Voluntary helpers in general practice

Ian Goodrick

For many years hospitals have had their Leagues of Friends, whose volunteers raised money and worked hard to provide extra services and comforts for patients. This work became so important that many hospitals employed a volunteer organiser to give a proper framework to the friends' charitable impulses. With the closure of so many hospitals, what can be more appropriate than the move to establish Leagues of Friends working directly with general practices? Now that care in the community is upon us there will be a much greater need and scope for good voluntary community initiatives.

Traditional use of volunteers in English medical care

Voluntary caring for the sick since the industrial revolution includes many forms of small scale philanthropy that grew up in the early and mid-Victorian eras.¹ Religious revival and philanthropy led to the creation of district visiting associations, whose aim was to relieve the squalor of the Victorian slums. The "Bible nurses" undertook simple home nursing, gave preventive advice, and encouraged a programme of religious revival and medical self help. From these charitable beginnings Ellen Ranyard developed London's first district nurse programmes, the forerunner of today's community nursing.

Towards the end of the nineteenth century many of the local philanthropic initiatives were coordinated into larger charities, and some grew into very large institutions, thus losing their local family and essentially feminine flavour.² Twentieth century social legislation and two world wars altered society's view of philanthropy. After the establishment of the National Health Service and the welfare state many of these charities seemed unnecessary and even undesirable.

A sideways glance at the history of our cottage hospitals shows how doctors have successfully focused the impulses of their local community to the benefit of their patients. It was local and it was seen to be good. Or was it really the community which steered their local doctors to its needs and wishes? In either case the voluntary impulse had an important role in providing medical amenities for patients in their own community.

Reviving local practical philanthropy in general practice

With the implementation of the "doctors' charter" in the late 1960s the role of the general practitioner was widened. The newly augmented primary health care teams were to take into account the needs of the community they served. Since then successive governments have consistently enlarged the span of general practice.

Whatever the political administration, many general practitioners found that there was a large gap between the ideal and the resources actually available to the patients at home. Despite this there is often a very

strong bond of trust between family doctors and their communities.³

In the early 1970s, frustrated by the slowness in response to many statutory agencies, a Norfolk general practitioner used his special relationship with the community to establish a volunteer scheme attached to his practice. In a series of descriptive articles Allibone showed how good will in the community can be focused by the local general practitioner and how the lay community can be involved in providing a range of services.⁴ Two hundred volunteers were recruited and trained in rural north Norfolk. They performed a range of tasks from shopping trips to simple home nursing all aimed at improving the quality of care for patients at home. Administrative tasks were carried out by a dedicated group of volunteers working with the primary health care team. Money was raised locally and the voluntary services coordinator became the key to transferring local resources direct to those in need in the community.⁵

Evolution of voluntary patient support groups

Three sorts of volunteer schemes evolved in general practice in the 1970s.

Outreach schemes have been mainly organised by large charities or health authorities and are usually only loosely linked with general practice. Both the British Red Cross and St John Ambulance Brigade have organised home nursing courses for volunteers. In one experiment volunteer nurses were attached to a health centre in Kent. They performed simple nursing, coped with social needs such as fetching library books, and relieved the loneliness of the patients. In this way they released the district nurse from trivial tasks. There were some administrative problems to do with insurance and professional frontiers, but the success of such schemes depended largely on the enthusiasm of the general practitioners and district nurses involved. In other cases the volunteer nursing schemes have been an outreach from local hospitals who were trying to unblock their beds.⁷

Social support model—A number of social support schemes were evolved based on the general practitioner's surgery. Simple caring tasks were undertaken—for example, shopping, visiting, sitting with an infirm patient to relieve the caring relative, transport to the surgery or chiropodist—all of which are helpful in allowing an infirm patient to remain at home. In 1983 a general practitioner from seaside Devon described how to set up a patient visiting scheme with the volunteer organiser based at the surgery and a part of the primary health care team.⁸ He invited other general practitioners to follow this model. Other practices did take this route and established schemes that stopped at the frontiers laid down by nursing and medical professionals.⁷

Home nursing schemes have gone further to provide support and help in virtually all aspects of general practice. The home nursing model has three essential characteristics: being based in or very near the general

practice surgery⁹; recruiting and training volunteers from the local community; and involving those volunteers in a wide range of tasks including simple home nursing.

