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).

D. P. MURRAY
Lieutenant Colonel, RAMC
Department of Genitourinary Medicine
British Military Hospital
Munster
BFPO 17.

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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.

BRIAN D. SUGDEN
47a Derbyshire Lane
Hucknall
Nottingham NG15 7JX.

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.

REX T. BARBER
110 Aldermans Hill
Palmers Green
London N13 4PT.

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

visit us. He said a couple of words to us. I did not understand either of them."

K. C. HARVEY

Cedrwydden
Park Avenue
Talgarth
Brecon
Powys.

Sir,

I should like to consider the relative merits of the papers in the March *Journal* (pp. 142-160) in order of publication.

I am afraid that Dr Donald's thesis on the pursuit of excellence and the search for truth shows clearly that he knows little of the disciplines of research and cares little for the aims of liberal (in the old sense) education. As one who was near the centre in the early days I can assure him that the separation of research and education was quite intentional, and both grew faster through being separated than they have done since recently coming together again. To employ, joined in unblessed union, the two disciplines "so that we can influence . . . the future modification" (of the structure of general practice) is to travel towards collectivist pseudopolitical indoctrination, not of excellence or of truth, but of the opinions, biased and unfounded on fact, of a thinker whose thinking is unsound. His road is not for me.

My only disagreement with Dr Irvine, however, is that I believe that the success of general practice will depend on its ability to cope well and kindly with the mass of undifferentiated illness in the community, rather than by the extent to which we can hammer out a cohesive discipline. I agree entirely with his "second concept of general practice", his "essence of being a professional person", and his "task of reaching agreement . . . about the basic aspects of the job". Both his method of setting out his arguments, and their content, appeal to me as honest, sensible, useful, and proper.

Professor Marinker seems to be advocating decentralization, while at the same time wanting it done at the centre by the proliferation of committees. This is a non-sequitur. Also, he is patronizing about the contribution of younger members to committees.

Dr Metcalfe and Professor McCormick appear to offer two mutually exclusive tasks—in my opinion the College must perform both. I agree with their section on the characteristics of medicine but find "Medicine and Society" ill thought out, based as it is on incorrect statements of the views of both doctors and patients. Its final sentences about pedestals and ivory towers is meaningless. They say our College should not speak for general practice—I say it must. They say that local activity must concentrate on research. As a faculty research adviser who has not had a single enquiry, idea, or project put to him in three years I know that the membership does not want this. However, I agree with their important statements that "(the College) is becoming resistant to change . . . (devoting activity) . . . to its maintenance and . . . ritual activities . . ." and that ". . . standard-setting (should not) mean the imposition of behaviour patterns . . ." I also agree with their advocacy of eschewing gowns and maces.

Our College, like many older institutions, has matured. In the period of prematurity such an institution has to struggle to survive and grow; while struggling, there is only time and substance for that which will best ensure survival—a process of almost biological natural selection. With maturity comes the question: To centralize (and ritualize, and dogmatize) or not? The biological way to successful replication is to channel survival need and survival effort into those parts of the whole which can still grow, that is, the faculties. The alternative of growth at the centre (without the massive membership which gives other institutions a satisfactory foundation) must eventually lead to involution and decay.

Let us support Dr Irvine, adding a few of his rival's best ideas to his thesis to make it even better.

F. H. STAINES

Top Meadow
Callington
Cornwall.

Sir,

Congratulations on four superb papers discussing the future of the College (March *Journal,* pp. 142-160). It must be healthy to make so radical a reassessment of aims. But it is not radical enough. Not only must future challenges be anticipated, but the dangers inherent in past success must be considered.

Surely most of us will agree with two major policy decisions being proposed: first, that the College should now concentrate a main educational effort on established and recently trained principals (after all one cannot continue to devote all resources to the three initial years and neglect the next 30); and secondly, that a great deal of the work must be done locally in small groups.

I believe that the failure of the College to find vigour for its new role can be found in its success with its last objective, vocational training. Training has attracted many, maybe most, of the vigorous college members. The attraction is not hard to understand—a generous trainers' grant, ready association with like-minded doctors, a sense of purpose, a supportive trainers' group, and unpaid help in the practice. Indeed, training now provides a cosy niche which it is hard to step out of, and into which many, maybe most, recently trained doctors would like to step. Like most occupants of niches, trainers probably do a good job, but hardly a dynamic or pioneering one.

So who will do the work of organizing and leading local groups? The college tutor with voluntary help of course—a college tutor for whom Dr Irvine suggests should receive "£500 for a notional two sessions" . . . since he believes that "many tutors would continue to work well beyond any notional sessional limit". Compare '£1,300 plus a trainee's help' for two sessions as a trainer and consider the chances of trainers giving up training to become tutors and what their partners would say if they did. A trifling honorarium will merely provide an excuse for a job inadequately done. If the College were to offer a sum equivalent to a trainer's grant, fewer of the best men would be deterred from doing the job, and they would have more right to demand practice time in which to do it.

As for the secretarial provision a small sum could be added to the tutor's payment to cover this, and each tutor would make his own arrangements within his practice, with all the benefits of 70 per cent reimbursement. Executive secretaries are all very well, but we should get the tutorial manpower right first. With the £5,000 to £7,000 suggested by Dr Irvine a faculty could finance four tutors *expected* to devote two sessions each.

There are plenty of trainers now. We need a (local) trainers' diaspora. If it does not occur, vocational training will damage, by siphoning off talent and energy, the very general-practice system it is trying to improve. Removing financial disincentive is important. I also believe we should extend the period before which a principal may train to, say, six years. And I believe we should consider limiting the time for which a trainer may train continuously, say to six years with a six-year break during which he would be expected to be involved in local education or research.

M. S. LAWRENCE
Education Co-ordinator,
Thames Valley Faculty

12 West Street
Chipping Norton
Oxon OX7 5AA.