
FROM THE FACULTIES

A future for the faculty? The Trent experience

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During the last ten years, on three occasions the Board of the Trent Faculty has considered its future role and structure. In 1974 proposals to restructure it on the basis of postgraduate medical centres foundered through lack of support in the Board itself. With hindsight, this can be seen to have been the right decision, for the plans would have perpetuated a cumbersome organization covering three widely separated medical schools in an area of 5,700 square miles.

In 1979 proposals were approved by the Faculty Board to operate the Faculty in four divisions; three based on the medical schools at Sheffield, Nottingham and Leicester with Lincolnshire on its own as the fourth. With the exceptions of Leicester, which has functioned as a subfaculty since 1974, and Lincolnshire for a short time, these proposals had as much impact as a damp squib. This was demonstrated by the almost total uninterest shown by members at their local centres.

Last year, the Faculty Board were unanimous in deciding that, as presently constituted, Trent Faculty had no future.

A logical decision?

The logic of this decision is based on the size of the Trent region, the number of faculty members (over 600), the reluctance of doctors to travel more than 20 miles to meetings, the poor state of east-west running roads, the extensive commitments of previously active members to education (as university lecturers to undergraduates, as regional advisers, course organizers, trainers and tutors to vocational training schemes) and to health service management (as members of health authorities, advisory committees, management teams, family practitioner and local medical committees).

The ability of the Faculty Board to influence postgraduate education regionwide proved to be completely ineffective, and the remoteness that members felt from the Faculty Board was echoed within the Board itself.

Proposals for the future

Proposals to be put before the Faculty's Annual General Meeting this month will, if adopted, result in the replacement of the Trent Faculty by three faculties, based on the medical schools of Sheffield, Nottingham and Leicester. At a stroke, the distances involved and the numbers of members in each faculty (about 200) will be reduced to manageable proportions. Moreover, the formation of the new faculties will provide each with the opportunity to start afresh with the enthusiasm and commitment that I remember so well in the fifties when I served as an associate member of the original North Midlands Faculty Board. I am convinced that within the new faculties there are scores of young College members who are waiting for a lead in order to develop and to implement their ideas for improving general practice.

One of them, Dr Mike Pringle, produced a paper for the Faculty Board following his devastating condemnation of its

previous performance at the 1982 AGM. In it he advocated:

An adequate secretariat with paid secretarial assistance.

A 'travelling show' of speakers and events to visit all postgraduate centres.

Weekend or day courses for selected groups of members such as new principals.

Conferences with patient groups and representatives.

Studies of regional morbidity statistics.

Maintenance of a register of members' interests.

Maintenance of a faculty practice information service.

Closer links with university departments of general practice.

Encouragement of postgraduate groups at practice level.

Explanation of the work of the College to medical students and vocational trainees.

A Faculty newsletter to send to all general practitioners.

The opening of all College events to all general practitioners.

Having considered this paper, the Faculty decided to:

Institute an education fellow (Trent Fellow) who will be funded for one session per week to explore the effectiveness of postgraduate education, offer assistance and make recommendations.

Reintroduce a newsletter.

Prepare a questionnaire to be sent to every general practitioner.

Develop a 'travelling show'.

The new faculties

These activities will be the launching pad for the new faculties. Together with its local medical school, each new faculty can consider general practitioner research, peer audit and preparation for computerization.

The new faculties will be organized better to run courses in practice management for new principals, practice managers, receptionists and community nurses, where these are not already being organized by family practitioner and local medical committees.

Dr Elizabeth Horder's concern for doctors' spouses will find favour in smaller faculties. Local consultants could be initiated into the art of general practice.

A recent correspondent wrote in *News and Views* (March *Journal*, p. 189) "I feel that the Trent members at the periphery are not getting a fair deal". I am certain that thousands of members throughout the country echo that sentiment. Council has demonstrated that it recognizes the need for faculties that have become too big for their membership, to divide into smaller units.

Implications for the College

John Fry and Gordon McLachlan writing of the future in the "History of the Royal College of General Practitioners" state that "the full flowering of the College's potential depends on the involvement and participation of individual members at local levels." Only in "small and beautiful" faculties can the boards know and identify the needs of all general practitioners, and of their members in particular.

Contemplating the future of the College, I look to the time when we shall have 20,000 members. The organization of such a membership will clearly be beyond the present faculty boards and Council as presently constituted. The College will perforce reorganize into smaller units which are relevant to its members' locations.

The BMA has achieved a successful democratic compromise with the Annual Conference of local medical committees, whose executive, the General Medical Services Committee is an autonomous body, representing every general practitioner in the country. Each of the 114 LMCs in Great Britain represents from 50 to 700 doctors in its area. Every doctor knows the LMC member he has elected in his own constituency. The communication channel from practice to LMC secretary to Chairman of GMSC has stood the test of time. It may not be fanciful to consider a future where Council contains the representatives of groups of smaller faculties and in conjunction with the Annual General Meeting of the College, there will be a conference of faculty representatives.

A reorganization into smaller faculties will not be carried

out without a complete rethink of the funding of faculty activities. Out of the present annual subscription of £90 only £1.50 to £2.50 can go towards each member's faculty. A faculty of 200 members has an income of £300 to £500. This will be totally inadequate for the kind of activities, backed by proper secretarial help, that we have been considering in Trent for its successor faculties.

The expertise which is so apparent at Princes Gate in the courses organized there requires to be reproduced at peripheral centres. Members in the future will want to obtain information at their local College office.

With the advent of computers, it should not be prohibitively expensive to reproduce Central Information Service material, bibliographies, research and practice activity data and care standards for local display. Devolution within the faculties will require devolution from headquarters to the faculties. North of England Faculty's office next door to that of the Postgraduate Dean should be an aspiration for all faculties.

Throughout the country, every faculty will have to devise its own strategy for bringing the College to its members. We live in challenging times, reminiscent of those that stimulated our founders to launch the College in 1952. The task remains the same—the improvement of the quality of general practice.

Each faculty must show how it meets the challenge.

Reference

Fry, J., Hunt, Lord, of Fawley & Pinsent, R. J. F. H. (1983). *A History of the Royal College of General Practitioners. The First 25 Years*. Lancaster: MTP Press.

PATIENTS' ACTIVITIES

Patient participation groups

What are patient participation groups—why have them—what do they do—and why is there a National Association? Mrs Joan Mant, who formerly worked for the College in the Central Information Service, and who now is Chairwoman of the National Association for Patient Participation, gives us answers to these questions.

THE patient participation group movement is alive and well and flourishing all over the country; each group different from the other—even the names are different. 'Patients' Committee', 'Doctor/Patient Association', 'Community Participation Group', 'Community Care', 'Centre Users' Group' are some of them but essentially each is a coming together of doctors, staff and patients—partners for health.

In his survey undertaken last year Dr Tim Paine describes the work of the groups under seven headings: voice and interaction, health education, community and practice support, special interest and self-help groups, fact-finding, providing information and fund raising, each group having different priorities to meet varying needs. Meetings of groups provide patients, doctors and staff with opportunities to discuss any or all of these subjects for the benefit of the practice as a whole.

What is a patient and how are groups formed?

Are patients the ones who attend the surgery, or all those registered with the practice? Usually a first meeting will decide committee members—those who come! Some groups have started from a response to a notice in the surgery, others from representatives of local organizations meeting with doctors and staff.

If doctors and patients are important to the success of a group, then so too are members of the practice staff. Practice managers and receptionists attending meetings can make sure that innovations are understood and in their turn patients can ask about perhaps the telephone system—is there one?



A Bristol patient participation group listens to a talk on coronary disease.