NEWS

Honorary Editor: Dr Edwin Martin
Editor: Janet Fricker

Contents

Healthcall; Eire's First GP Chair 279
At the Crossroads of time 280
Patient Libraries; The Care of Victims of Torture 281
Edinburgh Medical Festival 282
Wimbledon Doctor; Mastermind 283
G.P. Dress 284

Healthcall

LAST month, the College signed an agreement giving its official endorsement and approval of Healthcall, the 24-hour dial up medical information service.

Healthcall, run by Air Call Medical Services, is a library of 300 medical tapes that have been specially written for the public. To obtain informed unbiased medical information all they have to do is consult the Healthcall directory and dial the direct number of the topic they'd like to hear. The scripts for each Healthcall topic, produced by a team of doctors and specialists, have been reviewed and approved by an editorial board set up by the RCGP consisting of six GPs and one layperson.

The College welcomes Healthcall because it is responding to the public's increased awareness and concern about health matters. The tapes are intended to be complementary to visits to the doctor, and general practitioners are already finding them invaluable because they give information to the patient that would take them four to six minutes to provide.

At the House of Commons launch on April 29, Dr Colin Waine, a member of the editorial board said: "We favour the public knowing a lot more about the disorders to which they can fall victim. An informed patient enhances the consultation and this allows the doctor and patient to work together towards a better plan of management."

He stressed that the service is not intended to diagnose, but to give advice about specific areas of medicine.

Healthcall is already proving popular with the public. Since its launch in 1986, it has received almost three million calls and is currently handling over 100,000 calls a week. One of the advantages is that people can get confidential information in the privacy of their own homes and it is useful for delicate topics that they feel too embarrassed to talk to their doctors about. It is also helpful for relatives and friends who want more information on the patient's illness, but don't want to bother the doctor.

Calls will be charged at British Telecom's 'M' rate which is 22p per minute at cheap rate and 35p per minute at peak rate, with the average length of a tape being four minutes. Air Call have reimbursed the costs of the RCGP editorial board and will also pay the College a minimum of £10,000. The agreement says that after administrative expenses have been covered the money will be used for further educational programmes to benefit the community. □

Janet Fricker

Mr Maurice Henchey, the managing director of Air Call Medical Services, signs the RCGP endorsement of Healthcall, with Dr Douglas Garvie on the left and Dr Colin Waine on the right.

Eire's First GP Chair

SOUTHERN Ireland has appointed its first ever professor of general practice.

Bill Shannon, a member of the RCGP Council, takes up his chair at the Royal College of Surgeon's Medical School in Dublin on July 1.

Until now clinical students have had no formal teaching in general practice and have just been sent to local GPs for a couple of weeks.

"My appointment should help to restore the imbalance of the undergraduate medical curriculum, which until now has been entirely hospital centred," said Dr Shannon.

The department will also have a senior lecturer and two part-time GPs. They hope to be teaching the first batch of fourth year students by October and to become involved later with the preclinical behavioural sciences course. A teaching practice is being set up in the department and Dr Shannon hopes to be seeing patients from day one.

Dr Shannon said that it would be a real 'wrench' to leave his practice in Cork after 18 years. The new practice will be very different from the old and he is looking forward to the challenge. He is moving from a prosperous area where most patients are private to the deprived inner city where the majority receive free treatment. Dr Shannon hopes that the new practice will give him the opportunity to investigate different aspects of inner city health care.

"I'm hoping to redefine the GP's role in Irish general practice over the next 20 years and to look at some of the tasks that could be carried out by other key members of the team such as practice nurses who are still rare over here," he said. □

At the Crossroads of Time

THE RCGP is in its second flush of youthful endeavours. In the 1950's as a young founder member I was privileged to play a part in its inception. We really were intrepid and carefree pioneers. In the 1980's, as the longest serving member on Council, I am again privileged to play a part in the College at a momentous time, and to admire some of the enthusiasms of the new young members.

The College must constantly be prepared for change and to be changed. It is now a very different College from that founded on November 19, 1952. It was created as a supreme act of faith in British general practice by young and not so young GPs settling down after World War II into working in the NHS.

The birth was far from easy. It was vehemently opposed by the other Royal and non-Royal Colleges, and the early days were observed with concerned amusement by the BMA and with hope by the Ministry of Health. The story is well told by Lord Hunt in *A History of the Royal College of General Practitioners: the first 25 years.* Membership was open to all who believed in its ideals and who were prepared to work for them. It rapidly increased until, after six months it was ten per cent of all principals.

The College is now 35-years-old and approaching middle age. It is firmly rooted within the medical establishment, welcomed as a near equal by sister Colleges, and accepted gratefully by the government for consultation and cooperation.

Inevitably the College is no longer the exciting club of the 1950's with like minds rubbing shoulders and sparking off ideas in the smoky back rooms of rented premises. It is now a well-rounded professional and political body with a strong administrative structure and a core of experts in business methods, accountancy, data processing and communications. The College officers are tough skilled politicians and Council meets in plush premises at 14 Princes Gate. Now is the time to pause and take stock, to take compass readings and decide which road to take for the good of the College.

Recent events are but symptoms of potentially serious states of unease. With its total membership close to half of all GPs, growing by a thousand a year, and with a near majority of younger members, it is right to put the question "What sort of College do we want now and in the future" to the members and concerned outsiders.

In broad terms I hope that our College will continue to be a place where like minds meet for stimulation and that, as well as prompting the philosophy of good health care for all, it will be a professional leader and academic centre of learning. I hope that the College will continue to promote education, research, practice organization and the application of new technology. That it will facilitate team work, inform the public and perhaps most of all be a defender of our beliefs and principals.

