PRACTICE OBSERVED

847

Patient Participation

Survey of patient participation groups in the United Kingdom: II

TIM PAINE

The first part of this survey was published in last week's issue.

Survey
FINDING

Funding is an important—and for 44% of groups a daunting—aspect of running a patient participation group. Annual budgets seem to range between £50 and £150, though four groups spent well over this in 1981, one over £850. Large spending of this sort is usually accounted for by special projects, such as publishing booklets. With few exceptions groups attempt to raise as much as they can from the patients by arranging social functions, raffles, sponsored activities, and so on. One group does very well each year from a cake and biscuit stall at the local May Day fair. Roughly half the groups are helped out financially by their doctors, who donate between a quarter to a half of the budget. Sometimes this is only as a "starter"; more often it is a regular contribution. Financial help is frequently sought from outside organisations, either statutory or otherwise, usually for help with particular projects. Because this is an area of considerable practical interest to many groups, it will be dealt with in some detail.

Before their demise area health authorities made money available to three groups: £10 for leaflets, Bermsfield; £300 for making health education films, Aberdare; £700 to produce and publish a "centre users" guide, Kentish Town. One district management team allocated £10 to help a group to start operating, and a local social services department in London provided £50 for the same purpose. Local charities, firms, and other organisations have also helped: a total of £250 was granted over two years by three local charities to enable the Bristol group to publish their booklet; £270 was contributed by local charities to support the work of one community care group; £25 and £40 have been received by two other groups from local firms and organisations; £300 was given by the King's Fund in London to finance the Bristol group's 1981 health education programme, their application to the local area health authority having been turned down. Several groups have received fees from press, radio, and television. Drug companies are understood to have made small contributions to some budgets.

PROBLEMS

A list of the problems that groups commonly have (from my experience) was included in the questionnaire. Groups were asked to indicate those which applied to them and to mention others that they had found particularly difficult. Of the several that have already been mentioned, getting patients to participate is by far the commonest. Only one group denied any problem whatever in this area.

Failure to attract a reasonable number of patients to meetings bothers most groups. Apart from the general apathy shown by most patients, the two biggest difficulties appear to be the cost of communicating effectively with all the patients and the lack of freedom to publicise the group's activities. Effective publicity costs money in design, printing, or postage; it also encroaches on professional ethics. Any attempt to advertise meetings or other group activities outside the walls of the practice premises, it is feared, will bring down the wrath of local practitioners, the BMA, and even the General Medical Council on the heads of the doctors concerned. The position has, in fact, been clarified to a degree by the central ethical committee of the BMA, who have agreed that to advertise bona fide health education meetings in public places cannot be construed as being other than in the

Whitley Health Centre, Whitley Road, Bristol BS8 2PU
TIM PAINE, MRCP, MRCGP, general practitioner

848

BRITISH MEDICAL JOURNAL VOLUME 286 12 MARCH 1983

public's interest. Matters of domestic importance to the practice only are to be kept for patients' eyes and ears only, however.

Five groups reported adverse reactions to their publicising activities, and two of these had studiously avoided advertising any activities outside the practice. On the other hand, 17 groups regularly put up posters in chemist shops, libraries, and other suitable public places, and some even have their activities regularly reported on the radio without apparently incurring anybody's wrath.

Groups are fairly content about the degree of involvement of the doctors in group affairs, but less so about practice staff: 38% of groups obviously have great difficulty in getting staff to take any interest or play any part in their activities, though open hostility was not reported. One group tried to win over its staff by inviting them to judge a children's painting competition, meeting and chatting with them beforehand armed with glasses of sherry. The play worked quite well.

A few other difficulties were mentioned on the questionnaire: "When new doctors come into the practice we have to start from the beginning to educate them in patient participation." "The (committee) tend to represent an articulate, radical, middle class minority and so cannot have the authority and power which would accrue if they were truly representative of the whole body of patients."

"... but now support from patients is negligible and support comes from a handful of patients mostly advanced in years, and some have physical disability to a lesser or greater degree." "Finding times when a 'cross-section' of people can meet together. Pensioners prefer daylight hours; young people prefer evenings."

"Red tape—problems associated with operating an NHS health centre—consultation with administrator and staff committee invariably produces objections to most suggestions put forward."

"Diversity—far from apathy, we find that there are several strong areas of interest on the committee, resulting in only partial support for any one project. Thus it is difficult to get adequate commitment to make a project work."

