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.

What is meant by participation?

The College sees it as liaison and collaboration; patients see it as an opportunity to share in 'their' practice, to understand its organization and how to use it, to discuss preventive medicine and health education with the professionals, to give their time in helping man the voluntary groups that run self-help classes and transport patients to and from the surgery—and to support improvements in local health and community services. One group has a presence in the waiting room to help mothers with young children and those with a language problem; another publishes self-help booklets with material provided by the doctors; one or two have first-aid classes and many have regular health education sessions ranging from talks on women's diseases such as breast or cervical cancer, to talks on raised blood pressure or even how to contact a doctor.

All these activities are organized and run by the patients, who do not see the group as a complaints body (although it can be used in this way), but as a voice both for them and their doctors to use. Generally it is doctors with no attached group who feel that it would be a place for people to come to criticize. "If my patients want to complain they'll do it to me!" said one doctor. When?

Why have a national body?

Since all these activities take place locally why have a national body and what is the role of the National Association for Patient Participation (NAPP)?

The Association is formed of representatives from all groups who care to send one, to discuss problems and to pool experiences. It may be argued that no two problems are the same (the Isle of Wight does not have the same difficulties for instance as Kentish Town) but each can offer suggestions for the other and the NAPP meetings provide an opportunity for group representatives to ask "Has anyone met this problem?" or "Has anyone experience of setting up a repeat prescription collection scheme?"

As well as acting as a link and support for all groups, NAPP answers enquiries from the media, acts as a mouthpiece and provides a newsletter. It spreads the philosophy of patient participation whereby the patient takes an active part, not only in his own doctor/patient relationship, but also in the practice as a whole within the community.

Reference

Paine, T. (1983). Survey of patient participation groups in the United Kingdom; I. *British Medical Journal,* **286,** 768.
Survey of patient participation groups in the United Kingdom; II. *British Medical Journal,* **286,** 847.

Further information about NAPP can be obtained from the Chairwoman of the National Association for Patient Participation, Hazelbank, Peaslake, Guildford, Surrey GU5 9RJ.

LETTERS

What Sort of Fellow?

Sir,

Your leading article (March *Journal,* p. 131) has really touched my heart. I have been thinking about this topic for months, if not years.

I joined general practice in November 1972 and as soon as my house was straight, I started preparing for the MRCGP examination. I used to study from "News at 10" to three o'clock in the morning as that was the only time I could concentrate without disturbance. I failed the viva part first time in 1975 but later the same year I passed.

After all this hard work I got great satisfaction but did I become a better general practitioner straight away? I cannot be sure but I definitely enriched my knowledge tremendously. I think that my efforts towards the MRCGP examination were really worthwhile. Like anybody else, if you stay in the business longer, you get professionally more busy so naturally I have less time for study. I admit sometimes many magazines remain unwrapped. I save them to read later, and later does not come and after many months they pile up and I feel guilty. Then my wife is annoyed and I have to be ruthless and dispose of them. Years have passed by and now I realize I am really getting behind. It is very difficult to read just to enrich knowledge.

I enquired about research work with no success. I thought of doing an MD but I did not know how to go about it. I have gone through the prospectus for the MSc at Glasgow University but this is not feasible financially and because of family commitments. I think FRCGP by examination will be good; the MRCGP is a test of knowledge and an FRCGP examination would be a test of skill. It is a good idea to keep a 10 to 15 year gap from the first examination for one can struggle hard to achieve both within a few years.

I disagree that the FRCGP should be done every ten years as, when we grow older, it is very difficult to find stamina to keep doing exams. I am quite aware that there will be great resentment but we cannot deny or ignore gossip that election for fellowship is by "not what you know, but rather whom you know".

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Sir,

I read with interest Dr Buckley's editorial (March *Journal,* p. 131). I think he is right: in the present system of awarding fellowship much seems to be based on the 'old boy network'. The College seems to take little account of the people who help in general practice with such things as first aid and extended first aid (Red Cross and St John) in their county, district and community.

I feel that this is part of general practice—to be involved in the community—and this involves local government committees such as public health and environmental control, and also such outside committees as home safety, water safety and road safety.

Some of us give a great deal of service to home defence on the medical side, both for civil and what might be termed war emergencies.

Dr Buckley seems to infer, and possibly he is correct, that the people who work in the postgraduate centres and do relatively little work in general practice as a whole, seem to be awarded the fellowship. Many of these were against the College in the beginning and even campaigned against it, whilst there are many of us who are founder members, who have spent much time and money in helping the College, especially at the beginning, who are overlooked.

It is possible that the College does not take into account those people who, over very many years, have conducted national, regional and district first aid competitions and examinations for British Rail, electricity and gas boards, and have even covered boxing competitions.