PRACTICE OBSERVED

Organising a Practice

"Please reply impersonally": communication outside a rural practice

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The above exhortation, printed at the head of a letter from social services to me, represents the "pits," as Americans would say, of communication about patients between two disciplines of the primary care team. My purpose in this article is to show some special problems and strengths of communication between the practice and the world outside who arise because of a rural location.

The problems of remoteness are both real and acquired. We are 28 miles from the nearest district general hospital, and I am sure that as GPs our contacts with specialists are less personal because we do not know them so well—postgraduate courses tend to be week long affairs, miles away, rather than a lunch-time session at the postgraduate centre. Patients, too, are often intimidated and inconvenienced by the distances to hospital, and some of the older ones even frightened—this must influence referral rates.

The problems we acquire in communication with outside agencies because of our remoteness are rather more daunting, however. Many boundaries drawn up by others make a sense of humour and a large list of phone numbers essential. To name but a few: the council boundary bisects the practice area, this means two separate sets of social services, two ambulance services, two housing authorities, and two parliamentary constituencies. To get a patient in a village two or three miles from Halesworth, but just over the border in another district, into a part 3 home for elderly patients in the town is difficult. The system prefers that he is housed 10 or 15 miles from his home.

We are administered by Suffolk Family Practitioner Committee in Ipswich, but our nurses are run by Yarmouth. The

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cottage hospital is run by Yarmouth, but the obstetric beds are ultimately the responsibility of Ipswich. Emergency transfer can then mean a Norwich ambulance going to Ipswich, and so on. The list of these bureaucratic anomalies is endless.

The title of this article, "Please reply impersonally," while undoubtedly and commendably encouraging team responsibility in the social services, diminishes the quality of care in a rural area where the lines of personal communication are already long. Other problems that our patients have because of their remoteness is communication with what I call lay caring agencies—for example, marriage guidance, Samaritans, Alcoholics Anonymous, Gingerbread, etc. These are all miles away and of little immediate help in a crisis.

Radios and good neighbours

Our country location, however, has definite advantages in communicating with our patients, most of the people in the area being registered with one practice. Firstly, we have an excellent VHF car radio system with a "mobile base station" which can be moved from the surgery to the partners' houses at night and weekends. This also means that the ambulance control can be sure of a prompt response from the practice in case of a road traffic or other accident; we are all provided with equipment by the Suffolk Accident Rescue Service. This radio service has also recently been greatly improved with an extra radio at the cottage hospital to improve communication between ourselves and the casualty and obstetric departments. The money for the hospital radio was raised by the public at events sponsored by the League of Friends.

Secondly, the senior partner headed a committee that organised a comprehensive Good Neighbour Scheme in the town. Each street or part of a street has been allocated a volunteer "good neighbour" with a telephone, whose responsibility it is to keep an eye on the elderly and infirm people in his or her area.

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The scheme works well. Each inhabitant is informed who the "good neighbour" is and knows that appropriate help will be forthcoming if the person is contacted. The service includes occasional shopping, transport, and other social help, and the elderly people who live alone are provided with large red RSL signs to display if they are unwell and have no phone. We have a branch surgery that each partner visits once a week. This takes place in the sitting room of a pensioner's home about four miles from the surgery, and we have improved communication with it by installing a phone for her and paying the quarterly rental. This means that patients without a phone in that area find it easier to ask for a visit by sending a message directly to the branch surgery.

Because of the long lines of communication with social services and probation officers, for example, an attempt initiated by the probation officer, has been made to set up quarterly lunches where we, health visitors, social workers, police, teachers, and others meet in the local sports club. There were 39 of us at the last lunch, and I doubt its value without a formal agenda. We meet our own nurses and health visitors daily.

Pathology specimens and results have to go 30 miles to a laboratory, but an excellent van delivery service is provided daily. The cottage hospital ensures good communication of antenatal clinic blood results with an internal mailing system. The cottage hospital records are being linked to the computer

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at the district general hospital, though what tangible benefits this will have for us is uncertain. The receptionists in a rural area provide an excellent unstructured communication system. They are all local girls who live in the area, and the complexities of their family and social lives provide an astonishing amount of intelligence about "what is going on" in the social lives, which are of necessity also centred in the practice area. We provide a printed "hand-out" of surgery times and phone numbers for patients, and this, combined with letters sent by our practice nurse for selective call of patients for screening and the computer cards sent by the community health department for immunisation, complete the communication arrangements.

Conclusion

I have tried to describe the variety of structured and unstructured communication arrangements that occur in our rural area and some of our problems and successes. Of course, good communications have very little to do with good consultations. A great deal of information about the practice is also spread by legend and rumour. I well remember the patient who went quite pale when she saw me in the local supermarket and nearly fainted into the cheese counter. "I heard you'd gone to Australia," she said—she probably hoped I had!

