The use of transport in a rural practice

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IT IS THE PURPOSE OF this paper to describe one solution to a problem which faces many country practitioners namely: multiple surgery premises. This difficulty also faces many urban practitioners but for ethical and other reasons the solution presented here may not be acceptable.

Disadvantages of multiple surgeries

The disadvantages of multiple surgeries are in the main four in number. First is the impossibility of keeping and fully using adequate records. Second is the excessive financial outlay in equipping and maintaining more than one surgery. Third, for the dispensing doctor, is the difficulty of providing and maintaining more than one drug stock. Fourth is the extra time and effort put in by the doctor in his attempt to maintain the same standards as the doctor with only one surgery.

The practice

The practice to which I succeeded in 1961 contains some 2,000 patients scattered along the valley of the river Esk and its tributaries in the North Yorkshire moors. The patients are mainly concentrated in the villages of Grosmont, Egton, Egton Bridge, Glaisdale and Lealholm, and in each of these at the outset was either a surgery or call house. The number of surgeries held each week, divided among the five premises, was 17. It should be noted that the road between each of these villages presents a considerable natural obstacle. From Grosmont to Egton the road climbs 550 feet in a mile and a half. From Egton Bridge to Egton the road climbs the same height in under a mile. From Egton to Glaisdale the road at one point drops 250 feet in as many yards, the total distance being three miles. From Glaisdale to Lealholm the road falls some 350 feet in a mile and a half. One should note as well that there is a significant and regular annual snowfall and that because of the narrow and often sunken roads and exposure of the district, travel in the winter presents quite a problem.

Work load

During 1962 a day book was started and provides records which show that during last year the average number of services performed per patient per year was 6.3 with an attendance : visiting ratio of 1 : 1. There was thus an average of 20 visits per day. The average mileage per day was 70, with a scatter between 40 and 145. A simple time-study revealed that the average speed maintained between visits was 20 m.p.h.

During July, August and September 1965 the number of services per patient per year had fallen to 4.8. The A : V ratio and the average mileage remained the same.

These figures show the great significance of transport in this practice. It was plain that here lay the key to efficient organization.

A possible solution

The first answer to suggest itself was the mobile surgery. On first aquaintance this seemed very attractive for it certainly solved the three main problems. But first: What kind of vehicle? It would be of little use if easily rendered snowbound. One could only think of either a heavy lorry chassis or a lighter four-wheel drive chassis: either would be expensive. Rough estimates approached £2,000 and on top of this one had to account for depreciation and running costs. When the idea was put to the executive council they insisted that one static surgery should be retained. In this I am now sure they were right, but it meant that I should still have two surgeries which added further to the cost.

Plainly these high costs would have to be offset by savings of time and effort to either

doctor or patient. Clearly, it could accomplish the latter for it would be easy to bring the surgery nearer the patient; it had wheels. More than this: Was not the patient to be visited at the same time brought nearer the doctor? Unhappily the patients live either in the villages or on farms. Hamlets and groupings of farms are rare. There is only one place one could call a hamlet and where a mobile surgery could stop where there had been no facilities before. The use of a mobile surgery would not therefore shorten the distance to be travelled to any significant number of patients requiring a visit, nor would it save any visits to patients lacking transport of their own. Moreover, a mobile surgery is not the thing to take up and down farm tracks. To overcome this one could only either go home and fetch the car, or have someone else drive it round with you. Both involve a loss of time, so much so that there would undoubtedly be a longer working day. No patient would be saved the journey to surgery while the doctor would spend more time and money and gain nothing in efficiency by a reduced visiting list.

The final solution

The second possibility presented itself through the pages of the parish magazine. A group of parishes in Lincolnshire had, it seems, much the same problem; too many churches chasing too few parishioners. To solve it they instituted a bus service. The bus ran round the villages gathering the faithful and depositing them at one church. Could one apply this solution to the problem of too many surgeries?

