PRACTICE OBSERVED

The Course Organiser

Is there a need for a national association of course organisers?

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I have just returned from one of our Yorkshire course organisers' seminars, held in the College of Ripon and York St John. We usually meet every couple of months at the weekend to pool our ideas and help each other as course organisers for vocational training schemes in the region. Of course, these meetings have to be during the weekends "free" from our practices and inevitably at the expense of the time that we would otherwise spend at home with our families; but we—and, we hope, our families—have come to accept that this also is part and parcel of the job of being a course organiser.

This time, however, the meeting was tinged with sadness as we had just heard that another course organiser colleague, in his early 40s, had suffered a severe myocardial infarction. There was talk of surgery; there was uncertainty about his future and whether he would be able to continue to work; no one seemed to know.

I recalled that in the six years that I had been a course organiser there had been one case of severe hypertension associated with transient ischaemic attacks, two of myocardial infarction, one of myocardial infarction followed by bypass surgery and then premature retirement, and one death after a cerebrovascular accident among a group of 17 relatively young and active course organisers in Yorkshire. I do not know whether this is just an act of fate or whether there is an actual relation between the job and life expectancy. Perhaps this should be the subject of a national study, but whether any course organiser would live long enough to complete it is another matter.

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A new job description

It is, I believe, reasonable to suggest that the task of running a large vocational training scheme has become fraught with dangers and difficulties.¹ Amazingly enough, there is little information about the job apart from an outdated description, which now bears little resemblance to reality. At present, there are three main areas of responsibility for each course organiser.

Administrative—(1) Selection of relevant hospital posts and their further development to suit the training requirements of general practice. (2) Regular communication and liaison with hospital colleagues. (3) Selection of trainees, which has now become a time consuming and complicated task.² (4) Approval, appointment, and resumption of trainees. (5) Regular sorting out of the individual problems of trainees, hospital staff, trainers, and even family practitioner committees.

Educational—(1) Planning a curriculum of three years' duration. (2) Designing and running a weekly half day release course. (3) Organising monthly trainers' workshops. (4) Evaluating the trainees, trainers, and the course. (5) Active participation in regional courses for trainers and trainees.

Advisory—(1) Counselling those doctors who seek a change of career. (2) Advising those doctors who wish to enter training for general practice. (3) Active participation in many local, regional, and national committees. (4) Liaising with many community organisations and bodies. (5) Research.

It may be surprising to learn that officially all this work is expected to be carried out in two sessions—that is, six hours a week—of which three hours are usually spent at the half day release course. Perhaps we should question the wisdom of those who, without consultation, managed to negotiate such an open ended contract for their course organiser colleagues.

At our meeting last weekend there was the usual explosion of anger about the increasing amount of work expected of course organisers without a corresponding increase in the resources allocated to them. It seems that a job that started in the mid 1970s as a labour of love has now grown out of all proportion,

demanding more time and more sacrifice from the few enthusiasts. Although it is undeniably true that most course organisers enjoy their work, this cannot hide the fact that there is now an urgent need for radical reappraisal of their problems.

Firstly, I believe, there should be a new job description with a clear definition of areas of responsibility. Secondly, there should be, both locally and nationally, more educational and organisational support for course organisers, who are otherwise isolated. Thirdly, in view of the obvious difficulties in finding suitable candidates for the post, proper opportunities should be created for training new course organisers. Fourthly, it should be realised that no course organiser can discharge his many duties satisfactorily in only two sessions a week. The lack of flexibility in the number of sessions for which a course organiser can be appointed, and the linkage of the rate of remuneration to that of trainers, should stop.

The next stage of the campaign

I suggested to my course organiser colleagues in Yorkshire that

the time was ripe for the formation of a national association of course organisers that could, among other things, focus attention on our plight. There was unanimous agreement, and, happily, a steering committee for the association will now meet in London on 9 December 1983 to plan the next stage of the campaign. Before we left Ripon College, however, one course organiser colleague asked us to pose for a group photograph. We all did so. Sadly, I could not help but wonder of the many smiling faces in the photograph how many of them will still be there next time, when we meet again.

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Interesting GPs of the Past

A "Taylor made" practice

STEVEN WILLIAMS

Born in Northumberland in 1862 of humble stock, the young Henry Pearson Taylor was possessed of a short stature and pugnacious temperament. Academically undistinguished at school, he first trained as a chemist and druggist. Having been put on a shortlist of three out of 125 applicants for interview (times do not change), he was appointed as a dispenser at the Aberdeen Royal Infirmary. He admitted in later life to having disguised a black eye with watercolour for this occasion. Mixing with medical students and doctors gave him a desire to emulate them, and he studied medicine part time at Aberdeen University. The favourite of his classmates, he continued his dispensing to pay for his education. After leaving university he was only ever to meet two of his classmates again but corresponded with another about a patient.

