From the Dart to the Tagus

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YOU have chosen Tamar as the name of this new faculty. I have chosen the English Channel as the centre of my lecture. It lies in the middle of what I have to say, rather as the Tamar river lies between your two counties, dividing them, yet linking them, because of the bridges which men have made to cross it.

You have done me a very great honour in asking me to give this first McConaghey Memorial Lecture. I want to thank you most sincerely for that—but for more than that alone. You have given me the chance to think again, more deeply, about the character, interests, and contributions of someone to whom the College owes a great debt. You give me a chance to repay in some small way a personal debt for his kindness to me, which I acknowledged insufficiently when he was with us. And now, with Robin Pinsent here as your provost, you take me back to that exciting time when I was given my first job in the College as assistant secretary to the original research committee and when Robin, Mac, Ian Watson, Donald Crombie, and I were constantly working in one team.

We were all brought up to the story of Francis Drake on Plymouth Hoe and we warmed with pride at his confident, almost feckless, reaction to the Armada's approach. We see the Englishman as we like to think of him—a man of action, unruffled in the face of odds, David against Goliath, sportsman, leader.

Dartmouth, like Plymouth, belongs to the sea and to history (Figure 1). Like Plymouth it contributed to the fleet that drove off the Armada. It is another part of our island pride, with a natural and man-made beauty greater perhaps than this city had, even before a more recent enemy came here by night and rained destruction.

Throughout our history the English Channel has been our strength—the gulf which divides us from Europe, yet links us too, as wars have alternated with periods of peace, commerce, and exchange of ideas. Despite the aeroplane, it still divides us from our nearest neighbours, in a way which their own invisible frontiers can never do, and which they still envy.

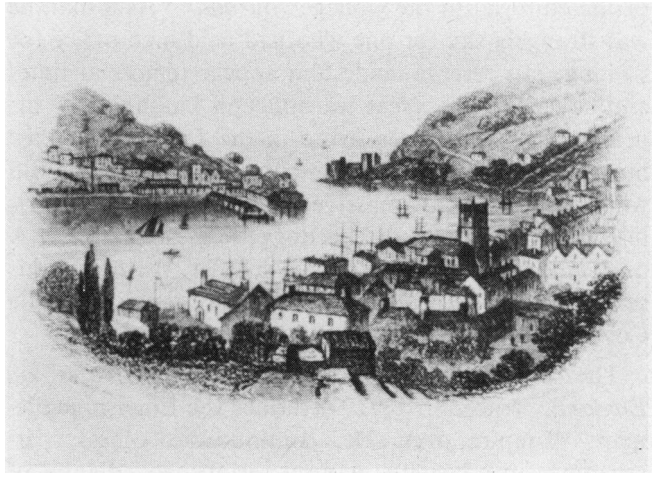

Figure 1. *Dartmouth.*

It was always about the wars that my generation of little boys used to learn. They were almost all with France.

It is not entirely surprising if some of our feelings for Europe are still insular and unenthusiastic.

Mac

Inevitably the visitor to Plymouth or Dartmouth thinks predominantly of the past. Perhaps those of you who live here do that too. What is certain is the fascination of the past for Mac. But for him it was not the history of the battles, so fascinating to little boys, but a very mature concern with the history of everyday things and the ordinary lives of ordinary people in this country and this county. Naturally I have been re-reading his published writings, some to remind myself, some for the first time. I was searching for the man, but what I found was history.

For example, I hoped to find something about what Mac was like as a doctor by reading his article on "The Doctor's Bag".[1] What I found was a quotation from Hippocrates: "Have also another apparatus ready to hand for journeys, simply prepared and handy too by method of arrangement, for one cannot overhaul everything."

The first McConaghey Memorial Lecture was given at the Inaugural Meeting of the Tamar Faculty on Saturday, 10 May 1980 at the Postgraduate Medical Centre, Plymouth, Devon.

No matter what the subject, Mac treated it from the historical viewpoint: 'Medical Ethics in a Changing World';[2] 'James Mackenzie';[3] 'State Medicine in Britain'.[4] Even 'The Contribution of the Family Doctor to Community Health'[5] quotes the Alexandrian physician, Herophilus, in the first paragraph: "When health is absent, wisdom cannot reveal itself, art cannot become manifest, strength cannot fight, wealth becomes useless and intelligence cannot be applied"—a useful approach to the definition of health, which reminds me of Freud's "The ability to love and to work."

