Ill-treated children *

FROM THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

(1) Definitions

THE ill-treated child syndrome can be defined as ' children who are ill-treated by adults '. It is also known as ' non-accidental injury in children ' and is best known as ' the battered baby syndrome '.

However, as general practitioners make their diagnosis in three dimensions, physical, psychological, and social (Pereira Gray, 1970) it is particularly necessary for them to include emotional ill-treatment, which has also been called the ' parental deprivation syndrome '.

(2) History

Caffey (1946), an American radiologist, first described a syndrome of subdural haematoma and multiple fractures in infants. Silverman (1953), another radiologist, suggested that the cause could be parental violence, and Kempe (1962) also from America in a classic paper first coined the term " battered baby syndrome ".

(3) Prevalence

The exact prevalence of this condition is not known. Kempe (1971) has estimated it at three per thousand live births, which would be equivalent to 1,500 to 2,000 children injured in the United Kingdom each year.

The Tunbridge Wells Committee (1973) estimated that the United Kingdom has 4,600 cases a year.

Many authors, like Gambrill (1973), have stressed how relatively rarely practitioners will see this condition: " Each general practitioner will expect to see an average new case once every ten years." But these figures are based on the serious cases and milder forms can be seen much more often in general practice. Those general practitioners who are interested in this condition are now reporting a prevalence of one per thousand of their practice population.

In other words, ill-treated children form a spectrum in which the severely battered form only a tip of the iceberg.

The general practitioner's problem is that he is, as always, having to define normality. There are many children in rough households, where children, wives, and others are hit at times and it is difficult to define when this constitutes ill-treatment.

(4) Causes

The causes so far known include:

(*a*) A group of parents who feel less caring towards their children than usual. Characteristically they have a lower than average tolerance to stress and less control over their emotions.

Factors which reduce the likelihood of parental feelings developing fully are now beginning to be identified and include: ill-treatment of the parents themselves when they were children, poor education, poverty, a handicapping condition in the parent, for example, epilepsy, and separation of mother and child at birth.

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(*b*) Severe blunting of emotional feeling in the parents, particularly the mother, is sometimes associated with puerperal depression.

(*c*) Psychopaths, a group of parents who express their feelings violently, i.e. who " talk with their fists ". Some of these patients are alcoholics.

(*d*) Psychotic parents (about five per cent).

(5) Pathology

The main pathological findings are:

(*a*) Bruises, which are often multiple,

(*b*) Burns, especially those compatible with cigarettes; ingestions are also suspicious,

(*c*) Ruptured frenulum of the tongue,

(*d*) Fractures, especially of the long bones, ribs, and skull,

(*e*) Subdural haematoma, which is the classic cause of death, and which is often thought to be associated with shaking and injuries to the skull. Shaking is in particular a much under-estimated risk for children under the age of two because of the pressures set up within the skull.

(6) Natural history

Prognosis

Experts are still arguing about the risk of death. The Tunbridge Wells Committee (1973) estimated up to 17 per cent died, whereas Castle and Kerr (1972) found a mortality rate of about one per cent. The Registrar General (1967) reported 71 deaths, 43 of which were in the first year of life. The College understands that the latest estimates of the death rate in 1976 are about 60–80 children a year (Department of Health and Social Security, 1976).

In one of the surveys of the National Society for the Prevention of Cruelty to Children, over 75 per cent of the initial sample followed up were still living at home with their parents and only 12 per cent of the children at that time were in care.

The sociological danger is that the ill-treatment may form part of the ' cycle of deprivation ' and may be passed on from one generation to the next.

(7) Characteristics of the families

The child

Physical battering is most common at an age when a child is immobile and unable to talk. Eighty eight per cent are either first or last children in the family.

The incidence in children with a birthweight of less than 2,500 grammes is about twice as high as in other children. O'Brien (1975) believes that adopted children are most unlikely to be injured.

The adult

The mother is usually the parent responsible, and she is usually aged under 30. General practitioners naturally consider both parents, because even if one causes the injuries exclusively, the other usually gives tacit consent. The mother's pregnancy was often unwanted and the mother may have sought abortion in pregnancy; paternity may be disputed. The N.S.P.C.C. has shown the mother is often pregnant, and marital stress is common.

The identi-kit is of unhappy, aggressive, socially isolated young parents, who may themselves have been injured in their own childhood. There are often absent or inadequate contacts with their own parents, ill-treatment being less common in the extended family.

