NEWS

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Spring Meeting 1988

This year's Spring meeting was hosted by the Severn faculty. The following is an account of the medical symposium by the publicity officer.

Medical Symposium

It is with some trepidation that a lone reviewer tackles the responsibility of reporting the Spring meeting, particularly this year when 300 doctors descended upon Cheltenham Spa for the symposium provocatively titled 'Conflict or cooperation — changing frontiers in family practice', at a time when much of the agenda is of national political importance.

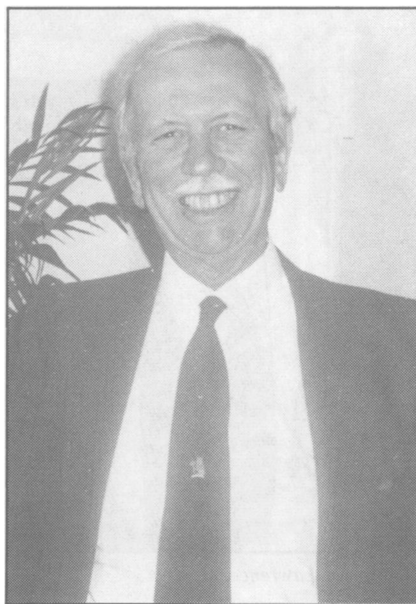
As always the scientific meeting formed the bulk of the programme and this was opened on Friday 22 April by Sir Richard Doll, who addressed the delegation with 'One million years of doctors lives', in which the habits of doctors (on their demise) were put under the microscope. It was clearly shown that blood borne carcinogens from tobacco smoke produced an excess of deaths from cancer of most body organs or from detrimental changes to the vascular supply to those organs. Sir Richard showed that there was no evidence to support the popularly held belief that smoking protected patients from death from ulcerative colitis or Parkinson's disease. In other words, the message of the last two decades that smoking is a health hazard was reaffirmed.

The following academic programme was typical of previous Spring meetings. The main menu, presented in the auspicious theatre of Cheltenham Town Hall, comprised talks booked over two years ago on topics which are now in the heat of debate within the profession. Concurrently, a programme of largely self-selected free standing papers of great diversity proceeded with crisp, clear deliveries in the drawing room atmosphere nearby. Audio-visual facilities, which had taken such careful planning, were put to the test and passed with flying colours.

The first day

Dr Jeremy Barnes, a GP in Gloucester, drew attention to the disparity of the Government's financial approach to the detection of large bowel cancer compared with cancer of the cervix. General practice methods of early screening, diagnosis and initial management were given and the audience was left in no doubt that its members should be more active in this field and that all techniques were within the skills of GPs.

Dr John Brown, a GP in Maidstone, in a well illustrated presentation, showed that the instruments, skills and procedures necessary to give an extended range of minor surgical operations to the population was well within the means of all GPs, and he exhorted the government to allow GPs a separate contract for minor surgery in much the same way as for obstetrics and family planning.



Dr Dick Bruce, chairman of the symposium organizing committee.

Dr E. Barrington-Ward, a hospice doctor from Inverness, described the classification of analgesics in terminal care; but he made the point that other methods of analgesia, such as transcutaneous electrical nerve stimulation, should not be overlooked, and that patient-controlled pumps, though ideal in theory, were often frightening to the patient. Overall, a compassionate approach by the GP was the most important adjunct to analgesic therapy.

The evening entertainments at the end of the day were well supported. The musical soiree in the elegance of the Pittville Pump Rooms left one with the impression that a person should not want for more. Another group visiting Gloucester Cathedral enjoyed an organ recital by the Dean and Cathedral organist. Visitors listened to a witty and informative description of the architecture and music of Gloucester Cathedral. This was followed by a meal in the Parliament Room, at which both the wine and the food excelled. Many new friends were made and old acquaintances renewed. A colleague described the evening as 'son et lumiere avec vin et saumon'.

The second day

The academic meeting on Saturday was opened with the debate, 'Diabetics don't usually need to attend hospital'. Professor Mattingly, University of Exeter, suggested that the incidence of long-term complications of diabetes was far too high and this indicated poor glycaemic control. Dr H. Williams, a GP in Trowbridge, for the motion, showed that GP care in some areas of the country could be as good as hospital care, and the better the organization of this care, the better the results. A lively debate followed on the practicalities of delivering such care and a feeling emerged that much more could be done to improve standards.

The ramifications of superannuation and employment law were presented by Dr Douglas Garvie, the College's Honorary Treasurer. Dr P. Omerod, a consultant physician in Cheltenham, talked on a subject which is familiar to most GPs — health and life insurance — and described

factors involved in his assessment of health risk.

Dr G. Beaumont, a lecturer in pharmaceutical medicine at the Welsh School of Pharmacy, scolded the audience as representatives of a profession spending too little time with its depressed patients. He said the profession treated such patients in an inadequate and inappropriate way. In reply to Dr Beaumont's presentation, a Cheshire GP suggested that GPs should be careful not to under-diagnose depression, but to treat it with adequate doses of antidepressant, to reduce irrelevant anxiolytic therapy and to give thought to changing social factors which may have contributed to the patient's depression.

The day's final session discussed whether community paediatricians were surplus to requirements. Strong arguments were fielded with Dr Colin Waine, RCGP Clinical and Research Division Chairman, and Dr H. Marcovitch, consultant paediatrician, Banbury, taking up positions for and against the motion. A vote taken at the end of the debate found the audience equally divided and suggested that the role of the community physician as adviser and a resource to GPs should be reassessed.

Freestanding papers

Unfortunately space does not allow all the papers presented to be detailed, but I shall record a few. Having considered the methods of assessing the consultation, Dr Mike Pringle, a GP in Collingham, and a member of College Council, was able to conclude that after a month of constant use in practice, video recording did not affect the consultation process. Dr M. Whitfield, senior lecturer in general practice, University of Bristol, showed the connection between doctors' attitudes and behaviour in the fields of prescribing, referral and prevention behaviour.

