NP

The Newsletter of NANP NATIONAL ASSOCIATION OF NON-PRINCIPALS

Issue 14 Winter 2001

PO Box 188
Chichester
West Sussex
PO19 1FP

Fax 01243 536428
Email info@nanp.org.uk
www.nanp.org.uk

Supplementary Lists—friend or foe?

The government has at long last agreed on the regulations for Supplementary Lists for English Non-Principals. And what a non-event it is. Our hopes had been for the scope for a whole new way of life in a set of NHS regulations that would pave the way for incoming Primary Care Trusts to embrace non-principals into the established mechanisms of the NHS – plug us into information cascades, clinical briefings, prescribing mechanisms etc.

But reading these 22 pages of regulations (someone has to) it's very hard to see what difference they are going to make, in their present guise. The process is going to run something like this:

- Each of 100 or so Health Authorities must have started to set up these lists from mid-December, finishing before April 2002
- In April 2002, all these Health Authorities will devolve their powers to 30 or so strategic Health Authorities, meaning that these supplementary lists will instead have to be managed by over 400 different Primary Care Trusts.

The Department expects that 10,000 non-principals will apply to go on these lists in the first year, each having to provide:

- Usual contact details
- evidence of medical qualifications
- GMC and JCPTGP details
- A detailed CV of all the clinical posts you've ever done, including the starting and finishing dates with an explanation of any gaps between appointments
- two referees relating to two recent posts as a doctor which lasted at least three months without a significant break, and where this is not possible, a full explanation and alternative referees
- details relating to any type of criminal activity (where you've been caught, that is)

You'll have to choose which single HA you feel is the most appropriate to apply to and, being accepted on this list, you'll be given a ticket to work anywhere. If you're a Celt wanting to work in an English town, you'll probably have to register in England somewhere – no guidance is given. In fact, guidance is particularly absent, which at the time of printing is a bit fresh as it is practically law. The other 21 pages of the document relate to how tough your life is going to be if you haven't been a particularly law-abiding citizen - all a bit punitive and bugger all about actually how Health Authorities/PCTs are going to realise the fantastic potential for increased services and care that a database of non-principals could bring to this demoralised and undermanned primary care workforce. We assume that it's going to be left up to their imagination. Ahem.

So what should have happened? Firstly, the establishment of 400+ different databases of variably peripatetic non-principals across England – and ultimately the UK – is lamentably poor planning. Can a non-principal realistically expect each PCT to apply the same criteria and standards when it comes to admitting or refusing applicants? And as proof of membership of a HA/PCT's Supplementary list will be

(Continued on page 2)

Golden handshakes

Since 1st April 2001 former GP registrars, retainers and locums taking up their first GMS or PMS post as a principal or assistant in England have been entitled to a 'Golden Hullo' payment. Similar schemes are being developed for Wales and Scotland. For those working more than half time the 'Hullo' is worth £5,000, or £10,000 in under-doctored PCG/PCTs. Doctors working 25-49% of full time get £3,000. A Golden Hullo can be claimed retrospectively.

For further information, including details of 'under-doctored areas' and application forms, see the Department of Health website (www.doh.gov.uk/pricare) "Golden Hello" section or contact your PCO.

Note that the Department of Health's intention is that practices pass the full amount to the doctor concerned (don't let your new practice pull a fast one!)

NANP meeting

Possibly, but we're leaving that up to you. It's our fifth birthday this coming spring, so to avoid losing touch with our membership we've invited non-principal group leaders, non-principal tutors and non-principal LMC representatives to a national meeting of non-principal representatives to be held on Saturday 23rd February in London.

We're all going to sit in a big circle, drink tea and discover from ourselves what it is we all want from the NANP and how we are all going to do it.

Not really a non-principal representative but feel you have a part to play? Please get in touch.

