
Role of branch surgeries in a rural area

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SUMMARY. Surveys of general practitioners and rural residents were conducted in Norfolk to establish the characteristics of branch surgeries in the district and the patients who use them. The branch surgeries tend to serve an unrepresentative section of patients, predominantly those disadvantaged both in health and personal mobility—those from manual social classes, the elderly and those without cars. While doctors and patients were agreed that lower standards of care are provided in most branch surgeries compared with main surgeries, the evidence suggests that branch surgeries nevertheless meet a social need.

Introduction

BRANCH surgeries are a long established, although declining, feature of British general practice. By increasing the density of the network of surgeries they can make general practice more accessible to patients and, perhaps, thereby reduce the need for home visits by doctors. This is particularly important in the more rural parts of the country where practices can cover large areas and involve lengthy journeys for both doctors and patients. Branch surgeries are also of special importance for the less mobile members of the community. Considering this well-developed role it is surprising how little information is available about them. Here we summarize a wider study which documented the current function of branch surgeries in a rural setting and evaluated their future prospects.¹ Attempts are made to answer questions such as, 'How wide a range of services is encompassed by the term "branch surgeries"?' 'Are doctors who run branch surgeries in any way different from those who do not?' 'Are the patients who attend branch surgeries similar to those attending main

surgeries?' 'How do variations in opening hours and in facilities affect patients?' 'What effect does the presence of a branch surgery have on consultation rates?' 'How do doctors and patients assess the advantages and disadvantages of branches?' 'Is the branch surgery an anachronism, or does it continue to have a useful role?'

The study was carried out in the predominantly rural county of Norfolk. The medical list of the Norfolk Family Practitioner Committee identified 82 branch surgeries in the county, most of which existed before the foundation of the National Health Service (NHS). Comparison with information collected by the County Council Planning Department in 1951 showed that since that date 19 new branch surgeries have been established and 53 have closed. New branches tend to be sited in villages, often villages near to the main towns, where the population has been growing rapidly. Closures tend to occur in villages in the remoter parts of the county where the population has declined or grown at a below average rate. Information from the medical list suggests that the typical branch surgery is in a village with a population of less than 1,000 (and often half this size), is located in a private house or village hall and opens one or two days a week. Other than these few simple facts, little information can be derived from the medical list and further analysis of the characteristics and role of branch surgeries requires the collection of data by special surveys.

Method

Questionnaire surveys of both doctors and patients were conducted. First, all registered practitioners in Norfolk were sent a questionnaire seeking information about personal characteristics, the practice, experience with branch surgeries and attitudes towards them. This allowed comparisons to be made between doctors with and doctors without branch surgeries, as well as between those practising in rural and urban areas. The second survey was a home interview of 346 adults sampled systematically from the electoral registers of selected Norfolk villages—some villages with a branch surgery and some with no surgery. All villages were three to six miles from a main surgery and 10 to 20 miles from general hospital services. Residents were asked to supply information on their personal characteristics, their use of general practitioner

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services and their attitudes towards them. Amalgamation of the responses with those of a previous survey with a similar design² permitted comparisons between people living in four villages containing a main surgery, five with a branch surgery and five villages with no surgery (total sample size was 940 villagers).

Results and Discussion

Survey of general practitioners

Branch characteristics. A total of 333 completed forms were returned (a response rate of 85 per cent). The general practitioners supplied information on 71 branch surgeries, the majority of which were held in private houses (32 per cent) or village halls (29 per cent), with only 19 per cent being in purpose-built premises and the remainder (characterized as "others") occupying a variety of buildings such as a converted barn, a former shop, a disused railway station and several occupying rooms in public houses. Most of the accommodation was rented, except for the purpose-built premises (ranging from permanent buildings to small wooden huts), which were mainly owned by the doctors. Opening hours varied considerably—from the extremes of one hour every two months to six days (14 hours) per week—but about two thirds of the branches were open one or two days per week for a total of one to three hours. The majority of branch surgeries had waiting accommodation for more than six patients (93 per cent), a consulting area with adequate privacy (84 per cent), adequate heating (86 per cent), a toilet (70 per cent) and hot water (68 per cent). Relatively few had a receptionist (24 per cent) or were equipped with a speculum (28 per cent), a peak-flow meter (13 per cent) or a vision test chart (35 per cent). These characteristics varied with the type of premises. The purpose-built surgeries in general were open for the longest hours and were the best equipped, while the surgeries held in private houses tended to be at the other end of the scale. While 75 per cent of the purpose-built branches had patients' records on the premises, the figures were 25 per cent for surgeries in private houses and 17 per cent in village halls. Altogether, 39 per cent of branches had notes on the premises, 17 per cent had an appointment system with the doctor transporting the relevant records and 14 per cent used a separate set of branch notes. The remainder did not have patients' records available.