Such parents often co-operate poorly with authorities including doctors, for example in failing to attend for antenatal care. They may be frequent attenders in general practice and this may represent a form of ' cry for help '. Selwyn Smith (1974) reports that in one third of cases of ill-treated children, the biological father was absent from home and in half these cases the mothers were living with some other man.

Social class

The bulk of the evidence suggests a higher prevalence in patients in the lower social classes who naturally are more likely to be subjected to multiple social pressures (Castle and Kerr, 1972). Perhaps the middle classes may be able to afford to employ a nanny or an *au pair*.

(8) Clinical features in general practice

Most of the children seen in general practice with bruises and injuries will not have been ill-treated. However, the following features are associated with this syndrome and particular care should be taken if two or more of these occur simultaneously.

(*a*) *The time of presentation*

Characteristically the battered child is presented late, some time having elapsed since the injury.

(*b*) *The presentation*

The child may be brought to a doctor other than the usual doctor, for example, an accident and emergency department or another practitioner.

(*c*) *Accompanying adult*

The injury may be presented not by the parent, but by some other person, particularly the grandparent.

(*d*) *Significant inconsistencies in the history*

There are often inconsistencies in the history of the injury, i.e. discrepancies when the story is repeated at different times to different people. Sometimes the description of the injury is not compatible with the development of the child at the time. Was the child capable of doing what it was alleged to have been doing?

(*e*) *The nature of the lesions*

Most physically ill-treated children show only bruising, especially when over two years old. Fractures are unusual in young children, especially during the first year of life, and should in themselves arouse the doctor's suspicions. Dappling of the skin and coldness and blueness of the hands and feet in association with low weight occur in emotionally deprived children.

(*f*) *Site of injuries*

Some sites of injuries are more likely than others to be associated with ill-treatment Bruises particularly on the face, i.e. forehead, mouth and jaw-line are important, as are bruises on the buttocks and back. One survey by the N.S.P.C.C. found that 73 per cent of 292 injured children had head and facial injuries. A ruptured frenulum of the tongue has been described as the classic injury. On the other hand, bruises on the arms and shins commonly occur through children knocking themselves or falling.

(*g*) *Multiple injuries in area or time*

The presence of multiple bruises increases suspicion of ill-treatment in proportion to the number. Similarly, repeated bruising over a period of time should arouse suspicion where an individual bruise might not attract attention.

(h) The timing of the injury

Children are more likely to be hit at times when they create problems for adults. Two of the commonest childhood disorders seen in general practice are: " He won't sleep, doctor ", or " He won't eat, doctor "; these are reminders of the times where ill-treatment from desperate parents may occur. Injuries are much commoner at meal times and after a child has been put to bed, when it cries and will not sleep.

(i) Reluctance to allow medical examination

General practitioners may find, especially in mild cases, a reluctance to allow full examination. Sometimes on home visits the child is conspicuous by its absence and great skill and tact may be needed to achieve examination at all.

THE ROLE OF THE GENERAL PRACTITIONER

There is at present an interesting debate in the medical profession about this syndrome and the role of doctors and general practitioners in particular. Some of the most distinguished paediatricians in the country have argued that as social service departments now have a statutory responsibility for the care of children and sole power with the courts to remove children to a place of safety, practitioners have no responsibility other than detection and referral to social workers and the " right doctor " (Court, Lister, and Franklin, 1974): " The doctor cannot abdicate a responsibility he never had ".

This rather narrow view overlooks the fact that general practitioners have a duty to provide all necessary medical care and attention to children, both for physical and emotional conditions. Furthermore, they also have a responsibility to other members of the household who are usually involved. The role of the general practitioner can be classified as follows:

(1) Suspecting the condition,

(2) Detection,

(3) Management in the home:
- (a) Accessibility,
- (b) Communication
  - (i) with the family,
  - (ii) within the practice,
  - (iii) outside the practice,
- (c) Continuing care,

(4) Management by removal to a place of safety,

(5) Prevention.

(1) Suspicion

The general practitioner and the health visitor working together are the ideal health team to suspect ill-treatment in children. They are in contact with more members of the community than any other medically qualified people and most of the situations where ill-treatment is likely to occur are (or should be) known to the practice.

The ' at risk ' concept is helpful and it is likely in the future that families will be identified in general practice before serious injury occurs.

