posed constitution of the Subfaculty and its possible future activities were considered. Professor David Metcalfe of Manchester University, representing College Council, raised several points ranging from finance to the name of the new Subfaculty which he suggested should not be so Welsh as to cause confusion at the College in London!

Words of encouragement and best wishes were received from the Provost and from Dr Bruce Lervy, Secretary of the Welsh Council. Dr B. W. McGuinness, who is Chairman of the Research and Organization Subcommittee of the Faculty, made a special plea for an increase in research activity in North Wales.

The need for a Subfaculty in North Wales has long been felt. The geographical split of North Wales from the rest of the Faculty has made it difficult for members and associates to attend meetings. The new Subfaculty should encourage the formation of small groups of general practitioners willing to learn from each other, promote research and improve practice organization. It is hoped that the Subfaculty will meet socially as well. At all times the Subfaculty and its members will remain very much a part of the Faculty of North Wales and Merseyside.

Officers of the Subfaculty Executive Committee were elected at the meeting. The Chairman is Dr J. Gwyn Thomas of Denbigh and the Honorary Secretary/Treasurer is Dr Huw Lloyd of Old Colwyn.

Obituary

Sam Lipetz

The funeral on 28 July 1983 at Edinburgh of Dr Sam Lipetz brought together a large company of heterogeneous mourners—Jews, Gentiles, Moslems, patients, sons and daughters of patients and an almost complete muster of his medical colleagues.

He was born in 1897 and his death closed a medical epoch of 60 years of general practice. Sam will personify 'The General Practitioner' for many who have known him, whom he taught and inspired and on whom his humanity rubbed off. His memory is all the more noteworthy as he worked in what would be decried today as the deprived inner city district where the slums later required to be torn down. In this district, ironically called 'Pleasance', he ebulliently and perseveringly supported and fought for his patients, their rights and their social conditions.

Sam returned from the first world war to qualify in medicine at Edinburgh in 1922.

In 1923 he settled in a two-man general practice in Edinburgh where he soon became a member of the then Panel Committee, defending the needs of his insured patients in the pugnacious Sam Lipetz style.

It is difficult to recall today the living conditions of the inhabitants of the Pleasance with common stair, shared ablutions and ill maintained tenements unequipped for adequate cooking, with often only a single cold water tap in each flat. Scarlet fever, diphtheria, osteomyelitis, measles, tuberculosis, gastro-intestinal infections, nephritis, rheumatic fever and pneumonia were the ravages that honed the diagnostic skill of Sam Lipetz (and that of his brother Julius) and laid the foundation to his well deserved reputation as a diagnostician.

Quite naturally it fell to Sam to become an innovative planner in the orbit of the Socialist Medical Association, amongst socialists who were passionately pressing for the clear and immediate needs of their patients.

When the debate arose in 1947 to shape the National Health Service, it was Sam who guided and cajoled somewhat reluctant Edinburgh general practitioner assemblies, abetted by his brother. Later he found himself a member of the Edinburgh Local Medical Committee where he gave unstinting service for over 20 years.

Sam's opportunity came when the Nuffield Provincial Hospital Trust in the early 1960s was willing to finance for all Edinburgh general practitioners a Diagnostic Centre, to be situated in the Cowgate, the former Livingstone Dispensary. Here he was able to develop the concept of a general practice centre where good general practice was able to flourish.

Most of us were greatly relieved when Sam supported the founding of our College and the South East Scotland Faculty on whose board he served for a number of years from the beginning. His remarkably impressive way of transmitting his vast fund of knowledge based on experience, without pomp and totally direct and humanely humble, blossomed further when he joined as part-time lecturer the Department of General Practice at Edinburgh University in 1958.

His energy and academic attitude and drive led him when 50 years old to complete a review of nearly 200 duodenal ulcer cases, in particular in relation to the early diagnostic test for occult blood, which achieved for him an MD in 1947.