In all those writings Mac himself is hard to find. He was not an easy man to know and I agree with the writer of the editorial in the College *Journal*:[6] "As a man he was strangely shy for one who had held high office for so long. His reserve made him appear remote at times and concealed the great warmth and kindliness of his personality." Whoever wrote in the *Lancet*[7] also saw him as reserved: "Few knew him well. Those who did will never forget his massive intellect, his warm heart, his serene tolerance, and his dogged determination." A quiet, dignified and determined scholar, therefore—his self-discipline exemplified by his daily swim at Castle Cove.

The French historian Taine,[8] in his *Notes on England,* written in 1872, describes the English gentleman: "Empire over self, continuous coolness, perseverance in adversity, natural seriousness, dignity of manner, the shunning of all affectation or boasting." Not a bad description of Mac, whose coolness and dignity remained unruffled even when I suggested in the College Council that the *Journal* might come out less frequently, since we all had far too much to read! I have forgotten what he replied, but not his look.

Dr Geoffrey Smerdon has written me a delightful description of the man who was his trainer: "I remember him a very quiet, brown man: brown because of his suit, his pipe, and the suntan which he always had; quiet, because, if things were going smoothly, he just nodded. Once when I was sitting in on a consultation, the patient came in, gave the history, was examined and departed with his prescription. I taxed Dr Mac with not having spoken a single word—needless to say, he made no reply."

I do see Mac as very British in his appearance, his character, his home, his work, and his dedication to voluntary service. I doubt whether he was very interested in foreigners or in foreign travel. Born in India, the son of a professional soldier who died at the hands of the Germans in 1916, and himself a colonel in the RAMC during the 1939 German war, I see him in the tradition of the defenders of Albion against invaders. He had a military bearing and a military self-discipline; even his helper in the surgery was for a time an ex-naval chief petty officer.

Would he then have been interested in what I intend to talk about? That is to say, those very foreigners with whom over the centuries we have fought, with whom we now find ourselves increasingly involved: the French and Germans, the Belgians and Dutch, and soon maybe the Spaniards and Portuguese? I do not know. But if it concerned the College, it would have concerned him too. If it concerned the status of the future of general practice, it would have concerned him too. Although he so obviously enjoyed the past, he realized that the importance of history is its relevance to the future. Moreover, Mac was a good listener and I believe that he would be indulgent to me now, as he was during his life, while I talk of things that mean as much to me as history meant to him.

My intention is to talk about general practitioners in Europe, their relationship to us, and ours to them. I want to share with you some of my own feelings about Europe and to argue that our College has a role beyond the Channel.

In doing this, I shall do something which Mac would never have done—talk about myself.

A French influence

I come from a large family in a rather dull London suburb, focused around the church of my grandfather, a Congregationalist minister. An education in Latin and Greek was regarded as obligatory, but there were musicians and artists in the family bursting out of these puritanical bonds, and even my grandfather escaped to holidays in Switzerland or Italy. I was taught French every Saturday by a French governess who responded to my hatred with love. My first two holidays abroad, as a child, started with excitement and ended with disillusionment and tears; and yet they remain constantly in my thoughts, as a sort of magic carpet—an escape from the discipline of school and of my particular home. After them even my model railway had to be converted into a French one.

At 18, I jumped at the chance to spend a few months in Paris, between school and university, studying music. My memory of that summer is of permanent sunshine and it is still uninfluenced by the discovery not so long ago of the letters which I wrote to my mother; in each and all I complained that it was raining. Europe, France in particular, represented the world of the imagination, the past, the beauties of architecture, music and painting, and to some extent liberation. It made no difference that I found myself working with a teacher who proved to be a much stricter disciplinarian than anyone I had met in England. Roger-Ducasse, musician and composer, introduced me to that cultured past which makes the French assume that France is without question the centre of civilization. He warned me off my intended career as a musician, but left me with a capacity to play the piano and the organ which has proved a major joy and, with painting, contributes much to my enjoyment of travelling.

I tell all this background to explain my own prejudice in favour of Europe but, as you will see, idealization

was sometimes followed by disillusionment. The journey was often better than the arrival—an experience which I have found to repeat itself in many other contexts in my life.

