pinch of salt, as cases were randomly selected (not consecutive), were aged over seven years, and in two thirds no cause at all was identified. Krech and colleagues (1976) report laboratory findings on 60,000 serum samples, and found a 23 per cent incidence of *M. pneumoniae* among 1,555 patients with "acute respiratory infection". They conclude, as Dr McSherry quoted, that "*M. pneumoniae* is the most frequent cause of acute infections of the respiratory tract", which is of course nonsense. It is only possible to conclude that, by the method used (serology), *M. pneumoniae* was the most commonly *identified* cause.

Secondly, it is curious the way things coincide. I am currently looking after a 10-year-old girl with pneumonia who, contrary to my previous experience, got steadily worse on amoxycillin and for 24 hours was quite worrying. She is now getting slowly better after a change to erythromycin at six days. Radiography excluded staph. pneumonia and she presumably has *M. pneumoniae* (too early for serological diagnosis).

It is often difficult and can take a long time to formulate a reasonable policy of management, but I think now, based on this case, previous experience and the literature, that in future I shall treat pneumonia in children with erythromycin as first choice to accommodate the known 20 per cent incidence of *M. pneumoniae,* but in adults will continue to use amoxycillin first.

And a further three weeks later he provided the final chapter:

On reflection, the conclusion to treat colds/coughs with erythromycin during an epidemic is possibly suspect, because how does one recognize an epidemic—by an outbreak of pneumonia in children perhaps? I have never consciously recognized one.

For completeness, the villain of the piece, the 10-year-old girl (now better), did indeed have mycoplasma pneumonia (titre 40, rising to 640).

Returning Questionnaires: Who Pays?

Sir,

I have this morning received a questionnaire concerning attitudes to postgraduate education from Dr Major of Northampton. This is the second or third questionnaire received in recent years which is accompanied by neither a stamped addressed envelope nor an explanation as to why not. I therefore do not intend to reply to this, or to similar questionnaires.

R. S. L. THOMAS

The Surgery
New Wokingham Road
Crowthorne RG11 6JL.

With both writers' permission, we asked Dr Major for his comments:

Dr Thomas is probably not the only GP whom I circularized with the questionnaire about postgraduate education in the Oxford Region to have been disgruntled at receiving it, but he is the only one to have written (by 1st class post) to inform me of the fact, without enclosing the completed questionnaire! All I can say in mitigation is that the Thames Valley Faculty Board allowed me to send the forms and bore the cost of printing and postage. One hundred and sixty 2nd class letters cost precisely £20. Double that sum and you have the reason why reply-paid envelopes were not included. Complaint is often made about increasing subscriptions to professional organizations—I've done it myself. I thought to try and keep costs down.

May I use your columns to thank those GPs who co-operated with my survey.

D. H. MAJOR

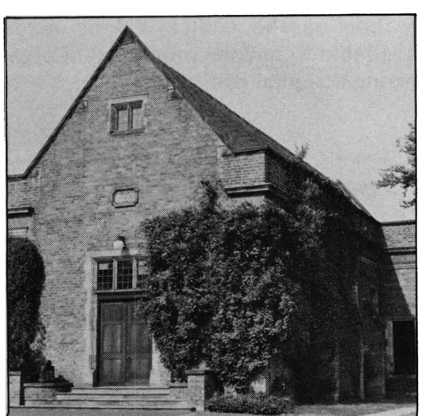
30 East Park Parade
Northampton NN1 4LD.

Correction

In Dr E. S. Hodgson's letter on occupational health (July *Journal,* page 451) the word 'not' was missed out of line 2 in the second paragraph. The sentence should have read "I am not sure that we continue to believe that they are of much value." Dr Hodgson assures us that one of the cornerstones of his practice is that he is almost totally opposed to pre-employment medical examinations as a case-finding exercise.

REPORT

Early Years in Practice



The conference centre at Alderley Park.

RECENTLY the College has been turning its mind to the increasing numbers of young doctors taking its examination, wondering what commitment these people feel they have to the College and what expectations they may have of it.

The Midland Faculty Board felt that young principals in general practice deserved special attention. Many seemed to disappear from the postgraduate educational scene, no doubt because of their new practice and other commitments. The problems and stresses of this stage of general practice were well remembered by Faculty Board members and it was therefore proposed, in September 1981, that a course aimed at recent members of the College be organized.

A timely offer of the Alderley House Conference Centre at Macclesfield as a venue was made by ICI Pharmaceuticals as evidence of their interest in general practice education, and this was gratefully accepted. A programme for a two-day residential course was devised and entitled 'Early Years in Practice'.

Eligibility to attend was widened to include recent entrants to general practice, and Section 63 (zero rating) approval was obtained. The course took place on 4–6 March 1982, Thursday afternoon to Saturday lunch.

ICI Pharmaceuticals proved to be generous hosts and the programme opened with a tour of their research departments.

