ated sexually transmitted disease. In Beilby's (1968) series of 58 patients with gonorrhoea, seven had coincidental herpes genitalis and one per cent condylomata accuminata (Barlow *et al.*, 1976).

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PULLED ELBOW

Sir,

I was interested to read Dr Hardy's description of the common condition, pulled elbow (April *Journal,* p. 224) but would like to disagree on a few points. His "disused forearm" is most appropriate but in my experience the position he describes is not characteristic—the arm is often held flat against the side—the most important feature being unwillingness to move the arm or have it touched.

I generally find gentle non-specific manipulation to be sufficient and painless—success, as Dr Hardy points out, being marked by a slight palpable click and rapid restoration of function. The condition, if missed, is usually cured by the radiographer who refuses to accept the existing position of the elbow joint and gently manipulates the arm till she can get an x-ray.

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WHAT KIND OF COLLEGE?

Sir,

Ever since my trainee days of 21 years ago, I have been greatly concerned about the future of general practice and the maintenance of its high ideals and standards, which I like to think have been reflected in my last ten years as a general-practitioner trainer. When I was first approached by the Royal College many years ago, I readily agreed to become an Associate, since it seemed to me that the College was what general practice needed if it was ever to be thought of as a specialty in its own right and not merely a member of the second eleven in the medical team.

Whilst I had always thought it perfectly possible, and indeed admirable at times, to practise a high standard of patient care from a small, cramped, ill-lit surgery with creaky floorboards and peeling wallpaper, four years ago I decided to strive for the Utopian ideal. And so, after two long years of disappointment, planning refusals, and local opposition, I began working in new purpose-built premises in April 1976, and a year later received the nod of approval from the JCPT, which is praise indeed.

However, after much hard work, one main problem has emerged. Expensive to build, the surgery is now expensive to run, so that to maintain even modest standards of general practice takes virtually all the practice income.

I suspect with hindsight that the profession's lack of knowledge about the problems of cash flow in running what amounts to a small business firm is due to the fact that in the past our seniors have thought it undignified to disucuss practice incomes and the exact cost of maintaining high standards.

Dr Irvine (March *Journal,* p. 146) describes three basic needs for the College membership, two of which are: first, support and encouragement from the College, and secondly, a good union to look after income and contract of service.

As far as I am concerned, patient demand and expectancy, and therefore workload, in medical practice have never been higher, but the doctor's financial expectancy has never been lower. The higher his standards, the lower his financial return becomes. The harder he works to provide expensive appointment systems and extra clinics for preventive medicine, with the extra staff and overheads that these entail, the lower his income will become. In fact, I was recently told by my practice accountant that after all expenses are paid, I am working for the enormous financial remuneration of £1 per hour!

I feel strongly that if the Royal College persists in striving for a 'Shangri-la' in general practice, with constant self review and assessment, then it should in future relate its aims more fully to a general practitioner's income and what the average doctor can reasonably hope to achieve. We do not have a benevolent Government and, as the Prime Minister said, doctors have no "political muscle". However, it seems clear that political muscle is what the College may need to acquire if it is to develop and achieve its aims, or leave them on the shelf forever.

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Sir,

I was recently at a faculty board meeting where discussions centred around the future of the College (March *Journal,* p. 142). One point that was raised was the inability of the College to attract established older general practitioners. Concern was also expressed at the failure to maintain the active interest of many of the vocationally trained new entrants to general practice, even when they have taken the examination. There appears to be a communication gap between the academic Valhalla and general practitioners who are attempting to practise in the real world outside Princess Gate.

To rectify this situation does not mean that there has to be a lowering of standards, objectives, or ideals. There should be an effort to convey to the general practitioners in the community that their College is constantly discussing and attempting to resolve problems that are faced by the average general practitioner. Unfortunately many of the efforts of the College have been lost in jargon.

Having just waded through Professor Marshall Marinker's Yorkshire Oration entitled "The chameleon, the Judas goat, and the cuckoo" (April *Journal,* p. 199) I fear that the gulf between the academics and the average general practitioner is becoming even wider. His thesis is good and few general practitioners would disagree with it. He maintains that common diseases are common; students would learn more about real medicine in the community than in the rarefied atmosphere of a medical school; and patients should be treated as whole people with emotional as well as physical problems. Unfortunately the message is lost in jargon, quotations, and references to obscure but erudite publications.

On reading the first section I was reminded of an interview that once occurred in Balham. A certain Mr Bluebottle was being interviewed at his forge, where he was employed putting the little holes in the end of toothbrushes. He told the interviewer: "Last week the highest of the highest came to