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PRACTICE OBSERVED

Research in General Practice

Clinical trial in general practice?

NIGEL C H STOTT

Why I started

Any doctor worth his or her salt should be asking questions about the fascinating array of problems about which we are consulted every day. The finest aspect of general practice is its colourful diversity, and yet even this has been seen as a disadvantage by those who think that only specialist clinics see enough material of a unified nature to permit research. There are many areas of the generalist's work that are highly suited to research: one of these is acute respiratory tract infections, which form about 60% of the work load of doctors working in primary health care.

So common and mild are many respiratory infections that often they are not even regarded as diseases; furthermore, there is no clear relation between many of the syndromes and the organism concerned,[1] and host resistance is equally variable. Dietary, socioeconomic, hereditary, family, and atmospheric factors all modify the individual's experience of respiratory symptoms and diseases. Doctors also show very diverse habits in diagnosing the individual syndromes,[2] and antibiotics are often overprescribed, to the detriment of the environment, the patient's expectations, and the person who foots the bill.

Clear guidelines for treatment are difficult to formulate because of this lack of insight into the environment-host-organism interrelation, and the field has been left wide open for exploitation by advertising, fashion, and dogmatic educators. The double-blind randomised controlled trial is probably the best way to begin to provide some of the answers to such awkward questions because it is possible to control for many factors, known and unknown, while testing a particular hypothesis or question.

The question I will use to illustrate the use of the randomised controlled trial is: Do patients with cough and purulent sputum merit antibiotic treatment?[3]

When I first posed this question in 1972 it seemed clear that patients with cough and purulent sputum were not treated uniformly by doctors. Some were given broad spectrum antibiotics, some were given penicillin, some were given cough mixtures, and some were given advice about soothing home remedies. A few were even sent off with a flea-in-the-ear about this being a "non-illness" that should be ignored. The scene was set for a trial to establish whether or not treatment with antibiotics would influence the symptoms or signs of this problem, which some patients clearly regard as an illness and some doctors are prepared to label as a disease. A controlled trial would also provide valuable information about the natural history of the problem.

What I did

Several stages were followed to get the trial underway: (*i*) search of literature; (*ii*) informal survey of local doctors' opinions; (*iii*) writing of a protocol; (*iv*) ethical committee approval; (*v*) application for research funds and support; (*vi*) discussion with statistical adviser; (*vii*) staff appointments; (*viii*) involvement of research practices; (*ix*) start quality control. In this article I cannot deal with each aspect fully, but several points are worth making because they are often overlooked and cause annoyance or regret.

(*i*) A literature search for related work is vital before a protocol is written because it is sad to work on a project only to find that someone else has done it already or that one of the methods used was less than ideal. Medical librarians, secretaries of local postgraduate centres, and the librarian of the Royal College of General Practitioners are all extremely helpful if you are in doubt about where to begin. It is also wise to read reviews of your subject written during the past five years or so to see whether your ideas are innovative or complementary to existing trends.

(*ii*) Consultations with local doctors and researchers for opinions can be helpful for both practical and political reasons. I found that the doctors were divided into those who treated cough and purulent sputum with antibiotics and those who did not. They were also helpful in clarifying suitable diagnostic criteria and exclusions from the study. For example:

Included: All patients from three group practices aged over 14 years who had cough and purulent sputum for up to seven days.

Excluded: Those with abnormal clinical signs in the chest on auscultation. Those with persistent sputum expectoration in winter months. Those with other chronic disease (diabetes, emphysema, etc). Those sensitive to tetracycline. Those pregnant (or possibly pregnant).

The aim was to study a healthy adult population with cough and purulent sputum of recent onset (= middle respiratory infection). This is not the most common of respiratory infections, but it was the most controversial because it was neither a true lower respiratory infection with chest signs (in which there is a high probability that the patient will be given an antibiotic) nor an uncomplicated upper respiratory infection (in which there is a high probability that the patient will not be given an antibiotic). I estimated that 200 cases would take about a year to collect from a population of 8000 patients . . . but I proved to be wrong (see below).

(*iii*) Writing a protocol is an excellent discipline, even if research funds are not needed, because it requires a review of the literature and a description of the question to be tested, the methods to be used, the resources likely to be needed, how analysis of results is to be done, and the likely implications for the future. I had decided to try to answer two basic questions: (*a*) Does antibiotic treatment modify the clinical course of middle respiratory infection in otherwise healthy adults who have been unwell for up to a week? (*b*) Does such treatment influence the incidence of subsequent infections?

These questions meant that I had to design a card for the doctor to record clinical symptoms and signs and a card for the patient to self-record symptoms while taking treatment or placebo on a day-to-day basis (fig 1). The doctors had to agree to review the patients at the end of week 1 and stop treatment if both doctor and patient were satisfied with the outcome, and if sputum was clear. Question (b) refers to the incidence of infections brought to the doctor and implies a need for either patient self-recording for a further six months (which is impractical) or using practices that keep good medical records to ensure that all day and night consultations and visits were recorded.