There is never enough time for the animated presentations on transcultural medicine of Dr Bashir Qureshi, a GP in Hounslow. He must surely be awarded a prize for packing so much into his 10 minutes and for providing such good humour.

Weekend impressions

So, what sort of doctor left the meeting on Saturday evening? To me it appeared as though fellowship, scholarship and entertainment had been shared and enjoyed by all. Guests, according to one lady, felt that the alternative programme had been a 'resounding success'. Certainly, they saw the Cotswolds in weather which ranks as the best so far this spring.

And during the conference dinner College history was made as we stood to listen to the College Grace which had been translated into Latin by the senior classics master of Cheltenham Ladies College, and put to music by John Sanders, the Gloucester Cathedral organist and master of the choristers.

What of the future for our committee? A small celebration, a meeting in May as a postmortem and, who knows, an annual reunion to build on friendships already strengthened. □

Paul Presley

Spring General Meeting

The Spring general meeting of the Royal College of General Practitioners was held at Cheltenham Racecourse on Sunday 24 April 1988.

The William Pickles lecture

The 1988 William Pickles Lecture was delivered by Dr Martin Lawrence, a GP in Chipping Norton, Oxford, and a health education lecturer at the University of Oxford.

His lecture, entitled 'All together now', considered the basic needs of an effective primary health care team: education, communication and evaluation for all members of the team. He also looked at the role of patients within the practice.

Dr Martin Lawrence.

In summarizing his lecture, Dr Lawrence said his hope for the future was one 'in which partnerships — all of them — provide the highest quality care and demonstrate that it is happening; in which team members — all of them — work together in mutual respect involving the patients to promote their health; in which acute care, chronic care and preventive care — all of them — are managed carefully and comprehensively; in which the practice registered population — all of it — is cared for using a performance review which ensures that those at risk are not missed'.

'All together now' will appear in a future issue of the *Journal*.

Fellows ad eundem

Fellowships ad eundem were conferred on Professor David Mattingly, Postgraduate Medical School, University of Exeter, and Professor Geoffrey Rose, London School of Hygiene and Tropical Medicine. This award is made to distinguished medical practitioners who have shown an interest in the College. It is normally reserved for UK doctors who are not general practitioners and for overseas medical practitioners.

The Chairman of Council introduced Professor David Mattingly. He said that Professor Mattingly had first established his reputation as an endocrinologist at the Hammersmith Hospital with what has become known as the Mattingly method of plasma cortisol estimation. The Chairman told the meeting that Professor Mattingly was later appointed the first director of the Postgraduate Medical Institute at the University of Exeter, and consultant physician at the Royal Devon and Exeter Hospital. With limited resources he built up the Institute and secured its funding, despite being in a university without a medical school and in a non-teaching health district. Professor Pereira Gray said 'as a College especially interested in education, we now applaud the man who achieved the first chair of postgraduate studies in England, from which he retired last year ... and we thank him for creating for general practice the first postgraduate department in a university in Europe'.

Professor Geoffrey Rose was introduced by Dr Stuart Carne. Professor Rose obtained a research fellowship at the London School of Hygiene and Tropical Medicine. After a period as visiting lecturer at John Hopkins in Baltimore he was appointed lecturer at the London School. He received promotion through senior lecturer to reader and in 1977 became professor and head of the department of epidemiology. Professor Rose has sat on numerous committees and advisory boards and has been honoured by numerous academic bodies both in this country and overseas. Dr Carne said that Professor Rose's 'interest in general prac-

tice evolved from his interest in preventive medicine. Our debt to him in that field can never be fully repaid.'

George Abercrombie award

This award, for meritorious literary work in general practice, was to be presented to Dr Julian Tudor Hart, Port Talbot, at the College's annual general meeting in November 1987. Dr Tudor Hart had a lecturing commitment abroad at that time and the presentation was deferred to this year's Spring meeting.

RCGP/Schering 1987 scholarship for trainers in general practice

This scholarship enables teachers in general practice to enhance their knowledge and skills by embarking on original projects. The scholarship can be used to assist the trainer in a visit to others. Scholarships were presented to: Dr J. Woodward, Sidcup, Kent for 'A study of doctor–pharmacist communication'; Dr R.W.D. Langlands, Haddington, East Lothian for 'Primary care in preventive medicine in the German Republic'; Dr A.R. Maisey, Princes Risborough, Buckinghamshire for 'Is there a normal life after vocational training?'; Dr D.G. Williams, Aylsham, Norfolk for 'Comparison between general practice teaching in the UK and other countries'; Dr J. Bligh, Chester for 'Study into independent learning and the development of material for individual use by trainers involved in half-day release courses'.

Fellowships

The following members were awarded fellowship of the College: Norman Stanton Spence Adair (Northern Ireland); Peter Lennard Aston (Mersey); David Logan Blair (West of Scotland); Gwendolen Mary Brown (Beds and Herts); Richard Coast Coast-Smith (West of Scotland); Brian Stephen Cole (East Anglia); Thomas Meredith Davies (East Anglia); William Grieves Donald (North of England); Kenneth Gordon Cathcart Evans (South-east Thames); Richard Flew (Thames Valley); Nigel John Grundy-Wheeler (Army — Overseas); David Rainsford Hannay (Sheffield); Kenneth Alexander Harden (West of Scotland); George Michael Robert Holliday (South-east Thames); Lawrence Percival Mackie (Midland); Ronald David Mann (South-west Thames); James Rodger (West of Scotland); William Robert Rowney (Northern Ireland); Alan Keith Scott (Yorkshire); John William Veitch (Cumbria); Michael Walter (South-east Thames).