First contact with Europe

My contact with general practitioners in Europe did not really start until 1964. It was then that I went to Zagreb in Yugoslavia, to study the three-year training course which Professor Vuletić had started for general practitioners after qualification.[9] I shall never forget the kindness which I experienced there. At that time Zagreb really did contribute important experience which we did not yet possess. Even recently I have discovered that Vuletić achieved in 1972 an assessment of the effects of his course on subsequent performance which again goes further than anything we had managed here at that time or even since.[10] This work is still unknown in this country.

My contact with Europe has been more intense since 1970. I would like to pick out three distinct activities. The first is a personal study done in France through a College Wolfson professorship; the second a week's seminar in Portugal with a small team from the College; and the third my six years with the Leeuwenhorst Group from 11 European countries, including some from Eastern Europe.

France

Three years ago I was offered the College's Wolfson professorship, which virtually says: "Here is money, go and travel." Such open assignments inevitably mean particularly difficult choices. My own was made because, through my French governess, I spoke French; because of my experience in UEMO, the political organization representing all general practitioners in the European Economic Community; and because of the remarkable lack of contact between general practitioners here and our colleagues in the country which is nearest to us.

The status of general practice in the EEC depends on the creation of a directive under the Treaty of Rome which will recognize it as a special postgraduate subject with a special training. This cannot be brought into force until the majority of the nine countries have actually instituted a special training.

Three years ago I knew that France, with Belgium and Italy, was undecided even about the intention of creating a special postgraduate training for general practice. Belgium and Italy, and possibly West Germany, might follow France's example. I decided therefore to use the Wolfson money to see if I could exert an infinitesimal influence on the training of general practitioners in France and French-speaking Belgium. I could at least present myself as the Secretary of the Leeuwenhorst Group, in other words, as a European. I would not be merely an English invader.

There was plenty of money, but not a single invitation. It is embarrassing to persuade a foreign university to invite an unknown pseudo-professor to come and teach. History makes it even more difficult if it is a question of a French university inviting an Englishman; and virtually impossible if it is a question of a French university inviting a mere general practitioner. The only solution was to forget about the word 'professor' and to go as a student, to examine what the French were doing. If I asked enough questions, people would probably ask me questions back. This tactic proved successful.

In France I started by visiting local general practitioners in centres where I knew that the university had the beginnings of an interest. In Belgium I started by getting an introduction to the Chief Medical Officer. In France I went to eight provincial universities and two of the 13 universities in Paris. That makes only a third of the total of all the medical schools in France but it was the majority of those where there were beginnings. In Belgium I went to four.

Power of the universities

Essentially what I discovered was the power of universities, backed by the Ministry of Universities in Paris. I had not previously realized the hierarchical nature of French society, nor the special status of university professors, which is only second to that of senior civil servants.[11] It is impossible for university people to recognize that general practitioners might be able to teach or form part of the university. There was almost total opposition. If there was to be vocational training it had to be added on as part of the undergraduate university course—an integral part of it for those who failed the competitive examination to specialize. This kept it under university control. With the help of their Ministry the universities were even managing to delay the passage of a government report, named after its chairman Fougère, which allowed vocational training to be as the universities wished, a third part of the undergraduate course.[12]

I found a few beginnings, but the only notable one was in the experimental medical school at Bobigny in Paris, where a three-year course was actually happening. There a considerable staff of practitioners had been installed by the Dean, Professor Cornillot, a natural rebel.[13]

Minister of Health

If I was impressed by the power of the universities, I was equally impressed by Madame Simone Veil, then Minister of Health—a remarkable woman of great charm and great determination. She had achieved many changes in her time as Minister of Health—not least the acceptance of family planning in Catholic France. On the question of vocational training for general practitioners she was in conflict with the Minister for Universities and with the universities themselves. The

Minister for Universities was also a woman.

During the course of my study Madame Veil managed to bring the Fougère Report to the Chamber of Deputies. This was happening at the end of 1978 just as I was completing my round of visits. The problem was how to see that my material was used. This was achieved through the help of my colleague in UEMO from Luxembourg who had entertained her when she came there. I received an invitation to write my report for *her*. The debate in the Chamber was going to be quite soon and it was already clear that Madame Veil was coming to the end of her time as Minister. I had an enormous amount of material, the report had to be short enough for a Minister to read, and there was very little time. With the help of a French patient as translator and a typist from the French Embassy, I did just manage it and the report went off in the diplomatic bag.[14] Whether Madame Veil actually saw it or read it, I shall never know. Top civil servants in France are not very good at answering letters.