(*iv*) Ethical committee approval: a brief account of the study (one page of typescript) is usually sufficient, and the secretary of the local medical committee will ensure that it is processed by the next meeting.

(*v*) A clinical trial often involves drug treatment, and pharmaceutical companies are very helpful. Pfizer Limited were kind enough to supply doxycycline capsules and identical placebo capsules in randomised, numbered bottles. The randomisation code was supplied in a sealed envelope and held by the statistical adviser until the project was completed. This meant that a DOUBLE-BLIND format was achieved with neither doctor nor patient knowing who was receiving the active drug.

The Welsh Medical Research Committee supported a part-time health visitor to assist with fieldwork and quality control. Every area has local research committees that supply small grants, but consultation with local academics will always help in the search for an appropriate fund-raising body if the researcher is in doubt.

(*vi*) A statistical adviser who is concerned from the outset is an asset and a friend, saves no end of time, and will do all the analysis of data, which few clinicians have the inclination or the skills to perform. If he does undertake more than advice do consider including him as a co-author—it is courteous and builds happier relationships for later projects.

(*vii*) Staff appointments are often necessary in clinical trials because clerical and fieldwork can be tedious or impossible if the clinician is trying to do it in his "spare time." I worked through the personnel and finance offices of the medical school, but practice managers are also helpful and many research or academic institutions will act as an "umbrella" for the general practice researcher and provide help with such matters. See the departmental head and you can expect a warm reception if you have done your homework and know what you hope to do.

(*viii*) Quality control of data is a recurrent nightmare for research workers: the thought that all your efforts may be smashed by discovering that observers are inconsistent or biased or that you have omitted a vital check which invalidates your results. Have no fear; no research is perfect, but you must try to establish quality checks. In the study on middle respiratory tract infection the following checks were made:

(*a*) All 22 doctors who participated were briefed by the researcher and subjected to a blind clinical signs study in which a series of patients seen by the doctors in their own surgeries were also auscultated by an independent clinician. Both doctors recorded the objective signs independently. This was repeated until the researcher was satisfied that chest signs were being interpreted consistently.

(*b*) Patient compliance when recording symptoms and taking treatment was assessed by counting the capsules in bottles returned by patients at the end of treatment and by a health visitor calling at the homes of a one-in-five sample of patients during the first week of treatment to check on recording and capsule count. The patients were not told that the health visitor would be calling.

(*c*) Respiratory diagnoses were checked daily on doctors' records to identify those who qualified for the trial but were not entered into it: 12 were found. Of these, the doctor forgot in seven, one could not swallow capsules, one had been nauseated by doxycycline previously, and three had refused to participate. (Two others started the trial but were non-responders because one changed his mind and the other could not be traced.)

Quality control was a time-consuming but essential part of the study, and I would have failed to find the time for this task without the assistance of a nurse or health visitor field-worker. She also played a valuable liaison role between the 22 practitioners and ensured that the capsule dispensers were always full and a good supply of cards was available in every practice. Reminders to doctors to include all suitable cases were sent at regular intervals but the field-worker's presence in the practices was probably more important.

NAME
ADDRESS
date of next visit
date (day of month)
Comments
day cough
night cough
yellow/green spit
clear spit
running nose
off colour
other symptoms (specify)
(a)
(b)
(c)
off work/school (cert)
off work/school (no cert)
did you smoke?
doctor
occupation
number cigarettes/day or oz tobacco/week
clinically febrile YES/NO
pulse rate
general clinical impression WELL ± TOXIC ILL
medicine bottle number
number tablets returned

FIG 1—Card for doctor and patient to record symptoms on.

What I found

The first discovery was that I could not complete the study in one year as my estimates about the frequency of middle respiratory tract infection had been optimistic. This is a very common error in clinical trials and hard to avoid because one is never 100% sure about the incidence of anything until a full survey is completed. Opinions are notoriously unreliable, and even a pilot study can lead to gross miscalculation.

The most important finding is illustrated in fig 2. Doxycycline and placebo groups were no different, whether judged by symptoms or duration of illness, purulent sputum, or time off school or work. The figure also illustrates the natural history of middle respiratory tract infection, nearly 30% of patients still having purulent sputum at seven days but this resolved over the next seven days. Similar trends were seen for other symptoms (cough, malaise, fever, headache, etc).

Patients (%)
Placebo (n = 103)
Doxycycline (n = 104)
Days after admission to trial

FIG 2—Percentage of patients recording yellow sputum each day after admission to trial.

