PRACTICE OBSERVED

Minimum Standards for Training

Selecting general practitioner trainers

D J PEREIRA GRAY

General practice differs from all other branches of medicine in accepting the principle that teaching is a privilege, which has to be earned, and is not a right accorded to those with senior status in the profession. This principle seems to be a characteristic of the generalist half of the medical profession because it has been adopted not just in the United Kingdom and other European countries, but in Canada, the United States, Australia, New Zealand, and other countries as well. Furthermore, in the United Kingdom teaching privileges once granted are subject to regular review every three to five years.

General practitioners believe that teaching skills are separate from, although closely related to, clinical medicine; that they require additional time to learn; and that time spent in teaching deserves additional remuneration. There is thus a continuing debate about appropriate criteria for the selection of general practitioner trainers with educational and medicopolitical factors operating. The scientific basis for selection is becoming slowly but steadily clarified. The most important recent research, the Manchester study,[1] supports many of the following criteria.

Apart from the educational issues, constraints on manpower also affect selection because in any one year in Britain there are only roughly 1650 vacancies for National Health Service general practitioner principals. This means that, given wastage, deferred entry, deaths, and reserves, it is unlikely that more than 2020 out of the 27 260 unrestricted principals in Britain at 1 October 1982 can be training at any one time. Unless training is to be extended to doctors pursuing a career in the specialties, only about 7·5% of the population of general practitioner principals (the highest grade) in the British National Health Service can be active teachers. In practice about 10%, of general practitioners can be approved trainers since partners and course organisers are also approved. Competition for trainer appointments may occur and might become intense in the future (table I).

Undergraduate training in the United Kingdom is still mainly done in hospital, and therefore the trainee year is of immense importance. This has been underlined by trainees,[2] trainers,[3] and those responsible for its organisation.[4] Furthermore, the preregistration year and two of the three years of postregistration vocational training also take place in hospital.

TABLE I—*Criteria for selecting trainers*

Enthusiasm
Courses for trainers
Premises
Practice library
Age-sex register
Cover when on call
Records
Teamwork
Audit
Teaching time

The trainee year provides the only serious opportunity for doctors to learn the principles of personal, primary, preventive, and continuing medical care based on homes and families.

Regional subcommittees in general practice have had statutory responsibility for selecting trainers since October 1973. Their constitution should reflect that of the national body, the Joint Committee on Postgraduate Training for General Practice, which has equal representation from the Royal College of General Practitioners and the General Medical Services Committees (the local medical committees) with others, such as postgraduate deans, consultants, and trainees. Regional educational committees in general practice are required to take into account the current policies of this body which is responsible for issuing national guidelines such as *Criteria for the Selection of Trainers in General Practice*.[5] These are currently being revised.

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Criteria

The first question in considering criteria is whether there are any that are so important that they should be essential for all prospective general practitioner trainers. There are, of course, many criteria in use that are not considered essential but which help the selection process. In the past decade 10 characteristics have emerged that are now generally accepted as essential criteria for selection.

(1) *Enthusiasm*—Learners gain much from enthusiastic teachers, and learning is more likely to take place if a teacher enjoys the job, since he will infect the learner with his enthusiasm. Although enthusiasm is hard to calibrate, it is usually reasonably easy to find out whether a given general practitioner is enthusiastic about his or her work, particularly on a practice visit when enthusiasm will nearly always leave marks on the practice organisation and clinical care. Furthermore, teaching is a form of communication and the ability to communicate, especially to listen and respond to suggestions and questions, will also become evident during a practice visit, which is essential.

(2) *Courses for trainers*—Once it is accepted that teaching is a separate skill that is independent of clinical medicine then it follows that those who wish to acquire it need help and preparation. Thus courses for trainers have become accepted all over Britain and attendance at one is required by most regional subcommittees in general practice. Many regions have had 100% attendance by all general practitioner trainers for some time (table II).[6]

(3) *Premises*—Premises are important because poor premises can constrain learning from even the best teachers. For example, if it is not possible for a trainee to work alongside a trainer because there is only one consulting room in a single handed practice training becomes so difficult that it is likely to suffer. Most regional committees in general practice therefore require enough consulting rooms to enable trainees to consult at the same time as the trainer and so ask questions when necessary and ease direct communication between learner and teacher.

