Postcard — disabled access

He fell to the floor gasping for breath ...

It could have been a charity runner (you know, the one dressed as a chicken) completing his first marathon. Or a mountaineer setting foot on a previously unassailable peak. Or the first explorer to reach the north pole by skateboard. But actually it was an old man visiting his GP — and the three flights of steps had finally proved too much for him.

Given the nature of primary care, one would imagine that most establishments would be aware of what makes for good access for people with a disability and be doing everything possible to improve it, even in older buildings not ideally suited to the purpose. But is this the case?

I was born with spina bifida — nothing strange in that — and I went to mainstream school, and then had a career in business ending up as a group director. Now I work as a consultant advising businesses on access issues and compliance with the Disability Discrimination Act, and there is something strange in that — my disability is seen almost as a qualification.

Being previously in the timber trade, an occupational hazard was being chastised in restaurants by my wife for constantly lifting tablecloths. What species of wood was the table, was it solid wood or veneer? ... sad but true. Now that I've become a consultant on access, the wifely punishment comes as I do my own 'on-the-hoof' mini access audits. Where can I park? Can I climb those stairs? How far is it to walk? Can someone using a wheelchair get in here?

Of course I would like to claim to be on some huge philanthropic quest for the world to be fully accessible to all (my next trick being world hunger and peace in Iraq) but of course, I'm just doing something that is intensely interesting to me — and I do like to think it's worthwhile.

Like it or not, the world didn't grow up accessible and most buildings just were not built with anything other than able-bodied access in mind. Would the National Gallery look quite so impressive if the front steps were replaced by a series of 1:15 ramps with resting places every 10 metres? Or imagine:

Ye Olde Architechy: Forsooth Sire for I am sore afraide, the access for knaves in personal wheeled chariots to yonder new castile is impeded manifold.

King William: Lo, thou art right. How am I to pour burning oil on all if they be restricted in their entrance. I shall decree from this day forth, no man may do unto another man less favourably because he be disadvantaged by disability. And further shall I decree that regulations for the raising of new castles ensure equal access for all.

Ye Olde Architechy: But Sire a castle that may be entered freely by all men …

But back to primary care. In the last 2 weeks I have had to visit both my GP and my dentist — one in a modern purpose-built (10-year-old) medical centre, the other an old Victorian house converted to a dental surgery. Both have access problems, but while the older property represented the greater professional challenge, the newer property was the more irritating simply because it suffers from stupidity!

The dentist had on-street parking, no drop kerbs, numerous trip hazards, stone steps, no hand rail, no assistance bell, a large door that challenged Geoff Capes to open it, a deep-pile mat, a small restricted lobby without room for manoeuvre, low lighting, and a narrow inward opening door from the lobby to the waiting room. There you go, that's the first four pages of my access report and I haven't even got into the place! I ask to use the loo (natural reaction to dentists) and have to climb what is best described as a carpeted ladder to the first floor. I could go on, but I really like my dentist, he may read this and, somehow, we all seem to imagine that dentists have the last laugh ('oh, sorry, did that hurt?'). Numerous things could be done to improve access but really, as with many old buildings, the possibilities — and the bill — are daunting.

The doctor's was a different matter. I said 'stupidity' but actually I meant 'lack of understanding'. They have a car park, no designated disabled spaces, a pathway but no drop kerb, a wide entrance door but a knob rather than a handle, once again a door doubling as a weight-training aid, a poorly defined door outline, no low-level sight panels, poor lighting levels, a high-level reception counter, and so on. Another four pages, but all the more frustrating because here so much could be put right for so little. Maybe no-one with any form of impairment, a baby buggie, or even a temporary mobility problem, ever visits a doctor.

This is not intended to be a slating of the medical professions, because they are no worse, and in most cases far better, than most other public service providers. But the guys who really get it right are the supermarkets, DIY multiples, and banks. Does anyone see a pattern here: 11.7 million disabled customers; estimated annual spending power £20 billion?

For me the important challenge is not just making things accessible but making them accessible in a way that does not spoil the environment around them for people without an impairment. The alterations should not be noticeable; in other words we should all be able to take access for granted and not realise that a particular service or design feature is addressing a particular access issue.

Talk of access and most people immediately think of people in wheelchairs. However over 11 million people in this country have some form of disability, and only around 5% of these use wheelchairs. Actually, access is for all of us. As we get longer in the tooth, we change, we have to hold the newspaper at arm's length to read it, we can no longer bound up three flights of steps, and we need somewhere to sit and catch our breath when walking the length of a long corridor.

The notice that's easy to read, the handrail on the stairs, the seat halfway along the corridor, may have happened by accident but more than likely were part of planned improvements to access, but hopefully ones that do not have to be seen as in any way 'special'. The fact remains that people will return to places or services that are 'easy' for them to use.

I am sure no primary care professional is deliberately making their service inaccessible (although in the 'no win, no fee' society I am sure one or two will find to their cost that they are breaking the law). My plea is to have a look around your surgery and if you cannot see at least three things you could do to improve access then you almost certainly need some professional help. You might even find that automatic front door useful yourself when you struggle back from visits laden with a black bag, five sets of notes and Mrs Jones's unused hoard of lactulose.

Martyn Weller

Vignette 2

One day a businessman came to see me. I had not met him before. He wanted me to destroy some notes. He and his wife had experienced infertility. His notes showed he had a low sperm count. After some time, his wife had undergone artificial insemination and got pregnant. He now had a daughter of about 6 or 8 years old.

He loved his daughter more than he could say. He wanted me to destroy any evidence that he was not her father.

At this time I had not had any particular training in medical ethics and the law, and was not sure what to do.

His concern was that his daughter should never learn that he was not her 'real' parent. It seemed likely that he had not got over his infertility. Loving his daughter more and more seemed to make it worse.

We did not have any counsellors then, so he got me in what was probably a '10-minute' consultation.' This is in quotation marks as we added 'fit-ins' on top of the 10-minute scheduled bookings as they came.

I told him what I felt about his unresolved grief.

He still wanted the records destroyed.

I told him what was usual to say at the time, that the records were the property of the Secretary of State. In any case, what if there were some genetic problem in the future? His daughter might need to have these records available to her.

He went away. I think he still wanted the records destroyed.

I did not see him again.

Leone Ridsdale