Resolutions

The meeting was asked to consider two resolutions. The first to appear on the agenda was a special resolution from Council asking that the following clause be in the Ordinances of the College as Ordinance 35(d): 'Each Faculty of the College shall appoint, not later than 21 clear days before each Annual General Meeting, one member of the Faculty to be the Deputy to the Faculty Representative or to be the Deputy to an additional Faculty Representative appointed under Ordinance 35(c), for the period up to the next Annual General Meeting. Such a Deputy will be entitled to attend Council meetings on behalf of the Faculty in place of the appointed Faculty Representative or additional Faculty Representative when the appointed Faculty Representative or the additional Faculty Representative is unable to be present, and shall have at such meetings the same rights to speak and vote as a full Council member. Except in an emergency, each Faculty must notify the Honorary Secretary of Council not later than 28 days prior to the commencement of a Council meeting of the attendance of the Deputy Faculty Representative at that Council meeting.'

Dr Bill Styles, the Honorary Secretary, proposed the resolution which was seconded by Dr Peter Hill, Deputy Vice-chairman. The resolution was carried.

The meeting also considered an ordinary resolution from the East Anglian Faculty: 'That Council members should hereafter receive reimbursement, at the usual College rate, of all locum expenses which are reasonably incurred as a result of undertaking authorized College activities, other than Council meetings, and that Council should produce guidelines to implement such policy as of the next financial year.'

After discussing this, it was agreed that the matter be referred to Council for further consideration.

Report from Council Chairman

Professor Denis Pereira Gray presented his report to the meeting. This will appear in the June news. ☐

Appointments

PROFESSOR Michael Drury has been elected as the first GP vice-chairman of the Conference of Royal Colleges and Faculties. The Conference provides a forum for the discussion of all academic topics. Professor Drury will hold this office until he retires as president of the RCGP.

Professor Drury has also recently been awarded fellowship of the Royal College of Physicians.

Dr Donald Burrell, a fellow of the College, has been elected vice-chairman of the National Association of Health Authorities. Dr Burrell is a practising GP and a member of the Wessex faculty. ☐

Dressing Matters

THE Disabled Living Foundation has produced a handbook and video teaching pack aimed at helping people with learning difficulties to dress themselves.

The handbook explains in clear and simple language how carers can teach those with learning difficulties to develop their skills so that they can be independent in dressing and clothing related tasks. It discusses the ways in which people can be encouraged to take an interest in their clothes and develop an insight into the effect of their appearance on others.

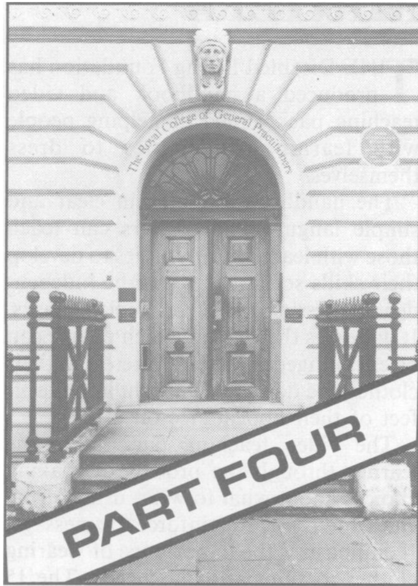
The video teaching pack takes the learner through the process of making choices about what to wear, using visual clues and music to reinforce the message. It emphasizes the importance of wearing clothes to suit particular needs. The 15 minute video is accompanied by a booklet outlining activities which can be undertaken with groups or individuals to reinforce the information contained in the video. The teaching pack is aimed at teenagers and adults.

Further details may be obtained from Mrs Ginny Jenkins, Disabled Living Foundation, 380-384 Harrow Road, London W9 2HU (tel: 01-289 6111). ☐

Holidays for Asthmatics

THE Asthma Society is arranging activity holiday courses for young asthmatics between the ages of 8 and 16 years. The courses will be held in Cumbria, Northumberland and Hampshire at the end of July and August and will be of a week's duration. The Asthma Society has found that the courses, which are under medical supervision, play an important part in improving the confidence of young asthmatics. The Society will consider providing a grant to help cover the cost of accommodation, and asks that GPs treating asthmatic children encourage the parents to apply for a place at one of the centres. Further details and application forms may be obtained from the Director, the Asthma Society, 300 Upper Street, London N1 2XX (tel: 01-266 2260). ☐

Clinical and Research Division



On 28 February 1952 nine men met at 7 Mansfield Street for the first meeting of a newly formed steering committee. At the eighth and final meeting on 19 November 1952 the College of General Practitioners was founded. In his opening address at that first meeting, John Hunt, the honorary secretary, explained that: 'The object of the Steering Committee is to guide us towards an academic headquarters for general practitioners in an attempt to raise the standard and status of general practice.'[1] Thus clinical care became one of the fundamental building blocks on which the College was founded.

Progressive development throughout the College's brief history brought the launch of the 'quality initiative' in 1983 and the assertion that 'unacceptable differences in the quality of general practice still persist today .. the days of freewheeling, of having influence without responsibility, are virtually over.'[2] The next three years saw continued debate and the production of policy statements[3,4] reaffirming the College's commitment to raising standards of clinical care in general practice.

In March 1987 the College responded to the Government's discussion document on primary care[5] with the publication of *The front line of the health service,*[6] which concluded with the challenge, 'The College now looks to the Government to join the profession in agreeing a properly resourced strategy for primary health care for the United Kingdom for at least the next 20 years.' The Government's response in its white paper *Promoting better health.*[7] has been to emphasize the need to raise standards of care and to promote health. In its turn, Council confirmed that the main thrust of future work within the College must be the improvement of clinical care for patients, and in June 1987 Council agreed the formation of a new division.

Thus, the Clinical and Research Division was created and was given the following terms of reference:

- to advise Council about all policies and protocols for the care of patients, including practical measurements of clinical performance in general practice;
- to coordinate clinical advice from the College, including preventive and anticipatory care;
- to assist the Honorary Secretary of Council in preparing evidence on clinical topics on behalf of the College for outside bodies;
- to ensure that clinical advice from the College is consistent with other clinical policies;
- to devise practical measurements of performance review for clinical care and encourage their use in day-to-day practice;
- to advise Council in all matters relating to research and to carry out such policies as Council shall from time to time determine;
- to advise Council on all matters relating to the College's research units.

