have difficulties in getting patients to complain at all; but it is interesting that five of these apparently lack a system designed to make it easier for patients to voice their feelings. That grumbles are common among patients is well known, even in the best run practices; few of these misgivings ever see the light of day, however, either because patients do not consider them serious enough to "make a fuss about" or because they fear repercussions.

There is a smattering of evidence from this survey that the patients of those practices with complaints systems that are designed to be sensitive, discreet, and confidential, thus preventing "exposure," are more willing to express their grievances. Only three groups reported difficulty in handling grievances. Details were not forthcoming, but it seems that one group feels that "the practice tends to see (grievances) as minor."

Health education

A patient participation group provides an extremely convenient forum for health education. Not surprisingly, therefore, all but seven groups put on programmes of regular meetings, discussions, and debates covering a wide range of topics. The most popular seem to be those about cancer, women's ailments, prevention of heart disease, when to call the doctor, where to have a baby, and alternative medicine. In most cases a local consultant is invited to give a talk or participate in a discussion or debate. The groups' own doctors also take an active part in many of these meetings.

Attendance at these sessions is seen as a problem, however, by 70% of groups. Often it is only a tiny minority of the patients on the practice list who put in an appearance, and this usually includes a steady band of regulars. This probably reflects the enthusiasm shown by the general public as a whole for evening meetings of any kind. It has been shown that a much better turnout may be achieved if personal invitations are sent to patients from their doctors to come to health education sessions of particular relevance to them. Such an approach by the Bristol group resulted in attendance rates of over 20% of men aged 35 to 55 to talks on the prevention of heart disease and of over 23% of women (same ages) to talks on breast and cervical cancer. Sending such invitations was obviously more laborious, and money had to be found to pay the postage (see "funding" below). The response and feedback was so enthusiastic, however, that more sessions were planned.

Several years ago the Aberdare group obtained funding from the area health authority to make videotapes of some of its health education talks. It was realised that a large proportion of the practice was not interested in attending meetings nor in reading reports of them in the local press. The answer, therefore, was to take the films to the patients, and several showings in various venues have taken place. One or two groups have put on first aid classes, and the West Kirby group is proud of the classes it has started in cardiopulmonary resuscitation, which now train about 30 people a week. The Birchfield group has produced two superbly illustrated booklets on "Health in the over 60s" (which won an award from a local charity in this field) and on the prevention of home accidents. Booklets or pamphlets provided by two other groups contain a variety of medical information for patients; another two groups are arranging medical book lending services for their patients. Three groups organise health centre open days, which allows patients to see a bit of what goes on behind the counter.

Community and practice support

This comes under two headings: the use of patients as volunteers and social activities.

Volunteers—Twelve groups operate community care services of varying complexity to meet some of the needs of fellow patients in difficulties. Fetching prescriptions, evening and night sitting, and transport are among the commonest tasks. Crèche facilities at surgeries and clinics and even clinic helpers are provided by some groups. One practice runs a weekly lunch club for its elderly patients who live alone; another has an enthusiastic circle of volunteers who knit for newborn babies and send flowers to those in hospital and hampers and presents to a few patients at Christmas. Yet another has found patients to act as interpreters. Voluntary work of this sort appeals to many patients. One respondent said it was her way of saying "thank you" to the practice for the help she had received herself. Nevertheless, half the groups that run volunteer schemes have difficulty at times in recruiting, though only three reported that too much demand is made on their volunteers. All the schemes are coordinated by patients, and in only one group was this job reckoned to be arduous. Practice based community care schemes are not the invention of groups. Several have been operating successfully for years, set up in practices by doctors who realised their potential but who have not joined the patient participation "movement."[1] One Scottish group is unique in having community care as its only interest and activity. It hopes to coordinate all the local helping organisations, both statutory and voluntary, acting as a bridge between them.

Social activities—A selection of these are organised by 12 groups—coffee mornings, outings, wine and cheese evenings, etc—and many are linked with fund raising. Some, however, are intended to help solely in breaking down barriers and towards building up community spirit and friendship among those whose lives lack these.

