

# NEWS

Editor: Nicola Roberts

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## The practice library

WHEN it was suggested to me in the summer of 1986 that I might like to do a project on practice libraries (funded by Stuart Pharmaceuticals), I had the impression, although no-one said anything to me, that a definitive list of what such a library should contain would be viewed as a good idea. I did not know then that the Joint Committee on Postgraduate Training for General Practise (JCPTGP) would introduce in January 1987 criteria that all training practices should have a library containing a selection of books and journals relevant to general practice.

I thought about trying to lay down a core content list, wondered why no-one had done so, recognized some of the difficulties and decided to concentrate on the basic organization of such a library. This was something I felt reasonably confident about. Accepting an invitation to sit in at a leader visitors' meeting of the JCPTGP, it was apparent that this approach would be useful. Comments about the hopelessness or non-existence of training practice libraries abounded. I was warned about the 'dust factor' inches deep on old and unused books; told anecdotes about whole libraries being borrowed for training inspections and the inability of the GP to read! This latter comment contrasted with my experience of over 20 years of working with family doctors.

However, the construction of a core contents list might be done by analysing the reading lists sent out to trainers by regional advisers. I wrote to all advisers, received 100 per cent response and started to look in detail at their recommendations. The range of information given out to trainers and trainees varied enormously. I had not realized the complexity of such a task.

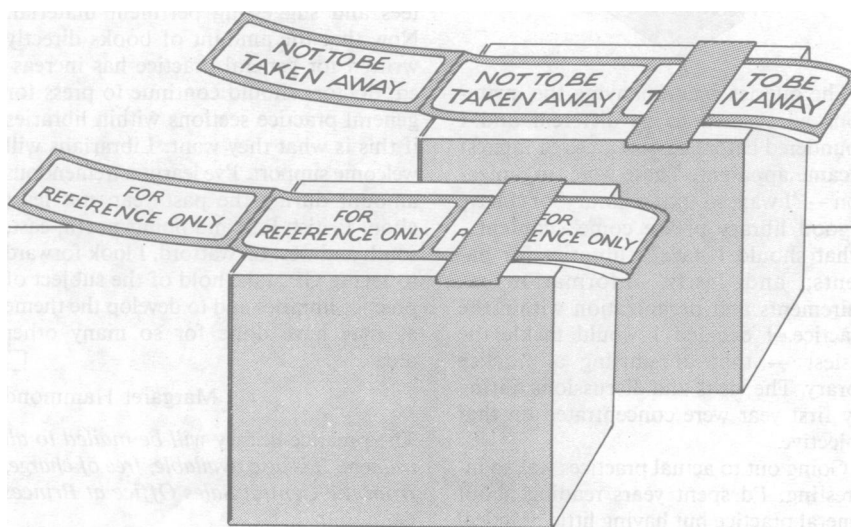
At the same time as writing to the

regional advisers, I also wrote to the regional librarians. This group endeavours to improve the standards and resources of medical libraries through a regional structure. I wanted to find out their attitudes to the establishment of practice libraries. The reactions were mixed. Some librarians thought the construction of such libraries duplicated existing resources and that GPs should use postgraduate medical centre and hospital libraries. Other librarians thought practice libraries an extension of the library network, and viewed their role as helping this new initiative. It was obvious that many librarians would like to take on this extended function, but were prevented by their present workloads from doing so.

In spite of these constraints, local initiatives flourished. A Cornish experiment of a librarian taking a new books collection to individual practices had had positive results, as had a Northern Ireland scheme for taking a portable computer terminal to individual practices for online

searching. Many librarians were talking to and preparing handouts for GPs as part of their user education programmes. There were numerous examples of surveys, standard setting exercises and assessments of information requirements of health care staff and provision of material throughout the country. In fact, there was so much going on that it was difficult to find an area that was not already being researched.

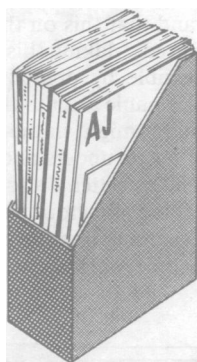
Concentrating on the needs of GPs, I felt that there was an enormous amount of material and therefore information coming, often unsolicited, into practice premises and that this on the whole was not being used. Making this information more accessible by organizing it could provide a valuable asset to the individual practice and it might in the long run encourage GPs to understand established library facilities better. I also wondered to what extent the numerous periodicals and pamphlets coming into the practices were seen by people working at the practice,



other than the doctors. Surely an article on the pros and cons of setting up a particular screening clinic would be of interest to everyone working on the premises. I was to learn later that some practices have a key file of articles that set practice policy and that attached and ancillary staff do see them. However making them available is not quite the same as actively involving practice staff.

