SOMETHING SPECIAL AT DUNDEE

THE East of Scotland Faculty held the 1975 Annual Spring Meeting of the College and faced the formidable geographical challenge of Dundee being several hundred miles from the homes of most college members. Naturally, the superb local resources were exploited and the meeting was held in the palatial new Ninewells Hospital. Nor was it surprising that the Faculty should tap the technical resources and teaching skills of Professor Knox's University Department of General Practice. None of these considerable physical advantages, however, was primarily responsible for what proved an unusually interesting and exciting meeting.

By all criteria this meeting succeeded. Doctors attended from every corner of the United Kingdom in numbers far greater than for other comparable events. Well over 200 applied on application forms distributed with the January *Journal* and over 250 were present on the day, with more than half from England and Wales. Secondly, for the first time in recent years, young doctors came in numbers and made their presence felt. The structure of the meeting enabled them to create and to release their energy and thus achieve the third fundamental objective of such meetings—real audience participation.

The technique adopted, for the first time in the history of the College, was to tackle the topic of quality by showing videotapes of consultations in general practice and arranging for a panel to discuss them. Not only were the Chairman and all the panel general practitioners in active practice, but four of the five were from the local Faculty itself. All present then completed modified-essay questions, and divided into small groups to discuss the answers.

The buzz of interest, the general noise level, and the fact that the topic of quality dominated even the coffee interval, all indicated interest and enthusiasm. Although academic purists might well have reversed the morning and afternoon sessions, there can be no doubt in terms of frankness and of readiness to discuss reality, this Spring Meeting broke new ground.

Particular tribute needs to be paid to the two local general practitioners who bravely allowed their consultations to be exposed, examined, and critically discussed by such an enormous audience. In what other branch of medicine would two clinicians allow their clinical competence to be scrutinised in such a way?

Watershed in development

It can be no coincidence that in the same year that a whole Spring Meeting considered quality of care, that the William Pickles lecturer, quite independently, should choose the same subject. In a clarion call for criteria Dr Donald Irvine concluded that the time has come for the College to stand its ground on standards. Such a move, if it becomes accepted policy, could prove a watershed in the development of the College.

The organisation of this meeting inevitably involved many people, but a special responsibility devolved on Dr Inglis Lamont, the local Faculty secretary, and Drs Dorward, Knox, Lawson, and Reid, who held office at this time.

Despite the difficulties, despite the doubts, there was something special this year at Dundee.

DUPLICATING PRIMARY CARE

> *" The time has come for health service prescription forms available to general practitioners . . . to be available to the family planning clinic doctor. This would enable the clinic doctor to treat the common cold and boil when it is obvious and save having to send someone away from a clinic to visit their general practitioner, wasting his time and the patient's for something that can be put right on the spot by a registered medical practitioner."*
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> Smith, M. (1975)

THE Chief Medical Officer of the Family Planning Association, Dr Michael Smith, has recently recommended that family planning clinics should be empowered to issue National Health Service prescription forms so that clinic doctors could treat general medical conditions through the National Health Service.

At first sight this seems a simple suggestion which might save the patient's time and that of the general practitioner. It might also lead to treatment being started earlier than would otherwise be the case and would almost certainly extend the interest in the work of clinic doctors.

Nevertheless this proposal needs to be seen in perspective—a perspective which includes similar suggestions from doctors working in other clinics, such as local authority welfare, and children's clinics.

The key consideration is the little understood danger of the fragmentation of medical care and the disadvantages of Dr Smith's proposal need to be restated.

A main advantage of the British system of medical care is that each patient should have one doctor who is able to see the whole picture and pattern of illness. The more episodes of illness that are treated outside the generalist system, whether in casualty, outpatients, or special clinics, the more the generalist loses the total view—the more the patient will be lost among different doctors. Primary physicians recognise patterns and pattern recognition depends on adequate input over the whole range of conditions from which patients suffer.

There is increasing concern in all branches of the medical profession about the co-ordination of treatment. Drug interactions, drug sensitivities, and side-effects are looming ever larger in the minds of all prescribing doctors. It is of extreme importance to the patient that one doctor, and as far as possible only one doctor, should be concerned with the co-ordination of all treatment. If separate hospitals and different clinics prescribe directly, it is only a matter of time before undesirable interactions occur, because no one doctor sees all the treatment and knows all the priorities.

Furthermore the greater the number of doctors involved with a single patient's care the greater the potential difficulties of communication between the doctors—often to the patient's detriment.

At present messages from the Family Planning Association are often given to the