Innovations in London

Peckham Health Project

Raising health consciousness

B H FISHER, MAGGIE COCHRANE

The political nature of medicine has always been obvious in primary care. Deprivation and the environment mould and create ill-health, and these forces merge with the personal experiences of patients. Being a personal physician is a profoundly unsatisfying job—waiting for people to walk in after they have fallen ill, often thinking themselves at fault, while what caused them to be sick is all around them: unhealthy living conditions, poor educational facilities, poor child-care facilities, appalling places of work, cigarette advertising. The list is endless and familiar. When this GP moved into a new health centre he wanted his practice to reflect these concerns. After discussions with a local community worker (who is co-author of this paper) the Peckham Health Project was conceived.

We and others who are concerned with health projects in Britain have been influenced by several things. We realise that medical intervention has had relatively little impact on the health of the community. Environmental changes, such as clean water, nutrition, and housing, have probably been more important in improving health than the personal physician.¹⁻³ We are also aware that doctors may display power and control over their patients, which is based on their class status and their monopoly of information and of health care.⁴⁻⁶ Furthermore, the women's movement emphasises that medicine is an agent of social control and of doctors' sexist attitudes to women. It has been shown that in medicine illness, madness, and acceptable and unacceptable behaviour have been defined and placed firmly within acceptable female roles.⁷⁻⁹

The increasing number of restrictions being made in the health services under successive governments—closing small local hospitals in particular and cutting services in general—has also highlighted the political nature of the decisions made about medical care.¹⁰ Alternative socialist solutions to problems of health are important models, in particular those from Tanzania, China, and Cuba.¹¹ Another influence has been the "growth movement", which by its practice criticises the drug-oriented, high technology medicine demanded by our consumer society. Finally, the Black Report documented how illness and inequalities in the provision of health care follow class lines.¹²

We are therefore particularly sensitised to the power of doctors, the class and socioeconomic nature of illness, and the system of medicine. We are particularly concerned with making primary care more democratic, caring, and community oriented.

Latter Health Centre, London SE15 3LW
B H FISHER, MB, BSc, general practitioner
MAGGIE COCHRANE, community worker

Beginnings

The health project was built from the community. Some explanation of our methodology is necessary. A community worker is a facilitator, who works in non-directive ways to help people to define and achieve their own goals. Collective solutions to environmental, social, and economic problems are emphasised rather than individual solutions. Coming together and recognising common pressures is often a first stage, followed by building participatory structures through collective action. This differs from usual interventions (such as health education) because it attempts to look at change from the inside, allowing ideas to flow at their own pace from the community.

Initially we approached a mother and toddler group on a local housing estate and had weekly discussions on health. These focused on the frustrations of dealing with doctors, the lack of useful information, and consultation with lay people. The women were desperate for more knowledge and a framework in which to apply it; they wanted to have discussions in which they were not patronised. This group became the "core" of the project, which lasted for four years, with women coming and going.

The community worker helped this group by arranging the venue, liaising with members of the group, doing the paper work, and, as the group grew, by encouraging and supporting individuals. At first people took initiatives very tentatively and were delicate in their criticism, often feeling that they had no right to criticise the National Health Service, particularly with a representative of that institution in the same room. The community worker also supervised funding.

We tried to limit the GP's role to giving information about medicine and organising medical care to ensure that the doctor responded to the group's demands as far as possible rather than imposing his views and agenda. The GP tried to explain things honestly and was explicit about his doubts and feelings about being a doctor. We always used first names.

Organisation

The Peckham Health Project was based at a local settlement community centre funded by the charity that was one minute's walk from the health centre in the middle of four high-density housing estates in South London. The lay participants in the health project came mainly from these estates. They were not members of the health centre practice. The health project led to a national winding down of the remaining group. It was eventually run by a committee drawn from the members and it was answerable to the whole settlement. It usually took up half a day a week of the GP's time plus some weekends and evenings. The community worker was always attached to the project part-time and then became full-time.