The division's early days were spent looking at some of the issues arising from the Government's white paper.[7] The role of the GP in developing the primary health care team, minor surgery, care for people over 75 years of age, the form the initial assessment of a new patient should take, and hospital referrals are some of the subjects that have been covered. The new division also inherited a series of subjects to consider from Council and these quite naturally have provided the main focus for the first year's work. As a result, working parties have been established to investigate care for the elderly, care for the terminally ill, care for the mentally handicapped, and AIDS.

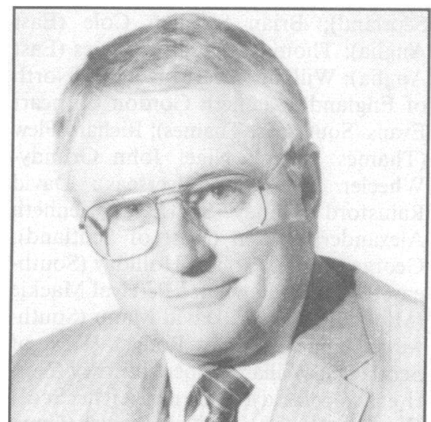
The terminal care working party will be chaired by myself and will examine the following areas:

- advice and support to the patient and relatives before death and to the relatives after death;
- coordination of primary care, hospital care and hospice care;
- the role of different members of the primary care team;
- symptom relief in terminal illness;
- research into the delivery of terminal care;
- the place of terminal care in undergraduate, postgraduate and continuing education;
- the role of the hospice or continuing care unit in the district general hospital;
- the relationship of the primary care team with other organizations such as the Marie Curie Memorial Foundation and the Cancer Relief MacMillan Fund;
- the psychological aspects of terminal illness, both social and spiritual, relating to patients and relatives.

The working party looking into mental handicap will be chaired by Dr Martin Barker and will examine the role of the GP and primary care team in the early diagnosis of mental handicap and the care needed for the mentally handicapped patient in the community. The working party will also examine the support needed by carers and the services available to them and the patient.

The series of clinical information folders produced by the College is being expanded and the division is actively involved in the production of new titles. Topics currently under review include rheumatology, the prevention of coronary heart disease, hypertension, motor neurone disease and multiple sclerosis, dementia, infertility and its problems, and skin disorders with a special emphasis on eczema and psoriasis.

In all its work the division is trying to utilize fully the experience, enthusiasm, energy and expertise of College members. However, conscious of the broadening of the health industry, the division encourages related external organizations to



Dr Colin Waine, Chairman, Clinical and Research Division.

College Action in the North East Thames Region

THE Joint Committee on Postgraduate Training for General Practice (JCPTGP), after receiving evidence that standards were repeatedly unsatisfactory in training practices in the North East Thames region has, for the first time, withdrawn its recognition of the scheme from 1 February 1989.

This decision has implications for the College and was discussed at the Council meeting on 11/12 March 1988 where it was agreed to support the Joint Committee. The College has also withdrawn its recognition from this region and the eligibility of trainees from training practices in this region to take the MRCGP examination.

The following statement was recently circulated widely to interested parties by the Chairman of Council:

On the 10 March 1988 Dr Dorothy Ward, Chairman of the JCPTGP, wrote to inform the College that the JCPTGP had decided to withdraw its approval of the training standards applied by the regional general practice sub-committee of the North East Thames region from 1 February 1989. This affects the arrangement whereby the Joint Committee approved vocational training on behalf of the College for the purposes of recognition and for eligibility for entry to the MRCGP examination.

The Council of the College discussed the JCPTGP letter at its meeting on 12 March 1988. It heard from its representatives that difficulties had been reported by JCPTGP visiting teams to this region over several years. In March 1985 a Joint Committee team had found that national minimum standards were not being met in some training practices and that the region's criteria were not within the Joint Committee's guidelines. The visitors therefore were unable to recommend re-approval. The officers of the Joint Committee met representatives from the region, and as a result of assurances given that the region would comply with JCPTGP guidelines, the JCPTGP did not withdraw approval at that time.

In June 1987 a different Joint Committee team visiting different practices reported that some still did not meet the national minimum criteria. The Joint Committee reviewed the position carefully on 25 February 1988, and decided that its approval should be withdrawn from this region. The Joint Committee informed the region that it would be willing to consider written evidence that minimum standards for the selection of trainers were being met and at such time would reconsider the question of a further visit for approval.

The Council of the College decided to support the Joint Committee's decision on standards. It reaffirmed that responsibility for recognition of vocational training for College purposes and for entry to the MRCGP examination rests with the College.

Since the standards of training in some practices in this region have been found to be inadequate, the College has decided to withdraw its recognition of the general practice element of vocational training in this region. The College wishes to minimize the effect of this decision on those trainees who already have entered into commitments in this region so implementation of this decision will be phased.

Doctors who complete the general practice element of self constructed schemes after 31 January 1990 will no longer be eligible to sit as trainees for the MRCGP examination if they have undertaken all or part of their training in training practices in the North East Thames region. Those doctors who can supply written evidence that they had entered a three year vocational training programme before 1 May 1988 will remain eligible to sit the examination. Those doctors who complete a three year programme of vocational training which includes training practices within this region after 1 May 1991 will not be eligible to sit as trainees. The hospital component of training in this region is not affected.

It is important that all trainees and prospective trainees in this region are immediately informed of these decisions.

The College is willing to receive written evidence that the minimum standards for the selection and reselection of general practitioner trainers are being met in the North East Thames region and will then reconsider the question of approval.

All enquiries should be addressed to the Honorary Secretary of Council (tel: 01-581 3232 exts 262/206). □

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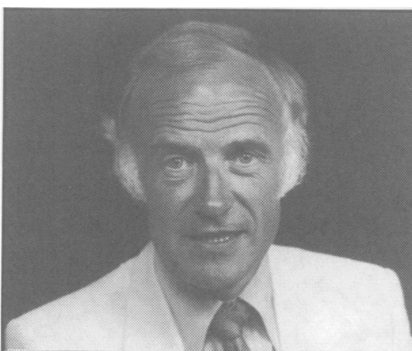
Clinical and Research Division

participate in its working parties. For example, the working party looking into mental handicap will include representatives from Mencap and Contact a Family, while the clinical information folder on skin disorders will be produced with the help of the National Eczema Society and the Psoriasis Association.