(4) *The practice library*—General practitioners have to deal with a wider range of clinical problems than any other clinician. It follows that they particularly need support from textbooks, which if they are to be most effective need to be available on the practice premises. Moreover, those who wish to teach general practice have an additional responsibility to make available to the trainee a selection of books and journals about the discipline of general practice itself. The practice library is a visible symbol of the priorities of the practice and its presence and use clarify the criterion of the Joint Committee on Postgraduate Training for General Practice: "A good trainer will be familiar with the main literature of his subject."[5] It is impossible for a single trainer to offer a comprehensive introduction to general medical practice in only 12 months, but he can offer the trainee the means to keep himself up to date and to learn the scope of general practice. Only by reading about the ideas, plans, and practice systems of other general practitioners can a trainee acquire a wider perspective of general practice than is possible from any one trainer, however excellent. Some practices now allocate 5% of the trainer's grant each year to books and journals on general practice.

(5) *Age-sex register*—A working age-sex register is the key to preventive care applied to populations of patients. It is simply not possible to immunise, say, 10 year old girls against rubella or offer cervical smears to 35 year old women unless the practice has an up to date age-sex register. This is an easy criterion for visitors to check, and the absence of an age-sex register shows that the practice does not rate preventive medicine particularly highly.[7]

(6) *Cover when on call*—General practitioner trainers are required to provide permanent cover for trainees working in the practice. This means that when on call a trainee should be able to get in touch with either the trainer or a named principal without difficulty. The trainee should know who to ring and should not feel inhibited in seeking advice or discussing any clinical difficulty which may arise. In practice trainees rarely use this facility, but it may be of considerable importance to patients, has medicolegal importance, and is an important support for young doctors facing the uncertainty of home visits at night.

(7) *Records*—The importance of organised medical records has been one of the main features of standard setting in general practice and is one of the relatively few criteria which the Joint Committee has specifically identified as a requirement.[5] In the past trainees have complained about standards of record keeping in general practice and of wasting time in consultations trying to get the papers into order. The Joint Committee now requires that continuation cards and all hospital records and investigations should be attached in chronological order. This means that trainees can see continuity of general practitioner care immediately. Looking at medical records is a good way of looking at clinical standards—the important but elusive key. Do the patients with asthma have regular peak flow rates recorded? What are the blood sugar concentrations of the diabetic patients? Are hypertensive patients regularly reviewed?

(8) *Teamwork*—Given the growing emphasis in general practice on preventive medicine[8] and the monitoring of chronic disease, the importance of doctors learning to work in teams in general practice is increasing[9]—hence the importance of having health visitors and nurses in training practices, and if these are simultaneously training postgraduate students in their own discipline so much the better. Of particular note is the presence of a nurse and a treatment room, because if these are absent it is likely that the patients will miss a great deal of preventive medicine, and trainees will miss the opportunity of learning to work with nurses in primary health care.

(9) *Audit*—The essential feature of medical audit in general practice is that the practice measures systematically some of its clinical and organisational activities. This leads the practice inevitably into setting aims or targets as well as evaluation. Sir George Pickering emphasised this feature of medical audit, which he saw as a characteristic of all good teaching units in all branches of medicine.[10] General practice is no exception. Good training practices almost invariably have several audits running at one time, and these may be one of the most influential forms of education for trainees, not to mention the partners themselves.

(10) *Teaching time*—The results of research suggest that the single most important criterion is the availability of trainer time with the trainee.[11] An estimated half the training grant represents payment for the time provided by the trainer and the other half for the responsibility of education and organisation.[5] The evidence of trainee opinion is overwhelming. Ronalds *et al* found a highly significant correlation between satisfaction as expressed by trainees and the amount of time provided by the trainer.[11] In their "value for money index" (table III) time was the single most important factor, and 94%, of trainees receiving four hours or more teaching a week considered their trainer was giving value for money in terms of training. In some regions the teaching timetables are examined and discussed with trainers during selection to clarify ambiguities. Teaching may be defined as including all shared surgeries, sitting in, joint home visits, random case and problem case analysis and weekly tutorials. Many training practices provide more time than this, but three and a half hours in 1983 may be regarded as a reasonable minimum and complies with the criteria of the Joint Committee.[5]

Discussion

When considering criteria for selecting trainers it is important to realise that standards in general practice are not static but are on an escalator moving upwards—what may be reasonable or appropriate one year may be inappropriate a few years later. Regional subcommittees in general practice have important responsibilities and are constantly pulled in two directions. On the one hand, as the results of new research appear they will want to incorporate the findings in their policies. For example, the Manchester study[1] showed that learning by trainees was improved if trainers had better books, better organised medical records, previous teaching experience, and were members of the Royal College of General Practitioners. On the other hand, regional committees in general practice must have regard to the standards and facilities in the practices in their region and must build with the bricks at their disposal.