1844

Aims

The aims were written down at various times. In 1979, half-way through the project, they read as follows:

- (1) To work with tenants in the locality to build a structure that will have some real influence on health care and awareness in the area.
- (2) To challenge the assumption in practical ways that health is the sole responsibility of the individual by helping people to respond collectively to health problems and complaints.
- (3) To promote a positive approach to health (as opposed to curing sickness) in the area by encouraging people to recognise and use of their own skills and experiences in response to their health needs.
- (4) To demystify what health workers do and why they do it.
- (5) To work with other agencies and individuals in the area whose prime task is spreading health care and awareness.¹³

Four years of the project

The group continued to explore new topics: vaginal examinations, breast cancer, children's illnesses, etc. A pamphlet was produced on children's illnesses: coughs, otitis media, sore throats, gastroenteritis, and urinary tract infection were described and information given clearly about when to call the doctor and when to self-treat. The information had been sought, analysed, and written down by the group. The community worker organised the printing and funding. A pamphlet on breastfeeding was produced, emphasising that mothers had a choice on infant feeding.

The feeling grew that these topics needed a wider audience and a member of the group suggested a public meeting on the menopause. Sixty middle-aged women braved a November night to listen to a talk by a registrar in gynaecology. A group of menopausal women began to meet to look collectively at the problems of the menopause, and this became a support group. It was run by someone who was experienced in group work but was not a doctor. The posters and organisation were handled by the group and the community worker.

Other groups were similarly formed—all with the aim of enhancing people's confidence in dealing with health matters and health workers. A cystitis and thrush group met and produced its own pamphlet based on Angela Kilmarin's approach to the problem. The GP began a "smokestop" group because he wanted to stop smoking, and it ran for three years. For the last year it was organised and facilitated entirely by a lay ex-smoker who was paid by the project. Thirty-five per cent of those who joined the group stopped smoking, and 22% substantially decreased their smoking at one year follow-up. A relaxation group and a group for women's self-defence were also formed. A group on the health of children rapidly shifted to look at a share of the group's depression. A startling pamphlet on depression in women was produced that the GP now uses to stimulate discussion with patients. All the pamphlets are useful in day-to-day surgery.

A video programme on doctor-patient relationships was produced. This dramatically showed the group's experiences with doctors by means of role-play and discussion. The video is used in regular training sessions with medical students. This not only gives the students a graphic picture of patients' frustrations but also gave members of the health project the opportunity to meet the students: they were struck by their youth, inexperience, and at times their pomposity. The video was also taken out to other lay groups, when members of the project could explain our approach. The project organised a meeting to complain against cuts in the local Health Service, and several members worked in the campaign against local hospital closures.

After about two years the project was well established and firmly based in the neighbourhood. Several women from the project had gained confidence and took a great deal of responsibility

in generating ideas and action around health. The GP and community worker, though still key workers, were no longer the prime sources of motivation. The project became widely known, health visitors and health education became involved. Conferences attended by the community worker have influenced ideas in health education.

At any one time there were between six and 12 women working with the project, many of whom had helped to plan it. Apart from this core group, between 15 and 30 people were concerned in one or other of the groups. Moreover, there were several hundred people who had brief contact with the project, perhaps by attending a public meeting or reading literature produced by the health project. They were very important as a means of spreading the word that something was happening around health.

Decline

The health project ended after four years. Most of the key members were ready to move on, either to take more responsible positions in the project had money been available to pay them, or to find alternative work, training, or accommodation. Internal difficulties at the settlement created communication problems for the community worker and some of the members of the health project, and the community worker eventually left the project. Not enough emphasis had been put on securing long-term funding, on replacing the community worker, and on extending the project to include other lay health workers. This led to a national winding down of the remaining group. It would have been irresponsible and demoralising to encourage new interest without adequate support. More emphasis should have been put into changing the assumptions of the administration and policy in the health district. Without this, resources are likely to stay scarce and health workers remain confused and defensive when approached by interested lay people. Similarly, a local autonomous structure for the project should have been created. This would have diminished the influence of problems at the settlement on the project. It would also have been a step nearer to the creation of long-term neighbourhood networks for health.