I spent a little time finding out about library and information provision in the offices of other professionals - solicitors, architects, engineers and discovered that these are usually very well organized. Law libraries have basic standards for content, and the categorization of architectural and engineering literature by one single classification makes arrangement in these libraries reasonably uniform. Classifications of medical literature and information are numerous.

Having decided that I would attempt to give guidance on the organization of practice libraries, I needed to visit 'real' practices to see what was needed and what was already in existence. A note saying I would welcome invitations appeared in the *Journal*. The week after this appeared in print I worried in case no-one contacted me, and a month later I worried about how I was going to respond to all the invitations. I still feel guilty that I haven't managed to visit all the practices who invited me, but I shall try and fit them in during the coming year as the project is to continue for another 12 months.



The queries accompanying the invitations all seemed to be different and I floundered before certain areas of interest became apparent. These were: organization — 'I want to start a library' or 'I have a good library please come'; content — 'what should I have?': libraries for patients; and lastly, information requirements and organization within the practice. I decided I would tackle the easiest — that of starting a practice library. The visits and discussions during my first year were concentrated on that objective.

Going out to actual practices was so interesting. I'd spent years reading about general practice but having little practical

experience of the realities. I was most struck with time, the lack of it and the professional use of it. The baby clinic and the training session; paperwork; the consulting sessions and the emergency call were only part of the day. I was extremely grateful for the time set aside for my visits. I sat in on practice meetings, met practice managers, talked to trainer and university teacher groups and joined doctors for a working coffee or lunch.

Eventually I managed to put a lot of the ideas I'd picked up from visits and correspondence with practices into *The practice library*.

Two years after starting my project, it is quite clear to me that GPs do read and are interested in the concept of a practice library. In a busy practice, however, the library can become just one more thing to cope with, which is why I believe it is important to sort out the organization first. This doesn't have to be too conformist, that takes the fun out of the job, but some ground rules might keep the initial enthusiasm going. The collection doesn't have to be large — a shelf of material is a start.

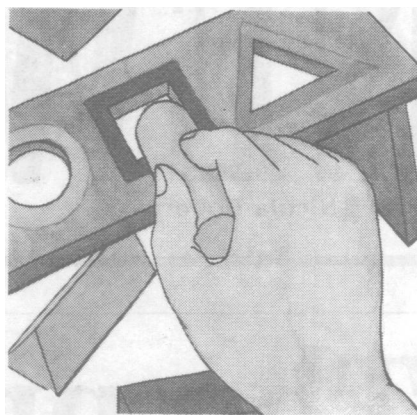
Practice secretaries, receptionists, managers and nurses need books and periodicals for their continuing training. Relevant material for them might already be in the practice library or, if not, it could be included. Provision of this material should be a growth area. A good practice library could be used as a teaching model for others in the same area and vocational training schemes could think about mini library co-operatives, especially for the purchase of library equipment. A regional library collection or co-operative could provide some of the very good general practice periodicals from other countries.

In no way should practice libraries duplicate the existing professional library services - they should complement them. General practitioners must continue to support postgraduate centre and hospital libraries by joining the relevant committees and suggesting pertinent material. Now that the amount of books directly written for general practice has increased, doctors should continue to press for general practice sections within libraries if this is what they want. Librarians will welcome support. I've learnt a tremendous amount during the past year, not least about British Rail and points north, east, south and west of Watford. I look forward to seeing GPs take hold of the subject of practice libraries and to develop the theme as they have done for so many other areas.

Margaret Hammond

*The practice library will be mailed to all trainers. It is also available, free of charge, from the Central Sales Office at Princes Gate.*

## Information guide



**A** NEW guide for parents and carers of children suffering mental disability has recently been published.

*Children with mental handicap* starts with three detailed case histories and goes on to outline the problems of mental handicap, its treatment and prevention, and the roles of the health and social services, and voluntary sector, education, and the law. Designed to be of practical support to parents and professional carers, the author, Fred Heddell, a director at MENCAP, stresses throughout the book the positive viewpoint that a child with special needs can be a valuable and cherished addition to the family. This book is published by The Crowood Press. □

## Preschool handbook

**T**HE College and the General Medical Services Committee (GMSC) have joined forces to improve the health of children in Britain. The two organizations have this month launched a handbook offering guidance on child surveillance in general practice.

