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

been clearly expressed at a conference on group practice at 14 Princes Gate in 1969 (Reedy, 1970). In the subsequent five years, three groups were formed independently of each other—at Berinsfield near Oxford, at Aberdare, and at Bristol. Now there were about 25 groups in England and Wales, and the number was still growing. He stressed that no two patient participation groups were alike and that this diversity was an expression of their adaptability to local circumstances and their potential for making health care more appropriate to need.

Mr Alec Dakin

Mr Alec Dakin, Chairman of the National Association for Patient Participation in General Practice, expressed the patients' point of view. He emphasized the great respect in which doctors were held, but felt that unless a more equal relationship could be established, rapport and communication would be difficult and treatment less effective. Doctors who favoured patient participation were met with a positive response which seemed helpful to doctors and patients. The outcome was improved communication, with patients taking more responsibility for the improvement of their own health and that of the community.

Mrs Jo Wood

Mrs Jo Wood, a social researcher from the University of Manchester, presented some results of her research into how doctors and patients viewed patient participation groups (Wood, 1980). Those who had experience of them felt that they increased understanding and effectiveness, reduced friction, and extended the doctor's role and were becoming an essential tool. Those doctors who did not have patient participation groups had the opposite views and regarded them as a current fad. Mrs Wood outlined the main functions of such groups as follows:

1. A planning tool.
2. A safety valve.
3. An educational tool.
4. Providing social support in the community.
5. The eyes and ears of the health team.

Brisk discussion followed, and topics included: the sort of doctors who started groups, the sort of people who came, the involvement of other members of the team, greater participation in the consultation, relationships with community health councils, and objective achievements of the groups.

Mrs Sheila Hillier

Mrs Sheila Hillier, Lecturer in Sociology at the London Hospital (deputizing at short notice for Professor Margot Jefferys), asked: "Can patients influence decisions about health care?" She saw this question in two ways: were patients competent to influence decisions and possibly initiate change, and if so would they be enabled to do so?

She went on to analyse possible barriers to the formation of patient participation groups, both from professionals in the primary care team and from the patients themselves. She described how change involved danger as well as opportunity and the anxieties which these groups aroused in general practitioners touched on issues at the heart of professional practice—accountability, responsibility, freedom to practise and control of one's professional life. General practice was changing, led from within the profession and influenced from outside. Maintenance of freedom carried a risk of isolation which made general practitioners more conscious of the dangers rather than the opportunities created by change—both organizational and clinical. Doctors could use the knowledge of lay people to learn about the quality and expectations of their lives in order to improve the service they received. This communication need not be one way: doctors were never allowed to say what they thought about their work, to admit the anger and resentment they felt about the demands made upon them. This was a recognition of equality, not of superiority. It was more mature to express these feelings in a patient group than to act them out with individual patients. Patients had a lot to contribute, and a better relationship followed a reciprocal exchange rather than giving and receiving.

Though not too much hope should be invested in patient participation groups, and what they might be able to achieve, it was important to 'normalize' the idea of patient participation, and the practical benefits should be emphasized rather than ideology.

Professor David Metcalfe

Professor David Metcalfe, Department of General Practice, Manchester, thought that lay participation should be encouraged because it was not possible to do without it if the National Health Service was to continue to serve its population and general practice to grow. Rapid changes in society must be matched by structural and process changes in general practice. He compared the somewhat rigid boundary between the hospital services and general practice with the flexible and diffuse boundary between general practice and the community. Most of the community was secure in its pay and prospects, although an increasing section was losing out on prosperity, but was it losing out on health care? Could general practice keep in contact with this section of society? Doctors knew what happened on their side of the boundary but knew little of the patients' side. This is where lay participation was needed.

Professor Metcalfe described the core function of general practice as providing first-contact care of acute illness. The great increase in demand from an ageing population could not be met by a contracting hospital

service, so the only solution was a greater emphasis on prevention, an extension of the role of the practice nurse, and improved practice records and information systems. These were changes for which general practice did not have a mandate. It should therefore negotiate a mandate by means of a patients' group based on the practice.