Assessment

One other similar, far-ranging project has been described before. The St Thomas's Health District and Community Health Council's Children's Health Club¹⁴ is narrower in scope. Projects that used the community development model more formally have been described by Hubley.¹⁵

Were our aims met? We helped several people to stop smoking. Members of the project changed their ideas about health and treated their own and their families' illnesses in a different way. We do not know, however, whether we made a measurable impact on the health of Peckham. Collective solutions to health problems were emphasised. Members found the groups useful for information and support. "Positive health" was a vital part of the project as epitomised by the smokestop and relaxation groups. One of the most important aspects, however, was demystification. Groups gained insights into the workings of the Health Service. They were less frightened and more realistic about medical care and more able to use it effectively. They took less on trust and became more demanding and critical of the Health Service.

So far, health professionals are concerned the most enthusiastic response came from health visitors and those concerned in health education. The GPs in the practice were singularly unresponsive, despite a number of attempts to bring them in, and saw the project at best as an impossible but worthy task and at worst as irrelevant and threatening. The Community Health Council and the department of general practice at the local hospital were supportive and the community

services gradually showed interest. Funding from community services was always denied.

We learnt that giving people information about health is not sufficient—people need the confidence and encouragement to use it. Health has so long been the province of the professional that the lay public are virtually disenfranchised from their own bodies. The health project affected people on a broad front: apart from health matters they also questioned other areas of their lives. Some were less happy; some changed their housing; some women made important changes in their sexual and emotional relationships. We feel that the health project was one catalyst in this process.

Such a project is an excellent vehicle for helping health workers explore the relationships between the Health Service and clients. It showed clearly to the GP how important most people feel in relation to the National Health Service. However, we consider we should feel oppressed by the Health Service. A strong lay organisation is a prerequisite for effective patient participation in health. This would be impossible to achieve, we feel, without the skills and community allegiance of a community worker who can catalyse this process far more effectively than a doctor. Such projects can help us look at alternative models of health care for the future.

What future does such an approach have for the Health Service in general and primary care in particular? Health projects like ours are springing up throughout the country, initiated by agencies outside the Health Service. They will flourish whether the Health Service is interested in them or not because they tap an immense reservoir of interest and demand for public concern in health. Projects that develop in the

Pathology of Partnerships

Bearable and unbearable partners

M H DALE

I only once seriously considered becoming a single-handed general practitioner, and I abandoned the idea while being interviewed for such a practice. Since 1948 I have always been in a partnership and have had 10 permanent partners with a few other birds of passage during this time. The number may seem large, but it is because of the change to groups that has occurred during the past 30 years. This has been particularly true of the dense urban areas in which I have spent most of my life.

Before I consider my permanent partners I want to look at those with whom I did not go into practice and those with whom I rapidly terminated any possible partnership arrangement. It would have been reasonable in 1948 to have entered practice with my father, but not only was I never formally asked by him, but I was well aware that our similar natures were unlikely to be conducive to a harmonious independent-contractor relationship. I have been intrigued by those apparently happy father-son practices that I have known, and have pondered on the Oedipal niceties of this arrangement.

Health Centre, Newquay, Cornwall
M H DALE, MB, FRCS, general practitioner

community offer immense scope for democratising an individual practice and for health education. If we care to listen to our patients and learn what kind of Health Service they would like at a local level we must concern ourselves in this process. We shall lose our credibility if we refuse.

