Waiting room at the Minden Medical Centre, Bury.

second floor office accommodation. We inspected the "shell" and decided on an area of 4100 sq ft on the first floor. Based on the pattern of negotiations pioneered by the other group practices, we agreed a basic rent for the space, plus an additional amortised rental for the internal works that were necessary to divide it up into "purpose-built group practice premises."

Design of accommodation

The negotiations were dichotomous: on the one hand, the private developer had to agree with us a rent for his additional internal construction works, while on the other hand, the district valuer, on behalf of the executive council, had to confirm that it was reasonable for 100% reimbursement. For this task we employed the indispensable services of a professional surveyor. The direct reimbursement of rent and rates was the third vital innovation of the original Family Doctor Charter that ensured the success of our new venture.

The fundamental design problem was to determine how we would fit an ideal arrangement of rooms for practice purposes into a fixed and far from ideal external shell. We were helped by the HMSO publication (1967) *Buildings for General Medical Practice*, by visits to many other existing practice premises, and by helpful advice from Dr G S Adams, the medical director of the General Practice Advisory Service Limited.

We had to learn the meaning of "the functional content of a room" and the "optimum spatial relationships" for these functions to be carried out. How much room do you need for a chair to be comfortably placed at a desk? How much room do you need in front of a couch to be unhampered in your examination of a patient? How far away from the waiting room can the consulting room be? How can the doctor communicate with the receptionist staff efficiently? These were but four of the many questions that had to be answered.

Doctors have been using consulting and examination rooms for over a century, and so we had considerable experience to draw on in deciding what was required from them. There was not much of a problem either in understanding what was required of a waiting room, though ideas of "the environmental qualities necessary" varied considerably. I have still been unable to persuade my partners of the need for piped music and selected video tapes to calm and inform the waiting patient. A 30 ft mural depicting the history of Bury and a smaller wall devoted to health education have, however, enormously improved the atmosphere of what was a very plain and depressing place (figure).

But two major new functions had arisen with the establishment of group practices of the early 1970s. Firstly, there was the need to find a design that would deal humanely and personally with large numbers of patients, and secondly, it became essential

to provide accommodation and other facilities not only for employed staff but for attached nurses, health visitors, and other local authority personnel.

RECEPTION

Ideally a reception area should welcome patients and put them at ease so that they can be dealt with expeditiously. They should not have to stand in a long queue, and their conversations with the receptionist should be private. The desk should be high enough to rest on, but low enough not to obscure the person on the other side. At least we got the height right (an expensive mistake if you don't), but we had to learn the hard way that it is important to separate the "prescription only" requests from the "other inquiries" and to divide the last into subgroups of different doctors. Our open flat-top desk has grown into a sectioned bank-like reception, with clearly labelled signs directing patients to the appropriate station. It has not yet evolved into the ideal trouble-free zone that we would wish for.

GENERAL OFFICE ACCOMMODATION

People need space, and there are statutory minimum legal requirements for office staff (Offices, Shops and Railway Premises Act 1963 and the Health and Safety at Work Act 1974). While the main determinant of the reception and waiting areas is the practice population, the office space required is more closely related to the number of staff employed. Thus we had to provide for staff a rest room and kitchen and of course private toilet facilities in addition to their working areas.

Typing—Specialisation of staff tasks creates a greater need for space, especially if the task has to be performed without distraction. So we have an extra room for audio-typing, shared by the part-time bookkeeper (a retired bank manager), who is responsible for the staff wages and the smooth running of our service company.

Manager's office—If we had a practice manager we would require a further office but our organisation has been unable to identify an appropriate job description, nor indeed discover the right person around whom to build one, and so for the time being we save on space.

TREATMENT, CONSULTING, AND EXAMINATION ROOMS

The fact that the treatment room is perfect for the job is fortuitous. In 1968-9 there were few large practices with firm views about the functional design and content of a nurse's treatment room. We arbitrarily provided two curtained cubicles for seated patients, a fixed desk for the nurse, plenty of cupboards, and a sink unit in a room whose dimensions were 16 ft x 13 ft. A private annex measuring 7 ft x 13 ft was added, which is now used for cervical smears, the fitting of intrauterine contraceptive devices, and minor operations.