Branch doctors. As branch surgeries are relics of a pre-NHS pattern of general practice, it is possible that the doctors who still operate them have a more conservative approach to their work than other general practitioners. This hypothesis was not supported by the evidence. Compared with rural general practitioners not operating a branch surgery, branch surgery doctors were generally younger and had the same proportion of higher qualifications. Their main premises were just as fully appointed as the national average,³ with high levels of

equipment and ancillary staff. Procedures such as fitting intrauterine contraceptive devices, excising cysts and stitching were equally likely to be performed by branch and non-branch doctors, both groups were involved in similar clinic and hospital work and both groups had equal levels of access to hospital facilities. They also shared a similar range of attitudes on the future of general practice.

Attendance. The numbers of patients attending branch surgeries varied considerably, but, as Table 1 shows, this variation is associated with the type of premises. While 58 per cent of doctors with purpose-built branch surgeries said they saw more than 20 patients per week, only 5 per cent of doctors with branch surgeries in private houses saw that number of patients. Doctors' estimates of the trends in attendance over the last five years showed purpose-built surgeries growing in popularity in contrast to the surgeries held in village halls and private houses (Table 2). As purpose-built branch

Table 1. Doctors' estimates of attendance at branch surgeries: percentages by type of premises.

Number of patients per week	Purpose-built	Village hall	Private house	Other	All branches
1-10	11	42	53	13	32
11-20	31	42	42	53	38
21 or more	58	16	5	34	30
Total	100	100	100	100	100

Table 2. Doctors' estimates of changes in attendance at branch surgeries in the last five years: percentages by type of premises.

	Purpose-built	Village hall	Private house	Other	All branches
Increase in attendance	53	5	15	40	29
Decrease in attendance	0	26	25	13	18
Attendance remained the same	47	69	60	47	53
Total	100	100	100	100	100

surgeries tend to be open longer in the week than other branches, it is not surprising to find the same trends of attendance with variations in opening times.

Patients. Branch surgery doctors were asked to compare the characteristics of patients presenting at the branch with those of patients presenting at the main surgery. A majority of doctors at purpose-built surgeries and at surgeries in the 'other' category saw a profile of patients similar in most respects to those at the main surgery. On the other hand, most doctors with branch surgeries in

village halls and in private houses said they saw greater proportions of elderly patients, females, working-class people, people without cars, patients with less serious conditions and more frequent attenders than they did at the main surgery. These differences were statistically significant ($P < 0.05$). There was a similar gradient of patients' characteristics associated with the opening times of the branches.

Survey of villagers

Branch characteristics. The survey of village residents also provided information on the characteristics of branch surgery users. The branch surgeries in the villages sampled in this survey were all near the lower end of the scale in terms of facilities. Two surgeries were held in private houses once a week and two were held twice a week in small wooden huts. Residents of these villages were asked how frequently they used the branch, and their replies in Table 3 confirm the impres-

Table 3. Users of branch surgeries by age, sex, occupational group and car ownership.

	Number of patients	Percentage who use a branch surgery			
		Always	Mostly	Some-times	Never
<i>Age (years)</i>					
18-44	79	9	5	35	51
45-64	78	9	23	33	35
65+	74	35	23	11	31
<i>Sex</i>					
Male	105	14	19	24	43
Female	125	19	15	30	36
<i>Social class</i>					
Non-manual	77	8	4	31	57
Manual	142	21	25	26	27
<i>Car ownership</i>					
Car owner	166	7	13	31	50
Not car owner	64	44	27	17	12

sions of the doctors. There are clear gradients in frequency of use associated with age, occupation and car ownership, although not with sex. The same gradients appeared in the distribution of people who said they had actually used the branch surgery in the previous four weeks.

Mobility. Respondents were also asked questions about whether the journey to the main surgery was too long, cost too much and whether public transport was inadequate. Table 4 shows widespread agreement among all groups in the population about the inadequacies of public transport. However, differences were revealed in the opinions on the time taken and the cost of travelling to the main surgery; these factors were more of a problem to old people, the working-class and non-car-owners. Therefore, it seems likely that, in addition to those people who use the branch for minor ailments and when convenient, there are those whose

Table 4. Opinion of accessibility of main surgery: percentage of respondents by age, sex, occupational group and car ownership.

