What is envisaged is co-operation between the health centre staff and the patients, rather than confrontation, the aim being to involve as many patients as possible and to use the unique and varied experience of as many of the 10,000 patients as possible to assist the practice team of 15 to provide a better service.

Our local Patients' Committee is an example of grass roots democracy in the NHS which is, more and more, being controlled at all levels, by appointed, not elected, bodies.

Our relations with the Community Health Council are excellent; the Community Health Council Secretary has already spoken to one open meeting of the patients.

Is there any good reason why this cannot also happen at every other health centre?

At a Valleys' Community Project Conference held at Aberfan on 8 February 1975 on *Health in the Valleys* at which I reported on the discussions at the primary care group, the following recommendations were made:-

(1) There should be more community participation in the primary care service.

(a) Community Health Councils could ask local doctors for appointments to visit their surgeries or health centres—in this way barriers between doctors and the Community Health Councils can be broken down.

(b) It was considered that the appropriate Community Health Council could "associate" with the patients' committee.

(c) There should be increasing democratic local control of the health services.

(2) There should be central exchequer control of health service finances, but with a larger and wider distribution of funds particularly to areas of greatest need.

(3) It should be an essential part of primary care that general health education should be provided for the community particularly at health centres.

A final remark in this discussion from the Secretary of the Patients' Committee was:

"If doctors are prepared to discuss the provision of health services with their patients this could benefit both doctors and patients and could provide a better service for the community."

Pritchard (1975) has a community participation group at Bennfield Health Centre. I am sure that many forms of patient participation will develop. Soon I hope the College will arrange a meeting of the doctors involved so that we can discuss our experiences.

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INVESTIGATIONS IN THE PRACTICE

Sir,

At a recent meeting of the Wessex Faculty on the Isle of Wight the question of the future pattern of general practice and the function of the MRCGP examination came under discussion. If one salient point emerged it was the fundamental importance of clinical excellence. One aspect of this is what might be termed "office procedures," i.e. procedures which can be performed for the patient in the surgery. As a contribution to this discussion I would like to enumerate those procedures which I regard as desirable for the modern general practitioner to have at his command and that his ability in them should be demonstrable in the MRCGP examination.

(1) The use of the opthalmoscope for diagnostic purposes.

(2) The use of the electrocardiogram.

(3) The use of the sigmoidoscope for diagnostic purposes.

(4) The ability to perform Eustachian catheterisation.

(5) The ability to perform indirect laryngoscopy, for diagnostic purposes.

(6) The ability to perform minor surgery under local anaesthetic.

(7) The ability to fit IUDs and to arrange the fitting of the contraceptive diaphragm.

(8) The knowledge of the indications and techniques for the intraarticular injections of cortisone and also its injection into soft tissues.

(9) The injection or rubber band treatment of haemorrhoids.

(10) The injection treatment for varicose veins.

These desiderata will no doubt evoke protests from the 'behaviourists' in our ranks. They are however, with the exceptions of numbers (4) and (5) techniques which have been in regular use in this practice for the last ten years or more without any detriment to the other aspects of general practice and it is my view that in the 1980s no one should become a principal in general practice without having mastered them.

Furthermore, they ought now to be available amongst the different members of a group practice.

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LETTERS TO AND FROM HOSPITALS

Sir,

I read with interest the article in the July *Journal* by C. J. Durkin and A. Edwards on referral letters from general practitioners.

I agree that such letters are important, although on occasions I have had it reported back to me that my careful letter has been brushed aside by a busy doctor, who only wants to hear what the patient has to say.

I would now welcome a follow-up research project on letters from the hospital to the general

practitioner, which I consider even more important. Ideally I consider that there should be an immediate discharge note given to the patient containing essential headings of—diagnosis—major procedures, and present treatment. This note is valueless if posted several days after the patient has been discharged, if important information is not recorded or if the writing is either illegible or consists of a series of initials and shorthand signs. In many cases this brief report is probably adequate.

For more complicated and major cases a full report following at a later date (but not too many weeks later) is valuable both for present information and instruction, and for future reference.

When I was a houseman I know that I found it annoying to have to spend valuable time writing discharge letters and reports.

Perhaps a further report by Mr Durkin and Mr Edwards would help my successors to realise how valuable these reports could be, and how well spent is the time taken to write them.

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THE NUFFIELD EXPERIMENT

Sir,

With reference to your Editorial on the *Nuffield Experiment* (August *Journal*): "It became apparent that this self-selected group was not composed of average practitioners. In terms of factual knowledge, for example, the average for this group was close to the distinction level in the M.R.C.G.P. examination and one or two of the group produced figures higher than those ever before recorded".

I am sure this group of practitioners were not average, but to compare their performance to the distinction level in the M.R.C.G.P. examination is completely fatuous. An assessment carried out during the 'calm' of a course can never be compared to the real 'nerve-racking' situation of an examination, even less to the M.R.C.G.P. examination which takes almost two full days and has an extremely broad assessment. How many of the group mentioned have taken the examination?

Later in your Editorial: "General practice has far to go—but it has at least started. Indeed in comparison with the other branches of the medical profession it is probably now ahead." With the publication of the Merrison Report (1975), the Royal College of General Practitioners and the General Medical Services Committee have both stated their case for the supervision of postgraduate training in general practice.

Until we can decide who acts on our behalf and we can be united, can we claim to be ahead of the other branches of the medical profession?

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COLLEGE EVIDENCE ON ABORTION (AMENDMENT BILL)

Sir,

The evidence of the Royal College of General Practitioners to the Select Committee considering Mr James White's Bill has given the impression that College members are united in their opposition to the Bill. Apparently not a single letter had been received by the College in favour of the Bill. Now, I readily admit that a very large number of doctors, possibly the majority, are in favour of the 1967 Abortion Act and indeed, may desire abortions on demand but, I am sure you would agree that this does not necessarily make such attitudes right in any absolute sense of right and wrong. Doctors, as others, have to abide by the dictates of conscience and those of us who regard the destruction of innocent human life as fundamentally wrong will always be opposed to abortion. The only special position for doctors in this matter is that, by their unique life-saving profession a decision to destroy human life is far more serious.

My own attitude to this matter including evidence of complications associated with abortion, was made clear to the Lane Committee (1974) and the fact is recorded in their report. No doubt the College was asked to give evidence to the present Select Committee, but it seems to me that a professional body though suited to give evidence on clinical and material facts cannot give opinions which appear to represent its members in matters relating to personal morals. The British Medical Association appear to have fallen into the same trap and have given the impression of a profession united in its support for the 1967 Abortion Act.

Having said this I readily admit that arguments against abortion usually depend on the acceptance of such God-given commandments as "Thou shalt not kill", and that these will have no meaning for those who do not believe in God, and regard all laws as entirely for the convenience of man. In this context it is interesting to find that there also exists an argument entirely derived from a sense of personal justice and some people have shown their opposition to abortion on this basis alone.

If abortion was wrong in 1966, it cannot be made right merely by an act of legislation; indeed the 1967 Act did not attempt to do this as the basis of abortion law in this country is