After 90 minutes of group work the participants produced questions for the main discussion period. These concentrated on five main topics:

1. What are patient participation groups for?
2. What are the areas of activity of such groups and should limits be set?
3. How can doctors and patients be convinced of the usefulness of such groups?
4. How can they be made to work?
5. Are they effective?

Discussion was brisk but time precluded discussion of the key final question.

Chairman

In his closing address, Dr John Horder, said that in his view the attitude of the College was thoroughly supportive of patient participation. He welcomed the widespread enthusiasm of the people involved, not least the National Association for Patient Participation in General Practice, who would keep up the interest engendered by this very successful study day.

PETER PRITCHARD

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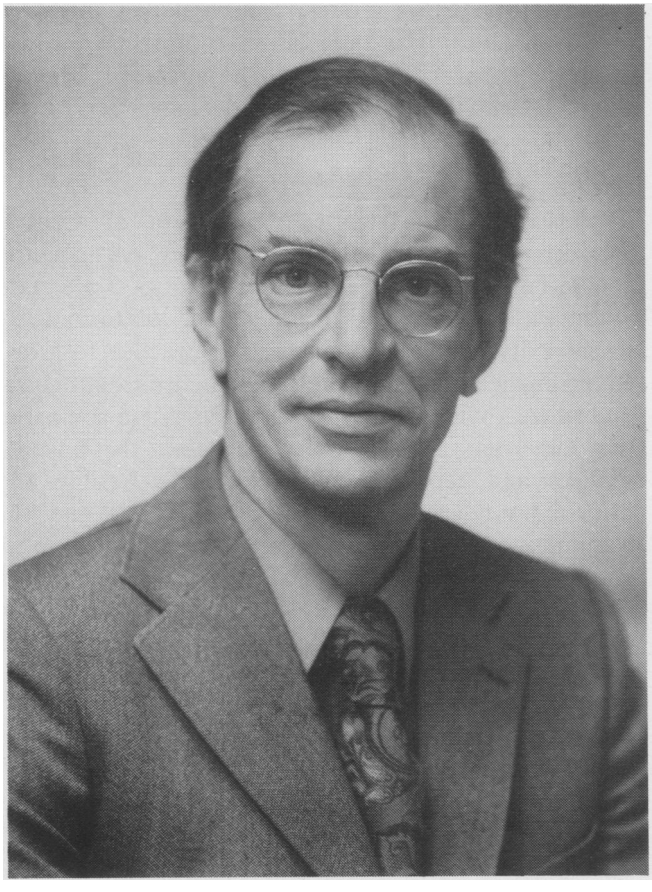
OBITUARY

John Chivers Graves, OBE, FRCGP

WITH the death of Dr John Graves at the age of 57 on 17 January 1980, an era has come to an end.



The facts and figures of the development of the Graves Medical Audiovisual Library from its early beginnings as the Medical Recording Service Foundation, with 25 listeners of the College of General Practitioners' tape recording services in 1957, is of course fully documented in the annual reports. From these we can discover that the membership rose to over 28,000 in 1978/79 and that a supporting gift of £25 from a pharmaceutical company in the first year was to become a budget of £130,000. But facts and figures tell only a fraction of the story.

In 1956 when a questionnaire was sent out to all the new College members, John and Valerie Graves insisted that it should include a question on the possible value of a service from the College library which would provide tapeslides as a basis of discussion for small groups of general practitioners. The response was sufficiently encouraging to lead to the formation of the College's Medical Recording Service.

For the first four years John and Valerie worked entirely on their own. A full tape or recording library was started in 1961, and in 1962 they were joined by a librarian and secretary to help service over 400 general practitioner discussion groups. By 1965 there was a staff of six, and although by then postgraduate medical centres had begun to spring up, there was a steadily growing demand for loans by nursing colleges, junior hospital doctors, industry, public health, and overseas customers.

The smallpox outbreak in 1963 showed how the wide distribution of visual teaching material helped general