"We have one committee member who is very critical and very persistent, getting us a bad name with the staff and making it difficult to work as a team."

"The ethics which prevent doctors from giving names and addresses is a great handicap (to effective communication)."

ACHIEVEMENTS

People often ask "What has actually been achieved having patient participation in your practice?" Groups were asked how they would respond to this question. Their replies fell into four broad categories: improvements offered or initiated by the group; contributions made to health care; contributions made to the practice organisation; services provided in the relationship and mutual understanding between the patients and the practice.

Services

These ranged from providing equipment, for example, through various activities such as self help groups, lunch clubs, and socials, to services such as transport, community care, pamphlets and guides, and crèches.

"An evening of music and poetry and a sponsored marathon runner (a patient) raised £360, and already a glucometer and audiometer have been purchased and put to good use."

"Crèche-minding at well baby clinics is now considered by the doctors to be an essential part of the surgery set up."

"Bringing the patients together enabling them to help one another."

"Citizens' advice service—very successful—on a voluntary basis."

"The constant care group (sitting service) is a considerable achievement."

"Collecting useful information about facilities in the locality for elderly, disabled, etc."

Health care

Several groups are proud of their health education programmes and booklets and the way they have been able to share in the effort to promote preventive care. The West Kirby sessions in cardiopulmonary resuscitation have already been mentioned. It has been shown conclusively in the United States that training a large proportion of the general public to be capable of reviving those who have collapsed with heart attacks has a greater impact on mortality than the provision of intensive care units and it is a great deal less costly. A group in the north of England had arranged for one of their doctors to talk on health topics at the local school. The successful outcome of lobbying for chiropody and ambulance improvements by a group in South Wales has been mentioned.

Practice organisation

"The most impressive array of achievements is in practice organisation."

"We were instrumental in getting the first lady doctor partner here; we now have three."

"More cheerful waiting room and toys being allowed. Improved notices and a clearer recorded message for phone."

"(This from a patient initiated group.)"

"Often quite simple things—for example, patients can't hear reception call their names because of poor acoustics, so we lobbied for a tannoy."

"Initially, when community was small, group was able to give support to doctor in obtaining suitable accommodation to provide an effective service to an ever growing community."

"Patients complaining are invited to 'sit in' with receptionists to see the other side of the coin. (One patient said that after three hours of this he now knew how Custer must have felt.)"

"The management group does influence the workers' group, and has been instrumental in formulating policy for the practice—for example, how new workers are appointed. It is controlled by patients."

"We have provided, and will continue to provide, accommodation for medical students who are attached to the practice for study."

"Sharing problems concerning the structure of the health centre and appointment system and changing the time of drug collections."

"Enabling patients to make better use of the health centre—going to a different doctor, when to ring up, etc."

"Perhaps the most impressive achievement of all was the way in which one group set about mending what seemed to be an irreparable rift among the partners. A meeting was requested by the group to which all the doctors came. Confidence was expressed by the group in each of the doctors, whose different personalities and approaches were considered entirely complementary. They were all asked to resolve their dispute in the interests of the practice, and this they did."

Mutual understanding

Many groups believe that setting up their group has led to definite improvements in mutual understanding and rapport between patients and practices.

"Being able to communicate with the doctors."

"The informal atmosphere at meetings enables patients to voice fears, concerns, etc. Doctor/patient barriers are beginning to be broken down."

BRITISH MEDICAL JOURNAL VOLUME 286 12 MARCH 1983

849

"Helping staff and doctors to become a bit more aware of patients' attitudes to the health centre and its services."

"Slowly establishing a sense of other uses for health centre than purely medical activities."

"Agreement by doctors that a group can start and to sending some sort of questionnaire."

"Attending the children's clinic is becoming a social event. The health centre is becoming part of the community."

"We are already aware of the changing attitudes of many of our patients—they are talking more freely and asking questions about themselves." (This from a doctor with an eight month old group.)

"People spoken to do seem to be highly delighted that somebody is taking an interest in their opinions and desires outside the privacy of the consulting room."

"I'm sure the group helped our first trainee to be accepted."

"It is perhaps an achievement that we as a group are beginning to argue strongly against fairly set views—for example, on the

need for a crèche, more privacy when speaking to the receptionists, and not accepting the change is not required, is difficult, receptionists can't cope, health board won't approve, etc."

"The committee sees its significant achievement as creating a forum in which a genuine dialogue is taking place between practice staff and patients."

"(The realisation that) a small group of patients can influence doctors and staff to the benefit of the practice as a whole."

