# Practice management — common problems

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RCGP General Administrator

I joined the Royal College of General Practitioners in 1983 as a typical patient, typical that is in my limited understanding of general practice. An early objective, therefore, was to find out at first hand what general practice was all about by spending time at Members' practices. The first visit I made was the key, because what started out as a purely fact-finding exercise soon extended to serious discussions about some of the difficulties of running a practice. In the course of these discussions it became clear that someone like myself, fresh to the subject but with direct and substantial experience of the theory and practice of management, could offer help and advice both to this and other practices I had been invited to visit. This article examines several key management issues raised during these visits.

In the two or three days spent at each practice I confined myself to an overview of the main elements — the partnership, team relationships and, in particular, management style — rather than a detailed assessment of processes and procedures. As far as possible I talked to all members of the team, or at least one representative from each discipline, and I attended practice meetings where they were held. I encouraged people to give me their views on the management and the organization of the practice, what its strengths were, what problems needed to be resolved, and how this could be done. The discussions often covered issues which had not yet been followed through to a conclusion within the practice or had not been previously identified. Frequently the practice needed to look at its activities from new angles, and to see where tensions and organizational difficulties were symptomatic of more fundamental problems. Above all I tried to demonstrate that 'management' is knowing what you want to do, how to get it done, and how to assess how well you did it.

## What I found

These visits have had several results. Firstly, I achieved my original objective, namely, I discovered a great deal about how surgeries work. I also identified the organizational dichotomy that was the obvious unresolved problem in all practices visited.

General practice has changed dramatically in the last 30 years, especially in the move from single-handed to group practices involving many more people, from an emphasis on the doctor-led hierarchy to a matrix or team concept of organization. Yet it would seem that the implications of this basic structural change have not always been fully recognized by general practitioners especially in the way organizations function and in the extent to which management acquires a direct and significant bearing on clinical performance. Given this lack of recognition, it is not altogether surprising that doctors who prefer to manage the practice themselves in a strict hierarchical structure tend to encounter one set of problems relating particularly to commitment; that others who have overreacted and turned to a totally consensus form of decision-making have met the leaderless team problem; and that others who clearly want to pass on some management functions within a doctor-led team tend to run into yet another predictable set of problems concerned largely with delegation and accountability.

Both the hierarchical and matrix approaches are valid whereas the leaderless consensus is not; however, it is essential to be clear which of the valid approaches is to be followed. Given that there must be a clear understanding of the responsibilities of partnership, the doctors' policy setting role and the matrix relationships within the team, the preferred approach — hierarchy or team — will determine the way in which policies are implemented, relationships are handled and the administration of the day-to-day practice matters is conducted. The two basic approaches are therefore worth looking at further.

## Hierarchy or matrix

Hierarchical practice management structures, where the doctors dictate policy and practice and all other members of the team react to that leadership, are easy to understand, easy to operate and require fewer skills than more participative group structures. However, such a hierarchy is not easy to impose on the modern primary health care team that includes, as it does, members who are answerable to totally different organizations. These members include the attached community nurse and health visitor, both of whom are employed by the district health authority and, significantly, an increasing number of secretarial staff in health centres. While contributing in a participative way to the practice's health care pro-

cesses, these team members are answerable for pay, rations, career, discipline and so on, to an authority that may have somewhat different aims and objectives. So, the hierarchical approach can easily founder for reasons which are all too obvious.

To cope with this dilemma much is made of the 'matrix' or team approach to management, geared as it is to deal with situations where members of the team may have bosses outside the narrow organization of that team. This has led in some cases to overconcern for equality, and consequently an anarchy of consensus. For a true matrix or team to work, the team members have to take a corporate approach, namely, to look wider than the specific interests of their own paymaster and contributions of their own professional skill, and therefore to contribute to the totality of the group's objectives and purposes. Such a corporate team must have a leader. And since it is true that a corporate-style organization is difficult to manage, particularly where several professional disciplines are involved, there is also a need for an experienced coordinator to ensure that the principal aims and objectives of the team are met, as opposed to the individual aims and purposes of the contributing members of that team.

To repeat, it is vital for general practitioners to recognize and identify which sort of organization they are operating in (hierarchical or matrix) and therefore the likely group of problems intrinsic to both. Having established this, three major issues follow:

1. a need for doctors to reappraise the nature of partnership;
2. a need to improve the relationships between members of the practice team;
3. a need for doctors to resolve their ambivalence to delegation.