The rooms were originally eight consulting rooms and nine examination rooms. As we took on more partners and trainees more space was needed. As a result of our latest conversion three anaesthetists and a cupboard opened the reception desk have been sacrificed to make room for two more consulting rooms and another examination room, but only one toilet. (We still have three other toilets scattered about.)

One of the examination rooms is reserved for doing electrocardiograms: it is quiet, isolated, and pleasantly decorated and allows both patient and technician to provide an unhurried recording.

COMMON ROOM

The common room doubles up for staff as a rest room during

the day and is used for the occasional lunchtime meeting and the regular monthly group meetings which grind on into the late evening.

ACCOMMODATION FOR NURSES AND HEALTH VISITORS

A separate room was provided for the district nurses who from the inception of the group had used our premises as their base. Their capacity to fill storage space with bulky nursing paraphernalia needs to be closely watched as it would, if allowed, consume the whole centre. It is an unquantifiable item, like Parkinson's Law, expands to meet the space available.

About five years after the centre opened we were faced with the threat of losing our attached health visitors unless we could provide them with adequate accommodation. They had been working closely with us but were separately housed in a health centre built by the area health authority a quarter of a mile away. Fortunately part of the "shell" adjacent to our premises had remained vacant and with the co-operation of the AHA and the approval of the regional health authority we leased an additional 1200 sq ft. The AHA accepted responsibility for building the internal works to accommodate our five health visitors and well-baby clinics.

The Minden Medical Centre has finally evolved into a 5300 sq ft rectangle which provides for preventive health at one end and general medical services at the other, with the administrative section—general office, reception, and waiting area—interposed. There is no corner of wasted space—something that never ceases to surprise me when I remember how enormous I believed the premises to be when we moved in 12 years ago.

Communications in the centre

Our faithful PABX 6 automatic telephone exchange with its six external lines and 20 internal extensions has finally reached

Mr. Tossack, fugeon at Alton, relates the case of a man flung by the beam of burning coal, when he recovered by blowing his breath into the patient's mouth, bleeding him in the arm, and causing him to be well rubbed and toiled about. And Dr. Frewen, of Sufes, mentions the case of a young man who was flung by the smoke of sea-coal, but was recovered by being plunged into cold water, and afterwards laid in a warm bed.

The practice of plunging persons suffocated by noxious vapours in cold water, would seem to be supported by the common experiment of suffocating dogs in the *gros de canis*, and afterwards recovering them, by throwing them into the neighbouring lake.

It has already been observed, that colds are the effect of an obfuscated peripatetic; the common causes of which we have likewise endeavored to point out, and are here supported by the common experiment of spending time in enumerating all the various symptoms of colds, as they are pretty generally known. It may not however be amiss to observe, that almost every cold is a kind of fever, which only differs in degree from some of those that have already been treated of.

No age, sex, or constitution is exempted from this disease; neither is it in the power of any medicine or regimen to prevent it. The inhabitants of every climate are liable to catch cold, nor can even the greatest circumspection defend them at all times from its attacks. Indeed, if the human body could be kept constantly in an uniform degree of warmth, such a thing as catching cold would be impossible: But as that cannot be effected by any means, the peripatetic must

be limited. The bulky cabinet containing its mechanical brain is housed in a little room of its own (6 ft x 12 ft). We are now in the throes of replacing it by a more disintegrating electronic system that can be programmed to do wondrous things with its 10 external lines and 30 extensions. It goes by the futuristic title of The Herald Call Connect System.

We have solved our telephone communications, but our system of calling patients forward from the waiting room for their consultations still leaves room for improvement. Although it would be a worthy entrant for Blackpool Illuminations, the call comes from a receptionist's supervision and thus fails as an efficient mechanical aid.

