# PRACTICE OBSERVED

## MRCGP Examination

### Why one should not take the MRCGP examination

SUZANNE JANE SAVAGE

You may wonder why I am suggesting that the membership examination of the Royal College of General Practitioners should not be taken when I have passed the examination myself and organise a preparation course for potential candidates. I am ambitious, too, that as many general practitioners as possible should pass the examination and so be able to join our college, whose aspirations I believe in.

By 1979 I had been a principal for several years. I felt proud of being a general practitioner and wanted to test my knowledge. I thought that I should belong to my college. I practised past papers and skimmed through my old standard textbooks, favourite general practice articles, and most recent medical journals. I then presented myself, a relatively unprepared candidate, at the examination. I found the day harrowing. It was difficult to express my views in the traditional essay paper; I enjoyed the modified essay question paper but overran the allotted time; I puzzled over the esoteric multiple choice questions.

I spent the next month in trepidation, fearing that I had failed to reach the viva. The first half hour viva, based on a log diary of 50 consecutive patients seen in surgery, seemed relevant and time passed all too quickly. My second half hour viva seems amusing to me now but seemed a nightmare at the time. The first examiner, who looked about 55, asked me how many times a week I would expect a man of 55 to have sexual intercourse. He became very heated when I would not state a definite number. The viva ended with the second examiner saying that the middle aged man whose thyrotoxicosis I had treated with $^{131}$I and subsequently allowed back to work had run over a bus queue in his steam roller. To my surprise I passed. I therefore lost any impetus I might have had to question the validity of the examination. I describe my experiences because they seem similar to those of many general practitioner principals who sit the examination.

**London SW16**
SUZANNE JANE SAVAGE, MB, MRCGP, general practitioner
Correspondence to: 293 Streatham High Road, London SW16

#### Failure

I have become more and more disturbed by what I have found while running a preparation course for the examination for the past three years. Kind, sensible, conscientious doctors are failing—the type of general practitioner that I would hope to have caring for me if I were ill. The idea of "an inclusive, rather than exclusive, membership," which the college is said to hope for,[1] is not being fulfilled. In many instances failure has so shaken the confidence of people who have taken the examination that I consider they have been rendered less able to cope with an already demanding job. Some are embittered by failure and do not feel kindly towards a college that they see as a censoring body only. Others, trainees especially, have seemed constrained rather than enriched by preparing for the examination.

Trainees who are at the end of their compulsory vocational training now make up the majority of those taking the examination. They seem to think that it is expected of them. At the fifth annual trainee conference one group commented that "the MRCGP examination is widely taken because of fear and market pressure." They have been at medical school (and I believe that the word "school" is all too relevant) for five years and have done a minimum of two years' prescribed experience in recognised postregistration hospital posts. The training year in general practice gives the trainee an exciting opportunity to develop his own framework to tackle problems in general practice. The potential for using the different skills that are relevant to our infinitely varied work can be explored. Passive learning, which the examination encourages because factual recall is most easily tested, is least relevant at this time. The need to study for an examination during these important months creates a conflict of goals for the trainee. On the one hand he is trying to expand his horizons, on the other he has a syllabus to cover. Parlett describes some students as having a "syllabus bound" style of learning.[2] Trainees who recognise this in themselves are particularly likely to be restricted by taking the MRCGP examination at the end of their trainee year. Unfortunately, the format of the examination tends to test knowledge rather than understanding.

In 1981 the overall pass rate was 60·2%; the pass rate for



trainee practitioners "born and trained in Britain" was 79·8%, compared with that of principals "of similar origin" of 71·1%.[3] The college is reticent about revealing any other breakdown of statistics, but these imply that the pass rate for principals (and trainees) trained overseas must be much lower than 60·2%. Doctors are used to passing examinations. Presumably "hope of success" rather than "fear of failure"[4] is the motive for taking a voluntary examination. Those who fear failing the examination might profitably consider how failure could affect them. If only pride is lost this is of no great consequence since we as a group perhaps have more than enough pride already. But if confidence and self esteem are badly shaken the so called "failures" return to their everyday practice less able to work effectively. Surely this is the last thing that those who advocate an examination for entry to our college desire?

#### Dilemma

Too many of those who have failed seem to think that they are bad doctors. But passing the examination only measures whether you can or not—a subjective assessment on one occasion. Failing candidates runs the risk of alienating half the doctors who were asking to enter the college. The college is sensitive to this dilemma and concerned enough about the examination's relevance for established general practitioners to be exploring other methods of assessment for membership. Unlike examinations in our fellow colleges, our examination is not designed to select those suitable for consultant training. Those who fail continue to work as general practitioners.