In addition to clinical care, the new division also has responsibility for research. Aware of the importance of research and of the need to effect a smooth transition from the former Research Division a Research Committee has been created as a part of the Clinical and Research Division. The chairman of the Research Committee is Professor John Bain.



Professor John Bain, Chairman, Research Committee

The aims and objectives of the Research Committee emphasize the work of the former division and many of the highly successful initiatives developed will be continued.

Of particular interest is the development of the research seminar. It is intended that each seminar should provide an opportunity for GPs and social scientists to present and discuss the different experiences and problems they have encountered in research into a common subject. □

Colin Waine

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Drugs and GPs

ON 30 March the College and the General Medical Services Committee (GMSC) jointly hosted a one day conference funded by the DHSS to examine the role of GPs in dealing with drug misusers. The idea of a study day came out of discussions held between the chief medical officer, Sir Donald Acheson, and representatives of the GMSC and Dr Douglas Garvie and Dr John Cohen from the College. It was felt that it was the responsibility of the two groups to take a lead in disseminating information to the profession on the treatment of drug misuse, particularly in light of the association of the acquired immune deficiency syndrome (AIDS) with drug abuse. Six speakers representing general practice, academia, hospital medicine and the DHSS addressed the conference.

Professor Denis Pereira Gray and Dr Michael Wilson chaired the day and expressed pleasure that the two bodies had combined forces in providing a forum for such an important topic. The success of this conference was an indication of how activities of mutual interest may lend themselves to future joint symposia.

Historical background

'In the 1970s, the GP's role was to direct people to the specialist. Today, GPs have an active role to play'. Dr John Strang, Consultant Psychiatrist, Maudsley Hospital

Until the 1960s drug misuse in the UK had not been regarded as a social problem. Growing recognition of misuse in London and the south east gave rise to wide concern among the general public and the profession. Recommendations from the Brain committee urged the government to change drug regulations, and the Misuse of Drugs Act 1971 (which is still the major relevant legislation in use today) was amended to control certain types of drugs and enforced doctors to notify the chief medical officer (CMO) at the Home Office of all opiate addicts under their care. According to government estimates, notifications of drug misusers represent only a small proportion of those actually misusing drugs — about one in five addicts are notified to the CMO, and government research undertaken in 1981/82 indicated that five times as many people are using non-notifiable drugs. Dr Dorothy Black, speaking on behalf of Sir Donald Acheson, said that there could be over 100,000 people in the UK misusing opiates and other drugs.

As a reaction to increasing awareness of the drugs 'epidemic' in the 1960s, the government established centrally funded drugs rehabilitation centres, which were usually hospital based. General practitioners became isolated from their addict patients despite government encouragement to maintain a GP link. Undergraduate and postgraduate education failed to emphasize the community management of drugs misuse. The combination of a lack of personal experience of treating addicts and of inadequate education in this area has now resulted in a dearth of essential expertise among GPs.

In the 1970s, concerned GPs initiated

Dr Michael Wilson and Professor Denis Pereira Gray.

a voluntary ban on the prescribing of amphetamines and reduced the prescribing of barbiturates. Current prescribing rates demonstrate a continuation of this trend, particularly in relation to benzodiazepines — in 1978 30.6 million prescriptions were issued for benzodiazepines while in 1986 the figure had dropped to 25.3 million. However, Dr Black stressed the importance of GPs applying this prescribing practice to short- and long-term benzodiazepines.

The future

'GPs and the primary health care team have the key role in prevention, support, treatment and appropriate referral to more specialized help.' Dr Dorothy Black, Senior Medical Officer, DHSS

Illicit heroin, arriving mainly from India and the Far East, continues to flood the UK. Control over these sources is limited. Addicts are no longer congregating around major cities and the south east of England, but can be found throughout the UK. Research undertaken by the government's drug information campaign indicates that drug misusers and their families and friends will often turn first to their GP for help. It is therefore increasingly likely that GPs and the primary health care team will be called upon to play a constructive role in the management of drug misuse. As the conference emphasized, it is important that GPs recognize the likelihood of patients in their area having a drugs problem.

The stereotype misuser

The message came across clearly from each speaker that drug misusers are not an archetypal group of people and should not be put into categories. Members of the 'normal general public' have drugs problems. The reasons for their addiction may not be immediately apparent, nor immediately rectifiable. Their addiction may

have begun as a result of curiosity or as a means of escaping a problem. GPs and their team should recognize that the stereotype of an addict as a greasy-haired society drop-out is not a true image.

Assessment

'Prescribing should not be seen as the panacea for addiction.' Dr Jacky Chang, GP, Stockport

Dr Jacky Chang told the conference that her experience of dealing with drug misusers had taught her to begin a first consultation with an assessment interview which she repeated at future meetings.

The prepared questions should cover the patient's drug history (What drugs? How taken? Sharing needles?); the pattern of consumption (Amount? Route? Future intentions?) and social history (Family background? Employment history?). But to obtain a full picture of the patient, a general assessment of intelligence, aspirations, hobbies and interests should also be made. Dr Chang said that the assessment interview should enable the GP to conclude:

- if the patient was a drug taker or not;
- if he or she was at risk from AIDS/hepatitis B;
- if he or she was:
  experimenting with drugs;
  taking drugs intermittently;
  dependent on drugs;
- if there were any associated problems;
- if the home environment was stable;
- if the patient had supportive family and friends.

As most drug misusers will be feeling a lack of self-esteem, Dr Chang said it would be destructive to the doctor–patient relationship if either the GP or the team 'sat in judgement' or tried to identify with the patient. She emphasized that GPs should not fall into the trap of automatically prescribing for patients, only if it was the right option for the individual patient.

