NEWS

Honorary Editor: Dr Edwin Martin
Editor: Janet Fricker

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French GP's visit

IN the spring of 1987 Professor Jean de Butler, a general practice teacher from France, visited Professor James Knox, head of the department of general practice at Dundee University under the French/British University exchange scheme. Here they describe the differences they identified between the two systems.

The objective of the visit was to exchange opinions, ideas and information on what can be achieved by two experienced general practice heads of department, one Scottish and the other French. Previously we had both participated in the Leeuwenhorst group, an international working party of teachers in general practice from different European countries, who had formulated a definition of the GP's work and the educational objectives.

It was interesting 12 years later to observe the implementation of ideas that had emanated from these recommendations, and been endorsed by the 1977 Resolution of the Comité des Ministres du Conseil de l'Europe.

Professor de Butler participated in several different general practice teaching sessions at the University, including a Communication Skills course. He also sat in on patient consultations and participated in house calls. He conducted a seminar with GP teachers at Ninewells Hospital on the theme 'Physical, Psychological and Social: clinical medicine in general practice'.

Professor de Butler found time to attend the Spring Meeting of the South East Scotland faculty of the RCGP which was organized by its Research and Education Division. The programme included a 12 month psychological follow up of patients using the general health questionnaire, the impact of a transient fruit-picking population on a rural practice, the care of myocardial infarction, a scheme for running a successful general practice diabetic clinic and the problems and current management of leg ulcers.

He also visited the Glenwood Health Centre at Glenrothes in Fife. Although trainees have worked as assistants under the supervision of appointed trainers for many years in Britain, this is still not possible in France.

The project confirmed the common ground which exists between general practice teachers in Scotland and France. Both adopt the same teaching and learning objectives in the undergraduate and vocational training phases of medical education.

But the visitor was constantly aware of the fundamental differences between courses for British and French students. In British universities, unlike the French, general practice is recognized as a freestanding discipline and is taught to medical students at an early stage. It is possible in the UK for GP teachers to have full professorial status although working outside hospitals and undertaking a caring role just like other colleagues in general practice. Also the status of general practice in Britain has led to the development of a training organization with an obligatory year devoted to the specific teaching of general practice in accordance with the EEC directive.

It is a cause for regret that such differences hinder both student and teacher academic exchanges, and we can only hope for a speedy resolution. □

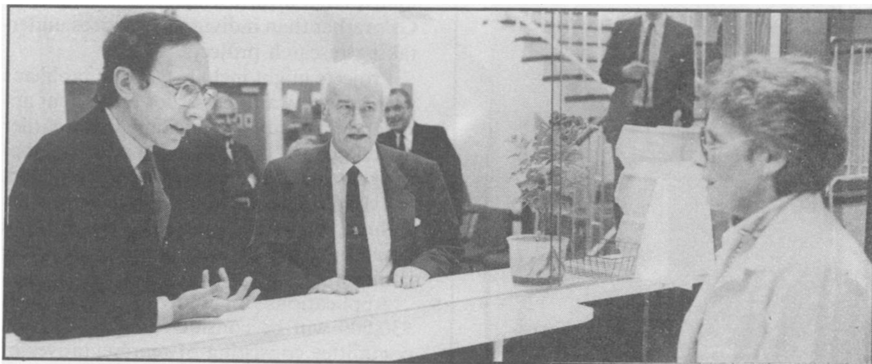
Edinburgh's New Building

EDINBURGH Medical School's department of general practice opened a new building in June bringing all their clinical and academic functions under one roof.

The new premises house all the department's work including the course for undergraduates, a 5,600 NHS patient practice, researchers who will be studying the structure of GP services and the library, video and computer facilities.

The Rt Hon Malcolm Rifkind, the Secretary of State for Scotland, attended the opening. He congratulated the department on a superb building, and commented that it was an example to other parts of the country and the world of how we are meeting the training needs of general practice — one of the most important aspects of the health service.

The new department, Levinson House, has been built on the site of the Old Town Dispensary which was founded in West Richmond Street in 1776. Professor John Howie, the head of department, would not have been able to acquire and extend Levinson House without the sponsorship of local businessman Mr Simon Levinson and Stuart Pharmaceuticals. □



The Rt Hon Malcolm Rifkind, Secretary of State for Scotland (left) accompanied by Dr Donald MacLean, senior lecturer at the department of general practice, talks to practice receptionist Mrs Margaret Alexander during his tour of Levinson House.

Health Care in the High Street

THE Pharmaceutical Society of Great Britain has devised an efficient scheme for getting health care information across to people while they are doing their shopping.

Members of the public visiting a pharmacy have been able to pick up leaflets on subjects as diverse as family planning, cystitis, drug abuse, breast and cervical screening and whooping cough immunization. The aim is to increase the general awareness of important health care issues and to reach anyone who might not be in touch with other sources of professional help.

Six million visits are made to pharmacies each day and as trained professionals with expertise in the actions of drugs and medicines pharmacists are in an ideal position to play a more prominent role in the field of preventive medicine.

The *Health Care in the High Street* scheme makes a lot of sense. After four years training pharmacists can do more than just counting pills into bottles. A survey by the Family Planning Association in 1981 showed that pharmacists wanted to extend their role into health prevention. Over 85 per cent of pharmacists said that they saw information giving as part of their future role.

In February 1986 the Pharmaceutical Society of Great Britain, the Family Planning Information Service, the Health Education Council, the National Pharmaceutical Association and the Scottish Health Education Group collaborated to start the scheme. Some 12,000 chemists shops were supplied with a leaflet stand for displays on pharmacy counters. They have since extended the role to hospital pharmacies which a large number of people attend daily.