## Partnerships

The effectiveness of the doctor partners as a management group is the key to success in any organizational structure. It is essential for general practitioners to spend some time working out what their partnership actually means, not only as a purely personal agreement, but also in terms of managing clinical practice and the functions of all team members. Searching questions need to be asked about such matters as the range and strength of the partnership agreement, the regularity and formality of partner meetings, the clear development and statement of practice policies or otherwise, the system of ensuring such policies are followed through or otherwise, and the means within partnerships for dealing with conflicts.

Most practices are organized as a small business in which all partners have a financial as well as emotional and professional investment. The doctors are the board of directors of that organization and have, therefore, to work in a corporate or unified fashion taking responsibility for and account of majority decisions. The law recognizes this, holding as it does each partner responsible for the sins of omission and commission of each and every partner. It would seem sensible, therefore, for partners to have a clear understanding of their relationships. Regular formal meetings are needed, held at a quiet time, without interruption, formally minuted, where the skills of communications, decision making, chairmanship, leadership, co-operation and accountability all have to be brought into play, and where there is time to stand back to diagnose problems. Anything less, and major issues are likely to continue to be unresolved.

In understanding the nature of their partnership, doctors can also more easily understand and agree the purpose of their activities. One of the first questions they need to ask is 'For whom is this practice run?' This should then be followed by 'What are we trying to achieve, how are we achieving it, how do we know if and when we have achieved it, how do we resolve any priority clash between one objective and another?'

## Relationships within the team

The other main issue that arose in discussion with partners at the practices I have visited was their relationship with colleagues, non-medical as well as other doctors. As a professional administrator, I was particularly interested in the doctors' relationships with the receptionists, secretaries and practice managers. In 1978 Jones and colleagues said, 'Clinical work must be backed up by good practice organisation'.[1] By and large, the practices that I visited indicated that doctors find it difficult to appreciate the importance not only of systems of organization but also of the people who have to make them work. It is interesting that a profession that is concerned with sensitizing itself to patients' needs and the hidden agendas of the consulting room is less skilled at applying the same techniques in the office. When it comes to day-to-day procedures that are basically administrative and clerical, it is those who operate them who are in the best position to advise and suggest improvements, just as it is doctors who together can best decide clinical policies.

Lack of management training means that the doctors' approach is a reflection of the general view that 'administration equals red tape'. Done well, however, administration is an essential contribution to the effective and efficient achievement of an organization's objectives.

## To manage or to delegate?

These reviews lead me to believe that, from the administrative point of view, a practice has all the partnership, procedural, paperflow systems, and personnel problems to be found in any other environment involving more than one activity and skill. Indeed most books and articles on management in general practice offer advice

and solutions appropriate to a borough council office or a printing works. In other words, management of a practice requires the same techniques as management anywhere else. Those techniques in essence consist of knowing which is the right choice to make between competing demands, and therefore the most appropriate use of time and energy. It is knowing how to delegate, how to communicate effectively, how to plan, how to set objectives, and how to monitor achievement. And it is knowing how to lead and how to support, how to encourage and motivate, how to cooperate, how to take responsibility, how to make decisions, and how to exercise authority.

Who is to implement and administer the practice, when policies have been agreed and relationship problems have been identified? Until now, the emphasis seems to have been on teaching the doctors themselves to manage and administer. Is this the right emphasis? Doctors employ accountants, solicitors and other professionals to advise them in areas in which they are either not competent or do not have the time to acquire the degree of specialism required. Similarly, if they want their practices to be administered well in whatever is the chosen style and structure, the acquisition of skills by the doctor may be less effective than the employment of a manager who is already trained.

Where doctors prefer to take direct management control of their practices, there is the problem of time as well as lack of skill. It seems unlikely that a general practitioner, if he is to continue putting his major energies into his clinical work, can run a group practice personally. Indeed, Prichard states: 'Health care relies on the professional and technical competence of trained people such as doctors and nurses, the patients' willingness to cooperate, and the efficient support of administrative systems. To make sure all three are in harmony requires sensitive but firm skills of coordination'.[2] Practitioners have to ask themselves if they really have the time to acquire and exercise the skills of management. If the answer is Yes, then they must examine the impact on their clinical effectiveness and the organization of their own time.

My own view is that a general practice of any size can benefit from a lay coordinator, or practice manager. The move towards group practice is a first recognition of the doctor's dependence on other skills and professions. It takes only a small step further to recognize the need for a non-medical colleague to allow the professional clinician the maximum time to exercise professional skill and to minimize the time needed for non-clinical matters — indeed, one could argue that the continuation of the independent contractor in his own business depends on it.