Organizing the practice

'Let's agree on stablizing your life.' Dr E. Martin, GP, Bedford

Dr Edwin Martin told the conference that to avoid tension in the practice, it was important for partners to discuss the possibility of taking on drug addicts and to plan specifically for their care. The workload involved in looking after such patients in his practice averaged at 32 consultations per patient per year. He said that his practice policy for dealing with these addicts had four parts: guidelines on who was accepted for treatment and their subsequent care, a practice–patient contract, liaison with other interested parties and regular audit. He said that immediate aims for all addicts in his practice were:

- to enable dependent patients to develop some social stability by withdrawing from the drugs street market and to stop the sharing of needles;
- to enable patients to immediately withdraw from illegal activities, for example drug dealing;
- to develop a secure and trusting relationship — patients are reassured that they will not be rejected from the practice list unless they become overtly aggressive to the GPs, the team, other patients or the premises;
- to make plans for changes in the patient's social life;
- to reduce drug taking;
- to accept that many patients have several dry runs before withdrawal from dependency;
- to recruit social service help to support patients.

Dr Martin said that when his practice identified an addict, he or she was invited to attend a consultation (which lasted longer than the standard 10 minutes). During this consultation a full history was taken. A physical examination would include full blood count, urea and electrolytes, blood sugar and urine drug screening. An estimate would be made of the risk of human immunodeficiency virus or hepatitis B infection. Partners and the Home Office drugs branch would be informed once it had been confirmed that the patient's addiction was of a longstanding nature.

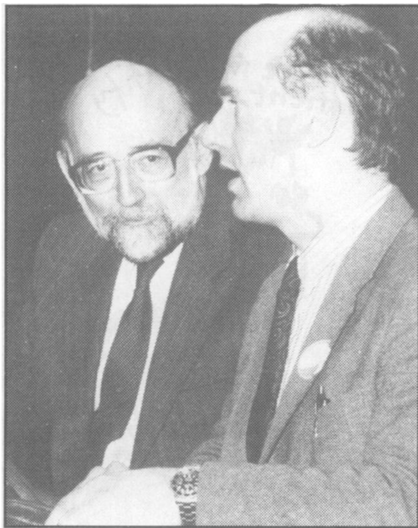
Before accepting an addict for treatment a formal contract had to be agreed:

- Patients would be prescribed a replacement for the opiates that they obtained on the streets. This was usually methadone mixture. Occasionally where it was known that opiate addicts were injecting and it was clear that they were going to continue injecting, they were prescribed methadone ampoules with instruction about the dangers of sharing needles. At times some patients were prescribed methadone tablets where they were not injecting and the mixture constantly made them sick.
- Patients must always consult their own doctor unless he was away, when a named second doctor would take over their care.
- Patients must turn up on time for their appointments and if they were late they would be given no priority and be expected to sit through to the end of surgery.
- Patients would not be thrown off the practice list for any reason other than aggressive acts to the doctor, the staff, other patients or the building.
- If it became clear to the doctor or any of the staff that patients were involved in illegal dealing activities, this information would be passed immediately to the drugs squad.
- At consultations the matter of reduction of drug intake would be raised and pursued. The patient would be expected to cooperate with this.

Combining forces

Ever increasing demands on GPs' time may make it difficult for them to accept drug misusers on their list. A national survey undertaken by Glanz and Taylor (*Br Med J* 1986; **293:** 427-430) found that GPs generally regard drug misusers as difficult to manage and less acceptable as patients than others in need of care.

Dr John Cohen suggested to the conference that the challenge of changing GPs' attitudes and developing appropriate skills rested with those with responsibility for postgraduate, vocational and con-



Sir Donald Acheson and a participant discussing the day.

tinuing education. He said a 'multiple input' approach may be the answer, using, among other things, lectures, discussion groups and home videos.

Dr Tom Waller, a GP in London, told the conference that it was important for GPs to utilize the voluntary sector and that non-statutory and self-help groups were at hand to provide advice and counselling. Dr Waller also described the workings of residential services such as concept houses, for example, Phoenix House and Alpha House, and explained the different stages of treatment employed in detoxifying addicts.

The conference felt that GPs treating drugs misusers should not work alone, but should learn to use the external expertise available to them and their patients. Such expertise may be found in the voluntary sector through self-help groups, telephone helplines and counselling groups.

In summing up the day, Professor Pereira Gray said, 'The greatest way forward is to rely on a large number of GPs taking up this challenge, rather than a small number of experts.' □

Nicola Roberts

A selection of reading material and voluntary sector contacts:

Druglink. The official journal of the Institute for the Study of Drug Dependence (ISDD). Available bimonthly from ISDD. The ISDD is a research and information centre from which a wide variety of publications on the non-medical use of drugs can be obtained. Telephone 01-404 4451.

Drug misuse — a practical handbook for GPs by Dr A. Banks and Dr T. Waller. Available from ISDD at £9.95 plus postage and packing.

SCODA (Standing Conference on Drug Abuse). This organization can provide up-to-date information on facilities throughout the UK for combating drug misuse. Address 1–4 Hatton Place, London EC1N 8DN.

Families Anonymous. Self-help groups which meet regularly and are open to anyone with a drug problem in a family member or friend. Address 5–7 Parsons Green, London SW6 4UL. Telephone 01-732 8060.

Narcotics Anonymous. Telephone 01-351 6794 (answerphone); 01-351 6066/7 (14.00–20.00 hours weekdays).

A telephone service is also available: dial 100 and ask for 'Freephone drugs problem'.

