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

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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

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and leaving the building, the waiting room, and the consulting rooms. Stores of equipment must be quickly available, especially in treatment and examination rooms. If in addition a nurse must have quick access to a treatment room and several examination rooms and also be able to oversee the reception room, problems of design become complex. All these conditions are provided for in our design, together with a staff entrance and cloakroom away from the main entrance; but we do not have the secretary's office or reception room close to the consulting rooms, and a system of intercommunication is therefore essential.

An unusual feature of the building is that examination rooms and a treatment room all communicate with a clinical room, which is the nurse's domain (Fig. 1). The consulting

FIG. 1.—Clinical room from the store room end, showing from left to right: examination room door, passage to consulting rooms (arrowed), examination room door, doorway to treatment room, and doorway to reception room with office beyond.

FIG. 2.—From the clinical room looking through an examination room, across the corridor, and into the consulting room beyond.

rooms are placed along one side of a corridor leading off the entrance hall. Directly opposite to each is an examination room, and at the far end of the examination room is the clinical room, with the nurse in attendance. It will be seen from Fig. 4 that the clinical room communicates with the reception room and the office, these three rooms forming a staff area into which patients do not penetrate and in which the nurse, secretary, and receptionist can circulate freely and help each other in times of need.

FIG. 3.—Waiting room from the hatch in reception area.

FIG. 4.—Plan of surgery. Scale 1 square=4 sq. ft. (0.37 m.²). Total area approximately 1,750 sq. ft. (162.5 m.²). Cost, excluding land and fees, £7,270. Architect, John A. Owen-Pawson. Builder, John Simmonds (Gloucester) Ltd. Location, Abbotswood Road, Brockworth, Gloucestershire.

Method of Use

During consultation sessions a signal light indicates to the nurse that a patient has been sent into an examination room. She gives the patient any necessary assistance and carries out instructions from the doctor—for instance, to collect or test a specimen of urine or remove a dressing. The common requirements for examination, such as gloves, sphygmomanometer, and stethoscope, are in the examination room. Special items, such as syringes, specimen containers, specula, and pessaries, are provided from the clinical room by the nurse, who assists at the examination if necessary. She will also provide trays for suturing, cervical smears, and other minor procedures, or she will give treatment such as penicillin or antitetanus serum injections or apply dressings. After completing his examination the doctor writes prescriptions or signs x-ray or pathological forms in the clinical room and gives instructions to the nurse if need be. She sees the patient out, tidies the examination room, and signals that it is ready for the next patient.

Clinic sessions may be conducted in the same way as consultation sessions. As an alternative, if a preliminary interview is not needed the receptionist can send patients direct to the examination rooms the session being conducted entirely from the clinical room. For some clinic sessions the nurse's duties may be supplemented or taken over—for instance, by a midwife during antenatal sessions and a health visitor during cervical smear sessions.

Though attendance on patients and doctors in examination rooms is the main part of the nurse's duties during consultation sessions she can use the treatment room, which communicates with both entrance hall and clinical room, as it is used in some conventional premises—for minor casualties

arriving during the session or for treatment of patients seen by a doctor but not needing to go into an examination room. At other than consultation times she can use the treatment and examination rooms for treatment or follow-up examination of patients referred to her by a doctor, such as the types of case listed by McGuinness (1970).

Discussion

It is becoming accepted that a nurse is a valuable asset in a general practitioner surgery, but the use made of her services is influenced by the type of service given by local authority nurses in the home. Some local authorities are quite willing to attach a district nurse to a practice so that she may carry out more efficiently in a surgery the routine dressings and injections formerly given in the home, but they are less inclined to allow an attached nurse to take part in the general running of the surgery. From the local authority standpoint a treatment room in a health centre well away from the consulting rooms may appear to be an adequate arrangement. To general practitioners who have had an ex-theatre sister at their elbows for 20 years it is primitive in the extreme. Moreover, in a small establishment such as a general-practitioner surgery no member of the staff should be isolated. Secretaries, receptionists, and nurses must be willing and able, if only in small measure, to give help where it is needed. But to be able and willing is not enough; premises must be so planned that help is possible.

There are without doubt many small surgeries up and down the country where the nurse or the receptionist gives the doctor the type of help we describe. Either its value has

not been recognized by designers of premises or they have found it too difficult to provide for it in group-practice-surgery designs. The Ministry of Health (1967) visualizes a nurse only in a treatment room. The National Building Agency and College of General Practitioners (1967) do not, in their plans, make provision for close proximity between examination rooms and nurse/treatment rooms.

One of the attractions of general practice is that to a greater or less extent, every general practitioner can shape his practice to conform to his own individual desires. We fully recognize that many do not wish to use separate examination rooms or to work in close co-operation with nurses, and will therefore need premises planned accordingly. To those who want both separate examination rooms and nursing assistance and are considering building or adapting new premises, we suggest that the present plan will be a better basis for improvement or adaptation to suit their own needs than many of those published in official guides.

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HOSPITAL TOPICS

The Middle Care Round

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Summary: As an experiment in postgraduate education a 25-week course in weekly ward rounds for general practitioners and local authority nurses was established at a district general hospital of 340 beds. A total of 73 rounds were held, divided into 12-, 4-, and 9-week courses, from January to December 1969. Ninety-nine general practitioners and district nurses (including health visitors) attended one or more of these rounds. Seventeen consultants participated and there were 273 doctor attendances and 190 nurse attendances. The average attendance per round was four doctors and two nurses. The number of rounds conducted by each of the consultants throughout the course varied from two to six. This paper presents an evaluation of the course.

Introduction

In relation to the patient and his general practitioner the "middle care" round was evolved to fill the gap between the care of the patient by the general practitioner and local authority nurse before admission to hospital and subsequent care after discharge. Thus the objectives of these rounds were not for the consultant to bring in cases of special interest, nor to keep such patients back from discharge.

The rounds demonstrated middle care to general practitioners and district nurses by means of (a) advances in technique in regard to investigation and diagnosis, (b) pre-operative and postoperative care, and (c) medical and nursing management of acute or chronic illness.

Postgraduate Course of Rounds

Recognition.—In October 1968, three months before the course began, approval was obtained from the dean of postgraduate studies, Cambridge, for recognition of each round as a third session (one and a half hours). Forms GPRC 3 and 5 were made available for completion.

Preparation.—After recognition had been secured 17 of the hospital consultants submitted information on which days and times they could conduct ward rounds for this purpose. A four- or six-week cycle was prepared comprising three rounds a week involving different specialties. Each cycle so prepared was circulated to consultants, general practitioners, and nurses before the start of each cycle and a reminder for each week was dispatched the week before. The course avoided the Easter, summer, and Christmas holiday periods. The full co-operation of the hospital nursing staff on each ward concerned was obtained. Each round was notified to 90 doctors and 123 nurses. The distribution of the rounds is shown in the Table.

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