Pros and cons

We enjoy the advantages of group practice—the availability of partners to discuss the clinical care of patients and the less welcome but equally necessary topic of practice organisation is reassuring. The presence on the spot of other colleagues from all disciplines offers mutual support in difficult circumstances, as well as the opportunity to develop special interests and skills. The disadvantage of practicing in a group is that one has to consider the effects on others of any action one may take.

Specially, however, my own gripes are about problems of car parking and first floor accessibility. But at least we now have a new and reliable lift and the prospect of implementing an ingenious system—of drop locks and barriers—for keeping trespassers off our tarmac.

The future

Although I foresee no major new developments, the years since 1969 have chronicled many changes in our accommodation. We hope that we will continue to react to the changing needs of our practice and to modify and refine the premises accordingly.

be liable to many changes. Such changes, however, when (small), do not affect the health; but, when great, they must prove harmful.

Did mothers reflect on their own importance, and lay it to heart, they would otherwise have every opportunity of informing themselves of the duties which they owe to their infant offspring. In their province, not only to form the body, but also to give the mind its most early bias. They have it very much in their power to make men healthy or unhealthy, useful in life, or the pests of society.

BUT the mother is not the only person concerned in the management of children. The father has an equal interest in their welfare, and ought to assist in every thing that respects either the improvement of the body or mind.

It is pity that the men should be so inattentive to this matter. Their negligence is a real reason why we know so little of the infant. It will ever be difficult to excel in such accomplishments as recommend them to the other sex. But men generally keep at such a distance from even the smallest acquaintance with the affairs of the nursery, that many would esteem it an affront, were they fuppoted to know any thing of them. Not so, however, with the kennel or the stable: A gentleman of the first rank is not ashamed to give directions concerning the management of his dogs or horses, yet would blush were he fuppoted in performing the same office for that being who derives his existence from himself, who is the heir of his fortunes, and the future hope of his country.

(Buchan's Domestic Medicine, 1786.)

Social Agencies

Marital problems presenting to a marriage counsellor*

ALIZA SHAPIRO

With the increased life expectancy in western society marriage is now likely to last between 40 and 50 years—a very long time indeed for two people to expect to be able to meet each other's needs without major upheavals. Add to this the dramatic change in the roles and expectations of women, which is radically altering traditional family patterns, and the appalling effects that the recession is having on family life. The shock, disorientation, and despair that redundancy may bring causes not only practical problems of economic survival but also feelings of failure and depression for the husband and not infrequently a loss of respect and trust on the part of the wife at a time when her support is most needed. It is not surprising therefore that these stresses and demands on marriages should also increase the demands for help. Before coming to a marriage counsellor people will usually explore all other avenues: trying to sort things out rationally between themselves; listening to good advice from families and friends; turning to their general practitioner in the hope that he or she will put them right; and lastly turning to a counsellor. Asking for help is usually perceived as weakness and a sign of failure, and yet it takes much strength and courage. Turning to a counsellor who is easily available and works in a non-medical setting may be less threatening than official referral to hospital or psychiatrist, and visits to a marriage counsellor do not appear on medical records.

Marriage guidance council

The first marriage guidance council was established in 1937, when the divorce rate was 7000 a year, compared to about 150 000 in 1980. Voluntary workers carried out the work—with more experience—seeing themselves mainly as a referral service. There are now 145 councils and 500 centres throughout England, Wales, and Northern Ireland, employing about 2000 counsellors, who still work with courage but now also with professional expertise. It is still a voluntary organisation but there are plans to pay professional workers to deal with more realistic case-loads. The Home Office provides over £1m, which covers only part of the considerable training costs. Although we do not charge our clients, it is taken for granted that at the first session the counsellor and client will negotiate a weekly contribution, ranging from 50p to £10 or £15 a session. Grants from local councils and the contributions from clients pay for our services and training.

*This is a shortened version of a paper given at a symposium on Help-seeking Related to Marital Breakdown on 21 October 1981 at the Avery Jones Postgraduate Medical Centre, Central Middlesex Hospital, London.

