LETTERS

The College and Nuclear War

The decision of the College Council to advise Dr John Horder (PRCGP) not to attend the second Congress of International Physicians for Prevention of Nuclear War, on the grounds that it might become 'political', is weak, naïve, selfish and inconsistent.

Weak because it betrays a lack of willingness by the College to involve itself in this difficult but major issue of preventive medicine: what price a policy on prevention in psychiatric disorders, arterial disease and family planning (RCGP, 1981) when most of the practice list is dead, the rest injured and requiring intensive hospital treatment in non-existent beds, following a nuclear attack (Medical Campaign against Nuclear Weapons, 1981)?

Naïve if it believes that general practice can operate in some rarified apolitical vacuum: the NHS itself is a supreme example of a political idea finding substance in medical practice. Every time a GP writes a sick note or counsels the family of an unemployed person s/he commits a political act—an act which has nothing to do with party politics, but concerned with society, government, the economy and the state. Good health is a political as well as a humanitarian or moral axiom. Doubters should consider recent excellent published examples of how inextricable are general medical practice and politics: Medical Aspects of Unemployment (Linford Rees, 1981); *Inequalities in Health* (Black, 1980); *A Survey of Primary Care in London* (Jarman, 1981); *Inner Cities* (Bolden, 1982); and the earlier paper "The Inverse Care Law" (Tudor Hart, 1971). The call for political change and involvement is implicit in all these publications, explicit in some.

Selfish in its failure to share the responsibility with other Royal Colleges: Sir Douglas Black of the RCP is to deliver the keynote speech at the April Congress with the Soviet Professor Tchasav. General practice ought to be playing its part; but a separate, quiet, academic existence is so much safer.

Inconsistent since Dr Horder himself, as Chairman of the Working Party which produced the College's *Report from General Practice 18, Health and Prevention in Primary Care* is in print there as concluding: "If preventive care is to be taken seriously, there are opportunities which the College should be more ready to seize in influencing political decisions than it has been hitherto". What better opportunity to seize than this Congress? Does the College really intend to concentrate on "play areas, and the division between traffic and pedestrian areas" *(Report 18),* when it could bring influence to bear to save the lives of millions of people?

Surely the College should participate in this major preventive congress: passive observation is not sufficient.

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Sir,

I write to register a protest at the decision by the College's Council to advise John Horder to withdraw from attending the forthcoming important medical conference on nuclear war. Its stated reason "that it is impossible to be certain that the meeting might not become political" is lamentably weak. The past twelve months have seen a further alarming escalation in the arms race and an increased sophistication of weapons which brings "first strike capability" closer, thereby rendering the notion of deterrence more and more insecure. We have also seen the introduction of the neutron bomb, which lowers the threshold between conventional and nuclear warfare. The risk of nuclear war increases with these developments, while military leaders speak of fighting and winning 'limited' nuclear wars.

The medical profession has become involved unavoidably by the Government's request that area health authorities draw up emergency war plans. Furthermore, our training equips us with the potential to understand the medical consequences of these weapons in a way that no other section of the community can. We therefore have a profound duty to learn what we can and disseminate this knowledge, both to those who make decisions and those affected by them. The tremendous growth of awareness and concern within the profession over the past year reflects this.

The fact that the College has remained silent, while increasing numbers of its members try to come to grips with this deeply important issue, is saddening enough. Now it has at last made a pronouncement, and it is entirely negative. Does it seriously believe that John Horder's presence at a meeting which "might . . . become political" would be so irrevocably embarrassing that he dare not attend? Such excessive timidity seems strangely inconsistent in the light of the College's most recent occasional paper, which has been widely quoted in both the medical press and the mass media during the past months for its highly political views on inner city councils.

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Using computers

Sir,

I was distressed to read Dr Potter's article "Computers in general practice: the patient's voice" in the November *Journal* (pp. 683-685).

Properly conceived and implemented, the introduction of a micro-computer in the surgery can be an enormous boon to patients and GPs alike. It is therefore of more than usual importance that colleagues who choose to voice their opinions on this subject be both knowledgeable as well as unbiased.

Dr Potter's questionnaire is open to the following criticisms:

1. It is not even remotely feasible for a practice to store its patients' medical records on a "small computer". An average practice would require 50-100 mega-bytes of memory, at least, to perform this function and the cost involved would be tens of thousands of pounds! Considering just the factor of patients joining and leaving the list makes the prospect far too daunting.