The handbook has been written for the primary health care team who is keen to develop the traditional approach of assessment and support to include a broader dimension of seeking answers to questions, 'Is the child growing up normally?' and 'Is the child protected against hazards?'

The first edition of *The handbook of preventive care for preschool children* was published in 1984 and was the result of a joint working party between the College and the GMSC. The latest edition takes into account many of the comments which had been made about the earlier edition.

*The handbook of preventive care for preschool children* is available from the Central Sales Office at Princes Gate, price £5.00. □

# The Royal Army Medical Corps

**'TO the Royal Army Medical Corps with admiration and high regard to a Corps whose contribution to victory has been beyond all calculation.'**

*(Field Marshal Lord Montgomery, Berlin, 1945)*

Take off your helmet, pull up a sand-bag. I want to tell you a war story that will have your hair standing on end (easier to cut). It's about a band of young and not-so-young doctors in the Army who form the GP cadre of the Royal Army Medical Corps (RAMC). It's an almost unbelievable saga that tells of how 300 GPs stretch from Fort William in Scotland to Port Stanley in the Falklands, guarding the health of soldiers and their families whilst producing and participating in an educational programme that is the envy of all.

How did it all start? There are many who would claim the battle honour, but the most reliable sources believe that the real beginnings of a comprehensive GP service, combining the knowledge and expertise required in war and peace, started with the visit of Dr John Fry, at the request of our director general, to the British Army of the Rhine (BAOR). Fresh from his discovery of the catarrhal child, John Fry was eager for further advances. He went to BAOR, where there were group practices with attached staff working in purpose-built premises, and declared that this was the general practice of the future.

The director general was so delighted by his report that he made John Fry honorary consultant in general practice to the Army, a post he filled until 1987.

So, at a stroke, all problems were solved, and the GPs worked on knowing that their future was bright. Little did they realize that there would be new battles which would have to be fought. Who would have imagined that the enemy of indolence — the Joint Committee on Postgraduate Training for General Practice — was planning attacks on standards and a blitzkrieg on records, producing regulations about training and even suggesting audit.

A quick appraisal of the enemy's strength made it apparent that the GP cadre would have to be reinforced by forming training practices, appointing trainers, using military hospitals and starting vocational training. Our leaders were cautious and set up a war room in the form of the department of general practice which would provide intelligence about the enemy's intentions. The department first commandeered a bedroom in the Royal Army medical college, later moved to the dissecting room in the bowels of the college and has recently been elevated to the top floor. The department was heavily camouflaged, and during the early years the enemy was caught on the hop by a steady barrage of educational material directed at trainees.

One of the most successful weapons

was a bi-annual one-week residential course for the preparation of candidates for the MRCGP examination.

There have, of course, been casualties. Nearly 90 per cent of our young doctors who undertake a six-year short service commission leave the glorious band for the rewards of the NHS. Most are so well qualified that they are, to our pride but also rather to our regret, actively sought after by principals in general practice. Happily, many join the Territorial Army so we meet occasionally as old friends and firm allies.

Recently the director general of the Army medical services requested a review of the general practice troops, and happily we are able to report that the cadre has never been in better condition. It has formed an alliance with the College's South West Thames faculty under the benign leadership of Dr Trevor Silver and all Army service members of the College belong to the faculty by invitation. The military hospitals also continue to lend active support by undertaking training modules for GP vocational training.

Members of the primary care practice teams have undergone intensive training and now rate amongst the most professional in the country. At present there are in-house courses for practice managers, nurses and receptionists. The health visitors and social workers attached to the practices are already of the highest standard and are committed to continuing education by attending regular meetings. Much active research into the way forward has been undertaken by Army GPs in the form of projects, and the overall position has been improved by the annual tri-service conference and the tri-service pre-trainers' courses.

The GP cadre needs constant reinforcement by young doctors. Major General R Evans is the recruiting officer and he would be delighted to while away a few hours telling you *his* war stories. A man of great humour and intellect, he has served with the RAMC for some 40 years which must tell you something of him and the Corps. He can be contacted as follows: Major General (Retd) R Evans CB, Medical Officer Recruiting, Regimental Headquarters, Royal Army Medical Corps, Keogh Barracks, Ash Vale, Aldershot, Hants GU12 4PO. ☐

Colonel T Bouchier Hayes

## Facilities for the disabled

**SPECIAL** facilities have been installed at Princes Gate to assist disabled visitors to the College.

To enable easier access to the building, a wheelchair and ramp are available. A separate toilet has been adapted which provides a low-placed mirror and an assistance alarm.

