In retrospect, I expected too much from an organization which covers more than 1,000 square miles, has 500 members, is organized by officers who work on a totally voluntary basis and within the constraints of a budget which devolves to them less than five per cent of the subscription fee.

Personal contacts locally

I have now been in general practice five years. Looking back, it was not the regional College faculty which met my needs. Rather it was involvement at a district level which was of more significance. The local new general practitioners' workshop and trainer–trainee sessions are organized and function largely through personal contact and initiative. Whilst my involvement in the faculty board has enabled me to learn more about what other postgraduate centres are doing and has provided a forum to organize meetings of special interest, what has been of more educational value, what filled that void between the end of vocational training and becoming a trainer myself, was organized at a much more local level and largely through personal contact. It is in local, personal contact that I believe lies the future of the faculties and in which the College could find a new role.

The College already has representation at district level. The College tutors are elected from district College members and represent them in each postgraduate centre. They know all the members in their districts and are able to welcome and integrate new members as they join. All faculties are inevitably different, but in ours at least, the tutors are chosen for their proven ability and past involvement in other district activities (particularly vocational training), and not necessarily for their College activities. Whilst many other posts are remunerative, College activities are not (and reasonably so). Nevertheless, the tutors are busy and this means that faculty activity may have to take lesser precedence.

If the College membership is to become active then it must be at a level which is accessible to them. Experience in our faculty reveals that meetings which necessitate travelling 40 or 60 miles are poorly attended, and that these 'one-off' events are of dubious educational value. On the other hand, those which occur once or twice a month at lunch time in the local postgraduate centre are better attended. Such a venue for College activities would have the advantage of enabling participants to identify with a building and not simply with a nebulous regional faculty.

District faculty boards

I believe that the College, like the NHS before it, has one layer of administration too many. That the ideals of self evaluation and improvement for which we all strive can be founded only upon trusting personal relationships and a sense of successful involvement. It is at this level that I feel my faculty should be most active, creating in effect a myriad of 'district faculty boards' centred around the College tutors; groups of College members who could warm a niche for new entrants. Each tutor should have a paid secretary. There is a need for some sort of regional faculty organization, but it should be slimline and effective; a secretariat liaising between the tutors with an elected representative to serve on the College Council. The faculties have served the College well. In the days when there were 50 college members per faculty they were ideal. Now that there are 50 members per district they are unwieldy.

I now know what I expect from my faculty. I want personal relationships with peers I respect and with whom I share common ideals, peers with whom I feel able to look at myself, my practice and my performance. I want a forum to discuss the clinical, academic, political and administrative questions of the day; one which is able to draw on the collective experience of regional faculty 'experts' and whose voice is heard. I want an active, immediate and successful regional newsletter. I want the opportunity to involve my family. I would like to see more devolution of discussion documents to the districts before minds are made up at Princes Gate. Above all, I want a College faculty which is seen as successful at a district level and which appeals to younger doctors and trainees: an organization which can fill the void between the end of vocational training and becoming a trainer oneself.

I once heard someone say that the College was its faculties and that the faculties were the members. I heard but did not understand.

Nowadays I only ever seem to hear people asking when the College is going to do something for them. The College has nothing to offer members but the opportunity for involvement—the opportunity to do something for themselves. There is massive inertia in the system and change comes slowly. This will continue until each of us recognizes the responsibilities which membership of the College entails. Past members fought to improve the College past. Present members must not be complacent about the College present but must assume responsibility for the College yet to come.

FROM THE FACULTIES

Audit in general practice

The second Syntex Symposium on Audit in General Practice was held in Shrewsbury on 19 November 1983. Dr Richard Moore describes the proceedings.

As in the first Symposium in 1981, doctors had been invited to submit an audit which they had done, both for discussion at the meeting and for consideration for the prize of £150 awarded by Syntex Pharmaceuticals. Seventeen such papers were submitted by 15 doctors, the subjects including among others the post-natal examination, time-keeping and appointments, out-patient referrals and deaths in the practice.

The Chairman was Dr John Horder, who started the proceedings by inviting members of the audience to ask themselves (as an audit of themselves perhaps): 'Why am I here?' and 'What do I hope to achieve by being here?'

Audit defined

Professor Robin Fraser defined audit as a systematic enquiry into an activity with the intention of making an improvement. He outlined the steps an effective audit should take; defining the area of enquiry and its aims, setting standards defining methods, collecting and analysing data, identifying and implementing change and then evaluating that change. As an example he described an audit in his own practice concerning the use of vitamin B_{12} injections. Basic reading led to a definition of reasons for using B_{12}. Patients receiving it were identified. Some were receiving it for appropriate

reasons, others not; some were even registered with other practices. At the end of the study all patients receiving B_{12} did so for appropriate reasons and in proper dosage, except one for whom withdrawal was considered undesirable.

