lectual failure, or of previously faddy or eccentric behaviour and those of advanced age are worthy of surveillance.

The implications of 'at risk' are therefore that without this concept preventive medicine can never achieve selectivity and precision. It is not to be confused with 'risk factors' which are abstract, or taking risks which is behavioural. It is not confined to children, for a person is at risk at every age for different reasons, but particularly when a fetus or beyond the age of 75 years.

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Oasis or Beachhead?

Sir,

I could not have put more politely the sentiments expressed by Dr Alastair Donald (March *Journal*, p. 183). He made some very enlightened statements and I wish to give him my support. I was particularly interested to read that lack of time per consultation is one of the chief complaints of doctors; it is certainly true for patients.

To put it bluntly, generally speaking the organization of general practice in this country is a mess, both for the doctor and the patient, with care being reduced to the equivalent of children being given Smarties by paternal doctors.

As for the general public, the tide is changing. The children are reaching adolescence, and some have already reached maturity; soon they will ditch medical help as organized today—some already have.

The College reminds me of timid, insecure teenagers who take praise and feel good for doing the so-called 'right things' but are not brave enough to act and speak as themselves. They usually end up going to a respectable university and living thoroughly ordinary and boring lives.

As for the present general practitioners, many of them will already be scarred for life; mentally, physically or by marital or family disharmony. I only hope that enough good doctors survive to develop a mature adult to adult service. At present we are losing good doctors as soon as they are produced. They get sucked into the mess.

From a doctor awaiting the new age.

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WORKING PARTY REPORTS

Evidence to the Government Inquiry into Human Fertilization and Embryology

This report of a working party of Council was considered by College Council at its meeting on 12 March 1983.

Introduction

1. General practitioners working as family doctors have a personal and continuing role at all stages in the management of subfertile couples, and have a duty to protect the autonomy of the patient and the family.
2. Family doctors are in a privileged position and are able to give an objective and informed opinion, balancing the enthusiasm of specialists in research of this nature, the needs of the subfertile couple and the interests of the community.
3. The subject evokes an emotional response initially. This is because it deals with the creation of human life, it is open to abuse and the importance of 'love' in human creation seems sometimes to be overshadowed by technical and scientific achievements.
4. Although there are conflicting views about the onset of human life, the process can be considered to commence at fertilization, since this is the point at which a genetically complete embryo is formed. From that moment, therefore, the embryo should be treated with respect and experimentation on human embryos should be subject to the same ethical considerations as on children and adults.
5. Experimentation on embryos has been going on for some time. Advances in medical science were made through unethical experiments such as those performed on human subjects during the last World War. However beneficial the information gained, the continuation of such unethical experiments cannot be justified.

Experimentation on human embryos

Experimentation on human embryos is unethical, because:

i) It is not in the interest of the subject under study.
ii) The mental, physical and legal state of the subject is such that informed consent cannot be obtained.
iii) The genetic parents are not able to give objective and informed consent because of their inevitable emotional vulnerability.
iv) It could be abused to the detriment of humanity.
v) Failure to maintain ethical standards in relation to human embryos represents a threat to the application of ethical standards in medicine and science generally.

Unethical procedures

In the light of the above views, the procedures listed below are considered to be unethical:

i) Cloning.
ii) Freezing of human embryos.
iii) Choosing the sex of human offspring by IVF techniques where this involves cloning and freezing techniques.
iv) Experimental use of human embryos.
v) Continuing development of the human embryo and fetus in vitro (ectogenesis).
vi) Continuing genetic manipulation of human embryos.
vii) The use of cloned IVF tissues and organs for transplantation.
viii) Teratogenicity studies on human embryos.

In Vitro Fertilization (IVF) and Embryo Transfer (ET)

IVF and ET for a subfertile couple is ethically acceptable. Couples should be counselled throughout the period of investigation and treatment and afterwards, whatever the final outcome. Family doctors are particularly well placed to provide such counselling because of their long-term involvement with the family.

As part of the treatment for subfertility, the induction of superovulation and the freezing of sperm and ova are ethically acceptable.

There will be some natural wastage of fertilized ova as part of the IVF

The members of the working party were Drs R. C. Froggatt, J. A. Lee, Maureen Reynolds, Clare Ronalds, W. McN. Styles and J. B. White.

procedure. This is considered acceptable since it is comparable to the normal process of human reproduction. Acceptable methods of disposal of human embryos must be agreed.

Experimentation on these unwanted embryos is specifically rejected as unethical.

