How to do it

Chair a committee

A G W WHITFIELD

British Medical Journal, 1978, 2, 936-937

Committees are like funerals. We all have to go to them and the older we get the more there seem to be. Moreover, increasing seniority shortens the odds of being the reason for the funeral or the chairman of the committee.

Regional and area medical officers, deans and postgraduate deans inevitably spend a good deal of their time in the chair at all sorts of committees, but there is no riding instructor to help them; they have to teach themselves the art of chairmanship. Nevertheless, they soon learn that the purpose of many committees—whose tedious deliberations occupy precious time—is merely to disseminate information, to sense feelings on various issues, and to give token recognition to democratic management (no important decisions ever being made during the proceedings).

Be prepared

It is easier and more efficient to have a regular day and time for meetings—for example, if they are monthly, “the first Thursday at 5 pm.” Many important factors must be considered in making such an arrangement, including your own certain availability and that of the secretary, the convenience of the other members, the freedom of the room in which your meetings are held, and the dates of meetings of any higher authority who may receive copies of your minutes for consideration. Once such an arrangement is made it should not be varied. As there are now so many public holidays on Mondays and Tuesdays there is something to be said for avoiding these days. At the first meeting you chair, it is wise to agree on who is to be deputy chairman; this should give you a valuable ally as well as ensuring that if you are ill and cannot attend the business of the meeting may proceed as usual.

The agenda should reach members long enough before the meeting to allow them to study and consider it, and obtain such further data regarding any particular item that they may wish. Every attempt should be made to avoid sending out supplementary papers subsequently, or placing them on the table at the meeting—in these circumstances they often cannot be adequately studied by members.

Make sure that the secretary knows to what address members wish their correspondence sent and they should be asked in writing to let the secretary have any matters they wish placed on the agenda at least four days before it is due to go out. Most of the business, however, will derive from the main function of the committee and will come directly to you, as chairman, or to the secretary from other sources.

As chairman, you should have two agenda meetings with the secretary—the first to discuss the draft agenda before it is typed for circulation, and the second a day or so before the meeting to decide how to handle each item. A well-recognised ploy is to put the more contentious items late in the batting order as, by then, some of the members may be either running out of verbal energy or beginning to think about their dinner. Not infrequently, it is necessary for someone who is not a member of the committee to attend for one particular item and, when this is so, it should be put as early as possible on the agenda so that the guest may leave immediately after it has been considered.

A wise chairman provides morning coffee or afternoon tea before the meeting and sherry, or some other reviving liquid, afterwards and he should be there in plenty of time to welcome early arrivals and stay until the last member leaves. This helps to establish warmth and friendship, and makes the committee work better. Moreover, some members may have travelled a long way.

The success of every meeting depends entirely on how much time and care you and your secretary give to it in advance. One sees chairmen arrive breathless at the last moment and, as soon as they sit down, it is obvious that they are taking the meeting blind; they haven't even looked at the agenda before coming. Inevitably in such circumstances everybody's time is wasted and nothing worth while emerges. Well before the meeting difficult items should be fully discussed with those most concerned, their views obtained, and you, as chairman, should decide what position you feel you should take in the matter and endeavour in further discussions to secure as much advance support as possible. After as few as three or four meetings you will be able to predict accurately what each member will say about any matter to be considered.

Each member plays a part

The business must start promptly at the appointed hour and should never last longer than 90 minutes, preferably much less. After an hour-and-a-half concentration and patience rapidly diminish. Your first words should be to welcome members, particularly new members, and to thank them for coming, and your last words should be to thank them again. Remember that you, as chairman, are the only member who may interrupt a speaker, but this must be done only when it is obvious that otherwise he will never stop. It is important that all members should take part in the proceedings and if, by half way through the meeting, a member has said nothing it is courteous for you to ask his comments on some suitable item. A member may have special knowledge or experience relating to an item on the agenda, or a decision reached may affect a member's work or department. In either circumstance, you would be wise to ask him to open the discussion and to speak again when others have voiced their opinions.

