getting them to take an adequate dose and experiencing pain relief without unpleasant side-effects, the next day they had gone back to homeopathic doses.

The contrast with patients in hospital who readily accept opiates is marked. The comfort of being at home seems to give them the courage to do without so much analgesia. I should be interested to know if refusal of adequate analgesia is common among patients dying at home.

A. HILLYARD

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THE JOURNAL

Sir,

I have been an ardent supporter of the RCGP since the day it was born. I still am. I am full of admiration for those marvellous people who had the foresight to dream up and actually start the College. It took great dedication and tenacity: no-one except those few originals ever thought it would emerge from its chrysalis, let alone grow into the respected body it is now. It has come to stay, is held in as high esteem by the general public as are the other Royal Colleges, and has definitely put general practice on the map.

In my view it has one blot. A large unhappy blot: its *Journal.* I have tried over and over again to decide why I do not like the *Journal.* Most of the articles if taken separately seem reasonable, but when put together the appetite wanes rapidly. Apart from the jargon, the endless statistics, the controversial articles which never seem controversial, the inconclusive conclusions, the overwhelmingly dull topics—there remain only the summaries of the main articles to whet the appetite rarely, and usually to prevent me reading the main text.

When Update took over the publication I was full of new hope. I fear this rapidly faded. The print and the lay-out are impeccable. So what is really wrong?

I have thought long and frequently on this and have reached a sad conclusion. I find it terribly dull, and insufferably boring. It does not at all seem to reflect the vital, exciting, ever changing, constantly challenging world of general practice. I have never yet found one 'live' article which makes me want to jump for joy, burst a blood vessel, get hot under the collar or even keep it for future reference. And I never ever get a laugh; yet every day in practice has its humour, from which I learn.

You, Sir, who yourself write so well and speak so eloquently, please take no offence. Get your staff together and have another look at our *Journal,* which should reflect our College as an index reflects a book. Find out if I alone hold these views. I suspect not. Try a '*Journal* audit' and find out the views at the grass roots. (How's that for jargon, the new infectious ailment?!)

Try a transfusion. Be erudite, by all means, but interest always, teach sometimes, and bore never.

CYRIL JOSEPHS

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PERSONAL CARE

Sir,

It is to be hoped that the simultaneous publication of two articles by Dr Pereira Gray and Dr Russell (November *Journal,* pp. 666 and 679) reviewing the limitations of combined lists and large group practices reflects the numerical ascendency of those who are tending towards a radical change in general practice.

Combined lists are usually contrary to the development of that close understanding between patient and doctor which is the continuing hallmark of the art of general practice. Their continuance, despite all the shortcomings, is fostered by a reluctance to enjoy the full responsibilities that come with having one's own list, whether it be inside or outside group practice. Despite the iniquities of the NHS (which are a reminder of our lack of virility rather than of a failing of our patients), if we are to do ourselves and our patients justice in our difficult task at the interface between the capabilities of modern medicine and the daily lives of our patients, we cannot forever escape a reversion to personalized primary care. The heartening paradox found even by the less altruistic of us is that accepting a marginally greater commitment removes many of the problems currently resident in our work.

These two prophetic articles deserve study by all who have an interest in the future of their own practices in particular and primary care in general. They portend the end of the era when we became one of the butts of British humour because of our apparent unwillingness to adhere to the traditions of being caring family doctors in favour of the transient glamour and superficial ease of being part of a depersonalized system. Whilst the application of such idealism may not be universally acceptable, it is the inevitable way forward if we are to alleviate job dissatisfaction and partnership discords, and it is probably the only way in which we can exploit fully the ever increasing potential of our future.

P. GROUT

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HOSPITAL POSTS FOR VOCATIONAL TRAINING

Sir,

I was recently looking at job advertisements in the *Journal* and came across one advertising four places in a well known vocational training scheme. On closer scrutiny I was surprised to see that two of the rotations advertised included no paediatrics, and the other two included no obstetrics. All four included three months of ENT and ophthalmology.

I am deeply worried that this sort of scheme, with the convenience of a package holiday, will become the 'normal' way of entering general practice, whereas the doctor who chooses suitable individual house jobs and does a separate trainee year will become a rarity. There is no doubt in my mind that the latter method, assuming it included paediatrics and obstetrics, would provide a more adequately trained general practitioner.

Enthusiasts for vocational training schemes will, of course, point to the half-day release course as being the great advantage of such schemes. Any benefits this may have, and none has been proven, cannot possibly compensate for the lack of clinical experience in vital subjects.

When vocational training schemes first originated, many doctors were anxious that these would be used by consultants to fill unpopular house jobs. Their fears cannot be allayed yet.

M. J. HAWKINS

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WOMEN GENERAL PRACTITIONERS

Sir,

I have read with interest the correspondence following your editorial. Recently I gave a lecture to a group of trainees about the problems of finding a partnership, and as one third of the trainees were women, the discussion naturally covered the problems that they might encounter.

