College of General Practitioners for their assistance with the literature search and to Mrs Joyce Jacobs for typing the manuscript.

References

- 1 Metcalfe DJH. Changing to problem oriented records. *Update 1978*; 12: 92-8.
- 2 Tait IG. The clinical record in British general practice. Part 1—A practical scheme for reform. *Br Med J* 1977; 94: 883-8.
- 3 Bull MJV. A simple problem oriented record card for general practice. *J R Coll Gen Pract* 1977; 27: 522-4.
- 4 Tomson P. Medical records VI. Multi-coded group practice. *Br Med J* 1981; 282: 1438-41.
- 5 Danthi A. Improving clinical record keeping. *Update 1978*; 14: 263-4.
- 6 Marsh GN, Thornham JR. Changing to A4 folders and updating records in a "bush" general practice. *Br Med J* 1980; 281: 215-7.
- 7 Gormick JJC. A4 folders—a step into the present. *Br Med J* 1981; 282: 943-5.
- 8 Tait IG. Medical records in a large practice. *Br Med J* 1981; 282: 1203-4.
- 9 Zander LJ. A framework for establishing a record system. *Br Med J* 1981; 282: 934-4.
- 10 Stuart D. Practical problems of improving records. *Br Med J* 1981; 282: 934-4.
- 11 McGee RW, Flood RAW. The Weaver index and register. *Practitioner* 1981; 225: 613-4.
- 12 Zander LJ, Berridge S, Thomas P. Medical records in general practice. London: Royal College of General Practitioners, 1978.

The Course Organiser

Day-release courses in the West Midlands

G W THORPE

Training courses for doctors who plan to enter general practice have changed over the past 10 years. This is because more doctors are training for general practice and also because there is a better understanding of teaching methods and of what is required to adapt the knowledge and experience that has been gained in hospital to a career in general practice.

The West Midlands Regional Health Authority covers 5000 square miles, much of it heavily industrialised but also containing country towns and farming country, and has a population of 5m, 2500 principals in general practice, and 130 trainees in general practice and twice that number in hospital posts. The logistic problems of organising effective courses are considerable.

In 1969 Dr Robin Street of Worcester started a voluntary half-day release course for trainees in general practice in the West Midlands, based on the university centre in Birmingham, travelling expenses and lecture fees being covered by section 63. It was realised very early that the strength of this course lay in providing a forum for discussion between trainees not only of problems concerning their training but also of their approach to all aspects of patient care. The first course in Birmingham was appropriately called "Orientation to General Practice" and consisted of informal lectures and discussions on clinical and

- 13 Nicol HE. Culling quality. *Br Med J* 1981; 282: 1091-2.
- 14 Royal College of General Practitioners and Office of Population Censuses and Surveys. *A classification of morbidity for morbidity statistics from general practice*. 3rd national study. London: RCGP, 1981.
- 15 US Department of Health, Education and Welfare. *National ambulatory medical care survey*. Washington DC: US Government Printing Office, 1974. Series 2-61.
- 16 World Organisation of National Colleges and Academies of General Practice. *An international classification of health problems in primary care*. Occasional paper No 1. London: Royal College of General Practitioners, 1978.
- 17 World Health Organisation. *An international classification of disease*. Geneva: WHO, 1967.
- 18 Hall JM. Disease coding in a problem oriented general practice. *J R Coll Gen Pract* 1974; 24: 469-75.
- 19 Clark EM. Disease coding in a problem oriented general practice. *J R Coll Gen Pract* 1974; 24: 469-75.
- 20 Dobson Smith WE. A classification of permanent and significant disease for general practitioners. *J R Coll Gen Pract* 1976; 26: 934-7.
- 21 Knight/Jones P. Classifying disease in general practice. *J R Coll Gen Pract* 1977; 27: 232-4.
- 22 Martin CJM, Clayton AD, Turner ID. A comparison of three systems of classifying presenting problems in general practice. *J R Coll Gen Pract* 1977; 27: 236-40.
- 23 Kuper P, Malek U, Olsen OM, Pedersen PA, Schramm J, Tesing WONGA. Disease classification for use in general practice. *Uganda Lancet* 1977; 138: 1614-23.
- 24 Campbell JK. Improving records in a group practice. *Br Med J* 1981; 282: 1126-8.