The Quality Initiative has activated a few GPs, but much still needs to be done to strengthen and improve general practice as a whole. There is still a need for the College to increase the professional status and respectability of general practice, and to represent it within the medical profession. It is possible in these quasi-political activities that some other organization may be aggrieved, but that has to be.

In the College at the moment there is much discussion about how to increase democracy and the possible benefits of devolving more decision making and activity to the periphery. Last month Dr Mike Pringle dscribed the deliberations of the Council Working Party on Quality which was set up by young members to look at the promotion of quality in practice within the College. This month Dr John Fry, the longest serving and most senior member of the Council, writes his view of the sort of College we should be looking for in the future.

The first College exam was held in 1965 with five entrants. In 1987 there are now nearly 2,000 candidates spread over the two annual exams. The change from an open to a closed entry was a landmark. Paradoxically members now tend to be more passive and less active than in the days of open membership. Perhaps this is a feature of a middle aged College. The challenge must be how to motivate, involve and represent a membership of some 15,000.

Faculty boards consist of elected doers who try hard to promote local activities. The College Council is the governing body consisting of faculty representatives, others elected by the whole College, and observers. It is large, meets infrequently and has become rather remote from the membership. Within the Council elected members tend to remain for a decade or more, and faculty representatives for five years or less. At Council meetings a few 'floor holders' tend to influence College policy. The College officers run the College together with the General Purposes Committee which is 'elected by Council' and served by an expert administrator with substantial staff.

The faculty structure was hastily created in 1953. It was based on the university and NHS regions. Since the work benches of general practice are the neighbourhood localities within a district, faculties have become artificial and over large with ensuing consequences. If the College is to succeed, then restructuring is necessary with much smaller peripheral sub units of faculties working closer with Family Practitioner Committees and Local Medical Committees. Our leaders have set goals for a brighter future with quality initiatives, rewards for excellence, anticipatory care, screening, prevention and health education. These are great in theory, but are not easy to achieve in practice. The challenge must be how to implement them and relate them to the real lives of ordinary practitioners and their patients. This can only be done through patience, sensitivity and leadership, with faculty members working together with all colleagues, members as well as non-members. There is a huge step between producing papers at Princes Gate and carrying them out into the periphery.

It is also worth thinking about the sort of College we do not want. There is no place for an elitist College. General practice is the most egalitarian branch of medicine. It has twice rejected attempts to produce classes of 'them and us'. No merit awards and no good practice allowances. In our well meaning endeavours to promote quality, we must take the greatest care to do so carefully and without threats, penalties or discrimination. There is also no place for a hierarchical bureaucracy in the College. Growth in numbers and in feelings of self-importance can lead to remoteness and a loss of democracy. We have to learn from other successful political and professional organizations about how to relate to the periphery. There is no place for a timid College that is not prepared to state the truth even if it upsets some long held views and traditions.

To sum up, I would ask the College to consider what sort of College it should be, the objectives and who should do what, where and when. Looking back over the past 35 years I am grateful for the friendships that the College has given me, and for the stimulus and confidence it has provided. I envy my younger colleagues who have another 35 years of membership. Yet our achievements must not blind us to the need to learn from the past to achieve a better future. □

John Fry

Patient Libraries

IN her research for a handbook on practice libraries Margaret Hammond, the Stuart Librarian, has found that there is growing interest in the development of patient libraries. Here she gives some tips on how to go about setting one up.

I'd realized that the Stuart Project would be an educational one, but I hadn't realized that the chief learner would be me! For the first time I'm learning about real general practice, and discovering things like I can only visit after half past eleven and before half four.

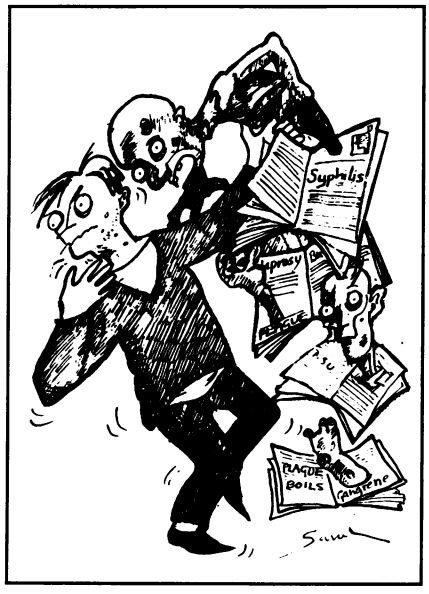
Originally I had not intended to consider patient libraries in detail, but after talking to doctors I discovered that there is a lot of enthusiasm for this area. Most of the surgeries I visited have a few books which they recommend to patients, but they still tend to be kept with their clinical material.

Doctors thinking of providing a separate library for patients should perhaps be concentrating on two different areas. The first being health education books written especially for the general public, like for example the Consumers' Association *Living Through Middle Age,* and the second a literary sometimes fictional account of a life event or handicap. *Dibs - In Search of Self,* by Virginia M Axline is a beautifully written account of the problems of a difficult child.

Before launching into buying books, why not first contact the local library service. They may be prepared to lend a collection of suitable material including large print and children's books. Such a scheme is currently being operated at Kentish Town Health Centre in London.

Many GPs will be aware of the accounts of the health libraries set up by Dr Chris Varnavides with an RHA grant (*British Medical Journal, 288, 535-537*) and Drs David McKinlay and Christopher Mason from appeals registered as charities (*Medeconomics,* 7(4), 28-30).