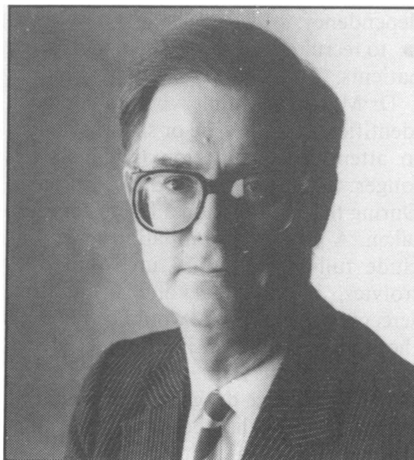
Dealing with Addicts — One GP's Personal Experience

SEEING is believing. I had never believed it possible, but I saw an addict get better. And not just better than before but completely better, totally drug-free and happy. I had no choice but to cast out my previous misconceptions and prejudices — of which there were many.

She told me that she had got 'clean' through Narcotics Anonymous. I laughed in gentle but disbelieving derision. She asked me if I had ever been to a meeting of that or of any other anonymous fellowship. I told her that I had not and that in any case God groups are not my style. She asked me if I thought I was God. On hearing my firm (if rather unconvincing) denial she said that a belief in something other than a God of Self was all that the anonymous fellowships require.

On that rather negative basis I went to a meeting of Narcotics Anonymous in May 1984. My first embarrassment was to meet two patients whom I had never realized were addicts. My next embarrassment was their assumption that I shared their problem. 'Plenty of doctors do' was their response to my further denial.

During most evenings of the summer of 1984 I went into the addiction unit of the Charter Clinic in Chelsea to learn from the patients about what they called addictive disease and their 12-step programme of recovery. I can think of more conventional ways of spending summer evenings but none more inspiring. They really were addicts and they really were getting better, contrary to my depressing experience of 20 years in city centre practice.



Robert Lefever.

I met James, alcoholic and cocaine addict, city slicker and owner of a mews cottage, with a wife, two children and a labrador; Tony, photographer, divorcee, alcoholic and tranquillizer addict; Frederick, advertiser, twice divorced, garbage head and garbage body ('anything is worth a try'); Tracey, retired hooker, heroin addict and still (at 17) a schoolgirl; Barry, single, guitarist of sorts and street addict extraordinary; and Elizabeth, mother of two, heroin addict and the sweetest innocent you ever set eyes upon — until you heard what she had been up to.

I know them still: James is back in business, Tony works as a counsellor, Fred is simply a genius, Tracey married another recovering addict last month, Barry works in broadcasting and really can play the guitar now that he is no longer stoned and Elizabeth sells toiletries instead of herself. In many ways they are among my closest friends — I shared my learning experience with them as well as the cameraderie of fresh adventure.

They suggested that I would learn more by going into full-time treatment, despite my lack of the essential qualification. So I did. I went to Hazelden in Minneapolis and I learned about the Minnesota model for the treatment of addiction. Since then I have been back to Hazelden four times

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Resourcing the NHS

THE College was recently invited to submit a memorandum to the Social Services Committee on the resourcing of the NHS. A summary of the memorandum is given below. Copies of the memorandum may be obtained from the Honorary Secretary's Office at Princes Gate.

1. Any review of National Health Service finance must involve examination of all its elements including the resources available for the family practitioner services. This memorandum outlines the future development of general practice as a service to patients and the effect of this on the resources needed for the NHS. It emphasizes that a greater proportion than hitherto will have to be allocated to general practice to support its present and anticipated responsibilities.

General practice services

2. The range of services available through general practice in future will be modified continuously to meet the changing needs of the population. Changes in practice will be affected by:

- The incorporation of new knowledge from medical research and of developments in medical technology into general practice. Many people who formerly were cared for in hospital outpatient departments will be looked after in general practice.
- The trend for shorter periods of hospitalization after acute illness and surgery.
- Demographic changes with a greater proportion of elderly people in the population; people need more primary medical care as they age.
- An increase in the community care of the mentally ill, the mentally handicapped, and the physically handicapped.

3. The philosophy of medical care is changing, with greater emphasis on prevention and the early diagnosis of disease. Health promotion and disease prevention have been high priorities for the College for many years.

4. Throughout these changes the traditional characteristics and values of general practice will continue to be important. The equitable provision of primary medical care through general practice for everyone must be preserved. General practice has always cared for the poorest and most vulnerable groups; this must be maintained.

5. Patients must remain free to choose who their GP shall be and should continue to have direct access to their doctor without referral from other agencies.

6. The referral system enables GPs and patients to select together the most appropriate source of secondary specialist care. Such an arrangement promotes the appropriate use of specialist services and ensures that scarce health service resources are deployed effectively.

7. The registered list of patients is a unique feature of British general practice. It enables every GP to have a precisely defined list of people for whom the practice is responsible. It provides a logical basis for planning services for patients in primary care and for evaluating performance and the uptake of these services. The benefits of the general practice list are yet to be fully exploited by the NHS.

8. The microcomputer is an essential tool for a population based approach to primary care. There has been little financial support for the development of computerization in general practice from the NHS. Such failure inhibits the evolution of a comprehensive preventive health care system.

9. The development of a broad range of services through general practice requires efficient organization and a multidisciplinary approach. The role of nurses in primary health care needs to be further developed.

Continuing education

10. Changes in the organization of general practice need to be matched by an effective system of continuing education. Only through this can doctors and practice staff be helped to provide better care for patients. In its response to the Government's green paper, the College proposed a network of locally based general practice tutors with the responsibility for providing this. Unfortunately the need for such provision was not recognized in the white paper that followed.

11. Realistic financial provision for continuing postgraduate medical education has been neglected for many years. A review should be undertaken of the cost of postgraduate education so that the DHSS and health authorities can make adequate provision for it in their strategic planning.

Resources for general practice

12. The College welcomes the Government's proposals for removing the restrictions on the types and numbers of staff that a GP can employ. However, its intention to cost limit these arrangements will seriously impede the future development of the range of services that could be available through general practice. Also the Government's intention to cost limit the resources for practice premises will adversely affect the quality of service available to patients. There is a particular and urgent need to encourage better quality premises in inner cities and other deprived areas.