(Accepted 11 May 1982)

allied subjects. Consultants and general practitioners made about equal contributions. Some of those who attended the early years of this course will remember the lively discussions, which were often continued into the evening at a local hostelry. With increasing numbers of doctors the training and the need to keep discussion groups to a manageable size, weekly courses have been developed in nine centres in the region and local course organisers are paid on a sessional basis. This has reduced time spent in travelling and encouraged local expertise.

During the early 1970s interest developed in teaching in small groups, where members of the group are encouraged to discuss their own experiences, thus learning from each other. In 1969 Dr Robin Street of Worcester started a voluntary half-day release course for trainees in general practice in the West Midlands, based on the university centre in Birmingham, travelling expenses and lecture fees being covered by section 63. It was realised very early that the strength of this course lay in providing a forum for discussion between trainees not only of problems concerning their training but also of their approach to all aspects of patient care. The first course in Birmingham was appropriately called "Orientation to General Practice" and consisted of informal lectures and discussions on clinical and

allied subjects. Consultants and general practitioners made about equal contributions. Some of those who attended the early years of this course will remember the lively discussions, which were often continued into the evening at a local hostelry. With increasing numbers of doctors the training and the need to keep discussion groups to a manageable size, weekly courses have been developed in nine centres in the region and local course organisers are paid on a sessional basis. This has reduced time spent in travelling and encouraged local expertise.

During the early 1970s interest developed in teaching in small groups, where members of the group are encouraged to discuss their own experiences, thus learning from each other. In 1969 Dr Robin Street of Worcester started a voluntary half-day release course for trainees in general practice in the West Midlands, based on the university centre in Birmingham, travelling expenses and lecture fees being covered by section 63. It was realised very early that the strength of this course lay in providing a forum for discussion between trainees not only of problems concerning their training but also of their approach to all aspects of patient care. The first course in Birmingham was appropriately called "Orientation to General Practice" and consisted of informal lectures and discussions on clinical and

Solihull, West Midlands B90 1JH
G W THORPE, senior general practitioner

Organising a Practice

Auditing practice organisation

A J M CAVENAGH

"They must be joking," was my immediate reaction to the invitation to contribute this article. Perhaps my blood ran a little higher than normal. I had been bemoaning the quality of our practice records over coffee, and it seemed that organising our practice, let alone auditing its organisation, lay far in the future. Characteristically, it was our senior, and in many ways most revolutionary, partner who brought me back to earth, his own vocational training had included a spell as a beachmaster in the second world war, and he has, I suspect, been undismayed by chaos ever since. "You don't remember the days when patients were let in by the maid, and all the incoming letters were simply stacked in a drawer," he said. "We've come a long way since then. It was the shortage of good maids which began it."

Nearly 30 years later the organisation of our group practice seems still to be limping out of the maid-and-drawer era, and the blame for this state of affairs has to rest squarely with us. We have failed to grasp the elemental truth that if you must choose between good organisation and advanced medical knowledge, the decision should go to the former. Without organisation what medicine you know cannot be delivered; expectations are disappointed, and misery results—witness the plight of our colleagues in orthopaedics who have been buried in their own cement. The wonderful advance of hip replacement is a tantalum to many of its would-be recipients who perish before they can receive it. Shortcomings in our own organisation stem from failure to ensure thorough delegation of duties, failure of in-service training, and failure to provide adequate nursing and office accommodation. We had simply trusted that good administration would prove to be an easily found trace element, whereas it is actually extrinsic factor—without it the whole organism is doomed to morbidity and early death.

"What we need is a five-year plan," said our Stakhanovite. Yet "audit" still makes the hackles rise. Dudley has described its progress from dirty word to bore, and I suspect that only when it slips into the subconscious will it really become useful. A waiting list is one of the luxuries general practice has to forego; whatever happens today must be dealt with more or less at once. But the treadmill of activity thus generated often precludes constructive planning, putting us in the admirable company of most general practitioners in the United Kingdom. Our practice consists of seven partners and two trainees, and any distinction it might claim derives from our GP hospital and, arguably, from what we do there. Our mediaeval premises became a pub in the eighteenth century and are still the theatre of alteration after 20 years as a group practice surgery. What follows are the conclusions of several sessions of collective discussion and brain-storming—definitely the substance of things hoped for.

