PRACTICE OBSERVED

Essays on Practice

Publicising patient participation groups

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Fourteen years on from its simultaneous emergence in three different British communities patient participation in general practice is no longer a new or controversial concept.[1] Nevertheless, though consumerism has changed much in that time, patient participation groups have had surprisingly little impact on general practice across Britain.

The reasons for this failure were the main topic for discussion at a recent workshop organised by the Royal Institute of Public Administration. To an audience consisting mainly of representatives of community health councils and local health authorities, Ann Richardson, a research fellow at the Policy Studies Institute, gave an introduction to her book, *Participating Patients* (to be published by the Policy Studies Institute in October), which is the result of eight months of research.

Coming and going

In the 1980s the number of patient participation groups rose steadily: there were 30 groups in 1981 and 35 in 1983, 12 having closed down.[2] Richardson studied 80 groups, 60 or 70 of which still exist. In 1986, however, only 1% of practices in Britain have such groups. The rapid emergence and disappearance of the groups are illustrated by her finding that one third of groups were less than two years old while only a third were over five years old. Furthermore, few were in cities: 30% of groups described their practice area as a small town, and 40% described it as a village.

Richardson suggested that the groups may have three functions: providing feedback to the doctor; mobilising voluntary work; and acting as a pressure group. The most important single determinant of success was the amount of support a group received from its doctor or doctors—a fifth of practices with groups have more than one doctor.

Groups may fail partly because they are not representative of all patients and partly because people do not know about them. Though most groups have a "democratic" structure, attendance is obviously voluntary, and those who join are often middle class "committee people." This is a self perpetuating problem when further office bearers are elected at poorly attended annual general meetings. As Mr Ghulam Malik, a community relations officer from north Staffordshire, pointed out, in Birmingham, where the percentage of black or coloured people was 18%, patient groups had at best a "token black." He believed that group members often saw the group as the gift of a benevolent doctor rather than as a body which can initiate change. Indeed, as Richardson said, only three groups were founded by patients, and none has succeeded without a general practitioner's support. One patient in Richardson's study had described herself as a member of "a *nice* pressure group." Malik believed that even with the best of intentions a group may sometimes succeed only in gaining better health care for its own members while neglecting the silent majority.

Why then have other kinds of pressure groups succeeded? Is it because they have a rigid national structure? In 1978 the National Association for Patient Participation in General Practice was formed, but it specifically did not impose uniform constitutions on groups—probably because such a move would have discouraged people from starting them.

Publicising the groups

Reaching patients who have not joined the groups is aggravated by the interpretation of some doctors of the General Medical Council guidelines on advertising[3]: "Doctors must also satisfy themselves, before entering into and while maintaining a connection with an organisation, that any advertisements issued by the organisation are factual, do not improperly advertise the personal qualities or services of individual doctors connected with the organisation, and do not make invidious comparisons with the services of other organisations."

The interpretation of "improperly" depends on the interpretation of such phrases as "currently accepted standards" and "customary limits," which are used elsewhere in the guidelines. It is also stated that "the council do not wish to hinder the dissemination of relevant *factual* information about individual practitioners" (my emphasis). The wording of these guidelines is so hard to interpret that doctors should surely follow the more intelligible recommendation of the BMA's central ethical committee that advertising bona fide health education meetings can be construed only as being in the public interest.[4,5] The pat on the back that participation groups received in the government's discussion document on primary health care could also be taken as support for publicising them.[6]

Richardson stated, however, that many groups had been told by general practitioners that they could do no more than display a newsletter in the surgery. She cited the case of a woman not being allowed to join a practice because the existence of a patient participation group was her main reason for applying.

Thus an important reason why there are not more patient participation groups is that doctors fear that publicising them might be interpreted as advertising for the practice. The debate on general practice advertising is, however, a separate issue: if guidelines were clear groups could publicise themselves whether or not advertising in general practice was allowed. This is illustrated by the Association of Community Health Councils' support for patients having "enough information to choose the practice with which they want to register" but rejection of general practice advertising.[7] The General Medical Council's committee on standards of professional conduct and ethics is due to make new recommendations on advertising in November. The onus is now on it to provide clear guidelines on the publicising of patient participation groups.

