NEWS

Editor: Nicola Roberts

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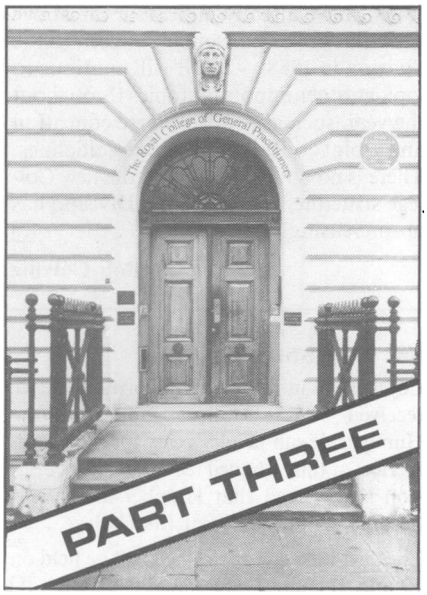
Education Division



COUNCIL, when considering and reviewing the structure of the College, agreed that the responsibilities of divisions should reflect priorities within the College, and that these responsibilities would need to be adjusted from time to time in order to take account of changing circumstances and priorities. Divisions should therefore be regarded as flexible structures whose size and areas of responsibility can be varied to tackle the main College targets of the day. In order to reflect new priorities within the College, the Education Division has had its remit widened to include responsibility for advising Council on matters not only relating to education but also performance review, including fellowship by assessment.

The new responsibilities for performance review are a direct response to the RCGP policy statement, *Quality in General Practice,* which emphasized the need to encourage higher standards of patient care by incorporating performance review into everyday practice. It was recognized that continuing education should be more relevant and practical, and that this could be achieved by linking it to measured performance in a practice setting.

The division will endeavour to meet its responsibilities by:

- exploring current assessment methods at all stages of training for general practice in cooperation with the Association of University Teachers in General Practice (AUTGP), regional advisers, course organizers and GP tutors;
- promoting higher training and assessment for young and established principals;
- facilitating the development and support of GP tutors in continuing medical education;
- encouraging teamwork in practices with partners, practice nurses, district nurses, health visitors and other paramedicals;
- determining the central support needed and the resources available to principals via distance learning;
- disseminating information on education initiatives and advising on educational resources;
- ensuring that the award of FRCGP is a formal recognition of sustained performance and progressive professional development by continuing the work on fellowship by assessment in cooperation with the Fellowship Committee and implementing a procedure of self-nomination for fellowship by peer scrutiny and practice-based assessment;
- responding to requests from Council for advice on matters relating to education, in particular, about the General Medical Council (GMC), the Joint Committee on Postgraduate Training for General Practice (JCPTGP) and other postgraduate educational organizations;
- encouraging the furtherance of peer review among practitioners as a learning and teaching exercise using the 'What Sort of Doctor' formula;
- establishing guidelines on joint hospital visiting with the Royal Colleges.

The divisional executive consists of 13 members drawn from both within and outside Council. All are active practitioners who bring much experience and knowledge to the division. Much of the division's work is undertaken by working parties or ad hoc groups. Over the last year the divisional executive has been responsible for producing over 16 topical reports on matters ranging from educational strategy and distance learning to practice nurse education and higher professional training in general practice. The division also works closely with the GMC and JCPTGP in order to fully advise Council on matters relating to education.

The division's priorities for 1988 are in the following areas.

Fellowship by Assessment

Fellowship by assessment has been given highest priority within the College by the Chairman of Council, and in order to progress this project, the division has been given responsibility for undertaking initial discussion and to report to General Purposes Committee (GPC) and Council. The division's work will complement and develop that already carried out by the Committee on Fellowship and the previous Membership Division Working Party.

The division has established a working group, chaired by Dr Peter Hill, to undertake the detailed work on fellowship by assessment, building upon principles endorsed by GPC as a basis for discussion. It is envisaged that a discussion document will be submitted to Council in the near future.

Distance Learning

Distance learning for general practice has developed considerably during the 1980s and the division has provided input into activities such as Promptcard, Meshtel and the Clinical Assessment for Systematic Education (CASE) programme developed by the Continuing Learning in Practice Project (CLIPP). The CASE programme is designed to meet the continuing education needs of individuals, but it can also be a useful tool for trainers. The programme comprises 10 booklets per year on topics drawn from

clinical general practice, material in each booklet being provided by doctors working within College faculties throughout the country. This programme is continuing to prove successful and a second series is being developed for 1988.

Continuing Medical Education

The division is progressing its work on continuing medical education for principals, and intends to produce a report setting out priorities for the College in relation to the Government's recent white paper, *Promoting Better Health.*

Education Resource Centre

The division is keen to promote the College's record of educational innovation and has taken steps to investigate ways of improving support to the faculties and individual members. In looking at ways of collecting and disseminating information and encouraging new initiatives for learning, the division is considering the establishment of a resource centre at the College to encourage the exchange of educational information and learning techniques between faculties throughout the country.

Dr Bob Colville, Chairman, Education Division.