Some find it stimulating to pit themselves against a problem and some feel the need to measure themselves against a yardstick: these should be encouraged and helped to pass the examination. There are some (about 50% of principals) who are unlikely to pass this hurdle in its present form and perhaps it is kinder to dissuade such doctors from attempting the examination. I would prefer to see *all* general practitioners capable of becoming college members and college membership renewable only to those who are willing to participate in continuing education. I would like to see the considerable energy and enthusiasm of the college examiners directed towards this aim.

Until my ideal has been achieved, potential candidates for the MRCGP examination should be sure why they want to take the examination; what it is they are taking; what effect studying for the examination may have on caring for their patients; and how they will feel if they fail. The potential candidate may well prefer to apply for associate membership. This carries all the advantages of college membership apart from the vote and registration.

#### References

1 Royal College of General Practitioners. *Looking forward.* London: RCGP, 1982.
2 Parlett ML. The syllabus bound student. In: Hudson L, ed. *The ecology of human intelligence.* Harmondsworth: Penguin, 1970.
3 Royal College of General Practitioners. *29th annual report 1981.* London: RCGP, 1981.
4 Entwistle NJ, Wilson JD. *Degrees of excellence: the academic achievement game.* London: Hodder and Stoughton Educational, 1977.

## Patient Participation

### Survey of patient participation groups in the United Kingdom: I

TIM PAINE

It is over 10 years since Dr Peter Pritchard started the first successful patient participation group at Berinsfield. Since then patient participation has emerged as a new dimension in health care, and the time is now ripe for a review of what has been achieved so far. Before reporting the results of a survey of patient participation groups, however, it is important to set the scene.

The essence of patient participation is that the receivers (potential or actual) and providers of health care work together in a spirit of mutual understanding to improve all aspects of the health care "system" in its broadest sense, particularly at the community level. This approach is obviously in radical contradistinction to the traditional health care model. Firstly, it challenges the adequacy—and appropriateness—of a profession always assuming that it knows what is best for the community it serves. Secondly, it recognises the very positive contribution that can and should be made to a community's health care by all those who live in it.

This basic change of approach may easily be dismissed by those who wish to do so as an undesirable and unnecessary aberration, conjured up in the minds of "Hampstead trendies" who are anxious to jump on the bandwagon of consumerism. The survey which follows will, I hope, prove otherwise. Patient participation is in fact very much in the highly respectable tradition of "whole person medicine," the basic beliefs of which are that it is important to recognise and respect the patient as a thinking, feeling, and unique person, who needs to be listened to and encouraged to decide things for himself or herself. Patient participation is, quite simply, counselling writ large.

**Whiteladies Health Centre, Whatley Road, Bristol BS8 2PU**
TIM PAINE, MRCP, MRCGP, general practitioner

#### Patients liaison group

It is easy for those who are involved to wax lyrical about the value and achievements of patient participation. What has occurred over these past 10 years, however, is not inconsiderable,



and points the way to a new and fruitful relationship between receivers and providers of health care. The recent initiative of the Royal College of General Practitioners in setting up a patients liaison group, in which lay members will make up at least half, to act as a "think tank" for the college is a most promising development. The lay contribution to many aspects of health care—for instance, all aspects of patient care, health education, practice organisation, and medical education—will be explored. The patients liaison group will report to the college council, which, it is hoped, will listen attentively and act positively. It will require a mammoth effort of broad mindedness, perspicacity, and humility on the part of the council, but if we are patient I believe that they will come up trumps. The college recognises, however, that patient participation is most realistic and most relevant at a local level, and its faculties are being encouraged to take up the challenge to experiment in their own areas. The college could play a vital part in coordinating and evaluating such exercises.

Patient participation groups will, of course, remain the "sharp end" of patient involvement, as it is at the level of the practice that the lay public interact most with the health care system. (This has always been a problem for community health councils, whose members are one vital step removed from the scene of the action.) Patient groups will be looked to more and more as a vital source of information for both the college's new patients' group and the faculties, and the National Association for Patient Participation should be able to act as an intermediary, along with other patient organisations.

So far only one university department of general practice has started a patient participation group. Let us hope that the college's initiative will encourage more to follow suit and to explore the educational potential of patient participation at all levels. Curtis[1] described the contribution of patient feedback in vocational training—again, a worth while new dimension for course organisers, trainers, and trainees to consider.

#### Survey

I circulated a questionnaire last year to the 37 groups known to be operating at the end of 1981. Replies were received from 36 (97%). Information was sought concerning each group's history, the practice, how the group works, its activities, its funding, particular problems, and achievements. A guarantee of confidentiality was given, so that in the description that follows individual groups are not identified unless the information is already common knowledge.