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Practice Research

Medical housing "lines"

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Abstract

General practitioners are often asked for medical certificates (housing "lines") by applicants for council housing who claim to have medical problems requiring housing priority. The results of a survey by questionnaire showed that general practitioners in Edinburgh do not know how the housing system works and that they seem to overestimate their patients' chances of obtaining suitable council housing. General practitioners need to know how the housing system works, and communication between general practitioners and housing departments should be improved.

A comparison was also made between the number of medical points awarded by a community medicine specialist and a group of general practitioners who had written housing "lines" for their patients. The general practitioners tended to award more points than the specialist. Social priority for housing should be recognised as an independent factor and a new category of top social priority added.

Introduction

Using the World Health Organisation's definition of ill health, anyone who lives in bad housing is thereby in a state of ill health.[1] Gray and Yarnell have outlined three elements of inadequate housing: physical structure (dilapidation), socioeconomic factors, and overcrowding (defined by statute).[2] Applicants for council housing or tenants who live in inadequate housing may turn to their general practitioners for medical certificates (housing "lines") to help them to change to other housing. Certificates are given to patients who claim medical priority to obtain a council house or to transfer from one council house to another. In Edinburgh the information on housing "lines" is assessed by a community medicine specialist, who awards medical points from 0 to 20 and a top medical priority over this.

This paper reports on a study of the level of knowledge of general practitioners in Edinburgh about the council housing system and what they think of it. A comparison was also made of how patients' problems were assessed by the community medicine specialist and by general practitioners.

Methods

A questionnaire (appendix 1) was sent to 50 Edinburgh general practitioners of 17 questions, 15 of which were factual, about the housing system. These were multiple choice questions with one correct answer, and a "don't know" category was included. The remaining two questions were open questions regarding general practitioners' thoughts about the system.

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Fifty practices were selected at random from the Lothian Audit Group Practice Directory, and general practitioners were picked at random from the 50 selected practices. The 50 general practitioners who were sent questionnaires represented about 10% of the general practitioners in Edinburgh. The questionnaire was sent with a letter of explanation and a reply paid envelope to encourage the doctors to reply.

General practitioners' views of medical priority were also compared with those of the community medicine specialist. Twenty consecutive applications for housing "lines" from general practitioners who worked from this medical centre (department of general practice, University of Edinburgh) were studied. Without knowing the specialist's assessment, the general practitioners who had written the housing "lines" to the specialist were asked to: (*a*) allocate medical points from 0 to 20, using their own feelings about priority or award top medical priority; (*b*) comment on their reasons for giving the lines. A 95% confidence interval for the difference between the general practitioner's and the specialist's allocation of points was calculated.

Results

Thirty eight (76%) of the 50 questionnaires were returned; two (4%) were incomplete. More than 50% of the answers to 10 of the factual questions were "don't know." Some of these 10 questions had particular importance for general practitioners—for example, the total number of applicants assessed by the specialist last year. Table I gives an analysis of the answers to some questions relating to the housing system. A more detailed analysis of these questions showed that general practitioners thought that the waiting and transfer lists were smaller and the number of top medical priority patients rehoused and housed in a year was greater than it was. For only five questions did more than half of the respondents attempt an answer other than "don't know," and for only one question did most respondents get the correct answer (table II).

The two "open" questions attracted comments from 25 (70%) and 23 (64%) respondents respectively. The replies to the question about how the present system affected general practitioners were broadly that the "lines" written did not seem to be fruitful owing to a lack of feedback and that patients' requests were for social rather than medical reasons. Suggestions for improving the system included having a specific "housing certificate" which did not require general practitioners to intervene, the community medicine specialist should do home visits, and guidelines for medical points should be made more widely available to general practitioners and patients.