Annual Symposium

In 1987 a symposium was held on 'Practising Prevention — Study Day for the Primary Health Care Team'. Once again the division has been given the task of arranging the 1988 symposium which will utilize lessons and conclusions drawn from an evaluation exercise carried out last year. A working group has been established to undertake the detailed work involved in organizing such an event, and it will also be responsible for preparatory work and a follow-up evaluation exercise.

As I have already indicated, the above activities are of particular concern to the division in 1988 — but it will continue to look at other important topics throughout the year, such as practice nurse education and joint hospital visiting guidelines. There is no doubt that within the new College structure, the Education Division has an increasingly vital role. □

Bob Colville

COUNCIL

COLLEGE Council met at Princes Gate on Friday 11 and Saturday 12 March.

President 1988/89

Council heard from Professor Michael Drury, the president, that he had written to all faculty representatives on Council inviting names of potential candidates for the College presidency. The president informed Council that the awards committee had considered the resulting list of candidates and that it had compiled a shortlist of eligible doctors who were willing to stand for election. Council was asked to identify one person from the shortlist of three to put forward for the membership to consider at its AGM in November. Dr Stuart Carne was elected.

Awards

Council approved the folliwing recommendations from the awards committee:

- 1989 James Mackenzie lecture, Dr Julian Tudor Hart.
- 1990 William Pickles lecture, Dr Bill Styles.
- Baron Dr Ver Heyden de Lancey memorial prize, Dr Mollie McBride.
- Foundation Council award, Dr Douglas Garvie.
- Honorary fellowship, Mrs Joan Mant.

AIDS

Council discussed the final report from the AIDS working party and agreed that it was important to establish national and local guidelines in an attempt to educate GPs and GP trainers about this disease. Council agreed that copies of the report should be sent to all faculties and divisions of the College. The General Purposes Committee (GPC) will be asked to consider ways of financing a general distribution of the report to each College member.

Withdrawal of JCPTGP approval

Council received a letter from Dr Dorothy Ward, chairman of the Joint Committee on Postgraduate Training for General Practice (JCPTGP), indicating that the JCPTGP would be withdrawing approval of training standards in the North East Thames region from 1 February 1989. This decision had been taken following an inspection by the Joint Committee of training arrangements in North East Thames in June of last year. The JCPTGP decision had been unanimous and reflected the views of both the College and the General Medical Services Committee members.

Council agreed that:

- the Joint Committee should be asked to make available to the College details of the basis of their decision;
- the GPC, the education division and the examination board of Council would consider the issue and its implications for the College and the MRCGP examination and report back to June Council.

Faculty Status

Council was informed of the correspondence received by the College supporting the Humberside sub-faculty's case for full status. In view of this, Council reconsidered its decision and agreed that Humberside should become a full faculty of the College.

The next meeting of Council will be held on 10 and 11 June 1988. □

Cancer Information

CANCERLINK, a support and information resources centre for cancer sufferers, their families and friends, has recently produced two booklets.

When a Child has Cancer approaches the illness from a parent's viewpoint, and begins by explaining some of the reactions parents may feel when first learning of their child's disease. It also considers how children of varying ages may react and this may provide parents with a clearer understanding of how to deal with any subsequent emotional stress. The booklet concludes by emphasizing '...nobody knows what causes cancer, there is nothing you could have done or not done to prevent this happening'.

The second booklet, *Life with Cancer,* is a guide for people with cancer, their families and friends and looks at types of cancer, available treatment and suggests how to get the best out of doctors.

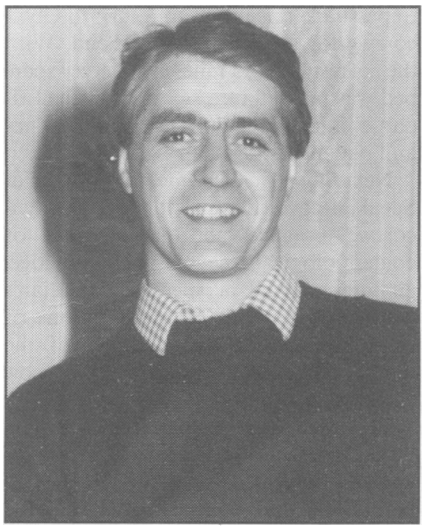
Both publications are available from Cancerlink at 46 Pentonville Road, London N1. The College is represented on Cancerlink by Dr Richard Baker, a member of the Severn Faculty. □

Faculty Secretaries Conference

THIS year's faculty secretaries conference was held last month at College headquarters in London. Twenty-four secretaries attended from different parts of the country and, as Dr Bill Styles, the honorary secretary of Council said in his introduction, an opportunity was provided for a two-way exchange of views and ideas relevant both to the College and general practice.

The meeting commenced with a talk by Dr David Murfin, chairman of the Services to Members and Faculties Division, who emphasized the priority of his division in developing faculties. He said that the division was fully aware of the problems some faculties may experience as a result of the increasing numbers of doctors joining the College. Dr Murfin felt it was important that effective communication was encouraged, and urged secretaries to make good use of newsletters and the news section of the *Journal*. He said it was important that faculties assess their work so that progress can be measured and areas for improvements highlighted.