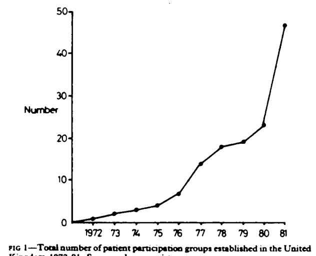


FIG 1—Total number of patient participation groups established in the United Kingdom 1972-81. Some no longer exist.

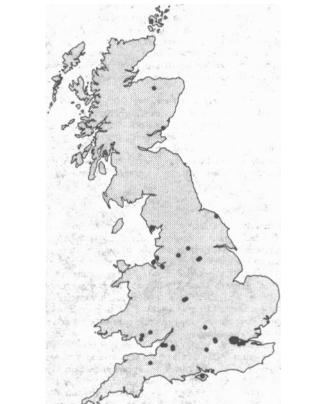

FIG 2—Location of 38 patient participation groups at the end of 1981.

HISTORY

The rate at which groups have started up is increasing.

*Rate at which groups have started up*

| Year | No | Practice |
|---|---|---|
| 1972 | 1 | Berinsfield, Oxford |
| 1973 | 1 | Aberdare, S Wales |
| 1974 | 1 | Bristol |
| 1975 | 2 | Glyncorrwg, S Wales; Taunton |
| 1976 | 3 | Isle of Wight; Limes Grove, London; West Kirby, Wirral |
| 1977 | 2 | Gallion's Reach, Thamesmead; Kentish Town, London |
| 1978 | 4 | Birley Moor, Sheffield; Buchanan Road, Sheffield; Egton, N Yorks; Lee Bank, Birmingham |
| 1979 | 3 | Basingstoke; Birchfield, Birmingham; Princes Park, Liverpool |
| 1980 | 6 | Darbishire House, Manchester; Kilburn, London; Royal Crescent, Bath; Runcorn, Cheshire; Stromness, Orkney; Walthamstow, London |
| 1981 | 13 | Abergwynfi, S Wales; Carnoustie, Angus; Craven Park, London; Dartford, Kent; Fairfield Park, Bath; Highfield, Cumbria; Keith, Aberdeenshire; Kings Cliffe, Peterborough; Lakeside, Thamesmead; Maghull, Merseyside; Pill, Avon; Todmorden, Lancs; Woodley, Reading |

Five or six other groups that operated for a while but have since ceased to do so were not included in this study, though it would be of great interest to know why they were not able to survive.

In most groups (75%) the idea came from one of the doctors. Patients have been the instigators of only three, and the remaining six were suggested by the practice manager or administrator 2; an attached social worker 1; a member of a community health council 1; "doctors and patients simultaneously" 1; and a doctor, minister, and social worker together 1.



PRACTICE

All but three of the 36 groups are associated with group practices of two to 10 partners, and all but 10 are based in health centres. Fourteen of the practices are in urban residential areas, 10 in industrial, nine in "town and country," and three are completely rural. Nineteen of the practices cater for a very largely working class population and three for a predominantly middle class one. The remaining 14 are described as "mixed."

HOW PATIENT PARTICIPATION GROUPS WORK

There is, fortunately, no "standard pattern" of how a patient participation group works. This makes it difficult, however, to describe and classify them.

*Membership*—One criterion that distinguishes groups is the position of patients of the practice in relation to the group that is supposed to be representing their interests. The commonest is the group that is, in effect, an association to which all patients of the practice or health centre automatically belong. The committee of such a group is simply the executive body within the group. A few groups *are* the committees, which usually aim at representing the interests of the whole practice (patients + staff), health centre, or, in the case of one Scottish group, the local community. Patients in these practices do not automatically belong to the group but are usually encouraged to attend and participate in its activities. (To confuse matters, a "patients' committee" may belong to either of the above categories. The titles adopted by different groups are given in the 1982 directory, available from Mrs Joan Mant, Hazelbank, Peaslake, Guildford, Surrey GU5 9RJ.)

I have no evidence whether or not "belonging" to the group makes any difference to the interest patients take in its affairs. Theoretically it might help to increase patients' identification with their group's aims and activities if they feel that they are members of it.

*Representation*—Over 70% of the groups pride themselves on being "democratic." The committee and officers, if such exist, are elected annually by the patients. What in fact happens is that the patients who attend the annual general meeting—from 0·1 to 2·0% of the practice list—formally vote in the new committee. I have not heard of the need for a poll at any of these. Far from there being competition among candidates, it is often hard to find patients who are willing to join the committee or hold office.

