FROM THE FACULTIES

'Amateur' organization

Can the faculties effectively carry out the tasks asked of them by the central College? Dr Peter Ellis, Honorary Secretary of the North and West London Faculty, gave his views in the Faculty newsletter:

The College, along with the other Royal Colleges, is responsible for visiting hospitals for recognition purposes. The organization of this visiting is delegated to the faculty by central College. In our faculty, I have recently been given the task of this organization. Unfortunately the total organization by the other Royal Colleges is carried out by full-time secretaries and administrators; the faculty organization, by me, must thus seem totally amateur. It involves much time and patience to find suitable and available doctors for these visits.

I am sure the 'amateur' status of the faculty cannot continue. The administrative work of the faculty has grown and continues to snowball. The organization of joint hospital visiting typifies this future. The organization of faculty meetings and education courses is a further example of our amateur efforts.

Our faculty is not alone in feeling that we must professionalize our activities and structure. The faculties have an important place in the structure and function of the College. The faculty must be assisted in its task by the appropriate administrative and secretarial support.

The future must indeed see many changes!

News and Views editor's comment—A Faculty Liaison Group is now established at Princes Gate. A series of study days is being arranged when small groups of faculty secretaries may discuss organization and future needs. As a pilot study, Princes Gate will provide administrative support for the Honorary Secretary of the East Anglia Faculty.

North West

Dr B. E. Marks reports experiments in the North West Faculty with forming a patients' liaison group.

Among the matters discussed at the early meetings of the College Patients' Liaison Group was the question of encouragement of the development of regional liaison groups by faculties. A suggestion along these lines was subsequently put before the North West Faculty Board and it was agreed to proceed with attempts to form a patients' liaison group in the region with the aim of mirroring at a more local level what the College has initiated centrally.

A meeting was consequently arranged to which all members of the Faculty were invited by means of the newsletter and to which all community health councils in the North West region were asked to send representatives. This took place in Manchester on 23 February and most of the community health councils in the region were represented. The decision was made to formally establish a patients' liaison group in the region consisting of seven community health council members, one member from a patient participation group and seven College members. The former will be chosen by the North West Regional Association of Community Health Councils and the latter by Faculty Board.

It is intended that the group will be a subcommittee of Faculty Board to which it will make recommendations and although responsive to requests for its views on appropriate matters, it will generate its own agenda and determine its own areas of interest. Meetings which will be held at two-monthly intervals at different venues in the region will be open to non-members of the group who are community health council members or officers or general practitioners, as observers.

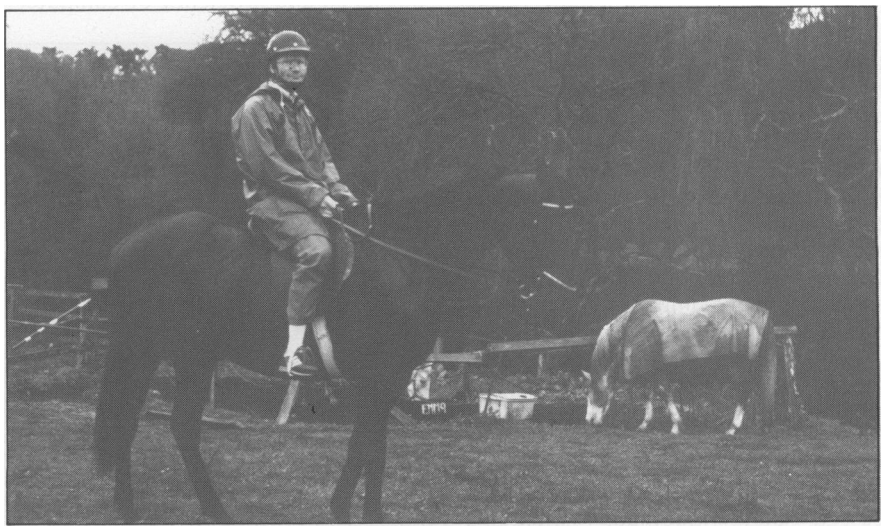
Practice exchange

Last spring Dr Jeremy Brown exchanged his practice and home in Lichfield with those of Dr Tessa Turnbull in New Zealand. Both doctors described their experiences for the Midland Faculty newsletter and we present extracts from their articles.

Dr Jeremy Brown:
You really begin to learn about a country when you work in it and listen to the hopes and fears of patients in the intimacy of the consultation.

I worked in a two-doctor practice in a small market town in the heart of the Kiwi fruit growing area. All was hustle and bustle with an air of expectancy as harvest time approached. The practice employed one full-time receptionist and one full-time nurse (the government reimburses the salary of one nurse per principal, but not of reception staff). We had an attached district nurse who was one of the nicest people I have ever met, and a public health nurse, who filled part of the role of a health visitor. The pace of work was very leisurely—15 minute appointments with substantial coffee breaks. There was less than one house call daily during normal hours. A one in two rota meant a lot of availability, but I was never required to get out of bed.

