

Middle Articles

GENERAL PRACTICE OBSERVED

Inquiry into Administrative Activities in General Practice

M. DRURY,* M.R.C.G.P. ; E. V. KUENSSBERG,† C.B.E., F.R.C.G.P.

British Medical Journal, 1970, 4, 42-44

The Royal College of General Practitioners and the Association of Medical Secretaries made a survey of administrative work in 140 practices in 1969. The practices were chosen because they were known to be interested in practice organization. The investigation was to find the range of delegation that had been reached and any deficiencies. A questionnaire was used.

Method

The first part of the questionnaire was completed by one doctor describing the practice. The second consisted of questions which were answered by each member of the staff, including wives, where appropriate, and nurses, who performed some administrative activities. They were asked about hours of work and the frequency of each activity.

Findings

The distribution and numbers of doctors and staff are shown in Table I. Many of the staff work part-time. If a full-time worker works 38 hours a week the number of nominal full-time workers is given by

$$\frac{\text{Total worker-hours per practice}}{38} = x \text{ workers}$$

It will be seen from Table II that single-handed doctors use significantly more workers per doctor than all other

TABLE I.—Distribution of Doctors and Staff

	No. of Doctors in Practice						
	1	2	3	4	5	6	7
No. of practices	31	25	28	28	15	8	5
No. of staff (not necessarily full-time)	57	66	105	110	74	60	37
Average No. of staff per group	1.84	2.64	3.75	3.9	4.93	7.50	7.40
Average No. of staff per practitioner	1.84	1.32	1.25	0.95	0.98	1.25	1.05

TABLE II.—Average Number of Workers Per Practice and Per Doctor in Practice on 38-hour Week

	No. of Doctors in Practice						
	1	2	3	4	5	6	7
Average No. of workers:							
Per practice	1	1.7	2.5	2.8	4.0	5.4	5.8
Per doctor	1	0.85	0.83	0.7	0.8	0.89	0.83

groups; four-man practices use significantly fewer. Within each group of practices with similar numbers of doctors (Table III) there was great variation in the number of staff hours worked. No relation between staff hours and number of patients per doctor seemed to exist. The average number of outside hours worked per doctor and staff hours per

doctor in practices of different sizes are given in Table IV. The great variations in general practice are reflected here, but there is no simple relation between staff hours used and number of outside hours of work done by the doctor.

The average number of staff for each group of doctors is given in Table I, but the variation within the groups of practices is shown in Table V. A high proportion of staff are employed part-time (see Table VI).

TABLE III.—Number of Staff Hours Worked Per Doctor

No. of Patients per Doctor	No. of Doctors per Practice				
	1	2	3	4	5
2,000	25.6	35.5	25.4	17.8	22.3
2,000-2,499	51.0	23.2	27.5	29.3	24.8
2,500-2,999	41.8	38.8	32.5	25.1	31.3
3,000	37.2	41.7	30.6	25.8	31.5

Numbers of six- and seven-doctor practices too small for calculation of meaningful figures.

TABLE IV.—Number of Outside Hours Worked by Doctor

Staff Hours Worked Per Doctor	No. of Doctors in Practice				
	1	2	3	4	5
<i>Practices with Fewer than 2,000 Patients Per Doctor</i>					
25	5.7	9.8	3.7	5.1	5.3
25-39	0	4.0	5.0	0	3.8
40	0	3.8	0	0	0
<i>Practices with 2,000-2,499 Patients Per Doctor</i>					
25	6.0	5.3	0.9	3.5	1.9
25-39	0	1.8	3.7	1.3	1.3
40	7.6	0	0	2.4	3.5
<i>Practices with 2,500-2,999 Patients Per Doctor</i>					
25	0	5.0	1.0	4.8	0.5
25-39	2.5	9.0	1.2	1.5	1.3
40	3.4	4.3	4.0	0	4.7
<i>Practices with 3,000 or More Patients Per Doctor</i>					
25	0	2.0	2.3	0.8	0
25-39	7.1	1.7	8.0	4.2	0.1
40	3.8	4.8	0	2.5	4.2

TABLE V.—Variations in Number of Staff Employed by Practices (Practices given as Percentage)

No. of Staff	No. of Doctors in Practice						
	1	2	3	4	5	6	7
1	38.6	16.0	7.1	—	—	—	—
2	48.4	28.0	17.9	14.3	—	—	—
3	6.5	40.0	25.0	25.0	33.3	—	20.0
4	6.5	12.0	21.4	39.3	13.3	—	—
5	—	—	14.3	7.1	26.7	25.0	—
6	—	4.0	3.6	7.1	6.7	25.0	20.0
7	—	—	7.1	3.6	6.7	12.5	20.0
8	—	—	3.6	3.6	—	25.0	—
9	—	—	—	—	13.3	—	—
10	—	—	—	—	—	—	20.0
11	—	—	—	—	—	—	20.0
15	—	—	—	—	—	12.5	—