## The practice manager

The practice manager ought to be the key figure in helping doctors raise the standard of general practice to the high level to which most of them aspire. Anticipatory care is the name of the game and patient education, prevention and the management of chronic illness are examples of activities which are time consuming. Above all, therefore, a good practice manager will help a practice maximize its use of time. Pritchard has put forward the valuable concept that time shares with money the principle that what matters is not the rate of spending or the total spent, but the value of goods or services obtained.[2] Cost effectiveness is mirrored by time effectiveness. It is for the practice manager, therefore, to analyse and question the practice administrative activity — length and number of surgeries, the management and support to clinics, the optimum use of staff, the need for and provision of good systems to support the medical team. He/she should maximize the effectiveness of the practice meetings by careful planning, preparation, and minuting.

Decisions on policy are a matter for the partners — policy on financial matters, on prescribing, on referral, on availability or indeed any other clinical activity. However, such decisions can and should only be made after taking due note of advice from other members of the team and on the basis of fact and advice from the professional person running the day-to-day work of the practice.

It is also the practice manager who should take the lead in computerizing. Most practices that have introduced computers so far have done so as the result of a particular interest shown by one of the partners. It is the doctors who have explored and developed the argument, and in many cases stimulated and supervised the installation. A good practice manager should relieve doctors of these onerous responsibilities and develop, install and manage computerization themselves.

A good practice manager earns his/her salary by increasing the income to the practice. The job, among other things, must be to ensure that revenue is maximized and that expenditure is cost effective. He/she should ensure that fees earned are claimed and paid, those services where extra revenue is available are streamlined, and the costs of various forms of treatment are compared so that partners can take rational decisions about policies in full knowledge of the financial implications.

The best way of knowing if a candidate has the qualities and practical skills needed is to judge their experience, talk to their previous employers and colleagues, and assess their commitments. Specific qualifications are not necessarily a guide, though higher education should have developed the confidence and the ability to analyse that is essential for the job. The same is true of specific experience. Clearly, medical experience will shorten the learning curve, but a fresh mind with the skills to adapt quickly and the abilities described could as well come from elsewhere.

## Conclusion

General practitioners can benefit from systematic approaches to practice management to support their clinical work. They will know what services they are providing, what needs improvement, and how to achieve the enhanced standard of patient care thus identified. An outsider, both of the practice and the profession, can provide the time and objectivity for this development, as my own experience has demonstrated.

The most stimulating aspect of my visits was the general awareness in the practices of the need for help and advice, and the continuous search for improvement. This is underlined by the steady flow of requests to the RCGP Library and Information Service either for a visit on the basis described in this article, or for information and guidance on all aspects of the practice and patient care. The general practitioner's ability and willingness to examine himself and his practice critically must be unique. It is exemplified in the College's concern with performance review and its Quality in Practice Initiative. It is perhaps the most important and optimistic factor in the development of primary health care in the next 30 years.

### References

1. Jones RVH, Bolden KJ, Pereira Gray DJ, *et al. Running a practice.* P13. London: Croom Helm, 1978.
2. Pritchard P, Low K, Whelan M. *Management in general practice.* Pp18, 113. Oxford University Press, 1984.

# Comment on the Report of the Committee of Inquiry into Human Fertilization and Embryology (Warnock Report)

## Introduction

The Royal College of General Practitioners welcomes the Report of the Committee of Inquiry into Human Fertilization and Embryology, and commends its authors for the clear and uncomplicated way in which they have presented their views and recommendations. The Committee has explored thoroughly the complex ethical and legal difficulties that are associated with recent developments in human fertilization and embryology and has taken account of a wide range of feelings and opinion.

When preparing its evidence for this Inquiry in 1983, the Council of the College was unable to reach a consensus view on whether or not experimentation on human embryos is ethically acceptable. We note that the Committee of Inquiry has encountered the same difficulties among its membership and that it has acknowledged these by presenting in its main report a majority view on this issue. That the Report should contain expressions of dissent on experimentation on human embryos and on surrogacy truly reflects the uncertainties of our society. When considering these matters, a consensus view is hard to reach at present. Undoubtedly views will change in time, and future policies will have to be sensitive to changes in public opinion.

There must be limits to new developments and practices in human fertilization and embryology. These limits will have to be defined — particularly for the extent to which experimentation can take place on human embryos, and also in relation to surrogacy.

We have considered the Committee's Report under five main headings:

1. The recommended new statutory licensing authority
2. Experimentation on human embryos
3. Surrogacy
4. Organization of infertility services
5. Other issues

## The recommended new statutory licensing authority

The College welcomes the recommendation that a new statutory licensing authority should be established to regulate research and certain types of treatment for infertility. The suggestion that such a body should be convened was contained in our evidence to the Committee of Inquiry and had the full backing of the Council of the College.