2. GPs who are serious about microcomputers would readily inform Dr Potter that they see no value in storing 'sensitive' data onto storage media. Their concern is chiefly to compile highly sophisticated computerized morbidity and 'at risk' registers. In this way the grave handicaps of manual records in preventive work, monitoring, and increasing practice income are minimized by the simultaneous assistance which can readily accrue from the new technology.
3. A computerized morbidity/at risk register can firstly be in encrypted form. Further, intelligent use of encrypted passwords can prevent even a determined expert from extracting the data—data moreover which need not be of a sensitive nature. What manual system of records can afford similar protection from prying eyes? In any case, a breach of confidentiality would lay a GP open to the attentions of the GMC. Does Dr Potter know all this? If so, why does he not enlighten the victims of his own questionnaire?
4. I would not hesitate to submit that if the respondents had been informed in detail of the safeguards and the potential benefits they would have answered very differently.

Notwithstanding the above criticisms, it must be said in Dr Potter's favour that it is wonderful to see a new entrant into our profession who is sensitive to the feelings of his patients and the immense importance of respecting and preserving confidentiality. It would be a pleasure to show him how to use a micro-computer properly!

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OPINION

The general practitioner tutor

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The East Anglian Faculty has a long tradition of educational activism, and Dr Stephen Oliver, the Faculty's representative, wrote the following paper for Council in September 1981. We reproduce it to stimulate discussion. It is one person's views, albeit based on wide discussion, particularly of the conference on continuing education held in Cambridge in March 1980 *(Journal* report, December, pp. 765-6), but we know that different views, and different policies based on these views, are held elsewhere.

The general practitioner tutor is a general practitioner, in active practice, responsible for the organization of postgraduate medical education for general practitioners in his district. He will have knowledge of the principles of adult education and the skill to apply them.

He will usually work from the local postgraduate centre where he should have office space and secretarial help. He will be responsible for planning postgraduate centre meetings for local general practitioners. He will work in the closest co-operation with the clinical tutor. The general practitioner tutor will be a member of the district postgraduate committee or its equivalent.

He will encourage and help his local colleagues to organise their own practice-based educational activities. He will have particular regard to the educational needs of the single-handed practitioner. He will have knowledge of simple research tools and improved record systems and encourage his local colleagues in their use. He will be prepared to advise on the provision of modern facilities for continuing education in new health centres, group practice premises and postgraduate centres.

While his primary responsibility is in the field of continuing medical education, he may advise on the placement of medical students in local practices. He will liaise, when necessary, with the local vocational training scheme course organizer or tutor over the effective use of resources and in programme planning.

Suggested Guidelines for GP Tutors

1. Identify learning needs. The district programme must be relevant to the educational needs of the local general practitioners as perceived by themselves and others—consultants, other health care workers, patients and so on. Methods must be developed to identify needs—personal contact, use of questionnaires etc.
2. Obtain feed-back about meetings. The successful planning of future meetings depends on feed-back from the participants at past meetings. Short questionnaires should be developed for use at the end of meetings. More detailed questionnaires at infrequent intervals, perhaps annually, should also be considered, as should an approach to non-attenders for information regarding subject matter and times of meetings preferred and reasons for non attendance.
3. Aim to involve the learner whenever possible.
4. Employ a wide variety of methods. If the district programme is to reflect the wide spectrum of motivation to learn among the doctors in the district, a similarly wide spectrum of educational activities must be available to them—from the passive, non threatening lecture to the highly participatory small group.
5. Co-operate with the clinical tutor. (Essential with respect to use of the postgraduate centre.) Meetings may be arranged with an appeal to both general practitioners and hospital doctors and require close co-operation with hospital colleagues, too, for success.
6. Co-operate with the local VTS organizer. This makes for better use of resources such as outside speakers; the PGME programme and half-day release programme should be planned to complement each other and therefore make postgraduate centre programmes more valuable to trainees. Trainees and training practices should act as valuable resources to the programme.
7. Plan regular meetings. Human beings are creatures of habit. Make attendance at meetings a good one.
8. Identify practice education secretaries. The GP tutor needs active support from his colleagues. Aim to identify one GP in each practice which might be expected to attend the postgraduate centre with whom you may liaise over educational matters. These practice education secretaries might meet once, twice or three times a year under the chairmanship of the GP tutor to discuss past and future programmes. Be prepared to delegate responsibility.
9. Don't forget the important social element. Much unrecognized learning takes place during the purely social part of a meeting. The better consultants and general practitioners know each other, the better the opportunity for improving the quality of their com-