"The provision of information is really no more than an opening gambit, but if a person is concerned about something like AIDS the first step to solving their problems is to get them to read about it," said Mr Bruce Rhodes, the assistant secretary of The Pharmaceutical Society of Great Britain.

Having read about it they can discuss their problem with the pharmacist who may provide all the advice they need, but quite frequently will refer them to an appropriate source which may well be the GP.

The scheme enables health care organizations to run national campaigns and reach a wide audience with important health care information. *Health Care in the High Street* provides administration, but it is up to the organization concerned to pay for the leaflets and postage.

Between 20 and 40 leaflets are sent to each pharmacy accompanied by a covering letter with background notes for the pharmacist's information. Some of the leaflets have been supported by national advertising campaigns directing people to the pharmacy for information.

Any organization can put leaflets up for the scheme, but material is carefully vetted for suitability.

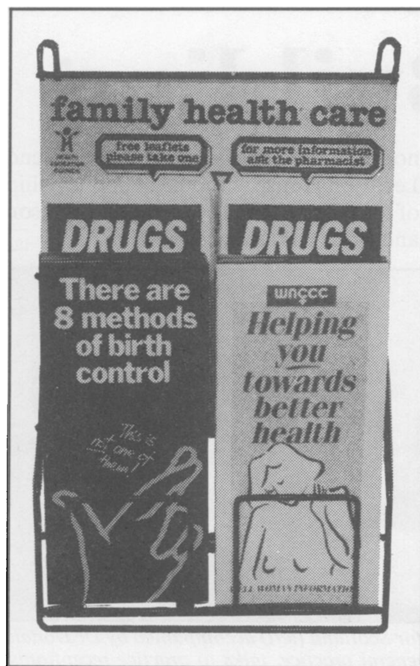
"We would like GPs involved in any health education organizations to be aware that they can use this scheme to get their message across to the public," said Mr Rhodes.

The scheme has proved very successful. Results of a survey carried out by Aston University in August 1986 indicate that of 200 pharmacies visited, over 90 per cent had the current material on display.

"Our only problem is that it is working too well and increasing the demand for leaflets beyond our expectations," said Mr Rhodes.

Organizations interested in using the leaflet stand (which is free) should write for details to Miss S. Zeelenberg, The Pharmaceutical Society of Great Britain, 1 Lambeth High Street, London SE1 7JN.

Janet Fricker



The leaflet stand.

Primary Care Development Fund

A £300,000 development fund intended to support projects that improve primary health care in the community was set up in June.

The fund is being jointly financed by The King's Fund, the Nuffield Provincial Hospitals' Trust and the Department of Health and Social Security.

The emphasis is on helping local initiatives that involve a significant number of GPs rather than individual practices undertaking research projects.

Projects might include tackling problems such as long waiting lists for outpatient appointments and hospital admissions, earlier discharges and better after support, developing guidelines for collaborative management of conditions like high blood pressure, asthma, diabetes, AIDS and cancer; and developing support services for care in the community.

Applications for individual grants of £30,000 will be considered by a selection committee consisting of representatives of the three funding bodies, the General Medical Services Committee and the Office of Health Economics. They say that they are planning to give special consideration to proposals relating to primary health care in areas of deprivation such as inner cities, declining industrial towns and rural areas.

The closing date is December 31, 1987 and further details can be obtained from The Secretary, Primary Care Development Fund, General Medical Services Committee, BMA House, Tavistock Square, London WC1H 9JP. Telephone: 01-387 4499. □

Australian Bi centennial Celebrations

AT the invitation of the Royal Australian College of General Practitioners, the College has been invited to send a delegation to a meeting in September 1988 at Surfers' Paradise near Brisbane.

If you are planning to be in Australia at that time and are interested in attending please contact Dr Douglas Garvie, honorary treasurer, at the College. □

Prison Medicine

DR Edwin Martin a part-time medical officer at Bedford Prison, describes the wind of change that is currently blowing through the prison medical service.

Although on an average day there are between 48,000 and 50,000 people in prison, the prison medical service remains a somewhat shadowy organization with little coming out in the way of information and medical papers. Yet prisoners are less healthy than the average population and medical problems such as epilepsy and psychiatric disease occur more frequently.

Since most of the care given is simple primary medical care, and 135 of the 245 prison medical officers are GPs working part-time in the service, prison medicine is a subject relevant to general practice.

The Prison Medical Service was set up in 1774 following the work of the reformer John Howard and public concern about the health of prisoners and the threat of typhus developing in gaols and spreading to the community. The service preceded the NHS by 174 years and remains separate from the NHS. Until recently prison medical officers had to sign the Official Secrets Act which made the dissemination of information about the medical care of prisoners extremely difficult. Isolation of the prison medical services from discussions within the profession has led to declining morale and allegations of poor standards which have at times been unjustified. The image has been of doctors with little public accountability, who deal with violent and difficult patients in the way they see fit with little external supervision.

The environment of Britain's overcrowded prisons with decaying buildings and low staff morale has added to the poor image of the medical service. Prisoners prove difficult patients to treat - they have destructive habits such as high alcohol intakes, heavy smoking and drugs, with a tendency towards poor dental hygiene and obesity. Such patients are particularly resistant to change.

The fact that prisoners cannot vote and the public prefers to forget about people who commit unpleasant crimes has meant that the prison service is low on the scale of priorities for health resources. This lack of funding has affected the training of both the medical officers and the hospital officers who help the doctors with the care of patients.