One thing stands out, that to achieve praise from Sam Lipetz for one's own action or patient handling as a general practitioner or young doctor was the ultimate accolade. Let us not forget him, along with his wife who supported and survives him.

E.V.K.

FROM THE MEDICAL SCHOOLS

On being a Dean of Medicine

I. M. RICHARDSON

Dean of the Faculty of Medicine and Professor of General Practice, University of Aberdeen

After one year as Dean-Elect of the Faculty of Medicine in the University of Aberdeen I became Dean on 1 October 1982. To a degree it was like moving from a trainee assistantship to full principalship—the reality of responsibility was something of a shock.

As medical student, lecturer, reader and finally as professor, I had progressed from ignorant awe of authority to assumed understanding of the Dean's role; my assumption was based on previous visible performance of the Dean as chairman of faculty, as the 'official' to whom I could go for support (or otherwise) of claims for additional staff, and, if personality were appropriate, as someone who would listen sympathetically to my academic problems.

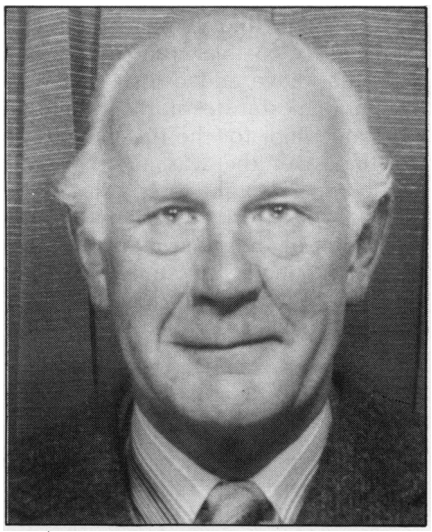
What I knew little or nothing about was the Dean's role as medical representative and spokesman on the many university committees and councils concerned with the policies, plans

and problems of the institution as a whole. Nor did I realize how many minor and major communications—information and requests—come to the Dean from within the University and from a host of national organizations ranging from overseas educational bodies to research councils and trusts. Despite knowledgeable and willing help from a variety of administrators I just had to set about learning to consult widely and to accept the by no means always palatable fact that the buck would not go away from my metaphorical desk. Amidst this welter of unforeseen responsibilities (for which no role-play exercises could prepare one) my personal pride in the status of deanship was rapidly replaced by a not too well controlled anxiety—but as always return of an evening to a secure, stable, loving home brought quick relief. At the risk of a mistaken presumption that some readers might be interested here are a few glimpses of deanery.

Chairing Faculty

The Faculty of Medicine is strictly speaking a Committee of the Senatus Academicus which is the supreme educational body in the ancient Scottish Universities. Faculty has just over 100 members; professors and readers are automatically members but lecturers and honorary (NHS) lecturers and students are elected in limited numbers; there are nine standing (sub) committees covering student admissions, failures, research, higher degrees, bursaries, education and the curriculum, planning and staffing, liaison with students and liaison with our clinical teaching outpost at Inverness. The Dean nominates the conveners of these committees leaving the choice of serving members to them; he is of course a member of every standing committee and in my view should attend whenever possible. Preparation of the agenda for the twice per term meetings of full Faculty is in the hands of a professional administrator and our full-time medically qualified Executive Dean.

Conducting the meeting is my responsibility; how long it lasts and how successful it is depend upon a fascinating interplay of problems, policies and personalities. We have to meet in a rectangular room with rows of (reasonably comfortable) chairs facing the table behind which sit the Dean and his officers. Members tend to sit in the same place, mostly seniors at the front and the less exalted at varying distances to the rear; these habits appear to be near universal and to be highly resistant to pleas for a more even mix.



Professor I. M. Richardson.