NPs need to be more involved with in medical politics

The NANP met with senior members of the General Practitioner's Committee (GPC) to look at ways of improving representation for all GPs. Together with the Overseas Doctors Association and Medical Women's Federation, the NANP was asked to identify how GPs – in our case non-principals – could be encouraged to work more closely with Local Medical Committees and the GPC itself. Various barriers were identified (we won't go into the details!), and the NANP has agreed to help in other

(Continued on page 7)

RCGP loves NPs

Tina Ambury, Honorary Secretary of the NANP, has recently been appointed as vice chair of the RCGP. Tina is therefore the only non-principal senior officer in the RCGP together with the RCGP President Lesley Southgate. No, that's 2 RCGP non-principal senior officers: Tina Ambury, Lesley Southgate and RCGP Honorary Secretary Maureen Baker. Actually, no, that's 3 non-principals: Tina Ambury, Lesley Southgate, Maureen Baker and RCGP Treasurer Tony Mathie. Oh, that's 4.

(Continued from page 1)

mandatory before accepting any post, how will individual practices be able to verify such membership? From the outset, supplementary lists should have been set up and managed by one central organisation that can co-ordinate the membership of supplementary lists for all the PCTs, but also homogenously administer such a database in a pro-active and sensitive way to support and enfranchise those GPs who are on the list. We haven't yet tired of putting pressure on the Department to rethink their strategy (in fact, we're cautiously optimistic that we may have a breakthrough). But in case we don't, prepare for a diet of bureaucracy and mismanagement on a scale now only found in a Latin-American Railway's Lost and Found department. Tequila, anyone?

Audit for non-principals

With revalidation and appraisal apparently on their way, and after the GMC's first pilot showed just how difficult it was for non-principals to provide evidence of audit, we're going to have to work out what outcomes we can attempt to audit, and which ones to run a mile from. The difficult part here is how to record a consecutive number of consultations, particularly if you want to do this retrospectively. You could have worked in a dozen different practices during this time, all using different computer systems.

Another way of course would be to do a prospective study – design a simple proforma of what you're trying to record and bring it with you to every surgery you go to. But what are you going to audit – here are a few ideas:

Asthma
- Did I check that inhaler technique had been assessed?
- Did I record a peak flow reading for a "wheezy" patient?

Febrile child
- Did I exclude (and record) signs of meningism?

Sore throat
- Did I prescribe antibiotics?

Coronary Heart Disease
- Did I check that the patient was on aspirin or alternative?

Hypertensives
- Did I check that they had had appropriate investigations?

Mental Health
- Did I exclude active suicidal ideation in depressed patients ?

Management
- Sick notes—did I record the reason issued?

For these you will of course have to go back to the practices and trudge through the old notes. Hassle for the practice? Nah, you're going out of your way to improve the care you're giving—if they moan, should you be working there again?

Either way, audit is not going to go away and you will have to do it at some stage in the near future.

If you have any other suggestions for how non-principals can audit their work, we'd love to know.

The National Association of Non-Principals

NANP
NATIONAL ASSOCIATION OF NON-PRINCIPALS
PO Box 185
Chichester
West Sussex
PO19 2ZA
Fax 01243 536428
Email info@nanp.org.uk
www.nanp.org.uk

Our constitution

Over the last two years, the NANP has helped change the way general practitioners are treated in general practice. We have already put into place many of our original objectives so some no longer apply. And changes within the NHS environment mean that we have new problems to solve.

The NANP is determined that the quality of Non Principals will be recognised. The best way forward on this is to ensure the processes of accountability are equitable. Quality and accountability are the new watchwords for the future of general practice.

These two principles are co-dependent and will be vital for every doctor working as a GP in the UK. Non-Principals should not be placed at a disadvantage by these processes and the NANP will fight to ensure this does not happen.

Being fully accountable and 'quality assured' GPs, Non Principals will be on an equal footing *in all respects* with Principals, barriers to integration will fall and general practice will be a more attractive career option for newly qualified doctors - and a safer place for patients.

Philosophy

The NANP seeks to act as a voice and a resource for all **NHS** General Practitioners who work beyond the traditional model of GPs as 'principals'.

The term 'non-principal' is easily understood to encompass careers such as locums, assistants, retainers or otherwise salaried GPs. However it is imbued with a sense of being left-out, of inclusion primarily through exclusion.

Since the NANP aims to achieve **equity and inclusion** for all GPs, irrespective of their specific post, we are evolving a more positive concept of the **'independent GP'**.