To ensure that helpers are available, disabled visitors are asked to notify the College prior to their arrival. ☐



# College team visits Australia and Singapore



**T**HE Royal Australian College of General Practitioners (RACGP) was established over 30 years ago having developed from a faculty of our own College. It was fitting therefore that to mark Australia's bicentennial year, a College team should visit the RACGP, and surprising perhaps that this was the first occasion that such a visit had been undertaken between the two Colleges.

The RCGP team was the president, Professor Michael Drury, together with Professor Denis Pereira Gray, chairman of Council, Dr Colin Waine, chairman of the Clinical and Research division and myself. We travelled to Australia at the beginning of September to attend the RACGP annual convention and scientific meeting at Surfers Paradise in Queensland.

The four day convention was attended by over 300 members of the 5,000 strong Australian College. A major theme of a first-class programme was the management of skin cancer. This is a particular problem in many northern parts of Australia and is related to the prolonged periods of intense sunshine to which many of the population are exposed. Most Australian GPs readily accept responsibility for the removal of a range of benign and malignant skin lesions and for arranging appropriate follow-up. Their long term results are impressive.

Otherwise the programme would have been familiar to British GPs with sessions

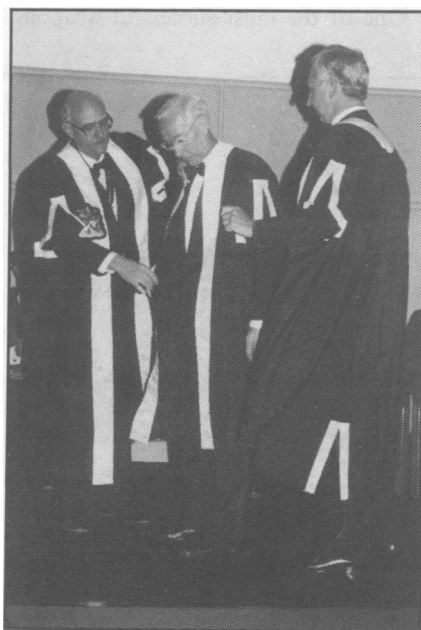
on chronic disease and practice management and an excellent series of papers describing the research projects that had been undertaken by those who were completing the family medicine training programme.

The College team contributed to the afternoon programme of the first day of the meeting. Michael Drury discussed the contribution of general practice to medical education with particular reference to the programme that has been developed in his own department in the University of Birmingham. I considered the development of vocational training in the UK, together with arrangements as they are at present and likely developments. Denis Pereira Gray discussed the continuing education of the established GP and the contribution that research in general practice can make to

this, and Colin Waine spoke about standards of patient care with particular reference to chronic disease and with diabetes mellitus and asthma as examples of how clinical protocols can be developed and used.

Informal discussions were dominated by the recent publication of a working party report on postgraduate medical education and manpower. This, the Doherty Report, has caused disappointment and indeed considerable anger amongst Australian College members for it has recommended that vocational training for general practice, whilst desirable, should not be made mandatory in Australia. The reasons for this are unacceptable, based as they are on the manpower problems that might be caused should GP training become compulsory, and the difficulties that this would pose for those who failed in their pursuit of a specialist career and who would then have problems switching to general practice. The British position was viewed with considerable envy by many of the doctors we spoke to, and the president of the Royal Australian College, Dr Eric Fisher, in his forthright valedictory address stated that the Doherty Report had set back the development of vocational training in general practice in Australia by many years.

The fact that Professor Victor Doherty, pro-vice chancellor (health sciences) for the University of Queensland, and author of the recent much criticized report, should have been invited some months previously to deliver the College's William Arnold Connelly Oration (Connelly was the first president of the RACGP) at the academic session of the convention, ensured a large and attentive audience. Most were disappointed however, for the oration dealt almost entirely with manpower statistics, failed to address the issue of vocational training for general practice and was received politely.

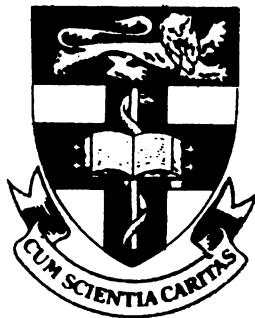


*Professor Pereira Gray and Dr Styles bestowing fellow ad eundum upon Dr Clark Munro*

The RCGP team was treated most hospitably by the members and officers of the Australian College who acted as generous hosts throughout. Many Australian College members are graduates of British universities who emigrated in the 1960s and 70s — indeed a sizeable proportion are overseas members and fellows of our own College who are interested to have first hand account of its activities and news. During the meeting Dr Geoff Gates, an RCGP fellow, was installed as the new president of the RACGP. He is a GP in Perth, Western Australia and qualified in November 1978.