Participation in the less straightforward and more debatable items on the agenda is not only variable but unpredictable. Of course we have one or two self-appointed sages whose participation is dependable no matter how much or how little their expertise may be and whose effect on their colleagues is clearly visible (and sometimes audible) from my vantage point; achieving a knife edge compromise between euphemisms for 'sit down and shut up' and the laissez-faire perpetuation of rhetorical diarrhoea is an art I am trying to master. Far commoner is the kind of informed, tolerant, incisive (but impersonal) critical debate to be expected of a community of highly intelligent scholars whose research skills have trained their minds to disciplined thinking; it is from such high quality argument that sound decisions are most likely to emerge, the Dean's role being to clarify, recapitulate and recommend.

When resources are scarce competition for what is available becomes keener—a lesson general practice and training facilities for it are now having to relearn—and within our Faculty departmental claims are growing sharper; with little growth likely in staff or equipment, and with external grant funds becoming tighter, every clinical unit in our medical school has to realize that only the highest quality research ideas have any chance of recruiting new money, a process that one way or another often invidiously involves the Dean as judge or facilitator. Here too the kind of reputation and relationship acquired over a long period is crucial to these difficult components of Deanship; because I have always preferred open democracy to closed autocracy, and especially because experience in general practice emphasizes the value of creating relationships and then using them for the good of others, I like to think that my professional integrity compensates for my rather severe insistence on high academic standards.

Community of Scholars

Association with Deans of Arts and Social Science, Science, Law and Divinity has taught me much about worlds other than Medicine. I suspect that I was not alone in my ignorance of the very demanding conceptual and technical standards of top honours degrees in these disciplines or indeed in how little I knew of teaching loads in some of their departments. What has given me alternating pleasure and pain is the rhetoric of debate in Senate; from a few academic lips come perceptive ideas expressed in the most exquisite and fluent prose sometimes laced with an illuminating and inimitable wit; from a few come what a former literary colleague used to call 'we has went utterances'; in between is a rich variety of tones of grey from which I hope to go on learning how more effectively as well as elegantly to give notice to my own thoughts.

Contributing to a lively and important debate floods my system with catecholamines (I therefore never drink coffee before a meeting!) but I have to overcome the stress in the interests of the Faculty I represent. For example recently an academic lawyer chose to attack the proposed composition of a new committee on which all the Deans would sit; he argued at great length, using pages of notes and repeated references to statutes, that the membership must be grounded in legal precept whereas to me the best basis for action seemed to be trust and experiment. The audience appeared to enjoy the exchange between us but a vote brought resounding defeat to the legalist and a state of exhaustion in me. What matters in an elected body charged with important responsibility is that Goliaths should be challenged even by those of us who can only muster a verbal catapult. How easy it is to opt for recessive anonymity thus letting the dominants direct, which they sometimes do to meet personal need rather than the good of the institution.

The concept of a University as a community of scholars may seem old fashioned, almost monastic. I have come to see this view as false. The essence of university work is teaching in a context of research; the quality and relevance of old and new knowledge are continually reviewed using established criteria and students have

to learn how to apply these methods of disciplined thinking. To me one of the major rewards of academic life including Deanship has been the opportunity to meet a variety of scholars inside and outside medicine, to draw upon their ideas, reason and feelings, and to see the effect upon them of my own thoughts and experience. I seem to see (but hope I am wrong) an anti-academic movement in general practice today which saddens me; for example I have seen and heard pejorative remarks made about higher degrees in general practice—needless to say by those who have never successfully undergone the hard prolonged discipline that an MD or PhD requires. It is my own view that such a degree is rightly required for virtually every senior university appointment in a major discipline—and that academic general practice ought to conform.

Et al.

Sitting on appointments committees, meeting the University Grants Committee, introducing visiting lecturers, welcoming delegates to conferences, examining applications for defrosting of vacant posts, dealing with students in a variety of difficulties, approving exciting developments in collaboration with other institutions, trying to recognize the growing points in research, teaching and service, twice yearly meetings with the other Scottish Deans and the Chief Medical Officer of the Scottish Home and Health Department, these are but some of the Dean's duties and privileges. For me one of the highest lights has been to promote the graduands in medicine at the summer ceremony when, after due presentation by the Dean in the ancient, sonorous Latin phrases, the ability and industry of our students are literally crowned with the degrees of Bachelor of Medicine and Bachelor of Surgery; at that moment all the cares dissolve and 'joy is unconfined'.