Table III shows the differences in assessment by the community medicine specialist and by general practitioners of 20 consecutive patients who were referred by six doctors at the medical centre to the specialist for medical housing points. The general practitioners stated their reasons for awarding points. Of the 20 requests, seven were for mainly social reasons, seven for mainly medical reasons, and six for a combination of social and medical reasons. In only three requests did the general practitioner award fewer points than the specialist. A 95% confidence interval for the difference in points awarded by the general practitioner and the specialist was (1·16, 6·84), indicating a significant difference.

TABLE I—*Analysis of answers to selected questions from the questionnaire (No of replies = 36)*

	Question	Answer	% Of doctors answering: Correct	Incorrect	Don't know
(1)	Maximum No of medical priority points	20	6	28	67
(3)	Total No of council housing stock	55 000	28	28	44
(4)	No of people on waiting list	13 000	17	28	56
(5)	No of people on transfer list	10 000	6	25	69
(6)	No of applicants assessed for medical points last year	5 000	17	17	67
(7)	No of top medical priority housed/rehoused last year	400	6	28	67
(11)	No of Edinburgh wards open only to top medical priority	20	3	19	78
(12)	Wards where no council housing available	20	3	33	64
(13)	Lowest No of points required for council house	10	14	22	64

TABLE II—*Analysis of the five questions in which more than half the respondents attempted to answer other than "don't know:" (No of replies = 36)*

	Question	Answer	% Of doctors answering: Correct	Incorrect	Don't know
(2)	Who assesses doctors' recommendations and awards medical points?	Community medicine specialist	84	8	8
(3)	Total No of council houses in Edinburgh	55 000	28	28	44
(8)	Who visits applicants' homes if they complain of dampness?	Environmental health officer	47	33	19
(9)	Who visits applicants if they claim medical priority?	No one	25	50	25
(10)	What is top medical priority?	A category over and above 20 medical points	25	36	39

TABLE III—*Comparison of assessments by community medicine specialist and general practitioner*

Case No	Assessment by general practitioner	Assessment by community medicine specialist	Difference (d)* (GP-CMS)	Assessment of patient's problem by general practitioner: Social	Medical and social	Medical
1	20	15	+5		X	
2	20	15	+5		X	
3	TMP	TMP	0			X
4	5	8	-3	X		
5	5	5	0	X		
6	TMP	15	+10			X
7	18	15	+3			X
8	TMP	TMP	0			X
9	20	15	+5	X		
10	TMP	15	+10			X
11	TMP	TMP	0			X
12	10	15	-5	X		
13	10	0	+10	X		
14	10	5	+5		X	
15	20	5	+15		X	
16	5	5	0		X	
17	10	0	+10	X		
18	20	5	+15	X		
19	20	TMP	-5			X
20	10	10	0		X	

*For the purpose of comparison top medical priority (TMP) = 25 points. Mean difference (d) = 4; standard deviation of d (sd) = 6·06, 95% confidence interval for difference = (1·16, 6·84).

Discussion

The results of the questionnaire indicate that general practitioners in Edinburgh do not know how the housing "line" system works. They are not aware of the other agencies and personnel who are concerned in assessing applicants, such as the environmental health officer and the housing visitor. General practitioners overestimate patients' chances of obtaining a suitable council house, and they think that waiting and transfer lists are smaller than they are. The findings also indicate that general practitioners tend to award more points than the community medicine specialist. This may be due either to general practitioners knowing their patients better and being more sympathetic to their needs or to the specialist being more aware of the constraints on resources.

The importance of medical points varies from one authority to another,[3] but awarding points accelerates rehousing or transfer to some extent.[4] The number of housing applicants who have medical problems is increasing, and an increasing proportion is elderly,[5] so general practitioners need to know how the housing system works. Therefore I offer the following suggestions:

(1) A certificate (to be provided by a social worker, health visitor, or general practitioner) should categorise social priority and include a top social priority category. Thus these major elements should be recognised in determining housing priority: the physical structure of and overcrowding in the existing accommodation; social priority; and medical priority.