For many years the hospital officers who carry out routine nursing duties were ordinary discipline officers who had been given a basic 13 week course in first aid and nursing procedures. The pay of both medical officers and hospital officers compares badly with those doing similar jobs in the community and the pay of part-time medical officers is not pensionable.

A typical cell at Bedford Prison.

As well as acting as a primary care physician catering for the needs of the individual prisoner, and an industrial medical officer looking after the environmental health of the prison, the prison medical officer is expected to supervise punishments. This is officially meant to protect the prisoner from physical or psychiatric injury during punishment, but the ethical divide between protecting the prisoner and supervising the punishment is debatable and many see this third role as incompatible with the other two. In a recent document the Royal College of Psychiatrists has acknowledged that prison medical officers require special qualities to adhere to the proper treatment ethic in a predominantly punishment-orientated organization.

The consequence of many of these problems has been that members of the prison medical service feel undervalued and, at times, cynical. It proves difficult to fill many of the posts.

Recent events have however proved a stimulus to change. In 1983 Richard Smith wrote a series of well researched articles in the *BMJ* which posed many questions about prison medicine. At about this time Dr John Kilgour, a former army doctor who had worked for the World Health Organization in Geneva, took over the post of Director of Medical Services for Prison Medicine. He approached the job with intelligence, enthusiasm and a refreshing determination to introduce reform. A further factor in opening the doors on prison medicine has been an investigation by the House of Commons Social Services Select Committee, which took evidence, visited many prisons and made some far reaching recommendations.

All of this happened at a time when the prison service found itself under strain. Years of neglect had led to decaying buildings which were having to cope with an increasing number of prisoners. Staff dissatisfaction had boiled over and work-to-rules and various forms of industrial action had become common. The Home Office gradually relaxed the strictures of the Official Secrets Act and articles by prison medical officers about routine medical care began to appear in the Journals.

A wind of change started blowing through the whole prison service. The doors of prisons were gradually opened to the media, a crash programme of replacing decaying Victorian prisons was

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Consultation room at Bedford Prison.

commenced and informed debate about the prison medical service started within the medical profession. The Royal College of Physicians set up a Training and Standards Committee with representatives from the RCGP, the Royal College of Psychiatrists, and the faculties of Occupational and Community Medicine to examine the standards of care and training within the service.

In some regions audits of deaths and disasters within the prison service have been instituted. Protocols have been developed for preventing suicide, and dealing with hepatitis B and AIDS, which emphasize the autonomy of the individual prisoners. There has even been talk of prisoners being allowed to self-medicate with simple household remedies — a subject unheard of in the past. Hospital officers now have an improved training and there are plans to increase the number of registered nurses employed within the service.

But there are still problems — some of which seem insoluble. The environment of a prison will never be a pleasant one for prisoners who are by definition people who have had their freedom removed. Although attitudes are changing, older prison staff are often set in their ways, and in the individual hospitals change is slow.

Many inmates are in prison because of their inability to manage their lives. Persuading such people to give up drugs, alcohol and smoking and to learn ways of coping with stress that do not involve violence, is a difficult and often thankless task. It has been estimated that up to 30 per cent of prisoners could benefit from psychiatric treatment, but coping with such men and women in the inappropriate environment of the prison, until they can be transferred to a hospital, would tax the skill and patience of a saint. But perhaps the biggest problem of all is the inertia and persistent red tape of the Home Civil Service machine.

Despite all this, the prison medical service is undoubtedly moving in the right direction. It is hoped that there will be much more contact with the NHS in the future, and that doctors will work both in the NHS and prison medical service. There has even been talk of amalgamating the two. There are signs that the Home Office is committed to improving continuing education for all members of the prison medical service.

Even if these changes occur, the prison doctor is left with a difficult and demanding group of patients. His job is taxing and at times dangerous. The one thing he can guarantee is that the general public will have no interest whatsoever in what is happening to prisoners until something goes wrong, and when that happens the doctor will, as always, be to blame. □

Cervical Cancer Video

LEICESTER Health Authority has produced a new video designed to educate the public about the risk of cervical cancer and the importance of women having regular smear tests.

Cervical Cancer, produced with the help of two gynaecologists, a pathologist, molecular biologist and a GP, provides a comprehensive introduction to a disease which kills thousands of women each year but can be easily cured if detected early enough.

The 11 minute video narrated by television personality Pamela Armstrong combines sophisticated computer graphics with live imagery to show the current state of knowledge concerning cervical cancer.

"We emphasize that the smear test is absolutely routine and painless and describe the treatments available," said Pamela Armstrong at the launch in June.

The video outlines measures that can be taken by women to minimize their chances of developing cervical cancer. These include reducing the number of sexual partners to lower the chance of infection from the human papilloma virus, which has been linked to the condition, and ensuring that casual male partners use condoms.

Intercourse should be avoided during puberty and the early teenage years when the transformation zone between the mucous secreting cells of the epithelium and the stratified squamous epithelium is exposed and particularly vulnerable to damage by external agents. Evidence also suggests that the cervix is vulnerable during pregnancy.

The scene of a woman having a smear test was filmed in the surgery of Dr Brian McAvoy, a member of the College and the senior lecturer in general practice at Leicester University.

"Since 60 to 70 per cent of smears are done in a GP's surgery we felt that it was very important to show a normal setting," said Dr McAvoy.

The makers hope the video will be distributed as widely as possible to the public through schools and women's groups and that the material could also be used in family planning clinics and well women clinics by GPs, nurses and health visitors.

The video is the second production of Leicestershire Health Authority's Health Education Video Unit. Its first production *AIDS* was a great success. It has sold over 1,900 copies and been placed in British Embassies throughout the world at the request of the Central Office of Information.