Special interest and self help groups

Sixteen groups have arranged a selection of group activities that appeal to certain patients—to help them slim, keep fit, give up smoking (the three most popular), cope with their condition (diabetes, old age, stroke, hypertension, back pain, alcoholism, bereavement, depression, hay fever, and cystitis have all been catered for), cope with their young children, or learn yoga. The popularity of such groups varies, and sometimes they fizzle out. I do not know how effective these groups are.

Fact finding

At least four groups have produced and circulated questionnaires, designed either to find out what patients think of the practice system, particularly appointments, or what their opinions are about their doctors' approach to looking after them. The responses from two such inquiries led to improvements in the appointments system and the system for requesting home visits, and to a realisation by the doctors that their patients would appreciate more information about what was wrong with them and their treatment than had been forthcoming during consultations.

Ten groups have carried out surveys into practice or health centre facilities and facilities in the practice area either to identify deficiencies or to produce guidebooks. Suggestion boxes have generally been disappointing and highly inefficient for collecting useful information. One group has examined the practice accounts "in order to make recommendations."

Providing information

Various publications are provided by several groups. Health education material has already been mentioned. West Kirby, Kentish Town, Walthamstow, Dartford, and Keith groups have all produced guides to their practices or health centres. Limes Grove, Birchfield, Fairfield Park, and Todmorden produce magazines or newsletters. The Bristol group has put together detailed handbooks on local accommodation for the elderly and on local day facilities and concessions, both of which are sold for 50p to patients and the general public. Several groups pin

the minutes of their committee meetings, and also those of the local community health council, on the practice notice board. Information about patients' rights is also displayed. The Isle of Wight and Bristol groups have annual "fixture cards" that list all meetings and give information about the groups and the services they offer.

Fund raising

Six groups have been successful in raising money to buy medical equipment; one group alone has bought peak flow meters (for asthmatic patients), home blood pressure kits, an enuresis (bed wetting) alarm, and a physiotherapy ultrasonic machine costing £500. Other groups have bought toys, plants, and pictures for the waiting room.

This is the first of two articles.

Reference

1 Curtis P, *et al.* Patient participation in a medical education environment. *J Fam Practice* 1981;13:247-53.

Looking Back

Doctor in the Dales

J D O'CONNOR

When my husband bought a practice in the Yorkshire Dales in 1933 our two children were very young so I did not intend to practise. Optimistically, however, we had my name put on the brass plate at the gate. The country folk had scarcely even heard of a woman doctor. Worse, we weren't even Yorkshire, but complete foreigners—it takes at least 10 years to become a local in those parts.

There were two surgeries a day, six days a week, with no half day, and fees were very low: a visit cost 3/6d (17·5p); with a bottle of medicine it was 7/-, and a consultation in the surgery was 3/-, so money was not plentiful. Soon after we arrived we consulted the other two doctors in the town about having a half day. Both were older men, who had been there for 20 to 30 years, and they would not agree to this. We decided to have one anyway, and eventually the others did the same. Our house was big and the surgery was in the house, though completely separate. Even on the half day we could not leave the premises, but the surgery door was locked.

The Dales people were shy and reserved, but the women felt that they could talk to me and confide in me. By degrees a few came to consult me, and soon I was looked on as a family friend. The children always gave me a warm welcome, even when they had to have an injection. The country people were good hard working folk who called a spade a spade. If they didn't like someone they said so, and you knew where you stood. I did a week's locum once in another dale even more remote than ours. My first visit there was to an old lady of 80 who greeted me with "We did hear that our doctor was ill and he had a woman doctor doing his work, but we've got to be thankful for anyone these days." In the same practice a man aged over 70 with bronchitis asked "Are you married?" "Yes." "Is your husband alive?" "Yes." "Oh well, in that case you can look at my chest."