(2) General practitioners could help to identify the patients who require medical priority by issuing a "medical certificate" which might have the following categories: (*a*) Present housing unsuitable owing to patient's severe locomotor disability. (*b*) Present housing unsuitable owing to patient's severe cardiorespiratory disability. (*c*) Present housing a major factor in militating against the patient's physical well being. (*d*) Present housing a major factor in militating against the patient's psychological well being.

(3) Communication between general practitioners and the local authority housing department should be improved and include feedback regarding "lines" written by general practitioners.

(4) A medical officer who has appropriate training could be used to assess medical needs and priorities of patients in their own environment.

The extent to which general practitioners should help to change people's environment (in this case to better and more suitable council housing) is debatable, but if they are to help prevent medical and social problems owing to housing it is something that they cannot afford to ignore.

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Appendix

Housing "line" questionnaire

(1) What is the maximum number of medical points that can be awarded to applicants for council houses in Edinburgh when the applicant is claiming medical priority?

10, 20, 30, 40, 50, Don't know

(2) Who assesses the doctors' recommendations and awards medical points?

Housing manager
Environmental health officer
Independent medical officer
Community medicine specialist
Other (please specify)
Don't know

(3) The total number of houses controlled by Edinburgh District Housing Department is:

15 000, 35 000, 55 000, 75 000, 100 000, Don't know

(4) The number of applicants on the waiting list for council houses in Edinburgh is:

3000, 5000, 9000, 13 000, 17 000, Don't know

(5) The number of council tenants who wish to change to another council house in Edinburgh and are on the transfer list is:

2500, 5000, 7500, 10 000, 12 500, Don't know

(6) Last year the total number of applicants assessed centrally for medical points was:

200, 500, 1000, 2000, 5000, Don't know

(7) Last year the number of applicants classified as having top medical priority who were housed or transferred was:

200, 400, 600, 800, 1000, Don't know

(8) If in his submission for a change of house, an applicant claims that his present house is damp, he will be visited by:

Health visitor
Social worker
Housing visitor
Environmental health officer
Community medicine specialist
Don't know

(9) Most applicants to the housing department who claim to have medical problems are visited by:

Health visitor
Social worker
Housing visitor
Community medicine specialist
None of these
Don't know

(10) Top medical priority for housing is:

Specially assessed by the environmental health officer
Specially assessed by the housing visitor
Given only to patients awaiting discharge from hospital
Given only to patients over 65 years of age
A category over and above the medical points system
Don't know

(11) In Edinburgh District's 62 wards the number of wards where access to existing council houses is available only to those with top medical priority is:

5, 10, 15, 20, 25, Don't know

(12) In Edinburgh District's 62 wards the number of wards where no council house is available (because there are no council houses or for other reasons) is:

5, 10, 15, 20, 25, Don't know

(13) The lowest number of points required by an applicant to be housed in a council house in Edinburgh is:

10, 20, 40, 70, 100, Don't know

(14) How many points are awarded for the following on application for a council house:

(i) Bedroom deficiency (for each bed space deficient):
1, 2, 3, 4, 5, Don't know
(ii) Shared bathroom/toilet:
1, 2, 3, 4, 5, Don't know
(iii) No inside WC:
1, 2, 3, 4, 5, Don't know
(iv) Each two months on waiting list:
1, 2, 3, 4, 5, Don't know

(15) How many points *may be* awarded for the special circumstances listed below:

(i) Children attending special school:
1, 2, 3, 4, 5, Don't know
(ii) Member of family at special institution:
1, 2, 3, 4, 5, Don't know
(iii) Shift worker:
1, 2, 3, 4, 5, Don't know
(iv) Households in high flats (5th storey and above) with children under 10 years:
1, 2, 3, 4, 5, Don't know

(16) Please list below any comments about how the present system for rehousing patients affects you.

(17) Please list any suggestions you have to improve the system.