During the academic session, Michael Drury presented to the RACGP on behalf of our College, 10 silver medals to be used as Rose-Hunt medals for presentation by the RACGP to those of its members who have given distinguished service over many years.

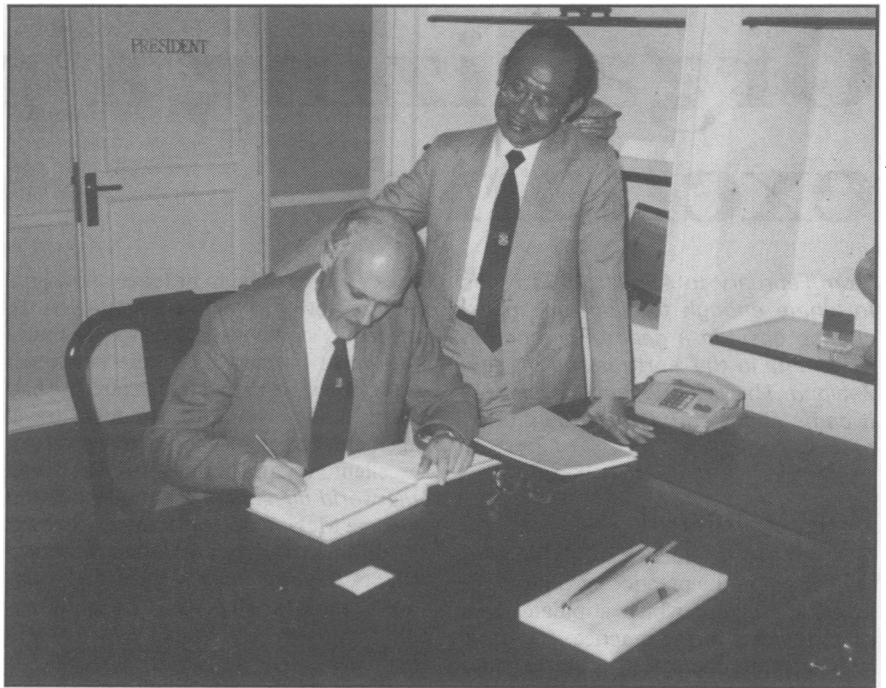
The fellowship *ad eundem gradum* of our College was awarded to Dr Eric Fisher, the outgoing president of the RACGP and to Dr Clarke Munro, former censor of that College. An honorary fellowship of the Royal Australian College was awarded to Michael Drury.



## Visit to Singapore

The visit to Australia provided an opportunity for the College team to spend two days in Singapore on the outward journey and to pay the College's respects to the College of General Practitioners there. Again, RCGP visitors were most hospitably received by their hosts, and particularly by Dr Lee Suan Yew, the president of the Singapore College, Dr Koh Eng Kheng, the vice-president of the College and Dr Goh Lee Gan, a member of council and senior lecturer in family medicine in the National University of Singapore.

We addressed a general meeting of the Singapore College, as well as the postgraduate students of the department of community, occupational and family medicine at the National University of



*Professor Pereira Gray signing the visitors' book at the headquarters of the Singapore College of General Practitioners. Next to him is the president of the Singapore College, Dr Lee Suan Yew*

Singapore, on undergraduate and postgraduate education and vocational training. We visited Alexandra Hospital at the specific request of Michael Drury who had served there in the postwar years as a medical officer in the Royal Army Medical Corps.

A visit to a new polytechnic enabled us to appreciate the high priority accorded to primary care in Singapore and the great emphasis placed on health promotion and prevention.

The membership of the Singapore College is about 500 — the average size of one of our own College faculties. Given its size, it has achieved a great deal in the last few years. It hosted the excellent WONCA conference of 1983 and, together with other specialist colleges, has established an Academy of Medicine and through this a medical library of the highest calibre. A computer workshop has been developed where GPs can obtain hands on experience in the use of computers in general practice.