Sperm and ova donation

Sperm and ova donation is ethically acceptable. Such donations should be made voluntarily *without* financial inducements.

The use of donated sperm, or donated ova or both gametes for IVF and ET to the female partner in a subfertile couple is ethically acceptable, given the informed consent of all parties concerned.

Full documentation of donors, including detailed medical history, should be recorded.

Regulations governing sperm and ova donation and preservation should be established.

Informed consent to research involving human ova or sperm should be obtained in every case from the donors; sperm or ova from banks should not be used for research unless collected and preserved specifically for this purpose.

Both surrogate motherhood and womb-leasing are unacceptable because the *in utero* development of the embryo is of such physical and emotional significance to the pregnant woman that it is likely to cause irresolvable emotional and legal conflicts.

Urgent attention must be given to:

i) The legal rights and obligations of donors.
ii) The legal rights of their progeny.
iii) The legitimacy of children born by AID, AIH and IVF.
iv) The rights of access of progeny to donor records.
v) The limits of liability of doctors involved in these procedures.

Trans-species 'fertilization'

Trans-species fertilization is only acceptable on the understanding that development cannot continue beyond the two cell stage. It is unacceptable for development to be encouraged beyond the two cell stage.

Resource implications

Expenditure on the investigation and treatment of subfertile couples has financial implications which should be considered in the light of overall medical needs of the community.

Since many of these techniques are new and under development, it may be both medically and economically prudent for these procedures to be carried out in NHS regional centres.

Regional centres and private clinics should be inspected regularly and licensed.

Recommendations for control in future development

A small, independent advisory committee should be set up to monitor developments in this field and to ensure that proper controls and standards are maintained.

Regional centres and private clinics should be required to submit annual reports to this committee.

Research in this field should be subject to ethical approval by the Standing Advisory Committee.

The Standing Advisory Committee should be representative of society generally, but should include representatives of the legal profession, medical profession (including a gynaecologist and a general practitioner), a paramedical representative and lay representatives. Specific attention should be given to the balance of male and female representation.

Advances in medical and scientific knowledge demand continuing consideration and such a committee should be able to reflect changes in public and professional opinion.

Further evidence to the Committee of Inquiry

The Royal College of General Practitioners would welcome the opportunity to comment further on this written evidence if requested to do so.

The working party report was sent to the DHSS on 19 March 1983 with this accompanying letter from the Honorary Secretary of Council, Dr J. C. Hasler:

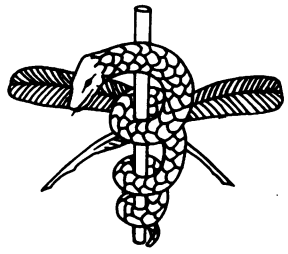
The Council of the Royal College of General Practitioners has considered this matter on two occasions and felt the subject was of such importance that it should set up a working party to discuss it further. This working party has reported to Council and its report is attached.

Members of Council found this report clear and concise and agreed it should be made available without alteration. However they found themselves in a dilemma which could not be resolved. The majority felt that any experimentation on human embryos was ethically unacceptable and supported the statements in the report. In doing this, they recognized that if any experimentation were acceptable, there was no logical way of saying at what point it ceased to be so. A minority of members however could not support the report *in toto,* since they were worried that if all experimentation on human embryos were abolished, important advances in medical care might be delayed or not achieved at all.

Council distinguished between experimentation on human life, and termination of that life. The majority support for no experimentation, therefore, in no way alters the College's view on abortion, which is that it should continue to be available. Council supported all the recommendations in the penultimate section.

Training for Practice Staff

Dr John Lee is a member of the Joint Working Party between the College and the Association of Medical Secretaries, Administrators and Receptionists (AMSPAR). In this brief report he discusses some of the working party's recommendations.



ANALYSIS of the claims for partial reimbursement of the salaries of general practitioners' ancillary staff shows that at present in the UK there are 4,503 staff employed full-time and 34,701 employed part-time. Most of these staff work as receptionists and probably less than 10 per cent have received formal training. In order to look at their needs, and methods by which training may be made available to them a joint working party of AMSPAR and the College was formed. This has now completed its task under the chairmanship of Professor Michael Drury, and has submitted its recommendations to Council.

The development of training

The formal training of ancillary staff began in 1963 with the development of a recognized training syllabus and the formation of the Association of Medical Secretaries later to become AMSPAR. Full time courses for school leavers were soon established and by August 1982, 121 colleges of further

education were organizing them. 16,321 people have obtained the medical secretarial qualification, 3,299 have obtained the receptionist qualification and 103 have obtained that of practice managers.