Since the early 1970s two library information services concerned with patient information and self help have developed. These are the Help for Health Information Service at Southampton and the Health Information Service at Stevenage. *The Health Information Handbook* by Robert Gann has sections with practical advice on setting up information services, on making the right contacts, organizing material and even suggests a basic collection of useful publications. The local postgraduate medical centre or public library should be able to obtain a copy.



Some helpful addresses are:
Help for Health Information Service,
Wessex Regional Library Unit,
Southampton General Hospital,
Southampton SO9 4XY.

Health Information Service,
Corey's Hill House,
Stevenage, Herts SG 1AB □

Child Accident Prevention Trust

THE Child Accident Prevention Trust, a medical organization encouraging investigation into child safety, is currently updating its research register. They would like to hear from any GPs who have either completed or are undertaking work in this field. Dr Tony Grieg, a member of RCGP, will be coordinating the work on behalf of the Trust. For further information please contact Louise Pankhurst, General Secretary, Child Accident Prevention Trust, 75 Portland Place, London W1N 3AL. Telephone 01 636 2545. □

Medical Foundation for the Care of Victims of Torture

DESPITE torture being banned under international law it is reported to be practised in one-third of the countries of the world.

Although everyone seeking asylum in the UK is entitled to free medical care under the NHS, many people who have been tortured feel unable to communicate their past experiences and cannot obtain the type of help which they and their families so badly need. People who were tortured in the presence of doctors often feel unable to enter a hospital or even approach a doctor.

The Medical Foundation for the Care of Victims of Torture acts as a link between anyone who has been tortured and the medical help available. The Foundation coordinates a referral network throughout the UK which covers the spectrum of British medicine and includes a number of GPs.

A typical case from the records of the Foundation concerns a teacher who was subjected over a period of six weeks to continual beatings. He was then stripped, his hands tied behind his back and suspended in this position for 16 hours over a period of two days. During this time his fingers were cut with razor blades, chilli powder was rubbed into his eyes, mouth, skin and genitals. He was beaten on the lower back and the soles of his feet with a baton. A red hot metal bar was pressed against his knees and lower back. A bicycle spoke was forced into his urethra.

This is just one example of a person living in this country who has been subjected to torture and needs help. But many are too frightened to ask for it. Family doctors are ideally placed to coordinate help for the physical, psychological and social problems faced by such people. GPs who want more information should write to: Helen Bamber, Amnesty International (British Section), 5 Roberts Place, London EC1R 0EJ. □

Edwin Martin

EDINBURGH 87 Medical Festival

Unfortunately we do not have the space to report on all the events of the festival but here is a selection ...

Fellowship by Assessment

THE Spring Meeting heard how the working party on fellowship by assessment has uncovered widespread dissatisfaction about the present system in the faculties.

Dr John Ferguson, the chairman of the working party, said: "The procedure for choosing fellows is shrouded in mystery, and anyone who is trying to nominate a potential fellow has to work behind the scenes."

At present candidates are nominated to the College's fellowship committee by members and fellows, and the names are brought before Council.

Dr Ferguson said that several members had said that they would not wish to be considered for fellowship using the current method.

"It is clear that we need to provide a more open system and should possibly even throw open the doors as far as self nomination," said Dr Ferguson. He added that people need to know what they are being assessed on.

He suggested that assessment should be based on an individual's curriculum vitae, a practice profile questionnaire identifying their contribution to the practice and whether they provide the basic range of services identified by the College.

Tamar, South East Thames, Beds and Herts and North West England are at present testing these criteria. Dr Ferguson said that the working party on fellowship by assessment should be able to report its findings to Council in the autumn. □

GP stress

A STUDY into stress among GPs is investigating whether doctors who have been on call the night before provide less good care for their patients.

Professor Howie, from the department of general practice at Edinburgh University, has recruited over 100 doctors from the Lothian Health Board to take part in a study beginning this autumn that will examine the relationship between stress and quality of care. They are being funded by the Scottish Home and Health Department.

"Stress is multifactoral, so we're attempting to look at not just the workload but also at how it is affected by personality," said Professor Howie at the Spring Meeting. Other factors that can have an effect are administrative tasks, telephone interruptions and domestic differences.

They hope to see if patients are affected by their doctor's mood and to produce results that can be used as the basis of negotiations with the DHSS about removing factors causing stress.

A pilot study has shown that GPs' reactions to stress differ, some speed up and others slow down. They tend to feel most stressed around 5 pm, towards the end of the evening and before going on call. It has also indicated that where GPs have tried to increase the consultation time to 7½ minutes they become more stressed. With five-minute consultations there was less stress because fewer people returned to the surgery.

It appears that female doctors are generally better able to take on a greater variety of commitments than men without feeling stressed. □

If Only I Had The Time

AT the Spring General Meeting the College announced its latest Continuing Learning In Practice Project (CLIPP), *If Only I Had The Time.*

The CLIPP Board have recognized that GPs need to improve their skills in areas such as time management, planning, delegation, leadership and in working as a member of a team.

The distance learning programme intends to cover areas like management of coronary heart disease, diabetes and chest infection, which are of relevance to GPs in their day-to-day work.

The idea is that the GP will receive a course book and then be sent instalments of the programme over a period of 18-months. Doctors will be presented with a series of problems relating to practice management, and will then be able to compare their decisions with those of colleagues.

Work on the project has only just started and CLIPP estimates that it should take at least a year to complete. *If Only I Had The Time* follows the Clinical Assessment for Systematic Education (CASE) programme which began in 1984. □

Infantile Colic

A STUDY by Livingstone GP Dr James Campbell has shown that a substantial number of babies suffering from infantile colic can be cured simply by changing their diet.

