

TABLE 11—Patients with hypertension treated by four doctors

	Dr A	Dr B	Dr C	Dr D
Total No. of patients on list	3002	2974	3362	2938
No with hypertension	111	97	109	101
No per 1000	37	33	32	34
Men	50	21	37	32
Women	43	26	74	53
England & Wales, 1971*	16.4			
Men	16.4			
Women	23.4			

* Mortality statistics from general practice, 1970-1.

visual display unit and printer, together with adapted software, cost roughly £5000. From the increase in income generated in the past two years (figs 4 and 5) it is clear that the expenses and outlay are at least covered.

For the National Health Service—Our experience shows that a

practice is able to organise its own immunisation and screening programmes. A cost conscious practice might find it difficult to do this when the alternative service provided by health authority facilities, together with the bureaucracy and central computing facilities that are required for operating the service, might be dismantled. Some of the savings would provide a capital fund (for computers or appropriate manual systems) to any practice showing a satisfactory response to their own programmes (such as a 90% rate for immunisations and an 80% rate for cervical cytology). In addition, community health physicians might then have more time and resources to fulfil their greatly undervalued potential as advisors to general practice.

I am grateful to my long suffering partners—Dr P G S Johnson, Dr A D S Johnson, Dr M Summerhayes, Dr O J C Parry-Jones, Dr J Birch, and Dr C Grant—and to all practice staff whose efficiency has made this paper possible.

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Rubella immunity in pregnant women in a north London practice

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Abstract

Congenital malformations due to rubella embryopathy are preventable. All women embarking on pregnancy should be immune and know that they are immune to rubella to guard against the risk of contracting the disease during pregnancy. A previous history of clinical rubella or rubella vaccination is not reliable, and women should be screened for antibodies when possible before planning to conceive, and particularly before a first pregnancy. As general practitioners committed to the practice of prevention, we should undertake rubella screening for all our women patients before they conceive. This could easily be incorporated into our contraceptive services. We will be greatly helped if family planning clinics adopted a policy of screening for rubella antibodies, always remembering that good documentation and communication will avoid duplication and confusion and reduce costs.

Introduction

The immunisation of schoolgirls between the ages of 11 and 13 was introduced in England, Wales, and Scotland in 1970 to prevent congenital abnormalities occurring as the result of rubella infection during pregnancy. Owing to low acceptance of vaccination and occasional vaccine failure, not all women embarking on a pregnancy are immune. I believe that the best way of achieving this aim is by screening women before they conceive.

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I am in a group practice of 8500 patients, with four principals working from a health centre. My personal list is nearly 3000. Our patients are mainly in social classes III, IV, and V. Early in 1978 a programme was initiated to screen for rubella antibody all women who came to me for family planning. Those who were susceptible were vaccinated and rechecked two months later to confirm the presence of antibodies. This policy was later extended to those who were not on the family planning register, and became part of a preconceptional service, available to all women in the child bearing age group.

The effect of this programme was studied by assessing the rubella status of women who came to me for maternity medical services with pregnancies confirmed between 1 August 1981 and 31 July 1983. Apart from asking the Public Health Laboratory to help, no special arrangements were made. The project was seen as part of good clinical practice, and remembering to "think prevention."

Method

Beginning in early 1978 all women who came to me for family planning services were counselled at some stage about the dangers of contracting rubella during pregnancy. They were offered screening for rubella immunity as part of my family planning service. If they accepted, which most did, a serum sample was sent to the Public Health Laboratory for estimation of rubella antibody, initially by haemagglutination and since 1979 by single radial haemolysis. Susceptible women were vaccinated, using RA27.3 vaccine, and rechecked two months later to confirm the presence of antibodies.

The records of women who were seropositive at this visit, at antenatal screening, or after vaccination were tagged. The date at which rubella immunity was confirmed was entered on our age-sex register. The study group contained 138 women with pregnancies confirmed between 1 August 1981 and 31 July 1983, including nine who miscarried. Pregnancies that were terminated are excluded because of difficulties with data retrieval. No termination for rubella infection was requested during the two year period. All the patients had shared care from us and the obstetricians.

Results

Table 1 gives the numbers of women who had preconceptional screening during the study and those who were found to be seronegative at antenatal screening. All the women had antenatal screening. None of the seronegative women was seropositive conceptually. Four women (6%) went through their pregnancies at risk of rubella infection. All four were primiparas. They had a vaccination postnatally, but interestingly, not all women embarking on a pregnancy are immune. I believe that the best way of achieving this aim is by screening women before they conceive.