Soon after graduating Taylor read an article by a colleague in the college magazine about his experience as a locum in Shetland. Being of an adventurous spirit, he was not deterred at the prospect of walking over barren hills in very bad weather and took up a locum tenens appointment there himself. He arrived in Mid Yell on 1 July 1900 to relieve the general practitioner, who was old and suffering from rheumatic fever. He stayed initially with a woman whom he described as "more like a mother than a landlady" and immediately fell in love with the beauty of the Mid Yell Voe. Later he was to fall in love and marry a woman from Mid Yell. The people of Yell and Fetlar, the practice population, liked him and petitioned

the parochial board to appoint him permanently, the old general practitioner being too ill to continue his duties. The board complied, and his initial salary was £55 a year for Yell and £15 a year for Fetlar. This was received for looking after pauper lunatics who could not pay doctor's fee and were compelled to "go on the board."

A life of hard work

Initially Taylor had to walk long distances to see his patients (the practice area is over one hundred square miles) and his first means of transport was a Shetland pony called Major. Unfortunately, the animal resented leaving home and had to be led to his destination. The return journey, however, was rather more comfortable. Major moving at high speed with the doctor on his back. Later he bought a bicycle and used this for three years. He then became the first owner of a car in Shetland but soon tired of its endless mechanical problems and invested in a motorboat in 1906, also the first in Shetland. In 1912 he became the proud owner of a Model T Ford car and never looked back. By then the road system, non-existent when he first arrived, had improved considerably. In that year he was also able to buy a motor boat to be used to visit Fetlar and coastal villages in Yell. No financial help was given to him in these purchases. If patients needed specialist inpatient treatment they had first to travel from Mid Yell in a rowing boat to board the *Earl of Zetland*. A four hour journey followed before Lerwick was reached, and then the patient would travel to Aberdeen by ship. This would take about another 14 hours. In 1924 a 31 year old girl underwent a two day journey by sea to reach Lerwick in Scotland. She was suffering from acute appendicitis and fortunately lived to tell the tale.

Hillend, Mid Yell, Shetland
STEVEN WILLIAMS, MR, MR, trainee general practitioner

FIG 1—Dr Taylor on his motorcycle, the first in Shetland.

Taylor commented on the courteous, hospitable, and civilised nature of the people of Shetland. He and his wife lived happily for many years at the "Haa of Resfirrh" in Mid Yell and are now both buried in the nearby cemetery close to the sea. Appointment systems were not operative in Taylor's day, and his household, now in her 80s, informed me that patients would arrive and be seen at the house at any time of the day or night. After his death Taylor donated the Haa to be used by the district nurse.

Taylor's hobbies included painting, and many of his beautiful watercolours are to be seen proudly displayed in the homes of the present day inhabitants of the islands. Model engineering was another beloved pastime, and an expert once remarked that a reflecting telescope made by Taylor was the best that he had seen from an amateur. It was not unknown for crews of ships with mechanical problems to ask his help.

The lack of government support for freight charges annoyed Taylor, who believed this to be a factor in the decline of the fishing industry in the northern isles of Shetland. Mid Yell Voe, an arm of the North Sea, is but a short distance from Whirlifish Voe, an arm of the Atlantic. Taylor had the idea that if they were joined together, at small expense, the power of the tide could be used to generate electricity, thus enabling pest to be produced on a commercial scale. This was never done, and commercial exploitation of the vast amounts of peat on Yell is still on a small and limited scale.

The waters around Shetland are some of the most treacherous in Britain, and Taylor often attended casualties from shipwrecks. He recounted a particularly sad incident of a German ship that went aground at Aywick in 1924, losing many lives. One brave young man went back into the sea three times to save his shipmates before finally drowning himself. The firebrand of the ship is still to be seen on the shore.

From an early age Taylor was a lover of animals and an antiscavengerist. The cost of bringing a veterinary surgeon to the islands was prohibitive to the poorer people, and on many occasions he attended to sick animals. On one occasion he splinted the broken leg of a horse against advice recommending that the animal be put out of its misery. Remarkably, the horse survived.