We endorse the proposed responsibilities for this body — that it should guide those who work in this area and also that it should advise Government and Ministers. We welcome its accountability to Parliament through an annual report setting out details of research work that is in progress.

The College supports the proposal that this group should have an executive function to grant licences to those who offer certain kinds of treatment for infertility, particularly those treatments that involve the storage and use of human gametes and embryos.

The College believes that this group should be responsible for providing ethical guidance on the types of research that are acceptable in the light of current

scientific knowledge and the attitudes of the general public. This group should keep the ethical issues that are related to human fertilization and embryology under constant review in the light of public and professional opinion. Its membership should be drawn widely and should include members of the health and legal professions as well as representatives of religious organizations.

Lay representation on this group should be substantial and we suggest also that there should be adequate representation from general practice. General practitioners are involved in the care of subfertile couples at all stages of management — providing counselling services and support from the earliest stage to the latest — helping couples to cope with the emotional and interpersonal difficulties that are often associated with subfertility. General practitioners are also well placed to offer opinion and guidance to Government and Ministers on the overall provision of infertility services and their future development.

## Experimentation on human embryos

The College acknowledges the succinct and comprehensive way in which the Committee of Inquiry has presented the arguments for and against the use of human embryos as research subjects.

In general, the range of views on this issue is wide — from those who are totally opposed to any form of research on human embryos to those who believe that important advances in medical care, and particularly in the field of certain genetic and metabolic diseases, will not be possible without it. This wide range of views is represented among the membership of our College. Each individual's opinions are based on his/her own personal beliefs and ethical values. With a membership of over 12,000 doctors it is not surprising that a well-defined consensus College view has not emerged. Perhaps more general agreement will become possible as more knowledge becomes available. In the meantime, the College believes that a mechanism must be established quickly for coping with the ethical issues related to experimentation on human embryos as they continue to present. We look to the new statutory licensing authority to provide the basis for this.

The College supports *in vitro* fertilization as a possible treatment for infertility when clinically indicated, and endorses the view that human embryos can be frozen with the aim to implant them at a later date in order to achieve a successful pregnancy.

## Surrogacy

The arguments for and against surrogacy have been well presented in the Report.

At present, little is known about the emotional effects of surrogacy on a pregnant mother and on the child to whom she gives birth. There is little evidence about the extent to which bonding takes place between a mother and child during pregnancy, and we can only guess at the possible irresolvable emotional conflicts that might develop between all parties concerned, including the resultant child.

Although we are concerned that surrogate mothers are at risk of exploitation and abuse, we believe that our present knowledge of the issues relating to this is incomplete. The College believes it would be premature to seek legal remedies to limit the activities of those, both professional and non-professional, who knowingly assist in the establishment of a surrogate pregnancy until more is known about the possible harmful effects of surrogacy on all the people concerned.

The effects of surrogacy should be kept under constant review by the recommended new statutory licensing authority. The practice of surrogacy should only be limited by the law if and when it can be shown to be harmful to any of the parties involved with it.

The College believes that the organization of surrogacy for commercial purposes is unacceptable and that legislation should be enacted to restrict this.

## Organization of infertility services

All forms of treatment for infertility, including *in vitro* fertilization, should be available through the National Health Service. We are concerned that in some parts of the country the levels of provision for subfertile couples is so low that they have no choice but to seek treatment from the private sector. We hope that the recommendations in this report will end this unfair distribution of services and that they will make such recourse by subfertile couples unnecessary in the future.

All forms of treatment for infertility should be available to all those couples who may need them, and we welcome the suggestion that these facilities be separate from other types of gynaecological activity. As well as making best use of available resources, such separation will make easier the development of the counselling and support services that are important parts of the treatment of subfertility.

We welcome the recommendation that a national working group be established to advise health authorities on the organization of infertility services. We believe that planning these services should take place at a regional level, and that the needs of the infertility services should be included in regional Health Authority strategic planning in the future. These services must be funded appropriately and without detriment to those being provided and developed for priority groups such as the elderly and the mentally ill.

