remembered not for his classic *Natural History of Disease,* but for a ridiculous little piece of rubber, suggested incidently by his wife, who understandably had tired somewhat of his weekend hobby of trying to stuff a great metal-tipped Einhorn tube down her oesophagus to study the gastric juices.

In the small compass at his command the author manages to give many little anecdotes of this kind, which make for light and easy reading. Each subject has his portrait and a succinct description of his syndrome or whatever.

This is a delightful little book, researched with care and compressed with great skill, but where are the ladies? Fifty-six eponyms—and all male. That will never do. Here is a chance for somebody.

J. R. MILES

REPORTS

Annual Symposium of the Royal College of General Practitioners

THE Annual Symposium of the Royal College of General Practitioners was held at the Royal Geographical Society, London, on Friday, 15 November 1979.

The theme was "Looking After Children" and had been chosen by the College to mark the International Year of the Child. The Chairman was Dr Denis Pereira Gray, General Practitioner, Exeter, and the meeting was attended by about 250 people.

Dr Graham Curtis Jenkins

Dr Graham Curtis Jenkins, General Practitioner, Ashford, opened with a paper entitled "What are we trying to achieve?". He suggested that the corner-stones of paediatric preventive medicine were: 1. Immunization; 2. Nutrition; 3. Health education; and 4. Treatment.

Dealing with immunization first, he pointed out that in the latest epidemic a figure of 90,000 children with notified pertussis, a five per cent admission rate, and 25 deaths, plus a lot of near misses, were a significant reminder of the failure of general practitioners to sell immunization successfully.

Turning to nutrition, he suggested that although breast feeding rates are increasing, in some deprived areas only five per cent of babies are breast fed beyond six weeks, even though breast feeding protects against lower respiratory infections and is virtually unknown in those children who suffer cot deaths.

In dealing with health education, he gave the teething myth, the winding myth, and the belief that picking up babies who are crying will spoil them as examples of misguided information about babies and their care which represented our failure as doctors to alter the beliefs of our patients.

He went on to argue that treatment should include the early detection of handicap, yet 50 per cent of children stopped coming to surveillance clinics after the age of one year, in spite of the fact that 10 per cent of children each year develop new and potentially serious disorders that can lead to handicap.

He went on to ask: "Where are we doctors going wrong?" and argued that first, we are failing to be aware that problems exist, and secondly, we are deluding ourselves that every general practitioner suitably trained can correct the situation.

Developing this theme, he advocated that we cannot wait to train all doctors, as more and more parents bypass general practitioners on their way to care, and he quoted as examples the direct admission of patients with asthma and the open door casualty departments.

Acknowledging the failures of the primary care services, he felt that change must occur as follows:

1. We must meet the challenge of prevention. Dr Curtis Jenkins suggested that this was the first priority, pointing out that information from other countries was relevant to our own.

2. We must accept the need for substantial and continuing re-education, giving up the illusion of curative medicine.

3. We must co-operate closely with those working on other parts of the child health services already involved in prevention, otherwise we will be bypassed in child care.

In summing up he suggested that we have to change our attitudes:

1. By giving back to parents their autonomy, removed by the giving of unnecessary prescriptions.

2. By giving up our exaggerated ideas about the power of curative medicine.

3. By admitting our failures and starting afresh.

Dr James Carne

Dr James Carne, General Practitioner, London, gave the second paper and his title was: "Meeting the challenge of the sick child." He concentrated on the help that could be given by the general practitioner to the child and his parents by a greater understanding of the parent/child relationship.

By treating the child as a person in his own right, rather than concentrating on the symptoms presented by

the parent (usually the mother), both the child and the parent could be helped to understand the psychopathology of the disease process, whether this was the cause of the presenting sickness or associated with a physical illness.

Dr Carne showed how, by using the techniques taught by Michael and Enid Balint, and applying them to the child and the parent/child relationship, better understanding in the handling of problems associated with illness in children could be achieved. He emphasized the importance of developing a good doctor/patient relationship during the antenatal period since this would give added security to the mother after the birth of her child and improve her management of illness should it occur.

Dr Michael Downham

Dr Michael Downham, Consultant Paediatrician, Newcastle, delivered a paper entitled "Danger signals". He pointed out that the main health problems for children today are: low birth weight, congenital abnormalities, cot deaths, acute infections, accidents, malignancy, and handicap, and went on to argue that within these are many possibilities for prevention.

However, he felt that most often the problem was failure to recognize the danger signals of acute illness, especially in the neonatal period, and he highlighted the non-specific symptoms of irritability, increased or altered crying, and reluctance to feed.