Training for general practice

I do not seriously imagine that my report had any influence on the fact that the Chamber of Deputies passed an Act last June creating a two-year special training for general practice. What I was urging was probably happening anyway.

I did hear early last month that the Minister for Universities, who is still in office, has totally changed her mind, removing from the post of adviser at least one university professor who had previously been influencing her against general practice. She seems even willing to create special professorships for general practitioners, against all the rigid traditions of promotion to professorships in French universities.

Portugal

A second opportunity arose last year. There was an invitation to bring a team of three or four English doctors to conduct a week's seminar in the Public Health School in Lisbon. This time the subject was not education, but the organization of its primary care service.

Portugal is very different from France—far poorer, and totally reliant on foreign aid. Politically it is divided and disturbed with frequent changes of government after a period of 20 years' dictatorship when it virtually went to sleep. It seems very difficult for anything effective to happen there.

The medical situation is chaotic. Primary care is provided by a variety of different agents—a small number of ageing practitioners, in the sense that we might recognize them, all now near to retirement. Clinics provide doctors who do sessions of not more than two hours and change from day to day—they are mostly specialists doing this work on the side to make some money. There are public health clinics dealing mainly with children and mixing prevention with care and cure. Hospital casualty departments are hopelessly overcrowded with people seeking primary care. Rural districts are often totally devoid of doctors. And yet, at the same time, there is an excessive number of young doctors, some of whom are now without work.[15] The excess is even greater than in France. The Government has therefore recently organized a form of compulsory one-year service in rural districts for these young doctors. It is by no means popular with them, because they all want to specialize and from that point of view this year is a waste of time. It contains no training and they may have to leave their families in the city where they live.

Portugal is virtually the only country which has now made a conscious decision to copy our own National Health Service and with that a decision to set up a proper primary care service. The first problem for my group, Marinker, Tudor Hart and Walker, was whether to follow our instructions and talk about what happens in the United Kingdom. This seemed to me precisely the wrong way to go about it. What we did do, in fact, was to talk about the problems of Portugal, introducing the experience of this country only if it seemed relevant. Language difficulties were considerable, but it was a most interesting experience. We found the same opposition from medical schools as we had found in France, but we also found opposition from the Portuguese Medical Association, which largely seemed to represent private practice. The Public Health School, the government of the day, and we, ourselves, in advocating a state service, threatened the possibility of lower earnings and less freedom of action for specialists.

We urged a service uniting primary care with prevention. Earnings for young doctors must make the service competitive with specialist careers, and teaching must make it interesting and worthwhile. But there were two major difficulties: who would be the teachers and who would provide the money?

Shortly after our visit to Portugal the parliament passed a law which introduced a national health service and later last year Marshall Marinker went back to advise again about the plan for primary care. But since his visit a government more sympathetic to private practice has come into power and further action appears to await the result of the next election.

The Leeuwenhorst Group

In 1974 the Dutch College organized the Second European Conference on teaching for general practice at Leeuwenhorst—a remarkable conference centre in the Dutch bulb fields originally built as a convent (Figure 2). There were participants from 11 countries, chosen not as national representatives but because they were known for their interest in general practice teaching. It was a good conference, and towards the end it seemed to Niels Bentsen (Denmark) and to myself that it would be a pity if the work was not carried on. We

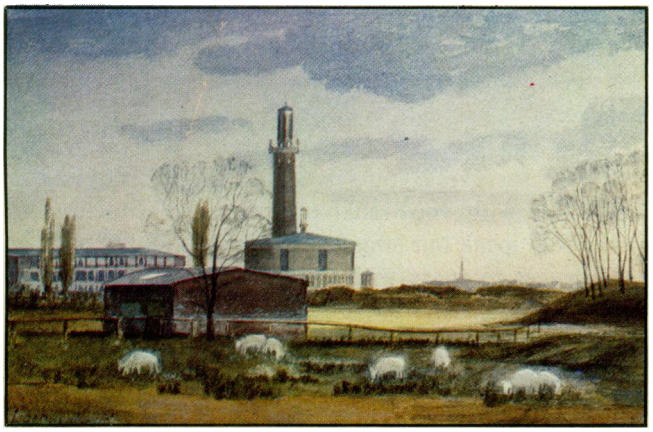

Figure 2. *Leeuwenhorst. Watercolour by J. P. Horder.*

suggested that a working party be formed with a member from each of the 11 countries, to see if a European definition of a general practitioner could be agreed. It never had been before.