Dr Campbell told the Spring Meeting that changing the baby's feed from normal to soya milk can have impressive results in stopping babies crying. Colic, he said, can be defined as excessive crying in an otherwise healthy baby for more than three hours a day or more than three days a week.

Over a two-year period Dr Campbell recruited 29 babies who were suffering from such symptoms. Then in a double blind crossover study he changed their diets from normal to soya milk and asked the mothers to keep a careful diary of symptoms.

In the first week, 16 of the babies improved and of these the symptoms returned in 12 when they were given a challenge test with cow's milk. If they remained symptom free it was assumed that they had got better spontaneously.

If there was no benefit from the soya milk the babies were then put on Cow and Gate's Pepti-junior, which is a pre-digested mix that is free of whole proteins and consists mostly of short chain peptides, and the test was repeated. Four of the five babies given this milk recovered. The remaining babies got better spontaneously, and only one baby failed to improve on either milk.

Dr Campbell said that the results showed substantial amounts of colic are due to intolerance of cow based feeds.

"But I have anxieties that soya milk might be used too readily and as a result other diagnoses may be missed," said Dr Campbell.

He added that for breast fed babies putting the mothers on a cows milk free diet could have a beneficial effect. □

Strawberries and Cream, Cuts and Sprains

MONDAY June 22 sees the start of the Wimbledon Tennis Championships and the busiest fortnight in GP Dr Peter Tudor Miles' working year. For Dr Tudor Miles, the vice-chairman of the College's South London faculty, is responsible for the medical care of nearly 1,000 players, staff and members.

Dr Tudor Miles inherited the post of physician to the All England Club 14-years ago when his senior partner retired. Tennis had always been his favourite sport and he played in the Junior Lawn Tennis Association tournaments before medicine took over.

"I still find the two weeks enjoyable. But after a while the novelty and glamour wore off and it became like any job," he said when I visited him at his practice in Wimbledon Village.

When the tennis starts everything else in Dr Tudor Miles' life comes to a standstill. From ten in the morning until nine at night he is called from one emergency to another. Although he has an examination room behind Number Two Court he is rarely there and finds it impossible to run a normal appointments system. Instead people contact him on his radio telephone and he tries to fit them into a busy schedule. He is helped by a team of physiotherapists and trainers who are experts in massage, taping twisted ankles, dealing with blisters and treating minor injuries. Fortunately St John's Ambulance teams are on hand to look after members of the public who have a tendency to keel over in the often blistering heat.

"Tennis players, like everyone else, get colds, hay fever and stomach upsets but because they are competing they are far more concerned by minor illnesses," he said.

As yet there is no drug testing for tennis players, so he is not limited in his choice of medicines.

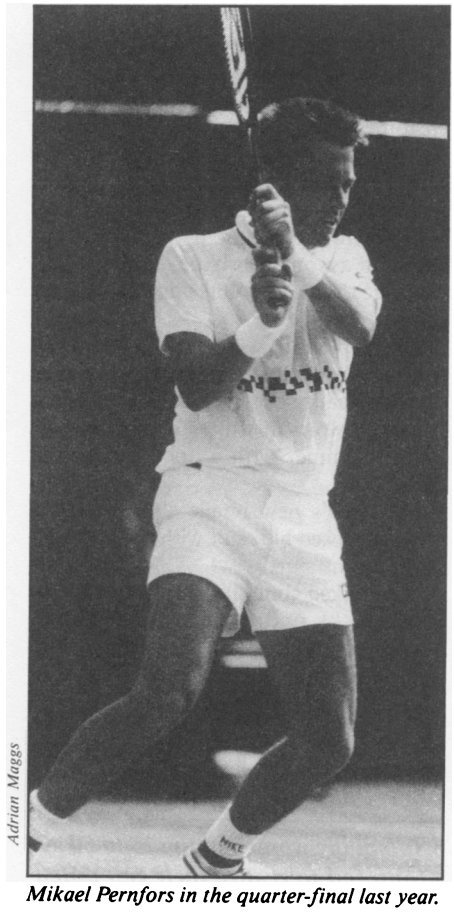
"Because of the nature of the game, drugs just are not a problem with competitors. Neither B-blockers nor body building steroids confer any advantages in tennis because it is speed and stamina that are all important," Dr Tudor Miles explained.

"Amphetamines might make players feel better, but they do nothing to enhance performance."

Injuries are common. Wimbledon is the first time in the season that the courts are used and players often slip on the lush grass and twist their knees and ankles.

Tennis elbow is quite a frequent problem and is often caused by overuse of back hand volleys or block volleys. It can be related both to faults in technique and equipment. Treatment involves rest from competitions, physiotherapy, injections and very occasionally operations.

"I have to protect the players' long term health interests and advise them when in my professional opinion it would be best to pull out," said Dr Tudor Miles.



Adrian Maggs

Mikael Pernfors in the quarter-final last year.

The stakes are high, and they do not always follow his advice. On one memorable occasion a man played through three rounds after a fractured wrist had been diagnosed.

Players like to bring their managers to medical consultations. "This can cause problems because managers are pretty influential with the players and often try to modify the doctor's advice."

Dr Tudor Miles also provides health care for all the ball boys, stewards, umpires, reporters and television and radio crews.

"The drivers of the courtesy cars seem to have the most problems. They're always complaining of sore feet and stiff necks because they're driving constantly in heavy traffic."

The knockout system means that towards the end of the tournament Dr Tudor Miles has fewer players to care for and he at last has time to relax and watch some tennis. □

Janet Fricker

College Mastermind

A MEMBER of the College has reached the final of *Mastermind,* the BBC television quiz, which is being held this month. Dr Jeremy Bradbrooke, from Trowbridge, Wiltshire, was persuaded to enter the competition by his three teenage children who were impressed by his general knowledge.