The patients paid a fee per item of service to which government added a small subsidy. Trauma however was fully funded by the health service (Accident Compensation Corporation) so that even in urban areas general prac-



Dr Brown riding at Hamilton, New Zealand.

titioners did much of their own casualty work. Drugs, with many irksome and complicated restrictions, were free. Hospital care was free but outpatients' clinics in the public sector were very limited so that there was a thriving parallel private system. There were virtually no chronic outpatient attenders except for very specialized problems and general practitioners coped with most chronic diseases.

New Zealand now overproduces doctors so that medical unemployment will soon be a problem and medical incomes average only about three-quarters of the British equivalent. New Zealand general practitioners took substantially more clinical responsibility than their British counterparts, despite only very rarely having access to their own beds. Yet paradoxically the status of general practice is undoubtedly lower. Vocational training is voluntary and in its infancy and postgraduate education is starved of funds. I visited several other practices and attended some small group educational meetings. I flew to Dunedin to attend the annual symposium of the Royal New Zealand College of General Practitioners (the equivalent to our Spring Meeting). The New Zealand College was until a few years ago a Faculty of our own College. I was impressed by the quality of the academic sessions (no Section 63 there) and even more so by the piper, haggis and Glenfiddich at the Scottish banquet and ball in the evening.

Dr Tessa Turnbull:

Professionally it was no problem to step into Dr Brown's shoes. The practice ran in a similar way to our own. Patient complaints were basically similar in both countries and Lichfield patients were very friendly. I found unemployment a social and a health factor that is not yet prevalent in New Zealand.

Unlike in Britain, listing or registration of a patient with a particular doctor occurs in New Zealand only on a voluntary basis. However, people are basically loyal and transferral on a local basis is rare. Listing obviously conveys advantages on a bureaucratic level and must be a help in research especially with the increasing use of computers in surgeries. It might be seen from the patient's view as restrictive to say the least. The doctor is as accountable to his patients as is the local plumber or mechanic and the right to choose or change your doctor must be a basic patient's right.

The British general practitioner appears to have more freedom to prescribe than his or her New Zealand counterpart. In New Zealand many drugs are restricted to 'specialists only'. This seems to me to be an attempt to restrict the inappropriate use of drugs but this is obviously not a prerogative of general practitioners. However, I have not found the restriction a great handicap—a phone call to an appropriate specialist, or the increasing use of other modes of therapy such as acupuncture, physiotherapy and counselling or referral for the appropriate investigations, bridges any gaps.

I was surprised by the 'courting' of doctors by pharmaceutical companies in Britain, particularly in the provision of lavish lunches and dinners. I did find it irksome to rely on the patient to return drugs used in emergencies from the doctor's bag.

In contrast to New Zealand, British general practice is in excellent spirits. Morale is high and I did not detect any hint of dissatisfaction on the part of patients I saw personally. It would be gratifying to embrace the best of both worlds—the accountability of kiwi doctor to his patients—both personally as a friend and professionally as a skilled provider, with the financial advantages of the British doctor and the greater opportunity for post graduate education. In short the kiwi patient is probably a little better off but the British doctor is definitely better off.

Dr Turnbull in Lichfield.

Dr Brown reports that the exchange venture was so successful that one of his partners, Dr Andrew Hall, has arranged to exchange in the autumn with Dr Turnbull's partner Dr Jeff Friis.

Thames Valley publish local statistics

The Thames Valley Faculty has introduced an 'information desk' as part of its new newsletter *Scope*. The intention is to provide facts and figures of an interesting and informative nature to readers in the Faculty area.

Dr Peter Pritchard compiles the information from diverse sources and presents it with his own commentary, although he leaves conclusions to be drawn by others.

The latest 'information desk' shows the proportion of elderly people in each district in the region. It also compares the proportion of the population in each district seen by the health visiting services and the proportion treated by the home nursing services.

The tables from *Scope* shown below compare hospital waiting lists. Dr Pritchard compiled them from statistics supplied by Dr A. Barr, the regional information scientist at the Oxford Regional Health Authority.

Table 1. Number of people waiting for operations in the Oxford region.

	March 1983	Increase since March 1982
Urgent	2,006	137
Non-urgent	34,809	4,094
Total	36,815	4,231

Table 2. Number waiting for operations in different specialities at March 1983.

	Urgent	Non-urgent
Traumatic and orthopaedic	618−	6,951+
Plastic surgery	446+	
General surgery	440+	8,636+
Gynaecology	160+	6,444−
Opthalmology	92+	
ENT		5,001+
Oral surgery		2,010+

The trends in the last six months are shown as + or −.