The conference was asked to consider nominations for the faculty secretary vacancy on the Faculty Development Committee. The conference elected Dr Mike Morris (East of Scotland faculty). The Committee will hold its first meeting in April under the chairmanship of Dr Jacky Hayden (North West England faculty).



Dr Mike Morris

Dr Richard Parrott, the honorary secretary of the Tamar faculty, informed the conference of the work being undertaken by a working party within his faculty on fellowship by assessment. The working party had been considering this issue for over a year and were producing guidelines for visits to doctors applying for fellowship by assessment. Dr Parrott promised to let faculties have a copy of these guidelines as soon as possible. Professor Pereira Gray, the chairman of Council, reaffirmed to the meeting the feeling within the College that this issue was a high priority for 1988. □

Mike Hodgkinson, Information Technology Centre, demonstrating the College's new computer network system at the conference.

RCGP Study Day for the Homeless

THE College, in collaboration with the Medical Campaign Project, the National Association of Voluntary Hostels, the Simon Community and the Bethany Hostel for Homeless Families, is hosting a study day in May to consider the medical care of homeless people. The intention is to identify the problems encountered in providing medical care for homeless people and to consider ways of overcoming these barriers. The incorporation of the care of the homeless into postgraduate education for general practice will also be discussed. Participants will be welcomed by the president of the College, Professor Michael Drury, who will introduce the day's agenda.

To enable participants to get a feel for the situations faced by homeless people, background information will be provided from three scene-setters working in different areas of the community. This will be followed by examples of specific projects being carried out around the country by doctors and voluntary workers. The afternoon will be set aside for group work and a summing up session.

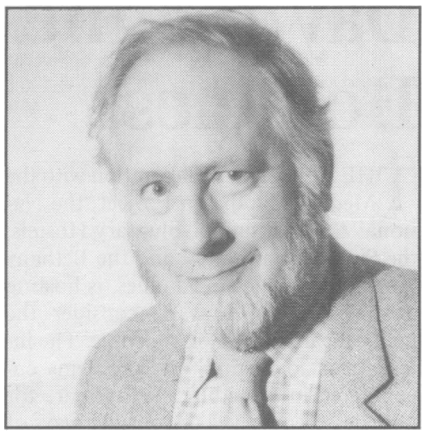
Regional advisers, faculty secretaries and members of relevant organizations have been invited to attend the day. Interested GPs are welcome to apply to the Central Secretariat at Princes Gate for a place. Registration costs £10, which includes coffee, lunch and tea (section 63 approval has been applied for) and cheques should be made out to the RCGP. The deadline for receipt of applications is 20 April. □

● A reference handbook has recently been published by INTERCOM, providing users with the telephone numbers and addresses of over 400 homeless advice centres, hostels and day centres in the Greater London area. It is intended for use by GPs, hostel workers, researchers, libraries, etc, and homeless people. It costs £6.45 (soft cover) and is available from Intercommunication Trust on 01-729 1434.

New Years Honour

THE College would like to extend its congratulations to Dr Colin Shannon who was recently awarded a CBE. Dr Shannon joined the College in 1966 and is a general practitioner in Hollesley, Suffolk. □

Pioneer at Glyncorrwg



Dr Julian Tudor Hart

DR Julian Tudor Hart recently completed 25 years of practice at Glyncorrwg, a mining village in South Wales. During that time, he has revolutionized the standard of medical care in his practice, pioneered population control of blood pressure, carried out epidemiological research of the highest quality, become an international figure on the politics and practice of primary care and fired a whole generation of doctors with his vision of what the future of general practice should be.

Last year, a surprise meeting was held at Glyncorrwg to mark this milestone in Julian's career, which was attended by virtually every doctor who had lived and worked at Glyncorrwg as a trainee, a partner or a research registrar. No organizer of a meeting ever had an easier task than to persuade this group to return to Glyncorrwg for a celebration weekend. With the nearest hotel 15 miles away, every spare bed was pressed into service. On the Friday evening, over 70 friends, colleagues and patients enjoyed an evening together.

Next day a medical meeting was held. Speakers covered the history of the Glyncorrwg practice, the development of epidemiological research in the practice, an international perspective of Julian's work, and a series of presentations of work being done by graduates of the 'unofficial University of Glyncorrwg', now working in other places.

Less well known than the work on blood pressure has been a series of epidemiological studies with the collaboration and support of the MRC Epidemiology and Medical Care Unit, at Northwick Park Hospital, Middlesex. The Director, Dr Tom Meade, pointed out that these studies all shared one characteristic — he had been told that they were impossible. That they had not only been completed, but had achieved consistent response rates of over 90% was a tribute to both Julian and Mary Hart. He doubted whether the work could have been done anywhere else. □

Graham Watt

Ian Dingwall Grant Award

THE Scottish Council is inviting applications for the Ian Dingwall Grant Award which is open to fully registered medical practitioners.

The £150 award is made to encourage young postgraduates preparing for a career in general practice to add to their experience. This may be done in one of the following ways:

- By spending a period of two weeks or so in a medical laboratory, library or university department reviewing a specific subject with the possible intention of preparing a pilot study, or to design a programme of continuing study or research which the applicant would complete later in his or her career.
- To plan visits to selected practices, health centres, academic departments or other institutions in the UK.
- Where an individual has already planned a visit abroad, the award might be used to supplement such a visit if this was considered appropriate.