Dr David Pendleton considered ways of observing ourselves at work in the consultation. He outlined the tasks that must be completed for a consultation to be successful, stressing that the most important one was to discover the real reason for the patient being there. This in turn depended on the doctor discovering, understanding and responding to the patient's own ideas. The information required for an audit of our consulting behaviour could be obtained by videorecording and then analysed by discussion in a peer group. Advice on how to do this constructively and without threat was given, and we were left with a strong challenge to observe ourselves.

Examine, change, measure

Dr Michael Sheldon, tongue firmly in cheek, declared that he was an excellent doctor and always did the right thing—until, that is, he began to audit his work, when he found he was ordinary. He outlined not only the benefits but also the difficulties of audit. Costs, time, inconvenience to patients and staff and disagreements with partners were some of the difficulties. To minimize them there were three essential rules—define the aims at the outset; keep the audit simple; delegate data collection to ancillary staff.

Much could be learned from close examination of ordinary and everyday events in our practices. The essential thing was to examine a situation, change it as necessary, then measure the change to see if it was effective. Like Professor Fraser he stressed the difference between audit and research: audit is about ourselves and what we do. He implied that just as developing countries need better sanitation not bigger monuments, we need an effective purge more than wonder-drugs.

The afternoon was spent in small groups discussing anxieties, difficulties, objectives and achievements. Each group was asked to report its most important conclusion. They were unanimous in agreeing that simplicity, feasibility and the willingness to change in the face of lessons learned were all essential.

Improvement in care

In summing up the day's activities Dr Horder referred to the fears often expressed that if we do not audit ourselves someone else will. He thought this was unrealistic but hoped that we would do it, because it needs to be done.

He then referred to the papers that had been submitted, saying that the adjudicators had read all of them carefully, and with interest. He congratulated their authors on their ideas and their work. Perhaps the most important thing was that they had done them. The adjudicators had considered their criteria carefully, looking for clear aims, logical collection and analysis of data and especially for evidence of change and re-evaluation. The last part was missing from most papers but was really the whole point of the exercise: that there should be improvement in care. They were unable to find a single best paper and so divided the award between two which came close to it. The winners were Dr R. M. Spokes of Coventry (Use of thyroxine substitution) and Dr V. Schrieber of Kidderminster (The use of diuretics in the elderly).

It is the hope of the organizers that those who attended will have found support, encouragement and guidance in the field of medical audit. That hope will be realized if they ask 'What am I doing, *really*?' and 'How can I do it better?' and then answer those questions.

MANAGEMENT IN GENERAL PRACTICE

The need for management training in the postgraduate education of general practitioners

ANDREW WILLIS

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My professor of biochemistry at medical school said that he felt it was more important to teach students how to use a library than the facts to be found within it. I believe the same principle underlies the increasing concern for management training for doctors.

IN 1979 I tried unsuccessfully to find a course in management skills for general practitioners. I therefore applied for a one-day seminar on 'Time management', run by an international business management consultancy. Around the table I joined executives from such companies as Shell, BMW, Rank Xerox and IBM. The consultancy had not had a doctor on one of their courses before.

It was undoubtedly the most worthwhile day of postgraduate education I have ever received. 'What, objectively, does your job entail?', they enquired. I wasn't sure. 'Even if you did know what you were trying to do', went on my polite but ruthless peers, 'how would you know whether or not you were doing it? Are you doing your job better this year than last year, or worse—or do you not really care? How would you like your practice to develop over the next year, and over the next ten years? What steps have been taken to consider such questions within your partnership?' Their questions were so reasonable, yet my training had been so inadequate in this respect that I could not answer them.

Only a minority of practices employ such techniques, for general practitioners have little incentive to improve the service they offer other than altruism, a notoriously unreliable motivating factor. Audits of our work that would be considered matters of regular, routine management review in any successful business are dressed up and published in our journals as research.

Meanwhile, we attempt to undertake a task that is in its totality beyond us. There will always be a greater demand for our time than we can meet. That demand may differ from one practice to another, and it is perhaps unhelpful for practitioners working in places with a relatively light work load to lay down standards of behaviour for others, whose circumstances may well be quite different. This leads to resentment and to loss of credibility. It is for individual practices to decide their priorities.

The incentive that 'unless the profession does this for itself, then someone else will' has obviously failed to produce widespread change. The College is now taking up