THE FUTURE SHAPE AND ORGANISATION OF GENERAL PRACTICE IN MEDICINE AND DENTISTRY IN NORTHERN IRELAND

Report on a Management Course for general medical and dental practitioners

THE Northern Ireland Council for Post-Graduate Medical Education sponsored a management course on this subject for general medical and general dental practitioners in the Ballygally Castle Hotel from 29th October to 3rd November, 1972. The course was arranged through the Northern Ireland Staffs Council for Health & Welfare Services and directed by two senior consultants of the Industrial Training Service (Team Management Unit), Messrs. W. C. Hurst and W. M. Scott. This article contains a summary of the members' conclusions about the subject matter.

A. THE HEALTH CENTRE CONCEPT

The future of general practice in medicine in Northern Ireland lies in the development of the concept of the health centre. This is probably true also in a major way of the future of general practice in dentistry.

The major arguments for this view are as follows:

The Needs of the Patient

It is now generally accepted that the medical needs of patients are inter-related with other needs and that a team approach, which integrates the contribution of different disciplines and enables new knowledge to be applied in such areas as preventative medicine and the pre-symptomatic detection of illness, must be the keynote for the future. The team approach, in the context of 'total patient care', can best be organised and deployed from within the framework of a health centre.

The Need to Change the Emphasis from Care in the Hospital to Care within the Community

Sir Keith Joseph, Secretary of State for Social Services in Great Britain, wrote in his foreword to the National Health Services reorganisation White Paper that 'the domiciliary and community services are underdeveloped'. This is a reflection of the failure to understand until recent years the ways in which medical needs inter-relate with social, psychological and other needs and the importance, therefore, of caring for the patient, wherever possible, within his normal environment of living. Because this has been insufficiently appreciated, the Community Services have suffered from an over-concentration of resources in the hospital sector. The health centre, embodying the team approach, is the means of redressing the balance. A shift of emphasis in this direction would not only benefit the patient in the prevention and earlier detection of illness. It could also result in a more economical use of the total financial and other resources available for medical and social care to the extent that it reduced the need for expensive curative treatment in hospitals.
The health centre is also the medium through which recent advances in knowledge and research relating to general practice, and the work of the new academic departments of general practice, can be put to good use, assisted and stimulated.

The need to Attract an Increased Number of Doctors into General Practice

Young and able doctors, who are being increasingly exposed during their training to new thinking and new approaches to medical care, will be increasingly disposed to work in general practice. They will be looking, however, for opportunities to relate their knowledge and skills with those of allied professional groups; for proper accommodation, equipment and facilities and for good conditions of service. A well organised health centre, and the team approach, could be as attractive for them in the future as hospital work has been the preference of so many of them in the past.

General Practice in Dentistry

The future of dental care will be increasingly concerned with ensuring for the population as a whole a healthy natural dentition rather than with the treatment of dental caries. If progress is to be made in this direction continuous attention will have to be paid to the education and influencing of the adult population in matters relating to their own dental health and that of their children. The efforts required to combat the current widespread ignorance and neglect in this area will be immense and it is highly doubtful that significant progress will be made if the dentist continues to do his work, as he does at present, in isolation from the total health team. If he were to be a full member, possibly based in the health centre, he could obtain great assistance and support from his colleagues in the implementation of new approaches to dental care whilst, at the same time, obtaining much more satisfaction from his work. Strong efforts should be made to overcome those difficulties connected with remuneration and allied matters which at present constitute barriers in the way of his full integration.

The Reorganisation of the system of Health and Personal Social Services in Northern Ireland

The general practitioner has consistently fought hard to maintain his independence and the individuality of his approach to his work. This has brought him many benefits in the past and can continue to do so in the health centre setting. If the general practitioner, however, is to make a full and positive contribution within the reorganised system of health and personal social services in Northern Ireland, and ensure an important and distinctive role for general practice, a better organisation of general practice is required. This would do no more than put general practice on a more equal basis with other parts of the medical service such as the hospital and local authority services, where, in the past, the degree of organisation has contrasted sharply with that of general practice. A well organised health centre, and an effective team contributing to the planning and execution of forms of care in the community, would provide a strong focus of resource and effort, with a degree of control over its own affairs, to relate and consult with the
new District Teams and, through the medical advisory committees, with the Area Boards.

To make a final point, the arguments from principle and from the practical needs of the situation for the development of the health centre concept, are supported by the evidence of what has actually happened and what is planned to take place with regard to health centres in Northern Ireland. Chart I gives details of the growth of health centres to date and the plans for further development to 1975.

**Chart I. Health Centre growth in Northern Ireland—Estimate**

| Item   | 1966/67 | 1967/68 | 1968/69 | 1969/70 | 1970/71 | 1971/72 | 1972/73 | 1973/74 | 1974/75 |
|--------|---------|---------|---------|---------|---------|---------|---------|---------|---------|
| Centres|         |         |         |         |         |         |         |         |         |
| Doctors| 2       | 3       | 12      | 18      | 22      | 29      | 35      | 48      | 63      |
|        | 6       | 10      | 51      | 88      | 99      | 126     | 153     | 228     | 379     |
| Patients| 11,000  | 17,000  | 85,000  | 162,000 | 200,000 | 252,000 | 315,000 | 455,000 | 745,000 |

It will be noted that by 1975 it is expected that 379 doctors, or 50 per cent of the total of general practitioners now in Northern Ireland, will be working in health centres. In view of the extent of what already exists, and the magnitude of what is planned, it is vital that the members of the profession give serious thought to the whole concept of the health centre approach; its purposes and objectives in regard to medical care; its place in the reorganised system of health and personal services and a number of important matters of operation and management.