In contrast to the elected committee is that composed of representatives who have been invited to help to run the group. Eight groups operate in this fashion, and those on their committees (or equivalent) have been asked to represent health centre or surgery users, local organisations (Women's Royal Voluntary Service, Women's Institute, St John Ambulance, etc), different communities served by the practice, or practice staff members, or all of these. There seems to be no evidence that the "democratic" system works any better than its counterpart, or vice versa. Six groups prefer to dispense with a formal committee altogether, though they usually have a convenor and secretary. One such group, when asked whether there was a committee, replied "No in principle; yes in practice."

Of the 30 groups with committees, all but three invariably have a patient in the chair. In those three one has a doctor and in the other two the office rotates between patients and staff—"whoever seems the best person for the job." Doctors oversee the executive activities of two of the groups without committee. Committee size varies from four to 25, and seems to bear no relation to practice size. Committees tend to meet monthly, though three meet every other month, four quarterly, and one meets three times a year.

The time commitment of secretaries, chairmen, and ordinary committee members varies enormously—from half an hour to 15 hours a month. The doctors concerned give between nil and six hours a month, though this may be more in the initial stages. In some groups—generally of the "democratic" kind—doctors are not invited to attend committee meetings. One such group is rethinking this policy after three years because "we are now feeling that perhaps we haven't connected very well with the staff and doctors on substantial issues about practice and health policy."

ACTIVITIES

Groups vary greatly in the extent of their activities and the relative priority they give to each. One group covers all seven categories, one group covers six, eight groups cover five, 11 groups cover four, eight groups cover three, four groups cover two, and three groups cover only one. The number of activities bears only a slight relation to the age of the group.

| *Activity* | *No of groups* |
|---|---|
| Voice and interaction | 32 |
| Health education | 30 |
| Community and practice support | 24 |
| Special interest and self help groups | 17 |
| Fact finding | 11 |
| Providing information | 17 |
| Fund raising | 9 |

*Voice and interaction*

For most groups this is the essence of patient participation—the direct communication between patients and their doctors outside the consulting room, a mutual listening process. Of the 36 groups surveyed, 29 provide specific opportunities for patients to express their thoughts and feelings about the service offered and to make suggestions as to how things might be improved. Such contributions appear to be welcomed by most doctors concerned with patient participation groups, though four groups feel that insufficient notice is taken of patients' opinions or requests.

There is a degree of frustration in almost half the groups at the reluctance of patients to come forward with their comments or suggestions. "They are too content!" was how one respondent put it. Two groups operate a "sit in" service in the waiting room; committee members take it in turn to chat and discuss the service provided with patients waiting to see their doctor. Despite this, however, constructive comments or criticism were seldom forthcoming.

The results of patients having a say in the running of their practices include the appointment of women partners; changes in surgery hours; changes in telephone answering machine messages; improvements in waiting areas; improvements in the call-in system; better health centre facilities for disabled patients; interpreters for foreign patients. Several groups have lobbied successfully for improvements in local health and community services, directing their requests to departments and organisations outside the practices. Such action has resulted in an improved chiropody service; the prevention of a planned cut back in the local ambulance service; speeding up plans for a health centre; better parking facilities at the health centre; improvements in visiting arrangements in the children's ward of the local hospital.

Over 85% of patient participation groups provide opportunities for patients to discuss health and other relevant matters with their doctors and practice teams. Emphasis was placed on how such interaction helps to break down the traditional barriers. Twelve groups have regular "brains trusts," or the like, at which the doctors are quizzed on matters relating to health, the practice, and the National Health Service by patients who attend.

Twenty groups have set up systems to handle grievances informally. These vary from contacting a person or giving a number to telephone to a form to fill in, which is designed to ensure strict confidentiality. An example of the last is the "speak up" system devised by the Isle of Wight group. Several groups

have difficulties in getting patients to complain at all; but it is interesting that five of these apparently lack a system designed to make it easier for patients to voice their feelings. That grumbles are common among patients is well known, even in the best run practices; few of these misgivings ever see the light of day, however, either because patients do not consider them serious enough to "make a fuss about" or because they fear repercussions.

There is a smattering of evidence from this survey that the patients of those practices with complaints systems that are designed to be sensitive, discreet, and confidential, thus preventing "exposure," are more willing to express their grievances. Only three groups reported difficulty in handling grievances. Details were not forthcoming, but it seems that one group feels that "the practice tends to see (grievances) as minor."

*Health education*

A patient participation group provides an extremely convenient forum for health education. Not surprisingly, therefore, all but seven groups put on programmes of regular meetings, discussions, and debates covering a wide range of topics. The most popular seem to be those about cancer, women's ailments, prevention of heart disease, when to call the doctor, where to have a baby, and alternative medicine. In most cases a local consultant is invited to give a talk or participate in a discussion or debate. The groups' own doctors also take an active part in many of these meetings.