(2) Detection

The detection rates so far reported from general practice are not high. The Battered Baby Research Unit of the N.S.P.C.C. reported 370 children of whom ten were referred by general practitioners directly (only 2½ per cent). Furthermore, it was noted that at least 60 of these had been children treated for the referred injuries by general practitioners only. " Without further evidence, it is only possible to speculate as to whether general

practitioners are slow to identify or to refer cases of child abuse" (Castle and Kerr, 1972). Practice well-baby clinics and regular surveillance should improve detection in general practice in the future.

(3) Management

(*a*) *Accessibility*

Accessibility is an important feature of general practice in the United Kingdom. Open-access surgeries and baby clinics can represent an important "life-line" for patients in trouble (Waine, 1974).

The extent to which families under stress turn to their general practitioner is one index of the doctor/patient relationship. Methods by which accessibility can be improved, including some flexibility in appointment systems and tolerance by doctors and staff to late calls and aggressive behaviour from parents, could prove fruitful subjects for research similar to Stockwell's (1972) nursing study of *The Unpopular Patient*.

(*b*) *Communication and the co-ordination of medical care*

The communication necessary in general practice can be subdivided into:

(i) Communication with patients,

(ii) Communication within the practice,

(iii) Communication outside the practice.

(*i*) *Communication with patients.* Communication with patients is the essence of the doctor/patient relationship. In the ideal consultation the patient feels free to talk to the doctor about his problems even when these are intense, emotional, and severe. Creating a relationship in which patients feel they can talk about the things that matter to them without pressure of time is one of the biggest organisational challenges confronting general practice today. Furthermore, general practitioners and health visitors must be skilled in identifying and understanding non-verbal communication.

The ordinary consultation in British general practice lasts on average only six minutes. On the other hand, general practitioners have an average of five contacts a year with each of their patients and therefore have an average of 20 contacts with families with two children each year. In five years this is equivalent to over ten hours of doctor time and provides a good base both for communication and professional understanding by the doctor (*Journal of the Royal College of General Practitioners*, 1973).

(*ii*) *Communication within the practice.* Communication within the practice is often still difficult in general practice. Although communication with health visitors and nurses is improving, it is sad that, even in 1973 as many as 21 per cent of health visitors in the United Kingdom were not yet fully attached to general practitioners (Department of Health, 1974a). If health visitors are not attached, communication within the practice must suffer. Record keeping is attracting increasing attention in general practice and the various medicosocial factors listed need to be recorded. Detailed records are in any case wise when a future appearance in court is possible.

(*iii*) *Communication outside the practice.* General practice has also been weak in relationships with social workers, partly because of lack of clarification of the practitioner's role. Nevertheless, it is going to be necessary, if adequate surveillance is to be achieved in the community, for general practitioners to be able to communicate outside the practice when they suspect or detect ill-treatment in children.

(*c*) *Continuing to care.* One of the most difficult roles in the management of these families is providing 'support'. Meetings in the surgery with the health visitor and N.S.P.C.C. worker can be most useful and the family should normally be told about them. Con-

tinuity of care for the child means that the general practitioner goes on and on, month after month, and year after year. The medical surveillance system must be good enough not to let the child slip through the system. A few parents will go to prison, some children will go into care, but the great majority of parents and children will remain in the home.

One of the most difficult skills in management is for the doctor and health visitor to maintain a detached and professional approach to the many problems which arise in these families.

Continuity of care for the patients means being accessible, making contact somehow, and creating a counselling relationship. This takes time and needs particular skills with rude and aggressive parents. However, the doctor, if he can treat such patients with dignity, may be offering the only model of civilised and caring behaviour available to the family.

Behaviour is infectious and violent or intolerant actions induce similar reactions, even among professionals in the caring professions. Sometimes the behaviour of the professionals is impulsive, impatient, rigid, and authoritarian, and exhibits unreasonable expectations of the family, and so mirrors closely the behaviour for which the family is being blamed.

(4) Removal to a place of safety

Most authorities have assumed in the past that if a child who has been ill-treated needs to go to a place of safety, then that place ought to be a hospital bed.

However, this need not be so. It depends on the individual child and its needs at the time. If the child has been injured and has for example, a fracture, then of course, immediate hospital care is required. But if no such injury has occurred and the removal is prophylactic, then other possibilities such as a children's home or a foster home need discussion.