Could the results be biased? Yes, all results can be biased, even those from double-blind randomised controlled trials if the randomisation process fails to provide two identical groups for study. This can happen by chance, and it is another nightmare for the researcher when he or she analyses the results. Fortunately, this study did not suffer from this chance defect but we had to show that the groups were balanced by age, sex, symptoms on entry, duration of illness, severity of illness, compliance with drug taking, occupation, and smoking habits.

SIDE EFFECTS OF TREATMENT

All treatments have some possible side effects, and a drug that causes rashes or nausea or diarrhoea is much less likely to be taken by patients than one that has no side effects. In a trial this can be a cause of failure and can lead to drop-outs from half of the study unless all patients are warned about possible transient or minor symptoms. In this study equal numbers of patients on placebo and doxycycline felt nauseated, and so it is likely that this was an effect of the infection or expectations which were set by the clinicians. None of the subjects, however, actually stopped taking the drug for this reason.

The lessons I learnt

(1) Always allow 50% additional time on your estimate for project duration.

(2) Plan for adequate fieldwork or clinical assistance, or both, even if you think that your present staff can carry the additional load.

(3) Take advice from as many sources as possible before starting the project. This helps to avoid mistakes and miscalculations, but it is time-consuming.

(4) The randomised controlled trial is a very powerful research tool that yields useful results, but it is also very demanding of time and resources. Sometimes small differences between two groups cannot be shown until very large numbers of cases are recruited into the trial. A statistician must guide you or you will be tempted to take short-cuts that you will regret subsequently.

The conclusions I was able to draw

Six years after the project on middle respiratory tract infection was published I find myself identifying two sets of conclusions. The first is a constant: that otherwise healthy adults who present to their doctors with cough and purulent sputum of up to seven days' duration and whose chests show no abnormal signs on auscultation—that is, middle respiratory tract infection—usually get better as quickly without as with antibiotic treatment. This finding has also been corroborated by controlled trials in children with various respiratory infections and in adults given early treatment for colds and influenza-like illness.[4-6] This study[3] also provided useful information about the natural history of middle respiratory tract infection by confirming that it is usual for symptoms to persist for up to a week, and in a third of patients they persist for several days longer. Patients can now be told what to expect, and this is a very important part of management, which other work has also highlighted.[7]

A second set of conclusions relates to the way the results of the study have been used by doctors and researchers since publication: it has been disappointing to find that many clinicians continue to prescribe antibiotics for middle respiratory tract infection, and the study has been misquoted in defence of this strategy. It has also been misquoted in defence of not giving antibiotics to patients with chronic bronchitis with acute exacerbation. I can only conclude that some clinicians seek to justify their clinical behaviour by misuse of references. Perhaps if more clinicians conducted clinical trials themselves they would learn how cautiously one has to interpret original work and that one detailed study can only provide a further fragment for the patchwork quilt of knowledge that we call science.

Opportunities for similar research

Evidence for the limited efficacy of antibiotics in many respiratory tract infections is now well documented, but there is a paucity of controlled clinical research into the relative efficacy of substances that are supposed to provide symptomatic relief. Analgesics, decongestants, cough suppressants, expectorants, and soothing vapours are all used, but do they have a pharmacological action or do they simply pander to mankind's tendency to seek magical cures for illness? A host of studies is waiting to be done in respiratory infections alone, but each one will need painstaking work on a large number of subjects to provide a definitive answer. In the meantime the Department of Health is becoming more hard-line in its attitude to paying for symptomatic treatment, so if you have a favourite mixture you had better evaluate it quickly!

If you do not like respiratory infections just try to examine the evidence for other favourite treatments. How is your management of: muscle sprains, low back-ache, tension symptoms, dysuria, tennis elbow, etc? General practice is riddled with remedies for symptoms or syndromes and many still await careful evaluation in the community. Most treatments will swing with fashion and advertising until a solid evaluation in the form of a clinical trial casts fresh light on the problem. Do not forget, however, that treatment other than drugs is also amenable to this approach and we need more assessments of non-drug treatments in general practice.[7] We also need to keep a watchful eye on those non-medical treatments that are being promoted and applied by healers on the fringes of medicine because some are harmful and others may merit our serious attention.[8]