Attendance at these sessions is seen as a problem, however, by 70% of groups. Often it is only a tiny minority of the patients on the practice list who put in an appearance, and this usually includes a steady band of regulars. This probably reflects the enthusiasm shown by the general public as a whole for evening meetings of any kind. It has been shown that a much better turnout may be achieved if personal invitations are sent to patients from their doctors to come to health education sessions of particular relevance to them. Such an approach by the Bristol group resulted in attendance rates of over 20% of men aged 35 to 55 to talks on the prevention of heart disease and of over 23% of women (same ages) to talks on breast and cervical cancer. Sending such invitations was obviously more laborious, and money had to be found to pay the postage (see "funding" below). The response and feedback was so enthusiastic, however, that more sessions were planned.

Several years ago the Aberdare group obtained funding from the area health authority to make videotapes of some of its health education talks. It was realised that a large proportion of the practice was not interested in attending meetings nor in reading reports of them in the local press. The answer, therefore, was to take the films to the patients, and several showings in various venues have taken place. One or two groups have put on first aid classes, and the West Kirby group is proud of the classes it has started in cardiopulmonary resuscitation, which now train about 30 people a week. The Birchfield group has produced two superbly illustrated booklets on "Health in the over 60s" (which won an award from a local charity in this field) and on the prevention of home accidents. Booklets or pamphlets provided by two other groups contain a variety of medical information for patients; another two groups are arranging medical book lending services for their patients. Three groups organise health centre open days, which allows patients to see a bit of what goes on behind the counter.

*Community and practice support*

This comes under two headings: the use of patients as volunteers and social activities.

*Volunteers*—Twelve groups operate community care services of varying complexity to meet some of the needs of fellow patients in difficulties. Fetching prescriptions, evening and night sitting, and transport are among the commonest tasks. Crèche facilities at surgeries and clinics and even clinic helpers are provided by some groups. One practice runs a weekly lunch club for its elderly patients who live alone; another has an enthusiastic circle of volunteers who knit for newborn babies and send flowers to those in hospital and hampers and presents to a few patients at Christmas. Yet another has found patients to act as interpreters. Voluntary work of this sort appeals to many patients. One respondent said it was her way of saying "thank you" to the practice for the help she had received herself. Nevertheless, half the groups that run volunteer schemes have difficulty at times in recruiting, though only three reported that too much demand is made on their volunteers. All the schemes are coordinated by patients, and in only one group was this job reckoned to be arduous. (Practice based community care schemes are not the invention of groups. Several have been operating successfully for years, set up in practices by doctors who realised their potential but who have not joined the patient participation "movement.") One Scottish group is unique in having community care as its only interest and activity. It hopes to coordinate all the local helping organisations, both statutory and voluntary, acting as a bridge between them.

*Social activities*—A selection of these are organised by 12 groups—coffee mornings, outings, wine and cheese evenings, etc—and many are linked with fund raising. Some, however, are intended to help solely in breaking down barriers and towards building up community spirit and friendship among those whose lives lack these.

*Special interest and self help groups*

Sixteen groups have arranged a selection of group activities that appeal to certain patients—to help them slim, keep fit, give up smoking (the three most popular), cope with their condition (diabetes, old age, stroke, hypertension, back pain, alcoholism, bereavement, depression, hay fever, and cystitis have all been catered for), cope with their young children, or learn yoga. The popularity of such groups varies, and sometimes they fizzle out. I do not know how effective these groups are.

*Fact finding*

At least four groups have produced and circulated questionnaires, designed either to find out what patients think of the practice system, particularly appointments, or what their opinions are about their doctors' approach to looking after them. The responses from two such inquiries led to improvements in the appointments system and the system for requesting home visits, and to a realisation by the doctors that their patients would appreciate more information about what was wrong with them and their treatment than had been forthcoming during consultations.

Ten groups have carried out surveys into practice or health centre facilities and facilities in the practice area either to identify deficiencies or to produce guidebooks. Suggestion boxes have generally been disappointing and highly inefficient for collecting useful information. One group has examined the practice accounts "in order to make recommendations."

*Providing information*

Various publications are provided by several groups. Health education material has already been mentioned. West Kirby, Kentish Town, Walthamstow, Dartford, and Keith groups have all produced guides to their practices or health centres. Limes Grove, Birchfield, Fairfield Park, and Todmorden produce magazines or newsletters. The Bristol group has put together detailed handbooks on local accommodation for the elderly and on local day facilities and concessions, both of which are sold for 50p to patients and the general public. Several groups pin



the minutes of their committee meetings, and also those of the local community health council, on the practice notice board. Information about patients' rights is also displayed. The Isle of Wight and Bristol groups have annual "fixture cards" that list all meetings and give information about the groups and the services they offer.