The advantages of hospital admission are:

(a) Constant availability of a bed,

(b) Specific treatment, e.g. for cranial injuries or fractures,

(c) Investigations, e.g. whole body x-rays and other tests may be needed and may be easy to arrange,

(d) A consultant opinion, which may be most helpful,

(e) Hospitals can resist demanding natural parents more easily than a foster parent.

The advantages of admission to a children's home or foster parents are:

(a) It is more natural for the child,

(b) Investigations, e.g. x-rays, and blood tests can often equally well be done on an outpatient basis,

(c) Communication difficulties are minimised. In hospital there is often difficulty in:

  (i) co-ordinating what is said to the family,

  (ii) co-ordinating communication between doctors.

(d) A community problem is contained within the community,

(e) A hospital bed costs about twice as much per week as a place in a children's home and about ten times as much as a local authority approved foster parent.

Removal of the child to a place of safety does not " take the heat out of the situation ", as is sometimes said. It often raises the emotional heat and may well place other siblings or members of the household at risk.

In all cases temporary removal anywhere represents only a short-term solution and the general practitioner's role is never to take his eye off the long-term questions, " Is this child eventually going to go home? If so, how can I promote its future physical and emotional health?"

(5) Prevention

The general practitioner should be chiefly concerned with prevention (McConaghey, 1974). Of the various levels of care, the prevention of illness is the highest and most important. If the quality of life of future generations is to be improved, the prevention of physical and emotional harm to children must rank as one of the most rewarding and essential services to society.

The general practitioner, operating as he does on the boundary between medicine and society (Marinker, 1973), is ideally placed, particularly working with home-based social workers, to undertake long-term prospective research within the National Health Service.

Donovan (1974) is leading groups of new mothers in his general practice. This has enabled many of them to share in the group their doubts and anxieties about their maternal feelings and so learn that such mixed feelings are common. Such methods may lead to hostile feelings towards children being contained and future injuries prevented.

Pre-battering syndrome

Traditionally the main reason for identifying as many features as possible of the ill-treated child syndrome was to aid diagnosis in a difficult case.

However, an equally important, and in the long run an even more important reason, may be the possibility of identifying children in situations where there is a potential for ill-treatment—a pre-battering syndrome.

This is already occurring and some practitioners and some health visitors are already able to spot families at risk and are adapting their visiting patterns accordingly.

Lynch (1976) has reported that more than half the battered children in Oxford had been seen previously by medical social workers in the maternity hospital after delivery.

The College believes that identification of at-risk families is possible even earlier. Given that some of the associated factors include certain personality traits, and unwanted pregnancy, hostile feelings towards the future child can be elicited during pregnancy. In the College's view, the general practitioner's role in antenatal care includes care for the women's emotional as well as physical problems.

Bonding

Studies on animals are increasingly providing evidence of the importance of the bonding process in which a mother makes physical contact with her child and establishes a physical relationship through touching, caressing and feeding.

Waine (1976), from the North of England Faculty of the College, emphasises that such bonding in humans is physically prevented in many special-care baby units all over the country. Not only are children physically separated from their mother, but continuing access by the mother to her baby is often impeded—often through excessive concern by the trained staff about the prevention of infection.

Similarly, some members of the College have suggested that ill-treatment may be less liable to occur after home confinement, where bonding is usually quick and deep.

Education

The College believes that the subject of ill-treated children ought to appear on the syllabus of vocational training courses and on courses designed for the continuing education of general practitioners, health visitors, and social workers.

Some of the members of the College are concerned that some doctors and health visitors still deny the existence of this syndrome, which must impede both detection and the provision of good care.

THE ORGANISATION OF CARE

(1) Legislation to protect ill-treated children,

(2) Registers,

(3) Case conferences,

(4) Evolving a policy of care: (a) Policy making bodies,
(b) Other life-threatening emotional crises.

(1) Legislation to protect ill-treated children

The legislation affecting children in relation to ill-treatment is not described here. Although it is the responsibility of Parliament, the College believes that those professionals who have continuing personal experience of such problems have a duty to communicate their experience to those who have responsibility for drafting legislation.

(2) Registers of ill-treated children

The advantages and disadvantages of keeping registers of children who have been injured, or who are at risk of ill-treatment, can be summarised as follows:

Advantages

(1) Professionals when confronted with an injury can check quickly if the child is on the at-risk register, e.g. accident and emergency departments.