Interesting GPs of the Past

George Johnston: 1797-1855

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Berwick-upon-Tweed may seem an unusual source for an interesting general practitioner of the past, and Dr George Johnston at first seems an unlikely candidate. He was born at Simprin, Berwickshire, the 10th of 15 children, of farming stock from the adjoining parishes of Ednam and Eccles, and apart from his student career in the town of Berwick-upon-Tweed and the neighbouring areas of North Northumberland and Berwickshire, with a total of only six weeks' holiday away from his work. But the same George Johnston was given an LLB, honours causa, of Aberdeen University, was offered a chair of natural philosophy, was on friendly terms with the leading naturalists of his day, and his name is commemorated by Othonia Johnston, named by Philip Gosse to honour "the father of our marine invertebrate biology."

Education

Dr Johnston attended Berwick Grammar School as a boarder (his father was by then farming at Ilderton near Wooler), and

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Natural history

Like most entrants to general practice George Johnston had time on his hands in his early years in practice, and it was then that he developed for pleasure the study of botany, which had

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been compulsory when he was a student. This study was put to such good use that in 1829 *The Flora of Berwick* was published, followed by *The History of British Zoophytes* (1838), *The History of British Sponges and Lithophytes* (1845), his *Introduction to Conchology* (1850), and the *Natural History of the Eastern Borders* (1853), which was followed posthumously in 1856 by his *Catalogue of British Worms*. In all he published at least 36 works. His books were illustrated by his wife Catherine, after whom he named Plumaria Catherine, one of his original identifications. While the field was wide open for this type of original research, none the less he took advantage of it to such

good effect that his name was well known to his fellow naturalists, and his botanical collection is preserved in the Royal Botanical Gardens, Edinburgh.

He was offered the chair of natural history in Queen's University, Belfast, in 1845 but declined for family reasons (his second daughter was to die 10 years later of the effects of gross thoracic kyphoscoliosis), but the suspicion remains that it was his liking for Berwick and its environs that prevented the move. When the chair of natural philosophy became vacant in Edinburgh in 1854, however, he applied but his application failed, in company with the applications of Huxley and Hugh Miller. An application for a British Museum fellowship also failed, even though it was supported by a testimonial from none other than Charles Darwin.

He must have maintained some links with Edinburgh after qualification because in the year that his first book was published he issued a challenge to the boys of Edinburgh High School that he would give a copy of his book to any student who could find 20 specimens not listed in his book. A schoolboy took up the challenge and found 26 specimens: this young man

found bigger prizes in Dr Johnston's third daughter, whom he married, and in Dr Johnston's practice, to which he succeeded. He was Philip MacLagan, whose grandson died in 1978, the fourth generation in the practice, and who came from a famous Edinburgh family: his father was physician to HM Forces and president in turn of the Royal College of Physicians and the Royal College of Surgeons of Edinburgh; his brother became Archbishop of York and another brother was lecturer in forensic medicine to the University of Edinburgh.

Berwickshire Naturalists Club

Dr Johnston attended the inaugural meeting of the British Association for the Advancement of Science in York on 29 September 1831; but in fact his most lasting memorial was an inaugural meeting that took place one week earlier on the 22nd. This was the first meeting of the Berwickshire Naturalists Club, the oldest surviving natural and local history society in Britain and which celebrated its 150th anniversary in 1981. The club had originally nine members, including six doctors and two ministers, but Dr Johnston was its founding father, whose initial idea it was and who kept it going through the difficult early years when on occasion he was the only member at meetings. The club has published an annual journal of its doings and of original work since 1831, now has some 350 members, and appears set fair for its second centenary in 50 years. One trend probably not noticeable in Dr Johnston's time is the increasing number of letters addressed to the secretary seeking information concerning the sun and sun-seeking activities of the Berwickshire Naturalists Club.

Civic duties

Dr Johnston was not slow to undertake civic duties in the town of Berwick and was three times mayor, was sheriff in 1843-4, and in Dr Johnston's practice, to which he succeeded. In 1841 what is now the Royal Highland Show visited Berwick and Dr Johnston's efforts were such that his fellow citizens were pleased to reward him with a handsome gift of plate.

Correspondence

He was a prolific correspondent, and his correspondents were sufficiently impressed by what he wrote that they preserved at least 429 of his letters, which were published in 1895, some 40 years after his death and covering 30 years of his life. He writes largely of his botanical work, but the commonplace and amusing crop up. For example, eight months after the opening of the railway line from Berwick to Edinburgh he wrote that he preferred not to travel at such dangerous speeds; and he was greatly refreshed by a three-week change of air—in Spital, on the south side of the mouth of the Tweed and quite one mile as the crow flies from his home in Berwick.