*Fund raising*

Six groups have been successful in raising money to buy medical equipment; one group alone has bought peak flow meters (for asthmatic patients), home blood pressure kits, an enuresis (bed wetting) alarm, and a physiotherapy ultrasonic machine costing £500. Other groups have bought toys, plants, and pictures for the waiting room.

This is the first of two articles.

**Reference**

[1] Curtis P, *et al.* Patient participation in a medical education environment. *J Fam Practice* 1981;**13**:247-53.

# *Looking Back*

## Doctor in the Dales

J D O'CONNOR

When my husband bought a practice in the Yorkshire Dales in 1933 our two children were very young so I did not intend to practise. Optimistically, however, we had my name put on the brass plate at the gate. The country folk had scarcely even heard of a woman doctor. Worse, we weren't even Yorkshire, but complete foreigners—it takes at least 10 years to become a local in those parts.

There were two surgeries a day, six days a week, with no half day, and fees were very low: a visit cost 3/6d (17·5p); with a bottle of medicine it was 7/-, and a consultation in the surgery was 3/-, so money was not plentiful. Soon after we arrived we consulted the other two doctors in the town about having a half day. Both were older men, who had been there for 20 to 30 years, and they would not agree to this. We decided to have one anyway, and eventually the others did the same. Our house was big and the surgery was in the house, though completely separate. Even on the half day we could not leave the premises, but the surgery door was locked.

The Dales people were shy and reserved, but the women felt that they could talk to me and confide in me. By degrees a few came to consult me, and soon I was looked on as a family friend. The children always gave me a warm welcome, even when they had to have an injection. The country people were good hard working folk who called a spade a spade. If they didn't like someone they said so, and you knew where you stood. I did a week's locum once in another dale even more remote than ours. My first visit there was to an old lady of 80 who greeted me with "We did hear that our doctor was ill and he had a woman doctor doing his work, but we've got to be thankful for anyone these days." In the same practice a man aged over 70 with bronchitis asked "Are you married?" "Yes." "Is your husband alive?" "Yes." "Oh well, in that case you can look at my chest."

Before I learnt to drive I walked to visit patients in the town and my husband drove me to any further away. My mongrel dog, who had one leg shorter than the others, hopped along after me everywhere I went and sat outside on the patients' doorsteps.

**Ballincar, Sligo, Ireland**
J D O'CONNOR, MB, BCH, retired general practitioner

Everyone knew Billy, so when I came out I would often find someone waiting beside him with a message, perhaps just for a prescription but frequently with a request for a visit. Billy nearly overdid his waiting once. When I was on holiday he went out in the car with my locum, also a dog lover. On one visit the doctor went in by the front door and left by the back door. He didn't miss Billy for four or five hours. He drove back the six miles and Billy was still waiting on the doorstep.

When the second world war started my husband was still in the Air Force Reserve so he volunteered for duty. Then early in 1940, the first bad snowfall arrived, and the roads in the country became blocked. The day before my husband was due to leave he was called to a confinement and could only drive the car one mile. He and the nurse had to walk along the tops of the walls to get to the farm, where they delivered twin girls successfully.

I got a bad start taking over the practice just then, but everyone was kind and helpful. I had to learn to drive the car but never lacked for volunteer teachers. There was very little traffic on the roads, and the lorry drivers soon got to know my car and gave me a wide berth. Driving at night with only sidelights, as required in wartime, was very hazardous. One night a farmer's wife cycled in to tell me I was needed at a cottage near her—telephones were not plentiful then. She came back in the car with me and kept saying "this is a dangerous corner," "sheep sometimes lie in the road here," and so on. At the cottage a young girl, an evacuee, had had to use the chamber pot, to which she was not accustomed. It broke and cut her buttock, which had to be stitched by candlelight. She and her mother returned to the city next day.

A doctor had other uses in those years of petrol rationing. I took the daily papers to the distributors in some villages, and always took medicines—and even groceries—to outlying farms and houses. People were very considerate during those awkward years. There were very few non-essential calls, and I found out how good and kind everyone was. I got many gifts of food.

On one visit to a hill farm, two large rams tethered together at their horns rushed past me as I opened the gate into the farmyard, nearly knocking me down and bumping into the car in their haste. Some months later I saw early lambs at that farm



and said to the farmer "You don't usually have lambs so early," and he replied "Those are thanks to you."

When the war ended my husband came home, but about a year later he got a slipped disk, a rarity at that time, so treatment was on trial. He had to lie flat on his back for 10 weeks but this did no good and traction was tried. Still no relief. Then he had to live in a plaster cast for three months, but the pain persisted. He insisted on an operation, which finally relieved the pain. That was the first operation of its kind in Leeds Infirmary.