Brecon, Powys
A J M CAVENAGH, BM, DRCOG, general practitioner

Working conditions and timetables

Three-quarters of our discussion centered on working conditions for the staff and the waiting room are produced when only three to four doctors are present. Outside commitments, in our own or neighbouring hospitals, administrative meetings, and holidays were havoc with this arrangement. Henceforth a rub-out board in reception will give details of each doctor's whereabouts for the next fortnight. (Routine timetable in black and alterations in red.) Intercommunication in the surgery will be facilitated by an enlarged and much more expensive telephone switchboard, with "dialling out" facilities for each doctor, which will be a major saving of telephonist's and doctor's time. Most of our useful intercommunication occurs at off-ice-time each morning, and a better timetable will improve attendance.

Although we have six consulting rooms, the optimal conditions for the staff and the waiting room are produced when only three to four doctors are present. Outside commitments, in our own or neighbouring hospitals, administrative meetings, and holidays were havoc with this arrangement. Henceforth a rub-out board in reception will give details of each doctor's whereabouts for the next fortnight. (Routine timetable in black and alterations in red.) Intercommunication in the surgery will be facilitated by an enlarged and much more expensive telephone switchboard, with "dialling out" facilities for each doctor, which will be a major saving of telephonist's and doctor's time. Most of our useful intercommunication occurs at off-ice-time each morning, and a better timetable will improve attendance.

Records and repeat prescriptions

We have had a good deal of stick from our regional adviser on these. Initially, we shall keep the Lloyd George envelope and contents, train our staff to winnow this down to size as suggested by Marsh,¹ and follow Campbell's² recommendations on sorting the contents. Maintaining the records will require at least one extra secretary/receptionist, who will be recruited as soon as we have adequate space. Working conditions for our receptionists have been positively Victorian, but an enlarged reception office, a separate records room, and a sitting-room—where they can briefly get away from it all—will change all this. Once the clinical records are in order we can proceed to compile a proper E book and morbidity register and start to make some constructive use of our age-sex register, which was completed last year.

Our repeat prescription card has been a failure, and if a patient is not in it possibly due to a frustrating hour of day writing repeat prescriptions, most of the time being wasted checking drug and dosage in the records. A window in "reception" will henceforth be devoted solely to handling prescriptions, and we shall ask for written requests only. All will be entered chronologically in the patient's notes, and a record of those on long-term treatment will be established to reduce the present lamentable lack of surveillance.

For me, after 15 years in practice away from medical school, postgraduate teaching presented various problems. The feeling that the doctors who I was to teach were in much closer contact with new aspects of medicine, and their theoretical knowledge more up to date, was at first threatening. I was able to accept, however, that from my own experience I had something important to teach about the application of knowledge and providing patient care and that teaching and learning at its best is a two-way process. I have often found difficulty in enlisting the help of either medical or lay authorities to lecture or lead a discussion on a topic relevant to general practice, because they lack personal experience of general practice their remarks may have little relevance to day-to-day patient care. It is interesting to find that a contribution that I thought was valuable received a low rating from the course members—and sometimes the other way round. On reflection, this only highlights the different needs and interests of young and older doctors; it does emphasise, however, that it is important for trainees to have a large say in the content of courses arranged on their behalf, and also that the gap in age between teachers and trainees should not be too wide.

As family doctors we should be good listeners a. well as advisers, but working in small groups I found it difficult initially not to provide both question and answer for the subjects under discussion, thus negating the idea of the group assessing and solving problems for themselves. To prepare a lecture or talk requires thought and time. To answer questions helpfully after such a talk is a test of one's own experience of the subject. To lead a small group discussion on the same subject requires experience and time spent in preparation, with clearly defined aims in mind; the way to achieve these aims must be clearly thought out and based on the experiences of those in the group.