## Other issues

a) We support the treatment of infertility by artificial insemination by donor (AID), by egg donation, by *in vitro* fertilization, by embryo donation and by the clinical use of frozen embryos. Practitioners and centres providing such treatment should do so only under licensing

arrangements with the new recommended statutory licensing authority.
b) We welcome the view that the statutory licensing authority should follow up the progress of children born as a result of new techniques in this field.
c) We are opposed to the sale or purchase of human gametes and embryos.
d) We support the recommendations that relate to the principles of provision. In particular, those that recommend the consent of both partners to treatment, the limitation to 10 of the number of children fathered by one donor of semen and the principles set out for egg donation.
e) While we appreciate the importance of sex selection for the purpose of avoiding hereditary sex-linked disorders, we would be unwilling to support any activities that made sex selection generally available for couples who wish to make use of it for social reasons only.
f) With the exception of recommendation 60 the College welcomes the recommendations in this Report that clarify the legal position of children born after AID, and in particular we welcome the recommendation that such a child be treated as the legitimate child of its mother and her husband. We welcome the recommendation that gives similar rights to children born after egg donation or embryo donation.
g) The College suggests that the view expressed in recommendation 60 be modified so that an embryo that has not yet been frozen, and which is already booked for an implantation operation at the date of the death of its father, shall not be disregarded for the purpose of succession to and inheritance from the latter.

### Conclusion

This Report has properly considered the moral, ethical and legal implications of recent developments in human fertilization and embryology — such consideration must continue in the future in the light of scientific developments and changing public opinion.

Only a few couples with the problem of subfertility will encounter many of the techniques considered in this Report and the difficult moral decisions associated with them. Yet every subfertile couple will have a general practitioner whose advice on treatment they will seek and with whom they will discuss future management. We believe that the support and counselling offered by general practitioners to these people to be of the greatest importance, and it is the aim of postgraduate training in general practice to help doctors to acquire the necessary knowledge, counselling skills and attitudes to undertake this difficult work with the people for whom they care.

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# National No-Smoking Day 1985

ALISON J. HILLHOUSE

National No-Smoking Day 1985 is on 20 March. The events this year look like being even more successful than National No-Smoking Day 1984, when 1.3 million smokers tried to give up for the day.

Requests for the campaign materials are flowing in steadily, and supplies were already running out by the end of January 1985. The specially produced posters, stickers, balloons and 'stuffers' for wage packets are now being reprinted in an attempt to respond to all the requests from health authorities, workplaces, schools, and other organizations who are planning to use them to stimulate action locally.

Press and media interest is building up, and the organizers already have a list of over 200 events being planned for the day all over the UK. These range from an in-house campaign in the Atomic Energy Authority's site at Dounreay in Caithness, to a proclamation of the day by the Mayor and Town Crier at St Austell in Cornwall, with many local events in places between.

National No-Smoking Day is sponsored by Action on Smoking and Health (ASH), the British Heart Foundation, the British Medical Association, the Cancer Research Campaign, the Chest, Heart and Stroke Association, the Health Education Council, the Imperial Cancer Research Fund, the National Society of Non-Smokers, the Scottish Health Education Group, Tenovus, and the Ulster Cancer Foundation. In other words, all the major bodies concerned with health education and the prevention of smoking induced disease, have joined forces to suggest to the 15 million cigarette smokers in the UK that they should try giving up, even for one day.

National No-Smoking Day aims to create a climate of encouragement and support for smokers who want to stop. Given the enormous health problems caused by smoking, it might seem frivolous to suggest that it is worth while stopping for one day only. The response to last year's No-Smoking Day, however, showed that the psychology was right, and that many smokers used the day as the start of a serious attempt to stop smoking for good. The format also allows non-smokers to support friends, colleagues or family members who want to stop, while those who stop just for the day feel that they have made a useful contribution to a national effort. The emphasis throughout is on enjoyable activities.

National No-Smoking Day looks set to become an annual event. It is popular with smokers and non-smokers alike, and helps to focus public attention on smoking as a health issue. Above all, it presents a positive and cheerful message which contributes to the growing public belief that the smoking epidemic can be defeated, and that smokers can be helped to give up the habit.

# MRCGP Examination results

The following candidates were successful in the Membership examination of December 1984. (*denotes distinction)

Margaret D. Abbott, C. B. Ackner, Kathryn R. Agascar, Janet Almond, Shahid Amin, Patrick Andrews, Philip Archer, A. M. Armstrong, Philip Astbury, P. H. Atkinson.