Applicants are welcome to submit other proposals which will be considered by the selection committee.

Eligible applicants will be fully registered medical practitioners under the

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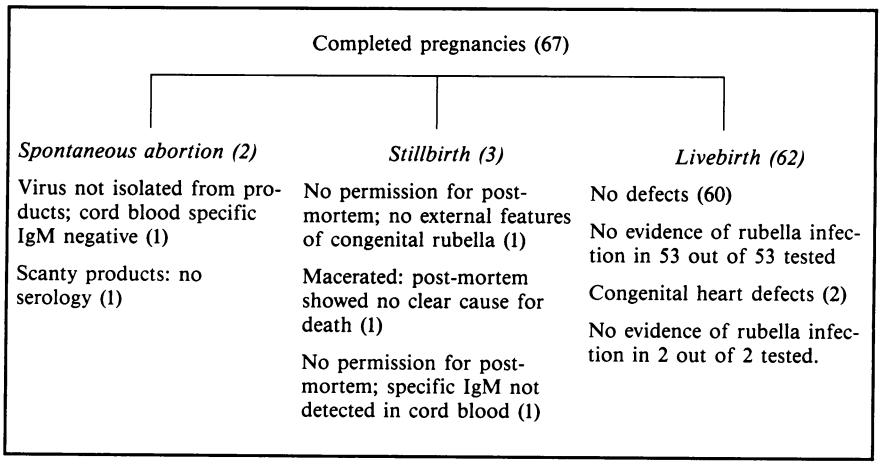
Rubella Surveillance

THE Royal College of Obstetricians and Gynaecologists has recently requested the assistance of RCGP members in reporting cases of rubella vaccination. There is currently no evidence to indicate whether vaccination during the early months of pregnancy, or in the weeks prior to conception, causes embryopathy. The RCOG is also encouraging obstetricians to report relevant cases to the Northern and Southern Registries involved with the National Congenital Rubella Surveillance Programme.

In 1981 the DHSS asked the programme to monitor the outcome of vaccine-associated pregnancies which were not terminated. Sixty-seven pregnancies were looked at, out of which 43 mothers were vaccinated before conception and 24 after. The results of the survey are shown in the diagram.

To enable the programme to carry on with its work, it is important that relevant cases continue to be reported. Correspondence should be addressed to: Northern Registry, University Department of Paediatrics and Child Health, D Floor, Clarendon Wing, General Infirmary, Belmont Grove, Leeds LS2 (Tel: 0532 432799 ext 3909), and Southern Registry, Department of Microbiology, Hospital for Sick Children, Great Ormond Street, London WC1N (Tel. 01 405 9200 ext 2141). □



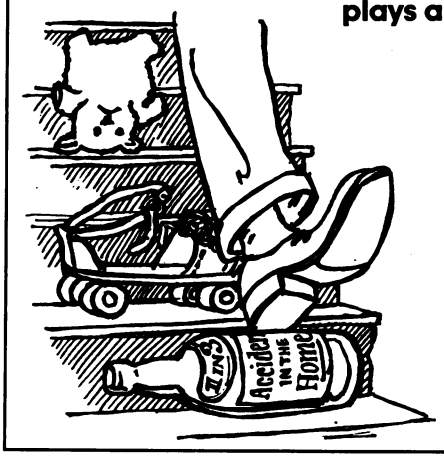
Cut Down On Your Drinking

GPs and other members of the primary care team tend to be wary of getting involved in alcohol problems. They are well aware of the difficulties and frustrations of trying to help 'alcoholics' kick the habit. Smoking, on the other hand, has aroused considerable interest and enthusiasm (some would say even fanaticism) and many general practices now have policies of actively looking for smokers and counselling them to give up.

Almost certainly much of the enthusiasm stems from the results of studies showing that brief intervention by GPs — advice backed up with an information booklet and the offer of a follow-up appointment — actually does result in a small but significant proportion of smokers kicking the habit at least for a year, and possibly for longer. Evidence that GPs could do more by counselling smokers in their surgery than 10,000 smoking withdrawal clinics seemed to convince health care professionals of the importance of this approach. So when the Health Education Council (as it then was) and ASH (Action on Smoking and Health) got together to produce and distribute the GUS kit, with its delightful Calman illustrations and its simulated EC10 prescribing 'Give Up Smoking!', the idea was well received.

Could this approach be used with alcohol? Several researchers, including Andy Haines and myself in London, and Peter Anderson and his team in Oxford, set out to find the answer. At first we had a number of reservations; certainly, the idea of intervening before the patient had developed major problems or full-blown alcohol dependence was appealing and would be in keeping with the increasingly popular preventive approach in general practice. It would also avoid the difficulties of asking GPs to increase their involvement with 'problem drinkers'. But there was the problem of defining who was at risk and therefore who should receive advice. In the case of smoking, it is not too difficult — anyone who smokes is at risk. But moderate drinking may actually be protective and limits therefore have to be defined. We chose 35 units or over per week for men and 21 or over for women. Then there was the problem of identifying patients with alcohol consumption in excess of the limits because everyone knows that drinkers never give reliable alcohol histories (or do they?). And then what about the advice? Most people would agree that the only acceptable message in the case of smoking is to give up completely. With alcohol, it has to be different. People drinking to excess should cut down on their drinking, but not necessarily stop completely. It seemed likely that this more subtle message might be difficult to get across.