TABLE 1—Rubella immune status of women with pregnancies confirmed between 1 August 1981 and 31 July 1983

Date pregnancy confirmed	Total No.	Preconceptional screening		Seronegative at antenatal screening		Record of school vaccination	
		No.	% (n/2)	No.	% (n/2)	No.	% (n/2)
1 Aug 81 to 31 Aug 82	64	35	55	4	6	2	
1 Aug 82 to 31 July 83	74	53	72	3	4	0	
Total	138	88	64	7	10	2	

Three women (6%) in the 1982-3 group were susceptible, two of them primiparas. One went to term safely and has now been vaccinated and rechecked. One contracted rubella at 18 weeks during the 1983 epidemic and elected to continue with the pregnancy, but is not yet a term. The third has so far escaped contact with rubella and not yet delivered, but, interestingly, she was screened during a previous pregnancy. The antibody titre was less than 8, but she had not been vaccinated postnatally.

It is alarming that of a total of seven women at risk for rubella infection during pregnancy, four were born after 1958 and should therefore have been vaccinated. Not all the women in the study group were known to me before they became pregnant. Some registered at the time pregnancy was confirmed, and some obtained family planning services elsewhere. Table II compares rubella status between women who came to me for conception and those who did not. The results show a reduction in the percentage of susceptible women embarking on pregnancy in the family planning group.

TABLE II—Number and percentage of seronegative women according to parity, time of screening, and whether on family planning list

	On family planning list		Not on family planning list	
	Primiparas (n=21)	Multiparas (n=26)	Primiparas (n=42)	Multiparas (n=29)
Preconceptional No tested	18 (85)	36 (100)	11 (26)	14 (55)
Seronegative on antenatal screening No tested	1 (6)	0	5 (11)	1 (4)

Discussion

The national rubella immunisation programme is aimed at 11 to 13 year old schoolgirls. By not immunising the girls until 11 to 13 and not immunising boys, this policy ensures that a periodic rubella epidemics occur because of the reservoir of infection in girls under 11 and boys. This is borne out by the results of rubella surveillance between 1978 and 1983.¹ The take up rate of the school vaccination programme is, at best, 85%.¹ It may be some time before all health districts reach the target of 95%.¹ Antibodies persist for up to 16 years after rubella vaccination, but 6% of susceptible women do not produce antibodies.¹ The woman who is vaccinated at 13 but does not

embark on her first pregnancy until the age of 30 may do so unaware that she is no longer adequately protected against rubella. Most antenatal clinics screen women for rubella antibody at booking, but though this provides valuable epidemiological evidence on the efficacy of rubella vaccination and data for future pregnancies, it is far too late for the current pregnancy.

Screening programmes conducted by general practitioners over recent years have shown that over 12% of women of reproductive age are susceptible to rubella.² In one study girls aged 13 to 21, who should all have had rubella vaccination, were screened in 11.7% of those girls were not immune.³ This is reflected by the 11.9% susceptible primiparas at antenatal screening in the study group (table II).

National publicity campaigns to encourage women to seek screening for rubella immunity are not cost effective since this only generated a 3% response, whereas a campaign conducted by one general practice, while probably more productive, still only achieved a 62% response,⁴ and may not be feasible for all general practitioners.

The practice of screening 11 to 13 year old schoolgirls and vaccinating the susceptible ones followed by rechecking two months later to ensure seroconversion,¹ is unlikely to be widely acceptable or practicable because schoolgirls dislike needles, and three are rather too many.

Present measures have not reduced the number of malformations due to congenitally acquired rubella notified after birth,⁵ or the number of terminations of pregnancy carried out on the grounds of rubella infection during early pregnancy.⁶ We may not know the full extent of congenital rubella after the 1983 epidemic until 1985, since abnormalities of hearing may not become apparent until children are 18 months to 2 years old.

The programme presented above has resulted in a lower proportion of women with seronegative results antenatally (5%) against the 10 to 12% reported elsewhere.¹ An appreciable number of pregnancies, however, are not "planned," nor do all women use family planning services, and the preconceptional rubella screening rate in primiparas is disappointing. This might be because younger, fit women without children are not in the habit of "thinking prevention." I believe that this may be improved by increased vigilance.

I thank Teresa Pershutti for researching the records and age-sex register, all ancillary staff, our practice manager for typing, secretarial, and clerical work for this audit, Ann Crick for typing, and the Public Health Laboratory for doing all those tests.

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Young Practitioner Groups

Challenges and contacts

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During my training as a doctor, and in particular as a vocational trainee, I enjoyed the stimulation from contact with my peers. Such temporaries and the opportunity to exchange views and ideas and share the excitement of newly acquired skills and knowledge. The first few years in general practice with the inevitable problems and additional responsibilities can be onerous, and although group practice provides some support, it is easy to become isolated and lose one's direction. In 1975, at the same time that I joined my teaching practice as a partner, one of the first small groups in the region was established. Based in Ashington, Northumberland, it was formed by local general practitioners who undertook to audit their care of patients with hypertension. After the success of this exercise, general practitioners from the region received a written invitation to join a group studying "clinical standards" which was to meet regularly during the next year. This invitation provided the opportunity to pursue the type of task that I had found so stimulating in my years of training. It would also form the core of a group of general practitioners that would continue to meet in Durham during the next six years.