Support from health care professionals

Whenever voluntary patient support groups are successful it is the enthusiastic support from doctors, nurses, and receptionists that really determines the frontiers.¹⁰ Many commentators emphasise the importance of support by general practitioners and district nurses. This may be in a practical way, such as making the surgery premises available or taking part in volunteer training programmes.¹¹

A recent survey showed that only 5% of doctors were actively involved in the organisation and management of volunteer patient support groups. About 30% said there are local groups available, and over 80% wanted to know more about the voluntary impulse and how it would be used to benefit their patients (unpublished data).

The present situation

Recent work has shown that there are 76 voluntary patient support groups in England. A third are in rural areas and a similar number in urban practices. The rest are in mixed areas or at the seaside. Fifty nine were attached to the doctor's surgery with a further 16 being independently organised but easily available to the primary health care team.¹² Many schemes seem to have started in the early 1980s as individual responses to local needs. At first many existed in virtual isolation with little contact with each other. In the past five years however, clusters have appeared, particularly in East Anglia and the south west. Some patient support schemes such as the Glaven Caring Scheme in Norfolk or the Westbank League of Friends in Devon have acted as role models in their regions. The concept spreads more rapidly when a facilitator has been employed by the local health authority or social services authority to encourage new schemes and to support existing ones, as in Dorset, Norfolk, and Essex (S Gill, paper delivered at conference on volunteers, Exeter, 1990).

Although some schemes are strictly limited in their purposes, such as providing transport or arranging shopping trips, other schemes seem to evolve and grow to provide a wide range of support for all who need it. The pattern of support and extra care has become quite sophisticated. Volunteers are used to help health visitors in supporting young families under stress. The support of a volunteer to provide a few hours' break once or twice a week can make caring for a patient at home more tolerable to the relatives. Some schemes have extended this support to the care of terminally ill patients. Other patient support groups have established luncheon clubs and day centres for elderly people, and this contributes greatly to the quality of life of the patient and the principle carer. Other schemes run successful carers' groups where the care givers can meet to discuss mutual problems. This approach has been extended to the running of bereavement groups.

Administrative and financial structures

In the past few years the administration and funding of such groups has followed two routes. Some schemes have become independent local charities with their own management committee and their own constitution. Money can be raised locally or by grants from local social services and health authorities. This model allows freedom and freshness in response to the needs as identified by the general practitioners and nurses in

the practice. Another approach is for the local health authority, as in Norfolk, or social services, as in Essex, to employ volunteer coordinators directly. These employed organisers, often working part time, recruit local helpers to provide the support needed for patients at home.

Volunteer coordinators—a new type of health worker

The volunteer coordinator has a vital role. Often beginning as a volunteer, she emerges as the key link between the volunteer, the patient, and the primary health care team. Indeed she is seen as a new sort of health care professional.¹³ In some schemes the coordinator is already a part of the primary health care team, attending weekly meetings and being involved in the training of volunteers.¹⁰ Of course there were difficulties at first in the acceptance of the volunteer coordinator,⁷ but some doctors have integrated the coordinator by employing her as a part time receptionist.⁸

There is no doubt that setting up a volunteer scheme brings about a large administrative burden. At first there was often no official provision to pay the coordinators' salary. In the mid-1980s there were only four volunteer services coordinators in paid employment.⁵ Since then the post has been recognised piecemeal and there are now at least five salaried appointments in the Exeter area alone (I Goodrick and M Nelson, personal communication). The central role of the coordinator is to transfer care from charitable resources in the community to the patient being looked after at home. Without such help most general practitioners are unlikely to be willing or able to extend their role in the community.⁵ This view has been strongly reinforced by the extra workload caused by the new general practitioner contract and the recent community care act.