Each year excessive drinking plays a part in:

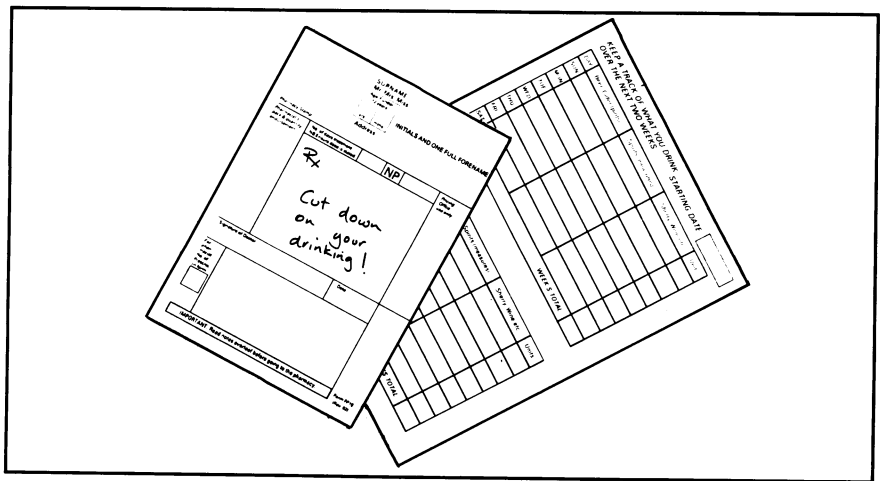


- 1400 deaths on the road (one in three of the total)
- Over 8 million days off work
- One in four emergency hospital admissions
- Nearly 70% of suicides
- One in three accidents in the home
- 60% of serious head injuries
- 17,000 admissions to psychiatric hospitals
- Up to 40,000 deaths in the UK

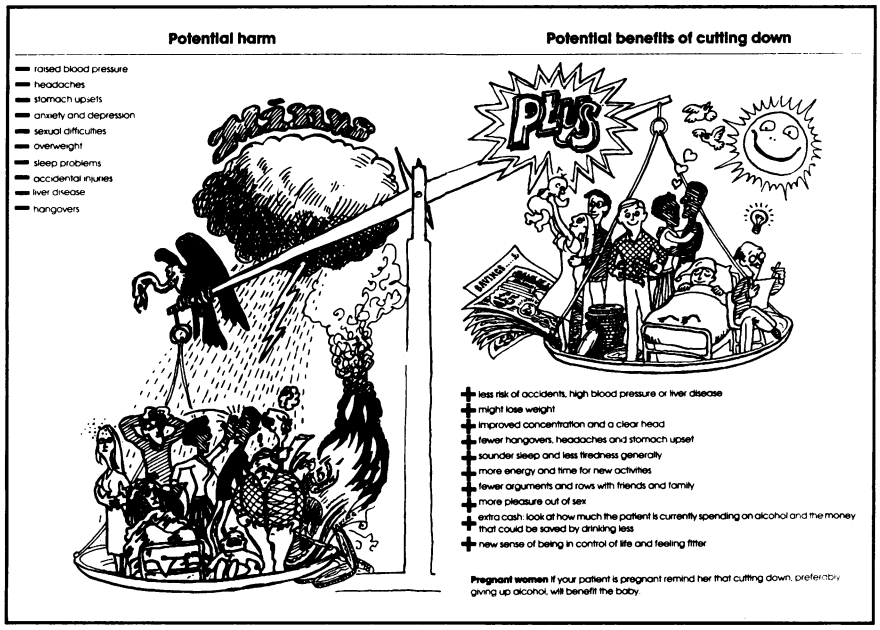
So it was with some trepidation that we embarked on a small study in our own practice using a health survey questionnaire asking about smoking, fitness and weight as well as drinking in order to identify our heavy drinkers. We were very gratified with the results; a 75% response to a questionnaire mailing in a deprived inner city practice, and around a 95% completion rate for each of the questions. Furthermore, the questionnaire seemed able to define a population of heavy drinkers, most of whom had not yet developed major drinking problems and only few of whom showed evidence of dependence. Encouraged, we went on to develop an intervention package and a protocol for a randomized controlled trial to evaluate it. The trial was eventually carried out in 47 of the MRC general practice research framework practices and a report of the encouraging results has now been submitted for publication.

In designing our intervention package, Andy Haines and myself collaborated closely with Peter Anderson and the Oxford team, drawing heavily on the experience of the smoking studies. We decided to adopt the same approach as the GUS kit; and so the COD pack (Cut down On your Drinking!) was born.