The range of ages and experience in the "clinical standards group" was wide; some were newly appointed principals, others were trainers or course organisers; only a few had experience of working in a similar group (Ashington). The 30 general practitioners who attended were split into three small groups, each to study one of the three aspects of care—structure, process, or outcome as described by Donabedian.¹ At first I felt apprehensive, most of the group members were older, more experienced, and many had been in general practice for many years with new concepts—the idea of determining our own task and working with and relating to other members of the group, most of whom were unknown to me. I soon realised that many of these difficulties were shared by other members of the group. Recognising that one could not criticise without being criticised allowed individuals to participate more freely in discussion, and thus to become more involved as time went by.

Process of care

The task was to consider the "process" of care, and during the monthly meetings the care of the wheezy child was discussed and analysed. Criteria for diagnosis, management plans for acute and chronic care, and descriptions of the tools best suited for care were produced and continually amended by referring to our own clinical practice, to published work, and to expert opinion. In 12 months a model of care for all children with asthma was developed which was both practical and, it was hoped, would improve the quality of care. Twenty seven of the other groups provided an opportunity to learn from their experiences. In addition to developing a clinical standard that

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could be used in clinical practice, I had found the meetings challenging and a new source of contact with my peers. Such was the positive feeling in my small group that even before the end of the course on clinical standards most of the members had expressed a wish to carry on with the meetings during the next year. It was important that the number of members in the group was maintained to allow it to function effectively, and although some members from more distant areas decided to join other more accessible groups, they were replaced by young principals in the Durham area who were invited to join. In retrospect the intention to follow the tried and tested format of the previous year was short sighted. We continued in our role of standard setters, concerning ourselves with the care of patients with asthma in general practice. This seemed to satisfy our needs for a short time only; although the clinical material was different, much of the work followed the same pattern and, as a result, was less stimulating than before.

A recurring theme to arise from discussion of clinical medicine was the belief that many of the management plans used were traditional, not based on any sound scientific evidence or the evidence that was quoted tended to come from outside general practice. Was research material from a London teaching hospital really relevant to general practice in the north east? How much of our clinical practice was based on our experience in hospital or reflected the views of consultants in local hospitals? Should we accept the dictates of these doctors, or were we, as ordinary general practitioners, qualified to provide acceptable guidelines on standards of care? This change in attitude led to another approach to the task that we had defined. We moved away from the clinical model and concentrated more on the delivery of care; the role of the hospital diabetic clinic and the resources available for diabetic care in our practice and the ways in which they might be improved. Having developed a standard for delivery of care, we met hospital consultants and arranged meetings with patients through the local branch of the British Diabetic Association to test their reactions to our ideas.

Part of the concept of developing a standard of care was concerned with implementing it in practice. It seemed sensible, therefore, to look at the records of children with asthma to check whether the guidelines that had been established in the previous year had been observed. To some extent we felt that we had achieved our aims, but, possibly more important, the exercise raised serious doubts as to the value and accuracy of records—a question to which most small groups have addressed themselves at one time or another.

Waning interest

Towards the end of the second year it became obvious that if the group was to continue it would have to change. Enthusiasm waned, attendances at the regular twice monthly meetings dropped, and for a short time during the summer the group disbanded.

Expansion of the Newcastle vocational training scheme in the mid- and late 1970s led to an increasing number of trainers and

ex-trainees in the Durham area. The network of personal contacts made through the scheme enabled two of us to generate enough interest in the local young practitioner population to establish a new group. Initially the group was made up of 12, it lacked some of the expertise that had been apparent during the course on standards, and although most were committed to regular meetings, they remained unsure of the various roles that were to play in the group and the direction the group should take. A great deal of experimentation took place while trying to allow the group to evolve. Although convened by two of us, neither wanted to adopt a leadership role by imposing on the group a particular task format. It was our intention that the group accepted this non-authoritarian style of leadership that it began to function properly. For a time trainers from hospital and general practice participated in the meetings but the mixture of what were essentially two separate groups (trainees and principals) provoked resistance from both and the idea was abandoned.