My Other Job

I am of course also Professor of General Practice, albeit with a department much reduced by the last three years of squeeze on university budgets. Though I still teach, the combined effect of reduced staff and the time demand of Deanship has been to halt our research programme—a sad end to our record of original work.

Has being Dean enhanced academic general practice locally or further afield? Perhaps the prudent answer should be that others must judge whether the association has been beneficial. Certainly I can claim to have agreed to become Dean in the belief that no harm and some good might result; I like to think that the association may have added just a little to the national stature of the discipline but I must (not for the first time) temper that with the warning that academic general practice still has some way to go before it can match the reputation of the older medical members of the university family. That process, advocated in 1917 by Sir James Mackenzie, will continue to depend on high quality scholarship and research and their illuminating effect on teaching—nothing less will do. Had Sir James been given the chance to teach medical students he would without doubt have done so in the context of his own outstanding research. Had he been made a Dean of Medicine I am sure that he would have been for me as much a model of deanship as he has always been a model of good general practice.

OTHER MEDICAL SCHOOL NEWS

Leicester

Dr Robin C. Fraser, MD, FRCGP has been appointed Professor of General Practice at the University of Leicester in succession to Marshall Marinker. Dr Fraser, who is 43, graduated from the University of Aberdeen in 1963 and entered general practice in Leicester in 1966. In 1974 he was awarded the degree of MD for his study of referrals to hospital from general practice.

He has been on the academic staff of Leicester University Medical School since it accepted its first students in 1975. Until early 1980 he was a part-time lecturer in general practice and latterly he has been a full-time senior lecturer. Dr Fraser is a former honorary secretary of the RCGP Research Committee and is a current member of the Research Division Executive. He is a founder member and honorary secretary of the General Practitioner Research Club.

His research interests include the general practitioner-hospital interface, population registers in general practice and the implementation of medical audit. He has published many articles in *The British Medical Journal, The Journal of the Royal College of General Practitioners* and other journals. He took up his new post on 1 October.

Southampton

Recent appointments in primary medical care, Aldermoor Health Centre, Southampton

Dr Charles Freer has been appointed as senior lecturer from 1 September 1983. Dr Freer was in general practice in Glasgow before becoming a lecturer in the Department of Community Medicine, Glasgow University. For the last two years he has been a member of staff in the Department of Family Practice, University of Michigan, Ann Arbor, USA. His recent research interests have included the use of health diaries and the care of the elderly.

Dr Ian Gregg who was formerly Director of the Department of Clinical Epidemiology in General Practice at the Cardio-Thoracic Unit London has joined the Primary Care Group as a senior research fellow. He has a long standing interest in respiratory illness in general practice and has published widely on the natural history and management of asthma.

Dr Ann-Louise Kinmonth and Dr Peter Burke have been appointed as lecturers in Primary Medical Care. Dr Kinmonth previously held the posts of research fellow and paediatric registrar in the Radcliffe Infirmary, Oxford and has recently been a trainee assistant in Berinsfield, Oxford. She has completed a thesis on the care of diabetic children and is planning to evaluate the primary care of children with chronic and disabling conditions.

Dr Burke is a graduate of University College, Dublin and has, until recently, been a vocational trainee in Holmes Chapel Health Centre, Cheshire. His research interests include doctor/patient communication and preventive medicine in general practice.

Dr Bruce Thomas has been appointed as clinical teacher in Primary Medical Care at Aldermoor Health Centre. He has recently retired from full-time practice, having been a principal in Waterlooville, Hampshire for 30 years. He is a graduate of Liverpool University and was awarded an MD for his studies of temporarily dependent patients in general practice.