The prototype GP intervention package consisted of a review of the patient's drinking patterns, and the possible effects of drinking on his or her life. Just taking the time to think about their drinking can prompt patients to reduce their consumption. A chart was used to show how the patient's consumption compared with the general population; many patients do not realize that their drinking is heavy because they are surrounded by friends or colleagues who drink as much or more than they do. Firm advice to cut down to



The prototype COD-Pack (written and devised by Paul Wallace, Peter Anderson and Heather Jones).



A sample from the GP booklet.

specific targets of not more than 14 units per week for women and 21 for men was given and backed up with a prototype COD pack with the prescription 'Cut down On your Drinking!' on the front cover. The pack contained a drinking diary to fill in daily for review at a follow up appointment four weeks later.

The prototype COD pack proved popular with the practices taking part in the trial and when the preliminary results started to indicate that the intervention might be effective, we decided to approach the Health Education Authority and Alcohol Concern about developing the package and evaluating it in general practices which had no prior commitment to this kind of work. Both organizations agreed and with their support the package has now been refined and a pilot study in south west England is currently underway, under the supervision of Ann Buxton in Exeter. The package includes a short booklet for GPs, with background information about alcohol and its relevance to general practice. There are also guidelines as to how to use the rest of the kit, which consists of a block of 100 health questionnaires, two population posters for the surgery and a patient booklet with the prescription to 'Cut down On your Drinking!'. Like the GUS kit, the booklet contains a wealth of illustrations and information and tips about how to cut down. There is a mini-population chart, a guide to how to calculate consumption in units, and a drinking diary.

The pilot study is not designed to assess the effectiveness of intervention; that was the purpose of the multi-centre trial. What it will show is how suitable the package is for use in general practice. The results should be available by the end of the year. □

Paul Wallace

Obstetric Units

SHORTLY before the publication of its report *Anaesthetic Services for Obstetrics — A Plan for the Future with Special Reference to the Smaller Obstetric Unit,* The Association of Anaesthetists of Great Britain and Ireland invited the College to put forward its own views on the document. The College responded by saying that it was concerned that the document appeared to favour high technology obstetrics and that it also overstated the need for intervention. The College's comments in detail were as follows:

- The College supports the recommendation that a named consultant anaesthetist should be responsible for obstetric anaesthetic services in each unit or district. This does not exist for all units or districts at the present time and the College believes that it should.
- The College supports the recommendation that mothers should be carefully selected before being booked for delivery in smaller units. This could perhaps be given greater emphasis in the final version of the document.
- The College supports the recommendation that anaesthetists' assistants should be properly trained for their role.
- The College would not support the wholesale closure of small obstetric units — in general the hazards of anaesthesia do not relate to small units.
- The College would question the statement that approximately one-third of mothers require the presence of an anaesthetist during childbirth. This may be true in high technology units, but in units where low-risk mothers are delivered the figure is well under 10%.
- The College is not convinced that there is a link between anaesthetic deaths and smaller units. Comparisons should be drawn with the number of anaesthetic deaths related to unsupervised anaesthesia delivered by junior staff in large units.
- The College recognizes the importance of the anaesthetist in obstetric care and in resuscitation. However, it would challenge the statement that 'many mothers' expect routine analgesia, including epidurals, during labour. It is the experience of GP obstetricians that an increasing proportion of mothers now wish to deliver their babies with a minimum of, and possibly with no, analgesia and certainly with a minimum of intervention.
- The College welcomes the highlighting of present deficiencies and supports the suggestions for overcoming these as presented in section 5 of the report.
- However good the selection of patients for home and/or small unit delivery there will always be the rare emergency. The document has not addressed the need for an 'emergency flying squad' service with the anaesthetist travelling to the patient. There may be occasions when an emergency would be best dealt with on site rather than, or prior to, the transfer of the patient to a district general unit. The College believes that an anaesthetist should be part of every flying squad team to provide support for such occasions. □

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Ian Dingwall Award

age of 36 years, who intend making a career in general practice, and who at the time of application are currently undertaking, or who within the past five years have already completed, full time post-registration training in Scotland. Trainees or assistants should consult with his or her principal before making a submission. Applicants should be thoroughly conversant with the existing provisions for extended and intensive courses, as applications made only to support such attendance at a course would not be considered.

The application should consist of four copies of a statement indicating ways in which the award would be used, plus a brief CV, and should reach the Secretary of the Scottish Council on or before 30 June 1988. Further information may be obtained from the Secretary, Dr David Blaney at 2 Hill Square, Edinburgh EH8 9DR. □

General Practitioners and Disability

IN their daily work GPs see many patients with physical disabilities. A long training in the diagnosis and treatment of disease does not always help them to think beyond the disease label. It has been said that 'disability is not an illness, more a way of life'. The education, training and hospital experience of doctors ensure that they look for symptom patterns and physical signs pointing to disease. They confirm the diagnosis by investigations and institute treatment. This is right, and forms a sound basis for medical practice. Wise consultants take a broader view and adjust their advice to the patient's background and temperament, or leave the GP to interpret appropriately. Often the GP is in a better position to continue supervision and to help the patient to achieve a good way of life.