London NW4 1QW

ALIZA SHAPIRO, marriage counsellor

TRAINING

Candidates for counselling training are interviewed in a one-day selection conference by two tutors and a psychiatrist from outside the organisation. Selecting the right people is crucial because our training facilities are limited. We look for people who are natural listeners, for empathy, for warmth, for the confidence to accept that other people are different, for an awareness of personal vulnerability and conflict, and for evidence that becoming a counsellor is not merely a roundabout way of asking for therapy.

Training is done at three-day residential courses at our college in Rugby once a term for two years, also by supervision, support, and teaching from a personal tutor who is allocated to each counsellor in training, and in weekly case discussion groups led by a tutor in which the focus is as much on the case as on the counsellor and the group dynamics. This last goes on throughout the counsellor's career. Finances prohibit counsellors going through a training analysis so the tutor's job is to spot areas of personal difficulties that may lead to overidentification, collusion with the client, or projection of the counsellor's feelings. Although the focus must be on the client's marriage, it is only when the counsellor can take account of his or her responses to the client's problems that the client's marriage can be properly understood. Contrary to usual teaching practice all marriage guidance training is experiential and is less about teaching than learning—to become aware of personality structure and development and of interpersonal behaviour and its effects on oneself and others. But once this is established experience needs to be firmly anchored in theory.

Our work

Our approach to counselling is client-centred, on Rogerian lines, though counsellors develop their own style. I try to adapt to the client's needs as much as possible and will work along analytical lines with a well-motivated client, but often find it easier when someone is very defended—that is, when people find it hard to acknowledge their true feelings and may become defensive—to borrow techniques from Gestalt or transactional analysis. My counselling is very different from that of a counsellor at an industrial health centre: it is more structured, short-term, and directive than at the London Marriage Guidance Council, where cases may go on for many months and may turn into long-term therapy. Though finding the psychological causes of clients' problems is important, clients at the industrial health centre may find it strange to deal with interpretations of unconscious behaviour though they can respond with real behavioural changes when they become aware of their role in family interactions. More sophisticated clients at LMGC often respond better to reflective analytically-oriented therapy, allowing the inner-self to unfold, and the counsellor accepting and encouraging the various phantasies attributed to him

through the client's transference. One approach is not more valuable than the other. What matters is what different clients respond to.

Problems present to us overtly, whereas they are likely to present to the general practitioner as physical symptoms. Clients are often searching for an opportunity to blame and to let off steam, and we hope for a mutually imposed solution. Whether or not a client is likely to benefit from counselling is decided by assessing whether he or she can change from the passive role of patient—in which the doctor can be relied on for diagnosis and cure—to the role of active participant. Counselling is a prior shared process that relies mainly on the client's motivation and incentive for change, in which one person helps another to help himself.

The problems presented range from young couples whose lives are developing in different directions to the "empty nest syndrome," when children have grown up, leaving behind two strangers whose search for meaning and purpose had been channelled into career for the husband and into the children for the wife. In between is premenstrual tension and depression, postnatal depression, menopausal depression, and "lack of communication," which usually means that each partner is in the front and expressing feelings exist that couples have spent years together without taking notice of their assumptions about their partner's behaviour or emotions.

Many clients have problems rooted in their general relationship. If a couple brings a specific sexual problem, such as primary or secondary impotence, premature ejaculation, retarded ejaculation, orgasmic dysfunction, or vaginismus, in an otherwise "OK" marriage we refer them to our Marital Sexual Dysfunction Clinic, whose approach is behaviourist and based on the work of Masters and Johnson and Kaplan.