The video costs £50 for VHS and Betamax and £65 for U-Matic. Previews can be arranged. Further information can be obtained from: The Health Education Video Unit, Clinical Sciences Building, Leicester Royal Infirmary, P.O. Box 65, Leicester LEX 7LX. Telephone 0533 550461. □

Kibbutz Doctor

WHEN I tell overseas colleagues that I am a family doctor who lives and works on a kibbutz in Israel their reaction is usually one of genuine fascination and curiosity which sometimes seems to border on envy. Comments range from: "That must be jolly interesting," to "Is it true that you don't actually get paid?" Or even, "I've got a couple of months break coming to me next summer, no chance of a locum there I suppose?" So perhaps a little elaboration is in order.

First I should explain that a kibbutz is a unique form of shared existence in which families and individuals live and work together on equal terms for their mutual benefit and advancement. All forms of work and leisure on a kibbutz are organized communally, and children's education follows a uniform pattern. No salaries are paid or retained, but each adult member who has been officially accepted into the community receives a living allowance according to his family's and his own personal needs. Meals are eaten communally in a large dining room and children are reared together in peer groups. The tendency for children to sleep away from their parents in special houses is disappearing and today most kibbutzim children live at home.

The kibbutz is governed by a general assembly which meets about two or three times a month. A smaller executive committee comprising elected office-holders such as the secretary and treasurer, as well as a few additional 'ordinary' members take care of day-to-day matters. Several other elected committees also exist to deal with specific aspects of kibbutz life such as education, work problems, finance and, of course, health.

About three per cent of the Israeli population live on kibbutzim, of which there are several hundred in the country. Each has a distinct personality derived from its particular history, locality, demographic characteristics and agricultural and industrial biases. Although they were originally based on agriculture almost all now possess some form of industry ranging from small carpentry workshops to heavy engineering factories.

Depending on how long they have been established and their stage of development kibbutzim have between 50 and 1,200 inhabitants. In sociological terms it is useful to view a kibbutz as a large extended family. Indeed if one defines a family as a social group which has to overcome certain developmental tasks together then this at least gives a theoretical insight into how a kibbutz functions.

As far as medicine is concerned there are two types of kibbutz doctors. There are those who are members of the kibbutz and contribute their earnings to the communal fund and have all the privileges and obligations which such membership bestows. And there are those, like myself, who are not in fact members but are employed by Kupat Holim, the Israeli Health Insurance Fund. They pay the kibbutz for the accommodation and other services with which they and their families are provided. Because of the family analogy it is unusual for doctors to practise in their own kibbutz. It is thus usually a non-member known as a 'lodger' who takes care of the kibbutz in which he lives. But the professional and social boundaries can often become blurred, and this aspect of kibbutz living has to be kept in check if a kibbutz doctor wants to remain an effective provider of health care for his large kibbutz 'family'.

I look after the health needs of 200 people on a small kibbutz in central Israel. I also cover two neighbouring rural villages of the more conventional kind, making the list size of my practice up to 1,200 patients.

As well as myself there is also a full-time nurse who is a member of the kibbutz. Larger kibbutzim usually have a full or part-time physiotherapist and often a psychologist and medical secretary in the team.

The kibbutz health committee is a good example of community participation in health provision at the primary care level. The purpose of this committee, which comprises three or four lay kibbutz members with myself as the professional adviser, is to oversee and regulate health provision and promotion. It deals with any personal, mental or emotional problems affecting kibbutz members or their children and, in conjunction with myself, discreetly arranges appropriate treatment outside the kibbutz if this is required.

The committee is also responsible for making 'social' arrangements within the kibbutz for members who are ill or pregnant. These may range from ensuring adequate transport for people visiting a hospitalized member, to arranging a welcome-home party for a new mother and her baby. The committee has other tasks including the consideration of members' applications for special or alternative medical treatments which may not normally be available on grounds of principal, or for financial reasons. In such circumstances I will often be asked for my professional opinion about the case before a decision is reached.

The committee is also a forum where members can have any health-related complaint or grievance aired and clarified, and this is naturally an area where I may also become directly involved. In a closed community such as a kibbutz this function is particularly important since a doctor has no choice in practical terms but to look after each and every member.

Removing a patient from my list is neither feasible nor desirable and it is important that any problems or professional misunderstandings arising on either side of the consulting desk are 'caught' at an early stage and resolved to the satisfaction of all parties. Fortunately most of the discussions necessary in this area are amicable and positive. Potential problems are resolved before they blow up into something bigger which could reverberate for a long time within so tight-knit a community.

The committee is also a useful channel by which I can obtain feedback about my professional work on the kibbutz and through which members and myself can initiate and promote preventive health measures and health education activities for the benefit of the whole community.

Israel is to be the venue in May 1989 of the next international WONCA conference, and kibbutz-based family medicine will be just one of the many models of community medical care existing in this country that we will be informing delegates about. Unfortunately Israel like other countries has strict licencing regulations regarding non-citizens who wish to practise medicine within her borders, so regrettably it is unlikely that any kibbutz locums will be available in conjunction with the conference.

Arthur Furst

No Laughing Matter

AN exhibition at the Wellcome Institute for the History of Medicine shows how in the nineteenth and early twentieth centuries anaesthetics gripped the public imagination.

Using rare archive material including press cuttings, books, photographs, paintings and prints *No Laughing Matter: A History of Anaesthesia* brings to life the vital role that was played by anaesthesia in war and peacetime. Instead of mounting a chronicle the exhibition examines anaesthesia in the contexts in which it developed — the relationship of anaesthetic practice to surgery, to war, to women and to industry.