In some cases the patient retains many positive abilities, and personal or practical adaptation may allow a way of life with little handicap. For example, traumatic amputation of lower limbs leads to a stable disability, definitive adaptation and a recognizable individual handicap. Norman Croucher[1] lost both legs below the knee when he was 19 years old but afterwards walked from John O'Groats to Land's End and climbed many mountains that unimpaired athletes would not attempt.

It is more difficult to adjust to unstable and progressive impairments, such as in multiple sclerosis, when disability and handicap are likely to occur but unpredictably. Fortunately a practice of 10,000 patients will only have about eight patients with multiple sclerosis, of whom only three or four will be severely disabled. Like others disabled by neurological disease they will live many years and pose many problems. The GP cannot have all the experience needed to help, but can learn from other patients with similar disabilities, from appropriate consultants, the remedial professions, nurses, social workers and especially by listening to the patient and supporting relatives.

The Royal College of Physicians' Rehabilitation Committee was established in 1979 and renamed the Disability Committee in 1983. I have represented the RCGP on this committee, composed largely of neurologists, rheumatologists and general physicians, since 1979. Their report 'Physical Disability in 1986 and Beyond'[2] appeared in the July 1986 *Journal of the Royal College of Physicians.* The short section on the size of the problem gives useful figures of prevalence of severe disability or handicap for a typical group practice of 10,000 patients:

Arthritis (all forms)	34.4
Heart disease	6.8
Respiratory condition	4.6
Stroke (survivors)	13.6
Parkinsonism	2.2
Multiple sclerosis	3.2
Paraplegia	1.4
Total	66.2

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Obituaries

C.H. GILL

MA, FRCGP

DR Cyril Gill, who was a GP in Hampstead, north London, for 33 years, died recently, aged 66 years.

Cyril Gill was educated at Eton, Trinity College, Cambridge, and University College Hospital in London, from which he graduated in 1952. He entered general practice in 1954 and established the largest teaching practice in the area. In 1972 he became a member of the College and, 10 years later, was made a fellow.

For many years he was secretary and later president of the Balint Society, a group of GPs and analysts who research the interactions between doctor and patient in the consultation. He came to explore and utilize the important connection between the patient's personality, his or her personal problems and the clinical symptoms that are displayed. This led him to organize seminars for GPs, where case discussion was used to explore the doctor–patient relationship. He was the co-author of two books and numerous articles on this subject. Through his teaching and his work he influenced a great many medical students, doctors and patients. From 1978 until his death, he was consultant to the Camden Bereavement Society.

His absorbing interest lay in people and how best to help them and he did this with great understanding and compassion. Many patients looked on him not only as a doctor, but also as a friend. I knew him well and could feel the intensity of his caring for his patients and the degree of unsparing attention that he brought to his profession.

As a keen gardener and plantsman, Cyril found much relaxation in his half-acre cottage garden in Hertfordshire. He felt deeply about conservation and nuclear disarmament. He came from a musical family and spent much of his leisure time listening to music and playing the clarinet in chamber music ensembles.

Cyril leaves his wife Hilda, daughters Janet and Helen, and grandaughter, Nicola. □

Vernon Ingram

RONALD COVE-SMITH

MA, MRCS, MRCP, FRCGP

DR Ronald Cove-Smith, a foundation member of the College, died recently aged 88 years.

Dr Cove-Smith qualified in 1923. While working as house physician to Sir Frederick Still, he became interested in juvenile rheumatic disease. He later became registrar at the West End Hospital for Nervous Diseases. He decided against becoming an honorary physician at the King's College Hospital where he had been working as medical registrar, and instead went into general practice in Maida Vale where he continued to work well into his eighties.

Dr Cove-Smith was appointed to many committees, including the chair of the education awards sub-committee of this College. He was at one time president of the London Medical Society, president of the Harveian Society, a BMA council member and a past chairman of the BMA charities committee. He was also appointed to the staff of the West London Hospital as a GP specialist in child rheumatism and became a consultant on juvenile rheumatism and cardiology to the London County Council (later the Greater London Council).

In his earlier years, Dr Cove-Smith had been an important member of England's 1920s rugby teams. He leaves his wife, Peggy, two daughters and a son. □

LORD HUNT OF FAWLEY

THE Duke of Edinburgh was represented by Professor Norman Blacklock at a memorial service held by the College for Dr John Hunt on 16 March at All Souls Church, London. Over 400 family, friends and colleagues attended, including foundation members, past College presidents and presidents of other Royal Colleges.

Dr the Hon. Jonathan Hunt, his son, and Professor Michael Drury, the president of the College, read the lessons, and an address was given by Dr Michael Linnett. The service was officiated by the Reverend Richard Bewes, the Right Reverend George Reindorp and the Reverend Lord Sandford.

Guests were invited back to Princes Gate where an exhibition portraying Dr Hunt's life was on display. □

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General Practitioners and Disability

Clearly, the wide range of diseases and relatively low prevalence of severe disability means that an individual GP will have little direct experience of any one of them. However, different diseases can produce similar kinds of loss of function. This emphasizes the importance of learning to think in terms of function and ability and not only of diagnosis and treatment of disease.

