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Building on the Past – How Historical Research Can Contribute to Our Understanding of the Spaces of General Practice

Introduction

In July the British Journal of General Practice published an analysis article outlining the importance of the physical spaces of general practice, entitled "Why the spaces in which we deliver care matter: implications and recommendations for general practice" (1). Drawing on supportive design literature, Kent et al highlight the active role that space plays in healthcare delivery, despite largely being neglected (1). Primary care estate is an NHS England priority area (2), and as such gaining an understanding of these buildings and people's experiences of using them is especially pertinent now in light of the recently updated Premises Costs Directions (PCD)(3). We know very little about the buildings through which primary care is delivered and even less about how these spaces are experienced by their users (staff and patients), the role that space plays in healthcare encounters and ultimately whether it has an impact upon health outcomes. To conduct this research comprehensively, a multifaceted approach will be needed drawing on multiple disciplines. Kent et al, hint at the possibility that this work can be informed by history, stating "*There may be lessons to learn from the GPs who worked from their homes in the past*". Through this analysis piece, we aim to build upon this suggestion, demonstrating the value of historical work within primary care research.

Lessons from the past

The buildings used to deliver primary care in the present have their origins in the past; thus, to understand these spaces fully, we need to understand their history. From taking a cursory look back at guidance from the 1950s, the space of general practice is not a new concern. It was deemed important enough to receive attention from Stephen Taylor in his report, 'Good General Practice' published in 1954 (4). Between 1951-1952 Taylor's team visited 41 surgeries across the country and his report states that the "…range of accommodation which doctors provide for themselves, and their patients is astonishing." Taylor recognised the role and impact that this space could have upon both the Doctor and the patient. He stressed that badly planned accommodation contributed to making the working day more complex and ultimately longer for the Doctor who wasted time moving from room to room and waiting for spaces to become available. By contrast, good accommodation reflected through a "cheerful and homely

atmosphere”, could help to improve the perception of care felt by the patient. Taylor’s report raised strikingly similar concerns to those expressed by Kent et al 70 years later.

The spaces of General Practice: a historical approach

We recently undertook a piece of scoping work utilising a historical lens to enhance our understanding of the physical spaces of general practice. This work consisted of a comparative analysis of four photographs between c.1950 and the present day, through which we were able to undertake a preliminary exploration of the physical spaces of consulting in general practice (5). The images depict how at the beginning of the period the clinical encounter took place predominantly in a domestic environment. This was either the patient’s home or a surgery within the GP’s house, thus intertwining the lives of doctors, their families, and their communities. Image 1 depicts the dispensing area of a rural general practice c.1950. The medicines are stored (and displayed) on a piece of furniture in the style of a Welsh dresser (furniture commonly found within domestic spaces). Image 2 is a photograph of a consulting room during the 1960s. The room has obvious domestic features such as a fireplace and mantle, it is possible that the surgery was inside a repurposed house. The room is furnished with a mixture of medical and personal items, the mantelpiece is used to display photographs and paintings, similarly to how it would appear in a home. The subsequent development of purpose-built clinical facilities replaced the homeliness of domestic furnishings with wipe-down chairs, plastic curtains and the removal of personal artefacts; more recently the move to remote consulting means that the patient and clinician no longer share the same physical space. This comparative analysis demonstrates visually how during this process domestic and human elements have been stripped away and replaced by practical furnishings, leaving spaces depersonalised.

Engaging with these photographs has led us to consider whether these changes have contributed to some of the recently evolving attitudes towards general practice in shifting the encounter from the ‘personal’ to the ‘impersonal’ space. It can be argued that through these changes the human element of general practice has been removed, resulting in further medicalisation of care. This preliminary work left us considering how the environment may relate to changing power dynamics within the medical encounter and the increasing sense of dehumanisation felt by both patients and clinicians.

The role of history in primary care research

There is no shying away from the challenges that currently face general practice. Whilst the impact of the change in UK Government is yet to be seen, concerns around delivering high-quality primary care in the context of workforce and workload pressures continue. There is a need to understand our increasingly diverse patient population and to counter widening health inequalities seen across the country. Concurrently, traditional scientific methods have been criticised for their reductionist approaches and a failure to integrate wider issues or context into findings (6). As a consequence, clinical guidance based upon the findings of such work may fail to recognise the complex interweaving of personal, societal and political influences on health. Novel approaches to research, including interdisciplinary work, are needed to address these complex ongoing challenges.