Dr Bradbrooke, who has always had a keen interest in history, has chosen the Crimean War as his special subject for the final.

In the first heat in February his special subject was the Franco-Prussian War. Dr Bradbrooke explained how the war first caught his attention.

"The Emperor Napolean III was in bad health with a bladder stone and I think one of the reasons the French lost was because of the awful discomfort he suffered."

He became interested in the Anglo-American War of 1812-1814, while he was working as a GP in Canada. He chose this subject for the semi-final in May.

"In Ontario I became fascinated by the many monuments I came across, especially one of the British general Isaac Brook who was killed repelling the Americans from Canada. He has an enormous monument the size of Nelson's Column just below Niagara Falls."

Dr Bradbrooke finds that studying for *Mastermind* is a bit like learning for an exam, and he thinks that his medical training has helped him to absorb facts. "Exam vivas are good experience for *Mastermind* and in clinical situations doctors get fairly used to coping under a certain amount of pressure."

The final can be seen on television on Sunday June 7. □

Dressed for Success

THE problem most busy female GPs experience is that the long hours required by their jobs leave little time to shop thoughtfully for a well planned working wardrobe. But dress can influence communication skills, and women are becoming increasingly aware of the importance of creating a professional looking image.

Susie Faux, the managing director of *Wardrobe,* believes that patients want their doctors to look both approachable and successful and that this can best be achieved by stylish dress.

"Some people can look confident and approachable with visual expressions, but others need help," said Suzie.

The *Wardrobe* consultancy service was established over 13 years ago to advise professional women on how to maximize their appearance and gain confidence in the process. Suzie, who regards herself as 'an evangelist in sartorial elegance' feels that too many women in the 25 to 50 age group fail to realize their full potential because they are unsure about how to dress. Whatever their role in life, she says, relaxed and confident people are far more effective.

The philosophy of *Wardrobe,* which they outlined in a series of clever advertisements on the London tubes, is: "We think it's more extravagant to buy a £5 teeshirt you loathe than a cashmere sweater you adore."

Suzie thinks that most women have far too many clothes, and that all they need is a small collection of classic fashions with cleverly matched and imaginative accessories to enable them to communicate their views more effectively and with greater authority. At *Wardrobe* women learn how to avoid making impulse buys because such purchases only lead to clothes being abandoned in their wardrobes.

Dr Tina Challacombe, a GP from Greenwich, who visited *Wardrobe* for advice on her professional appearance, agreed that her main problem was lack of time for shopping. "I leave it to the last minute and so it's no wonder that when I rush round the shops I make mistakes."

Having young children, two dogs to walk and a home to run means that Tina has to do everything in a hurry in the morning. She hardly has time to bother with makeup, and only uses a touch of eye shadow and lipstick.

"Women who work always look tired, so it's a good idea to use eyeliner and mascara to accentuate your eyes," Suzie advised.

Suzie thought bronze coloured eye shadow would suit Tina more than the out-of-date green shade she used, and suggested that she should highlight under the brow with peach to make it stand out. Suzie added that it would only take her a few minutes to apply a pale foundation and that bronzing powder could be used to accentuate cheek bones. The look was completed with coral lipstick. One tip was that tying the hair back can make the face look years younger.

Every woman who walks into *Wardrobe* is entitled to a personal profile as part of the service. They keep a file on each customer with a photograph and notes on her size, colouring, lifestyle and the sort of clothes she likes so that she need never make a fashion mistake again.

"It is like painting by numbers. We focus on a woman's shape and try to accentuate the good points and camouflage the bad," said Suzie.

Suzie always suggests that the first step to a new wardrobe should be via a suit.

"The beauty of a suit is its versatility, it can be worn in winter with a sweater and in summer with a linen shirt," said Suzie.

For Tina's new image she selected a stylish checked blue suit with a long jacket and elegant skirt.

Tina talked about her fashion problems at work. "I find coats quite awkward. When I'm making home visits I'm in and out of the car all the time and have to keep taking my coat on and off because it's uncomfortable to drive in. I'd wear an anorak, except that it looks so awful," said Tina.

"Too many women in the 25 to 50 age group fail to realize their full potential because they are unsure about how to dress."

Suzie said that a mac would solve this problem and produced a classic in dark putty that Tina immediately fell in love with.

Suzie suggested how she could avoid wearing low shoes to work by keeping an old pair in the car for driving.

Suzie mainly sells clothes by the German designer Jil Sander as well as Max Mara and George Rech, and there is no doubt that shopping at *Wardrobe* is not cheap. The designer clothes Suzie selected for Tina cost over £500.

Suzie knows her clothes are expensive,

Anne Darlington

Dr Tina Challacombe wearing her Wardrobe *outfit.*

but insists that professional women cannot afford not to dress well if they want to hold down a good job. "I believe that it is much better to buy even one wonderful jacket and skirt in a season, one you know will stand up in fashion terms for years, rather than cheap things that won't."

Even if her customers can afford to buy more, Suzie stops them because she wants to make sure they are buying something that will blend with the rest of their wardrobe. She recommends starting from scratch by looking at your shape in relation to the clothes you already own.

"We always ask customers to make three piles of clothes when they get home. The first consists of clothes that go with their new image and should be laid with the things they have just bought. The second consists of garments they love but never wear, and these should be carefully weeded through, and the third consists of mistakes and disasters which should be sent straight to Oxfam."

