# Patient-doctor seminars

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**Summary**

Two Birmingham general practitioners held a series of informal seminars with groups of their patients and an account of the object, method and scope of these sessions is given in the belief that they are of significance for a better understanding of health and the community's responsibility for it.

## Aims

Our idea of holding patient-seminars arose independently. One of us was concerned to elicit patient reaction to the appointments system and surgery routine. The other wished to hear opinions about health in the community and allow an opportunity for patients to express themselves in an informal atmosphere. Together we decided that a series of seminars might shed new light on all these and related subjects such as the doctor-patient relationship. We wanted to avoid a fixed agenda, but the prospect of a new health centre for our area provided a focus for exploring the issue of the community's responsibility (or lack of it) for its health.

## Method

One of us was new to the partnership and had about 200 patients on his list. It was decided to invite all these and an equal number of patients randomly selected from the other doctor's list of about 3,000. Those under 18 were ineligible, but where a minor's name was selected, both parents were invited. Choice of a husband or wife entailed inclusion of the other partner. In this way a total of 398 patients was invited. No one was excluded for illness or any other reason. The letter of invitation, personally signed by the appropriate doctor, and accompanied by a stamped postcard for reply, read thus:

"We are starting informal talks between patients and doctors in order to explore ways of providing a better Health Service.

We would like to know your criticisms and views of our practice, and of the wider problems of health in the community.

Would you be kind enough, therefore, to come and have a cup of coffee with us and discuss any ideas for the future? If you are prepared to accept such an invitation please return the postcard within the next few days."

The response was as follows:

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| 182 | accepted, |
| 30 | declined, |
| 46 | address not known or moved away |
| 140 | no reply |
| 398 | |

Dated invitations were then sent out in relays and a series of 12 weekly meetings were arranged during the summer months. Transport was arranged when required and 133 people attended in all. Seminars worked best when consisting of 10–12 people.

## Form of the meetings

Each session, held in a pleasant surgery waiting room, began with coffee at 20.00 hours. One of the doctors introduced the discussion at 20.15 and we made a point of finishing at 21.30 punctually. The proceedings were recorded on tape and an unobtrusive secretary took shorthand notes.

Two principles emerged early on in the series:

(1) The doctor's three minute introduction, in which the group was welcomed and invited to contribute its views on the surgery and proposed health centre, tended to determine the content of the evening's discussion. There was little attempt by groups to evade this lead by exploring other issues of interest, e.g. hospital experiences.

(2) The groups were invariably eager to conduct a 'brains-trust' operation. Early on the doctors had to learn to resist pressure to make them prescribers of what should and should not be the done thing. Their role came to be one of *agents provocateurs*, and discussion consequently flourished.

## Subjects discussed

With the proposed health centre as a focus, a wide range of topics came up for comment and debate. Some of the many subjects discussed and ideas exchanged included:

*Health-centre facilities*

Pharmacy
Coffee bar
Library
Stage
X-ray facilities
Blood examinations
Transport for the elderly
Nurses
Social workers
Probation officers

*Educational opportunities*

Lectures in child care
Care of the elderly
Danger of drugs
Obesity
Education in personal responsibility for health
Understanding by patient of his/her disease

*Community commitment*

Organisation of baby sitting
Visiting the elderly
Housing
Community action against pollution
Co-operation with local churches and representation of local churches in health centre

*Role of doctor and patient*

Honesty of the doctor
Fallibility of the doctor
Who should run the health centre
Representation of patients

'Internal' matters about the surgery, appointment system, receptionists and waiting room took up little time. One important question, however, in this area was "Why only five minutes?" and in retrospect we were too evasive and defensive on this issue.

## Tasks of the groups in relation to subjects discussed

This section tries to show how discussion of the subjects listed helped the groups to examine their understanding of health and the community's responsibility for it. The task of the seminars was not defined beyond the introductory letter and the presiding doctor's opening remarks. These, with subsequent leads and questions contributed by both doctors, tended in the direction: "Given that a health centre is to be built in our area, what facilities should be provided to ensure that it would serve as a *health* centre for *your* needs?"

This underlying question was complex and the initial responses of the groups showed that people's ideas of health were *primarily* geared to:

(1) *The doctor-patient relationship.* A health centre to be staffed by about ten doctors was seen as a threat to the relationship. Reassurance was constantly sought that people would be able to see the doctor of their choice.

(2) *The hospital model.* The coming health centre was envisaged as an opportunity to extend hospital services into the community (e.g. x-ray equipment and minor surgery).

(3) *Preventive medicine.* e.g. "Could people over 50 have a yearly check-up?"