In Devon and Cornwall in June 1980 only about a third of trainers had an age-sex register (table I). This was not at that time a mandatory criterion. By June 1983, however, 85%, of a larger number of trainers had age-sex registers, which had become the norm. Furthermore, although approved trainers form less than a tenth of unrestricted principals in the National Health Service, most work in partnership, so that standards set by regional general practice committees affect training practices and about one quarter of all principals.[12]

The rate of change in training practices is far faster than is generally recognised (table II). For example, in Devon and Cornwall as well as definite improvements in practice premises organised medical records (grade 3)* as classified by inspection on practice visits, rose from 19%, to 77%, and the provision of a separate consulting room for a trainee from 26%, to 66%,—both

TABLE II—*Summary of changes in training practices in Devon and Cornwall*

Factor	Percentage						
	June 1980	Dec 1980	June 1981	Dec 1981	June 1982	Dec 1982	June 1983
Practice							
Premises	48	45	47	44	41	42	42
Health centre	51	60	62	65	65	70	73
Purpose planned	26	43	46	49	59	67	66
Separate consulting room for trainee	19	28	38	50	62	70	77
Records grade (3 or more)	38	49	62	69	75	81	85
Age-sex register	—	—	—	44	41	43	45
A partner an approved trainer							
Personal							
Fellowship of the Royal College of General Practitioners (FRCGP)	27	12	6	8	7	8	8
Membership of Royal College of General Practitioners (MRCGP)	51	60	68	65	66	67	68
MRCGP by examination	34	38	44	44	48	51	52
Attended course for trainers	82	93	97	100	100	100	100
Attended course for trainers in Exeter	51	55	60	63	62	61	63
Assessment visit							
Regional adviser has visited practice in person	68	84	91	96	95	100	100
Office holds Joint Committee for Postgraduate Training in General Practice style report	42	68	89	94	97	99	100
Total No of trainers	73	76	81	87	94	95	96

TABLE III—*Value for money index*

Give your trainer a score:		Possible points	Points scored
1. How many hours of teaching do you receive on average per week?			
None	score	0	
Less than ½ hour	score	9	
½ hour but less than 1 hour	score	18	
1 hour but less than 2 hours	score	27	
2 hours but less than 4 hours	score	36	
4 hours or more	score	45	
Now for each of the following variables add the points indicated. Score 0 for each that you do not have.			
2. If the practice has an adequate library	add	7	
3. If you always have a back-up cover when on call	add	8	
If your trainer regularly uses the following teaching methods			
4. Trainer sitting in on trainee	add	9	
5. Problem case analysis	add	7	
If it is easy to discuss the following with your trainer.			
6. Practice management problems	add	11	
7. Trainee-staff relationship problems	add	10	
8. Trainee-trainer relationship difficulties	add	11	
9. If you have been shown any form of clinical audit in your practice	add	5	
10. From your total score	DEDUCT	69	
To give your final score			

Key
Your trainee's score will be between −69 and +44.
If he scores zero, he has a 50:50 chance of being thought to give value for money.
If he has a negative score, his chance of being thought to give value for money is less than 50:50.
If he has a positive score, his chance of being thought to give value for money is more than 50:50.

TABLE IV—*Characteristics of trainers in Devon and Cornwall: half year ending 30 June 1983*

District	No of trainers	Attended trainers' course		Separate room for trainee	Records grade 3 or more	Age-sex register	Premises		Partner an approved trainer	FRCGP	MRCGP	MRCGP by examination
		Exeter					Health centre	Purpose built				
Cornwall	26	26	18	17	22	18	8	15	15	1	12	11
Exeter	24	24	12	20	19	24	10	21	9	3	23	19
North Devon	13	13	7	11	13	13	11	12	8	—	4	4
Plymouth	20	20	17	9	15	17	9	15	6	2	16	13
Torbay	13	13	7	7	5	10	3	7	5	2	6	3
Total	96	96	61	64	74	82	41	70	43	8	65	50

District	New approvals	Reapprovals	Retected	Pending	Resigned or retired	Deferred	No of general practitioner trainers	No of general practitioners in health district	% trainers
Cornwall	—	11	—	—	—	—	26	247	11
Exeter	—	6	—	3	—	—	24	157	15
North Devon	—	—	—	1	—	—	13	73	18
Plymouth	1	3	—	—	1	—	20	156	13
Torbay	—	2	—	—	—	—	13	118	11
Total	1	22	—	4	—	1	96	751	13

FRCGP, MRCGP = Fellowship, membership of the Royal College of General Practitioners
Figures for trainers include course organisers.

in the three years June 1980 to June 1983. Nevertheless there were considerable differences in trainers and training practices among the five vocational schemes (table III). Many other criteria are used in the selection process some of which receive greater emphasis in some regions than others (table IV). There is space here only for the 10 listed above about whose importance a general consensus has emerged.