## Impressions of the visit

It could have been predicted that a two week visit to the other side of the world was hardly enough time to acquire other than fleeting impressions. Nevertheless, the occasion was a memorable one with many lasting memories. In both Singapore

and Australia, we were invariably greeted by enthusiastic hosts who very much appreciated the fact that we had travelled so far to exchange views and ideas. There was considerable interest in how things are at present in the UK and to hear about the latest developments in clinical practice and medical education. But the overwhelming feeling was one of considerable respect for our College and for what it has achieved in the past, and much interest and keenness to work closely with us in the future.

Difficulties in providing high quality and comprehensive primary medical care through general practice are similar throughout the world. There is much for us to learn from each other and considerable help and support that we can share.

Finding so many members and fellows of our own College scattered in such distant parts was indeed a pleasant surprise, and we need to consider ways in which we can communicate more effectively with a group that forms a sizeable proportion of our membership to ensure that we are kept abreast of developments overseas.

A more detailed report of the visit will be made to the International Committee of Council together with recommendations for follow-up in Singapore and Australia, and to foster greater awareness within our College of the fast moving developments taking place in other countries.

Bill Styles



# Organizing a practice exchange

*From February to August 1988 I was fortunate enough to work on an exchange basis in a general practice in Matamata in the North Island of New Zealand. This is a brief account of how it came about and some thoughts on looking back.*

## How it started

**I**N our group practice of six doctors, included in the practice agreement is a sabbatical clause which stipulates that after 10 years in the practice, and at 10 year intervals thereafter, a partner may take sabbatical leave for up to six months. During such leave, the absent partner pays half the expense of employing a locum and the practice pays the other half.

This arrangement was arrived at after looking at a number of neighbouring practices, the aim being to allow a partner to do something either unpaid, or paid relatively little, and not be too much out of pocket. An extension of this agreement is that if a partner is absent for only three months (as is the case with my partner who is also about to go to New Zealand), he does not pay any locum expenses, but the practice bears the entire cost. Thus, it makes no difference financially to the practice as a whole if a partner takes a sabbatical for three or six months. In 1990 one of my partners hopes to take a three months' sabbatical walking in the Pyrenees — there is no stipulation that medical work should be undertaken!

In my particular case, I had been thinking for a while of going to New Zealand when a patient came to see me one day and in passing asked if I knew anyone who might be willing to do a six month exchange with her nephew who was a GP in New Zealand. I immediately volunteered myself and this is how the exchange came about.

## Organizing the exchange

I should say at the beginning that quite a lot of organization is involved, and I would advise that anyone planning an exchange should start doing so at least a full year ahead — it is surprising how time passes. Having decided where to go and for how long, the first step is to ensure that all necessary passports are valid until comfortably beyond the anticipated time of return. The next thing to do is to

decide on the route to be taken and where and for how long to do any stop-overs. In my family's case, we decided to take round the world tickets which were not much more expensive than a return fare. We had many discussions with our local travel agent, and by chance found out about an excellent Fontana book called *The round the world air guide* by Katie Wood and George McDonald. Amazingly, there are 57 different varieties of round the world flights. Having fixed a route and stop-overs, the next step was to acquire appropriate visas. This takes at least a month per visa.

While all this was going on, we also wrote to the New Zealand High Commission who gave us all the information we needed on necessary steps to obtain employment in New Zealand, together with how to obtain registration with the New Zealand Medical Council (NZMC). Briefly, the New Zealand authorities require expatriate doctors to have a medical examination (including chest X-ray and WR) and possibly a reference from a colleague. They also require evidence of intended employment and an onward journey from New Zealand, together with financial resources sufficient to last beyond the duration of the stay. One last important point, a work visa for New Zealand may be for single or multiple entry. We had a long weekend in Sydney and it was therefore essential that our visas recorded multiple entries. The NZMC

recognizes both British qualifications and a GMC registration. On arrival in New Zealand an interview is conducted by a member of the NZMC, who will need to see the originals of degrees, diplomas and registration certificates.

No travel immunizations are necessary for New Zealand, but it is worth emphasising that Hepatitis B is quite prevalent, the carrier rate in schools varying between 10 and 60 per cent. I would advise a doctor going there to ensure the family is immunized.

Another important organizational step is to agree the terms and conditions under which the exchange should take place. My exchange partner (Paul) was paid BMA rates, but in New Zealand payment is entirely on an item of service basis, and it was agreed that I should receive 65 per cent of total earnings. Thus, I had an incentive to work hard and maintain the practice in a financially healthy state, and we found this arrangement worked well. Concerning the use of each other's houses, cars, etc, we followed the general principle that wear and tear should be the responsibility of the principal, but that the locum should be responsible for making good any damage and breakages. We had an agreement drawn up by Paul's solicitor which I am sure we both found to be a useful safeguard. This covered dates of the exchange, on-call duties, malpractice insurance, sickness, relationships with staff, remuneration, leave, telephone charges and an arbitration clause, in addition to the matters already mentioned. This may seem rather ponderous, but I would regard it as desirable for a longer exchange.