Tina said that there was nothing worse than being in a consultation and finding that you were wearing the same Marks and Spencer blouse as your patient. "As a GP I don't really need to maintain an image in order to succeed in my profession, but I think it's important for my own self respect. I'm aware that I have bought too many cheap things in the past and my wardrobe definitely needs reappraisal."□

Janet Fricker

FACULTY NEWS

Contents

Feeling and Focus in the Faculty; Faculty Prescribing Fund 285
Man at the Helm 286
Prescribing Meeting 287
GP Experience for Hospital Doctors/Photo Competition 288

Feeling and Focus in the Faculty

SINCE the publication in 1978 of papers discussing the future of the College there have been a number of important changes, many with significant implications for the future. These include the publication of the government discussion documents, *Primary Health Care - An Agenda for Discussion* and *Neighbourhood Nursing - A Focus for Care.* In the College the recent resignation of the chairman of Council has provoked a process of introspection and agonizing over 'Whither now?' and 'What kind of College?' But the steadily growing membership makes it increasingly difficult to find consensus answers to the questions that are now being raised.

In 1983 the North of England faculty recognized that its members were feeling progressively more remote and detached from the workings of the College, both centrally and regionally. The faculty structure has been in existence since the College started in the mid-1950s, with the principal activity centred round the faculty board which often seemed to be a self-perpetuating oligarchy. 'Representatives' generally had personal views since there were no mechanisms available to reflect any other, and open elections at AGMs usually produced the predictable array of well-known names.

In recognition of these communication and representation difficulties, the North of England faculty adopted a new structure. Members wanted a local unit of the College in which they could become more actively involved, influence general practice in their area and organize their own continuing medical education and standard setting activities. But there remained a need for the College to be active at a regional level in order to maintain links with the University and Regional Health Authority.

The answer was for the focus to shift towards establishing sub-faculties corresponding to the area covered by each of its eight FPCs and LMCs. This was achieved after discussions of a report by a small Working Party both at board level and the AGM. The following year specific proposals for devolution were made. Accepting the principal, the reasons for it and the proposals for restructuring have not been difficult. Implementation, however, has been harder.

Varying but significant levels of activity are now occurring in five of the North of England sub-faculty areas. Two other areas are not yet large enough to sustain an independent existence, and one geographically large area has several pockets of activity which are as yet uncoordinated.

Significant developments have usually been the result of action by enthusiastic constituency representatives on whom the burden of implementation at a local level has fallen. Devolution has increased the opportunities for two-way communications and this has been enhanced by an expanding but rapidly produced newsletter being published between each board meeting. Views of the members are gathered locally for presentation at faculty level, and issues raised both centrally and at faculty level are devolved to the periphery for discussion.

The faculty's response to the green paper was significantly enhanced by the direct involvement of nearly half the membership in local discussions. The faculty board is now having to critically re-examine its own way of working and is beginning to overcome its tendency to pre-empt discussions that belong to the sub-faculties. This has helped the faculty to take a broader view and develop new initiatives such as a faculty Patient Liaison Group.

The process of shifting the focus of the faculty towards individual practices has only been under way for the past three years. However, its purpose in helping to implement a policy of improving quality in general practice remains clear. □

Peter Hill

Faculty Prescribing Fund

AS part of the College's policy to encourage faculties to produce improvements in general practice prescribing, a new faculty prescribing fund has been launched for 1987/88. A sum of £10,000 has been set aside and faculties are invited to submit applications to support prescribing projects for up to £2000. The Faculty Liaison Group will administer the fund and monitor the projects, while an assessment panel consisting of Professor Michael Drury, Professor John Bain, Professor Idris Williams, Dr Edwin Martin and Dr Bill Styles will consider applications and recommend the level of support to be given. Further details can be obtained from Allan Thomas at the College. □

Man at the Helm

ROGER Chapman, who retired last month as secretary of the Beds and Herts faculty, reflects on the pleasures and frustrations of his four years in office. He reviews the progress his faculty made and remembers the projects and initiatives that never quite got off the ground.

"Roger, Michael here. I was wondering if you'd be prepared to help out with some faculty work? What we had in mind was a minute secretary."

"What would that involve?" I asked cautiously.

"There shouldn't be too much work. Just taking and producing minutes for four faculty board meetings a year. But it would be a tremendous help."

At that stage in my career I had not learned to say 'no', and I became the minute secretary and some 18 months later faculty secretary.

Last month I retired after four years as secretary of Beds and Herts, and they have probably been the most stimulating and exciting of my career so far.

The Job

There must be as many different job descriptions as there are faculty secretaries, as each secretary brings his own style, interests and attributes to the post. My work can however be divided into the following areas: servicing the faculty, responding for the faculty, innovating and raising the faculty's profile.

The secretary's workload depends on things like his personality and vision, the faculty size and the extent of his administrative support. Other major factors are the extent of faculty activity, the involvement of other members and the industry of College officers and the College Council.

Secretaries service the work of the faculty board and its sub-committees through notices of meetings, agendas and minutes. Applications for Section 63 approval and the organization of venues, caterers and speakers frequently left me feeling like an over-stretched juggler. Fortunately not too many balls seem to have been dropped.

An area which always proves difficult to handle is the request for a faculty response.

"What does your faculty feel about ....?"

"Would your faculty care to make a nomination to ....?"

"Is your faculty experiencing any difficulties in the area of ....?"

Such questions are best handled if the faculty has an effective infra structure for key members to be able to canvass opinion when the need arises.

The secretary can be a major force for innovation in areas of organization, research, education and contact with outside bodies. My own experience was that I had neither the time or energy to properly explore new fields. We hear too often at faculty secretaries conferences that the secretary sits in isolation attempting to combine too many roles. I feel that it must be the responsibility of all the officers, board members and indeed faculty members to get involved and then to help plan and initiate.