Looking to the future, selection criteria and selection procedures are continuing to change. In the Midland region trainers take a written examination and in the Oxford region video recordings are used during extended practice visits. The conclusion seems to be that the emphasis in selection is moving on from the physical or structural aspects of training practices towards the teaching process and the outcomes of training. As the results of research clarify the factors associated with better learning so these will come to be rated more highly by trainees choosing practices and by regional committees in general practice selecting and reselecting general practitioner trainers.

Dr K J Bolden, regional adviser (Devon and Cornwall), Dr M S Hall (associate adviser), and Dr A J B Edwards (course organiser) led many of the visits to training practices from which these figures were obtained. Dr R C W Hughes (regional adviser, Gloucester, Avon and Somerset), and Dr V R Bruce and Dr K H Gay (associate advisers) contributed substantially to the selection process in the south western region. Mrs Pat Parsley kept the records and compiled the tables in the regional advisers' office. The "value for money index" is from *Fourth National Trainee Conference, Occasional Paper 18* and is reproduced with permission from the editor of the RCGP Occasional Papers.

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Conference Report

Reading the printout on the wall: decision making in general practice

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The Department of Industry scheme may have opened up the the joys—and sorrows—of computing to many more general practitioners than before but it remains a minority sport. It will probably come as no surprise, however, to learn that the computer world is eyeing up the staid old world of general practice for its next assault, this time with a further generation of as yet embryonic programs aimed at helping doctors with areas where making clinical decisions is particularly difficult.

A conference on decision making in general practice (1-4 December 1983) was therefore both timely and important. Conceived by Dr Mike Sheldon in Nottingham, it brought together three sets of people: ordinary general practitioners, those who are actually designing the next generation of software, and psychologists and social scientists, who have been looking at how doctors make decisions. Thoroughly well organised with papers circulated before the meeting and a host of luminaries attending, we spent three days looking into the future and trying to read the dimly perceived printout on the wall.

The main application of computers that the conference looked at was decision aids—small programs that aim at helping with a particular clinical area. Dr Robin Knill-Jones, a gastroenterologist from Glasgow, and Dr Bill Dunwoodie, from the department of general practice, presented their current work on a program to help general practitioners to clarify upper gastrointestinal problems. It seems that patients like the idea that they can now be "interviewed" by the computer, and the computer is better at getting an accurate history in some interesting ways. For example, patients consistently admit to drinking more to the computer than they do to either their general practitioner or a psychiatrist. (I find myself engaged on a similar project when slinking off to the automatic cash point to find out how big my overdraft is rather than face my friendly bank teller.)

Happily, none of these diagnostic helps is intended to replace the doctor. In Glasgow it is being used much like a laboratory test—when the general practitioner finds the problem clinically ambiguous he may ask a patient to spend five minutes answering the computer's set of questions, as a kind of in house second opinion. Since the printout includes the reasons that the computer suggests a particular set of diagnoses it also educates rather than mystifies.

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The rules we use

The use and dependability of such programs to help with diagnosis depends, however, on elucidating how decisions are actually made now—an arcane business at the best of times. What rules do we follow when we decide to refer this old lady but not that one with the same condition? Why do we ask patients questions in a particular order, and what difference does it make if we change the sequence? Why is there a wide range of behaviours among general practitioners that is independent of their patients? In short, if computers are going to progress beyond being glamourised age-sex registers we will have to be a good deal clearer than we are about how and why we make decisions.

In opposition to this need for logic and clarity is the fact, articulated by many speakers, that general practice by its nature deals with the fluid and complex problems of real people that are often undifferentiated into a disease entity that a computer might recognise. At its best general practice aims at seeing these issues from the patient's point of view and not just from a clinical perspective. This is often of necessity a matter of personal understanding. Reducing it to a set of logical rules is immensely difficult and perhaps impossible. Dr Paul Freeling, articulating the ghost of Balint, pointed out how dangerous organising illness into concrete diagnoses can be: "Computers should not instruct patients in how to have their diagnosis."