A historical lens is seldom integrated into contemporary medical research, more often considered in the context of medical education or perhaps seen as an 'interest' as opposed to a methodological approach. Criticism has also been levelled at historical approaches used to demonstrate narratives of advancement and scientific progress (7). History can, and should, be used beyond this simple story of 'progress', instead providing a lens for context and nuance of understanding. A recent open letter by Bellis et al. highlighted the benefits of a more collaborative approach and considered how an understanding of the past can positively influence the development of future knowledge (8). The experience of the past shapes the experience of the present and the future. For historians, context is key: it shapes the building of knowledge, but also considers how events are perceived and interpreted. Greater integration of context into contemporary medical research therefore offers the provision of novel deeper exploration of the issues faced. Thus, the benefits of engaging with historical research and contribution that such work could make to enhance and improve our understanding of wider social and cultural contexts within which general practice operates are clear.

Future Research

At present, there is no complete record of the current general practice or wider primary care estate, but a recent 2022 report identified that around one-fifth of general practice buildings were built before the founding of the NHS in 1948 (9). As a starting point, there is a need to document the current buildings that constitute the general practice estate, collating information about the age and type of building (for example, whether it is a converted house or purpose-built facility) and to use this information to create a taxonomy. This can be enhanced by photographs of both external and internal spaces with this visual collection then be used to underpin future

research. Whilst this data can help us to consider issues such as accessibility, it can also be evaluated to explore the interplay between healthcare outcomes and the places in which they occur. Whilst 'place' may be regarded as a passive actor within a healthcare encounter, re-conceptualising it as 'active' considers how it is a participant in delivering care, thus influencing experiences and outcomes. This may be particularly relevant for work exploring health inequalities and whether the buildings of general practice contribute to inequity of care for certain populations. With so little known about general practice infrastructure, we do not know whether those in areas of multiple deprivation, for example, may be older and risk structural issues, such as poor ventilation, or accessibility concerns for staff and patients.

Equally, work that explores the needs of patients and staff is warranted. Power manifests itself within the spatial structures of healthcare: who designs these spaces and for whom (10). Unilateral decision-making about capital expenditure without integration of the views of those who use the space risks not reflecting the needs of staff and patients, disempowering them and perpetuating potential inequalities. An example might be the development of centralised purpose-built facilities that may not suit the needs of rural communities by reducing easy access to more local spaces. A greater understanding of these buildings and spaces, coupled with a transdisciplinary lens to view space as an 'active determinant' of a healthcare encounter, will allow for an evaluation of whose needs they serve and reduce perpetuating inequalities in future design.

Conclusion

The general practice estate is itself a historical problem: the buildings and spaces through which primary care is delivered are themselves a legacy of the past. Therefore, we strongly advocate for the role that historical research can play in helping us not only unpick how these spaces were developed but also to understand how they shape health encounters. Not acknowledging the history of these spaces is at odds with many patients' experiences; by bringing these into context, we may be better placed to create environments that strengthen relationships between patients and clinicians and not just clinical efficiency. There is a role for pausing, reflecting and looking back to the past before moving forward to ensure that changes are holistic and fully understood. A temporal approach, using the knowledge of spaces of care in the past, ensures that changes of the future are placed within context and are not delivered within an ahistorical vacuum. It is time to challenge the current paradigm and to test out how

history, when applied as an academic discipline, can be integrated with primary care to enhance research, policy and delivery of care.

Image 1: Dispensing area in a rural practice c.1950

Image 2: Consulting room c.1966

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Images

Figure 1 - Dispensing area in a rural practice c.1950. Provenance unknown but likely to be part of a collection of materials relating to a BBC documentary about rural general practice. Royal College of General Practitioners Heritage Collections

Figure 2 – Consulting room at a practice in Reigate c.1966. Provenance unknown, but polaroid photograph affixed to manuscript written by Dr Lawerence Dulake, entitled, 'A partnership in General Practice since 1800' dated 1966. Royal College of General Practitioners Heritage Collections

Authors:

Barbara Caddick, Senior Research Associate, Centre for Academic Primary Care and Department of History, University of Bristol

Helen Leach, NIHR In Practice Fellow, University of Warwick

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Competing interests

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