General practice

Little information is available about his medical work in general practice from his own writing, but the minutes of Berwick Dispensary give some side lights. He was appointed surgeon to the dispensary in 1818 (founded in 1814 and now Berwick Infirmary) and became physician there in 1831 by succession rather than by any particular qualifications, and the minutes note that he proposed himself to fill the vacancy of physician at the institution. His work at the dispensary was given freely apart from one shilling and six pence per mile for visits to patients living within 12 miles of Berwick. His comment

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in a letter in 1852 that "both my horses are very weary" spoke of the distances he must have travelled on horse back; for example, a patient with a fractured thigh was treated at his home eight miles from Berwick by Dr Johnston on behalf of the dispensary from 16 to 28 February 1832, and he was visited daily; the patient complained because Dr Johnston's success in the dispensary was visited only once in 10 days. When the main east coast railway line between Edinburgh and London was being constructed extra work came to the dispensary, and in 1848 the secretary wrote to the railway directors for payment of £2, the cost for "the effusion of blood by the amputation of William Dickson's thigh rendered necessary by an accident on the railway near Reston which destroyed two of the mattresses." The impression given is that incidents such as these occurred in the daily work of any general practitioner of those times who looked after his patients from birth to death, with second opinions available from general practitioner colleagues. When the railway line was completed, infirmary facilities were available 60 miles distant in Edinburgh Royal Infirmary, which the patient could then reach by rail and then by cab. Dr Johnston was senior physician in the dispensary by 1852, and as such enjoyed the confidence of his colleagues so that his obituary in the *Edinburgh Medical Journal* stated that "he never sought to earn his consulting fee by changing the treatment prescribed by the general practitioner who had

referred the patient"—a commendation as applicable today as then, even if there is no longer a fee.

Patients attending the dispensary were kept in their proper place. The hours of attendance were between 12.30 and 2.30 on Sundays only, though this was later modified to 9-10 on Wednesdays and Saturdays. The dispensary supplied a visiting service, but requests for visits had to be made before 10 am or else the visit might be delayed to the following day; again this strikes a modern note in the National Health Service with similar exhortations still seeming to fall on deaf ears. Patients coming to the dispensary were "to be as clean as possible in person and clothes." There was to be "no noise or quarrelling in the waiting-room but each was to wait his turn patiently." They were expected to answer questions put to them "modestly and according to the truth" and were to take every medicine according to direction and not to waste or destroy them. They would "behave soberly, attend regularly, and conform to the rules on pain of dismissal." This was no empty threat; as each year in the early years of the dispensary two or three patients were dismissed for irregularity.

Despite the stresses and strains of his medical career, however, Dr George Johnston could still say to correspondents that his life had been "one grand hobby, work continuous but rarely severe," an epitaph which any of today's medical practitioners would be happy to have.

Training in General Practice

Part-time training: is it viable?

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Providing part-time training for doctors with domestic responsibilities has been discussed recently.¹ Apart from Swerdlow and Rue's account² of 15 years' experience in the Oxford region, most published comment relates either to the theoretical concept or to personal life histories. Many of the anecdotal comments have aroused considerable passion, as borne out by the correspondence columns of this and other journals.³⁻⁵ This article considers the practical problems of part-time training and suggests ways in which difficulties may be overcome and the educational value increased.

What is the demand?

While not all those who seek part-time training are women, it is likely that the demand will be related to the number of

women undergraduates. These have increased from 20% in 1960, to 29% in 1970, to 34% in 1974,⁶ and for the medical school at Nottingham, 42% in 1981. What cannot be easily estimated is how many of these women will enter general practice, and of these, how many will seek part-time training. Ward's recent paper⁷ on careers of medical women showed that 31% of women in two cohorts (12 years and 26 to 28 years after qualification) were in general practice and another 25% were in "community medicine." The participation index of the 1385 women still practising was 0.73, showing that the average commitment was 73% of full-time work.

A national survey of all trainees in 1980⁸ showed that only 39 doctors out of the 1680 who replied were training part-time, and eight of these were men. Only 54% of trainees responded to the questionnaire, however. Since 1972 there have been 139 trainees on the Nottingham Vocational Training Scheme (37% women), of whom seven (5%) had done either all or part of their training part-time. If the trainees who are in Nottingham now are considered the percentage of women rises to 50%, and those training part-time to 10% of the total. Demand for part-time training may be higher at the moment owing to the requirements of the Vocational Training Act. It seems likely, however, that between 5 and 10% of trainees will seek less than full-time training in the future.

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