(2) Registers help to ensure follow-up when families with children at risk move from one area to another.

(3) Data are generated about incidence, prevalence, and the characteristics of families with the condition.

(4) Such statistics identify trends and highlight the need for changes in organisation.

(5) Such statistics also educate all the caring professions in the area.

Disadvantages

(1) Loss of confidentiality. Intimate information about families is made more widely available.

(2) Their use provides a poor model of human relationships. The creation and use of secret files to which patients/clients have no access is undesirable, unless absolutely essential.

The onus of proof always rests on those who wish to use such registers/files to show that there is no better system available.

On balance, it is the view of the College that the advantages clearly outweigh the disadvantages and the use of at-risk registers should at present therefore be supported. These registers are normally maintained by the local social services department, and general practitioners should note that the ethical code of social workers has not yet been agreed or implemented.

(3) Case conferences

Case conferences are fashionable. They are put forward widely as the ideal method for the management of this condition. They have many advantages and many disadvantages.

The technique of clinical decision-taking by multidisciplinary teams has not been based on any controlled trial of decision-taking. It has developed through anecdotal

evidence of errors. The method therefore depends on, as yet, unconfirmed value judgements.

The objectives of case conferences are:

(a) *Communication.* To inform, more competently than by any other method available, all those involved in the problem.

(b) *Decision-taking.* To take, more effectively than would otherwise be possible, decisions in the interest of the child and family.

The advantages of case conferences are:

(1) They bring people together who might not otherwise meet.

(2) They educate those involved about the nature and extent of the problem.

(3) They support the field workers by sharing the burden of responsibility (the hand-holding role).

(4) The police may agree not to act without first consulting the conference.

(5) Pressure from the conference may force other professionals or relevant departments to provide resources more readily, such as housing.

(6) Many heads may be better than a few.

(7) The problems are more likely to be fully documented.

The disadvantages are:

(1) They disrupt the work of many professional people by being held at fixed times in the day.

(2) They take time, often one or two hours.

(3) Inevitably they spread confidential information about people.

(4) They offer a bad model of behaviour by being formal, by dealing with personal problems impersonally, and by being held without the knowledge of, and usually without the consent of, the people who are being discussed.

(5) They are expensive.

(6) Professional responsibilities may become blurred or diminished.

A typical case conference consists of a local authority social worker, a representative from the N.S.P.C.C., a consultant paediatrician, a paediatric registrar, the general practitioner, the health visitor, a police officer and perhaps a representative from the housing department. It is often organised by a district community physician or a member of his staff.

Before attending, general practitioners should establish who will be present and, if the police are to be there, what principles govern police action in that area. Each conference is likely to cost the various government departments (through the staff involved, administration, and transport) about £50 at 1976 prices.

Quite often several members of the case conference either do not know all the members of the family personally or may have never visited the home. If this happens then two unfortunate consequences tend to occur. Either these members of the conference stay relatively silent, which is a waste of time and money, or they participate in taking the decisions with the effect that the decision-making process moves from those who do know the family as individuals to those who do not.

Evolving a policy of care

(a) *Policy-making bodies*

No single person, no group of people, no organisation, and no government in any country yet knows how best to organise the medical and social care of children being ill-treated in their homes.

The origins of the ill-treatment of children are rooted in the very nature of society itself and many of the causative factors have not yet been discovered. Predisposing factors which are already known such as the experiences of the parents themselves as children, poor education, and poverty will not be soluble in the foreseeable future. The ill-treated child syndrome is therefore a complex medicosocial family problem which will continue for many years, perhaps for ever.

Normally in medical care only well-proven treatments becomes standard throughout the country and new methods of management are normally subjected to prospective controlled trials. The College believes this is not the time to standardise treatment; on the contrary there is an urgent need for experimentation with different methods in different areas and for objective evaluation of the different methods.

The *principle* of dealing with such families must be to provide a flexible, tolerant, compassionate, and highly-skilled professional medical and social service where it is needed—in the home. The professionals must be able to cope with the parents and simultaneously care for the child. Such a team must always have the power to apply for removal of the child, by a court order, to a place of safety.

Yet all the efforts of central policy-making bodies at present seem to be directed in the opposite direction. The policy of the Tunbridge Wells Study Group (1973) and the Department of Health (1974b) is to admit the child to hospital immediately on the least suspicion, to hold case conferences every time, and to promote case conferences as policy-making and decision-taking bodies.

