mittee. A questionnaire was then sent to all group leaders asking them for details.

Eleven groups were active in the region, five in Edinburgh, four in Fife, one in West Lothian and one in the Borders. Apart from self-descriptive titles such as "The Borders Discussion Group", there were groups on health education, for young principals, on talking to patients, audit, research and preparation for the MRCGP.

Numbers ranged from six to 20 and a total of 136 doctors were members. One third were women and 40 per cent were members of the College. Sixty-nine per cent attended regularly. Three quarters of the doctors were under 40. The number of meetings from October to March ranged from one to ten, with a total of 61 meetings and an average of 12 a month. Most took place in the home or workplace of one of the doctors. Only two groups met in hospitals. Three groups had invited guest speakers. Most groups were made up solely of principals, but in two or three of the groups, trainees were included. A wide range of topics was covered, including therapeutics, practice management, MEQ and MCQ papers, doctor/patient relationship, role playing, audio visual tapes, student teaching in the practice, the 'inappropriate request', investigating complaints, 'hang-ups', and specific diseases such as hypertension, diabetes and so on. Random case analysis was universally popular.

Although it would perhaps be wrong to describe this review as an audit, it gives us some understanding of what is going on in continuing education through small groups in the region, and it might prove useful as a comparison for future developments. Perhaps other regions may undertake a similar exercise, and compare their answers with mine.

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CONTINUING EDUCATION

The Bransholme GP Clinical Club

P. N. K. HEYLINGS and N. ALEXANDER, Holderness

This is a communication about postgraduate education in a health centre, where one British and 11 Asian doctors meet regularly each month. Two are members of the College. We feel as a group that more people should know about our activities, since they prove that standards set by the College in postgraduate education can be reached outside 'official' College groups through the inspiration of College members. Our group is called the Bransholme GP Clinical Club.

IT is becoming more and more clear that postgraduate education must satisfy the following criteria if doctors are to attend regularly:

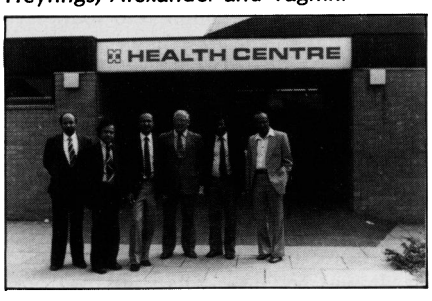
1. The GPs must be personally involved in individual meetings.
2. Meetings should be easy to get to.
3. The meetings must be time-saving—they must make use of time that cannot profitably be used otherwise.
4. The meetings should be sponsored by helpful drug firms who will provide refreshments, even though the subject of the meeting has nothing to do with their product.
5. Meetings should be held in suitable premises wherever possible. However, keen doctors will always manage to attend somehow, if they can just find the time.
6. Doctors must be willing to go ahead and set up meetings in health centres, sometimes without the co-operation of the Area Health Authority, who may be unsympathetic to GP postgraduate education if it conflicts with any of their committees' attitudes and decisions, or formal allocation of rooms.

We meet in our consulting rooms and the public area outside these rooms. There is no space in the Area Health Authority part of the building which can be made simultaneously available for lectures and food at a time convenient to the doctors. Our staff room is too small and is used by other staff at lunchtimes, when we meet.

We meet regularly every third Friday at lunch time for no more than one hour, sometimes less, including eating and having a chat with the pharmaceutical representative who is our host.

Attendance at meetings varies from four to 13. Since the meetings are Section 63 approved they are widely publicized throughout Humberside. One trainee has attended; two doctors who do not practise in the health centre attend regularly.

A chairman is elected at each meeting by common consent and is responsible for the minutes. For the first six months these were passed to the postgraduate dean, whose office supported our Section 63 application. The main cost to the postgraduate scheme is the £2 per head which is given to each patient to cover travelling expenses. Our practice manager looks after the attendance sheet and the money.



Six members of the Bransholme Clinical Club. From left to right: Drs Mahindora, Chowdhury, Ghosh, Heylings, Alexander and Yagnik.

Patients, who take part in the sessions by invitation, wait either in the main waiting room or in individual examination rooms.

We eat in the public area between the consulting rooms and hold the clinical meeting in several of the consulting suites and examination rooms, depending on the number of patients we see. Late-comers eat when and where they can. Quick sips of wine and mouthfuls of chicken are interspersed with tit-bits of clinical knowledge, but it is good fun.

