Middle Articles

GENERAL PRACTICE OBSERVED

Hythe Medical Centre—an Appraisal

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The Hythe Medical Centre has been working for two years—too short a time for full assessment. I feel, however, that interest in the health centre concept has developed so rapidly that objective criticism can now be useful. The opinions expressed are my own, and I hope will lead to further discussion and perhaps a truer picture. The centre was described when it was opened (*B.M.J.*, 3 July 1965, p. 42), and not long afterwards your Special Correspondent (*B.M.J.*, 11 December 1965, p. 1425) recorded comparative attitudes to the centre and our group practice centre at Blackfield.

The Centre

The centre is attached to Hythe General Practitioner Hospital and provides accommodation for three general-practitioner firms, visiting consultants, and local authority services, including a school dental unit, child psychiatric clinics, and speech and audiology clinics. It contains a new casualty department, a small x-ray unit, and facilities for electrocardiography. The pathology room is available mainly for consultative advice, for specimen collection, and as a depot. The name "medical" rather than "health" centre seemed to describe its function more aptly. The hospital has 22 beds—11 maternity and 11 general—and a physiotherapy department. The reception and office are managed by an administrative officer appointed by both county and hospital boards, with a staff of 11 part-time secretaries. The records include those of the N.H.S., the consultant sessions, and the school medical service. Health visitors and district nurse-midwives are attached to practices and work from the centre.

History.—Hythe lies between Southampton Water and the New Forest. Southampton is 11 miles (18 km.) away by road. Between Hythe and Fawley is an industrial belt which includes the Fawley Refinery. In 1959 the three larger practices in the area were beginning to think of increasing their surgery accommodation because of the steady rise in the population. As a group of doctors we knew each other well. We shared a general practitioner hospital and had founded our own medical society. Some of us had already sought special help from the county medical officer, who had allowed health visitors to assist in running our baby clinics. It was he who approached us to seek advice in siting a proposed welfare clinic, and then entered with enthusiasm into our common interest in the possibility of a comprehensive health centre. Although Hythe Hospital was already listed for closure under the hospital plan, we insisted that the centre must, so far as was possible, be combined with it. A desire for more accommodation and better diagnostic facilities had broadened to include an ambitious scheme to lower the barriers within the tripartite health service in our part of the country.

Planning.—This seemed incredibly difficult. Our main difficulties were that agreement in policy lagged behind design. Considerable time could have been saved if we had decided on the basic design of surgery accommodation and the various sections of the building before the building itself was discussed. Planning of centres will now be easier with access to existing centre designs. The most depressing delay occurred because ministerial study of the plans took more than 10 months. A great improvement should now accrue from the formation of a ministerial department with special knowledge of health centres. Expert criticism should help to remove faults in design and may even speed building. In retrospect I regret our too ready acceptance of parts of the building which did not then seem to be our direct concern. In fact, every aspect of work in a health centre is in some way important. I am sure, too, that where costs have to be reduced the plans should be discussed by the doctors themselves. We could have suggested several items that might have been omitted without detriment. The most notable feature of planning was a committee representative of all three branches of the Health Service in the area.

The Building

The building is attractive, bright, and pleasant to work in. The three main wings meet at the reception and office area and the main entrance. In criticizing lay-out and shape, I think points may be made in favour of a design based on a "circulation diagram," avoiding the necessity of everyone tending to meet at one point. The single-storey building saves building costs but increases the spread and the distance to be walked. The tile floor covering is attractive and wears well, but I would now be in favour of carpet over concrete, with a lessening of noise.

Each general-practitioner suite comprises two consulting-rooms with two intervening examination rooms. This arrangement is ideal for antenatal and baby clinics, for a midwife or health visitor can then use the second consulting-room. I miss a secretary/nurse close at hand, and a great improvement would be a small practice office for her, with space for the health visitor. Our real failure was in the design of the office and reception area. Doctors' secretaries need more privacy and space, and problems arise from the grouping of several telephones in a constricted area. Our open counter with adjacent office space is about to be screened and secretaries will be given more room. If there is a central office the practice suites must be next door. Two of ours are much too far away.