The future for the voluntary impulse in general practice

With the new emphasis on community care and the rising number of frail elderly people living at home there is a real opportunity to extend the boundaries of general practice to provide a complete caring domiciliary service. It is becoming evident that the state cannot or will not undertake all this work, so the role of voluntary helpers in general practice becomes more important and varied.

There is an obvious danger that professional caring agencies such as social services or health authorities may be tempted to use volunteer schemes to carry out what would otherwise be statutory duties. Many volunteer schemes declare their independence and define their work as being the provision of extra care, comfort, and support for patients being nursed at home. Another great strength of voluntary organisations is their capacity to innovate and respond quickly to new needs, as in the growth of the hospice care movement or respite care initiatives.

Certainly those patients who are most at risk need to be identified and volunteers have been used in this task.^{14,15} There is also a need to be accountable for the selection, training, and support of volunteers.¹⁰ The growth of voluntary patient support schemes has shown that harnessing the local good will can bring positive benefits by avoiding social admissions to hospital, shortening hospital stays, providing support for caring relatives, and releasing district nurses from non-nursing duties.¹³

There may be some advantages in consultative and financial partnerships between voluntary care schemes and local authorities,¹⁶ provided that independence and integrity are not lost in the deal. Well thought out

partnerships between local authorities and voluntary patient support groups can work to the benefit of patients.¹⁷

Practical considerations

The many practical aspects to the formation and running of a successful volunteer patient support group were explored at a national conference in Exeter in 1990. A professor of general practice described the trend lines of change and a medical historian charted the voluntary contributions made to British medicine. Against this backdrop, two volunteer coordinators described how to attract, prepare, and support volunteers. The evolution of the volunteer organiser was explored and her relationship with established members of the primary health care team such as receptionists, district nurses, and health visitors was discussed. A lawyer reminded the conference that the milk of human kindness did not come cheap and that there was an ever present need to be accountable in providing training, supervision, and insurance. A professional researcher described the effects of care giving on a carer's working life—the change of greatest benefit would be a flexible approach to time keeping by employers. A lay member of the Royal College of General Practitioners described the work of patient participation groups, which mainly have an advisory role in representing the interests of all patients and receiving suggestions about the services provided by the doctors; she went on to welcome volunteer patient support groups, which provide extra practical support and comfort direct to patients looked after by the primary health care team, and wondered whether the two could not be linked. A general practitioner emphasised the need for proper organisation, arguing that volunteer groups do better if they project a smart and successful image as well as a kind heart. From

every direction there was agreement that there is real scope for voluntary helpers in general practice but that there is also an urgent need for some sort of manual of good practice.

Conclusion

General practitioners still retain a notional independent status which allows us to act solely in the interests of our patients and community. With a team of well trained volunteers and the help of a voluntary services coordinator every general practitioner can have a real resource with which to extend effective domiciliary care in the practice.