This tension between the complexity and richness of the practice and the degree of logic and clarity required to produce any worthwhile computer system was a recurring theme through the conference. Both Professor Ian McWhinney and Professor John Howie pointed out that much of what general practitioners do is inevitably implicit—it is not necessarily a failure to be unable to state exactly why we do things. To try and see the world from the patient's point of view perhaps means that, by definition, hard and fast rules, decision trees, and protocols have only a limited place in general practice.

The difficulty, however, of trying to accept the best that new technology has to offer without getting lumbered with the worst seems to be a trick that as a society we are extremely bad at. Too often the advantages and drawbacks come as a single indivisible package, and to refuse new technology is seen as refusing progress. As Mike Fitter, from the Medical Research Council's social science research unit, asked: "What is so special about general practice that will prevent us going the same way as that now dying breed the corner grocer?" Interestingly, the consensus seemed to be that there were many aspects of practice where computers, no matter how "smart," would always be inappropriate—a point underlined by Ann Cartwright, who hoped that general practitioners would not become so enamoured with their new toys that they spent even less time with their patients.

Computers, however, were not at the heart of this conference. Their long shadow might have been there, cast back from the future and concentrating our minds, but many of the most interesting papers and discussion focused on how we make decisions in the mundane and uncomputerised present. Janet Gale, an educational psychologist, and Dr Phillip Marsden, a consultant neurologist, presented work from their recent book about how we actually formulate diagnoses.[1] By using careful and detailed stimulated recall of video recorded consultations they found that doctors, from house officers to consultants, start construing information from patients as soon as they get it. None of us, it seems, waits till we have enough data and then begins to formulate hypotheses, but rather from the first instant we begin to put particular meanings and constructions on the information we get and this in turn guides our next question. This is not at all the way that computer programs have thus far worked.

Dr Ben Essex, a general practitioner from London, produced a fascinating paper that was in the best tradition of idiosyncratic, creative research in general practice. For every patient seen during nine months he recorded the problem, his management, and any factors that he felt had influenced him while formulating his decisions. From this large amount of work he had distilled out over 300 "rules of thumb" about how and why he took decisions as a general practitioner. These were surprisingly general. For example: reassurance may be appropriate only after identifying the aetiology of the anxiety; decisions to assess compliance should precede decisions to evaluate treatment. Many of his "rules" had a ring of truth to them, and here, it seemed, was a new way in which to try and bring understanding to some of the areas we normally feel are inaccessibly complex. The computer hubs, too, were drawn like bees round honey to such a rich source of personal knowledge already distilled into potentially computer compatible form.

One of the most hopeful things about the conference was the openness of the computer experts who were there. Far from pushing their theories or expectations of what computerised diagnostic aids have to offer, they were interested to learn what general practitioners' real needs might be. In fact the most important aspect of the conference was that it brought these two groups together. The novelty of the technology means that no one is quite sure what is possible. That general practitioners must participate in the gestational phase of the next generation of programs is vitally important—we will get only the computer systems we deserve, and without planning and help from practising doctors we are likely to end up with elegant but useless toys.

This conference was an important step on the road to ensuring that we end up with useful systems that genuinely improve care without frightening off either patients or their general practitioners.

Reference

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ONE HUNDRED YEARS AGO Hinton's plaster-of-Paris bandage-machine: This invention is for the purpose of impregnating bandages with dry plaster-of-Paris, and rolling them at the same time, and is a very much cleaner method than at present employed, namely, rolling them by hand; besides, the plaster-of-Paris is more evenly spread in the meshes of the bandage. The machine, which has been patented, consists of a suitable framework, on which is mounted a box, or hopper, for containing the plaster-of-Paris. At the bottom of the hopper, there is an elongated slit; within this is placed a fluted roller. On the end of the spindle on which the roller is placed, there is a pulley mounted, driven by means of a belt or strap from another pulley mounted on the end of a horizontal shaft of small diameter, supported by the framework, and provided with a crank-arm or handle on which the bandage is wound. The bandage to be impregnated with the dry plaster-of-Paris is passed under the machine, and brought round the roller at the back of the hopper; it then passes under the hopper, and under a stretcher which is placed there for the purpose of spreading the plaster evenly in the meshes of the bandage. The bandage is rolled up whilst the plaster is being incorporated with it, just in the same manner as it is wound up by an ordinary bandage-machine. The bandage, after being rolled, is removed, and only requires soaking in water a few minutes, when it is ready for use, or a number can be made at once, placed in a dry tin, and kept for use when required. By this machine, the plaster is more equally distributed in the bandage, and the bandages are more easily made. It has been used largely at the Royal Albert Edward Infirmary, Wigan, for some time, and it is found to answer the purpose for which it is intended. Mr. Hinton will be glad to supply the machine, or furnish testimonials and particulars respecting it, if communications be addressed to him at the above Infirmary at Wigan. (*British Medical Journal* 1884;i:1096.)