In addition to the weekly half-day release courses a series of optional symposia are held in the West Midlands that introduce subjects which are particularly relevant to general practice and in which some trainees may have little previous experience. These optional courses cover family planning, geriatrics,

rheumatology, psychiatry, practice finance and organisation, industrial medicine, the MRCPG examination, orthopaedics, diabetes, ophthalmology, dermatology and ENT, and psychosexual medicine. There is also an extended course in paediatrics. There is some debate as to how much time a doctor in training should spend away from his or her training practice without losing the continuity of care which it is so important to experience and not to miss the frequent but important occurrence such as an unusual collapse, a mentally disturbed patient or an acute social problem. Courses, however good, can only supplement the year's general practice experience and this should always be kept in mind. In many parts of the country release courses for doctors in hospital training schemes aimed towards general practice are run successfully. Such schemes in the West Midlands have had some success, but conflicting interests make regular attendance difficult. There are, however, obvious advantages in having contact throughout the training period with the ultimate reality of the work for which the training is designed.

Taking time out of my practice has presented some problems, and could have been done only with the support of family and partners. Now that vocational training has an established place in medical education, payment on a sessional basis makes course organising financially viable. It still calls for the continued support of both family and partners, and spending extra hours to maintain the continuity of the care of one's patients.

I believe that the purpose of vocational training for general practice is, firstly, to reorientate previous knowledge and experience to deal with people in their own families and homes; and, secondly, to encourage those in training to recognise areas where their previous experience has been weak and to make these good; and thirdly, to be introduced to all aspects of running a general practice, including the financial and legal implications of employing staff. This can be done only within the framework of a working practice, but having the opportunity to stand back and discuss the issues with contemporaries and others of longer experience can only add to the value of the training.

"Why, she could not eat." On these premises I was to undertake to cure a patient who, for aught I knew, might be at that moment in *articulo mortis*. I visited my patient, whom I afterwards found both old and ugly, but I was doubtful on one point: to see no part of her form: she insisted on my ascertaining her disease with a door between us, the being in one room and I in another. . . . I however could not collect enough from the attendants as to cause me to suspect she had a cancer; and I did all, under such circumstances, that I could well do. I gave her an opiate. This lady was no sooner prescribed for than my attention was directed to the youngest wife, who was pleased to need advice, though her sparkling eyes and smiling lips denoted little of disease. She was extremely pretty, and removed her veil with such confidence that I could not but be struck by her beauty. . . . I ordered her some medicine which I am sure she did not take, and which, in all probability she did not require. . . . I cannot conclude without telling you how all Frank medical men are teased by the Turks for apothecaries, who they denigrate as *madmen*. I am solicited for it at every corner, and it is lamentable to observe that hardly a man arrives at the age of five-and-thirty, whose deaucheria has not been rendered debilitated, and dependent on adjuvantive excitement for his pleasures. (*London Medical and Physical Journal* 1829;7:374-8.)

THE GENERAL PRACTITIONER. I wish by no means to underrate the character and importance of the general practitioner. We are a body of men who exist because the wants of society have raised us up. The pure practitioner of surgery, or of obstetrics, can subsist only in a populous city. The physician, indeed, earns his bread in the country; but there is room for one physician only there; whereas there may be twenty general practitioners. (*London Medical Gazette* 1830;8:620.)

Appointments system

To audit the appointments system also needs better records. At present, the day's appointments are simply listed on A4 paper in a loose-leaf folder for each doctor, running up to a month ahead. At least 50% of appointments are made by telephone and our revamped "reception" will have three telephones on the counter instead of the one we now have. We have no record of whether the patient saw the doctor with whom he is registered, or whether he was fitted in as an emergency with another doctor. From the customer's point of view most important of all—we have not yet adopted the common transatlantic practice (typical of the impatient society) of registering the time of arrival and the time seen, which has a galvanising effect on all concerned.

Referrals, library, and training

A significant minority of referrals are inevitably informal, by telephone as an emergency. Kyle's report,³ however, is now more than 10 years old and due for repetition. Even with improved clinical records, a prospective study will be necessary to be fully comprehensive, and the part-time help of an additional secretary will be required.

Two members of the practice constitute the library sub-committee, charged with the task of updating the library and preventing depletion. They are generally successful, and a collection of text books relevant to general practice and teaching. The hospital, which is empowered to spend a fixed sum on books annually, can contribute its own library facilities on special topics. An index of the library and a record of loans will be essential to its survival.