13. Careful studies of health care should be established to determine how the level and distribution of resources can match patient need. A greater proportion of NHS resources will have to be allocated to general practice as it undertakes more responsibilities. The College has proposed that a national development fund should be created to promote innovation in general practice. Its introduction on the basis of performance effectively would link new investment with improved services for patients, together with greater accountability for those who provide them.

14. The paradox must be overcome whereby the practice that innovates, that purchases the latest equipment and that employs a wide range of high quality staff is at financial disadvantage when compared with those who do not. Disincentives to investment and to high standards of patient care should be removed from the present NHS GP contract. □

Health Care Ethics

THE University of Manchester is offering an MA in health care ethics which may be taken either in one year as a full-time student or on a two or three year part-time basis. All students will take four taught courses and complete a dissertation of about 20,000 words. There are two compulsory core courses and two additional courses will be selected from a list of approved options. The core courses are moral philosophy and cases from health care practice. Optional courses include medico-legal problems, religious faiths and medical ethics, medical ethics in historical context and medicine in modern society. For further information, contact Mrs S. Ibbotson, Department of Education, University of Manchester, Oxford Road, Manchester M13 9PL.

The University also welcomes applications from candidates wishing to undertake research in any aspect of health care ethics, working towards the award of either MPhil or PhD. □

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Dealing with Addicts — One GP's Personal Experience

and have also visited centres in New York, Florida, Georgia and California. Alcoholics Anonymous (upon whose principles the Minnesota model of inpatient treatment is based) was born in the USA so it is inevitable that America has many more years of understanding of this concept of addiction treatment.

By 1985 my wife and I were already committed to setting up a treatment centre, which we did in March 1986. It sounds easy but the reality is rather less straightforward.

The first problem was trying to find appropriate premises and the next problem was trying to raise the money from charities. After seven months of work on three separate projects in London we had failed to raise a penny for any of them. So we gave up, partly I confess in angry impatience, and remortgaged our home and our practice premises and bought a property just south of Canterbury. The builders moved in and so did the frost, which meant that the builders could not move out. By March 1986, when 16 staff, my wife and I returned from our final training in Hazelden, the PROMIS Recovery Centre was still just a set of smart notepaper and brochures.

The centre still had no charitable support, nor any significant day-to-day support from patients because there were few who would tolerate co-existence with builders in the 'permafrost' (the builder's word, not mine) of that particular winter. The bank closed all overdraft facilities within three months of opening and they foreclosed on the mortgage of our home. Life was not a bundle of fun, particularly as my medical practice, providing my only income, bore the brunt of my anxiety and loss of consultation time, which, in private practice, is what one sells.

The charities did not come over the hill to relieve the beseiged fort, but a new bank, Barclays, did. (I may not believe in a formal God but I now know where he banks.)

We remortgaged the property in Kent, moved down to the basement of our home and converted the rest of what had been our family home for the whole of our married life into a half-way (follow-on) house for 11 addicts, and we survived.

Now, after two years of operation, the PROMIS Recovery Centre has seen over 300 patients. Seventy discharged themselves or were put out for treating the place as a rest home but 70 per cent of those who completed treatment are still fully drug and alcohol free. The half-way house has been full virtually from the day it opened and we are looking to expand.

Anyone who wants to see us in London or in Kent has only to ask: seeing is believing. □

Robert Lefever

Pregnancy Education

LAST year, I spent six weeks attached to the education department of BBC TV as a British Association media fellow. *Having a baby* was one of the productions I observed as it was filmed and edited. I was impressed by the high quality of professional input and at the same time the strong desire to convey the views and attitudes of the many individual pregnant women featured in the series.

The programmes aim to inform, but also to empower women to make choices and, if necessary, to ask for changes in the ways their pregnancies are managed.

I am sure the series will be seen by a large audience. I commend it to all colleagues, both as a public education exercise and as a personal updating of knowledge and attitudes. The programmes are supported by a BBC home video and book.

BBC continuing education programmes may be recorded 'off air' by bona fide teachers or students (which includes trainers, trainees and undergraduate teachers of general practice) for use for instructional purposes. Recordings must be used on the premises where they are made and must be destroyed within 12 months. Further details may be obtained from BBC Education, London W5 2PA. Telephone 01-991 8031. □

Peter Campion

Obituaries

LEONARD S. CALVERT
MRCS, FRCGP

AFTER a long illness Dr Leonard S. Calvert died at his home on 8 March 1988 at the age of 76 years.

Born in 1911 at Lightcliffe near Halifax, he was educated at the Leys School and worked in the family mill at Illingworth for a year before studying medicine at Leeds University, qualifying in 1936. After holding the posts of house physician and surgeon at Bradford Royal Infirmary, he entered general practice and eventually settled, just before the War, in East Yorkshire.

During the War he served in South Africa and Egypt and rose to the rank of squadron leader.

On his return to the East Riding he began to weld together the present practice and watched, not always with approval, the change from cottage industry to purpose-built premises with the proliferation of ancillary staff. Always abreast of the times, he became a founder member of the College and later became a fellow. He followed his two main interests, obstetrics and manipulative medicine until his retirement in 1976.

Leonard lived life to the full — a keen fisherman and excellent shot, he also found time to cut and set semi-precious stones and, in his retirement, became a useful golfer.

He is missed by his many friends and the community who owe him a long debt of gratitude. □

Robert Blair

BEN STUART BENNETT
FRCGP

DR BEN BENNETT, a fellow of the College, died recently. After qualifying at St Bartholomew's Hospital, he joined the Royal Air Force and served at home and in Germany. On leaving the RAF, he returned to Worcester to practice family medicine. He later became a course organizer for Hereford and Worcester trainees.

He had many interests including sketching and fly-fishing. He also sang with the Worcester Festival Choral Society. □

Diary Dates

Information course

The Royal Institute of Public Health and Hygiene is running a course 'Information and information services: their role in the planning and evaluation of health care services'. The course is arranged in two parts. Part one commences 20 May to 8 July and part two from 9 September to 21 October (Fridays only). Further details may be obtained from Ms Adamides on 01-580 2731. □