We found it possible to explore some of these ' primary assumptions ' and work at wider and deeper issues. Thus with reference to the above:

A. While the *doctor-patient relationship* was generally seen as a *sine qua non*, it was realised that it is possible to distinguish between (a) preserving the *personal* character of the relationship and (b) dispensing with the notion that the doctor-patient relationship is the *only* fruitful medium of health, the responsibility for which is more extensive, e.g. "The health centre should operate a baby-sitting agency to relieve the loneliness of unmarried mothers." "Could we be taught more about coping with our children's illnesses so as not to have to bother the doctor?"

B. The hospital, in which illness is dominant and determinative of medicine's task, was an inadequate model for a *health* centre. Such a centre need not be doctor controlled unless it too is to become an illness centre or mini-hospital, e.g. " there should be representation for patients on the Board of Management." " Would a coffee bar or tennis court be more use than a surgery? " " We need local advice on housing." " Could the social services and clergy be involved?"

C. *Preventive medicine* implies more than a search for incipient disease, e.g. one person spoke out for proper educational facilities for family planning, another for vigorous community action to stop pollution of the atmosphere by a local factory.

D. One further theme—*the role of the doctor*—came up for review. Apart from the father-confessor image, that of the honest liar in the face of death was mentioned more than once and one middle-aged woman stated (at least with honesty!) that she expected her doctor to be "my last bastion against truth." We restrained ourselves from exploring the implications of this evidence of collusion by medicine and society in avoiding the death issue, but were left in no doubt that further work could be done here.

## Evaluation

This is necessarily impressionistic and our central conclusion is that such seminars provide a fruitful starting-point for a community appraisal of health. They provided a learning situation in which to scrutinise easy assumptions and step out of established roles. Especially we learned (embryonically perhaps, but embryos have potential) that a health centre can be envisaged as a focal point of a community's responsible concern for its own health (which does not have to mean illness) and that it may be more contributory to health to install a coffee bar than an x-ray machine, a Women's Voluntary

Service worker than an extra surgery, a housing expert than a member of the Royal College of Physicians.

This suggests that community development may be a sounder criterion of health than mortality and morbidity statistics. Above all we would want to stress our finding that the patient will respond, and respond with insight and enthusiasm, to questions about health in society, thus substantiating our conviction that health is too vital a responsibility to be entrusted to the sole direction of the medical profession.

### Future implications

(1) Our experience has shown us that these groups could profitably be continued to explore in greater depth the issues described above. There was a strong demand for follow-up.

(2) The distinctive role of the family doctor in the future will best be safeguarded not by his being seduced into mimicking the hospital model of working, which is illness-orientated, but by his commitment to the task of fostering responsibility for health by and in the local community. This, we believe, was implicit in the most often heard plea of our seminars, for the *personal* relationship of doctor-patient which was felt by patients to be at risk when concentrations of medical men were poised to probe ever more efficiently to the root of their illnesses. 'Still', they were asking 'what about *us*?'

### Follow-up

An account of the seminars was presented to a lunchtime meeting of general practitioners at Selly Oak hospital and created considerable interest, expressed in reactions both of appreciation and antagonism. Medical students and a hospital surgical consultant participated enthusiastically. Our experience has been of interest also to a University Department of Social Administration and, inevitably, to the media (Italian!) The real follow-up, of course, is with patients, and not only, we would suggest, with those outside hospital.

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## GENERAL PRACTICE

In an inaugural address to my year at Cambridge, the then Regius Professor of Physic, the famous John Ryle, said that general practice still claims the cream of the medical profession. I believe this to be true.

The doctor who sets himself up to cover the whole range of medicine, obviously with help from hospitals and other bodies, and who does this conscientiously and well is a man of high ideals who is the cream of medicine. Good general practice, is more demanding of its practitioners than any other branch of medicine. Technical skills are needed but in addition a breadth of understanding of the human condition and a desire to help are factors which make general practice a high calling.

But in their understanding of general practice it seems that general practitioners have not developed into psychological and social diagnosticians in the way that they should. They have not moved from being sick body doctors. Of course this is unfair criticism as a generality, but there is some truth in it. There is now a wealth of psychological and social knowledge which is of value to doctors. How many read anything about it? How many have analysed their practices in psychological and social terms, in the same way as they have their physical diagnoses? And yet these analyses are relevant to understanding their patients and their problems. If general practitioners do not do this they are missing out on an important area of medical practice. And if they do not do it then others will. There is a growing army of psychologists, sociologists, statisticians, medical social workers, health visitors and so on who will take these spheres over.

REFERENCE

Rhodes, P. (1973). *South London Faculty Journal*, January, pp. 5–11.