

## Doctor-patient relationship

This follows from the last principle and we are at last beginning to see a move in this direction. I believe we should have doctor-patient participatory groups, not just patient-participation. The traditional hierarchical structure of the doctor-patient relationship needs to be finally put to rest.

One of the main reasons why alternative practitioners have had such an increase in their clientele has been for this reason—not just because of their actual therapies. They are seen to be on the patients' side helping them to get better! Doctors are viewed as fighting the *disease* and all too often this involves fighting the patient—'It is better to know what sort of patient has the disease than what sort of disease the patient has.'

## Physician—heal thyself

The increase in depression, divorce, alcoholism and suicide amongst doctors must become of central concern to the profession. No advances in health care will come about until we have tackled this problem. If we avoid it, the medical profession will be bypassed by patients as they seek help from other practitioners.

The problems start at medical school. The undergraduate curriculum is unbalanced and it is essential to introduce educational experiences which recognize and respect the autonomy of the student, that nurture and encourage his or her ability to respond to persons as well as to the diseases.

## The Future

The British Holistic Medical Association was set up to foster and develop the principles and practice of holistic medicine. Membership is open to doctors of all fields and specialties and to medical students. It is embarking on an educational programme geared for the medical and allied professions, the public and medical students.

It has produced guides to the alternative therapies and a number of self-help cassettes for distribution directly to the public. There will be a close liaison with the British Association for Holistic Health. The next Annual Conference will be held in Oxford, 28-30 September. The theme will be the application of holistic approaches within the NHS. The two areas of clinical focus are cancer and birth.

Any further enquiries can be made to the British Holistic Medical Association, 179 Gloucester Place, London NW1 6DX. (Tel: (01) 262-5299.)

# FROM THE FACULTIES

## Yorkshire Faculty learns by answering questions

Although the Yorkshire Faculty took as their 'Spring Meeting' theme the dialogue between patients and doctors (a splendid and enlightening meeting), it has in general favoured approach to the community health councils at district level. Dr R. Mulroy reports.

**I**N the Wakefield district, the relationship between the community health council and general practice can at best be described as cool, if it exists at all. Stimulated by my faculty and the college, I, like Dr Murfin (*April Journal*, p.237) established contact with the local community health council secretary, Miss Lesley Pattenson. We arranged two meetings. On the first occasion, Miss Pattenson visited the half-day release scheme and met trainees and trainers. Two days later, I visited the community health council.

Miss Pattenson first confounded us with a questionnaire based on the origins, functions and constitution of our own community health council. Few of us scored a pass. She exposed the wide gap between the medical model and real life. She easily found gaps in our armour, though I felt that she had found some deficiencies that did not exist. (The burden of male chauvinism lies easily on my shoulders.) This session scored more heavily with the trainees for 'new knowledge' than any previous session in the last three years, apart from a session which we held with the police.

For my return visit to the community health council, I asked if they could give me prior knowledge of some questions they wished to ask. The panel shows the list of questions that was produced. Let me say that the first and most important aspect of the meeting was that the community health councils are on the same side as us. They do have an interest in the community and the patient. Of course, their ideas of general practice are coloured by the fact that their immediate knowledge of general practice is based, in the main, on patients' complaints. They hear little of the good things. Perhaps that is our fault. Can we remedy it? In 'informing' our local community health council, we may learn something. It is, I found, a salutary, rewarding and not painful experience.

### List of items for discussion at Dr Mulroy's visit

1. Regular visiting for elderly or over 80s. Any regular check-ups on these patients?
2. GPs' training in counselling skills and communication. (What about GPs already in practice as well as trainees?)
3. What is the attitude of GPs to the use of generic drugs as opposed to commercially named products?
4. Attitude of GPs to patients 'thrown off' benefits, eg invalidity/mobility/attendance by DHSS, particularly in regard to presenting good written evidence for patients wishing to appeal?
5. Care of the elderly in the community.
6. Are suitable arrangements made for CHCs to visit GPs and their premises? If not, how can they be improved?
7. Liaison with local ambulance service.
8. What are Dr Mulroy's views on repeat prescriptions? Also what is the cause of high blood pressure? How often should a patient have blood pressure taken?
9. Ethnic minorities and their GPs.
10. Views on how the deputizing service operates in the Wakefield district.
11. Do GPs keep half an hour free after normal appointment times for people unable to make appointments?
12. Do GPs in the Wakefield area experience delays in the transfer of medical records?
13. Why don't GPs put more emphasis on prevention?
14. Attitudes of GPs to self-help groups and 'alternative' forms of care or help, such as Well Women's Centres.
15. Do GPs tend to devote less time to treating their working class patients than middle class patients (as implied by the Black Report)? If so, how can this situation be improved through GP training?