A. G. Baird, P. N. Barker, Jill A. Bartlett, H. K. Batra, G. R. Beach, Marie T. Beattie, Berenice R. Beaumont, D. M. Begg, Helen S. Belger, P. S. Berry, M. J. Betterton, M. J. Beverton, H. S. Bhachu, M. A. Bhojani, Kim Billington, James Blackstock, C. E. Blake, A. J. Bolton, Pamela Booker, D. F. Booth, Maria C. Bradley, *Paul Bradley, G. C. Bradley-Smith, Jill Braybrooke, Patricia A. M. Breen, K. J. Brennan, E. M. Brooke, N. G. Bruce, Margot E. Buck, P. W. Buckler, M. N. M. Buckney, *J. D. Budd, D. M. Bull, Kathleen M. Burns, Kilian J. Bute, H. J. Butland, A. J. Byron, J. R. Bywater.

Agnes D. Capaldi, Mary R. Carney, Kirsteen Carr, L. N. Cartwright, A. L. Challis, S. P. Chan, Helen G. Charley, P. K. Christian, C. W. Clarke, Judith Clarke, Angela Clifton-Brown, H. C. C. Coleridge, J. W. Collins, D. J. Conaty, T. P. Connery, T. F. M. Cooper, Anne E. Covington, Elizabeth W. H. Cowan, I. D. Cox, Deborah E. Crawley, R. P. Croft, Sheilagh M. Cronin, N. J. C. Culverwell, K. T. Cunningham, Mark Cunningham-Hill.

Susan P. Dale, P. J. Denner, K. S. Dennis, Susanna M. A. Denniston, Hilary W. Devonshire, Nicholas Deytrikh, J. C. Dixon, M. D. Dixon, Angus Donald, J. M. Doody, Alison Douglas, Diana E. Drife, Frances E. Duggan, J. A. Dunne, L. D. Dunne.

Jill E. Edwards, Katharine M. Edwards, M. A. Edwards, M. C. Edwards, Ann T. Egan, Sarah J. Egelstaff, S. D. Elliot, C. J. Elliott, D. R. Elliott, Sandra Emerson, W. A. Emery, T. E. Escott, Mark Euden, D. R. Evans, Gillian F. Evans, K. M. Evans, M. R. Evason, Rosemary M. Eyre-Brook.

C. J. Fawcett, P. G. Fermie, D. C. Fish, A. P. Fitzpatrick, P. Clare Fleming, P. T. Fletcher, Deborah F. Flute, Kathleen E. Fordham, S. E. Fordham, *Janet C. Foster, Mary Y. Frame, A. C. Freeman, Kazimierz Fuks, A. A. Fyall.

M. J. Gannon, G. M. P. Gardiner, S. R. Gash, Emer M. M. Gavin, Maria H. Gawlinska, T. M. Gent, M. D. Germer, P. R. Getting, Mary G. Gibbs, G. D. Gillespie, S. O. Gilmer, Philippa K. Godfrey, *I. D. Gold, Alison M. Goldie, Janet E. Goldstein, C. D. Good, Elizabeth A. Goodburn, Pamela L. Gooder, Carol M. Goodman, Helen R. Gordon, R. K. Goulds, A. R. Grange, Kathryn E. Grant, B. J. Greenaway, W. V. H. Gregg.

D. E. Hague, Deborah J. Halsey, I. J. D. Hamilton, Ewan Hamnett, S. J. Hargreaves, R. A. G. Harker, P. J. Harney, Joanna M. Harries, Francesca Harvey, Olivia T. Headon, S. R. Heard, D. L. Hearn, J. P. Heatley, J. S. Heaton-Renshaw, K. B. Heller, Jane Hempson Brown, L. R. Hendry, *Penelope J. Henley, N. C. Hewett, T. G. Heyes, B. A. Hill, D. C. W. Hilton, Gillian A. Hodgson, C. M. Holliday, J. D. P. Holliday, J. J. C. Holliday, G. M. Howie, P. K. Howie, Susan Huey, E. J. Hughes, Isabelle L. Hughes, K. J. Hurrell, Carolyn Huston.

P. T. Jagger, H. R. Jenner, Caroline R. Jessel, J. A. Jewell, S. K. R. Johnson, R. C. M. Jones, R. L. D. Jones, T. W. Jones, Kalpana Joshi, C. B. Judge.

*Renee L. Kathuria, C. C. Kelleher, Olivia Kemp, Caroline J. Kennedy-Cooke, A. P. Kenny, Frances N. Kerr, I. P. Killeen, N. H. T. King, Fiona R. A. Kingston, K. E. Kotowski, P. D. Kraus.

Susan Lack, J. E. Ladd, P. M. Landy, C. E. Langan, J. D. Latham, Barbara I. M. Laue, C. W. Lawson, D. J. Lawton, G. J. Lazell, Gail A. Le Fevre, A. C. Leahy, B. W. Lean, R. M. Leary, P. A. Leftley, S. M. Leslie, S. W. Little, J. D. T. Lock, Bridget M. Logan, D. R. Logan, C. A. Long, Susan E. H. Lumb.