Being independent may mean different things to different GPs:

- Independent of an employed status
- Independent of the "Red Book"
- Independent of certain non-clinical responsibilities
- Flexibility to choose your own career path, unrestrained by the constraints of traditional partnerships or principal posts.

As the field of Primary Care continues to change, 'independent' may come to denote other working styles.

The success of the NANP will lie in responding to and shaping those changes.

Aims

To unite all general practitioners by promoting quality and equality in primary care through

- Standard setting and progress.
- Collecting and dissemination of information
- Campaigning.
- Support.

Objectives

Standard setting and progress

- Identify and respond to changes in the health care environment that affect independent GPs
- Develop new systems for maintaining or improving the quality of care given by independent GPs
- Develop new systems for maintaining or improving the welfare of independent GPs

Collecting & dissemination of information

- Maintain and distribute a database of names and addresses of independent GPs for the purposes of improving their professional welfare.
- Produce and distribute a regular newsletter for members, to include an up-to-date list of all local groups and educational facilitators

Campaigning

- Lobbying of the DoH to allow all GPs access to the NHS superannuation scheme.
- Campaign for the full inclusion of all GPs into the NHS' "information cascade" such as clinical guidelines, British National Formularies and the NHS Net.
- Campaign for the full inclusion and participation of all GPs in the structures and processes of revalidation.

Supporting

- Hold a regular national conference to promote the aims and objectives of the NANP.
- Promote and facilitate the equitable provision of and access to continuing medical education for all GPs.
- Promote and facilitate research on issues relating to independent GPs
- Promote, provide and facilitate professional support for individual GPs through local support groups.
- To ensure the representation of all general practitioners through local medical committees (LMCs) and thus the British Medical Association (BMA).
- Strengthen our existing links and broaden our relationship with the Royal College of General Practitioners (RCGP) and the BMA.

Book Review

Joint and Soft Tissue Injection
Trevor Silver, 3rd edition
ISBN 1-85775-564-2 119 pages
Radcliffe Medical Press 2002

This book is subtitled 'Injecting with confidence'. Can a book really remove the twinge of anxiety one experiences when standing, needle in hand, contemplating a painful shoulder or wrist?

One feels very exposed when injecting, and none of us like causing pain without achieving benefit. An underconfident doctor means a tense patient and a lower success rate. Silver believes that the practical problems and poor results many doctors experience with injecting, and the lack of good evidence from trials of efficacy, stem from failing to make an accurate anatomical diagnosis. Consequently, many injections are put where they can do only harm, not good.

The author describes the anatomy and pathology, and how to examine to make an accurate diagnosis. One is then in a position to inject properly. Photographs of injections are accompanied by diagrams showing the anatomy under the surface with the injector's hands and needle in the same place. This is helpful, especially as the subjects, like patients in real life, have a generous layer of adipose tissue over their anatomical landmarks. It all makes sense.

This third edition of the book includes a chapter on soft tissue imaging by Dr David Silver. I had not thought of asking for an ultrasound study of a problem shoulder or a plantar fasciitis, but I now see how useful it could be, were radiology departments able to provide such a service.

As a locum, arranging to do injections can be difficult and I have been hiding behind that excuse. This very practical and comprehensive guide has encouraged me to create the opportunity to improve my skills.

Judith Harvey
judith.harvey@btclick.com

New Council Member

Dr Judith Harvey from North London is the latest member to join the NANP council.

Judith was a GP principal in Buckinghamshire for ten years, first under GMS, then PMS. After travelling the world last year, she returned to London to discover the pleasures of being a non-principal.

Judith said "Five years ago I would have been begging a hand-me-down BNF. Now I have a right to my own copy. NANP must continue to make NPs' lives easier by negotiating for them the things principals take for granted." And Judith isn't new to medical politics. As chair of an LMC, Judith introduced non-principal representation and is now an LMC member representing non-principals. And as a member of GPC Judith represented PMS GPs. "I believe political representation is crucial to NANP's objectives. Soon most GPs may be working outside the GMS contract. NPs know how to organise continuing professional development, about informing and supporting non-GMS GPs, about superannuation problems. I believe we should embrace the positive concept of 'independent GPs' and use our experience to show our profession the way."