We have now reached the indefensible position of depending heavily on our trainees for the service we provide. But the unhappy trainees here have been those whose work load was deliberately reduced. The requirements of trainees vary so much that only regular discussion can make sure that their needs are met, and even this sort of meeting can lapse if not regularly scheduled. A training diary, listing topics covered and outside activities (such as special clinics attended), will make for much better use of time all round. The long-term and short-term objectives of each trainee's year need continual review and the timetable adjusted.

Medical students

Attachments of medical students are increasing annually, but we have run these on a hand-to-mouth basis with little forethought. If we believe (a) in our style of practice and (b) that the subversion of youth is a legitimate aim, then we must give more time and thought to the individual student's programme. Most career choices are made by the third clinical year. The earlier in their programme that students are attached, the greater the likelihood of their opting for family practice. More time, however, must be allowed for teaching at this stage. All the students have wished for more direct patient contact than we have given them hitherto, and this must be planned. Our visitor's book is essential for follow-up. Individual diaries and comment provide a valuable record of what has been achieved during the visit and a spur to improvement. Students pull few punches!

Building and finance

Our old pub still has a long way to go before it has been fully exploited. We shall use the whole ground floor with its recent extension of four consulting rooms and a waiting room for clinical purposes, upstairs to be reserved for administration and accommodation. Ultimately all improvements must be

self-supporting. Like most doctors, our business acumen is pathetic. Our accountant, however, is committed to making the whole building earn revenue, as notional rent or otherwise, and will review progress annually. The illness of one partner led to a review of our life and sickness policies, which had become hopelessly outmoded by inflation. Simultaneously the value of our premises has risen, and both these vital factors will henceforth be reviewed regularly.

The appointment of a practice manager six months ago has greatly improved our office organisation, exemplified by a typed agenda and minutes at practice meetings. He came to us from the clear-thinking realms of the construction industry, and it is a hard job to see how we ever managed without him. More and more problems are simply piled on to his willing shoulders. Though the most modest of men, he confessed recently that his efforts at improving business methods and financial management have so far saved the practice more than his salary costs us. Now that the supply of experienced executives is better than ever, it is surely the time to encourage other practices to follow suit.

Perhaps it all began with the shortage of good maids, but the wheel of progress has almost turned full circle. The capped and aproned helpers of yesterday are now in their 40s, and many of their own choosing and are far more concerned in the running of the practice than they were. Were our predecessors to leap from their pictures on the library wall, they would recognise nearly everything we are doing, and most of our patients. Deliberate organisation, planning, and audit might have been foreign concepts to them, but they had a more personal knowledge of their patients than most of us will ever achieve. I hope we shall remember this as our five-year plans unfold.

References

- 1 Dudley HAF. Self-examination in vogue. *Br Med J* 1981; 282: 47.
- 2 Marsh GN, Thornham JR. Changing to A4 folders and updating records in a "bush" general practice. *Br Med J* 1980; 281: 215-7.
- 3 Campbell JK. Medical records III Improving records in a group practice. *Br Med J* 1980; 282: 1126-8.
- 4 Kyle D. Contribution to a general-practitioner hospital. *Br Med J* 1971; 1: 148-51.

FEIGNED DISEASES. The following extract from a rare book, called the *History of Knavery*, may give an idea of the art that is frequently practised by rogues. It is a notice published in the year 1702, and in the following words:—"That people may not be imposed upon by beggars, who pretend to be lame, dumb, etc. who really are not so, this is to give notice to the public that the following rogues are doing their utmost to deceive the public. The first is a man called Richard Alegh, a boy of eleven years of age, who pretended himself lame in both legs, so that he used to go along on his knees, they were covered with his legs and turned backwards, so that he never used them from that time to this, but followed the trade of begging; that he usually got five shillings a day sometimes more; that he had been over all the counties, especially the west of England, where his brother carried him on a horse, and pretended he was born so. He hath also given an account that he knows of other beggars that pretend to be lame and dumb, and of some that use their arms in their breeches, and wear a wooden stump in their sleeve. The said president and governors caused his legs to be set straight; and he has now the use of them, and walks upright." Savages, in his *Novels*, makes mention of a mendicant who gave to his child all the appearances of *hydrocephalus*, by opening the integuments of the head near the vertex, and then introducing air between them and the muscles. This infamous fraud was discovered by removing the patch which covered the hole, and prevented the air from passing out. (*London Medical and Physical Journal* 1823;8:361-64.)