty years after that report, however, general professional training was rediscovered and introduced for all doctors with whatever specialty interest. As so often in life it was not the sheer common sense of the proposals that prevailed but rather the pressures of realpolitik because the older established royal colleges discovered that accelerating specialty interests they were less and less able to present integrated policies and thus were losing influence, while their middle grade staff, arrested in their career advancement, found it difficult if not impossible to transfer to general practice because of the limitations imposed by the NHS Acts, which were made more stringent under the amendments of 1987. General professional training therefore was finally introduced with an appreciable impact on the whole of medicine and allowed general practice to develop an integrated postgraduate training of five years' duration, incorporating three years of general professional training followed by two years of further professional training in general practice. The duration and quality of training for general practice thus became comparable with that of the other specialties, and the weakness of British general practice identified by Dame Annis Gillie in 1963 was finally corrected—namely, its academic standard of entry.

Articulate doctors

But the changes in postgraduate education allowed even more fundamental adjustments in the undergraduate curriculum, which in the year 2000 were at last beginning to benefit the whole of medicine. Observers of the 1960s must have been incredulous at the content of undergraduate medical education, which succeeded in taking the most brilliant of the nation's schoolchildren—highly motivated, articulate, and with wide cultural interests—and over five or six years converting them into subdued stereotypes who could communicate with patients only with difficulty but were dedicated to collecting data. Reflecting, perhaps, that the great strength of Scottish medicine, and of the Edinburgh Medical School in particular 200 years earlier, lay in the breadth of its curriculum, which allowed a freedom of choice to students, undergraduate medical education was radically reviewed, and English literature, history, moral philosophy, and communication skills found places in the curriculum at the expense of basic sciences. The medical faculties became the source of some brilliant university debaters, and doctors once again influenced beyond their discipline the society

in which they lived. Junior hospital doctors, in their renewed confidence, no longer thought it necessary to disguise themselves as ancillary staff.

In 1991 it had become mandatory for all principals in general practice to hold the membership diploma of the Royal College of General Practitioners. This had not been the wish or intention of the college and for many years the GMSC had vigorously opposed it, but this policy was reversed largely as a result of the successful action brought by Mrs Robins of the Patients Society against a practitioner who was not a member of the college. In his summing up Lord Denning had declared, "It, graduate in medicine from a university is simply to demonstrate competence to enter specialty training. To practise in a specialty as important as general practice without any further assessment of competence by the profession is to expose a doctor to the risk of challenge of his professional skill in the courts. Duration of training, however satisfactorily completed, is not, in itself, a substitute for formal assessment." After this judgment the defence societies increased substantially their subscription rates for practitioners who were not members of the college, which led the GMSC, not unimpressed of a growing General Medical Council, to recommend that all entrants to general practice should obtain membership of the college. Far from being a retreat by the GMSC, this action led to the most fruitful period of cooperation between these two bodies and to a renaissance of primary care, which was at last sufficiently funded to allow for the first time an efficient and cost effective deployment of the high level of skills available to the community from the extended educational programmes.

Responsible patients

One of the striking features of general practice in the year 2000 was a change in the relationship between doctor and patient, placing greater responsibility on the shoulders of patients. Much was written a generation earlier about "the doctor-patient relationship" while the contract between general practitioner and government was a feature of earlier years in the NHS. The year 2000 saw the introduction of a new style of contract between doctor and patient. This had taken many years to develop and had been opposed in many quarters, but finally agreement was reached on a range of contracts to be negotiated between patients and general practitioners. The object of these contracts was to identify the patient's own responsibility for his health and well-being. To obtain access to the full range of medical services free of charge a patient had to promise to take a moderate amount of exercise, to abstain from smoking and excessive consumption of alcohol, to maintain his weight within agreed limits, and to pursue a hobby. In return the patient then had unrestricted access on demand from the general practitioner services, provided that the patient agreed to undergo a series of routine screening checks carried out by practice nurses. Mothers who repeatedly failed to attend for antenatal examination or to bring their children for immunisation received reduced allowances. In the same way patients who were heavy smokers or consumed excessive quantities of alcohol had reduced priorities on medical services and received low priority on waiting lists. Conversely, of course, those who fulfilled their health responsibilities were rewarded.

It was easy for the patient in the year 2000 to obtain professional advice in his own home since his television set gave him access to videodata through which he could present his symptoms and shared his way down a diagnostic pathway leading to prescription of treatment. Medicines could then be ordered from a chemist through the same system and treatment begun

without personal contact with a doctor. Electronic publishing through systems of videodata was also the standard means of providing constantly updated information to practitioners in their surgeries and in their homes. Pre-prescriptions were automatically processed by microcomputers constantly updated from a central unit to safeguard against possible drug interaction.

The safety of medicines had advanced immeasurably from the mid-1980s after the compulsory introduction of postmarketing surveillance, and drugs were licensed earlier than before, provided that the Royal College of General Practitioners through its continuous morbidity recording was able to monitor 10 000 patients on any new drug for one year. After this full licence was obtained if side effects were within an acceptable range, having regard to the therapeutic purpose of the medicine. This system was completely computerised and had been introduced with far less difficulty than either the government or the pharmaceutical industry had envisaged and in fact placed Britain in the forefront of countries in respect of safety of medicines. The unique opportunities of the medical records of the NHS had been belatedly recognised and placed the British pharmaceutical industry at enormous advantage in relation to its international competitors, since they had priority access to surveillance systems and thus the earlier marketing of their products.

The general practitioner then of the year 2000 was a recognisable descendant from his predecessor of the early 1980s, owing, however, much to an older tradition in medicine when it was the mother of sciences and extended its cultural influence throughout society. The general practitioner of the year 2000 was a personal doctor to his patients—in some ways more than ever before—because of the unremitting advance of medical technology requiring that the overzealous specialist should be restrained and thus wisdom was sometimes at a premium. The temptation for a parent, for example, to wish to eradicate unwanted genes from an unborn child was great, and it often fell to the general practitioner to offer counsel in this frightening world of bioengineering, where scientific logic threatened to eradicate human eccentricity. It was the general practitioner who had to represent the interests of his patients and help to steer a pathway through a bewildering world of medical technology.

At the close of life obituary interventions to maintain life were increasingly reported. The year 2000 saw the publication of the report of a select committee entitled "Dying with Dignity," which permitted a person to appoint three executors (not more than one being a relative or a person with financial interest) who were allowed, should the situation arise, to decide whether a person should be allowed to die without further medical intervention.

By the year 2000 it was appreciated that there was no such thing as a truly "general" practitioner, but that there was a range of personal doctoring in an age of high technology where the quality of relationship between doctor and patient was valued as highly as any technical expertise, although the two were by no means incompatible. More than half the medical profession were general practitioners, and they practised in many different styles and places. Enlightened governments concentrated their services where they were needed most—the inner city task forces became particularly successful—while doctors, and indeed the whole primary care team, developed special skills fitted to the environments in which they worked. To be a general practitioner was the ultimate aim of every young medical student, and it was no wonder then that competition to enter practice was so great. No wonder also that its leaders were given a special place of honour at that Royal Banquet.