**Digging out of snowdrifts**

The worst snowfall for many years was in 1947, when roads became blocked and impassable. One afternoon at the beginning of this I was called to an emergency in a village six miles away. I had to dig three times to get the car out of drifts and was rather shaken when I finally got to the house. The husband of the patient offered to drive back with me but I said, "I may not be able to get home but you certainly would not get back," so I set off alone. To my relief after a short distance I saw in the mirror the snowplough behind me. I pulled into a cutting that had been dug to allow cars to meet or pass, thinking I would have an easy run home behind the plough. But the plough itself soon got stuck in a huge snowdrift. As the men shovelled the snow out the blizzard blew it back, and things looked hopeless. Then the men from the quarries began to arrive on their way home from work. They took shovels from their cars (everyone carried a shovel at that critical time) and fell to work cheerfully in spite of the adverse conditions. Eventually a track was cleared and the snowplough started. The rest of the cars followed slowly and carefully, taking the easier road back to the town. No car, no pedestrian, went up that road for the next nine weeks.

The railway was our lifeline for many weeks. All sorts of things went by engine—day-old chicks, hen food and other feedstuffs, groceries. Sometimes the goods had to be dropped at inconvenient places, to be picked up by the locals. I had to be dropped once on top of an embankment and slide down it, carrying all my essentials in a haversack, as I had been doing all those weeks. As I walked back from that visit the road was blocked by an enormous snowdrift so I climbed to the top of the wall and made my way along it. At one stage I put my foot suddenly wrong and was up to my thigh in snow. At the top of the hill I found the road had been cleared. A huge snowplough, making its first appearance in the district, was turning round to go back to Horton as it couldn't tackle the drift that evening. A workman who lived nearby had just got off the plough so he heaved me up in his place and I rode to Horton at a high altitude, with a new view of familiar country covered in snow.

I had one very alarming experience about that time. A farmer's wife was having weekly injections and had had three or four without a reaction, but on my fifth visit she collapsed completely and slid out of her chair onto the floor, apparently dead. There was no one anywhere near, but while trying to support the patient I managed to get Coramine from my bag and give her one, two, three injections, with no response. So I tried adrenaline. After two injections there was a feeble flicker of the eyelids. I gave her a third injection, and the pulse began to return. But it seemed hours before my husband arrived to pick me up on his way back from another remote farm, and we could move the patient to a settee. I was more shaken than the patient, who remembered nothing of the emergency.

In a country practice a lot of time was spent on the road. One afternoon I noted the mileage, 53 miles, but I had done only three visits and been out three hours. Luckily it was beautiful country—harsh but beautiful—which made the long drives enjoyable, and the patients were all friendly and pleasant. So when the time came to retire and leave there were sad farewells and tears. Five years ago the brass plate with our names on it was still on the gatepost below the plate put up by our successor—and 45 years on the people of Settle still had a woman doctor looking after them.

# *After Acheson . . .*

## Constructing a primary care unit: the support

IAN KEY

The family practitioner committee had always viewed favourably my proposals for improving the service of the practice by converting it to a primary care unit and modifying the premises. The administrator and his colleagues guided me through the intricacies of the cost rent scheme and the means of obtaining improvement grants. Within a week of my taking over the practice the administrator visited me and was most encouraging about my proposals. He said that full support would be given to the project both financially and administratively and that full cooperation with his committee would be forthcoming. This indeed proved to be the case. The administrator wrote to the chief planning officer of the local authority supporting my application for planning approval for the building work, he accurately calculated the cost/rent, which was of great help in the financial negotiations required, and above all he was constantly available to advise me.

**Sidcup, Kent**
IAN KEY, MB, BS, general practitioner
Correspondence to: 69 Station Road, Sidcup, Kent

Early in February 1982 he examined the details of the plans and specifications in the tenders and wrote to my partner and me formally approving the project and confirmed that the improvement grants had been awarded. He had accurately calculated the cost/rent payable, based on the floor area of the premises, and this calculation set the financial limits and was a great help in considering what further improvements were possible as more finance became available. The family practitioner committee liaised most helpfully and usefully both with the architect and with the bank. They kept in constant touch with me and were always helpful and encouraging. The whole project was assisted by the far sighted view taken by the committee, particularly in accepting that there are likely to be three doctors practising from the premises in the near future.



**Financing**

From the beginning I realised that financing the whole project—purchasing and modernising the premises—would have to be paid for with either free or borrowed money: free by means of improvement grants and borrowed from the cheapest source available. Then once the project was completed the cost/rent scheme would become effective.