No sooner had Horace Wells used nitrous oxide at the Massachusetts General Hospital in 1845 and William Morton demonstrated ether at the same place in 1846 than a host of other people appeared claiming their share of the credit. Frederic Dennis, the professor of clinical surgery at Cornell University, saw anaesthesia as the product of a unique American spirit. "Anaesthesia with its worldwide blessings is confessedly American," he wrote in 1905.

It is thought, although inevitably disputed, that Robert Liston's trial of the 'Yankee dodge' at University College Hospital, London on December 21, 1846 was the first use of anaesthesia in Britain.

Unfortunately medical historians know little about the day-to-day anaesthetic practice in the past, such as who the anaesthetists were, what they used, who their suppliers were and what the anaesthetic agents cost. But it appears that chloroform, because of its portability and the ease with which it could be administered, became widely used in general practice in Britain. According to one author writing in 1905 GPs' methods of giving chloroform were often quite slapdash:

"Chloroform has generally been poured on freely from the original ½lb or 1lb bottle, with no particular regard paid to the quantity used."

Early texts reveal a world where the anaesthetist undertook a battery of chemical tests involving agents such as egg white and sulphuric acid to see if there were any dangerous impurities in the chloroform he was about to use.

It is hardly surprising that such free use of anaesthetics led to incidences of addiction. In the exhibition there is a reproduction of *The British Medical Journal* of 1888 reporting the case of a midwife who became 'a victim to the chloroform habit'. At the inquest it was said that she 'would take a pint of chloroform in the day'.

Oral surgery posed special problems with competition between the surgeon and anaesthetist for space and the danger of the unconscious patient inhaling blood. Such technical difficulties ensured that tonsillectomies were performed without anaesthetics by GPs in Britain until the inter-war years.

Financial considerations had a bearing on the use of analgesia in labour. In Britain before the advent of the NHS mothers had to pay directly for anaesthetic drugs. In 1934, only 0.5 per cent of midwives supervised home confinements involving the use of analgesics.

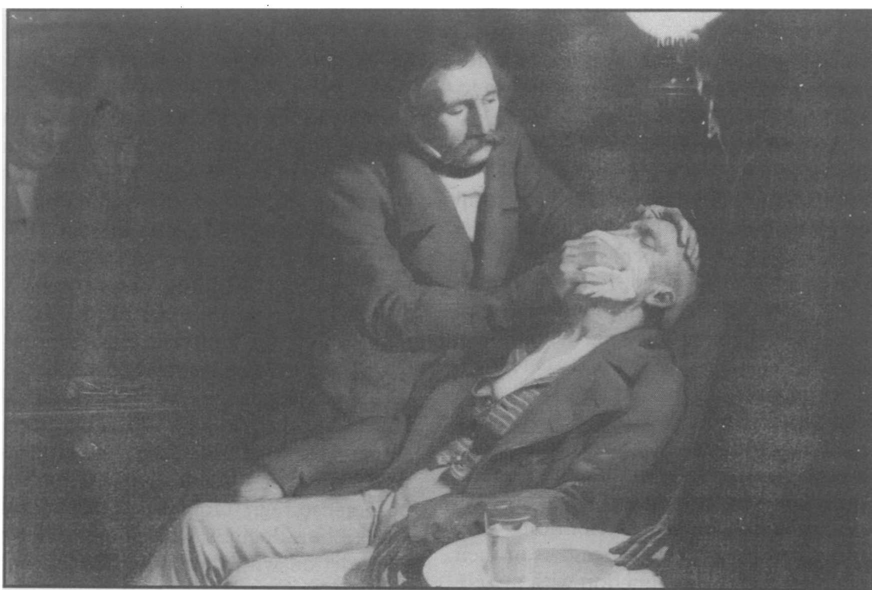
The two World Wars were responsible for considerable advances in anaesthesia. The conditions under which anaesthetics had to be given, the physical state of the troops and the nature of battle wounds all posed special problems. The solutions tended to become permanent features of anaesthetics in civilian life. Ether was usually the preferred agent, but with men who had been living in the trenches for six months and who had numerous broncho-pulmonary complaints ether often produced respiratory complications.

The Second World War saw a dramatic decline in the number of deaths attributable to events associated with anaesthesia. The development of intravenous barbiturates, particularly pentothal, made it possible to avoid giving inhalational anaesthetics where they were contraindicated. But the most important factor in reducing the death rate was the use of blood and plasma to combat shock.

From its first use, anaesthesia, in fact and fiction, has been associated with crimes such as rape, theft and kidnapping. The exhibition shows contemporary reports of robbery by means of chloroform and attempted rape while under anaesthesia. Another use reported in *Punch* was the use of ether to render honey bees inactive in order to obtain their honey.

No Laughing Matter: Historical Aspects of Anaesthesia runs at the Wellcome Institute for the History of Medicine, 183 Euston Road, London NW1 until September 25. It is open from 9.45 to 5.15 Monday to Fridays except public holidays. □

Janet Fricker



The first use of ether in dental surgery, 1846. From a painting by E. Board.

Diabetes conference

THE RCGP, in collaboration with Rybar Laboratories, is holding a National Conference on Diabetes in November. The aim is to promote a team approach to the care of diabetic patients in general practice. They hope to examine the role of team members and the organization of diabetic care in general practice and to explore the relationship between primary and secondary care services for diabetic patients.