Practice Research

Well man clinic in general practice

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Abstract

The establishment of a well man clinic run entirely by a nurse in general practice showed an appreciable number of men to be hypertensive, smokers, or overweight; it also showed some previously undetected disease. Efforts were made either to treat or to counsel men in whom these findings were made. A well man clinic may have greater value than a well woman clinic.

Women live considerably longer than men. All general practitioners are aware that the women aged over 70, and especially over 80, in their practices greatly outnumber the men. It is therefore paradoxical that most of the enthusiasm for screening well people seems to be directed at women, the more so because women are screened routinely far more regularly than men. Women are screened, firstly, in association with contraceptive usage, especially the pill; secondly, during antenatal and postnatal care; and, thirdly, concomitantly with regular investigations for cervical cancer. The paucity of screening of men is therefore surprising. In addition, women of all ages consult their general practitioner more often than men.[1] Every consultation presents an opportunity, at least, for bringing health preventive measures up to date.[2 3] It cannot, of course, be assumed—nor indeed is it the case—that screening and attending the doctor result in longer life. Nevertheless, it would not be an unreasonable assumption that if men were screened as rigorously as women at least a small number of them might be prevented from dying early, particularly from cerebrovascular and cardiovascular disease.[4] In view of this our practice, which had established a well woman clinic in 1976, belatedly set up a well man clinic in 1983.[5 6]

Method and results

Discussions within the primary health team at house committee meetings concluded that the work could be done by a nurse. Doctors would participate only in the general organisation and the screening protocol because they do not find preventive health care challenging and their training in recent decades at medical schools has not prepared them for it. The recent plethora of publications from the Royal Society of General Practitioners has attempted to rectify this, but many doctors still consider such work tedious and would give a higher priority to improving the clinical standards of care for sick people.[7 8] Conversely, nurses seem far more enthusiastic about preventive care and have appropriate training, knowledge, and skills. Above all, they are happier to work to a protocol and by rote than are doctors. The excellent antenatal care that is carried out by midwives is a good example of this. In addition to having attached district nurses our practice had employed a practice nurse for 16 years. She had pioneered the well woman clinic and subsequently carried out the well man clinic.

The clinic, for well men aged 30-69, was advertised as part of National Health Service care by posters in the waiting room. In addition, a letter from the practice doctors about the clinic was handed to men attending the surgery and copies left on seats in the waiting room. Consultations by appointment were booked for every 10 minutes. Although by no means swamped by applications for the clinic, the nurse quickly had a waiting list. This could be reduced by withdrawing the waiting room letters, in which case demand tended to fall.

The protocol for the clinic included obtaining information about the patient's occupation, personal history (any symptoms), family history, smoking and drinking habits, height, weight, and blood pressure while seated (diastolic recorded at the fifth Korotkoff sound). Postprandial urine was tested for albumin and glucose. Our intention to record the peak flow of smokers was, regrettably, never implemented. The data were recorded on a modified A4 immunisation and screening investigation sheet.[12]

After the assessment men were advised to try and achieve their correct weight for height, and an appropriate diet sheet was given. Smokers were exhorted to stop, advice was given about how to stop, and relevant leaflets were provided. Physical exercise was recommended as appropriate. An antitetanus booster injection every five years was offered, and men with no previous immunisation were offered a full course. Patients were reassured if they were found to be truly well and were recommended to have their blood pressure measured every five years. If their blood pressure was raised on the first recording two further measurements were taken on different days and at different times of day. If the blood pressure settled they were advised to have yearly checks. Men with a diastolic blood pressure persistently of 100 mm Hg or more or with one recorded increase in blood pressure but with a bad family history of cerebrovascular or cardiovascular disease had blood taken for biochemical profile and measurement of cholesterol and triglyceride concentrations. They were then referred to their general practitioner. The nurse was free to initiate investigations such as measurement of haemoglobin concentration in patients showing pallor or tiredness or electrocardiography in patients with cardiac irregularities.