Thus the authorities are seeking to standardise a remote, formal, impersonal and multidisciplinary solution to a local interpersonal problem in a family. The policy of some units of the N.S.P.C.C. of providing local family support in the home on an open access and continuing basis may in the long term prove a more important model.

An alternative role for central, regional, and area health service authorities could be to build up and support field workers in the three caring professions (social work, nursing, and medicine). There is a particular need to promote education and also to ensure that executive departments such as social security and housing are flexible and respond to local needs. Central policy-making bodies should also support prospective, long-term, home-based, research on families where ill-treatment of children may occur.

The College does not oppose holding big case conferences about ill-treated children. It does, however, consider that they may not be as desirable as many authorities currently believe.

In particular a system which because of the formality of the procedures is beginning to make some general practitioners reluctant to notify ill-treatment and is making it difficult for many general practitioners and health visitors to attend conferences, needs review.

The College believes that the advantages of case conferences need to be critically evaluated and that both the attendance at them of key professionals and at the Courts need to be examined. Case conferences may be the best system so far available, but other methods of organising care need to be developed and equally need critical assessment.

(b) *Life-threatening emotional crises in the home*

Ill-treatment of children should not be considered as a problem in isolation. It is a

condition of society itself, and police statistics reveal a society where offences against the person are becoming more common.

Generalist doctors, working in the field, see such problems in their perspective in relation to the whole range of life-threatening emotional crises occurring in the home.

It may be helpful to consider ill-treatment of children as a crisis like abortion and attempted suicide. In both conditions a life is at stake, usually a young one, and injury to a person occurs. Both cause fundamental conflict between the rights of individuals, the duties of the state, and the responsibilities of the medical profession. Both create intense emotions among lay people, among the caring professions, and among members of Parliament.

Experience has shown that in the interests of the patient(s) involved, it is often wiser for decision-taking and continuing responsibility to rest with field workers. Only field workers who know the home, and all those in it, can assess the emotional and social pressures (such as personality difficulties, marital problems, housing, and poverty) which drive patients to seek violent solutions to the problems of their lives.

Above all, the responsibility for preventing such events lies not in hospital, but in the home. Slowly, shakily, but progressively, general practitioners are awakening and rising to the challenge of the care in the community of such major life-threatening medical and social crises.

Attempted suicide is no longer a crime, and is rightly regarded as an acute emotional crisis—usually involving the family. Abortion is also now not usually a crime and is similarly regarded as another acute personal emotional crisis.

The College believes that in the future the management of a family which ill-treats its children will similarly be recognised as a serious life-threatening distortion of the family's emotions. If this is so, future management will depend less and less on police prosecution and legal restraint, although these will always be necessary for more severe cases, and will come to depend more and more on highly skilled, and caring social workers, doctors, and health visitors working together in the community.

Conclusion

The care of the ill-treated child will continue in the years ahead to be one of the most difficult and complex clinical problems in family practice. Few conditions are so challenging in the physical, psychological, and social dimensions; few are potentially so serious; few are more difficult to manage. This is a family disease and will always involve the family doctor.

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HOLDING ON TO YOUR M.R.C.G.P.

Letter from a reader

"I am an M.R.C.G.P. by examination. The annual subscription has just gone up to £35, for very little return to the average member. What is the situation if one elects to resign from the College, as the M.R.C.G.P. itself is a qualification registered with the General Medical Council?"

Answer

A distinction has to be made between the basic medical qualification as required by the Medical Act for being a registered medical practitioner whose name is on the General Medical Council register and the M.R.C.G.P. which is a diploma granted by the Royal College of General Practitioners.

The fact that this is a registrable qualification is not a legal requirement, but a courtesy on the part of the General Medical Council. A diplomate of the Royal College of General Practitioners obtains this diploma by examination and his membership of the College depends upon his subscribing to its aims and objects and the payment of an annual subscription.

Therefore, resignation from the College for whatever reason would not entitle the individual to continue to use the title M.R.C.G.P. after his name. In fact, the Royal College of General Practitioners could sue him for continuing to do so.

Of course the position may alter when the Government introduces legislation to give effect to the recommendations of the Merrison Committee on Regulation of the Medical Profession, since there may well be statutory provisions for a specialist register and accreditation.

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