The RCGP hopes that delegates from all the disciplines involved in the care of diabetic patients will attend the conference on November 11, 1987. Further details can be obtained from Janet Hawkins at the College. □

FACULTY NEWS

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Study of Trainers' Workshops

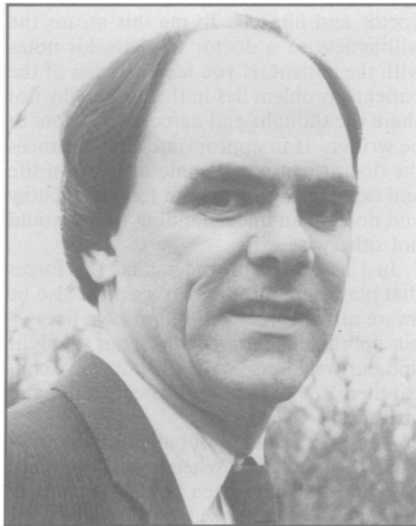
PETER Ellis, one of the winners of the 1985 Schering Scholarships - the College Award which is intended to enable teachers in general practice to improve their knowledge and skills by visiting others - used his award to investigate the communication problems of trainers' workshops. He sent questionnaires out to trainers and visited groups in the North and West London area. Here he gives his recommendations for the improvements of workshops.

The format of trainers' workshops usually consisted of monthly evening meetings, composed of tired doctors, some on call, some unfed, and all not functioning as a group. Leadership was often not apparent, and where it was attempted it was not always welcome.

The workshops I visited were themselves varied, but I suspect that the following two scenarios will be familiar to many.

Workshop A had no obvious starting or finishing time, attendance seemed erratic and there was no apparent leader or task for the meeting and all members seemed involved in the talking. As members started leaving a vague attempt was made towards some type of task. However members did appear to feel free to spontaneously bring up real problems without fear of reprimand or rebuke from other members. A new member of this workshop might soon feel at home and be able to move it forward towards new ventures.

Participants attending **workshop B** entered the room and took up their seats without acknowledging the presence of any other group members. My presence was questioned by a couple of members. The obvious leader started the evening



Peter Ellis.

apologizing for a slight delay, and then handed over to the meeting's chairman who produced various handouts. The session ended at the appropriate time, with the chairman handing back to the leader to organize the following session. I noticed that a new member of the workshop had not contributed in any way all evening.

This was certainly a meeting high in organizational efficiency, which fulfilled set educational objectives. But a new member would find it difficult to contribute and might indeed find it impossible to get the workshop to change direction.

In their replies to the questionnaire trainers often seemed unsure about who was in fact the workshop's leader. Indeed members often thought different people were in charge.

The aims of the workshop were seldom known, and most workshops did not have a set curriculum that was in any way known to the participants.

All workshops appeared to be open to new trainers, but new trainers seemed to find it difficult to alter the functioning or direction of a workshop and sometimes felt like intruders. Many trainers were not happy with their workshops, but attended because they felt it was compulsory within the region.

Individual problems concerned with training were occasionally talked about at workshops but would more often be discussed within the practice or at another meeting of doctors, for instance a young practitioner group. In the same way, trainers appeared to receive more support in their training from their own practices and courses than from workshops.

Reading appeared to be largely self-directed and although teaching skills were occasionally learnt during workshops they were more often acquired elsewhere, either on courses or during other aspects of the trainer's work.

Many respondents praised residential trainers' courses where training was the main activity. Trainers said that they felt much more anonymous and unknown at these courses, and that they were not simply 'monthly turnouts'. One group commenting on residential courses, realized that trainers' workshops had an almost impossible task since there was too much to do and too many areas to cover. They considered areas of interest including the trainer as a doctor, the doctor as a trainer and the trainer as an employer.

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Looking Back

DR DAVID CANNON gave his reflections on retirement after 37 years of medical practice when he spoke at the AGM of the Beds and Herts faculty in May.

Retirement has led me to consider both what patients expected of me, and what my expectations were as a doctor.

Patients expect their doctor to be competent, able to communicate and to show compassion. Competence, to me, means considering the 'patient' not just in the physical, social and psychological terms we are taught, but as a human being with a spiritual dimension, which we as physicians often ignore to the detriment of our patients. I hope that as a christian my allegiance has been obvious in my work and relationships without being too obtrusive.

Competence also means being able to do the job, being aware of recent advances in medicine, and careful in both diagnosis and treatment.

I fear that a number of practitioners are being led astray by the current fashion for alternative medicine. Such therapists have time, use their eyes, ears and hands together with an understanding of human behaviour. In addition doctors have a comprehension of anatomy, physiology, development and disease which should give us an advantage. We must not let our skills deteriorate.

Patients expect their doctors to be able to communicate. But many doctors have an inbuilt handicap in communicating with patients who have been brought up under different circumstances. Recently while clearing out our attic I found a 1934 newspaper cutting from the *Sunderland Echo*, in which my father, a Methodist minister, was appealing for gifts of shoes for his parishioners so that the children might be able to go to school. How could I, with no such problems, communicate with children with multiple deprivations. As doctors we need to learn about events which have taken place in our patients' lives and which cause them to react to their problems in the way they do.

The last 15 years has seen the GP's consultation dissected, and I am not sure whether such concern may not have hindered communications between the doctor and his patient. Of course consultation is near the heart of general practice, but the centre must be the patient.

The last ten years has seen an increasing use of the computer in general practice. It is a useful tool — a means to an end — but not an end in itself. Surely it is time that this facility was standardized so that each hospital, practice and FPC uses the same machine and can communicate facts to one another, leaving the doctor free to concentrate on his patients.

The patient expects honesty between the doctor and himself. To me this means the willingness of a doctor to share his notes with the patient. If you feel the basis of the patient's problem lies in the mind, why not share the thought and agree on the note to be written. If in appropriate circumstances the doctor can reveal some of his own life and experience patients can feel an empathy and develop an understanding which would not otherwise exist.