The main aims of the course were to provide members with an opportunity to examine their clinical activities, exchange opinions and views with their colleagues, and discuss attainable standards of clinical care; these activities were to take place in small group discussions. Three members had agreed to give a short talk on a practice activity or item of clinical audit which they had carried out, and there was also a lecture on interviewing skills.

The Midland Faculty Provost and Chairman were invited to attend the course as group leaders, each having had considerable experience in group work and having expressed interest in the course. The President of the College also attended, and Jack Norell, our erstwhile College Dean, paid us a flying visit in our final session.

A questionnaire was sent to each doctor with the request that it be returned, completed, two weeks before the course commenced. Each doctor was asked to provide information on his or her medical and practice background, and keep a five-day log of prescriptions, which were categorized into six groups: analgesics, antidepressants, hypnotics, hypotensive drugs, sedatives/tranquillizers and 'others'.

Thirty applications were accepted for the course, seven of whom withdrew at short notice; 12 of the 23 attending were College members. Eighteen completed questionnaires were received in time for processing and five more were brought to the course. The completed questionnaire was returned to each doctor together with the group's average and range in the various responses. It was hoped that this information would be of interest to the participants, indicating where they were placed in the group's spectrum on each variable, and would help them to identify with their group.

Course Content

It is difficult to report accurately on group discussions. The following paragraphs attempt to summarize or give extracts or quotations from the 'report back' sessions.

1. *Defined problems*

The management and burden of minor illnesses (the challenge of patient education).

The frustrations produced in: a) the care of the elderly, b) the compromise of standards with time.

Unsatisfactory medical records.

Difficult patients.

Partners: their idiosyncracies, the problems of sharing work-load, the acceptance of responsibility for problem patients, and poor communication between partners.

Keeping up to date.

The job definition of a general practitioner—"Can we do it all?"

Continuing care, 24-hour responsibility, coping with the chronic sick—"Should we or shouldn't we be screening?"

Outside commitments—"There's a lot of it about."

Increasing work-load (see previous comment).

2. *Proposed solutions.* Here the groups tended to revert to discussing problems. (Sevarenid's Law: The chief cause of problems is solutions.) It was obvious to all that pat solutions did not exist. However, certain remedial activities were proposed:

Improving records: if nothing else, this improves morale.

Measuring practice activities: "In order to improve, we have to know where we start from." "Choose something you think you do well first."

Personal lists (in group practice). This produced arguments for and against. The conclusion reached was that the essence of this policy was continuing personal care, especially of the chronic sick.

Support groups, viz. postgraduate centres and RCGP activities.

Practice meetings— a surprising number did not have regular meetings.

3. *Standards.* This, as expected, proved a difficult subject on which to achieve agreement, although the following were identified as markers:

Good medical records (good = legible, organized and summarized).

An efficient, well-monitored repeat prescribing system.

Practice equipment.

Accessibility of the doctor.

"A clinical management plan"—this model, borrowed from business management, involved the defining of achievable goals (for example, in the management of hypertensives, diabetics, etc.) and the subsequent measuring of success or failure by clinical audit.

4. *Evaluation of the course.* Some participants said that insufficient time had been allocated to problem-solving, the pre-course audit, clinical problems and the session on interviewing skills. The length of the course was thought to be about right and the Thursday–Saturday format met with general approval. The contributions by three of the course members describing their audit activities were greatly appreciated. The group work was described as fun and the questionnaire feedback as helpful. ICI scored 10 out of 10 for hospitality. A number of doctors expressed the feeling of having found something to take back to the practice, particularly a desire to continue the discussions that had been raised, and to look again at the problems in practice. Seven letters of appreciation of the course were subsequently received and the group leaders also appeared to be heartened and stimulated by the experience. One young doctor had described himself in the questionnaire as "growing clinically very cynical" (this after two years as a principal) and had expressed his wish "to recover my medical virginity". He was subsequently reported as having "enjoyed the mental sigmoidoscopy" and being "virgo intacta once more".

Conclusions

This kind of response is not computer-compatible, nor easy to measure or validate. In general practice and continuing education, however, we often deal with problems rather than diseases, feelings rather than clinical signs, and in trying to measure our success in these areas we often have to be content with subjective responses as the only measure of assessment available. We need not be too apologetic about this. The allocation of many awards and distinctions involves subjective criteria. The assessment scores on Nobel Prize or Academy Award candidates are never published. We do, however, in my opinon, need more help from educationalists and psychologists in this difficult area of evaluation.

The true measure of a course such as this lies in its ability to give the doctor attending something worthwhile to take back to the practice, whether it is a clearer identification of the problems and methods of tackling them, or of areas in clinical practice or organization where he or she compares less favourably with his or her peers.

What subsequently happens as a result (the outcome of the course) will depend on the doctor's motivation, the nature and extent of his or her problems and the continuing education resources available in the area. It is in the hope that such courses be organized elsewhere and their effects followed up and continued locally, that this description has been given. Further information on the course will be made available to anyone interested in organizing a similar programme.

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