The good doctor was also the medical officer of health for the northern isles of Yell, Fetlar, and Unst. His duties in this capacity entailed writing an annual report for the local and central authorities on the health and sanitation of the islands. Often he reported the outbreak of infectious diseases such as measles, scarlet fever, or typhoid. Smallpox vaccination was compulsory but uptake was poor owing to the conscience clause. Because of the isolation of the islands diseases such as measles

were not endemic and, if brought to the islands, often by fishing boat, would spread rapidly and create considerable public health problems. Some cases had to go to the fever hospital at Lerwick. There was in fact a local fever hospital at Unst, but it was never used because staff could not be found to work it from among the locals. There was another outbreak of measles in 1977 and 1978, and attention was again drawn to the low degree of herd immunity and poor uptake of measles vaccination.

In his report in 1896 Taylor mentioned a rise in the incidence of illegitimate births on the islands. The fathers usually got off scot free despite attempts by the doctor to identify them. Taylor thought this responsible for the rise in immorality in his area.

Tuberculosis was still a major problem at that time and featured repeatedly in his reports. Most people believed it to be a hereditary disease and could not be convinced that poor housing and sanitation were responsible for intergenerational spread. He advocated building shelters separate from the house for the diseased person and once got a reprimand from the General Medical Council for allowing one of his patients to use an African herbal "cure" for the disease. Health education directed at children was seen by Taylor as the answer to the tuberculosis problem. He had foreseen the direction of future general practice philosophy, but according to people who knew him he was a chain smoker of cigarettes in a holder and would have made a poor modern day health education counsellor. Maternity cases were dealt with mainly by local women with experience of such work. Many of these women knew nothing of antiseptics but were aware of the value of cleanliness. Taylor said that he encountered very few problems and no maternal deaths during his long career on Yell. He thought that maternal mortality was a problem of urban rather than rural areas and hospital confinement not necessary for his patients.

The Dewar report³

The record of Dr Henry Pearson Taylor's spoken report to the Dewar committee at Lerwick town hall in 1912 makes interesting reading. This committee was set up as the result of the representations of members of parliament for the highlands of Scotland, who pointed out that the Lloyd George National Health Insurance Act was inappropriate for the people of the highlands and islands.⁴ The act applied only to men and women who were regular wage earners. The irregular and low income of the crofters made them very vulnerable but unable to qualify for the scheme. This all came at a time of great concern at the lack of good doctors and the low standards of medical care in the region. The only financial inducement for doctors to practise there was the occasional Poor Law patient; private practice was rare. Informal, unsatisfactory, and shortlived medical insurance clubs also existed.

FIG 2—The Haa of Resfirrh in Taylor's time.

FIG 3—A map of Shetland in Dr Taylor's time.

In his opinion, however, the people might object because of an increase in rates. This hospital has still not materialised, but something resembling it will open in March 1984, in the form of a continuing care unit with about 10 beds. This will serve three communities.

Lack of any holidays was mentioned as a problem by Taylor to the committee, and he stated that before then he had not had a break from work since 1902, when he gave evidence to the Royal Commission on the Poor Law at Edinburgh and received 10 days paid leave for doing so. Before that he had not had a break for 15 years. At that time, and to this day, doctors had to pay a large proportion of locum tenens expenses including travel to Shetland.

The conclusion of the Dewar committee, "from each according to his ability and to each according to his needs," was radical thinking for those days, but its proposals, to be implemented in the Highlands and Islands Medical Scheme, met with little resistance from the government. It was concluded that access to health care was a basic human right, and financial grants were made to realise this.

Owing to the first world war and the depression, however, it was 10 years before even some of the proposals, such as free houses for doctors and nurses, were considered. Most of the then substantial fund went on increasing doctors' basic salaries. The Highlands and Islands Medical Scheme did, nevertheless, revolutionise medical practice in the highlands and islands of Scotland. In the 1920s for the first time good doctors, and enough of them, became available. The Treasury doubled the grant in the 1930s with the proviso that it should be administered by the new local authorities, the aim being to reduce excessive expenditure. This resulted in a new hospital at Lerwick and a consultant surgeon being appointed. There are now two surgical teams in Shetland, the rest of the community and hospital care being carried out by general practitioners and community medical officers. Other specialists visit quarterly or monthly.

In 1948 the Highlands and Islands Medical Scheme was easily absorbed into the National Health Service, probably because it had already conceded the need for a centrally run health service.

Dr Taylor retired in 1935 owing to ill health. An article was dedicated to him in *Medical World*, praising him and admonishing the Department of Health for Scotland for not giving pensions to its poor country general practitioners.⁵ These doctors were not pensionable because they might also have private patients, a poor consolation to Dr Taylor in his retirement. He died at Gilbert Bakin Hospital on 23 June 1943 aged 82. His friend and colleague Dr Saxby wrote: "Only a country doctor, he has shown by his life of self sacrifice that no greater love hath any man than this, that a man lay down—that is, devote—his life for his friends."

I thank all the people in Yell who helped with this project.

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