D. C. MacAuley, P. M. MacKay, N. F. T. Mackie, Jane R. Mackrell, P. K. Madon, Sunil Maini, P. J. Manders, B. M. Markey, R. C. L. Mathewson, Susanna M. Maybin, Pauline S. McAlavey, Joanna H. McDonnell, N. J. McFetridge, June E. A. McKnight, Dolores B. R. McMahon, Mary M. McManners, Thomas McMaster, T. M. McMillan, Baron Mendes da Costa, M. J. Middleman, Jill P. Millar, P. J. Moorhouse, A. T. Morgan, G. J. A. Morris, Susanne M. Morris, G. R. Morse, J. E. Moss, A. C. Murray, C. F. M. Murray, E. M. Murray, Marleen Murray.

S. H. Nissenbaum.

T. G. O'Donovan, D. R. O'Leary, M. A. O'Loughlin, Mary A. O'Mahony, Anne G. M. O'Reilly, C. G. Oates, P. J. Old, Susan G. Overal, Karen Overs, B. C. Owen.

Susan F. Pack, Janet R. Parish, Susan L. Parker, *Yvette M. Parker, S. J. Parkes, P. A. Patchett, A. G. Paterson, Mary M. Peddie, Lindsay A. Phillips, *N. D. T. Pimm, D. R. Plenty, Lynn J. Porter, Rosemary A. Poston, J. R. C. Potter, D. G. M. Powell, A. M. Procter.

P. M. Quinn, J. C. Quirke.

Alicia M. Rawlinson, Patricia J. Ray, B. A. Reid, Clifford Richards, Shona M. W. Richardson, Stephen Richardson, Elaine Robb, G. P. Roberts, P. M. Robertson, *Karen A. Robinson, Jennifer D. Rowden, V. L. Rowe, R. G. Rowland, S. P. Ruffles.

P. J. Sagar, *C. J. Salisbury, R. L. Salmon, Carolyn Samuel, Wesley Scott-Smith, Deirdre J. Shawe, S. A. Shearer, Elizabeth A. Shephard, P. R. Shepherd, J. H. Shribman, Elizabeth M. Y. Shui, Ronald Simpson, O. S. Singh, D. B. Slattery, R. E. G. Sloan, Caroline M. Sloper, D. J. G. Smart, Alison D. Smith, D. D. Smith, F. R. Smith, M. D. Smith, *Sara M. L. B. Smith, R. E. B. Solomons, J. M. Sommerville, A. G. Southwell, Caroline M. Spencer-Palmer, J. E. Spicer, Gordon Stainer, *Mary R. Stainer, Paul Staten, Thomas Stenhouse, R. J. Stephens, Anne G. Stevenson, Dorothy E. Steyn, Andrew Storer, J. P. Strauss, Gillian D. Summers, R. A. H. Swain, W. St. C. Symmers, Gabor Szekely.

M. J. Tate, G. R. W. Thomas, S. D. Thompson, A. D. Thomson, A. G. Thomson, Janet M. G. Thomson, Sandra M. M. Tighe, P. D. Toon, Susan V. Toothill, Penelope A. Trafford, D. J. Turner, Neil Turner, K. P. Tutte, Carolyn S. Tweed, A. T. Tylee.

V. S. Ubhi.

Janice Vaughan, Fiona B. Vella, C. M. Vincini.

Karen A. Walker, Robert Walker, Siobhan Wallace, G. A. Walpole, Jacqueline A. Ward, Caroline Warren-Browne, N. J. Warrington, Valerie J. Wass, Elizabeth J. Watkins, *N. E. Wengrowe, G. P. White, Patricia M. Whittaker, *Alison J. Wickert, N. M. Wilkinson, P. G. N. G. Williams, Janet Willis, D. S. Mac G. Wilson, T. K. Wilson, C. J. Woods, D. M. M. Woods.

N. T. Yarr, Helen Yates, P. A. Yates, Elaine R. Yeo, B. K. Young, Jean I. Young.

# Miscellany

During the debate on the *Journal* which preceded the December Council meeting, criticism was expressed at the amount of pharmaceutical advertising carried. Could I suggest that the answer could well be with the readership? Many of you will have relationships with commercial firms outwith the pharmaceutical industry. Why not suggest that they advertise in the *Journal?* After all, the circulation of the *Journal* is increasing relentlessly, and is distributed to a group of high income people who need motor cars, computers, radios and hi-fi; who bank and who need insurance. How about it?