Evidence from the Department of Health's Multi-Centre Study suggested that it might be helpful to consider cot deaths and acute infections in the post-neonatal age range together, because there was considerable overlap, in that sudden infant deaths appeared to be caused by acute rapidly developing illness, although many still remain unexplained. It was, however, certain that major symptoms suggesting severe illness could be identified in approximately half the babies who died suddenly in the postneonatal phase. Although at times the symptoms were not recognized by parents, more often they had recognized the need for help but had not received it. As sources of failure he emphasized lack of paediatric knowledge by primary care doctors and nurses (for example, failure to recognize the rash of meningococcal septicaemia), consultations delayed by the doctor or his receptionist, inadequate arrangements for reassessment, and delayed hospital admission. For earlier diagnosis of chronic and acute illness he suggested:

1. Listening more carefully to parents, who usually knew the extent of their child's illness.

2. A better understanding of the social context of symptoms.

3. More paediatric training for general practitioners.

4. Considering practice arrangements for children, such as open sessions, the vital role of the receptionist, arrangements for reassessment, and the potential disruptive element of deputizing services.

He emphasized the need for prospective morbidity studies in general practice to examine the prevalence and range of non-specific symptoms.

The fourth section of the Symposium was intended to underline the importance of prevention, and was shared between Dr Ross Taylor and Dr Keith Beswick.

Dr Ross Taylor

Dr Ross Taylor, Senior Lecturer in General Practice at the University of Aberdeen, took as his theme "Drug induced disease in children". He reviewed briefly the ways in which children are especially or exclusively at risk from the ill-effects of drugs:

1. Indirect injury to the child through the mother.

a) by the action of drugs on differentiating fetal tissues in early pregnancy;

b) on differentiated but developing fetal organs and tissues in later pregnancy;

c) at and around the time of parturition;

d) on the young breast fed infant.

2. Accidental self-poisoning. Here Dr Taylor highlighted the disappointing effect of large-scale public educational campaigns, contrasted with the dramatic effects of simple regulatory measures.

3. The fact that a child is not a little man. Dr Taylor pointed out that metabolic differences determine that:

a) some drugs are relatively contra-indicated in children because the child is particularly susceptible to their toxic effects;

b) in general, adult doses of drugs simply cannot be scaled down for children.

Finally, Dr Taylor raised three issues for discussion:

1. Do we exercise sufficient care in prescribing for children?

2. Are we sufficiently alert to the potential of drugs as producers of disease?

3. Are we sufficiently willing to alter our prescribing behaviour in response to new information about adverse effects?

Dr Keith Beswick

Dr Keith Beswick, General Practitioner, Oxfordshire, spoke on "The prevention of child abuse", and described the growth of services aimed at preventing child abuse in his area. From the pioneering work of his own practice, services had developed to cover all the practices in a town of 16,000 people and the 12,000 people in neighbouring villages. He suggested that the most difficult part of starting prevention programmes was the painful business of coming to terms with child abuse. He emphasized the value of a team approach and

described the reactions expressed by team workers as follows:

1. Instead of recognizing early open warning signs as a sense of failure, it became possible to realize that they were calls for help and then to channel action in a positive manner.

2. Increasing experience and open discussion had enabled team workers to come to terms with violent feelings in the family.

3. The setting up of a programme for prevention enabled workers to look for those who might benefit from help, instead of regarding them with a sense of hopelessness.

4. The importance of open discussion of the problem of child abuse could prevent denial of its occurrence by even the key worker concerned.

In conclusion, he pointed out that his team had been able to meet the fears and anxieties of parents directly and to accept that parents can feel very frightened when they feel anger towards their children.

Dr Alastair Donald and Professor James Farquhar

The final section of the Symposium had as its theme "Better training—the key to progress." Dr Alastair Donald, General Practitioner, Edinburgh and Professor James Farquhar, Professor of Child Health, University of Edinburgh outlined an experimental scheme for training in child care, which had been developed in Edinburgh between the Regional Committee for Postgraduate Training, the Edinburgh School of Community Paediatrics, and the South-East Scotland Faculty of the Royal College of General Practitioners.

The stimulus for developing the scheme arose from the shortage of junior hospital posts in paediatrics. Dr Donald explained that while most young doctors wished to hold such a post, on reflection, after entering general practice, they expressed some dissatisfaction at the experience that these posts had offered because they were almost exclusively concerned with illness and yielded little training in preventive paediatrics.

With the support of the Scottish Home and Help Department, an experimental scheme had been derived offering a six-month period of training—half of which was based in a selected general practice and the other half in the School of Community Paediatrics.

Practices selected for training were those in which the trainer offered a full range of preventive paediatric services. The trainees undertook a range of agreed tasks relevant to the care of children but were not exclusively concerned in the care of children in the practice.

At the School of Community Paediatrics, in addition to the theoretical aspects of the course, there were attachments to clinical units and trainees had the opportunity of attending during on-call periods, to observe and examine children admitted as emergencies.

It was intended that, if successful, this training programme would form the basis of common core training for general practitioners, clinical medical officers, and specialist paediatricians, as one component in a wider training programme.

Professor Farquhar described the inception and growth of the School of Community Paediatrics at Edinburgh, pointing out that at first it was designed for community medical officers but that its courses were later modified to meet the needs of general practitioners.

The medical concept of the course allowed the consumer to select topics or groups of topics to meet his needs. The attendance could range from half a day to nine weeks and could even be spread over several years.