The first 100 men were analysed. Thirty were from social classes I and II, 61 from social class III, and nine from social classes IV and V. Of 25 men who were 15% or more overweight were three 25% overweight. Of 29 smokers, 16 smoked more than 10 cigarettes a day. Nineteen men were found to have an initial diastolic blood pressure of 100 mm Hg or more, and 14 had a persistent diastolic blood pressure of 100 mm Hg or more. No appreciable urine abnormality was found in any of the men. Sixty six patients received a booster antitetanus injection, and two were given a primary course. Fifty five patients had consulted their doctor in the past six months and 63 in the past 12 months. Twenty one patients were referred to the doctor, most for hypertension. One early case of Parkinson's disease was detected, and one possible case of thyroid abnormality with irregular pulse needed investigation. In one confessed heavy drinker liver function tests yielded abnormal results.

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Discussion

The results show that there was an appreciable number of men in the practice population with undetected, untreated hypertension. There was also an appreciable number of men with a diastolic blood pressure that required annual checking. Obesity together with lack of exercise seemed to be a major problem. Despite considerable efforts at almost every consultation and major campaigns with pamphlets and notices in the waiting room, nearly a third of the men smoked. The level of immunisation to tetanus in the practice was not good but was easily rectified. The fees for service accruing for the tetanus immunisations more than covered the 30% of the nurse's wages paid by the practice for the time she spent in the clinic.[13] The results confirm that a trained nurse working to a protocol can carry out a large amount of preventive care and can suspect the presence of organic disease either from symptoms or from observation of physical signs. She may then refer the patient to a doctor for diagnosis.

Our findings also show that regular attendance to see a doctor—two thirds of the men examined had seen their doctor in the previous 12 months—in a reasonably careful general practice that has espoused the concept of preventive care in the past few years does not necessarily result in effective preventive care.[9] The men who attended—and their wives, who had often encouraged them to attend—considered the clinic to be a welcome adjunct to the overall practice care. They were surprised to find it running without charge as part of the National Health Service. The clinic continues and is here to stay.

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(*Accepted 21 November 1983*)

Medical rehousing

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Abstract

A local authority and its medical adviser collaborated to assess the needs of applicants who have special requirements for medical rehousing. Some characteristics of the applicants were examined, together with how successfully their needs were met. Over half the applicants were aged over 55. Some three years after their initial application 41% of applicants considered to have medical priority had been rehoused compared with 36% of those with no medical priority.

Introduction

The adverse effects of substandard housing on health have long been recognised. The proportion of dwellings in disrepair or lacking standard amenities has now declined (decennial census reports 1951-81 of the Office of Population Censuses and Surveys). Medical advisers to local authorities have therefore concentrated on giving advice on how to meet the needs of those who for medical reasons have special requirements for rehousing. I report here a study of applications for rehousing in Portsmouth, which has a population of 175 000, of whom 104 000 live in owner occupied dwellings, 25 000 in privately rented accommodation, and 41 000 in council owned dwellings.[1] In addition, the city owns dwellings housing 60 000 people in a neighbouring borough.

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Procedures and policies

Applicants on the waiting list for housing are awarded points by the housing department on the basis of, for instance, overcrowding, disrepair, lack of standard amenities, and length of time on the list. About 60% of the applicants for rehousing and 70% of the applicants for transfer apply for priority on medical grounds (Portsmouth City Council, minutes of health and housing committee, 1982-3). These applicants are asked to complete a form stating their medical grounds, and this is forwarded in confidence to the Portsmouth and south east Hampshire community health services department to be processed by a senior clinical medical officer.

The senior clinical medical officer may: (1) refuse priority rehousing on medical grounds; (2) award points on a scale of one to 20 based on a patient's statement of medical needs; (3) award a strong recommendation, which implies early rehousing outside the points system; (4) defer assessment and request a report from the general practitioner with the written consent of the applicant. This is done when the information given by the applicant is insufficient; or (5) inform the environmental health department when a private tenant alleges disrepair or the housing department when a city tenant alleges disrepair.

The points awarded are added to the applicant's points total. The criteria for awarding priority on medical grounds were arrived at by agreement with the housing department and are as follows: "An

application may be given priority on the housing or transfer list on medical grounds if the applicant or any person living at the same address suffers from a disability or illness which renders the present dwelling unsuitable because of its size, position, condition, or lack of amenities. Priority may also be given where it is desirable for an applicant to move in order to care for a relative who is disabled or elderly and it is likely that rehousing would mitigate the severity of the illness or disability or its effects on the lives of the applicants or relatives." A distinction is thus made between cases in which there are medical factors relevant to rehousing (when points are awarded on medical grounds) and those in which housing conditions are defective (when applicants are awarded points by the housing department without any need for medical advice).