Many women will opt for part-time partnerships. By working over 20 hours

in the practice, a part-time general practitioner will attract allowances from the family practitioner committee of at least £4,185 per year, plus £700 per year for out-of-hours cover. She may also be eligible for a vocational trainee allowance of £855 per year. Thus any partnership in a non-restricted area can reduce its workload without incurring any additional expense by employing a part-time partner at a salary between £4,000 and £6,000 a year. Unfortunately, salaried partnership is not recognized by the FPC nor in common law. The salaried partner is still liable for the debts, tax, negligence, and acts of omission of the other partners. Thus, the part-time partner must ensure that she has a comprehensive contract, specifying hours of work, a stated percentage share of profits, an agreed minimum salary, and also insist that money should be retained in the partnership account for tax purposes.

The additional problem facing full-time women partners is that of maternity leave. Most partnerships have an agreement that, if one of the partners is absent owing to sickness, he shall, at his own expense, provide a locum for the practice after a certain specified period of absence. Failing this, he shall pay the remaining partners at the prevailing BMA rates for locums. No doubt a similar clause could be included to cover maternity leave.

But now the snags appear. First, the FPC will only pay sickness payments of up to £125 per week provided that a locum has been employed from outside the practice. (Maternity leave payments rules are very similar but are only paid for a maximum of 13 weeks.)

Secondly, reliable locums are hard to find. Thus, the sick or pregnant partner may have to pay the remaining partners at BMA rates which are at least £200 per week, without any reimbursement from the FPC.

Thirdly, if locums are not available, the additional workload for the remaining partners can be quite considerable, especially in a small partnership. In a society progressing gradually towards a 35-hour working week, the retention of free time and the non-interruption of holiday plans are more important to many doctors than an increase in salary.

Finally, most general practitioners are paying tax above the basic level. An additional income for locum duties will be lost to the tax man. It should be noted that locum rates are still below the average weekly earnings of most general practitioners.

I regretfully concluded that our female colleagues are liable to be exploited or suffer discrimination. How many general practitioners looking for a replacement partner in a practice whose circumstances do not necessarily require a woman partner would choose a female replacement? Probably the answer is inversely proportional to the number of good male applicants. As the number of women graduates increases, there is an urgent need for the profession to negotiate better maternity leave payments with the Government.

K. C. HARVEY

Medical Centre
Hay-on-Wye
via Hereford.

ROYAL COLLEGE OF PHYSICIANS OF IRELAND

Sir,

In your Medical News section (January *Journal,* p. 59) you quote Professor T. Counihan as saying that the recent dinner given by the regional vocational training committee at the Royal College of Physicians was the first occasion in history at which the College has welcomed representatives from the Royal College of General Practitioners.

The Chairman of Irish Council of the Royal College of General Practitioners has been a guest at the annual St Luke's day dinner of the Royal College of Physicians almost since the inception of Irish Council.

J. S. MCCORMICK
Professor of Community Health
Trinity College

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AMSPAR/RCGP WORKING PARTY

Sir,

At its meeting on 12 December 1979, the joint Working Party of AMSPAR and the RCGP agreed the following statement:

"The Joint Working Party of AMSPAR and RCGP is supporting the establishment of courses for middle management in eight centres commencing in September 1980. The Joint Working Party is to monitor and evaluate these courses which are designed for practice administrators/managers and intending administrators/managers."

The Working Party believes that such co-operation between our two organizations represents an important advance in the improvement of training facilities for ancillary staff.

S. O. OLIVER
Chairman,
Joint AMSPAR/RCGP Working Party
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SINGLE-HANDED PRACTICES

Sir,

The Rural Practice Sub-Committee of the BMA's General Medical Services Committee has asked me to prepare a report on the difficulties experienced by doctors who take over single-handed practices. I would be most grateful if any doctor who has experienced any such difficulty would kindly get in touch with me.

The report will contain no detail by which a doctor or practice could be identified. It will be used to try and influence Departmental policy towards more effective continuity of patient care when single-handed practices change hands.

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GENERAL PRACTITIONERS AND CLINICAL PSYCHOLOGISTS

Sir,

We welcomed the section devoted to behavioural problems in general practice in the June 1979 issue of the *Journal.* It was particularly gratifying to note that two of the articles were written by clinical psychologists who reported close co-operation with general practitioners in the spirit of the role envisaged for us by Trethowan (1977).

We had developed a clinical psychology unit in a Newham district health centre (Hallam and Liddell, 1978) which provided a new service in an area in great need of psychiatric provision. However, after two years of operation, the number of referrals from general practitioners was lower than that from psychiatrists, social services, or self-referred clients. With the aim of expanding our service, we systematically attempted to contact every general practitioner listed in Newham. Half were contacted by telephone and half by pre-arranged visit during a three-month period. In this way we were able to discuss our service with 69 per cent of those contacted. Of the 31 per cent not contacted, 11 per cent no longer practised in Newham, five per cent were on sick or maternity leave, it was impossible to find a mutually satisfactory time for 10 per cent of the sample, and only five per cent actually refused to spare us the time. Six months after the beginning of the survey, general practitioners' referrals constituted the largest proportion of our patients.

We feel that the interchange of ideas