Membership

Sir,

The logical answer to those who decry the MRCGP and an alternative assessment within practice environs must be a combination of both, which is a belief I have held from the first discussions about having an examination as a criteria for membership.

The simple problem is that a passed examination says nothing about future competence. Equally, competence in passing an examination says nothing about actual practice and treatment of patients. Failure equally says something about the preparation for the likely questions, but little about character, concern, and many other desirable attributes.

On the other hand, seeing a doctor at his practice when he knows he is going to be assessed is unlikely to be necessarily truthful. Being on show means a few hours of trying to produce what you think the assessors will want to see. This too, therefore, is not a very good method of fact finding.

However, both methods together might provide more than either alone. So, have the MRCGP, and confirm it after a practice visit three years later. Those who can provide sufficient experience or for other reasons could claim exemption, can just endure the latter. Other professions have a period of apprenticeship; members gain full recognition some years later, after passing a preliminary qualifying examination. Then there is a full recognition of their status, as members of the body concerned.

I recommend we do the same if we are going, as presumably we feel we should, to try and provide some measure of our standards.

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Terminal Care

Sir,

In their article on terminal care in the home (September *Journal* pp. 531-537), the authors commented that there were considerable differences between the general practitioners' and the carers' perceptions of the patients' problems. This would be a highly significant statement worthy of further study, as finding the reasons for this discrepancy would be of benefit to general practitioners caring for the terminally ill at home. However, the presentation of this information on Table 3 renders any comparison between the two groups invalid, as the doctors and carers are referring to the same patients in only 49 cases. It would not be an unreasonable conjecture that in the 26 cases where a reply from the general practitioners was forthcoming, but not from the carers, the problems of the dying were less; conversely, in the 29 cases where a reply was forthcoming from the relatives and not the general practitioners, the problems of the dying may have been greater.

It would be interesting to compare these findings in the 49 cases.

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REPORT

Association of University Teachers of General Practice

The Association of University Teachers of General Practice held their 1981 Annual Scientific Meeting in Belfast. The attendance was similar to previous years, but the academic programme and the social aspects surpassed that of previous years. The delegates were surprised how quiet Belfast was, despite the deaths of two H-block detainees just before and during the meeting.

The meeting began on Wednesday, 8 July with a tour of Dunluce Health Centre where the University Department of General Practice is situated. The party of almost one hundred was divided into small groups for demonstration of the computer facilities and the closed circuit television. (See September *Journal,* pp. 557-560.) The computerized record system is at present being developed and will complement the existing manual system. It will be used for service work and research and will eventually provide each GP with a problem summary and data base, encounter data, drug medications and the facility to print out repeat prescriptions. There was no doubt during this two-hour demonstration that the facilities in Dunluce Health Centre are second to none.

The scientific papers for the remainder of the morning looked at contrasting teaching techniques, with Neil Carson describing the undergraduate course at Monash University, Melbourne: this was very structured but extremely well thought out. Dean Southgate from the Flinders University of South Australia then described a course of teaching on alcohol and its effects. Chris Donovan described the general practice teaching at the Royal Free.

The afternoon session began with two papers on assessment: firstly Jim Bamber (Queen's University) described the value of the MEQ in the assessment of learning in final MB, then Jack Marshall (from Adelaide) spoke on the value of the patient management problem in measuring problem solving. Both these papers raised a number of issues and useful discussion. Stuart Wood (Glasgow) ended the day with a description of his attachment to a university department and a hay fever study which he had carried out.

The following day the morning was taken up by clinical research papers: David Metcalfe (Manchester) on verbal behaviour in the consultation, Michael Drury (Birmingham) on monitoring for adverse effects of drugs, James McCormick (Dublin) on some practitioners' criteria of hypertension, George Lewith (Southampton) on a trial of acupuncture in shingles and post-herpetic neuralgia and, finally, two papers from Queen's: Cameron Ramsey on aspects of the care of epileptics and Margaret Cupples on the use of digoxin in general practice. This group of papers produced lively discussion and the morning session passed quickly. The afternoon was taken up by the social programme: firstly, a visit to Mount Stewart House, which had magnificent gardens, and secondly, a reception at Stormont, the former Houses of Parliament, Northern Ireland. The hospitality at both these visits was outstanding.

The last day of the meeting was again filled by a series of scientific

papers: Campbell Murdoch (Dundee) on a Down's Family Project, Robin Hull (Birmingham) on the trials and tribulations of international research, Eric Wilkes (Sheffield) comparing mothers' reactions to home and hospital deliveries, Keith Leiper (Southampton) on students' attitudes to the care of the elderly, David Gregory (Newcastle) on the referral process, Mike Courtenay (St. Thomas's) on a study with Inner London principals and Ian Stevenson (Edinburgh) with some new facts on deputising services.