The countries present, and therefore the members of the working party, included Hungary, East Germany, Yugoslavia, Norway, and Austria, the rest being from the EEC. For some reason the Netherlands had two members and we had three. We, of course, had the job definition which originated in Manchester ready to offer. It was modified a little and agreed quite quickly, so that we went on to discuss educational objectives and we published a pamphlet.[16] That first pamphlet has prospered far more than we could ever have imagined. The definition has been quoted so much that everyone must be tired of hearing it. It was taken over by UEMO who recommended it to the Advisory Committee on Medical Training at the EEC Commission in Brussels. So it has now become the official EEC definition.

Our second document on the general practitioner's contribution to undergraduate education has gone into limbo.[17] I doubt if it was very popular in any medical school, since it took a radical approach to the extent of the general practitioner's role as an undergraduate teacher. Whether it will prove to be one of those documents that people will be quoting in ten years' time remains to be seen.

The third document on continuing education has only just been distributed (September *Journal*).[18] It argues strongly for small group teaching and for active learning.

For the members of this group its process has been at least as interesting as its tasks. At first we had subgroups that spoke French, German, and English. This gradually reduced itself to English, only one member having continuing difficulty. The East German, a delightful lady doctor, unfortunately had to be a rare attender. National prejudices and traditions still cause destructive arguments between France and West Germany and there is a certain fear in the Group that it will be dominated by the United Kingdom; we are referred to as the Anglo-Saxons.

We have, of course, the enormous advantage of speaking our own language, and in most of the topics our own activity has been at least ten years ahead of the rest of the other countries, the Netherlands coming closest to us (Figure 3). Despite arguments, we have become so attached to each other that there is a real danger that the Group might continue to meet merely for the sake of meeting.

I feel ashamed to have been talking so much about my own background and activities. The temptation increases as one gets older, but Mac resisted it till the last, at least in what he wrote.

Europe

But it will not have been difficult to see the common themes and purpose in what I have described. I feel for Europe as Mac felt for history. I believe that this island's future lies with Europe and that the College has a part to play. I believe in the generalist's role in medicine no less than he did and I want to see it flourish in Europe. The general practitioners there have been going through all the same problems as faced us in the 1950s but, except in the Netherlands, their difficulties are greater and they are years behind us in dealing with them.

Maxwell[19] produced a chart which tried to estimate the strength of general practice in different countries. The opposing strength of specialization is the central difficulty in them all. Only a fool would be unable to see the benefits of specialization; they are unquestionable. We general practitioners can only exist today because specialists are also there. But we can also see that the pendulum has swung too far—excessive resources, excessive prestige, prejudiced career choices, contempt for the generalist, and a danger of class distinction within our profession. In our own country these problems are receding, but they are still very real in France. "I hope you won't become a generalist" said one dean of a medical school to a new intake of students. "The education of generalists does not matter: that's the end of it," said a French government official to a depu-

Figure 3. *Amsterdam. Watercolour by J. P. Horder.*

tation of general practitioners only three years ago.

In France, Germany, Belgium, Spain, Portugal and Italy patients are free to consult specialists direct. Thirty per cent of patients in France actually do this.[20] In each of these countries there is a growing excess of doctors emerging from medical schools—the problem in Italy reaching proportions which are disastrous and tragic, yet remaining totally uncontrolled. It is not difficult to see why the general practitioner in these countries is under threat of competition and unemployment that we have never experienced because of our tradition of referral to consultants, and because of our strict control of entry to medical schools.

The College

Most of us here have had the exciting experience of starting a new institution which has contributed most powerfully to restoring the balance between specialists and generalists in medicine in this country.

Those of us who have been involved with Europe—and I would particularly mention two—Ekke Kuenssberg, for his leadership in the European research workshop against great difficulties, and Alan Rowe, whose understanding of medical politics in Europe astounds me—have had the same sort of satisfaction in seeing a trend going the way we all want it to go.