Our constitution governs the conduct of the club:

1. Meetings are open to all GPs.
2. Meetings are for the joint exchange of clinical information between GPs, not experts, consultants or practice teams. Letters in patients' files (readily available) act as specialist opinion.
3. Cases are presented by consent, not by regulation or by turn.
4. The meetings are centred on the presentation of cases from the GPs own practice and mainly to other GPs working locally.
5. GPs are encouraged to demonstrate their methods of diagnosis and treatment.
6. Undiagnosed or untreated cases are presented. Doctors are encouraged to show how good they are at treatment, but have to face the inquisition of their colleagues after each case or set of cases.

In our first year we held 12 meetings at which 36 cases were presented. During

the year average attendance was seven doctors.

Before the clinical club was started, the feeling of co-operation in the health centre was marred by professional and administrative problems, partnership and business difficulties. However, when we were all brought together on common clinical ground, relationships and a high degree of mutual respect developed. At last each doctor was able to display his individual talents to his colleagues, who were willing to listen with open minds.

We believe that we have demonstrated adequately through the continuing success of the club that College members can and should splinter off from official College functions to develop the original ideology of the College amongst non-MRCGP colleagues.

REPORT

Joint Committee for Postgraduate Training in General Practice

SOME organizations (WHO, UNICEF) strike lucky in their acronyms. No such memorably euphony has come the way of the Joint Committee on Postgraduate Training for General Practice, but the initials are now nevertheless very well known to most of those in vocational training, and they will be interested in the committee's Annual Report for 1981. One of the best-known names in general practice—Dr Jack Norell—disappears from its list of officers, and he is replaced by Dr Douglas Price, who is in practice in Surrey and who was formerly Regional Adviser for the South West Thames region; he became Medical Executive Officer in February 1982.

In January 1981 the Committee began its task of issuing Certificates of Prescribed or Equivalent Experience; hundreds were processed every month, the total reaching just over 2,500 by the end of the year. Nearly all were for Prescribed Experience, with only 341 decisions being made in respect of Certificates of Equivalent Experience. Of these, 202 (60 per cent) were refused, and the applicants usually advised to take a further short (3–6 months) traineeship as additional experience. The Committee reports that although it was feeling its way at first, it has steadily acquired case-law that is now enabling it to reach decisions promptly and authoritatively.

A major part of the Committee's work is visiting the regions to inspect schemes. An increasing number of these visits are reassessments, and the policy is now for the visiting to be done in a single day by a single person, who tends to concentrate on the features of the scheme that are known to require particular attention. The visitors are tending to focus on the training practices, since they feel that it is no longer possible to assess the schemes as entities if the majority of doctors are choosing to construct their own programme. In the practices, an increasing amount of attention is being paid to medical records, since the quality of these is attracting so much adverse comment from visitors.

The single most important part of the visit, the Committee says, is always held to be the private meeting with trainees, and the visitors make special efforts to hear and read the views of as many trainees as possible.

In 1981 there were 21 visits which resulted in 12 schemes being given unqualified approval and nine being approved with reservations (none was not approved).

Many other important discussions took place with other bodies having an interest in vocational training and in the implementation of the Regulations. In particular, the Committee voiced its concern over the Department of Health's decision to withdraw funding from two experimental vocational training schemes containing 18-month components in general practice.

Copies of the report are available from the Administrative Secretary, JCPTGP, 14 Princes Gate, London, SW7 1PU.

CONFERENCE REPORT

Sixth National Trainee Conference—Churchill College, Cambridge, 19-21 July

BY a clear and substantial majority, the Sixth National Conference of GP Trainees carried the motion of the centrepiece debate, that "Doctors have a duty to oppose the Nuclear Arms Race." It was a conference of alternatives: a discussion on the opening afternoon of "alternatives to the MRCGP" overwhelmingly produced a resolution for a change in the current exam system of gaining membership of the RCGP; and the second day saw a wide-ranging symposium on alternative, or complementary, medicine systems.

Not until the last few minutes of the final morning did a single real spark fly at what has in the past been a gathering of firebrands. The 250 doctors who attended—mostly trainees, some trainers, some delegated, some representative, about half women, half men—seemed uncharacteristically calm and quietly spoken; happy to listen and content to chat over coffee. Contributions from the floor were unspectacular. It was too late when, just before lunch on Wednesday, some began to grumble that there had been too little discussion of trainee affairs, too little heard from national and regional representatives about the year's activities, and too much by way of lecture about herbalism. It was an unfortunate way of thanking the organizers Dr Peter Kaye, Dr Peter Bailey and Claire Downham, who had worked so efficiently throughout the year to produce a conference without hitches. The social programme was perhaps the best ever: King's College Hall and Choral Scholars take a lot of beating.

The conference began with an untabled plea from Dr Amanda Howe (Sheffield trainee) for consideration during the conference of the current industrial action in the NHS.

The main item of the first day was a discussion about membership of the RCGP, three papers being presented.

Dr Nick Bradley (Exeter trainee) pre-