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References

1 Gardner PS, Stanfield JP, Wright AE, Court SDM, Green CA. Viruses, bacteria, and respiratory disease in children. *Br Med J* 1960;i:1077-81.
2 Howie JGR, Richardson IM, Gill G, Durno D. Respiratory illness and antibiotic use in general practice. *J R Coll Gen Pract* 1971;21:657-63.
3 Stott NCH, West RR. Randomised controlled trial of antibiotics in patients with cough and purulent sputum. *Br Med J* 1976;ii:556-9.
4 Gordon M, Lovell SS, Dugdale AE. The value of antibiotics in minor respiratory illness in children: a controlled trial. *Med J Aust* 1974;i:304-7.
5 Howie JGR, Clark GA. Double-blind trial of early dimethylchlortetracycline in minor respiratory illness in general practice. *Lancet* 1970;ii:1099-1102.
6 Taylor B, Abbott GD, Kerr MMcK, Fergusson DM. Amoxycillin and co-trimoxazole in presumed viral respiratory infections of childhood: placebo or controlled trial. *Br Med J* 1977;ii:552-4.
7 Stott NCH. Management and outcome of winter upper respiratory tract infections in children aged 0-9 years. *Br Med J* 1979;i:29-31.
8 Lewith GT. *Acupuncture: its place in western medical science.* Wellingborough: Thorsons, 1982.

Organising a Practice

Communication in the practice

K W MILLER

Two changes in the pattern of British general practice over the past two decades have increased the need for good communications in practices: more and more doctors practise in partnerships and the number of employed and attached staff has grown. This is well illustrated in our semirural practice near Bristol. When I joined my late senior partner more than 25 years ago there were just the two of us and a part-time secretary. Her job was to sit in my partner's dining room answering the telephone and entering requests for visits in the appropriate book. Between calls she kept up to date with the latest issues of *Vogue*, *Country Life*, and *The Tatler* before they came to rest in the waiting room. Charming and decorative, she has long since retired to raise a family, and life has become more complex. Today there are six partners, two trainees, a practice manager, and no fewer than 28 other non-domestic staff working in the practice, which now is run from a converted private house in the original village and from a health centre two miles away, where a small new-town for Bristol commuters has grown. Many of these people are part-time, of course, which increases the communication problem, and the treatment-room nurses at the health centre are shared with another practice.

When we moved into the health centre the county medical officer of health bet me that the practice would split in two within five years. I think it is a measure of our success in maintaining good communications that 10 years later we are still a closely knit practice and fully expect to remain so. No partner has ever left, and secretaries and nurses seem to do so only if their husbands move or they become pregnant, and even then they usually return soon after. One receptionist joined us 25 years ago to help out for a few weeks and has been with us ever since.

There are many practices that can claim the same degree of stability and staff loyalty. All will be different, but all would probably agree that good communications are high on the list of factors that have led to their success. How then is close liaison between six individualists of quite different personalities achieved, so that in the end coherent policies emerge, decisions are taken, everyone feels involved, and splits do not form within the group? Partners usually communicate informally during their day-to-day contact (all right if there are only two or three and all work from the same building) and more formally by practice meetings.

Practice meetings

There seems to be surprisingly little consensus among practices as to the form practice meetings should take and how often they should be held. We hold a lunch-time meeting on the same day each week and at the same time. This is attended by all partners, the two trainees, and the practice manager. A simple lunch is prepared on the premises and there is always a bottle of wine—vin ordinaire for routine meetings and something a little better when guests are present. Some practices hold evening meetings, but I would not recommend this as a routine. Stephen Taylor[1] advised either fortnightly or monthly—"between 8 and 9 pm in the drawing room of one of the partners"—but nowadays most of us value our time off too highly to want to turn out

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except on special occasions, such as deciding on a new partner. Lunch-time meetings cannot ramble on indefinitely as some partners will have afternoon clinics to attend, the doctors are feeling reasonably fresh, and the duty doctor is less likely to be called away.

An agenda is essential, and ours is prepared by the practice manager, typed out and distributed to all the doctors. It starts with statistics of the previous week's work, and then lists items for discussion. The chair is taken by each doctor in rotation, including the trainees for whom this is a useful part of their instruction. The practice manager acts as secretary, recording decisions taken and noting matters requiring action with the name of the person responsible for carrying them out and reporting on the action taken at the next meeting. An analysis of work done by the partners during the previous week is presented: numbers of surgeries held, numbers of patients seen in surgery, number of visits for each partner, and totals for the practice, and the number of repeat prescriptions issued at each of the two surgeries. Also included are committee meetings, local medical committee meetings, and other commitments such as hospital clinics. We think that these are of interest in their own right, and any imbalance in the work load, especially between the two ends of the practice, can be spotted so that no one gets the chance of becoming paranoid about their work load. We all think we are working harder than our partners, and it can be very salutary to see the figures in black and white. It is also useful in deciding on the need to employ locums, part-time assistants, or new partners.