If, after 10 or 15 minutes on any item, it is obvious that no

consensus decision is going to be reached the best course is to thank members for a useful discussion and say that you will put the matter on the agenda for the next meeting for reconsideration. You may think it helpful to ask any member who has been particularly vocal to prepare a paper on the subject for that meeting. Alternatively, if it is an important matter, you can set up a subcommittee or working party or, if it is of little consequence, you can offer to reconsider it should the need arise.

The draft minutes should be sent to members within three or four days with a courteous letter thanking them again for attending and asking them to let the secretary have any amendments they wish made. Sometimes a member of your committee

may never attend. Possibly he has another standing commitment at the same time which is more important to him, or he may just be too busy. If he never sends an apology, however, it means that he has no real interest in the work of the committee. In either case you should write to the body he represents, pointing out the difficulty, and asking if they wish to make another nomination.

Finally, as chairman, don't expect any plaudits or gratitude but be prepared to dodge brickbats, for even if all your committee's decisions are the right ones they will displease a few.

Eventually this series will be collected into a book and hence no reprints will be available from the authors.

Clinical Topics

Early detection of scoliosis

JOHN S BELSTEAD, M A EDGAR

British Medical Journal, 1978, 2, 937-938

Adolescent idiopathic scoliosis is usually a right-sided curvature of the lower thoracic spine that affects mainly girls. It leads to a cosmetic deformity and in severe cases to respiratory impairment and premature death. The deformity usually deteriorates during growth, especially during the adolescent spurt.

The quoted incidence varies from 0.13%¹ to as much as 13.6%², but the incidence of curves needing treatment is about 3-6 per 1000.³ In 1968 Wynn-Davies⁴ showed an increased incidence of adolescent idiopathic scoliosis in siblings of patients with the condition. In 1972 Cowell *et al*⁵ showed that by examining siblings' curves scoliosis could be detected at an early stage, with the result that management was made easier. Since then they have extended their screening to include adolescents at school so that adolescent idiopathic scoliosis may be diagnosed as early as possible. The curvature is readily detected clinically by bending the patient forward and looking for rib asymmetry.

To investigate at what stage and by whom adolescent idiopathic scoliosis is diagnosed in the UK we reviewed the records of patients who attended the scoliosis unit at the Royal National Orthopaedic Hospital, London.

Patients and methods

Details of new patients who attend the scoliosis unit are recorded on data sheets, which are then stored in a computer. This information includes the age when the deformity was first noticed, the person who made this observation, and the Cobb angle of the curve on

the initial anteroposterior spinal radiograph taken with the patient standing.

The relevant data from 260 patients with adolescent idiopathic scoliosis who attended over the past five years was retrieved from the computer.

Results

Of the 260 patients, 200 were girls. The average age of the whole group was 14 years (range 10.6-20.1 years). The patients were divided into four groups depending on how the curve had first presented. Most patients were referred to the scoliosis unit shortly after the curve was detected: group 1 comprised those whose condition was discovered by a doctor, usually the general practitioner, during an examination for another reason; group 2 those whose scoliosis was diagnosed at a routine school medical examination; and group 3 those whose curve was first noticed by family or friends. Group 4 comprised patients who were referred to the scoliosis unit late, after treatment or observation elsewhere.

The number of patients in each group, their ages, and the Cobb angles of their curves are shown in the table.

Details of patients referred to scoliosis unit with adolescent idiopathic scoliosis

Group	No of patients	Mean (±SD) age (years)	Mean (±SD) Cobb angle	% Under 40°
1	22	14.1 ± 1.0	56 ± 18	12
2	21	12.9 ± 1.0	49 ± 15	25
3	172	14.0 ± 1.8	56 ± 16	15
4	46	15.5 ± 1.5	65 ± 20	5

Discussion

Conservative treatment of adolescent idiopathic scoliosis using modern cosmetic braces or domiciliary Cotrel traction is most effective with curves of 20° to 40°. Most curves with a Cobb angle over 50° should be treated surgically by correction and fusion with a Harrington rod, particularly if the patient is still growing. Almost all the Cobb angles in patients referred to the scoliosis unit came within the surgical range; even

Westminster Hospital, London SW1
JOHN S BELSTEAD, FRCS, senior registrar in orthopaedic surgery
Royal National Orthopaedic Hospital, London W1
M A EDGAR, MCHIR, FRCS, consultant orthopaedic surgeon