except on special occasions, such as deciding on a new partner. Lunch-time meetings cannot resemble on indefinite occasions 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. The 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 paralysed about their work load. We all think we are working hard, but the partners, and it can be very satisfying 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 assistant. 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 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 Depart-

ment 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 are for the doctors, some 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 relax 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 speciality, 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.

References

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LIMITS OF MEDICAL ART. Whoever penetrates sufficiently far in the knowledge of physics 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 see 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. (*Gaestis of Health 1821* 3:630.)

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 advertisement.

The process of elimination started that day. When a large number of young doctors apply on time it is not for 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 is a bad thing. 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 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 in the earlier and more popular years. 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 paracetamol taste. 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 working 200 or 300 miles away and of whom I had no personal 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 fun to put in an interest of which the applicant knows little but thinks will sound good. The interviewing committee may well have in the local expert who will be able to discuss "wine making" or "pottery."

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 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.

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 far 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 it organised by the academic departments of the university. The emphasis is on interdisciplinary 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

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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.

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 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 allow 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 course 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 presentations 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 but many of the speakers are so contented in 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 scope 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

Training for General Practice

Whether we like it or not it is now impossible to enter general practice as a principal without undergoing an approved postgraduate training scheme—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 of training to the needs of the trainee. As for the trainers who are to take a policy document: this is training as the JCPTGP would like it to be rather than training as it is. There are few vocational training schemes that match the idealism we read here. It needs many schemes have obstacles 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 trainers who are able to find time to do the "occasional evening surgery" and "attend practice meetings" while also doing a busy hospital job...

their own continuing education and there are advantages in basing some of these educational facilities in the practice premises. The training of the general practitioner is 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 match the high 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.

The JCPTGP acknowledges that a vocational training scheme can do more than provide the training with learning opportunities, and it is up to us to decide whether we take 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 exhaustive. 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—*avert illat*, 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.