- 1 Prochaska F. *The voluntary impulse: philanthropy in modern Britain*. London: Faber and Faber, 1988.
- 2 Harrison B. *Peaceable kingdom: stability and change in modern Britain*. Oxford: Clarendon, 1982.
- 3 Berger J, Moir J. *A Fortunate Man*. London: Allen Lane, 1967.
- 4 Allibone A. Caring in the Villages. North Norfolk launches a self help scheme. *BMA News Review* 1977 February: 49.
- 5 Allibone A. Volunteers in General Practice—It does work. *BMJ* 1987;283: 1581.
- 6 Davidson K, Mocroft I. *Volunteers in primary health care*. London: Volunteer Health Centre, 1981.
- 7 Green PA. Why not start a Karing group? *J R Coll Gen Pract* 1983;33:304.
- 8 Goodrick I. When the community really cares. *GMS News Review* 1988;14:6.
- 9 Nesbitt M, White D. Extending care from the primary health care team. *Primary Health Care* 1988;4:32-4.
- 10 Watt A. Community health initiatives and their relationship to general practice. *J R Coll Gen Pract* 1986;36:72-3.
- 11 Goodrick I, White D, Nisbett M. Are volunteers a resource which the GP can use in the care of patients? London: King's Fund Institute, 1991:41. (Research report 10.)
- 12 Haynes A. Informal Carers and GPs. *The Practitioner* 1988;232:705.
- 13 Carpenter GI, Demopoulos GR. Screening the elderly in the community, controlled trial of dependency surveillance using a questionnaire administered by volunteers. *BMJ* 1990;300:1253-6.
- 14 Black N. Partnership for health: voluntary organisations and the NHS. *BMJ* 1988;296:82.
- 15 Allibone A. The value of the GP's independence in the care of the elderly. *Publication Update* 1986;Jan:432-50.

(Accepted 21 April 1992)

RECOLLECTIONS

General practice 50 years ago

Just before joining the army in 1942 a short time in general practice seemed a useful way to broaden a somewhat limited medical experience. The practice was in a small town on the River Tyne and its industrial life centred on its two shipyards then busy repairing and building assorted frigates and destroyers. Although the barefoot children of the 1930s were no longer seen, signs of past poverty were everywhere. Many children were undernourished and signs of old rickets were common. Although there was an immunisation programme, the uptake was far from complete and you still saw the occasional child dying of diphtheria or measles. Most of the working population was employed in the shipyards or local coalmines and was just beginning to enjoy the high wages the war had brought.

The practice with two general practitioners had a list of 20 000 or so. The pre-NHS service covered medical care for those in work—mainly men—by a capitation fee but spouses and families had to be paid for privately as were drugs and dressings. The practice was a dispensing one and I soon learnt the easiest way to dilute stock solutions of Mist Expect Stim as well as the differing properties of white, pink, and yellow aspirin. Surgery hours were 9-11 am and from 5 pm every weekday except for Thursday afternoons. Morning surgeries, especially on Mondays, could be a nightmare with perhaps 65 or 70 patients to be seen before 11 o'clock if you wanted to finish dispensing and house calls before evening surgery. Fortunately, many were routine—certificates and repeat prescriptions (white, pink, or yellow?).

Chronic bronchitis, tuberculosis, hypertension, assorted "rheumatic" disorders, and angina were the stock

problems. The major female complaints were tiredness (a "tonic" required) and pregnancy, wanted or otherwise. Tuesday afternoons were occupied by a session of industrial medicine at one of the two shipyards and every other week the practice was on call for emergencies at the local cottage hospital, where we also gave anaesthetics for visiting surgeons.

As well as routine house calls we had several "chronics" who were seen at home every four or five weeks. These included a few, mostly elderly, but some of working age, who were loosely labelled "hysterics." One of these was a man of 45 or so who had been off work for many years with hysterical sensory loss in both legs. On one of my fleeting visits he complained of loss of voice. Although looking back the diagnosis was obvious, I immediately thought, "Ah, hysterical aphonia." Within weeks his bronchial carcinoma became obvious and progressed rapidly. His severe pain was treated with increasing doses of morphine. One evening, after a massive dose, I warned his long suffering wife that he was unlikely to survive the night. Much to my surprise no one appeared at morning surgery to collect a death certificate. In the afternoon I saw him sitting up in bed saying, "That was wonderful stuff you gave me last night. Best night's sleep I've had for years." He died some weeks later.

I have never forgotten what I learnt from my short experience of the real world, but three things remain in my mind; that you should never jump to conclusions; that morphine resistance at massive levels was a real phenomenon not emphasised by our teachers; and that general practice was not for me.—L M FRANKS is consulting editor, "Cancer Surveys," in London