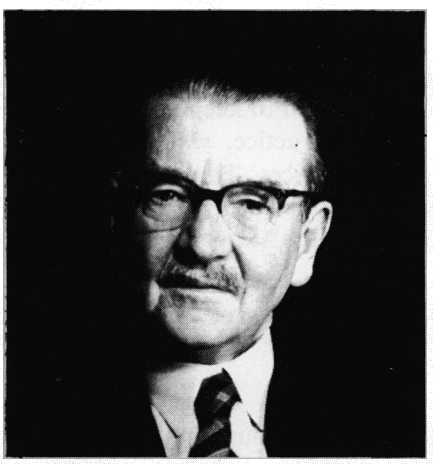
Bernard Reiss (Cambridge) began the last session by describing practice educational meetings as a new influence in general practice. Godfrey Fowler (Oxford) then spoke of anti-smoking education in general practice; this was followed by Dr Eric Button (Southampton) giving his experience as a psychologist in primary care. The meeting ended with two papers from Scotland; John Bain showing videotapes of patient/receptionist confrontations which were too real for comfort and Mike Porter ending the meeting with his presentation on non-attendance at the Edinburgh Breast Screening Clinic.

This was the most successful meeting which the Association has had to date, both academically and socially, and we will always be grateful to our Belfast colleagues for all their effort.

T. S. MURRAY; D. C. MORRELL

OBITUARY

Lindsey (Willett) Batten FRCP, FRCGP



Lindsey (Willett) Batten

I shall give a very personal account of Lindsey Batten. You will have your own memories and they may be about other times in his life and other aspects of him as a person.

When I was asked to write about him, I suddenly thought of a moment 25 years ago when I was driving to a postgraduate meeting in Highgate. There was Lindsey driving just in front of me to the same meeting. He was in a battered old green car and driving much too fast around corners. I had a job to keep up with him.

Trying to keep up with Lindsey was always difficult, and it still is today as I write about him. He set a very high standard to those of us who knew him in the earliest days of the Royal College of General Practitioners. I remember sitting in his home in Hampstead late one evening when a call came in from Notting Hill. "That's a very old patient of mine and I must go", said Lindsey, undeterred by the distance, the time of day or breaking up the meeting. I suspect that he considered himself almost always to be on call. That is just one aspect and example of the personal service in which he believed so fervently.

Sociologists tell doctors that patients want three things from them—that they should be available, be technically competent and give personal care. The Notting Hill patient was a diabetic in coma and Lindsey was available at once.

His technical competence shines out in a lecture he once gave to medical students at St Bartholomew's Hospital which was afterwards printed—"The Essence of General Practice". His knowledge and skill were recognised in 1964 by the award of the Fellowship of the oldest of the Royal Colleges, the Physicians, an award not often given at that time to general practitioners; and by our own College as soon as we established fellowships.

Continuous personal care was something Lindsey stressed above all. To quote him, from 1962: "single, individual, personal responsibility for patients seems to me to lie at the very heart of practice, as I have known it and understood it. We doctors can, with great advantage, interchange opinions; but the patient, and responsibility for him, we cannot share. If we attempt it, he must be the loser". These are uncompromising words: "our patient must be personally ours and we personally his"; Lindsey was against group practice.

He was a great supporter of the College when it was new and weak. General practice was his real love. He left early in his career the specialist paediatric appointments he held at Shadwell and St Bartholomew's Hospital, but he never lost his interest in clinical medicine for children and their parents. His two books in this field: *The Single-Handed Mother* and *Health For The Young* were both a success.

His advocacy of general practice at a time when its survival was in question was powerful. He loved it and he feared for it: "taking care and continuous care of the patient are jobs which must be done by the general practitioner if they are to be done at all. Of course, they need not be done at all. If present trends continue, the time may come when they are not. That may not disturb the death-rate; but something good will have been lost, many citizens will find themselves very much at sea and the hippocratic art will have been dealt an almost mortal blow". There is pessimism here, a liking for the past and a note of warning, which are typical.

Nevertheless he fought continuously for his belief in the value of the general doctor concerned with the whole man. He was a powerful advocate because he had an outstanding capacity to present his beliefs, whether in speech or writing. He had a skill with language, a love of literature and an ability to quote from English, Latin or Greek classics which was rare in doctors even of his vintage. This was why his 1960 James Mackenzie Lecture was so successful that the whole audience rose spontaneously from their seats to applaud, as they had never done for any of his predecessors.

He retired from practice at the age of 73. I believe that both his wife, Molly, and he were particularly happy when they came to live at Crockham Hill. They cared together for a very large garden as if they were 30-year olds. Molly was a painter. Lindsey continued to write and to read widely. There were madrigals and motets, to compensate for leaving the Hampstead Choral Society which he had helped to run. Music meant a great deal to Lindsey.

But even at this time he was having trouble with his eyes. One of his last writings was about "growing old gracefully".

We say goodbye to a very fine doctor and a very cultured, courteous man.

J. P. H.