**B. THE ORGANISATION OF COMMUNITY CARE AND OF THE HEALTH CENTRE**

_The organisation of community care, in the context of the new Area Board and District structure, and the management of the health centre, should be achieved through the establishment of a community care committee based on the health centre; the appointment of a management sub-committee from the main committee with responsibility for the administration of the centre and the appointment of a health centre administrative officer._

_The Community Care Committee_

The community care committee would contribute to the planning of programmes and other forms of care and would share in their delivery in collaboration with the new Area Board and District structure. Its functions would be to integrate the various services and professional groups in a team approach to total patient care in the field. Community care committees should be established throughout Northern Ireland for a minimum population of 25,000 and a maximum of 50,000. This would mean that, outside Belfast, each District would have either two or three community care committees.

The way in which the community care committees would complement the reorganised system of health and personal social services is illustrated in Chart II.
The suggested composition of such a committee, based on a health centre for a typical population of 25,000, is given below:

- Representatives of the general practitioners.
- One representative from the community doctors and dentists.
- One representative from each of the following:
  - Health visitors
  - District nurses/midwives
  - Social workers
Secretaries and receptionists
Para-medical (physiotherapists, chiropodists, speech therapists, etc.)
Hospital (representative from the Medical Staff Committee)
General dental practitioners

It might be advisable also to have one or two representatives from the public to advise on the views of the patients using the health centres or the services of general practitioners and others outside the centres. They might be appointed from District Committees.

General practitioners might be represented by one member from each partnership group and single handed practices would be grouped each to provide a representative. A representative from the hospital medical staff committee would assist in the integration of services at community level and likewise a general practitioner member of the committee should be appointed to the hospital medical staff committee. All general practitioners in Northern Ireland should be represented including those who, although not working in health centres in the provincial towns, would carry on with their practices in the surrounding villages and rural areas. Health centres in the Belfast areas tend to be smaller, but community care committees could be formed by grouping two or three smaller centres into one for purposes of representation.

The committee should meet regularly to plan and co-ordinate all programmes of community care and for discussion of policy matters in relation to the health centre.

The Management Sub-Committee

This committee, to be appointed from the main committee, should consist of the chairman and one or two members. It would be concerned with the day to day administrations of the health centre and oversight of the work of the health centre administrative officer.

The Administrative Officer

With the building of larger health centres (at present a health centre caring for a population of 25,000 would have some 55–60 staff) a new approach to the management of health centres is necessary. Management functions at present are being carried out by a number of people and groups including doctors, nurses, senior secretaries, county health committees and others. In circumstances such as these, uncertainty about responsibility and a lack of co-ordination could develop with undesirable effects on morale and the proper use of the time of professional and other staff.

A professional administrative officer is needed to act as co-ordinator, to be the focal point of responsibility and generally to administer the work of the centre under the direction of the community care committee and its management sub-committee. The administrative officer could be appointed by the community care committee and his salary paid by the Area Board, possibly with a contribution from the general practitioners. In this way, and since he would report to the community care committee, he should have the confidence of the doctors and
other staff and become a member of the caring team. Various matters of qualifications and experience, remuneration and career structure for the administrative officer would have to be examined and resolved but there is no reason to think these would present great difficulty if the principle should be accepted as sound. The appointment of an administrative officer would enable doctors and others to concentrate on care for the patient, which is their chief concern and training, and delegate matters of administration to a person who is properly trained and qualified for this different activity.

C. THE COMMUNITY CARE TEAM

The whole tenor of this paper assumes an approach to community care teams, working from health centres and general practices, which recognises the variety of professional skills which need to be integrated on an equal basis to care for the patient. A diagrammatic representation of this team is given below in Chart III.

![Diagram of Community Care Team]

Many, if not most, doctors have little experience of the ways in which such a team might function and insufficient knowledge of the nature and scope of the services which members of the team other than themselves could offer. There is therefore a great need for training, including regular discussion within practice teams of case situations; wider discussions within community care committees and discussions and education at regional level such as the Royal College of General Practitioners and the British Medical Association.

Some notes on the role and work of various members of the team are set out below.
The Health Visitor

She should be attached to the practice and do her work with no geographical boundaries. It is desirable that family doctors should be consulted and participate in the interviewing and selection of all health visitors and nurses.

District Nurse/Midwife

Like the health visitor, she should be attached to a practice and do her work with no geographical boundaries. She should spend at least one week each year in the treatment room and one week in hospital. With the virtual disappearance of domiciliary midwifery, the general role of the district midwife needs to be radically reconsidered.

Treatment Room Nurse

She should work permanently in the treatment room and should not be a district nurse. She requires special training in hospital casualty departments and out-patient clinics. She also requires training in resuscitation and should accompany the doctor on accident calls and cardiac emergencies. The Maystown report drew no distinction between home nurses and treatment room nurses. With the increase in numbers of treatment room nurses, and with the need for specialised training, a new career structure for these nurses is necessary.

The Social Worker

There is a strong case for the attachment of the social worker to health centres or practices if she is to become a full member of the community care team. A confident working relationship between social workers and medical practitioners should be developed, expressed, for example, in a full exchange of relevant information regarding patients.

Secretaries/Receptionists

Appointments to these posts and allocations of work should be done by the community care committee or its management sub-committee. Receptionists should be attached to practices and become members of the community care team and recognised as such by the patient.

D. Records

A matter of considerable concern to patients about health centres is the confidentiality of records. It might be thought that all staff members working in health centres should make an affirmation in regard to confidentiality and should be continuously reminded of the importance of the matter.
The material in this article reflects the views of a group which was neither specially selected nor representative of the general practitioner members of the two professions concerned. It is hoped, nevertheless, that it will stimulate wider thought and discussion about important aspects of the future pattern of medical and social care in Northern Ireland.

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