Adjacent to the centre is an ambulance station, which ensures speedy transfer of patients from the maternity unit or casualty department to the major Southampton hospitals.

Administration

One of the major advantages to the patient is the availability of his or her own doctor, consultant, health visitor, and district nurse-midwife, and diagnostic services under one roof. Appointments can usually be arranged with great ease at the same counter. The charge that in health centres a patient is less able to see his own doctor is unfounded. Where real difficulty does arise is in the impossibility of several secretaries,

Perhaps midwives will one day go out from the hospital and work in the district. A mental welfare officer works from the centre. His help to our patients and to ourselves is of great value. A common room is available to everyone. Here one may meet the children's officer, the probation officer, or the parish priest.

In the Hythe area each school has a general-practitioner medical officer. We usually work with a health visitor from

1. Entrance hall.
2. Reception.
3. Card index.
4. Pram shelter.
5. Corridor.
6. Waiting.
7. Recovery room.
8. Minor operations.
9. Consulting room.
10. Examination.
11. Sluice.
12. Treatment.
13. Nurse.
14. Cloaks.
15. Store.
16. Trolleys.
17. Link to hospital.
18. Toilet.
19. Laboratory and store.
20. Anteroom.
21. Urine test.
22. Health visitor.
23. Kitchenette.
24. Staff common room.
25. Office.
26. Playroom.
27. Interview.
28. Records.
29. L.H.A. medical room.
30. Dark room.
31. Lecture hall.
32. Caretaker and meter room.
33. Dental surgery.
34. Red Cross store.

often interchanging duties, knowing one's practice and the idiosyncrasies of the patients as did the doctor's wife or practice secretary. So far as possible one secretary for each practice copes with the visiting-list, repeat prescriptions, and practice business during the morning surgery. One secretary arranges appointments for the three practices. In my view the real problem in health centres is the maintenance of family practice in which the doctor is not too "distant" and the secretary is able to allay the anxieties of the patient. I think a nursing or paramedical training will become increasingly necessary for a secretary. After all, it is she who decides on priorities.

General Practice in a Health Centre

How has our work altered? Can we give our patients a better service? I find the environment good for medicine and the ease of consultation with specialist and colleagues an advantage. The greatest advance, perhaps, is in the growing use of the medical team as a unit in general practice—the family doctor, the health visitor, and the district nurse-midwife. I am now more conscious of being a personal doctor than before. Can you really be one with an N.H.S. list of two to three thousand and no help? Close proximity to the hospital ensures that the doctor is quickly available to the labour ward or casualty department. Antenatal clinics can cover both hospital and district cases with help from both hospital midwife and district nurse-midwife. The health visitor broadens the work of the practice and shares its burden.

The casualty department and practice treatment room will soon be combined, with a resultant saving of nursing time. District midwives can deliver short-stay cases in hospital.

another practice, and thus between us know two-thirds of the children seen.

An Integrated Medical Service

At Blackfield, 5 miles (8 km.) away, we have a group practice centre to look after the other half of two of the practices. An automatic exchange links the two centres. A group practice centre certainly has the advantage of speed in building. Here, too, changes in structure or policy can be rapidly implemented. I think that a health centre is the answer when integration with a hospital or with local health authority services on a large scale is envisaged, but otherwise private enterprise is certainly less cumbersome. Twelve doctors work from the two centres, and provide the area with an integrated medical service. A house committee meets at Hythe; it consists of our hospital matron, administrative officers of hospital and centre, and doctors from each practice. Hythe Medical Society continues to fulfil a most important role in linking us together and enabling us to meet our consultant colleagues professionally and socially. The three practices, however, retain their complete identity and do not share a rota system except for casualty work.

The Future

A health centre should be an ideal place for planning health education, and we have started some schemes here. This centre should also make a good base for general practice research, but so far no plan has been adopted. It is possible that we would

need expert advice, with secretarial and financial assistance. Time spent on consultation increases steadily, and it is thought that time could be saved by bringing some patients to us by special transport arrangements.