Just as we try to understand the forces that play upon our patients we must also be aware of the forces within our own lives — our upbringing, our prejudices, our strengths and our weaknesses. Such factors have contributed to our present behaviour and attitudes.

A third expectation of patients is compassion. The accolade, "When my husband died he could not have been kinder" is one we all value. When analysed, particularly at the time of death, it means availability, reliability and continuity of care. I wonder if these characteristics of family medicine are not disappearing. Is the rise in the use of commerical deputising services a symptom of changing attitudes. I often wonder if those who use the deputising service as a way of running their practice would call out the deputy if they or a member of their family were ill. This attitude will affect the relationship between doctors and patients and lead to a greater readiness to seek redress for what is seen as a failure in care or standard of service.

What are the doctor's expectations? A rewarding, satisfying and fulfilling life? For me this occurred by meeting and accepting challenges, such as: the challenge of working in a remote 120 bedded hospital in Nigeria, with three doctors serving a population of 150,000; the challenge of becoming a GP without the benefit of vocational training; and the challenge of passing the MRCGP 30 years after qualifying and subsequently becoming an examiner. I believe that to avoid such challenges leads to a stunting of personal growth, and a decline of skills and talents.

But one of the most important factors has been the relationships I have formed over the years with partners, members of the primary health care team and patients. Occasionally one hears colleagues, who are dissatisfied with their role as GPs, making disparaging remarks about patients. The opportunity to share patients' problems and secrets and to be invited into their homes is a privilege we should continue to acknowledge and respect. If one enjoys the patients, then the work itself is enjoyable.

Of greatest importance are relationships at home. I realized this when my first wife, Margaret, died of a sub-arachnoid haemorrhage after an illness lasting only seven days. Suddenly there was no one to share with and from 'we' it became 'I'. I have learnt that if you love someone you should tell them and not expect it to be taken for granted.

Mary is a patient who I have known for most of her life. After a deprived upbringing she married and produced two lively sons, but breast feeding unfortunately led to complete atrophy of her mammary tissue. This destroyed her self-image and such self-esteem as she possessed. After many attempts admission for breast augmentation was finally arranged.

On my retirement she sent a gift of gladiolus corms accompanied by a letter which concluded: "When they bloom each year perhaps you will remember the young lady's life you helped to bloom again."

Already they are showing through the soil of our new home, and each year I will remember Mary.

Is it not helping lives to bloom again that general practice is all about? □

Dr David Cannon (right) being presented with a lamp by his partner Dr Tony Bryer on his retirement in March.

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Discussion

The functions of trainers' workshops at present appear to include: advice on teaching methods and techniques, peer group and trainer support, problems with curriculum planning and targets and involvement with vocational training schemes.

Trainers' workshops have evolved following no particular model and have developed as an independent movement. Despite criticisms it must be recognized that trainers' workshops continue to exist and carry out group functions. However they are of variable quality, often attempt to do far too much, and in doing so spread the icing far too thinly.

Administration and, in particular, the running of a vocational training scheme, is not an appropriate role for trainers' groups. The members of many trainers' workshops have no group identity and no community involved in peer group learning exists. Such a community needs to be clearly established with definite boundaries within the groups. The workshops themselves need to be for a fixed duration of time with a definite end point.

At the start a residential workshop might be held to establish boundaries that are crucial to the existence of a peer learning community.

Trainers' workshops should give sensitive support and help with the practical applications of training and a Balint style of approach, looking at the trainer/trainee relationships, might be helpful.

The person leading this group must have group experience, but need not be a trainer or even a doctor. Experience from group work outside medicine can have much to offer and an educationalist may well be the most appropriate person. The curriculum needs to be planned well in advance and must be relevant to all members of the workshop.

In the first year of training, trainers can have special problems and needs. However good a trainer may be, he will not have had the type of experience he needs to develop the trainer/trainee relationship before. The workshop should not be used to report on an individual trainer for assessment purposes, nor should the leader be expected to give assessment reports. The essence of a good workshop experience is that the group feel able to criticize each individual because of the trust which is created.

It is hard to trust when one is being assessed. In the same way, members should not be involved in assessing each other for approval or re-approval. They may choose to assess each other on an informal basis with sound educational objectives. Certainly there is evidence of several workshops beginning to carry out an informal visiting programme in line with the 'What Sort of Doctor?' report.

Above all, workshops need to be individual and should not be made to conform to any national or regional standards. Change will mean cultural, organizational, and educational modifications. The alternative, however, is for workshops to simply exist and continue to stagnate. Change is uncomfortable, but change brings with it great opportunities. □

Practice Computers

WHEN in 1983 the North West England faculty considered its structure we realized that to be more effective and relevant to our 600 members we needed to divide into workable units. It was logical to split the faculty according to either districts or postgraduate centres.

It was also proposed that the faculty would benefit from an administrative secretary and a microcomputer. Joanne Haslingden started work in September 1984 and in 1985 the faculty development fund granted resources for a microcomputer.

Princes Gate suggested that the faculty hardware should be compatible with the developing systems in London. In the days before the Amstrad this meant an IBM personal computer. Members of the faculty board who knew about computers advised that one of the golden rules of computerization was to look at the software before committing oneself to the hardware.

Faculty secretaries interested in using computers were invited to work with Mike Hodgkinson, the College's information technology manager, to produce the specification for a faculty database to run a commercial software package called *PFS File.*

A database structure was devised that presented standard information in a uniform way but allowed the possibility of entering different levels of information according to local faculty needs.