NP North West

Morecambe Bay Non-Principals

There are about 15 of us in the group at the moment, and we meet up every 6 weeks and have two 'educational' meetings in succession followed by a social event. The 'educational' meetings range from the purely clinical—for example our recent Dermatology review given by one of the local GPs who works as a clinical assistant in Dermatology—to our forthcoming meeting when we will discuss revalidation and our response to it. At present the HA operates a 'locum bank' and we expect this will evolve to become its Supplementary list. We are currently negotiating increased links with the LMC. Past meetings have focused on our Personal Education Plans, enabling us to pool ideas about ways of meeting our educational needs despite the lack of continuity inherent in locum work. We have also used the expertise of group members for some very successful meetings, for example earlier this year we discussed the work of the local Community Drug Team. The social aspect of the group is important too, particularly as we live scattered across this rural area. New members are always welcome!

Rachel Gilbert
rachelfgilbert@yahoo.com

NP Scotland

North of Scotland Support Group

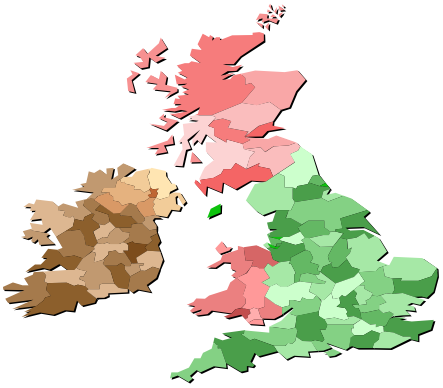
Our story at present is a mixture of some interesting plans and developments and the ever-present problem of getting bodies together over such a spread out area as our own. Our monthly pub meetings just tick over and no more, especially since a couple of our activists have had their style cramped by little things like becoming a partner and going to Canada! However we did manage to get a constitution together , and we've had a very interesting meeting with the PHCT to discuss NP input to help the North's severe rural recruitment crisis. We still run an automated locum advert board using a BT voicemail service, and most recently we've approached the local Trust to set up central correspondence files for each locum. In short, we're the go-ahead forum where two's a quorum!

Moray Grigor
MJGrigor@aol.com

NP Scotland

Borders Non-Principals Group

Borders Non-Principals Group have monthly evening meetings in a central Borders location. The meetings are attended by 10-12 non-principals each month, which is excellent for one of the smaller NP groups and with considerable travelling distances for some members. Our evenings are divided into two parts, the first 45 minutes is for networking and mutual support; the second part we have a guest speaker to lead a discussion about a clinical topic.



Our group already produces a detailed locum list giving GMC No. and medical defence details, with copies of CV, certificates etc. kept on file at the PCT - so the proposed supplementary list will not be a problem for us. Regarding revalidation, we have PGEA approval for all our meetings and strongly encourage NPs to keep a copy of their PGEA certificates in a revalidation folder, even it they have no intention of becoming a principal.

The other new development in the Borders is a CPD scheme offering protected learning time for all Borders GP practices. This involves practices closing for half a day at regular intervals, with cover by the GP Coop service. NPs are warmly invited to attend these meetings, which in turn not only offers a CPD programme but also helps develop a team spirit between practices and NPs. The meetings also offer the chance for NPs to check out practices they might apply to for a partnership vacancy if one arose.

Joe Wilton
joe.wilton@doctors.org.uk

NP North West

Chester Non Principals Group

The Chester Non Principals Group has been in existence for about 2 years now & we currently have a database with 45 members (although we suspect some of them have left the country to avoid our persistent mailing techniques!) We meet every 2-3 months for mainly educational meetings, with topics ranging from NHS Pensions for Locums to Chiropractic. However, it says something about our members that the most well attended meeting (which is being repeated this year by popular demand) is our pre-Christmas Wine Tasting Extravaganza run by a local wine merchant! We have members from Chester City & rural Cheshire and welcome any one who has an interest in socialising with some "light-hearted" education thrown in for good measure.