Before I learnt to drive I walked to visit patients in the town and my husband drove me to any further away. My mongrel dog, who had one leg shorter than the others, hopped along after me everywhere I went and sat outside on the patients' doorsteps. Everyone knew Billy, so when I came out I would often find someone waiting beside him with a message, perhaps just for a prescription but frequently with a request for a visit. Billy nearly overdid his waiting once. When I was on holiday he went out in the car with my locum, also a dog lover. On one visit the doctor went in by the front door and left by the back door. He didn't miss Billy for four or five hours. He drove back the six miles and Billy was still waiting on the doorstep.

When the second world war started my husband was still in the Air Force Reserve so he volunteered for duty. Then early in 1940, the first bad snowfall arrived, and the roads in the country became blocked. The day before my husband was due to leave he was called to a confinement and could only drive the car one mile. He and the nurse had to walk along the tops of the walls to get to the farm, where they delivered twin girls successfully.

I got a bad start taking over the practice just then, but everyone was kind and helpful. I had to learn to drive the car but never lacked for volunteer teachers. There was very little traffic on the roads, and the lorry drivers soon got to know my car and gave me a wide berth. Driving at night with only sidelights, as required in wartime, was very hazardous. One night a farmer's wife cycled in to tell me I was needed at a cottage near her—telephones were not plentiful then. She came back in the car with me and kept saying "this is a dangerous corner," "sheep sometimes lie in the road here," and so on. At the cottage a young girl, an evacuee, had had to use the chamber pot, to which she was not accustomed. It broke and cut her buttock, which had to be stitched by candlelight. She and her mother returned to the city next day.

A doctor had other uses in those years of petrol rationing. I took the daily papers to the distributors in some villages, and always took medicines—and even groceries—to outlying farms and houses. People were very considerate during those awkward years. There were very few non-essential calls, and I found out how good and kind everyone was. I got many gifts of food.

On one visit to a hill farm, two large rams tethered together at their horns rushed past me as I opened the gate into the farmyard, nearly knocking me down and bumping into the car in their haste. Some months later I saw early lambs at that farm

Ballincar, Sligo, Ireland
J D O'CONNOR, MB, BCH, retired general practitioner

and said to the farmer "You don't usually have lambs so early," and he replied "Those are thanks to you."

When the war ended my husband came home, but about a year later he got a slipped disk, a rarity at that time, so treatment was on trial. He had to lie flat on his back for 10 weeks but this did no good and traction was tried. Still no relief. Then he had to live in a plaster cast for three months, but the pain persisted. He insisted on an operation, which finally relieved the pain. That was the first operation of its kind in Leeds Infirmary.

Digging out of snowdrifts

The worst snowfall for many years was in 1947, when roads became blocked and impassable. One afternoon at the beginning of this I was called to an emergency in a village six miles away. I had to dig three times to get the car out of drifts and was rather shaken when I finally got to the house. The husband of the patient offered to drive back with me but I said, "I may not be able to get home but you certainly would not get back," so I set off alone. To my relief after a short distance I saw in the mirror the snowplough behind me. I pulled into a cutting that had been dug to allow cars to meet or pass, thinking I would have an easy run home behind the plough. But the plough itself soon got stuck in a huge snowdrift. As the men shovelled the snow out the blizzard blew it back, and things looked hopeless. Then the men from the quarries began to arrive on their way home from work. They took shovels from their cars (everyone carried a shovel at that critical time) and fell to work cheerfully in spite of the adverse conditions. Eventually a track was cleared and the snowplough started. The rest of the cars followed slowly and carefully, taking the easier road back to the town. No car, no pedestrian, went up that road for the next nine weeks.