The next item is usually rearrangement of on-call duties. Since we do not have a computer we find that the easiest way to work out an on-duty roster is for each partner to have the same night on each week, while weekends are worked out in advance for the year. They are then swapped around when partners are away on holiday, sick leave, or just want a particular weekend free. The bargaining that goes on would not put a Bedouin camel dealer to shame. It is important, however, not to spend too much time on this, and reasonably firm chairmanship is useful here. The rest of the meeting is taken up with the usual run of the mill affairs of the practice, so that whether the problems are trivial or important each partner has a chance to air his views and decisions may be arrived at by consensus. On rare occasions more sensitive matters need discussion—a partner feels that he has been unfairly treated, a patient complains, a partner has had a row with a patient and wants to remove the patient from his list. On these occasions plain speaking supported by underlying mutual respect will bring disagreements into the open before feuds or cliques develop, which can ruin a successful practice. Once a year when the accounts are prepared a special meeting is held, which is attended by the trainees and the practice accountant. The whole afternoon is given up to this meeting, all partners being provided with a copy of the draft accounts at least a week beforehand.

Occasionally, if there is not much business to discuss we hold a clinical rather than an administrative meeting, though in a successful partnership most clinical contact between partners is day to day. About once a quarter a local radiologist attends to discuss interesting films which we have requested. Since we use five different *x*-ray departments, this entails the practice manager collecting suitable films from each hospital for the radiologist to comment on. This is especially interesting when his interpretation varies from the original report. It is also a form of audit, and we press him to criticise our use of the *x*-ray department. Perhaps because it is also an occasion for a bottle of our better claret he has so far contented himself with pointing out that our results, in terms of pathology discovered, compare favourably with the hospitals. From time to time we ask another expert to talk to us informally—usually on how best to use his services. An educational psychologist, a senior social worker, the manager of the local social security office, and various clinicians have come along and seemed to enjoy themselves. We tried having a journal club without much success, but it is probably worth trying again and we plan to look at prescribing habits now that the Department of Health can produce detailed computer print-outs of prescriptions written by individual partners and trainees.

The "gossip point"

Should health visitors, nurses, secretaries, and other staff attend these meetings? Except occasionally for the clinical meetings, we think not. The meetings would be too cumbersome and time-consuming, and much of the discussion is of interest only to the partners. Nevertheless, good communications with the rest of the practice team are important; indeed, the larger the practice team the more important they become. The essential thing is to have a focus for the practice—what Stephen Taylor called "a gossip point"—when all staff meet informally and naturally during the day. There is little point in having a common room, however well appointed, at the other end of the building if nobody uses it. In our practice the "gossip point" is a little room off the main office to which all members of the practice gravitate—the doctors to read their mail, sign cheques, complete insurance forms, and, of course, just gossip and drink their morning cup of coffee. Here, too, the district nurses and health visitor call daily to discuss patients and their problems, and the practice manager and secretaries are always around. I have noticed that not all practices, especially those in health centres, have such a focal point and feel that they miss out as a result, a point emphasised by Stephen Taylor over 25 years ago.

Last of all there are the purely social meetings, which are important in fostering close relations among all members of the practice. An annual Christmas party for all staff, held in the surgery on a Saturday evening before Christmas to which wives and husbands are invited, is always popular. An occasional practice outing may be equally enjoyable. We had an excellent evening cruise by narrow boat up the river Avon followed by a barbeque, which was a great success. But not too often. Doctors and staff should get away from surgery and office and each other when the day's work is done. The only exception for the doctors is a regular night out to hear the Welsh National Opera, with supper afterwards.

I have said little about communications with consultants. A practice builds a good reputation with colleagues by, among other things, being meticulous about sending properly detailed referral letters, but there may also be a social side to this relationship. For some years we have held an annual surgery party attended by the doctors and their wives to which we invite newly appointed consultants and some old friends whose help we especially appreciate. Sometimes referred to as our "Noah's ark" parties, because we usually have two guests from each specialty, they help to cement good working relationships—so there are few consultants with whom we are not on Christian name terms. A personal relationship of this sort can only benefit our patients, which, after all, is what the whole exercise is about.

Reference

[1] Taylor S. *Good general practice.* London: Oxford University Press, 1954.

LIMITS OF MEDICAL ART Whoever penetrates sufficiently far in the knowledge of physic will unfortunately find medicine does not possess that omnipotent power over disease that younger practitioners are prone to attribute to it, or as it might be wished: and, moreover, if his practice and attention be sufficient . . . he will clearly discern the actual limits by which the power of the medical art is bounded, despising the vain attempts of the ignorant or less experienced to pass it; neither deluding the friends of the patient with false hopes, nor depressing his patient with an air of scepticism; nor above all, to annoy his patient with nauseating, unavailing medicines. (*Gazette of Health* 1821;5:630.)

Shortlisting Trainees

Thoughtful applications wanted in Birmingham

K G DICKINSON

For some time I have been a member of various committees that select trainees for general practice. Recently I have become more involved, and the potential power is worrying. I was asked to prepare the initial shortlist of candidates for interview at a district general hospital for the two-year hospital period of the vocational training scheme. The hospital has a fine reputation and an excellent postgraduate centre with a very efficient secretary and a clinical tutor who is keenly interested in training. In the past the shortlisting was done mainly by the clinical tutor, but, he argued, as the aim is to produce well-trained general practitioners it was only reasonable that a seasoned general practitioner should do the initial work. It may be that he was put off by the 90 applications for two posts that had been advertised locally and in the *BMJ*.