Liz Mangan
lizmangan@ukonline.co.uk

Local

NP NI

Northern Ireland GP Locum Association

Our locum group currently consists of around 170 people. We try to hold a meeting in Belfast once a month, which attracts around 15-25 people at a time. This usually consists of a PGEA accredited talk with a meal afterwards. In addition, our members in the North West usually have their own meetings.

Politically we are represented on all four Local Medical Committees as well as having 3 representatives on GPC, including a retainee. We have always found our Principal colleagues in these groups welcoming and supportive of our needs.

Our Health Minister has not made clear to us if we are to be included on supplementary lists, or indeed if they are to be set up. The general feeling here is that the minister has generally ignored the wishes of GPs in the consultation stage and there may yet be some weeping and gnashing of teeth and we would generally be supportive of this.

Michael McKenna
michealmck@msn.com

NP Scotland

Forth Valley Non-Principals Group

The Forth Valley non-principals group is just two years old and still evolving. At any one time we have around twenty to thirty members so our small

Groups

size means a strong sense of 'ownership' of what goes on. This has allowed us to take turns in organising meetings and dealing with administration rather than landing everything on one or two people. The downside is that long term planning of our educational meetings doesn't really happen.

We meet roughly every month for educational meetings, with every third or fourth meeting being a business session. Recent topics include management of soft-tissue injuries, personal learning plans and public health.
Our local health board already collects and circulates the 'locum list' to all practices, roughly every three months or so. Any health board circulars are now being sent out to locums, which is useful, though unfortunately information about educational meetings is sparse. Also, unlike some regions in Scotland, BNFs are being provided to us by the board (so far). Superannuation forms are causing a bit of confusion as they are difficult to use and the health board are anxious about using them as they seem to feel they could become responsible for locums who are working in other regions. Our IT expert also hopes to send out an icon that practices can put on their desktops, so when they need a locum the up to date list is only a mouse-click away.

Joy Tomlinson
joy.tomlinson@virgin.net

NP Mid-Sussex

Mid Sussex Non Principal Group

We have a membership of 55 doctors who meet every 2 - 3 months. Attendance varies between 10 and 23. We meet in a restaurant paid for by drug reps. Administration is organised by the postgraduate centre who are paid by the Health Authority. After each meeting I send out a synopsis of what was discussed. The G.P tutor and a rep from the Health Authority usually attend.

At our last meeting a member of the PCT came to ask if anyone would join their executive committee - important as the Health Authority will cease to exist in its present form next year, and we need our voices heard. Other issues discussed were PDPs, appraisal and revalidation. Locum rates are reviewed and increased by 6% each year. These rates are sent to all practices by the H.A, along with current lists of locums. We are considering putting together a folder of local information for new locums. Perhaps the PCT will help us with funding this? If you don't ask you don't get!

Our group always manages to discuss many topics. With new members always joining we provide an important local source of information and support, as well as up to date locum lists for practices.

Barbara Turk
DRBKTURK@aol.com

NP South West

Basingstoke Sessional GPs

We continue to meet monthly and have enjoyed local consultant speakers in cardiology, GU medicine and obstetrics as well as a discussion of PUNs & DENs, book reviews and a local GP Allergy Specialist. Our December meeting is unashamedly social at a local Pizza place and without sponsorship for a change. We welcome anyone GP qualified but not in partnership in the area and have a steady influx of new GPs as well as established local non-principals.

Harriet Walford
harrietw@lineone.net

NP Trent

Lincoln NPG

Our group is thriving with about 35 members. I send a newsletter out every 2 months with details of our next meeting, and any locum vacancies in the area. We have meetings every 2 months in the postgraduate centre of Lincoln County Hospital, and we usually have a drug sponsored buffet before the talk. We have a social dinner (drug - sponsored) in winter and in summer, which is good fun. This year we had meetings on self-defence (extremely useful), revalidation—I am now giving out certificates of attendance at the meetings for everyone's learning portfolios— and a CPR update. In Lincolnshire a scheme called TARGET has been set up whereby, once a month, GPs and practice staff have a protected afternoon off for continuing education. So far the scheme is working well, and non-principals are welcome to attend. Many of the members are still concerned about revalidation—in particular how it will affect locums and those taking career breaks—but at least by attending NPG meetings, TARGET etc. it is easy to show we are keeping up to date.