I am indebted to all the people who took time to complete the questionnaire, often at considerable length and in considerable detail. I would be glad to hear of new groups and in due course learn how they are faring.

Information on setting up and running a patient participation group may be obtained from Mrs Joan Mant, chairwoman of the National Association for Patient Participation, Hazlebank, Pleslake, Guildford, Surrey GU5 9R1; tel 0366-730405.

The GP and the Medical Student

Students from Leicester University

M M TELLIS

Having a student in the practice is a great challenge. The attachment can easily become a dismal failure, and the student may come away from it feeling puzzled and unhappy. They just did not seem interested in me. "During the consultations I sat in like a fly on the wall." "I did not understand most of what was happening." "It was either above my head clinically or most of what happened seemed related to what had happened before, and I had no part in it—and so on. The attachment can also be a great success, giving the student a new insight and understanding about what is happening to patients. For a short time the student is made to feel that he is a member of the primary care team. His opinion is sought. He is allowed to share responsibility for a few patients and to experience the relationship between the general practitioner and his patient.

Our practice at Measham has been closely linked to the department of general practice at the University of Leicester since before the first medical students were accepted in 1975. The practice serves a semirural community of 11 000 patients. There are five full-time partners who teach undergraduates, one half-time partner, and a trainee in the practice, which is committed to undergraduate teaching and is paid by the university at a rate similar to that for teaching a trainee. The payment is important, for not only does it help to compensate for the time spent with the student, but it alters the teacher's status from that of an amateur.

The medical students at Leicester have a general practice component in every year of the course, but our practice is concerned with the main block of general practice teaching in the fourth year—the middle clinical year—when each student spends four weeks in a practice. We take one or two students five times a year.

Measham, Leicestershire

M M TELLIS, MRCP, senior general practitioner

Correspondence to: Measham Medical Unit, Measham, Burton-on-Trent, Staffs.

What the student does

Each week the student spends one and a half days in the university department. At the end of the four weeks the student is examined and must pass to graduate. While in the practice the student has to write up one long case, prepare cases to present at seminars at the university, and gather data for the group project.

To be successful the attachment must be planned in some detail well before it begins. The practice manager prepares a timetable for the student. The student spends most of his time with the partners, but learns much from other members of the team with whom he spends a short time. This may be the only opportunity for a future paediatric surgeon to discover what role the health visitor plays or for the future general surgeon to observe the advantages and difficulties of nursing patients at home after early discharge from hospital. The future geriatrician will see what it is really like to nurse incontinent, demented patients at home. Spending a couple of hours at a busy time on the appointments desk may make the student realise that the life of the appointments clerk is not an easy one.

The doctors' appointments are retimed. Normally nine patients are booked an hour, but when the partner is teaching this is reduced to six. It is ludicrous to pretend that a partner can see patients at the normal rate when teaching. If the rate of patients is reduced, several things may happen: the student may be treated as though he is not there, the consultations may become very hurried, or the surgery may run very late, making the patients very ill-tempered.

The student's first day in practice is an important one. We try to make him feel welcome. The proposed timetable is discussed with him and may be altered. He is introduced to the other members of the team at office and attends the partners' morning meetings, where the day's visits are shared out and difficult clinical and administrative problems and practice "news" are discussed. It is very important that the student does not "get lost" in the practice. For this reason one partner always has a special responsibility for him. The practice manager also keeps

850

BRITISH MEDICAL JOURNAL VOLUME 286 12 MARCH 1983

an eye on how he relates to the whole team and helps when necessary.

The kernel of general practice teaching is the consultation, whether it is in the surgery or at home. Here the student can actually become concerned in the business of caring for patients in the community. Here he will see different doctors in real life situations, and what he sees will very much influence his future performance.

The consultation will be a flop if the patient is not prepared for a student to be present. Patients who are to be seen at the teaching surgery are given a card when they arrive in the waiting room explaining that a student will be present at the consultation if they wish it. If they do not wish it the receptionist advises the doctor beforehand. The card system saves the embarrassment of the patient having to tell the doctor. There is a real choice about the student's presence. There is a real choice about the student's presence. There is a real choice about the student's presence.

Before the consultation starts the partner briefly outlines the events leading up to the consultation and the patient's background, if appropriate. Every patient is a new patient for the student, and he will feel lost if he is not put in the picture beforehand. Some consultations will be like opening a novel in the middle, reading 10 pages, and then closing it again. We try to explain the plot beforehand.

