tables, graphs, elaborate diagrams, and terrifyingly complicated mathematical formulae. To the statisticians these may be fascinating, but many of us would prefer simpler fare. There are lies, damned lies, and statistics.

Finally, in the field of education, Professor P. S. Byrne, our worthy President, launches some startling theories in his Marsden Lecture in the November *Journal.*

The emphasis throughout is on change and innovation, but I must take issue with him. The concept of the basic doctor is all very well in theory, but the end product rolling off Professor Byrne's production lines smacks to some extent of the robot—a combination of a perfectionist and barefoot doctor who has the answer to every clinical problem; the paragon who can make his own decisions in the semi or council flat, or the detached villa, without calling out his consultant colleagues from their beds or their armchairs after hours. Is consultation at the bedside to disappear?

The whole crux of the proposed discussion hinges on the question of whether the extra years of tuition and apprenticeship will produce better doctors; whether doing away with conventional examinations in the clinical disciplines is a sound move or merely a gesture to the winds of change; whether scrapping scientific subjects is permissible. Surely anatomy, physiology, and pharmacology are the essential foundations of clinical medicine?

Finally, the Professor states again and again that his end product is to be groomed for the National Health Service, with the blessing of the General Medical Services Committee and the Department of Health and Social Security. What of students and graduates who propose to enter private practice, occupational medicine, or the armed forces? Is the New Jerusalem to be a closed shop for conformists?

The College must be forward in its outlook, but flexible and tolerant to those whose careers it is privileged to mould. Above all, it must eschew political dogma from whatever source.

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OUT-OF-HOURS WORK

Sir,

I doubt if doctors using deputising services are either lazy or uninterested in what happens to their patients; it is more likely that they are obliged to see one patient per five minutes and 70 or more patients in a single day, at the end of which it is hardly surprising if they then feel it best to be "off-duty".

Dr Barley's suggestion (of having one doctor on for one week per year for night visits for an area of say 50 doctors) is useful.

I have myself circulated a questionnaire to doctors in our Health District (West Surrey and North-east Hants) to discover what support there might be for a deputising service here. Of 120 doctors written to, 69 replied; 25 were in favour and 41 against. Half the district is built up and the other half less so. Most of the replies in favour were from doctors in the more built up areas.

Further surveys might be useful in determining attitudes and progress towards the use of deputising services.

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Sir,

I found the results of the two studies relating to night calls (January *Journal*) very interesting, and believe that they reflect the different attitudes held by general practitioners and hospital doctors.

The general practitioners regarded only seven per cent of calls as irresponsible, and 48 per cent as genuine emergencies, while the deputising doctor regarded 14 per cent as medically essential, and 56 per cent as having either trivial symptoms or no symptoms at all. These are diametrically opposed results, which might be explained in several ways. There may be differences in the extent to which the practice populations have been educated in proper use of medical services at night, and perhaps patients are more willing to call a deputising doctor (who they may believe to be working on a shift system) rather than call their own doctor from his bed). I suspect, however, that the general practitioners placed a higher proportion of calls into the "justifiable" category because they understood the psychology of the patient more fully than the clinically orientated hospital doctor, and appreciated that a situation may be anxiety provoking and therefore justifying a call, in the eyes of a patient, while having little clinical content in the eyes of the doctor.

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LABELLING VACCINES

Sir,

Human fallibility being what it is, it seems highly likely that at times, in the middle of busy immunisation clinics, triple vaccine has been given when a mother specifically requested that pertussis should be excluded, or it has inappropriately been given to a four year old having his pre-school booster, and so on.

There, but for the Grace of God . . . or maybe, unwittingly, there in spite of the Grace of God. . . .

I have often wondered whether the pharmaceutical companies who manufacture vaccines have ever considered putting their heads together to devise a colour coding of labels similar to the different strengths and preparations of insulin? It would seem that such a measure would improve the efficiency and safety of the immunisation programme.

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MULTI-DISCIPLINARY COMMUNICATION

Sir,

Few doctors do not harbour a secret wish to communicate with the hundred or so other professionals in their immediate vicinity. In some areas, a loosely constituted luncheon club meets once a month for a vague lecture, and makes the faithful feel less guilty. Seldom is any real attempt made to come to grips with the problem. Here is a suggested model.

Firstly, about 12 people are encouraged to form a central executive group. Six of these are known for sensitivity, awareness and skill in small groups (' enablers ') and the other six are known for lively, stimulating ideas, social contacts and practical ability (idea-and-action people).

The committee then stimulates the formation of up to six study groups, each containing up to ten professionals from different walks of life, with a balance of personalities, interests, occupations, and ideological attitudes. In addition, each group contains one ' enabler ' and one ' idea-and-action person ' derived from the central committee.

Meeting one evening a month, each group is chaired and organised by one member in turn. At the end of the year, after ten meetings, the group is terminated and a new membership devised for the following year. Commonly the first meeting is chaired by the ' idea-and-action ' person for the purpose of planning the forthcoming meetings. Subsequently a brief summary is provided by each member of the proceedings of the meeting for which they were responsible. The final meeting is conducted by the ' enabler ' for the purpose of reviewing the progress and achievements of the group. The initial plan, on-going summaries, and final report are collated and submitted to the central committee for future planning, and possibly for general circulation.

Needless to say, this model is as applicable to a single discipline (e.g. all the local family doctors) as to multidisciplinary communication, catering for any number between two and sixty. Individual members (and individual groups) are at complete liberty to plan a varied, stimulating programme. Excursions, invited speakers, films, cultural events, unusual or radical topics for discussion would all be in order.

Within the space of five years, one would come into intimate contact with up to 50 different professionals from the local scene. With a minimum amount of work, and little expense, a considerable amount of pleasure and professional learning could be achieved.

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THE ETHICS OF QUESTIONING RELATIVES AFTER BEREAVEMENT

Sir,

I would like to comment on Kate Danaher's, letter commenting on Dr McCarthy's article.

At a recent weekly seminar for seven trainees in the South-east Lincolnshire vocational training scheme for general practice, the chosen subject was *Bereavement*. After a technique which is proving very successful for a variety of topics, I selected seven patients from my practice who has suffered bereavement.

I obtained the agreement of each, to meet " a young doctor training to be a general practitioner " and discuss what bereavement had meant and did mean for him or her for approximately one hour. Subsequently, the seven trainees with two trainers discussed what they had learnt from " their patient ", and it was generally agreed that a fruitful learning experience had been achieved.

I was not unmindful of the sensitivity of the memories that I was asking my patients to recall; when thanking them afterwards I found that they appreciated the opportunity to discuss their feelings with sympathetic listeners, and felt better as a result, were pleased to take part in educating the general practitioners of the future, and not