The number of applicants has steadily risen over the years as entry into general practice has become more popular and our scheme has established itself as well thought out and practical. Potential candidates were invited in the advertisement to apply for either of two slightly different rotations (one did not include obstetrics) or submit themselves for both. We thought that one scheme was possibly better, but in the event applications were fairly equally distributed between the two. The due date for submitting the applications was one month after the insertion and distribution of the advertisements.

The process of elimination started that day. When a large number of young doctors apply on time it is not fair to them to consider late applications, of which there were about five. The secretary at the postgraduate centre did some initial sorting, handed me my homework in various assorted piles, and provided me with a comfortable chair, a quiet room, lunch, and coffee. Two and a half hours later I had looked through every application and reduced the pile to 20, then to 15, and finally to 12. Then I stopped, exhausted, and had more coffee. I started again, and after an even more difficult session reduced the list to 18. I finally gave up when I had come down once more to 15.

What we do not want

The initial sorting was easy. Applications that were illegible or had a badly photocopied curriculum vitae were rejected—about 20. Applications that had been put together in haste, with little thought, were also easily dismissed—about 10. Applications that consisted of just a curriculum vitae and a very brief letter were also removed. One does expect a candidate to show some interest in the position and outline in a little detail why he would like to work in our hospital, even if it is not true.

Now the hard work started. There were probably 30 good applicants, and another 10 to 15 were obviously adequate. I had to read each letter of application with care. It does not help, therefore, if it is overlong. I do not need to have the philosophy of general practice spelt out in great detail to understand that an applicant is keen—too much detail in fact is boring. What is of course even more critical is the presentation of the curriculum vitae. It must be laid out well and clearly typed. It must be up to date and not have insertions added on. Again, it should not be too detailed. I am not interested in a doctor who played hockey for the school second team, but if he represented his university or went to Europe on tour with his home club I would like to know. Similarly, a standard elective done while a fifth-year student is of little interest, but if the doctor had spent extra time in New Guinea because of a crisis in the hospital he should mention it.

It is irritating to have to ferret around in a curriculum vitae trying to discover what job the applicant is doing, and I think that this should be clearly typed in at the top of the curriculum vitae and possibly added in later for completeness. If the career structure has been somewhat erratic in time and place it is necessary to make the pattern discernible. Gaps in time due to illness, or time out for other reasons, will not stop someone being shortlisted if one knows what has happened. But unexplained gaps lead to suspicion and—in a competitive world—elimination. The referees should, if possible, be consultants who have had recent contact with the applicant. It is not to a doctor's advantage to use two consultants as referees from the same firm in a hospital that he worked at two years earlier and mention no one else. The referees should know about the application and be prepared to write a reference at short notice. It does not help if a referee is away at the time that the request for a reference arrives.

The final shortlisting had a parochial air about it. Some candidates were known to be keen, worked in the hospital or had done so recently, and were probably local graduates. They were favoured over possibly equally good candidates who were now working 200 or 300 miles away and of whom we had no local knowledge. Excellent applications from two or three doctors who had left Britain and were working in the Far East were rejected because it would have been impossible to interview them. I was sorry to do so, because they seemed to be people of talent and originality. I have little doubt that they will get into a scheme when they return to Britain. I would tend to favour them as I tend to favour the odd balls who have done something original in medicine or outside it. Even having had a letter published in the *BMJ* must be a plus, and a short research article an even greater advantage. Interests should be stated to give some idea of personality. "Reading" as a hobby seems somewhat thin and is surely expected of all of us. It can be fatal to put in an interest of which the applicant knows little but thinks will sound good. The interviewing committee may well have on it the local expert who will be able to discuss "wine making" or "pottery."

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The final list

In the shortlisting and interviewing that I have been concerned in the sex of the applicants was not discussed at any stage, but positive and negative racial feelings were aired openly and discussed, prejudices accepted and rejected, and in the end rational non-racial decisions taken. This can be difficult. Does one, for instance, appoint an obviously intelligent doctor whose command of English is poor because of having been in Britain only for a short time? I think not, when there are so many excellent candidates presenting themselves for interview without such a problem. The final agreement on the shortlisting rested with the clinical tutor and his consultant colleagues. It was their job to reduce my final list of 15 to 12 and to add other applicants whom I might have overlooked. The result was two groups of six doctors who were invited to attend for interview one afternoon. Four days before the event four had withdrawn and were replaced in part by local applicants not originally shortlisted. The interviewing committee consisted of six consultants and myself, and each candidate had about 20 minutes of our time. They had to sell themselves as reasonable, competent, hard-working, thinking doctors. The extroverts tended to do better with some of the committee and the quieter ones with others. Some candidates did not seem to correspond with their curriculum vitae at all, and one could feel the general relief when they left the room. Most of those who were interviewed were excellent, and it was difficult to reject anyone. The references tended to be of little value if written in a stylised form, and the consultant who obtained top marks had rung me up at 8 am on the interview day to check that I would read his reference carefully.