Mekala Mahalingam
mekala@tinyonline.co.uk

NP South East

Berkshire NP Group

The Berkshire NP Group is still going strong with 28 members. The group has been running primarily to provide information and support for members rather than education. In November 1999 there was a lot of local education available (subsidised for NPs), with refresher courses and some regular GP meetings but, unfortunately, this situation has changed. Attendance at meetings is very variable, partly owing to other commitments, but also perhaps because there is not a regular, formal educational/PGEA approved element. This is something we need to address as a group.

Recent events include a drug sponsored resuscitation course with the local hospital training officer. We continue to produce a locum list which is now sent to each of the PCG/Ts for practice circulation. Berkshire Health Authority has no supplementary list as yet or shown any interest in contacting local NPs with a view to compiling one. We live in hope!

Susannah Denny
sjd.enigmamm@ntlworld.com

NP North West

East Cheshire Non-Principals Group

The Group is meeting every 2 months, and these meetings are well attended.
The group has over 40 current members, but is keen for new members to join.
We now have an infant website at www.ecnpg.org.uk.

Edward Taylor
ecnpg@ecnpg.org.uk

Medical Mailings

Ever wondered how to get those publications you used to get when you were a registrar or principal. We explain how.

Most if not all medical publications are as equally available to all GPs. Its just a case of knowing where to get them and making sure you don't fall off the publisher's waiting list every time you have a birthday.

If in doubt or if you have any difficulties getting hold of these publications, call The Medical Mailing Company on 0800 626 387. You may need to provide your GMC number to obtain some of these mailings.

Some may require you to have a practice address, so if you're very peripatetic the address of a practice where you've been known for the last few months would be useful too - have these details to hand. Naturally, you'll have to ask them to actually mail it to your home address and let the practice know that you've used their address for this purpose.

British National Formulary
www.bnf.org
How you get your BNF depends on where you live (see box).

Drug and Therapeutics Bulletin (DTB)
www.which.net/health/dtb
The DTB have a contract with the Department of Health to supply the DTB to every doctor in England and Wales (apparently in Scotland it's one for every practice but for Northern Ireland we're afraid its the same old story!) Otherwise, you'll probably have to pay. Either way, call 0845 983 0082.

MeReC Bulletin
www.npc.co.uk/merec.htm
This is now only published in electronic format, but don't let that you put you off as you can download and print off the issues yourself at home.

BMA News
www.bma.org.uk
This used to be sent to all GPs on the BMA's database as "BMA News Review", but alas no more. You'll actually have to be a member now. To join the BMA call 0207 387 4499.

GMC Newsletter
www.gmc-uk.org
This goes out free to all doctors on the GMC's general register - you are a doctor, aren't you?

Bandolier
www.ebandolier.com
Thanks to the support of Bandolier's editors, NANP members can receive free copies (normally £3 each) of this excellent publication by sending your contact details to bandolier@pru.ox.ac.uk or by fax to 01865 226978.

NICE Guidelines
www.nice.org.uk
If you want one particular guideline, contact the NHS Response Line 08701 555 455.
If you want to go on their mailing list, contact NICE direct at nice@nice.nhs.uk

Health in Ageing/Best Practice (used to be called **Medical Monitor**)
www.medicom.co.uk
Call 01372 471671 to receive copies.

Clinical Evidence
www.clinicalevidence.org
We're trying to persuade the DoH to send these to non-principals at the moment.

Pulse/The Practitioner (United Business Media)
Call Elizabeth Ravi on 0207 861 6183 to go on the list.

GP
www.gponline.com
Call The Medical Mailing Company on 0800 626 387

Medeconomics/MIMS/GPnet
Despite being published by the same company as GP, you have to call 0208 606 7500.