The times and venues of the meetings were changed. Until now meetings had always been held for two hours in the evening at the local postgraduate centre in the city hospital. The facilities were good, there was adequate parking, lecture and conference rooms were available, and it was accessible to most members. For a time we met at lunchtime to ease the pressure on evening food of hours commitments. This was popular but it was difficult to book rooms in the postgraduate centre. We therefore chose to meet in our own practice premises on a rota. Initially, lunch was provided by drug firms, but as their presentations crowded the time available for business we decided to provide our own—less grand—refreshments. We did, however, continue to use the educational material provided—for instance, video tapes, tape-slides, multiple essay questions. Topics were agreed at the beginning of each term and were planned to run for two sessions only. The variety of the content and format reflected the interests, weaknesses, and expertise of the members. Clinical themes such as urinary tract infection, arthritis, and management of low back pain were researched and discussed. Peer group review of random case analysis, records, video consultations, and examination of practice premises and organisation was used. The widening scope of subjects was paralleled by the increasing use of additional resources, such as film and video presentations, the attendance at our meetings of hospital consultants and members of the extended primary care team, and presentations by group members of subjects of their choice. They had a special interest or knowledge. The task that encompassed problems with which most of the group identified was often more diligently pursued and thus a much greater level of success was achieved.

It seemed inevitable that the growing number of trainers in the group would want to discuss topics related to teaching. The workshops for those of us concerned in vocational training were held infrequently, and there was dissatisfaction about the critical standard of teaching provided in the practices. The type of work that the group had already done was readily transferred to the one to one relationship of trainer and trainee, and to the seminar or small group work sessions. The methods used in the group that we had used to learn could just as well be applied to trainee groups. Recognising the type of presentation or material that had been most stimulating, the accumulated experience of the various techniques in random case analysis, and the critical skills that had allowed assessment of the value of particular aspects of practice organisation proved invaluable for training. Seminars for four to six trainees from 11 practices were arranged and led by group members, trainers and non-trainers participated in teaching. The transition was successful, providing a new dimension and stimulation for the group. Acquiring video equipment enabled us to use our own practice premises and material from the MSD Foundation as a teaching aid and for analysis of techniques in consultation and group work.

For 18 months the two groups ran in parallel, the trainer group meeting weekly during term time and the group of 11 principals meeting monthly to discuss teaching and group in practice. Inevitably, the latter group became stale, it began to contract

members left and the pressure on the remaining members increased. To swell the ranks and provide some new impetus the two groups amalgamated, but, as before, the mixture of two distinct peer groups was a disadvantage. In 1980 the group was dissolved. Despite the demise of the group, in a few months the next generation of the Durham practitioner group had begun to form. A nucleus of the old members serving to attract new members and leaving the way open again to develop new leadership, new ideas, and new tasks.

The lifespan of any group is limited—either predetermined or by death from natural causes. During the life of the group there is a corporate desire to preserve its integrity, to protect and support its members, and eventually, a sense of loss when the group disbands. Much of the pressure to succeed falls on the group leader. It is his or her lot to motivate and stimulate, to try to preserve the change of ideas, beliefs, and attitudes between individuals, to use his or her skill to avoid the problems and pitfalls which may lead to dissatisfaction in the group, and, ultimately, to accept responsibility for its fate. The proliferation of the small group must to some extent be due to the enjoyment that may be derived from the experience of group work. Its value, however, should not be measured simply by its popularity. It is the subsequent implementation of the acquired skills and knowledge and the change in attitude that will become evident in the practice of medicine which will ultimately reflect the success of small groups.

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Diary of Urban Marks: 1880-1948

As a natural sequence of events the record of my life should be inserted here but who you read this may have the opportunity of perusing that as a separate volume which I compiled on my way home. There are however a few outstanding events which I think it would not be out of place to record here.

In addition to recording Dr Bell a locum for the practice I turned the conduct of my affairs over to John Puntan, a solicitor who was more than a brother to me. John acted under power of attorney and as such had complete control of my estate. He was as pleased as I was when Bell undertook the management of the practice. John took care of the financial part of it and kept strict accounts for me dating from the time that he took over. Bell stayed for three months and then took over the practice or what was left of it, of the late Brynmor Evans at Landore. The executors of Brynmor's estate had been trying to sell the practice as a going concern since the day of Brynmor's tragic death but no one thought that at such a time a buyer could be found. It has to be remembered that there were hundreds of practices vacant in the British Isles and very few medical men were left in the country. However, there it was and Bell left. John found another man and was extremely pleased to inform me in a letter which he sent to me that he had found an old colleague of mine by the name of Groves had consented to take charge at the salary paid to Bell. I was not quite as pleased as John at the news knowing full well what kind of a man Groves used to be. Still, I could do nothing in the matter as I was tied up at work. It was too expensive to even if one could get a message through. This could only be done at the weekends, always provided that there was no fighting taking place and the authorities did not want the wires. So, perforce I had to rest content and wait. From the letters I received from May, Groves turned out to be a very peculiar man. He would not dine with me and insisted on having his meals alone. This was undoubtedly due to the old disease of the nose and as well as the fact that he was a confirmed bachelor and probably had the society of women. May told me that the thought he took me but could never prove this. He held a surgery if he thought fit and did as little work as possible. What caused him to leave, I do not know. He was here about four months and then I suspect that Puntan gave him notice.