The RCP report reviews the present situation regarding disability and the principles of medical involvement. An earlier report said in 1978 that 'rehabilitation is an integral part of patient care, and is therefore the concern of all clinicians'. From this base the report looks at the future evolution of medical services for the disabled. It proposes that they should be led in districts by consultants with designated responsibilities for generic services which are to be available for all districts:

- Disabled living centres
- Housing, housing modifications and rehousing
- The physically disabled school leaver
- Support services for younger severely disabled and handicapped people
- Driving for the disabled
- Sexual counselling
- Head injury services
- Visual handicap
- Hearing impairment
- Communications aids
- Wheelchairs
- Orthotics and prosthetics
- Urinary continence services
- Stoma care services
- Pressure sores

A system of checks and audit and a timetable for the development of services is suggested.

The role of the GP is described as follows:

- Defines patients' problems in physical, psychological and social terms;
- Helps the patient in the management of everyday maladies;
- Together with the district nurse and health visitor provides information about a wide range of assistance, advice and support;
- Helps the disabled person to live with disability and the family to support this;
- Refers to social workers, remedial therapists and other agencies, including voluntary societies working in the community;
- Refers to appropriate consultants, including those with particular expertise in disability and makes appropriate use of the specific district disability services (such as continence and stoma care).

How are these areas covered during medical education? In Oxford and other medical schools, undergraduates spend two weeks in general practice at the start of their clinical years. They have the chance to spend a day in the home of a disabled patient. During vocational training the first three functions listed above are well covered but no clear agreement exists about how to tackle the remaining three aspects.

As with most areas of learning, doing is the most important. However, some guidance and reporting back are needed. Rehabilitation consultants, remedial therapists, clinical psychologists, disablement resettlement officers and specialist social workers can give guidance. Visits to some of the generic services and special sessions on stroke illness or disabling arthritis may be possible. The trainee will learn by reporting back and integrating actual experience but to do this he or she will need to be guided towards appropriate patients and a list of such patients will be useful.

Finally, what qualities does the principal in practice need to have for dealing with disability? First, sensitivity to the needs of patients beyond purely medical needs, both in terms of the practical aspects of daily living and in terms of support from the family and community. Next, a working knowledge of the facilities available, the people providing them and how they may be contacted. This may involve, for example, more detailed assessment of the problems of daily living by an occupational therapist or a study of financial, occupational or emotional problems by a social worker. Then a plan must be formulated together with the patient and communicated to all concerned. To combine successfully the elements of information, assessment, communication and coordination requires considerable skill in teamwork.

There is much work to be done in the identification of disability.[3] The patients with severe disability will probably number less than 15 per GP. Many tend to be very independent and do not want to 'bother the doctor'. Regular contact should be established to deal early with problems such as pressure sores or urinary infection which may be endured by the patient. At the same time the need for independence must be respected. Disability attacks individual autonomy and solutions need to be worked out with the patient, who may feel angry or depressed by the condition.

The patient and family must be the centre of concern. There is an important role for GPs in helping patients to come to terms with their disability. It requires knowledge of available services, skill to introduce them appropriately and wisdom to decide how to support the efforts of the patient without sapping healthy independence. There is much to learn and to do. □

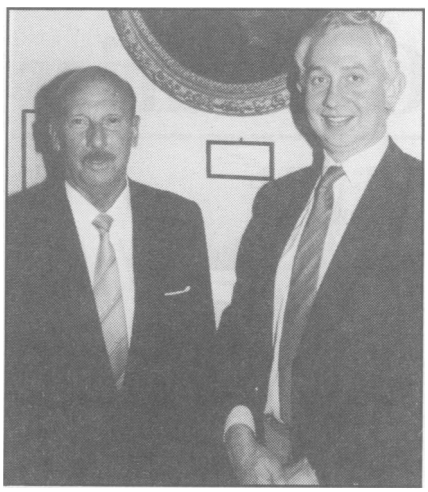
J.J. McMullan

References

1. Croucher N. *A man and his mountains.* Kingswood: Kaye and Ward, 1984.
2. Royal College of Physicians. Physical disability in 1986 and beyond. *J R Coll Physicians* 1986; **20:** 160-194.
3. Tulloch AJ. Prevalence of disability observed in an Oxfordshire practice. *J R Coll Gen Pract* 1985; **35:** 368-370.

Visit by Uruguayan Health Minister

THE College's Honorary Secretary, Dr Bill Styles, recently met with Dr Raul Ugarte, the Uruguayan Minister for Public Health during his visit to Britain. Dr Ugarte, whose principal responsibilities include the organization and management of medical assistance services and hygiene in Uruguay, was keen to discuss vocational training for general practice as well as the organization of primary care in the UK. □



Dr Bill Styles and Dr Raul Ugarte.

Medical Report Fees

THE British United Provident Association (BUPA) has decided to pay a fee of around £12 to GPs providing medical reports. From 15 March, BUPA will pay a fee for all medical reports received on existing and prospective subscribers to the association. The current system requires that prospective subscribers bear this cost themselves, and many GPs have found this to be unsatisfactory.

The fee will be paid for a short medical report taken from recent medical records and without a medical examination. □