*The Tasman Glacier, New Zealand*

## What I did there

I hope to write at greater length on this in due course, but basically the actual medicine is very much the same in New Zealand as it is here, with the following differences. In Matamata there were hardly any home visits — less than one per week. I could see 40 or more patients per day and still be home by 5 pm! Drug names are mostly the same or similar and I encountered few problems. The nearest hospital was at a distance, so the practice dealt with all the trauma — suturing lacerations, X-raying possible fractures, as well as being called to the occasional road accident. Serious injuries were stabilized first (drip, etc) and transferred by helicopter. Most obstetrics was done in the local maternity unit, making me wonder how necessary many of our hospital deliveries are in the UK.

Lastly, all consultations are paid for by the patient, except those for injuries which are government funded. There is a good state-run hospital system, but consultants do much more private work than here, and about one third of the people have health insurance.

Part of our time in New Zealand included a two week holiday which we spent touring the South Island — a beautiful place and we had many remarkable experiences there, including observing an albatross colony, wild penguins and climbing a 10,000 ft peak adjacent to Mt Cook in the southern alps. We went to the world famous Milford Sound, and all-in-all had one of the best and most varied holidays that one could imagine. North Island we explored at weekends — again, a place with great variety, with volcanos rising to 8-9,000 ft, beautiful lakes and numerous thermal areas with geysers, steaming cliffs, boiling mud pools and all sorts of weird phenomena. Although there were three quite significant earthquakes during our stay in New Zealand, we never felt any of them which was, if anything, a slight disappointment. My work schedule included a half day, most of which I spent gliding at a very good and convenient club nearby.

## How the family coped

The school system in New Zealand consists of a junior school catering for children up to age 10, an intermediate school containing only two age bands, the 11 and 12 year olds, and college from 13 years on. I had one son at intermediate and the other son at college. Both enjoyed their experience, made friends easily and generally joined in whatever was going on. My younger son also attended the local

scout group. In comparative terms, we felt that the education system in New Zealand is about a year behind that in the UK, and as a result our older boy was in a group averaging about a year older than him, and this seemed about right. Rugby is, of course, a national religion in New Zealand and we were lucky enough to go to two of the matches on the Wales tour. My wife probably had the most difficult time. The boys and I had plenty to occupy us during the days, but particularly during the first couple of months my wife had long periods of time with nothing to do. The neighbours were fairly friendly and made her welcome, but there is a limit to how much time you can spend in other people's houses, especially when strangers. As time went by she began to build up her own circle of friends, and by the last couple of months was really quite involved in the local community. Both she and my younger son were homesick at times and we all found ourselves dependent on a regular supply of letters from friends and relatives at home. By the time we left we had forged quite a few close relationships, many of which I hope will continue by correspondence, and indeed it looks as though over the next few years we shall have a steady trickle of visitors from the other side of the world.

## Hindsight on the benefits

At the time of writing, the things that stand out most in my mind are the holiday aspects, the sights we have seen and the experiences we have had — the Taj Mahal, sitting in the back of an open Land Rover with a tiger somewhere nearby, tea at Raffles Hotel in Singapore and many other memories. Medically, I have dusted off and used some old skills and have gained greater confidence. Working in a different environment has been interesting and stimulating. Being away from some of my more demanding and wearing patients has been good for me and possibly good for them. I have certainly come to appreciate the good things about the NHS much more, but have also found benefits, both to the patient and to myself, of doing minor surgery and obstetrics. It is quite interesting to see Britain and Europe from the other end of the world, and for anyone who might be experiencing the early stages of burn-out, or whose nose is too firmly pressed to the grindstone, a sabbatical would seem an ideal antidote. □

Chris Barry

*Dr Chris Barry is the honorary secretary at the Wessex faculty.*

# London Lighthouse



*London Lighthouse's 24 bed residential unit has been designed to be more like a home than a hospital*

**L**ONDON Lighthouse, Britain's first residential and support centre for men and women affected by AIDS recently welcomed its first residents.