The railway was our lifeline for many weeks. All sorts of things went by engine—day-old chicks, hen food and other feedstuffs, groceries. Sometimes the goods had to be dropped at inconvenient places, to be picked up by the locals. I had to be dropped once on top of an embankment and slide down it, carrying all my essentials in a haversack, as I had been doing all those weeks. As I walked back from that visit the road was blocked by an enormous snowdrift so I climbed to the top of the wall and made my way along it. At one stage I put my foot suddenly wrong and was up to my thigh in snow. At the top of the hill I found the road had been cleared. A huge snowplough, making its first appearance in the district, was turning round to go back to Horton as it couldn't tackle the drift that evening. A workman who lived nearby had just got off the plough so he heaved me up in his place and I rode to Horton at a high altitude, with a new view of familiar country covered in snow.

I had one very alarming experience about that time. A farmer's wife was having weekly injections and had had three or four without a reaction, but on my fifth visit she collapsed completely and slid out of her chair onto the floor, apparently dead. There was no one anywhere near, but while trying to support the patient I managed to get Coramine from my bag and give her one, two, three injections, with no response. So I tried adrenaline. After two injections there was a feeble flicker of the eyelids. I gave her a third injection, and the pulse began to return. But it seemed hours before my husband arrived to pick me up on his way back from another remote farm, and we could move the patient to a settee. I was more shaken than the patient, who remembered nothing of the emergency.

In a country practice a lot of time was spent on the road. One afternoon I noted the mileage, 53 miles, but I had done only three visits and been out three hours. Luckily it was beautiful country—harsh but beautiful—which made the long drives enjoyable, and the patients were all friendly and pleasant. So when the time came to retire and leave there were sad farewells and tears. Five years ago the brass plate with our names on it was still on the gatepost below the plate put up by our successor—and 45 years on the people of Settle still had a woman doctor looking after them.

After Acheson . . .

Constructing a primary care unit: the support

IAN KEY

The family practitioner committee had always viewed favourably my proposals for improving the service of the practice by converting it to a primary care unit and modifying the premises. The administrator and his colleagues guided me through the intricacies of the cost/rent scheme and the means of obtaining improvement grants. Within a week of my taking over the practice the administrator visited me and was most encouraging about my proposals. He said that full support would be given to the project both financially and administratively and that full cooperation with his committee would be forthcoming. This indeed proved to be the case. The administrator wrote to the chief planning officer of the local authority supporting my application for planning approval for the building work, he accurately calculated the cost/rent, which was of great help in the financial negotiations required, and above all he was constantly available to advise me.

Early in February 1982 he examined the details of the plans and specifications in the tenders and wrote to my partner and me formally approving the project and confirmed that the improvement grants had been awarded. He had accurately calculated the cost/rent payable, based on the floor area of the premises, and this calculation set the financial limits and was a great help in considering what further improvements were possible as more finance became available. The family practitioner committee liaised most helpfully and usefully both with the architect and with the bank. They kept in constant touch with me and were always helpful and encouraging. The whole project was assisted by the far sighted view taken by the committee, particularly in accepting that there are likely to be three doctors practising from the premises in the near future.

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Financing

From the beginning I realised that financing the whole project—purchasing and modernising the premises—would have to be paid for with either free or borrowed money: free by means of improvement grants and borrowed from the cheapest source available. Then once the project was completed the cost/rent scheme would become effective.

In July 1981 I visited the local branch of the high street bank with which I had been a customer for many years. I explained to the manager that a partner and I had been appointed to the practice and asked if the bank would be interested in financing the scheme. True to the bank's well known advertisement, the manager listened and said that the bank had schemes for doctors to borrow money for developments such as I had in mind.

When, however, my proposed partner withdrew in August the financial situation altered so far as the bank was concerned, especially because I would be too old to take on a 20 year loan. Therefore, the initial purchase of the premises had to be through the General Practice Finance Corporation, and even during the conveyancing the corporation's rate of interest rose from 16% to 18% and then to 18¼%. The loan granted by the corporation was at 18%, and my quarterly repayments to the corporation, of both capital and interest, were just over £3000. The notional rent that I received for the use of the surgery premises was £105 a quarter. The financial burden of this discrepancy I would have to bear myself until the cost/rent scheme became effective, and it was a very real spur to get the project completed as quickly as possible.