Doctor/UPDATE
www.doctorupdate.net
gp-update@rbi.co.uk
Call The Medical Mailing Company on 0800 626 387

Get your BNF!
The DoH in **England** distributes the BNF to all non-principals registered on the NANP's database. They've had a few teething problems due to the large demand for copies, but seem now to have it licked. If you have just joined and want the current version of the BNF, call 0541 555 455.

In **Scotland**, the Common Services Agency distributes the BNF through the non-principals' Primary Care Trust or Health Board—so you must notify your Health Board of your existence!.

If you live in **Wales** or **Northern Ireland**, your local Health Authority still has responsibility so you need to send your contact details to the chief executive of your Health Authority.

Paradise Hospital

NP Article

I am on a one year placement with Voluntary Services Overseas (VSO) here in Vanuatu, South Pacific, 2000 km east of Australia between the Solomon Islands and Fiji. The country consists of 80 islands, 68 of which are uninhabited. The population is less than 200,000, consisting of mainly Melanesians with a few Polynesians. The weather is tropical—in the rainy season, which coincides with UK winter, temperatures reach 30-34 C and humidity of 85-90%.

I am based in Lolowai Bay Hospital in the northern Penama Province, made up of the islands of Ambae, Maewo and Pentecost. The bay is formed from an extinct volcanic crater, and I think must be the most beautiful setting for a hospital anywhere in the world.

I am the only doctor in the Province, serving a population of 24,000 with the aid of a 31 bed hospital and 26 staff, including 14 nurses and a small operating theatre where I carry out minor operations, including closed reductions of fractures, incision and drainage of abscesses and the occasional Caesarean sections.

We have a small laboratory where we can do haematology tests, urinalysis, malaria slides, and stool examination - biochemistry has to be sent to the regional hospital. We have a small but useful x-ray department, but the range of drugs we can supply is quite limited, often running out of stocks.

Being the only doctor, I have to know something about everything. If there is a condition that I am not sure about or beyond my capabilities, I can fly the patient to the regional hospital. However, the flights are expensive and we only have 4 flights a week. But we manage somehow.

Despite the wonderful scenery and climate, daily life isn't that easy. The hospital generator has to be turned off every night in order to save money and, as there is no pollution here, drinking water is simply collected off the roofs and stored in tanks—delicious! Water for all other use is pumped from a nearby lake and hence has a lovely brown tinge to it. But when the pumps break down, all the water has to be collected from buckets.

Even though daily living may not be as easy as in the UK, there is a lot of job satisfaction that cannot be found back home. Here, I work for the benefit of the patient and not for a salary. Because of the limited resources, patients seem more grateful with whatever we can do for them. Yes, we do save lives, but we have lost a few.

Elizabeth RoZario
erozario@vanuatu.gov.vu

Ever thought of spending some time abroad helping others in underprivileged parts of the world? Contact these organisations to find out a little bit more about more about what you could offer:

Voluntary Services Oversees
020 8780 7200
www.vso.org.uk
enquiry@vso.org.uk

Médecins Sans Frontiére
020 7713 5600
office@london.msf.org
www.msf.org

tax deductible membership...

After a couple of years corresponding with the Inland revenue, NANP membership is now tax-deductible. If you're paying tax at the full rate, you'll be saving £18 a year on NANP membership.

...and free for some

Are you off abroad anywhere? Doing something vaguely doctorish? We'd love to know how you get on, particularly if it'll be of interest to other non-principals. And if you'll be working for a charity like VSO or MSF we'll reimburse your NANP membership during that time on your return. Just let us know the dates.

(Continued from page 2)
ways too to try and motivate non-principals into participating more in medical politics. Dr John Chisholm, GPC chairman, agreed at the meeting to write the next editorial for the NANP newsletter to show how and why this could be done.

The National Association of Non-Principals

NANP
NATIONAL ASSOCIATION OF NON-PRINCIPALS
PO Box 188 Chichester West Sussex PO19 2ZA
Fax: 01243 536428
Email: info@nanp.org.uk
www.nanp.org.uk

Contact the NANP

NANP
PO Box 188
Chichester
West Sussex
PO19 1FP

Fax/answerphone 01243 536428
Email info@nanp.org.uk
www.nanp.org.uk

Council Members