It was fortunate that the garage supplying the buses which carried school children to and from the trains was situated in Egton, the natural geographical centre of the practice, and the site by now of a new house and surgery in course of erection; and the garage proprietor was willing to take on the task. Based on previous surgery attendances and an estimate of the amount of private transport in the area it was decided to provide 99 seats per week (the vehicle having 11 seats): 44 from Grosmont: 44 from Glaisdale and Lealholm, and 11 from Egton Bridge. The stopping places were to be the old surgeries and call houses which were retained at £10 per annum each, as places for the delivery and collection of medicines. The distance to Grosmont and back is three miles and the journey takes about 20 minutes in total travelling time. The distance to Egton Bridge and Esk Valley and back is seven and a half miles and takes 25 minutes. The distance to Glaisdale and Lealholm and back is nine miles and takes 35 minutes. The estimated cost worked out at £320 per year, or roughly the same as the annual rental of the surgeries it replaced. On 4 October 1965 with the enthusiastic support of the executive council and with the approval of my neighbouring colleagues, the scheme was started.

Public reaction

At first the idea was not readily accepted by the patients. The fear of change in this district is based on sound historical evidence. Most of the changes taking place in the last 50 years have left people worse off. Fear of change, fear of how the service would fare in the winter and a certain amount of parochial jealousy from the villages that had lost surgeries were the main grounds for objection. That the buses are now accepted is true, but one cannot say more. Certainly the patients are aware that there is now a more efficient service. But if the better service I now give were ever to be connected by the patients with the buses I should be surprised.

Development

In November 1967 the scheme still operates and has become a small but diminishing part of life in the district. A re-appraisal was made in September 1966 when it was found that on average only one-third of the seats were filled. It was decided that the service to Egton Bridge should be retained but the service to the other villages was halved so that now only 55 seats are provided each week. Contrarily, costs have gone up so that 55 seats per week now cost the same as the original £320 per year. While there is real need to keep the service going for these few at the moment, I wonder for how much longer this will be so.

Assessment

It is impossible to say precisely what savings have been brought by the buses themselves, so many other things happened at the same time. The most significant of these was my move to a house in the centre of the practice from one two miles away in Egton Bridge. Nevertheless, the number of services now required of me by each patient each year has fallen to 3.6.

The number of attendances at surgery has fallen by 30 per cent while the number of visits, if one rules out the effect of a policy to reduce the amount of visiting to old people, remains the same.

Most of the fall in surgery attendances is accounted for by the fact that few patients now come to surgery simply to collect medicines. The bus collects them for them. The remainder is accounted for by such factors as the possession now of a haemoglobinometer, centrifuge and microscope which enable many clinical problems to be resolved without the need for a return to surgery by the patient.

The average distance I travel each year has fallen by roughly 6,000 miles. The fact that my home is now in the centre of the practice saves 3,000 miles. The rest is undoubtedly saved in not having to shuttle back and forth between surgeries.

The total time saved is difficult to estimate but having to do less motoring probably saves an hour each day and the reduced surgery attendances four hours each week.

The disadvantages to the patients of the bus service are, first, that they must wait in the surgery until all the others on the bus have been seen and, second, that they cannot come to surgery anonymously. No one seems to complain of the former unless the bus is late and people are kept waiting outside in the cold. There have been no complaints of the latter disadvantage.

There is no doubt that the replacement of branch surgeries by a bus service to a central surgery confers formidable advantages. Nor is there any doubt that it could be worked in other similar practices, but oddly enough the scheme for the repayment of surgery rent and rates will now weigh against their initiation for there is as yet no means of reclaiming the hire of a surgery bus. However, the advantages are so great that only rarely should they be outweighed by economic factors.

The Minister of Health would do well to consider including the hire of transport, where it replaces multiple surgeries, in the rent repayment scheme, for it is difficult in this situation to justify charging the patients a fare for their ride. After all, the bus replaces a waiting room and surgery which they previously used free of charge. It is somewhat ironical that in this way country patients are spared the expense of a bus fare while it would be unthinkable for a doctor to spare any patient this expense in the town.

HEALTH EDUCATION

Health education in general practice

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THE GOVERNMENT HAS ESTABLISHED a new central organization for health education named the Health Education Council. This council, under the chairmanship of the Baroness Serota, J.P., will take over and expand the functions of the Central Council of Health Education, and will organize the development of health education in England and Wales and Northern Ireland. In Scotland the Secretary of State for Scotland is establishing a health education unit in the Scottish Home and Health Department to stimulate health education in Scotland.

These developments come at a time when more and more thought is being given as to what part general practice has to play in health education. A working party on health education has been set up by the education committee of the College and, in an endeavour to find out how much health education was being carried out in this field, the members of the research