Two months ago I wrote a document urging that the Leeuwenhorst Group had completed its work and should disband. I had to withdraw it. I had failed to realize the moral support which this group provides to general practitioners in other countries, even though I had been struck by what had been said about the importance of our College when the group had met there last October. It was clear that many of them felt on arrival that they had returned to a spiritual home for which they possessed no parallel in their own countries. One day one of them rang me at seven o'clock in the morning in his concern for the College building during the Iranian siege.

At present our role in European general practice is to give rather than to get. We started first, we have a College, we have three-year training, we have research, we have a national organization for continuing education. It is only too easy to feel superior. Yet nothing is more dangerous in dealing with proud countries like France, Germany, or Spain. They resent the growing dominance of our language, they fear our National Health Service, they are convinced that in their countries medicine is practised better than in ours. If you ask me whether this is actually so, I cannot answer. I was not there to look at that, and anyway we have no agreed criteria by which to judge. As far as I could see, the problems were very much the same and the way doctors dealt with them was not very different either.

The art of good conversation is to be a good listener. Michael Balint stressed the priority of listening among the skills of general practice. The same principle applies in converse with foreign doctors. I believe that the experiences I have described in France and Portugal were based on this principle and that it was fundamental to success.

What can we get in return if, as a College, we continue to involve ourselves in Europe? Yugoslavia helped us with vocational training. The Dutch, who invariably speak our language, have a variety of parallel experiences to share with us. How many of you have read Huygens' remarkable account of families which he has followed over 25 years?[21] The French already have experience in continuing education from which we can profit and I believe that, now they have started, they may catch up very fast. But what we can all get from each other is the experience of seeing ourselves as others see us—in the same way as we do in the small groups we are now trying to promote within this country, where one doctor compares his own performance with that of his fellows.

Conclusion

I want to conclude by returning home—first to Mac, then to this new faculty, in which he would have been an elder statesman if he had lived until today.

I talked of Dartmouth and Plymouth as foremost in the defence of this island against the foreigner. It would have been fairer to balance that with their long history of trading with France, Spain and Portugal. I presented Mac as the sort of Englishman who, when abroad, asks for his bacon and eggs, marmalade, and *The Times* newspaper, and observes the foreigner with that amused and superior curiosity which never forgets that the Englishman is different. This was equally unfair.

Dr R. M. S. McConaghey, Honorary Editor of the Journal of the Royal College of General Practitioners, 1954-1971.

The fact is that Mac was *not* superior. I found him at last in his account[22] of how the College *Journal* started: "It is almost as though it had grown of itself. The first meeting of the research committee of the College was held in Bath, one day in early Spring (1953) . . . There was no secretary, no treasurer, and no funds, but a chairman was found willing to shoulder, if necessary, all the secretarial and most of the other work of the committee; an arrangement agreeable to all." "A research register was compiled to keep people informed of each other's interests and problems . . . . To keep the

research register alive, it was proposed that a newsletter should be circulated to all whose names appeared in the register. Four of those newsletters were issued for the research committee by their chairman, Robin Pinsent. It was after the issue of *Newsletter Number 4* in April 1954 that the research committee realized that too much was being shouldered by its chairman and that, whether he liked it or not, the work of the committee must be more equally shared. In the share-out the task of editor fell to me; with no previous experience of editing, little of writing, a complete ignorance of the niceties of punctuation and an inherent inability to spell, I felt singularly ill equipped for the job . . . . To undertake the production of a journal without any training was bold. Looking back, I am horrified at my presumption and I still have moments of agony . . . "

When I was in Zagreb in March, I found up-to-date copies of our College *Journal* in the Library of the Public Health School there. I believe that I would have found the *Journal* in the capital cities of all the countries included in the Leeuwenhorst Group, because Mac, with the help of Irene Scawn and John Burdon, and Denis Pereira Gray with the help of his wife, Jill, have progressively created a *Journal* which is unique in its concentration on the original research of general practitioners. This *Journal,* born and bred in the homes of two Devonshire doctors, has become one of those bridges which links practitioners in this country not just with Europe, but with two thirds of the countries in the world.