References

- McKeown T. Reasons for the decline of mortality in England and Wales during the 19th century. *Population Studies* 1962;16:94-122.
- McKeown T. An interpretation of the decline in mortality in England and Wales during the 20th century. *Population Studies* 1975;29:44-22.
- Williamson JD, Donahue K. *Self care in health*. London: Croom Helm, 1978:64.
- Tuckett D, ed. *An introduction to medical sociology*. London: Tavistock Publications, 1979:206.
- Marsden H. The women's health movement. *Int J Health Serv* 1975; 5:217-23.
- Ehrenreich B, English D. *Compliments and disorders*. London: Writers and Readers Publishing Co., 1976.
- Politics of Health Group. *Care and the NHS*. London: Blackrose Press, 1978.
- Ficker B. Primary care in Cuba. *Update* 1981;23:1273-81.
- Report of a Research Working Group. *Inequality in health*. London: DHSS, 1980. (Black Report).
- Peckham Health Project. *Report, 1979*. Put Street Settlement, East Surrey (Grove, Camden Estate, SE15).
- Smith H. Health education by children for children. *Br Med J* 1981;283: 782-3.
- Hubley J. Community development and health education. *The Journal of Health Education* 1979;10:113-19.
- Hubley J. A community development approach to health education in a municipal authority. In: *Community Development and Health Education*. 10th International Conference on Health Education, 4 September 1979.

There have been times when additional or replacement partners have had to be found, and these have been humbling experiences. Extensive interviews have often been misleading. One potential partner, who after in-depth interviews was considered to be entirely suitable started work one bright and sunny morning and as he came through the door cheerfully remarked, "better the day, better the deed." His verbal communication was strictly limited to clichés, and a few short weeks were all that were necessary for the existing partners to decide that a daily dose of "many a mickle makes a muckle" was sufficient grounds to suggest that he leave. Another potential partner came to grief because he proved to be accident prone to a nerve-shattering degree; this again was not revealed by scrupulous interview techniques.

My own first serious attempt at entering into practice came to nothing. The senior partner was elderly and had carried a wartime load and was ready to take things more easily. His existing two partners agreed that he was justified in doing this. I was no longer in the first flush of youth: for the previous six years I had first been in the army forgetting my studies and then in hospital relieving my trade. It rapidly became apparent that what was wanted was not a replacement partner but rather someone to do the work in a small share as I was just getting away with. Happily for me this impasse was resolved by the

1846

two existing partners deciding that they too were unprepared to carry the senior partner indefinitely, and so I joined them as a third partner on reasonable and fair terms.

My senior partner Alec was a dedicated bachelor, an excellent doctor, and someone for whom I developed a profound respect. Our partnership lasted till his retirement shortly before his death. Those early days of the NHS were remarkable not least for the work we all did, and in our partnership Alec did most of all; so much so that he caused annoyance by his habit of never refusing a visit at any time of day or night even if it was for one of our patients who had seen the young doctor in the morning and had not been cured by 3 am that night. He caused problems also by insisting on routine daily visiting list of never less than 15 patients (Sundays included). This was hard to keep up with even if it could have been justified as a useful exercise. Any annoyance I must confess, largely arising from the thought of what might have been had the first offer been accepted and the elderly coxster been with us.

Three partners is a good number especially if two are young and one considerably older. Ideas can be floated and balanced judgments be made with little frustration, and I cannot recall any serious divergence of opinion during this time. But when the partnership had to be increased to four the decision making became more difficult and prolonged and the frustration greater, with either two against two or three against one. This period coincided with the big changes which were necessary for survival during the later 50s and early 60s, and tempers did flare at times and communication between sensible adults was diminished as such. The recent lull at Stansted was undoubtedly felt that I was at times impossible, and it is with something akin to guilt that I am at this still feel no need for apologies. It would no doubt have been more appropriate to have banged our heads together rather than allow the dissolution of the partnership, which did occur. The two younger partners moved off to other countries or practices.