Successes and failures

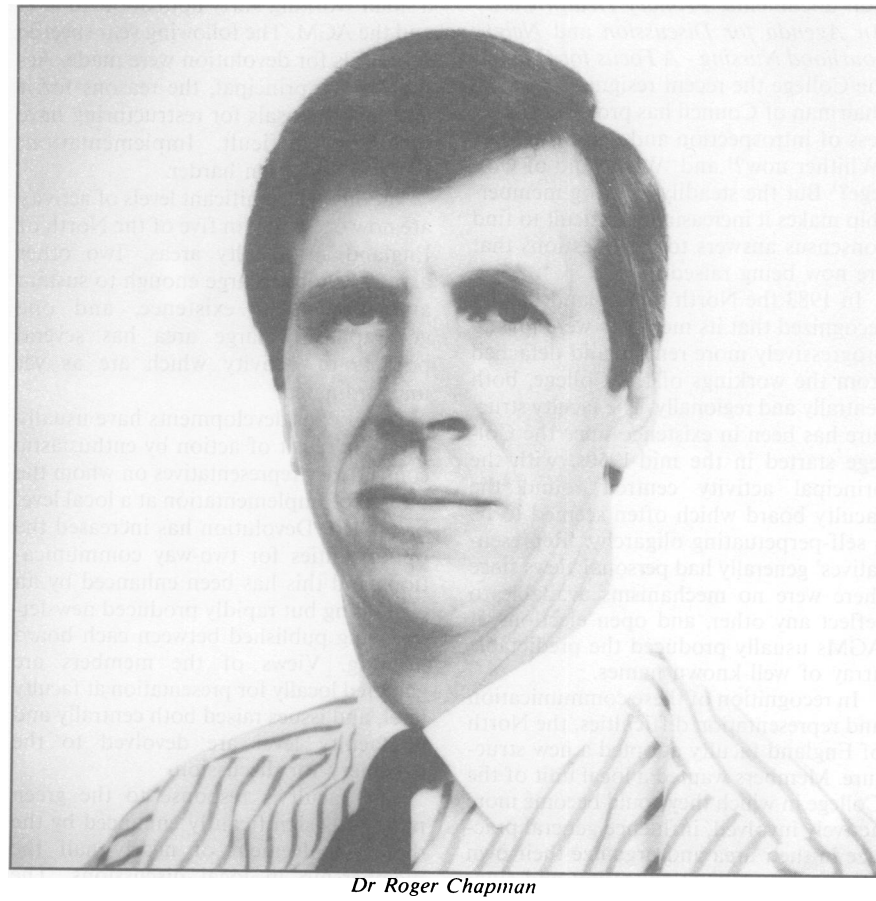
The faculty secretary is in an ideal position to see how effectively the structure of the faculty meets the needs of the members. I was concerned by the limited involvement ordinary members had with the activities of both the faculty and College.

We tried to solve the problem by rotating board meetings around members' surgeries throughout the faculty area. This has been, by and large, a success although I continue to be disappointed by the lack of response from members.

At the next AGM the faculty is implementing a constitutional change to ensure the election to the board of designated area representatives. It is hoped that the representatives will keep the board in touch with the feelings and opinions of local members and increase participation. This change should make my successor's job easier in a number of areas.

One of my aims has been to raise the faculty's profile in order to encourage the active involvement of more members. Routine contact with new members, an educational programme and regular editions of faculty news have gone some way to achieving this. Increasing cross representation between faculty boards and local medical committees has also helped.

For the last two years I was delighted to be able to take advantage of the Faculty Development Fund and employ an administrative secretary. The creation of a faculty office removed an enormous load and it is now difficult to imagine how I coped without such back-up. The presence



Dr Roger Chapman

of an administrative secretary should ensure continuity and support for my successor.

I am not so happy about my record in delegation and of involving other members. I know that this is a weakness of mine, which was to the disadvantage of the faculty, its members and indeed myself. The very task of identifying a successor, a major worry for some time, would doubtless have been made much easier if I had worked harder to involve others.

I regret that we have not followed the lead of other faculties in forging contacts with bodies in both the health and lay fields. An attempt by our Provost to put together such an initiative with the aim of briefing the local District Health Authorities foundered through lack of time.

Costs and frustrations

There have been costs which on the whole have been acceptable, but on occasions the burden has felt heavy. Nearly all the secretarial work has had to be taken home and if for no other reason than the strain on my family, four years has been enough.

I have also had less energy to put into the development of the practice, and at an early stage I realized that I could not also become a trainer. I know too that there have been times when, because of pressing work, patients have not had the attention they deserve.

The costs are compounded by certain frustrations. I discovered how difficult it can be to contact doctors on the telephone, and the frustration is not made any easier by the knowledge that I must be just as elusive. I find it frustrating that so few doctors seem willing to get involved in either political or faculty affairs. One of the less acceptable aspects of my job has been to ensure that there are sufficient nominations to make a constitutional board at the AGM.

Conclusion

I value the contacts I have made and the relationships I now enjoy with doctors from all over our faculty area and from many different parts of the country. Being a faculty secretary opened doors for me that might otherwise have remained closed. Opportunities like doing the MSD leadership course and becoming an advisor to the Association of Health Centre and Practice Administrators have been some of the advantages.

If any readers are offered the chance of becoming involved with the life of their faculty I do not believe they should turn it down lightly. □

Prescribing Meeting

IN March the Bedfordshire and Hertfordshire faculty held a meeting to consider their two prescribing projects. One project looked at the results of a questionnaire involving 332 of the faculty's doctors and the other analysed 107 doctors' PD8 forms.