Most students following these courses are full-time and usually are school leavers. It is however possible for more mature students to take courses over an extended period of time, completing sections separately, in order to achieve the same qualification. The working party was sensitive to the fact that training does not necessarily produce good receptionists but was convinced that there is an important need to provide a nationally co-ordinated system of both pre-service and in-service training.

Problems that may arise

The working party was satisfied that the full-time educational programme for medical receptionists run by AMSPAR is educationally sound, well organized and meets the need. However, we identified several problems with part-time in-service training. Some doctors and their staff do not see any need for formal training outside the practice; they are therefore reluctant to make arrangements for their staff.

Courses held in colleges of further education may be difficult to reach and may involve much time in travel to them. We also thought that receptionists would be apprehensive of any formal course and possible assessment.

Suggestions for in-service training

We have suggested several solutions to the difficulties of establishing in-service training courses for receptionists. We recommend that there should be central registration of all courses and an assessing body set up by agreement between the College, AMSPAR and the British Medical Association.

We suggest that courses should be easily accessible and for example could be held in local postgraduate centres, health centres, large group practices or in hospitals as well as in colleges of further education. Organization of these courses should rely on a doctor or educationalist with a special interest in this field, guided by an advisory group. Application for their registration should be accompanied by evidence that bodies such as the local medical committee, the local college of further education, the health authority, the local faculty of the College and the local branch of AMSPAR have been consulted about their planning.

In-service courses should be limited to small groups of 8 to 10 people as a learning cell. All members would be on part-time release from their posts as receptionists and these courses would not be open to the full-time student. Ten sessions of two hours each is thought to be the right length for a course module. Full-time training for a school leaver to become a receptionist takes 300 hours of teaching time. For an in-service training programme 80 hours, consisting of four courses of ten two-hour modules, plus work experience, would seem to be appropriate.

The course would reflect the main subject areas of the syllabus for AMSPAR's Certificate of Medical Reception. Each module would include assessment by interview with a local panel; simple written tests based on course content; short written projects and presentations and role played exercises assessed by the course organizer.

A local certificate would be issued for each satisfactorily completed module. On completion of the four modules the student would then be assessed on the whole range of the course, and, if successful, would be awarded the AMSPAR Certificate in Medical Reception.

DATES FOR YOUR DIARY

MRCGP Examinations

Autumn 1983

Written papers. Tuesday 1 November 1983
Orals. Edinburgh and London: week of 12-17 December 1983
Closing date: 8 September 1983
8 weeks: 11 February 1984

Spring 1984 (provisional)

Written papers. Tuesday 15 May 1984
Orals. Edinburgh: week beginning 2 July 1984
London: week beginning 9 July 1984 (ending 14 July)
Closing date: 15 March 1984
8 weeks: 1 September 1984

Application forms and further details may be obtained from the Examination Administrator at the College.

Human Louse Control Management

A three-day intensive course will be held in Liverpool from 31 August to 2 September 1983.

The principal course tutor will be John W. Maunder, Head of the Skin Entomology Unit, London School of Hygiene and Tropical Medicine.

Full details and application forms can be obtained from Joanna Wickenden, Skin Entomology Unit, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT. (Tel: 01 636-8636, ext. 337.)

Chronic Skin Conditions

A seminar on the topic of chronic skin conditions, the NHS, the patient and the community is being organized jointly by the Department of Dermatology, Welsh National School of Medicine, and the Disabled Living Foundation. It is to be held in Cardiff on Monday 20 June 1983. The seminar aims to consider the various and complicated problems arising from chronic skin conditions and the delegates will include consultant dermatologists, general practitioners, physiotherapists and occupational therapists, community nurses and health visitors. Industrial medical officers, members of community health councils and voluntary bodies associated with skin conditions have also been invited. Section 63 approval has been applied for.

Further details can be obtained from Mrs Joy Hayes, Conference Organizer, Welsh National School of Medicine, Heath Park, Cardiff CF4 4XW. (Tel: 0222-755944.)

This will be one of a series of seminars. Others will be held in Manchester, Newcastle-upon-Tyne, Southampton and Cambridge. The dates and venues of these have yet to be confirmed. Further details about them can be obtained from Ms Margaret Dowden, Disabled Living Foundation, 346 Kensington High Street, London W14 8NS (Tel: 01 602-2491.)

New Directions in Cardiology Humanistic Approaches

The inaugural conference of the International Society for Humanism in Cardiology will be held on Monday 6 June