Dress and manner do matter. A casual or too diffident approach can be damning. It is necessary to sit up, speak up, and know when to shut up at an interview, but it is as important to make certain of being shortlisted. A curriculum vitae reflects one's interests, activities, personality, and lifestyle. It is essential to see that it does one more than justice.

Overcoming Isolation

Keeping up to date in Gateshead

COLIN M LEON, J R YOUNG

The postgraduate centre is a "temporary" wooden structure in the grounds of the Queen Elizabeth Hospital, Gateshead. It is situated rather too near to the main road and bus route for comfort or security and rather too far from the two other hospitals in Gateshead to allow their junior hospital doctors easy access. It has served its purpose well over the last 13 years, however, and there will be some nostalgic regrets when it is superseded by a large, modern teaching centre in the near future.

The organisation and administration of the centre is provided by the secretary/librarian and the clinical tutor (in that order), and the programme is produced by the clinical tutor and the general practitioner course organiser. The incumbents of the posts have changed over the years but the philosophy of the centre has continued relatively unchanged.

Our philosophy

We see our postgraduate centre as the most important locus for the continuing medical education of the general practitioners and community and hospital doctors. Its work is not meant to compete with or to replace the organised postgraduate training leading to higher examinations that is organised by the academic departments of the university. The emphasis is on inter-disciplinary discussion nearer to the "place of work" as a continuing process in all specialties, including community and family practice. The Queen Elizabeth Hospital, being only five miles from the university hospitals, is also conveniently situated for benefiting from and contributing to the organised courses.

We see our centre as a place for socialising and for breaking down artificial barriers between hospital and general practice. We believe that we have developed a better understanding with the other health workers by addressing some of our problems in a multidisciplinary way. We have included clinical psychologists, social workers, health visitors, midwives, health educationists, radiographers, and others in our topic discussions and case presentations, and we feel that there has been a much better mutual understanding as a result. We pay particular heed to the importance of team work in health care. We believe in involvement. Doctors come to the postgraduate centre to learn rather than to be taught, and the best way to learn is to be concerned in the educational process. Finally, we believe that continuing medical education must be enjoyable.

The Postgraduate Medical Centre, Gateshead NE9 6SX
COLIN M LEON, MB, FRCGP, general practitioner and course organiser
J R YOUNG, MB, FRCR, clinical tutor

The programme

Our clinical and GP tutors together devise the programme, and we would like to claim that programmes are based on clear educational objectives, preferably phrased in behavioural terms. Honesty must prevail, however. Programmes are based on several well established criteria. A newly appointed consultant, and more recently a newly appointed principal in general practice, is always invited to give an "inaugural lecture." This is a bit like a parliamentary maiden speech, but it at least allows a new consultant the opportunity to declare his interests and allows discussion about the service that he intends to provide. We have an "ideas book" where the consumers can enter topics that they would like discussed. This commonly leads to—"What a good idea; when/how are you going to present it?"

We do not believe that any one format is particularly appropriate to this form of postgraduate education. We use the formal lecture by the respected specialist from the teaching hospital, who arrives and impresses us with his account of the recent advances in his specialty. We have case presentation by GPs, singly or jointly with a consultant. We encourage topic presentation by a pressure group (or individual), such as the gynaecological oncologist who wished to improve the service that the cervical cytology unit was providing, and the lady from the health education centre who was feeling neglected by the town's general practitioners. We have seminars and discussion groups, and each term one "slot" is reserved for a presentation by one of the general practice vocational trainees in the town. This innovation has been particularly successful. We have occasional half-day and full-day symposia, usually funded by a pharmaceutical company, whose help and generosity we happily acknowledge. One recent innovation has been a series of "plain man's" guides to various aspects of advanced technology—for example, M-mode echocardiography (*Update* 1 May 1982). General practitioners are interested in these advances, and greater understanding leads to a sensible use of these facilities and this in turn leads to better patient care, which is, after all, our prime objective.

The supper colloquium was introduced by the previous clinical tutor and has been continued. This is held once a term and is limited to 12 doctors on a first come, first served basis. We provide an excellent three course meal, accompanied by the appropriate wines. The colloquium starts with the port and is the part of the proceedings whereby the invited prestigious guest pays for his supper by leading a round-the-table discussion on his chosen topic, or indeed, on whatever subject the guests introduce and the host allows. We rarely finish before midnight and many of our speakers have commented on this civilised and painless method of continuing medical education.