The modules available were: Developmental paediatrics 1 (before, during, and after birth), developmental paediatrics 2, the school child, learning and behavioural problems, chronic illness and handicap, analysis of paediatric symptoms, and field visits.

Dr Donald's search of paediatric training for trainees had led to further modification of the curriculum and the addition of clinical teaching.

Professor Farquhar pointed out that the Symposium had heard it argued that without more paediatric skill in general practice there was a danger of hospital departments becoming the parents' choice of help. There was evidence that this was already happening.

Some of the general practitioners who questioned the need for a programme such as the School provided might even be unaware of how much could be done by detection and help or might judge it folly to be wise.

Those who criticize the course and say that it is too limited and no substitute for a six-month house job must conjure up from nowhere adequate house jobs.

It was accepted that the course did not provide for the trainee the experience of clerking 50 cases of bronchiolitis, of terminating 75 febrile convulsions, or of setting up 100 scalp vein infusions, but neither did he have to test routinely 1,000 urine samples or complete 2,000 laboratory request forms. As a result of attending this course he may well be orientated for caring for children in the community.

Professor Farquhar ended by saying that the course existed, it worked, it was fresh and malleable, and was being shaped in the light of continuing experience.

The President

The President of the College, Dr E. V. Kuenssberg, looked ahead into the 1980s and spoke of his 40 years' experience of general practice in a large group partnership in a deprived area, experience based on 25 years of the family recording system, of several thousand three-generation families, several hundred four-generation families, and not least in having had six grandchildren.

Dr Kuenssberg emphasized that the child was so often the child of the parents and it was striking how the same problems recurred in families: there were insecure children of insecure parents and fat children with fat

parents. The current fashion was for small families with one or two children, and he wondered if some of the security of the large family was being lost.

Looking ahead to training, Dr Kuenssberg reminded the meeting of the Evidence of the College to the Royal Commission on Medical Education (RCGP, 1977), and agreed that specific paediatric teaching was necessary for vocational trainees. He was concerned at how little could be done in an average five-minute consultation.

Dr Kuenssberg also spoke of *Occasional Paper 6, Some Aims for Training for General Practice* (RCGP, 1978), which brought together many of the aims for future general practitioners. He considered that attitudes were most important and needed to change, particularly so that the authoritarian image of the general practitioner receded and that children were never again told: "Here's the man with the black bag who will take you away." This was the idle threat with which mothers or aunts struggled to control their own children.

Dr Kuenssberg hoped that in the period before the vocationally trained came into post as principals, doctors would overcome their traditional prejudices and work together. He hoped that clinical and medical officers could be assimilated into general practice in a part-time capacity, perhaps as part-time partners or in some other form of associateship. With reference to joint training, he thought it was important that general practitioners should listen to consumer groups, especially groups of patients, but resist becoming embroiled in medical politics. Above all, general practitioners must learn to evaluate their day-to-day work so that later in the 1980s it would be possible to justify changes incurred on a scientific basis.

In closing, Dr Kuenssberg said that he believed that if general practice should ever be deprived of the care of children, it would surely mean the end of general practice itself.

Chairman

The Chairman, Dr D. J. Pereira Gray, began his summing up by emphasizing the commitment of general practice to the care of children. He quoted from the College's statement on child policy: "The College will require training programmes to include satisfactory training in child care. The College examination will require all candidates to demonstrate adequate knowledge of the principles and practice of child care reflecting the increased responsibilities of general practice" (RCGP, 1978). About 1,000 candidates a year were now taking the examination.

It was clear from several papers during the day that there was now an urgent need to undertake research in the care of children through general practice and he hoped that a growing number of projects which were springing up would receive appropriate support and resources.

Finally, he hoped that the theoretical ideas which had been discussed with such interest during the day would now be translated into action in the several hundred practices which were represented at the meeting. Child care in general practice was ripe for the full integration of preventive and therapeutic medicine, and he personally believed that the provision of regular weekly sessions for children one afternoon each week was a helpful starting point.

C. WAINE

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Patient participation in general practice

THE notion that patients should have a say in the way a practice is run may initially provoke a hostile reaction from general practitioners, but more mature consideration is likely to give qualified approval to patient participation.

This was the general feeling expressed at a study day held at 14 Princes Gate, London by the Royal College of General Practitioners on 16 January 1980, which was attended by 65 general practitioners, eight patient representatives, four social scientists, and two medical students.

Chairman

Dr John Horder, President of the College, took the chair. He outlined the aims of the day: to increase knowledge of this new development, to study the skills needed for this type of patient/doctor communication, and to explore mutual attitudes to this change. He welcomed the initiative of the College, which related to what he saw were the present priorities of the College: namely, for general practitioners to examine what they were doing, particularly by adopting small group methods; to look at the place of prevention; and to look at their job satisfaction in relation to their use of time.

Dr Peter Pritchard

Dr Peter Pritchard, who had helped to start one of the early groups in 1972, described how the idea had first