To capture the student's interest, we plan that his role in the consultation should change during the month's attachment. During the first surgery the student takes little part in the consultations. At the end of the four weeks he talks to the patients on his own. During his first surgery the student acclimates himself to the new situation and the different clinical method. At this early stage, however, it is possible for the student to take some part in the consultation when he is invited to by the teacher, who should, of course, be sensitive to the feelings of the patient and decide whether or not it will be damaging to the consultation for the student to join in. In some consultations it is better if the student plays no part because either patient or teacher would feel uncomfortable. For example, if the teacher does not know the patient he may wish to establish rapport with the patient without bringing in a third person. On the other hand, when there is a robust relationship between the patient and teacher the student may be brought fully into the consultation, and sometimes the trio can usefully discuss the patient's problem and its management. Very occasionally the teacher may feel during the consultation that it would be better if he were alone with the patient and the student is tactfully asked to leave. More often the student is an asset to the consultation,

making the patient feel that a very real interest is being taken in him.

After the first few surgeries the student takes a more prominent part in consultations. The teacher may change chairs with the student after asking the patient if he minds if — — — practises being a doctor. The student then attempts to formulate the patient's problem. As the consultation advances the teacher gradually takes the reins back from the student, perhaps concluding the consultation by writing a prescription after discussing the content with the student. Towards the end of the attachment the patient may be asked if he minds if the student doctor sees him before the teacher. The teacher then has a chance to join up with his other work before the student asks him to join him to conclude the consultation.

One or two of the surgeries are recorded on video (after obtaining the patient's permission, of course) and analysed later by the teacher and the student. The video recorder is a marvellous teaching tool if used properly. It can be terrifying and destructive, but if used sensitively can give the student a valuable insight into his behaviour with patients. The student and teacher should have developed a trusting rapport by the time it is used, and then it may be both constructive and supportive for the student. The consultation may be looked at from different standpoints, the clinical process discussed unhurriedly, the non-verbal communication between the student and the patient studied, and the strengths and weaknesses of the student highlighted by the teacher in a kindly way. The student also has an opportunity to discuss the shortcomings of his teacher when the teacher is leading a consultation!

The attachment also gives the student an opportunity to see patients at home. Just as in surgery consultations, the student starts by watching the teacher at work and then gradually becomes more involved. Soon after the student starts the attachment he is given two or three patients to monitor at home. He will call and see the patients on his own, with the teacher keeping a careful eye on what is happening and at times calling to see the patient with the student. The student thus develops his own relationship with the family and has some limited responsibility for them.

It is hoped that after the student leaves the practice he will have new insights into the problems of the patients that he sees. It is also hoped that he will have experienced a little of the caring that a practice can give its patients.

I thank my partners, staff, and Professor Marshall Marinker for their help in developing this programme.

THE SURGEON'S PARROT John Noble, a surgeon at the Bristol Infirmary in the late 18th and early 19th centuries, was a "rough diamond" noted for his pugacity towards colleagues and students. With his patients he was a different man, gentle and kind; and he was likewise, invariably, with his adored companion Pol, who outlived him by a short period and whose skeleton was preserved in the museum of the Infirmary. Richard Smith junior, colleague and friend of John Noble, and master of medical biographies, records that the skeleton of the parrot was in the museum and one day a whim seized me to place under it the following:—"The following is an epitaph of which an extract is given here as a fine example of Richard Smith's style:

Sacred to the Memory of Poor Pol who, during twenty years was the companion playmate of John Noble Esq. Senior Surgeon to the Bristol Infirmary

In many of his qualities, Pol was the counterpoint of his master. He was talkative and facetious when pleased, but silent and morose when out of humour. He seldom forgot a

favour and never failed to resent an injury. On the contrary, if the offender were within reach, he pinched him with all his might. He was of a bold sturdy and determined disposition, unaccustomed to give way and always ready to fight lustily in defence of what he considered to be his right. He was exceedingly fond of the good things of life and no dish was too highly seasoned for him. In fact both Indies contributed to his appetite.

When young and in full feather, he was agile well-proportioned and handsome looking. If he had any political principles they were, like his master's—

whimsical.

Whether he fell victim to old age and high living, or from grief occasioned by the loss of his kind master (for so he was, invariably, to Poor Pol) remains to this day and so will probably ever continue a matter of doubt and uncertainty

Source: Bristol Infirmary: Biographical Memoirs Vol III pp 76-7.