TABLE VI.—Percentage of Staff Working Part-Time

Hours Worked	No. of Doctors in Practice						
	1	2	3	4	5	6	7
2-9	22.8	12.1	11.4	5.5	4.1	8.3	2.7
10-19	15.8	12.1	20.0	15.5	18.9	16.7	13.5
20-29	31.6	33.3	23.8	35.5	14.9	30.0	32.4
30-42	26.3	42.4	43.8	43.6	62.2	45.0	51.4
Not given	3.5	—	—	—	—	—	—

* Chairman, Association of Medical Secretaries, and General Practitioner, Worcester.

† Chairman, Practice Organization Committee, Royal College of General Practitioners.

The figures for individual practices show that those employing full-time staff (38 hours or more per worker per week) use fewer staff hours overall than those using a combination of part-time staff. This does not mean that it is more or less efficient to employ full-time staff, but practices employing full-time staff include a wider range of activities than those employing part-time staff (Table VII). These

TABLE VII.—Percentage of Practices Employing Staff of Various Categories

	No. of Doctors in Practice						
	1	2	3	4	5	6	7
Receptionist ..	35.1	37.9	41.0	49.1	44.6	56.7	54.1
Secretary ..	10.5	12.1	8.6	7.3	4.1	3.3	8.1
Secretary/receptionist ..	31.6	36.4	30.5	26.4	32.4	18.3	21.6
Secretary/administrator ..	—	—	1.0	1.0	2.7	3.3	—
Clerk/receptionist ..	5.3	4.5	5.7	5.5	1.4	6.7	5.4
Medical social worker ..	—	—	—	1.0*	—	—	—
Radiographer ..	—	—	—	1.0*	—	—	—
Laboratory technician ..	—	—	—	1.0*	—	—	—
Physiotherapist ..	—	—	—	1.0*	—	—	—
Nurse/receptionist ..	14.0	—	4.8	2.7	6.7	5.0	2.7
Dispenser/receptionist ..	—	1.5	1.9	2.7	4.1	3.3	—
Caretaker/receptionist ..	1.8	4.5	1.9	—	1.4	—	2.7
Research secretary ..	—	—	1.0	—	—	1.7	—
Book-keeper ..	1.8	1.5	1.9	1.0	1.4	—	2.7
Practice administration supervisor ..	—	1.5	1.9	—	1.4	1.7	2.7

*One practice.

findings show that it may be more efficient to employ one full-time worker than two part-time workers doing the same number of hours.

The titles used are deceptive. Of those called receptionists 45% also do secretarial duties and 90% of the secretaries do reception duties. Receptionists, secretary/receptionists, and clerk/receptionists between them deal with 90% of the filing. Even in practices with the largest numbers of staff there is a tendency for all major administrative activities to be shared among the staff.

The hours worked by the various categories of staff are shown in Table VIII. The relation of work done by staff to their normal staff category and to their qualifications and

TABLE VIII.—Hours Worked by Staff of Various Categories

	Code	No.	Hours Worked		
			Total	Average	Range
Receptionist ..	01	228	5,647	24.8	2-48
Secretary ..	02	38	1,025	27.0	2-43
Secretary/receptionist ..	03	147	4,477	30.5	5-50
Secretary/administrator ..	04	6	190	31.7	19-42
Clerk/receptionist ..	05	25	596	23.8	3-40
Medical social worker ..	06	2	61	30.5	6-55
Radiographer ..	07	1	16	16.0	—
Laboratory technician ..	08	1	21	21.0	—
Physiotherapist ..	09	1	3	3.0	—
Nurse/receptionist ..	10	25	622	24.9	5-44
Dispenser/receptionist ..	11	11	418	38.0	22-44
Caretaker/receptionist ..	12	8	161	20.1	2-40
Research secretary ..	13	2	26	13.0	—
Book-keeper ..	14	7	65	9.3	2-25
Practice administration supervisor ..	15	5	209	41.8	38-50
Total ..		507	13,537	26.7	2-50

previous training was analysed. Of those with nursing qualifications 85% were used regularly for reception duties, 50% for executive council administrative procedures, 90% for making appointments, 60% for sorting mail, and 12% for book-keeping. Of those holding secretarial qualifications 40% tested urine, 30% weighed and measured, and 15% did dressings. The trained medical secretaries regularly carried out all the listed duties, and of the seven book-keepers five did reception work, two regularly tested urine and weighed and measured patients, and one regularly did dressings.

