their doctors (implying that often they are not) and are keen to be involved in decisions about their health and treatment. These criticisms have been made of some teaching practices. So to aim at bringing the general standard up to the present best is not good enough.

I believe it is because patients, and some doctors, are not satisfied with current NHS general practitioner services that they are voting with their feet and are turning to private or alternative medicine.

One way of enabling doctors to improve their services is to increase their consultation time with each patient. This would mean a radical change in the pattern of work for most general practitioners, involving the delegation of some work and an increased number of ancillary staff.

With a safe basic income from a large list there is no financial incentive to change the pattern of work. A simple service payment system, such as that used by doctors for private patients, instead of the capitation fee may introduce a healthy element of competition betwen doctors and transfer the responsibility for health care from the doctor back to the patient.

I am saddened that Council has not suggested any major changes for the future. Attending to minor details will not adequately improve the quality of care. We need to establish what would be the best possible service for patients and doctors, and then work towards it.

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Out-of-hospital Cardiac Arrest

Sir,

In your editorial (May *Journal*, p. 259) you imply that ambulancemen should be the people to be given the apparatus and training to correct ventricular fibrillation.

The main reason why general practitioners do not routinely carry defibrillators is that of cost—over £1,000 each. Most younger general practitioners are trained and experienced in their use.

My paper[1] demonstrated that on many occasions cardiac arrest occurred in the presence of the general practitioner and only comparatively rarely in the ambulance. The problem is one of equipping general practitioners first, and equipping and training ambulance personnel should be the second consideration.

If a doctor buys a defibrillator his income for that year is diminished by £1,000. Unless the cost of a defibrillator is drastically reduced, or another way of equipping interested general practitioners is found, ventricular fibrillation in the community will usually continue to be fatal.

D. C. RAWLINS
The Surgery
Anchor Road
Coleford
Bath BA3 5PG.

Reference

1. Rawlins DC. Study of the management of suspected cardiac infarction by British immediate care doctors. *Br Med J* 1981; **282:** 1677-1679.

General Practice Diabetic Care

Sir,

I recently attended a conference on diabetic care services throughout the UK, during which I learned of the British Diabetic Association's geographical survey of consultant physicians. This, basically, was a questionnaire about the services they provided.

The results did not take into account any organized independent services that general practitioners are providing. It did note the areas where general practitioners ran clinics for patients discharged from the local hospital diabetic clinics.

I suspect that there are some general practitioners, like myself, who provide a service for their patients completely separated from the local hospital diabetic clinic. In order that the survey should be entirely accurate, I would be grateful to hear from any general practitioner who runs an independent clinic for his diabetic patients.

P. R. W. TASKER
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County Court Road
Kings Lynn
Norfolk PE30 5EL

Epidemiology and Research in General Practice

Sir,

The College and Mrs Jill Pereira Gray deserve congratulation for their pioneer venture in publishing the epidemiological researches of the late Dr G. I. Watson for whom I had a profound respect and admiration (April *Journal*, p.243). His premature passing was a grievous loss to world medicine as well as to the College.

I have recently returned from a busman's holiday in East Africa where I had spent most of my working life and where malaria remains a major problem—especially now that the emergence of resistant strains of plasmodia has eroded faith in traditional prophylactic regimes. Ronald Ross's discovery of the malaria parasite in 1897 is immortalized in his own words:

> "This day relenting God
> Hath placed within my hand
> A wondrous thing; and God
> Be praised. At His command
> Seeking His secret deeds
> With tears and toiling breath
> I find thy cunning seeds
> O million murdering Death."

This is taken from his book of poems *In Exile* which was presented to me long ago by Ian's distinguished father Sir Malcolm Watson. This letter is accompanied by the book* as a small but heartfelt personal tribute to Sir Malcolm's illustrious son.

A. L. CRADDOCK
48 Bear Croft
Weobley
Hereford HR4 8TA

**The book is now in the College library—Ed.*

Smoking and Schoolchildren

Sir,

I was interested to read the article on smoking habits in Dublin school children (September *Journal*, p. 569).

I did a survey on smoking habits of fourth formers in Spring 1983 with the help of a sixth form group. A confidential (✓ only) questionnaire was completed by 256 out of 257 pupils, 55 per cent boys; 45 per cent girls.

My findings were similar and may be of interest:

- Of 52 pupils taking 'O' levels only, 10 per cent smoked; of 204 pupils taking CSEs and 'O' levels or CSEs only, 30 per cent smoked.
- Of 89 pupils whose fathers were smokers, 38 per cent smoked; of 167 pupils whose fathers were nonsmokers, 19 per cent smoked.
- Of 88 pupils whose mothers were smokers, 36 per cent smoked; of 168 pupils whose mothers were nonsmokers, 20 per cent smoked.
- Of 95 pupils whose 'best friend' was

a smoker, 52 per cent smoked; of 161 pupils whose 'best friend' was a non-smoker, 10 per cent smoked.

All these differences were significant ($p = < 0.05$).

- 26 per cent of the children—equal numbers of boys and girls—smoked one or more cigarettes per week.
- 32 per cent of all smokers were smoking regularly before the age of 12 years.
- 58 per cent of all smokers wanted to give up.
- The reasons given by nonsmokers for not smoking were: health risk 78 per cent; expense 49 per cent; dislike of taste 30 per cent; parental prohibition 29 per cent; unsociability 28 per cent.

JOCELYN TEWSON

The Manor House
Ickford
Bucks.

DATES FOR YOUR DIARY

West of Scotland Faculty

A series of six seminars on prescribing for general practitioners has been planned from January to June 1984. Dr Martin J. Brodie, Consultant Physician and Clinical Pharmacologist at the Western Infirmary, Glasgow, will deal with practical clinical pharmacology. The venue will be the Western District Postgraduate Medical Centre and a wide range of drug prescribing problems will be considered by small groups. Further details can be obtained from Dr S. F. Wood, Honorary Secretary, West of Scotland Faculty, University Department of General Practice, Woodside Health Centre, Barr Street, Glasgow G20 7LR. Tel: 041-332 997 (Ext. 228).

MRCGP Examinations

Spring 1984
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, 14 Princes Gate, Hyde Park, London SW7 1PU.

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Papers submitted for publication should not have been published before or be currently submitted to any other journal. They should be typed, on one side of the paper only, in double spacing and with generous margins. A4 is preferred paper size. The first page should contain the title, which should be as brief as possible, the name(s) of author(s), degrees, position, town of residence, and the address for correspondence.

Original articles should normally be no longer than 2,000 words, arranged in the usual order of summary, introduction, aims, method, results, references, and acknowledgements. Short reports of up to 600 words are acceptable. Letters to the Editor should be brief—400 words maximum.

Illustrations of all kinds, including photographs, are welcomed. Graphs and other line drawings need not be submitted as finished artwork—rough drawings are sufficient, provided they are clear and adequately annotated.

Metric units, SI units and the 24-hour clock are preferred. Numerals up to 10 should be spelt, those over 10 typed as figures. Use the approved names of drugs, though proprietary names may follow in brackets. Avoid abbreviations.

References should be in the Vancouver style as used in the *Journal*. Their accuracy must be checked before submission. The title page, figures, tables, legends and references should all be on separate sheets of paper.

Two copies of each article should be submitted, with a stamped addressed envelope, and the author should keep a copy. One copy will be returned if the paper is rejected.

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