I work on the assumption that problems are in part caused by the fear of letting go of behaviour patterns that once helped us to survive the total helplessness and dependence of early childhood. We all had to adapt to get approval—in extreme cases even to survive. We did this by withdrawing to hide our pain; by screaming till someone noticed; by being overgenerous in order to get love; by withholding for fear that our love was not wanted or that we would get nothing in return—by disowning parts of ourselves that seemed not to be acceptable. By and large our acquired knowledge serves us well. We learn to compromise and tolerate frustration and sometimes even to value ourselves as much as we value others. In most of the couples who come to us these survival mechanisms have effectively broken down. The collisions no longer serve their purpose, the projections have been reversed, and early experiences have been internalised so effectively that the client still responds as he had learned to do in the past, too frightened to find out whether he still needs to be dependent, passive, or powerless.

Time and again husbands who will do anything for a quiet life

OF BURNS.

When the burn is violent, or has occasioned a high degree of inflammation, and there is reason to fear a gangrene or mortification, the same means must be used to prevent it as are recommended in other violent inflammations. The patient, in this case, must live low, drink freely of cold water, and use such cooling medicines as will have his body kept open. But if the burn parts should become livid or black, with other symptoms of mortification, it will be necessary to bathe them frequently with warm camphorated spirits of wine, and to use such medicines as will have a cooling effect on the skin. A middle-aged man, of a good constitution, fell into a large vessel full of boiling water, and miserably caldled about one half of his body.

come to us genuinely hurt and puzzled because their wives have become ever more domineering, demanding, and nagging. It is easier to blame the other person than to get down to the hard work of understanding that the more they collapse by giving in to their natural impulse to withdraw and out the more their partner will be strident and aggressive to get a response. We try to help our clients to recover from their sense of themselves that were disowned and to accept the separateness that makes each one of us unique.

Contrary to the experience in child guidance—where opportunities for family therapy arise because a child is the identified patient—on the rare occasion when families are seen in marriage guidance it is the parents who present the main problem, recognising that the difficulties experienced by the couple are often acted out by the children. Parents then seem to be less resistant to dealing with the problem at source, before the children act up with delinquent behaviour.

In view of the rising divorce rate I think that conciliation work with the whole family is important. Once a couple has decided to separate the children face upheaval, distress, and guilt at losing daily contact with one of their parents, and they often become weapons with which parents express their vindictiveness, bitterness, and pain at each other. Not infrequently the idea that children need to be consulted for their own views, feelings, and preferences before decisions are taken by the parents is unworkable to the detriment of the children. In the event of an unworkable and unworkable, find it hard to separate their own feelings from those of their children, looking at them more as extensions of themselves than as individuals. Divorce without undue bitterness and animosity is rare. The role of all concerned can often be achieved when all parties are given the space and respect to air their feelings.

Closer co-operation between counsellors and other helping professions would be invaluable. Marriage counsellors are often criticised for being too non-directive and for not accepting the authority role that is imposed. Present training is changing this, and we are aware that we need to use this "authority" to support our clients. One point where this supportive role can break down is when a client is referred to one agency by another. It would be helpful then if the worker from the referring agency could participate when referral is discussed with the client, or if this is impractical, if a meeting between the two workers could be arranged before the transfer takes place. This works well in general practice when the counsellor is part of the practice team and has a good working relationship with the general practitioner, and in family therapy where the counsellor or social worker and psychiatrist work together.

I suggest that until there is such co-operation between different agencies we may lose people who may help because the delicate bond of trust established with the initial worker is broken—a risk that could be lessened to the benefit of workers and patients alike.

As his clothes were on, the burning, in some parts, was very deep before they could be got off. For the first two days the caldled parts had been frequently anointed with cold water, and afterwards with oil, which is a very proper application for recent burnings. On the third day, when I first laid him, his fever was high and his body collic, for which he was bled, and had an emollient clyster administered; poultices of bread and milk were used, and the burnings were likewise applied to the affected parts, to abate the heat and inflammation. His fever still continuing high, he was bled a second time, was kept strictly on the cooling regimen, took the saline mixture with small doses of the tincture of myrrh, and, to prevent the spreading of the burn, was administered. By this course, the man was well in three weeks as to be able to attend his business.

(Buchan's Domestic Medicine, 1786.)