Administrative Activities Done by Staff

The 507 administrative staff were asked to record the frequency of a number of activities. The results were analysed to show the percentage of practices in which the

TABLE IX.—Percentage of Practices in which Certain Administrative Activities were Performed by Staff

	No. of Doctors in Practice						
	1	2	3	4	5	6	7
Shorthand ..	45	77	93	82	93	100	80
Dictaphone typing ..	48	54	64	61	73	75	80
Operate telephone exchange ..	45	88	89	89	80	87	80
Executive council administration procedures ..	93	92	100	96	100	100	100
Deal with visit requests ..	97	96	100	100	100	100	100
Operate appointment system ..	84	85	90	100	100	100	80
Check in appointments ..	84	88	96	96	100	100	80
Make hospital appointments ..	93	96	100	96	93	100	100
Sort mail ..	87	88	100	100	100	100	100
File and sort letters from specialists ..	100	100	100	100	100	100	100
Abstract from specialists' reports ..	61	38	61	61	53	62	80
Handle medical records envelopes for consultations ..	87	85	100	96	100	100	100
Handle medical records envelopes for visits ..	97	88	93	93	93	100	100
Help doctor in consulting room ..	61	36	61	75	73	75	100
Chaperone ..	68	58	77	75	87	75	100
Test urine ..	61	50	61	86	60	87	100
Weigh and measure ..	52	42	54	68	58	75	80
Assist at minor procedures ..	55	58	43	68	73	62	60
Do dressings ..	33	19	43	46	33	62	60
Take pathological samples ..	23	15	11	32	33	62	20
Care for medical equipment ..	58	58	61	68	87	75	100
Operate E.C.G. machine ..	6	0	3.6	6	16	12	0
Operate haemoglobinometer ..	13	11	3.6	57	13	0	0
Send accounts ..	71	77	84.7	99	93	100	80
Pay bills ..	64	73	82	79	80	87	80
Pay wages ..	48	50	75	82	80	87	80
Staff deductions ..	64	65	75	68	73	75	80
Keep research statistical records ..	90	85	71	79	73	75	60

frequency occurred (Table IX). The figures for all activities are reduced by about 5% if one includes only practices where they are a regular part of the duties. All activities in one- and two-doctor practices are reduced by from 10 to 20% if the activities done only daily or at least once a week are included.

Training of Staff

The doctors were asked what training they would have liked their staff to have; 71% said that they would prefer to have staff who had been previously trained while 10% would prefer to train their own. About 15% of all staff had had special training for their jobs (Table X). In most practices the administrative staff were given a high degree of responsibility, for over 90% stated that they were asked to exercise discretion in deciding on the urgency of requests for visits and requests for consultation appointments.

TABLE X.—Percentage of Staff with Professional Qualifications (Included in Administrative Activities)

	No. of Doctors in Practice						
	1	2	3	4	5	6	7
Nursing ..	17.5	4.5	11.4	10.9	12.2	8.3	8.1
Dispensing ..	—	1.5	1.0	—	4.1	3.3	—
Technical ..	—	—	—	1.0	—	—	—
Book-keeping ..	5.3	3.0	8.6	2.7	4.1	8.3	2.7
Shorthand ..	17.5	16.7	21.0	19.1	20.3	16.7	18.9
Typing ..	24.5	22.7	25.7	24.5	25.7	16.7	21.6
Secretarial ..	14.0	9.1	8.6	7.3	16.2	5.0	—
Medical secretary ..	3.5	3.0	1.0	5.5	6.8	—	2.7
Executive council course ..	1.8	—	—	—	—	—	—
Other ..	—	3.0	4.8	6.4	2.7	—	2.7

Discussion

The most striking finding was the large variation between staffing structures and methods of working in apparently similar practices. There was no uniformity in job description, staff classification, or delegation of administration. The inquiry confirms that each practice obtains staff from whatever sources are available and moulds them to its needs and the degree of sophistication and specialization it is prepared to develop. The financial disincentive of the 1969 reimbursement scheme may be a barrier to the employment of some highly qualified staff. This variation is an inherent quality

of the doctor and his staff and it must therefore be due to the individual doctor's failure or success in delegating administration, or to his failure or success in obtaining and training staff to whom he can delegate.

There was not one of the activities listed in Table IX which was not carried out by administrative staff in some practice. It might be argued that some—doing dressings or taking pathological samples—were more properly the function of a nurse; that others, such as operating an E.C.G. machine or a haemoglobinometer, were peculiar to certain practices only.

