BRITISH MIGRAINE ASSOCIATION

The British Migraine Association has awarded gold medals (valued at £250) for 1975 to Professor J. W. Lance of Australia, Dr A. M. Harper of Glasgow, and Dr K. M. Hay of Birmingham.

Dr K. M. Hay, *M.B.E.*, M.A., M.D., F.R.C.G.P., is a general practitioner in Birmingham and has been studying migraine for over 25 years. Dr Hay was presented with his medal by Mrs Aeronwy Thomas-Ellis who is the daughter of the Welsh poet Dylan Thomas at a Poetry Reading and Reception held at the Royal Overseas League on 9 January 1976.

THE MEDICINES COMMISSION

Dr M. J. Linnett, *O.B.E.*, F.R.C.G.P., general practitioner, London, has been appointed one of four new members of the Medicines Commission.

PETER DEBYE PRIZE

The State University of Limburg at Maastricht, Holland, is offering an appreciation prize of 20,000 francs (about £3,400) for the first time in 1976. It will be awarded to a person or group considered to have made a fundamental contribution to integral medicine. In this respect the integration of psycho-social health care within the field of primary health care will be a special—though not exclusive—point of consideration.

Recommendations should be made to Professor Dr M. A. J. Romme, Chairman of the Jury, Peter Debye Prize, The University of Limburg, Maastricht, Holland.

REGIONAL HEALTH AUTHORITIES' FUNDS

The financial allocations to Regional Health Authorities in England have now been published. The highest revenue expenditure per head of population was North-east Thames (£62·6) followed by the North-west Thames (£61·5) and South-west Thames (£59·8) and South-east Thames (£58·4) per head.

The regions with the lowest revenue expenditure per head of population were the Trent Region (£40·9), the West Midlands (£43·5) and East Anglia (£43·6) per head.

For the year 1974/75 the highest capital expenditure per head of population was in the Oxford Region (£8·2) followed by the Trent Region (£6·5), East Anglia (£5·7) and South-west Thames (£5·5) per head of population.

EMIGRATION

Dr David Owens, speaking in Parliament in February 1976, reported that for the year ending 1973 the outflow of British or Irish-born doctors was 920, the inflow was 630, and the net loss was 290. Of the outflow, 395 left hospital posts and 64 left general medical practice in the National Health Service.

SICKNESS COVER FOR THE SELF-EMPLOYED

Self-employed and non-employed people visiting West Germany will be eligible for medical treatment with effect from February 1976. In future this treatment will be provided on the same basis as for Germans themselves, i.e. the treatment will be free with a small fixed charge for any medicine prescribed, provided that such patients obtain a special certificate of entitlement to give to the German sickness insurance authorities. The procedure for obtaining treatment in West Germany is described in leaflet SA28, *Medical Treatment for Holiday Makers and other Temporary Visitors to Countries of The European Economic Community.*

Applications for the certificate of entitlement should be sent to the Department of Health and Social Security, Overseas Group, Newcastle upon Tyne, NE98 1YX, using form CM1—amended as appropriate—which can be obtained at the Department's local offices.

Denmark

Self-employed and non-employed visitors to Denmark are already able to obtain immediately necessary treatment under a bilateral agreement with that country.

VIRAL HEPATITIS

Viral hepatitis is prescribed as an industrial disease with effect from 9 January 1976.

Industrial benefits became payable for viral hepatitis from 2 February 1976.

REVIEW BODY ON DOCTORS' AND DENTISTS' REMUNERATION

The Review Body has issued a second supplement to the Fifth Report, 1975, recommending an increase in the reimbursement of expenses to general medical practitioners.

The Review Body concludes that "a measure of adjustment if justified at this time to avoid a situation in which a further underpayment might result". It recommends that "the provision for average practice expenses for 1975–76 should be £3,575. This represents an increased provision of £200 which should be reimbursed through the basic practice allowance and capitation fees, so as to maintain the current relationship in average gross remuneration between these items."

CORRESPONDENCE

OUT-OF-HOURS WORK

Sir,

The problem of out-of-hours work has again received attention in the *Journal* (January) and I write to offer some personal observations about deputising services:

I worked for the Tees-side service for 18 months whilst a vocational trainee in that area from 1971–74, making over 2,000 home visits. At first I attempted to classify these into 'reasonable' and 'unreasonable' calls; but so subjective was this that I abandoned the attempt. There were exceedingly few unreasonable calls, considering all the factors, including the patient's personality; and most of these few were made by relatives without the consent of the patient.

I wish that I had been able to go with Dr Roger Gabriel and explain to him the reasons why the 132 cases judged not medically necessary by him had called the doctor. They did not of course require the services of a physician from the Royal Infirmary, but a doctor trained in primary care.

Herein lies the crux of the problem. A doctor working for a deputising service needs some experience of, and greater awareness of, general practice. I do not believe that previous knowledge of the patient is necessary, and in very few cases did I find lack of it a handicap. I found the experience of deputising exceedingly useful, not least in the M.R.C.G.P. examination, where multiple choice questions so often relate to a 'new' patient. Some months my cheque from the deputising service was greater than that as a trainee, and I do not believe that any deputising doctor is exploited.

Let us distinguish any shortcomings of an alternative service itself from personal shortcomings of its employees. The commercial nature of these services means that they must become efficient, and to this end radio telephones, well equipped cars with experienced local drivers, and switchboard staff who are state registered nurses are used. Were their doctors always suitably experienced and trained (ideally practising local general practitioners and trainees) their standard of care could not be less than the extended-cover system in which I now participate.

As I try to find addresses in the dark, without driver or radio to obtain directions or further calls, and seeing patients of other local practices, of whom I have no personal knowledge, access to records, or continuity of care, I often reflect on these points, as does my wife, tied to the house and telephone not only at night, but throughout a fine Saturday or Sunday.

If we only treated patients requiring urgent medical aid most of us would be redundant. We must see patients who feel they need a consultation with a doctor; few will abuse us; all accept that their personal doctor cannot always be available. It is up to us to organise out-of-hours work, and a commercial service often seems better able to do this than individual and individualistic practices and practitioners.

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REFERENCES

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Sir,

I was most interested in your January *Journal* in which you discuss various methods of providing for night calls. The real problem seems to me to be the difficulty experienced by general practitioners when the same doctor is forced to work, not only during the night, but all day on either side of the night and often consecutive days and nights at weekends.

Even one telephone call, not requiring an actual visit, strategically placed at 0100 hours can completely ruin a whole night's sleep. This must present a danger to patients, since a tired, irritable doctor, is not a good doctor. Can you imagine the public outcry if other public servants like bus and train drivers, who hold other lives in their hands, were permitted to work continuously for 96 hours.

The solution, if we are to avoid Government direction and salaried service with set shift hours, must be worked out between ourselves. I have not heard these suggestions made elsewhere and they may be of interest to others.

In any urban population of approximately 140,000 to 150,000 people, there will be 50 or so established and experienced general practitioners. It can be shown that the average night call rate that such a population will generate is of the order of seven to ten calls per night. If all 50 or so general practitioners agreed to a rota, it would be possible for each general practitioner to be on for