The activities so far described are perhaps more appropriate to the needs of the general practitioner and are enhanced by the attendance of hospital doctors and others. General practitioners are as welcome to attend the other programmes produced at the centre and do. Each of the hospital disciplines contributes to the educational programme, which in turn is often interdisciplinary—such as joint meetings of obstetricians and paediatricians, or surgeons and radiologists, or pathologists and physicians. Radiologists, haematologists, and pathologists give seminars to trainee physicians and surgeons to help them to prepare for higher examinations. The centre extends its aegis over activities held in the local practices and in the other hospitals in the area.

There is a general practitioners' workshop that meets fortnightly in the evenings, rotating through the practices and health centres of the group members. General practitioners in the northern region have become much more concerned in providing their own continuing education and there are advantages in basing some of these educational facilities in the practice premises. The timing of the session can be decided by the group, and many of the group activities would be impossible in the constraints of the 1/3 lunchtime session. There are obvious benefits to be found when general practitioners willingly expose their premises and organisation to the critical gaze of their peers. It is interesting that there are regular attenders at the workshop who rarely attend the postgraduate centre and, of course, vice versa. We believe that continuing medical education should not be provided only at the postgraduate centre and its lecture theatre or seminar rooms. There are advantages in using the work places of those for whom we, in the centre, have an educational responsibility. It is our fond belief in Gateshead that the hospital-based clinical tutor and the GP course organiser working together from a district postgraduate centre is more effective, and indeed cost effective, in providing continuing medical education for all the professional groups who provide patient care.

The problems—the future

The difficulties created by the inadequate building should be solved when the new teaching centre on the Queen Elizabeth Hospital site is commissioned in 1985. The solution to other problems is not so obvious. Despite our policy of encouraging participation by all doctors in the district and our attempts at making the centre an enjoyable place to visit, we still cannot reach more than a small proportion of doctors, particularly family doctors. We tend to see the same loyal, familiar faces week after week. Greater centralisation of acute medicine and surgery in the near future should help, particularly in regard to the hospital junior staff. The clinical tutor tends to emerge from the depths of the hospital rather than from general practice and thus may not have the necessary training that the job demands, even though he or she may have particular experience in a specialty. In the next few years, for instance, there will be a greater demand for more up-to-date and accurate advice to junior doctors because of the changes in staffing structure. We feel that the clinical tutor may gain from having more detailed in-course training than is now available through the regional meetings of clinical tutors and the National Association of Clinical Tutors. The general practice course organiser has already received some instruction in educational methods. The clinical tutor, like many other doctors in similar positions, is regarded as being omniscient.

Training for General Practice

Whether we like it or not it is now impossible to enter general practice as a principal without three years' postregistration experience in approved posts—approved, that is, by the Joint Committee on Postgraduate Training for General Practice. The JCPTGP has produced a booklet, *Training for General Practice,* in the hope that it will provide an authoritative guide to vocational training. It is slim but ambitious, attempting to cover everything from the organisation and aims of training to the philosophy of general practice. It reads like a policy document: this is training as the JCPTGP would like it to be rather than training as it is. There can be few vocational training schemes that meet the idealised criteria we read here. How many schemes have obstetrics as part of the hospital rotation, for instance? How easy is it for the aspiring GP to gain obstetric or other experience if he is one of the many who are unable or unwilling to join a formal training scheme? Hospital consultants who are sympathetic to the needs of trainees and GP trainers who regularly give five hours of teaching a week are, I feel, less numerous than the booklet would have us believe. As for the trainees who are able to find time to do "the occasional evening surgery" and "attend practice meetings" while also doing a busy hospital job. . . .

The JCPTGP acknowledges that a vocational training scheme can do no more than provide the trainee with learning opportunities, and it is up to him whether he takes them or not. None the less it believes that a compulsory period of postgraduate training will produce better GPs than did the less structured approach of the past. Whether you share this view or not, if you are thinking of entering general practice it is worth flipping through this booklet to see what vocational training is supposed to offer. There is guidance for those who have not had formal training, and the complexities of the certification system are unravelled. The list of useful addresses is exhaustive, and the suggested reading list is exhausting. Doctors who have already started their training might find it interesting to compare their experience of reality with the worthy theorising of the JCPTGP. Indeed, anyone with an interest in vocational training should read this booklet. But have a salt cellar handy.—KEVIN ILSLEY, general practitioner, Bromyard, Herefordshire.

Training for General Practice; £1; available from regional advisers or from the Joint Committee on Postgraduate Training for General Practice, 14 Princes Gate, London SW7 1PU.