It is apparent that many research and statistical records kept in a high percentage of practices are of a very simple operational nature. Nevertheless, in a proportion of practices nearly all these activities were regularly performed by staff, and if in some why not in all? There are two reasons. Firstly, doctors may not be aware of how much work can be done by staff. Secondly, there are no trained staff employed to whom this work can be reliably delegated, or the practitioner underestimates the capability of his staff or has other scruples.

Solutions

There is clearly a need for practices to be furnished with information on the organization of administrative work. Only simple skills are required to cover efficient handling and storage of records, normal office practices, management of efficient appointment systems, and efficient handling of all incoming and outgoing communications. The office side of gen-

eral practice needs to be run as efficiently as the office side of any business organization. The problem of part-time against full-time employment is conditioned by the variety of general practice but may be rooted in the traditional hours still worked in general practice—morning and late afternoon consulting sessions requiring split shifts. The late finishing, though much earlier than some years ago, around 6 p.m., makes it necessary to have part-time workers to cover the hours from 4.30 to 6.30 p.m. to allow full-time staff who have been on duty from 8.30 a.m. to finish at 5 p.m. Less skilled people may be employed on a part-time basis at a lower wage in preference to a fully trained experienced person making a life career in this employment at a very much higher salary. It appears that at least 32 staff hours per doctor are required and that, as it may be more efficient to employ full-time rather than part-time staff, about one administrative worker is necessary per doctor. Most doctors would like staff to be trained before employment. Most doctors use "generalist" staff rather than "specialist" staff. The figures in Table VII are interesting, as they indicate clearly that the large groups are in fact beginning to use their staff in a specialist way. It is likely that there is a critical size above which it pays to use specialist book-keepers, filing clerks, etc., and, as yet, doctors do not work in groups of this size.

We thank the staff and the doctors of the surveyed practices for their help. We are also grateful for the valuable help of Dr. Donald Crombie and Mrs. P. J. Jones, of the Research and Statistical Unit of the Royal College of General Practitioners, Birmingham.

Reprints and a list of doctors who took part in the survey are available from E. V. K., 191 Crewe Road North, Edinburgh EH5 2NT.

Design of Surgery Premises and Employment of Nurses

IVOR COOKSON,* M.B., F.R.C.G.P. ; F. W. MILLARD,* M.B., M.R.C.G.P.

British Medical Journal, 1970, 4, 44-46

Summary: The surgery premises of many general practitioners have no accommodation for a nurse. Some have only a nurse/treatment room away from the consulting and examination rooms. Modern designs are no better, and are inadequate in view of the present trend to employ more nurses in group practices. Much of the value of a nurse is lost if she cannot help patient and doctor at the time of examination. The premises described here were designed to enable her to do so by combining the treatment room with a clinical room and a set of examination rooms.

Introduction

In recent years there have been many reports of employment of nurses in general practice (Baldwin, 1967; Marsh, 1967; Pinsent, 1968; McGuinness, 1970), and many relating to design of general-practice premises (*British Medical Journal*, 1965; Whitaker, 1965; Ministry of Health, 1967; National Building Agency and College of General Practitioners, 1967). There is, however, little or no literature relating to premises specifically designed so that a group of general practitioners can make full use of the aid that nurses can give.

Some of the published plans show no accommodation for a nurse at all. Some, especially local authority health centres, show a treatment room at a distance from some if not all of the examination rooms. It is evident from such a plan that the intention is to delegate to the nurse procedures usually carried out by the doctor, ranging from ear syringing to electro-

cardiography (Sanctuary *et al.*, 1965), or to arrange for her special sessions for allergy testing (Murray, 1967) or follow-up of cases of obesity and hypertension (McGuinness, 1970). Delegation of these duties is a valuable way of using the services of a nurse, but a great advantage is lost if she cannot help the doctor with his own examination and treatment of the patient. For this she needs quick and easy access to examination rooms as well as to the treatment room; to provide it, premises must be specially designed.

We have employed surgery nurses for over 20 years, at first nurse/secretary/receptionist, but eventually as nurse/superintendent, when secretaries and receptionists were engaged. Because of postwar building regulations our original surgery was so small and compact that a nurse was always close at hand but did not have facilities to help the doctors as she might have done. Experience of nursing help was acquired, however, and ideas were formed of how it might be more fully used. These were put into effect when the opportunity arose to build a new surgery.

Surgery Design

Every surgery design is a compromise. Ideally, the office should be close to the reception room, and the records room close to both. The health visitor's room and the treatment room should be directly off the entrance hall, as should the waiting room and patients' lavatory, but the former should also be near the reception room and overlook a park. The reception room should allow a view of patients entering

* General Practitioner, Brockworth, Gloucester.