Several encouraging factors emerged from the projects. The majority of doctors in the faculty made accurate records of repeat prescribing and regularly saw their patients who were receiving repeat prescriptions. They prescribed at least some drugs generically and nearly 40 per cent prescribed most drugs generically.

More than a third of those responding to the questionnaire regularly audited their pattern of repeat prescribing and more than a quarter regularly audited prescribing patterns for selected groups of drugs. Between 25 per cent and 40 per cent of practices had prescribing policies for drug groups such as antibiotics, psychotropic drugs, bronchodilators, anti hypertensives and minor remedies.

In the PD8 analysis four groups of drugs consisting of antibiotics, non steroidal anti inflammatory drugs, beta blockers and psychotropic drugs were chosen for consideration. For each group the number of different drugs used, the percentage of the drugs prescribed generically, and the prescription rate and cost per thousand patients were calculated. Each doctor was given his own figures and a comparison with the mean for the group.

After presentations of the projects participants considered whether it was possible to learn anything by comparing their individual figures with those of their colleagues and whether they were able to define any objectives which might help them to prescribe better. Subjects such as what is meant by good prescribing, the value of standing back and looking at one's prescribing patterns, developing practice policies and the advantages and disadvantages of generic prescribing were considered.

The 42 participants were then divided into five groups to compare their individual figures and consider why there were differences in prescribing behaviour within the group and what could be learned about good prescribing from this. In several groups discussions centred around whether or not to prescribe antibiotics for upper respiratory tract infections, the pressure to prescribe Benzodiazepines, the reasons for prescribing three or four beta blocker drugs and the problems of involving practices in defining joint policies for the treatment of various conditions.

In the plenary session at the end of the evening the various discussions were shared and the benefits of prescribing peer review considered. The meeting concluded that the main benefit of the evening had been the encouragement of critical thinking in prescribing and persuading doctors to break out of prescribing patterns which had merely become habit. □

Edwin Martin

GP Experience for Hospital Doctors

AT the 1979 AGM the College passed the motion that the RCGP should explore ways of providing postgraduate experience in general practice for interested trainee hospital specialists. The Wessex faculty, who proposed the motion, are now in the position to explore the possibility further. Here Dr Paul Hooper, the faculty's Provost, describes their exciting new pilot scheme.

When I became provost of the faculty in the autumn of 1985 I decided to try and launch the scheme. The first thing I did was to write to the presidents of all the other clinical Royal Colleges and the British Paediatric Association to ask for their views and whether they had any objections to the Wessex faculty implementing this scheme. They all wrote back expressing enthusiasm for the project, except the Royal College of Surgeons, who felt that time limitations would make it difficult for them to include a period for general practice.

The next step was to explore the financial implications and in this we have been exceptionally lucky in having the enthusiastic encouragement of the postgraduate dean of Southampton University, Professor Philip Rhodes. He used his good offices at the Ministry to ensure that there would be no opposition to the payment of specialists doing general practice as ordinary trainees and, of course, presumably the trainer will get similar remuneration.

The idea is that a doctor, having decided to go into the hospital service, should enter a teaching practice for a period of three to six months at either the Senior House Officer or registrar stage of his career. My own personal preference is that he should undertake this period after he has obtained his higher qualifications, when I think he will be far more likely to benefit from his mature experience and to see the relationship between his speciality and general practice.

Such a scheme would enhance trainees' skills as consultants by giving them greater experience of the environment in which general practice operates and a better understanding of the reasons for referrals. They will form deeper insights into how patients present in their physical, psychiatric and social aspects and through repeated one-to-one patient contact will be able to improve consultation skills.

On the advice of Professor Rhodes I also wrote to the chairman of the Education Committee at the General Medical Council, and in his reply last summer Professor Arthur Crisp said that he had been engaged in discussions with the DHSS about the establishment of an experimental scheme for the rotation of trainee registrars in psychiatry into general practice for periods of six months. So it looks as though the concept is being considered elsewhere.

All clinical tutors and trainers in the Wessex region were informed of the scheme, and trainers were asked to volunteer to accept junior hospital specialists. We are lucky in Wessex in that we seem to have more trainers than are required and so it has been possible to start implementing the scheme. I have been gratified to discover that over 40 training practices are interested and enthusiastic to take on these young doctors.

At the beginning of March a letter was sent to clinical tutors and postgraduate advisers informing them that practices were now available to accept young specialists and notices were sent to all the hospitals in the Wessex faculty advertising 'Electives in General Practice'. Within a week of the notices appearing in hospitals Dr Robert Thomas, the regional adviser in general practice for Wessex, had already received two applications.

We realize that this is only the beginning of a very long process, but the idea is that we should start it in Wessex as a pilot study and see how it goes. □

Photographic Competition

This dramatic picture of a man with tetanus won the North East Scotland faculty's photographic competition.

Dr Martin Pucci, a GP from Ellon in Aberdeenshire, won £25 for the unusual picture showing two classic late symptoms of the disease - *Risus Sardonicus* ('smile' due to facial muscle spasm) and *Opisthotonos* (spasm of the neck and back). He took the photograph while doing a Surgery SHO job at Aberdeen.

"The patient was a farm worker with peripheral vascular disease and open ischaemic ulcers so presumably the infection gained entry via these. He was admitted because of abdominal pains. His abdomen was rigid, not due to intra-abdominal pathology, but due to abdominal wall muscle spasms," said Dr Pucci. The patient had to be ventilated, but unfortunately died some weeks later.

The idea of the competition was to provide material for a slide library the North East Scotland faculty is hoping to set up.