In July 1981 I visited the local branch of the high street bank with which I had been a customer for many years. I explained to the manager that a partner and I had been appointed to the practice and asked if the bank would be interested in financing the scheme. True to the bank's well known advertisement, the manager listened and said that the bank had schemes for doctors to borrow money for developments such as I had in mind.

When, however, my proposed partner withdrew in August the financial situation altered so far as the bank was concerned, especially because I would be too old to take on a 20 year loan. Therefore, the initial purchase of the premises had to be through the General Practice Finance Corporation, and even during the conveyancing the corporation's rate of interest rose from 16% to 18% and then to 18½%. The loan granted by the corporation was at 18%, and my quarterly repayments to the corporation, of both capital and interest, were just over £3000. The notional rent that I received for the use of the surgery premises was £105 a quarter. The financial burden of this discrepancy I would have to bear myself until the cost/rent scheme became effective, and it was a very real spur to get the project completed as quickly as possible.

As soon as it was clear that the building plans would be approved, I looked for means of financing the work. The General Practice Finance Corporation intimated that they would probably be willing, and of course the cost/rent would cover their interest payments but not the capital. Furthermore, the corporation was concerned that the value of the finished building would not be as great as the money spent on it, and therefore suggested that I might have to use my own house as additional security.

Therefore, knowing that a partner would be starting soon, I consulted the "listening" bank once more. The bank was very interested indeed and quickly made an offer to finance the entire project. My partner and I were given a choice of either a "floating" or a fixed rate of interest, the fixed rate at the time being 16%. The cost/rent applicable would be at the General Practice Finance Corporation's rate of interest at the time of accepting the tender and agreeing the contract, and this was then 17½%. With very little hesitation therefore we accepted the bank's offer, and the bank made the money available to clear the General Practice Finance Corporation loan almost immediately.

Being a two doctor practice now, my partner and I were able to obtain two improvement grants, and we had the funds for the work in the original specification. Once the accurate cost/rent calculation—dependent on the floor area of the premises—had been made, however, we realised that the original design was well below the financial limits of cost/rent. I put it to the bank that we had in effect more finance available, particularly because the difference in interest charged by the bank and by the General Practice Finance Corporation was now in my favour. The bank was therefore prepared to advance more money, provided that we did not exceed the cost/rent limits, and thus many more improvements to the premises were possible—such as double glazing throughout and thermal insulation of the external walls.

As the building work proceeded the architect's certificates for payment to the builder were issued, and these were taken to the bank, where finance was made available immediately. In fact, the builder's final account was not presented until two months after the work was completed on 19 June, when the cost/rent became applicable. Receipts for payments to the builder, the architect, and the solicitor for the conveyancing were presented to the family practitioner committee for the assessment of an interim cost/rent. At the time of writing (October 1982) this is being paid regularly, but the final calculation will depend on the presentation of all the accounts, including the 5% retention owing to the builder but not to be paid until six months after completion of the work. It was undoubtedly the bank that made the project financially possible—and positively pleasant. The bank interest and capital repayment are covered by the cost/rent paid. The advantage of having a friendly bank close by the premises was enormous because it was so easy to discuss problems as they arose with the manager and his staff.

**Comments**

Unlike the practices discussed in the Acheson report[1] ours is not in central London but is 10 miles from it, and it is essentially a suburban practice with a reasonably stable population, although we do have immigrant patients, single parent families, and temporary residents. Also, the practice area is classified as "open," and the practice that I took over was a large one, in contrast with so many of those in inner London that are in "restricted" areas and are small.

Nevertheless, in a little less than nine months—remarkably quickly—our practice and the surgery premises were converted into a primary care unit. The financial hazards, which could affect me personally, made speed essential. That the project was completed so quickly is due to the cooperation of all concerned—the architect, the solicitor, the bank, the family practitioner committee, the builder, the staff of the practice, the patients, and my wife. It was a very happy time, and above all it was great fun for everyone.

It was certainly worth the effort. Within a few days of completion my partner and I were running concurrent surgeries, the staff were handling the new telephone switchboard and intercommunication units as though they had been doing so for years, the midwife was holding the antenatal clinic in the treatment room, the attached district nurse was holding clinics in the treatment room, the health visitor was able to extend the well baby clinic into her room, the treatment room, and one of the consulting rooms, and the practice was running as a true primary care unit. The patients appreciate the service very much, and being Londoners they do not hesitate to say so.

I thank my staff and my wife for help and cooperation throughout.

A fully detailed account of the work done to improve Dr Key's premises, including plans, drawings, and names of architects and contractors, is on file at the Medical Architectural Research Unit at the Polytechnic of North London, Holloway, London N7 8DB.

**Reference**

[1] London Health Planning Consortium Study Group. *Primary health care in inner London.* London: London Health Planning Consortium, 1981. (Acheson report.)

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