This event coincided with our entry into a purpose-built, 10-man health centre in the late '60s and the friend of my

childhood and myself decided that two further partners must be found. But we decided also that we would have individual lists and personalised incomes with only the expenses and rota duties shared. This change meant considerable work but proved to be well worth while: most of the partnership problems disappeared as individual partners were free to run their own lists in their own way and in a way which did not affect the other partners. No longer could a partner feel that he was carrying an undue proportion of the work or receiving less remuneration than he was entitled to. Golf could be played as and when necessary, and committees sat upon to the individual's heart's desire.

I must mention one other partner, a friend whom I had seen grow from childhood and who eventually joined the group and who had a personal tragedy that ended in suicide. Although this occurred some years ago, it still remains hard for me to accept that he was unable to come and tell me of his problem. I am now a junior partner once again, having had a fleeting retirement and then moved some 250 miles. To achieve this the initial discussions on partnership were almost entirely finance dominated, and the workload was restrained by limited commitment. As with so many burdens it is not until you put them down that you realise how heavy they had become. The burden of practice administration has now been largely left behind, and the decision making left after consultation to my younger senior partner.

These experiences have suggested to me at least three important principles: (1) an objective measurement of partnership workload on an individual basis is not possible; (2) the bedrock of a successful partnership is to get the money right; (3) partners must communicate with each other.

When trying to find the right partnership or partner there are two golden rules: (1) always work together before you finalise any agreement; (2) get the money right.

In conclusion, I think that even if all the problems of partnership cannot be attributed to money it is undeniable that if the money is wrong partnership problems are inevitable. What is "right money" is, of course, another subject.

Immediate care schemes

I would like to make a plea for more recognition of the work of immediate care schemes and BASICS. British Association of Immediate Care Schemes, both from inside the medical profession and also from central and local Government, so that while schemes maintain their voluntary basis they receive the status and recognition that, for example, the Royal National Lifeboat Institution does at sea. Immediate care is very much a specialty in its own right and deserves to be recognised as such. The recent lull at Stansted was an excellent example of the role that immediate care schemes should have at major incidents. It had been anticipated that the Saffron Walden Accident Group (SWAG) would provide both the medical team and the medical incident officer for all incidents in and around Stansted, including aircraft crashes, ground incidents and accidents, and hijack. Accordingly, plans were drawn up for coping with the large numbers of casualties that could be expected on such occasions, including annual exercises with the other emergency services.

On this occasion there were four immediate care teams and their emergency equipment on scene as the aircraft landed, with over 20 more doctors on standby ready to proceed to the airport should the hijackers blow up the aircraft and its 100 passengers and crew, who had threatened this operation was carried out by two SWAG radio operators, who also alerted local hospitals (which have SWAG radio in the casualty departments), dealt with many inquiries, and assisted the senior SWAG doctor at the scene to maintain between two and four doctors in four-hourly shifts at the

airport. This was done with assistance from other immediate care schemes in Cambridgeshire (MAGPAs), Chingford (NE Met Accident Unit), north-east Essex (NEEDS), and Hertfordshire (NW Met Accident Unit), and when the incident ended unexpectedly early there were already plans to continue this presence for a further 24 hours. Over 30 doctors were concerned, more than 10 of whom actually went to the airport. At the scene of the incident the senior SWAG doctor assumed the role of medical incident officer and liaised with senior officers from the other services. When the aircraft moved near the terminus a casualty clearing station and field hospital were set up with Essex Ambulance Service with responsibility for dealing with all civilian casualties, including the pregnant woman, the co-pilot, and all those who subsequently went to hospital, as well as screened the remaining passengers before their debriefing by the police. An aircraft hijack is a somewhat different problem from a crash, but fortunately this one went almost unexpectedly well, probably owing to the inexperience of the hijackers. But if things had gone wrong the medical resources available should have been able to cope, and it was an excellent example of co-operation among immediate care schemes and inter-service planning, which worked well in the actual event—no jargon, Saffron Walden Accident Group.