As soon as it was clear that the building plans would be approved, I looked for means of financing the work. The General Practice Finance Corporation intimated that they would probably be willing, and of course the cost/rent would cover their interest payments but not the capital. Furthermore, the corporation was concerned that the value of the finished building would not be as great as the money spent on it, and therefore suggested that I might have to use my own house as additional security.

Therefore, knowing that a partner would be starting soon, I consulted the "listening" bank once more. The bank was very interested indeed and quickly made an offer to finance the entire project. My partner and I were given a choice of either a "floating" or a fixed rate of interest, the fixed rate at the time being 16%. The cost/rent applicable would be at the General Practice Finance Corporation's rate of interest at the time of accepting the tender and agreeing the contract, and this was then 17¾%. With very little hesitation therefore we accepted the bank's offer, and the bank made the money available to clear the General Practice Finance Corporation loan almost immediately.

Being a two doctor practice now, my partner and I were able to obtain two improvement grants, and we had the funds for the work in the original specification. Once the accurate cost/rent calculation—dependent on the floor area of the premises—had been made, however, we realised that the original design was well below the financial limits of cost/rent. I put it to the bank that we had in effect more finance available, particularly because the difference in interest charged by the bank and by the General Practice Finance Corporation was now in my favour. The bank was therefore prepared to advance more money, provided that we did not exceed the cost/rent limits, and thus many more improvements to the premises were possible—such as double glazing throughout and thermal insulation of the external walls.

As the building work proceeded the architect's certificates for payment to the builder were issued, and these were taken to the bank, where finance was made available immediately. In fact, the builder's final account was not presented until two months after the work was completed on 19 June, when the cost/rent became applicable. Receipts for payments to the builder, the architect, and the solicitor for the conveyancing were presented to the family practitioner committee for the assessment of an interim cost/rent. At the time of writing (October 1982) this is being paid regularly, but the final calculation will depend on the presentation of all the accounts, including the 5% retention owing to the builder but not to be paid until six months after completion of the work. It was undoubtedly the bank that made the project financially possible—and positively pleasant. The bank interest and capital repayment are covered by the cost/rent paid. The advantage of having a friendly bank close by the premises was enormous because it was so easy to discuss problems as they arose with the manager and his staff.

Comments

Unlike the practices discussed in the Acheson report[1] ours is not in central London but is 10 miles from it, and it is essentially a suburban practice with a reasonably stable population, although we do have immigrant patients, single parent families, and temporary residents. Also, the practice area is classified as "open," and the practice that I took over was a large one, in contrast with so many of those in inner London that are in "restricted" areas and are small.

Nevertheless, in a little less than nine months—remarkably quickly—our practice and the surgery premises were converted into a primary care unit. The financial hazards, which could affect me personally, made speed essential. That the project was completed so quickly is due to the cooperation of all concerned—the architect, the solicitor, the bank, the family practitioner committee, the builder, the staff of the practice, the patients, and my wife. It was a very happy time, and above all it was great fun for everyone.

It was certainly worth the effort. Within a few days of completion my partner and I were running concurrent surgeries, the staff were handling the new telephone switchboard and intercommunication units as though they had been doing so for years, the midwife was handling the antenatal clinic in the treatment room, the attached district nurse was holding clinics in the treatment room, the health visitor was able to extend the well baby clinic into her room, the treatment room, and one of the consulting rooms, and the practice was running as a true primary care unit. The patients appreciate the service very much, and being Londoners they do not hesitate to say so.

I thank my staff and my wife for help and cooperation throughout. A fully detailed account of the work done to improve Dr Key's premises, including plans, drawings, and names of architects and contractors, is on file at the Medical Architectural Research Unit at the Polytechnic of North London, Holloway, London N7 8DB.

Reference

1 London Health Planning Consortium Study Group. *Primary health care in inner London*. London: London Health Planning Consortium, 1981. (Acheson report.)

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