Methods of study and results

Every year some 2000 people apply for rehousing and transfer on medical grounds, so that a sampling procedure was necessary for this study. A sample using every tenth applicant from the alphabetically filed records was rejected because some of the applications would have been too recent for the outcome of the application to be assessed. It was decided to use the first 100 applicants for housing and the first 100 applicants for transfer in 1980. The number of applications does not fluctuate during the year, implying that the sample drawn from the beginning of the year is probably representative.

Table I shows the age distribution of the applicants as stated by the housing department, table II shows the type of housing requested, and table III shows alleged defects in existing housing. Of the 100 applicants for rehousing, 24 made repeated applications: 13 applied twice, six three times, and four four times. Of the 100 applicants for transfer, 35 made repeated applications: 22 applied twice, five three times, two four times, four five times, and two six or more times. Fifteen applications for rehousing were referred to the environmental health department because of alleged defects in current housing. Twenty applications for transfer were referred to the housing department for alleged defects in accommodation owned by the council.

TABLE I—*Age distribution of applicants*

Age	Rehousing (n = 100)	Transfer (n = 100)	Total (n = 200)
0-4	5	1	6
5-14	4	4	8
15-24	5	2	7
25-34	7	3	10
35-44	2	1	3
45-54	4	3	7
55-64	10	1	11
65-74	11	4	15
≥75	13	6	19
Not known	29	79	118

TABLE II—*Type of housing requested*

	Rehousing (n = 100)	Transfer (n = 100)	Total (n = 200)
Ground floor flat or equivalent	41	31	72
Move to be near a caring relative	9	12	21
Larger	5	11	16
Centrally heated	3	7	10
Quieter area	1	8	9
Smaller	3	5	8
Elsewhere		7	7
Flat with warden	3	4	7
House	3	3	6
Flat suitable for wheelchair	3	2	5
With garden		5	5
With bath	1		1
Not stated	28	5	33

TABLE III—*Alleged defects of existing housing*

	Rehousing (n = 100)	Transfer (n = 100)	Total (n = 200)
Stairs	29	22	51
Damp	13	21	34
Overcrowding	11	8	19
Noisy	3	9	12
Too small	7	3	10
Too large	5	6	11
Too far from relatives	2	8	10
Too cold	5	2	7
Outside lavatory	6		6
Central heating		4	4
Not stated	19	17	36

TABLE IV—*Types of housing recommended*

Ground floor flat or equivalent	38	21	59
Warden controlled	2	2	4
Flat suitable for wheelchair	2	2	4
Near relative		9	9
Quieter area		6	6
Others	12	17	29
Total	54	57	111

TABLE V—*Outcome three years after initial application*

	No medical grounds	Medical grounds	Total
	Applicants for housing		
No rehoused	20	22	42
No not rehoused	31	27	58
	Applicants for transfer		
No rehoused	17	18	35
No not rehoused	34	31	65

Table IV shows the type of housing recommended, and table V gives the outcomes three years after the initial applications were made.

Of the 82 applicants for housing and transfer whose ages were stated, 45 (55%) were over 55. Out of 167 applications for a specific type of housing 72 (43%) were for a ground floor flat or equivalent, 21 (12%) for rehousing near a caring relative, seven (4%) for a flat with a warden, and five (3%) for a flat designed for the use of a wheelchair. This implies a degree of immobility or dependence, or both, in 105 of the 200.

Fifty three applicants (27%) did not advance medical reasons. Thirty four applicants (17%) alleged dampness, which is not in itself an indication for rehousing or transfer as the most effective solution is to rectify the defect. Nineteen applicants (10%) complained of overcrowding, which in the absence of any related illness is not a ground for medical priority as the housing department awards points for it anyway. Many applicants made multiple requests for consideration despite being asked to reapply only if their circumstances changed.

Discussion

At first sight the system of awarding points for medical priority appears to have little effect on the chance of an applicant being rehoused or transferred. The award of points, however, increases the applicant's points total and thus, to a certain extent, must accelerate rehousing or transfer. Applicants with special housing requirements are possibly more difficult to place than those without. Our experience with the success of rehousing people contrasts with that of Gray, who found that fewer than 4% of applications were successful.[2] This difference is probably due to the fact that in Portsmouth the number of medical points that may be awarded is a higher proportion (40%) of the average threshold level required for rehousing or transfer. In this respect Portsmouth lies in the middle of the range quoted by Thomas and Yarnell.[3]

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(*Accepted 24 October 1983*)