	Takes too long to get to main surgery	Costs too much to get to main surgery	Inadequate public transport to main surgery
<i>Age (years)</i>			
18-44	16	23	75
45-64	25	30	83
65+	36	50	74
<i>Sex</i>			
Male	27	38	76
Female	25	32	79
<i>Social class</i>			
Non-manual	10	15	74
Manual	30	40	79
<i>Car ownership</i>			
Car owner	14	24	73
Not car owner	41	52	82

mobility difficulties give them little choice. The size of this group will clearly vary from place to place but recent research suggests it can be substantial, especially where the numbers of the elderly are increasing.⁴

We concluded that, besides those in less than ideal premises and open for only short periods, the branch surgeries most likely to close are the ones attended not by a representative cross-section of patients but by the less mobile and socially more vulnerable groups.

Effect of branch surgeries on consultation rates

Does the presence of a branch surgery increase consultations or just divert those patients who would otherwise go to the main surgery or ask for a home visit? In the surveyed villages with no surgery facilities at all, 16 per cent of respondents had seen a general practitioner in a four-week period, compared with 21 per cent of respondents in villages with a main surgery. Residents of villages with branch surgeries had the highest consultation rate, 23 per cent in a four-week period. The groups which contributed most to this figure were the elderly and the people without cars. A

Table 5. Respondents who consulted a general practitioner in a four-week reference period: percentage by place or mode of consultation.

	Main surgery	Branch surgery	Home	Tele-phone
Villagers with a main surgery ($n = 316$)	17.4	0	2.8	1.3
Villagers with a branch surgery ($n = 282$)	12.8	7.8	2.8	0.4
Villagers with no surgery ($n = 342$)	12.9	0	2.3	1.8

Note: A few respondents consulted at more than one location.

closer examination of consultation rates according to where the consultation took place reveals the effects of branch surgeries in the study villages (Table 5). While both branch surgery and no-surgery villages had lower consultation rates at the main surgery compared with villages with a main surgery, the presence of a branch is associated with an additional 7.8 per cent of respondents consulting in a four-week reference period. None of these differences is statistically significant, however, and considerably larger samples would be necessary to reach firm conclusions. Morbidity was an important variable not controlled for in the comparisons. No differences in home visiting rates are apparent in Table 5, although 75 per cent of the general practitioners with branch surgeries who were questioned said they thought that the branch surgery reduced such visits in the village concerned.

Advantages and disadvantages of branch surgeries

Most doctors who commented on their own branch surgeries were well aware of their poor facilities and primitive conditions, which, the doctors felt, implied low standards of care. However, the average estimate of the proportion of patients seen at the branch without needing to be referred to the main surgery was 84 per cent. The most frequently mentioned advantage of a branch surgery was the reduction in travel for patients. Doctors estimated that, on average, 35 per cent of branch surgery patients could easily attend the main surgery; thus, by implication, 65 per cent cannot. When invited to identify advantages to themselves of the branch surgery, several doctors mentioned their closer involvement in village life.

The survey of village residents, the consumers, as it were, certainly did not reveal any cosy or romantic impressions. People who never used the branch surgery said the reasons were the poor facilities and limited opening hours. Of the branch users, few compared the service favourably with that of the main surgery except in terms of accessibility. For the mobile majority of the rural population this is unlikely to be a significant benefit, but for those too young, old or infirm to drive, or with financial or family circumstances that preclude private transport, accessibility is one of the most pressing problems of rural life.

Conclusions

Our study leaves no doubts about the inadequacies of the facilities at many branch surgeries and that many doctors see these as barriers to the provision of a satisfactory standard of care. The chief benefit of branch surgeries is that they improve the accessibility of general practice to patients. The branch surgeries that are thought to provide the lowest levels of care are used more by those from manual social classes, by the elderly

and by those without cars—people who tend to have relatively low levels of personal mobility and who experience the greatest problems in getting to the main surgery. These are also the type of people likely to have a greater than average need for health care. A continuation of the current trend towards closure of poorly equipped branch surgeries in rural areas therefore seems likely to impose great problems on these already disadvantaged groups.

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Kawasaki disease

Kawasaki disease is an acute, multisystem illness that predominantly affects young children and has been described throughout the world. The triphasic course includes an initial phase of acute illness marked by high fever, conjunctival injection, oral changes, and erythematous rash. The second, subacute, phase begins with a decline of the acute findings and proceeds with desquamation of rash, joint manifestations, thrombocytosis, and cardiac disease. Most deaths (1 to 2 per cent of cases) occur in this phase, usually resulting from myocardial infarction. During the third phase all signs of clinical illness subside. The prognosis is related to the degree of cardiac involvement, and 14 to 20 per cent of patients develop coronary artery aneurysms. Inhibition of platelet aggregation, combined with symptomatic relief and supportive measures, forms the cornerstone of therapy. Family physicians need to be aware of this illness, particularly since it can no longer be considered rare.

Source: Soman M, Faulkner S, Snively GG. Kawasaki disease. *J Fam Pract* 1983; **16**: 723-726.