The North Kensington centre, which cost nearly £5 million to build, equip and furnish, is the only AIDS organization in the world offering a range of integrated services and support from one, community-based centre. These include a 24 bed residential unit providing convalescent, respite and terminal care; home support services; counselling, health, exercise and training programmes. Support is also offered to relations, partners and friends. A drop-in centre opens this month. Over 2,000 people a year are expected to use the centre which needs 85 full and part-time staff and several hundred trained volunteers to maintain its extensive range of services. The residential unit is open to anyone with HIV infection and places are offered on the basis of need. The unit is staffed by a residential services manager, the principal medical officer and 27 trained nurses.

London Lighthouse will consider referrals from people with HIV infection, their carers, GPs, hospital nursing and medical staff and community workers. Anyone making the referral must have the consent of the person concerned. □

*The College and London Lighthouse are planning a joint conference to be held in December of this year. Its aims include enhancing GPs' awareness about key issues surrounding AIDS sufferers, and encouraging good working relationships between the College and agencies involved in the care and support of people with the disease. The conference will be attended by an invited audience.*

# The Patients' Liaison Group

**F**IVE years ago the College, on the recommendation of what was then its Communication division, established a forum for patient and GP representatives. The Patients' Liaison Group (PLG) as it is currently known, now reflects the spirit of the declaration made at Alma Ata in 1978 by the World Health Organization, that patients have a 'right and a responsibility' to participate in personal and policy decision making.

The PLG has seven lay members and seven GP members. It is charged with ensuring close communication with all parts of the College and its objectives and targets therefore complement activities in other parts of the College. One of its two vice-chairs, Denis Durno, who practices in Aberdeen, is an observer on council. Another of the group's GP members, Lotte Newman from London is, by coincidence, currently vice-chairman of council, ensuring that the dialogue within the PLG is reflected in College deliberations.

Nancy Dennis, who has been a lay member of the group for five years and has held the chair since 1986, welcomes the College's commitment to working with and not just for patients. She is not alone in seeing the group's method of working as stimulating and challenging.

Maureen Pearson, the group's lay vice-chairperson, believes that 'doctors and lay

members have at times held differing views. By frank and open discussion, we've gained a greater understanding of each other's views and ambitions. Service providers and consumers should benefit as a result'.

Kay Richmond, a single-handed GP from South Glamorgan, echoes this, 'Much of the dissatisfaction with primary health care expressed by consumers and providers could be greatly diminished if both groups had a meaningful dialogue with each other'.

That process of dialogue is only a means to several ends and the group's objectives in working towards successful dialogue can be summarized as responding to requests from council, representing the views of patients, initiating new areas for discussion, giving patients an effective voice in primary health care by promoting participation and an exchange of views.

In practice, this entails a mix of approaches — seminars, working parties, ad-hoc discussions on particular issues, carefully researched reports derived from questionnaires and good practice.

Anne Davies, epitomises the approach of working from direct experience. An example of her contribution is that contained in a draft folder of information to be included in a practice leaflet in which she urges that account be taken of the needs of the less able-bodied. 'As a wheel-chair user myself, and taking part in the sub-group concerned with practice assessment, I have written a check list which gives details of what to look for regarding access into practices'.

Dr George Taylor, a PLG member from Newcastle, believes that the group has limitations. 'The national PLG is not truly representative of patients, yet it must try and give a patient's perspective'. However,

the PLG has been successfully mirrored in two faculties (in the North of England and the North-West) through patient participation groups.

The local/national perspective motivates many of the PLG's members. Doreen Bugler, chairperson of the Macclesfield Community Health Council (CHC), brings experience from a family practitioner sub-group of her CHC and provides regular liaison with her local medical committee. Peggy Jackson from Sheffield is deeply involved in her local health centre in Birley Moor.

Jonathan Graffy (a willing GP guinea pig for a practice visit involving patients) brings the depth and breadth of inner city issues from Hackney. Not surprisingly, he highlights the concerns of groups who may receive a poor deal from some GPs, including the homeless and individuals from different cultures.

Where the PLG goes in the future is partly in its own hands — partly in others. Its role and functions have been tested and strengthened by two reviews in as many years. Jimmie Miller, a retired health authority administrator living in the Scottish borders, sees the group as being central in the debate about patient choice and marketing of services.

Nancy Dennis (who retires from the chair at the end of the year) is quite clear. 'It will always be important that lay members do not get caught up in the system, but retain fresh minds, put forward patient concerns and constructive ideas about tackling problems — as well as having unlimited energy and willingness to take on all the work involved'. □

**Jeremy Fennell**

*Jeremy Fennell is a lay member of the Patients' Liaison Group.*

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