The relationship of the profession with the Government, or the apparent lack of it, must have saddened many doctors. First we had the deputizing crisis and now the proposals for a limited list. On both occasions, the intention of the Government was thrust upon the profession without prior consultation. The result is ill-feeling and acrimony, not a suitable atmosphere in which issues of importance to the nation's health should be debated. Some time ago, Kenneth Robinson remarked 'You cannot have a health service without the doctors.' Ministers please note.

Regarding the limited list controversy, I see that the Chief Medical Officer, Dr Donald Acheson, has said that 'The list will be as clinically sound as is possible.' Apparently, in his advice to ministers he has drawn on 33 years of clinical contact with patients, 18 of which were as a consultant physician. One might justifiably ask, how many as a general practitioner? The more the Government's proposals are scrutinized, the more one's opinion moves away from the need to secure £100 million towards the desire for control.

We already have a system of medical care in which the prescribers are among the most economical in Europe, even the world, and the country commits less of its gross national product to health care than most of our comparable European neighbours. Compassionate people, of whatever political persuasion might pause to reflect on the implications for the National Health Service if the Government's proposals succeed. Looking to the future, what of the antibiotics and antidepressants? Will investigation be next on the hitlist? Many branches of the profession have already moved towards more effective prescribing policies.

Surely the way forward for the Government would have been to harness existing strategies and commit funds so that they could be fully developed. Policies could then evolve which would cover the whole of prescribing, not merely tranquillizers, analgesics and antacids.

To me, Richard Asher was a medical essayist without rival. However, those who enjoyed his writings might like to be acquainted with those of Lewis Thomas. His collection of essays entitled *The youngest science: notes of a medicine watcher,* was published by the Oxford University Press in 1984.

Rubella immunization campaigns continue to attract publicity, justifiably so. However, let us not lose sight of the appalling rate of uptake of measles vaccination. Surely a challenge for general practice.

The recently released report on the Sudden Infant Death Syndrome expresses the usual criticism of general practitioners. Interesting that one of the members of the team who reported is now a private general practitioner. Not for him the rigours of NHS general practice? Those who advocate more intensive training of general practitioners in child care might pause to reflect on the fact that whilst such training is sought by virtually all trainees, the paediatricians have not always been most forthcoming in releasing jobs for vocational training schemes. The situation, happily, appears to be improving, and links between the College and the British Paediatric Association are much better now that the College has an observer on the Council of the BPA.

The health visitors have recently announced their policy statement on child surveillance. Undoubtedly it will be read with great interest by general practitioners. When it has been suitably digested, why not a conference sponsored jointly by the HVA and RCGP with contributions from community medicine and the British Paediatric Association? The aim might be 'Just what is worthwhile, and who should do it?'

Those who criticize the apparent lack of interest by general practitioners in paediatric surveillance might like to pause and note that, already, 30,000 paediatric cards have been sold by the BMA and RCGP since their launch in October 1984. Also, the booklets which accompanied them have all been sold, and a reprint of both cards and booklets is now taking place. A second edition of the booklet is in preparation.

You will know that, after the autumn elections for Council, John Ball now treads the corridors of Princes Gate. I hope he feels welcome. He has accepted an invitation to join the advisory panel for the College Information Service. I know that the Director, Ms Mary-Anne Piggott, welcomes his courteous acceptance. Other doctors who have been invited to join the panel are Dr Ridsdill-Smith, Dr Oldroyd, Dr McKinlay, Dr Pringle and Dr Stoddart.

I have heard that spot diagnoses have been, and maybe still are, prominent in the DCH examination. Doctors, by virtue of their need to visit patients, have to a considerable extent become slaves of the internal combustion engine and the framework in which it is carried. The reader may now justifiably question the relationship between the automobile and the DCH. Patience, all will be revealed. Exchanging motor cars can be a traumatic experience, especially to one's bank account. However, the very transaction allows one to indulge in a little spot diagnosis. This must be reached while the salesman is inspecting the model you are offering in part exchange. The following diagnoses are certainly possible: first, spastic colon — the trip around your proffered vehicle is only punctuated by the occasional grimace; secondly, crescendo angina — on this occasion, the trip is punctuated by multiple beatings on the chest, accompanied by expressions of acute agony; the third category is prolapsed piles — here the trip around the car is punctuated by multiple genuflections, which are themselves accompanied by visual expressions of extreme discomfort.

Last week a patient came into the consulting room and remarked, 'I've been reading the magazines in the waiting room. I see the Titanic has sunk.'