Plans are advanced towards setting up a high-frequency radio link between the centre, doctors, and midwives. The suggestion has been made that doctors working from health centres should be salaried. We have no wish for this, and seek to retain our independence. Finally I am sure that this centre must remain an experimental venture, and also that there must be pooling of knowledge on the design and administration of health centres to aid their future development in this country.

STUDENT HEALTH

Hospital Admissions among Students during a Three-year Period

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A recent leading article in the *British Medical Journal* (1967) discussed the special arrangements needed for the management of psychological problems among university students. It also contained the following comment about their physical health: "He [the student of 30 years ago] suffered from influenza, the occasional inflamed appendix, and athletic injuries . . . The incidence of these physical maladies has altered little." In other words, students are to be regarded as a comparatively healthy group exempt from serious illness or disability. How true is this?

Reference has been made to the prevalence of chronic illness and to the special problems of handicapped students who, as a result of a more enlightened educational approach, are reaching university in increasing numbers (Grant, 1960). In a report of the Expert Committee on University Health Services (W.H.O., 1966) the suggestion is made that, in fact, a "wide range of acute and chronic medical and surgical disorders is seen." A brief study of the reasons for admission to hospital among students attending the University of Newcastle upon Tyne during a three-year period (September 1963 to August 1966) certainly lends support to this view.

Sources and Nature of Information

Shortly after its inception in 1963 arrangements were made for the university health service to be notified of the admission of students to the main teaching hospital in the area. Initial information about admission to other hospitals was obtained from medical certificates accounting for absence from studies, copies of which were sent to the health service by the university administration. Information came also from tutors and the wardens of halls of residence who were concerned about the implications of absence through illness or injury, which in some instances had occasioned admission to hospital either in the student's home town or elsewhere.

Clinical information was obtained in a number of ways. As the period covered by the inquiry progressed, an increasing number of students were registered with the university health service general practice, and reports about hospital admissions among them were received in the usual way, but in a number of instances follow-up inquiries had to be initiated as a result

Summary

An attempt is made at an objective criticism of the Medical Centre at Hythe. Some suggestions are included regarding possible planning for future health centres, particularly in relation to reception and office arrangements.

The main advantages of health centre practice are the availability to the patient of his or her own doctor and easy access to consultant advice and diagnostic aid.

The centre encourages the concept of a medical team in general practice. Together with a neighbouring group practice centre the area now has an integrated medical service.

of information received from one or other of the sources mentioned in the foregoing paragraph. Sufficient diagnostic information was invariably available for purposes of simple classification.

It is inevitable that a survey of this kind should be incomplete. In particular, information about admissions during university vacations is likely to have been defective, though knowledge of admissions during term will have been more reliable.

Results and Discussion

Student numbers (postgraduates included) varied somewhat from year to year during the three years under review, with a mean annual figure of 4,610. Approximately one-quarter of the students were women.

During the three years 213 men were admitted to hospital on 229 occasions for the investigation or treatment of 215 different conditions, and 120 women were admitted on 129 occasions for 124 conditions. Altogether, therefore, 333 students were admitted on 358 occasions for 339 conditions. There was little annual variation in the proportions admitted, and a reasonable interpretation of the findings would be to say that annual admission rates were between 2 and 3% of the total population at risk, with, as might be expected, a somewhat higher proportion of women admitted than men. Analysis of causes of admission into broad categories according to the *International Classification of Diseases* is given in the Table. In some instances diagnostic descriptions have been adapted or modified for the sake of brevity. Because of the small numbers in some of the subgroups, the findings in the sexes have been combined. Much of the Table is self-explanatory, but five of the items call for special comment.

Group V

Mental, psychoneurotic, and personality disorders predominated as a cause of admission. (In fact, 36 men were admitted on 47 occasions and 24 women on 28.) The difficulties of psychiatric diagnosis among late adolescents and young adults are well known, and though the neat classification given in the Table may not be entirely accurate it reflects the spectrum of psychological disorders among students and underlines the importance of adequate facilities for dealing with them. The majority of students are, of course, living away from home,

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