Since the computer arrived in January 1986 we have used it for wordprocessing letters welcoming new members, drafting minutes and transmitting correspondence electronically to Princes Gate by a modem link.

The faculty board felt that it would be unrealistic to ask members to complete a lengthy questionnaire and decided that the first priority was to establish where members worked and the postgraduate centre they attended. By grouping members into practices and districts we were able to improve communication without dramatically increasing mailing costs.

Since the faculty is interested in young principals' groups and inter-practice visits we also decided to keep a record of faculty members who were either involved or wanted to become involved with these activities. We asked about practice organization because we felt that the faculty could play an important role in linking doctors with similar needs.

Because the faculty computer is not compatible with the Princes Gate computer holding the membership list we have been unable to directly download this information. The problem was resolved, however, when the basic details were entered by staff in the Information Technology Centre at Princes Gate. In future the new local area network at Princes Gate should be able to download directly, or transfer disc to disc.

When budgeting for a computer and an administrative secretary one of our mistakes was to make no allowance for in-post training. Our secretary has attended the College computerization course and a local course on wordprocessing. This was offset by the support training provided by the Princes Gate staff and Manchester University department of general practice.

We have already found considerable advantages from using a computer as a wordprocessor and hope that the faculty will soon benefit from the data we are collecting. □

Jacky Hayden

Performance Review

IN 1986 the East Anglian Regional Advisers Office set up a General Practice Performance Review Unit.

The aim was to encourage individual GPs to undertake audit or performance review, to undertake or sponsor large scale audit projects and to advise the regional general practice sub-committee on performance review and the educational needs that became evident from the process, and finally to advise health authorities and the FPC on performance review.

The first two aims are concerned with encouraging and monitoring performance review within individual practices. Where larger scale audits are undertaken the unit standardizes the methods used so that true comparisons between practices are made possible. The latter two aims are concerned with interpreting information that has been generated from general practice about this discipline.

The East Anglian Reporting System (EARS), which was originally the idea of Dr Ken Mourin, has now been brought under the umbrella of the Performance Review Unit and is being sponsored by the East Anglia faculty of the College.

In the summer of 1986 all the practices in the East Anglian region were asked through the FPC mailing if they were interested in taking part in EARS. Then in the autumn of 1986 the 113 doctors who had expressed an interest were sent a letter explaining the aims and methods of EARS. They also received a questionnaire asking for basic practice information and a list of ideas for further research. The 93 questionnaires which were returned formed the data base for the EARS research framework audit or performance review by individual practitioners.

The practices are spread evenly throughout the region with a fair mix of urban and rural practices with a total practice population for the EARS practices of 650,000. The protocols for projects using EARS will be monitored by the Performance Review Unit who will also offer their services for the analysis, interpretation and presentation of results.

Projects being considered include practice based continuing education, the possibility of using the system for collecting certain aspects of general practice morbidity data for regional planning, an infectious disease study and the study of the workload generated by elderly patients.

The faculty board has agreed to underwrite the production of a quarterly news letter for the doctors taking part. This will keep practices informed about projects suggested and the outcome of those which have been completed. □

Arthur Hibble

The University of Manchester
Department of General Practice
Centre for Primary Care Research

CLINICAL RESEARCH FELLOW
(Part-time)

Applications are invited from GPs for this newly created post. The fellow will form part of a multi-disciplinary team engaged on a variety of research projects commissioned by the DHSS. These include studies of the management of chronic illness in general practice, the effects of practice organisation on accessibility and a review of outcome measures for use in general practice. The Fellow will contribute to ongoing projects and be encouraged to develop his/her own area of research, in consultation with the DHSS.

Remuneration will allow a doctor to spend up to 5 sessions per week on research. It is expected that the Fellow will also retain a clinical commitment. Initially, the appointment will be for 2 years (starting date to be negotiated), but it is hoped that this will be extended.

Applicants should have a strong commitment to undertaking research in general practice. Applications are encouraged from both recently qualified GPs and more experienced doctors who would like the opportunity to devote more time to research. Salary in the range (under review) £11 510–£20 260 p.a. (pro rata).

Further particulars available from Lesley Hallam, Rusholme Health Centre, Walmer Street, Manchester M14 5NP. Applicants should submit CV, letter of application and names of two referees by August 28th.

(2017)

WELSH MRCGP COURSE AT ABERYSTWYTH, DYFED

Tuesday 15th to Saturday 19th September 1987

The above course has been instigated by a decision of the Welsh Council of the RCGP and will be a residential course in buildings of the University College of Wales where opportunity will be offered for individual and group work in preparation for MCQ, MEQ and vivas of the MRCGP examination. Examiners of the College will be present. Pre-course work will be required and Section 63 approval has been sought.

Course members will be required to pay for the Course which will not be more than the sum receivable under Section 63, at the start of the Course and a deposit of £50 will be required on confirmation of being offered a place on the Course.

Please apply to: Mrs Janet Eagles, Postgraduate Centre, Bronglais General Hospital, Aberystwyth, Dyfed SY23 1ER.

PATERSON/BURN 4-DAY COURSE IN MEDICAL MANIPULATION

The next course in this series will be held at Hermitage House, Church Terrace, Richmond, Surrey, from 15th to 18th September, 1987. It is based on the tutors' "An Introduction to Medical Manipulation" and their "Examination of the Back", of which the former forms an integral part of the course.

The fee for the course, inclusive of the book, and coffee, lunch and tea on each day, is £140.

To avoid disappointment, those interested should apply early (with cheque payable to Drs Paterson and Burn) to Dr J.K. Paterson, 7 Wesley Court, London W1N 3LE.

(2021)