The College *Journal* was Mac's major contribution. It has indeed achieved what he regarded as the only excuse for publishing yet another medical journal: "To reflect general practice from within, by providing a vehicle through which general practitioners might communicate their many and varied interests."

Mac, like others among us, had the excitement of starting something new. You in this faculty now have a similar opportunity.

I have been urging how important it is that we Europeans should communicate with each other. You are now creating a more appropriate organization for yourselves in Devon and Cornwall to do the same. The *Journal,* the new faculty, and our bridges across the Channel are all examples of the same purpose for which our College was started—to sustain enthusiasm for the endless challenge of trying to do a worthwhile job better, through sharing ideals, enthusiasm, and ways of working.

I know very little of the problems of country practice and hesitate to speak of them. But as a city doctor I see no room for complacency at all. What is happening to accessibility, to continuity, to personal care, and even to our role as generalists and integrators? These are the only qualities which distinguish us from other doctors. I believe that they are all at risk, chiefly in group practices. Are we really supplying what our patients want and need?

You have created a smaller faculty, so that you can discuss difficult problems like these. I believe that you already intend to use the method of forming small groups in local areas, so that as many members and associates as possible can be drawn into the work of the faculty. I hope you will go even further and draw doctors into these groups without regard to whether they belong to the College at all. Doubtless also you will invite specialists to join in your discussions at times. I am sure you have a much closer relationship with them than is possible for people like myself working in large cities.

What we all want is that as many doctors as possible should *give* of their experience. Small groups allow people who may not often speak to start to do so about their many and varied interests. It has always been obvious that the people who get the most out of the College are the people who put the most into it and into their daily work. I believe that the small group may prove to be the way which gradually allows the majority of doctors to get this form of fulfilment. Each group needs to have its freedom and yet, for the faculty, there will be a subtle task of leadership and organization.

You have chosen as your Provost a member of the earliest group to be inspired by the purposes to which we all subscribe. You have been wise to draw him out of a well deserved, but premature, retirement. There will be no need for him this time to shoulder all the work.

I am sure you are already considering how to sustain and develop the work of the new faculty. You have the sustained example of the newsletter which Robin started, Mac developed into a *Journal,* and Denis made famous.

I shall end with the same quotation as Robin Pinsent used in his Mackenzie Lecture:

"O Lord God, when thou givest us thy servants to endeavour any great matter, grant us also to know that it is not the beginning, but the continuing of the same until it be thoroughly finished, which yieldeth the true glory."

Sir Francis Drake

But there is one respect in which this does *not* apply—the work of our College will never be finished.

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COLLEGE ACCOMMODATION

Charges for college accommodation are reduced for members (i.e. fellows, members and associates). Members of overseas colleges are welcome when rooms are available. All charges for accommodation include breakfast and are subject to VAT. A service charge of 12½ per cent is added. Children aged 12 years and over, when accompanied by their parents, can always be accommodated; for those between the ages of six and 12 years, two rooms are being made available on a trial basis. Children under the age of six cannot be accommodated and dogs are not allowed. Residents are asked to arrive before 18.30 hours to take up their reservations.

From 1 April 1980, charges will be (per night):

	Members	Others
Single room	£8	£16
Double room	£16	£32
Flat 1	£25	£40
Flat 3 (self-catering with kitchen)	£35	£60

Charges are also reduced for members hiring reception rooms compared with outside organizations which apply to hold meetings at the College. All hirings are subject to approval and VAT is added.

	Members	Others
Long room	£60	£120
John Hunt room	£40	£80
Common room and terrace	£40	£80
Kitchen/Dining room	£20	£40

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Whenever possible bookings should be made well in advance and in writing. Telephone bookings can be accepted only between 9.30 hours and 17.30 hours on Mondays to Fridays. Outside these hours, an Autophone service is available.

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Low back pain in family practice

Eighty-three women between the ages of 25 and 44 years who presented with low back pain during a one-year period were compared with a control group of women matched by age and socio-economic status. The patients with low back pain presented a larger number of problems to their family physicians during the course of the year, but there were no significant differences noted in the prevalence of symptoms of anxiety and depression during their visits, or in the number of psychological problems presented by the two groups, or in the number of psychoactive medications received for problems other than low back pain. The results suggest that low back pain patients may represent a group who more readily present their symptoms to physicians but that they are no more likely to have psychological problems than similar patients who do not have low back pain.

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