The Data Protection Act

MA PIGGOTT
Head of Information Service

The Data Protection Act received royal assent in July 1984. The act is designed to regulate and monitor the use of automatically processed information relating to individuals. The Registrar is currently consulting with representatives of data users and it is expected that detailed guidance notes and registration forms will be available in July.

The General Medical Services Committee/British Medical Association are currently preparing guidelines for general practitioners as to how they should comply with the act. Two points are particularly relevant to general practitioners, first registration — whether it is the practice itself or individual members of the primary health care team that should register, and secondly, the act has implications for subject access and disclosure of health information from medical records. Table 1 summarizes the timetable for the Data Protection Act.

Table 1. Data Protection Act timetable.

Date	Event
July 1984	Act passed.
August 1984	Data Protection Registrar appointed.
September 1984	Data subjects who suffer damage from the loss or unauthorized disclosure of data can from this date seek compensation or erasure of data if there is a risk of further disclosure.
A (September 1985?)	Registration commences. For a period of six months following the start of registration, the Registrar will receive applications for registration. During this period an application for registration or amendment of registered details will only be refused in very restricted circumstances.
A + six months (February 1986?)	Registration of initial activities must be completed within six months of the start of registration. It will be an offence to hold unregistered data after the end of this period. Individuals have the right to claim compensation for damage suffered as a result of inaccurate data.
A + 24 months (September 1987?)	Two years after the start of registration the full powers of the Registrar come into force, for example, formal notices which may have been issued by him during the two year period become effective from this date and have to be complied with. From this date, the Registrar can refuse an application on the grounds that it does not comply with the data protection principles. Subject access provisions come into effect.

Everyone registered with the Data Protection Registrar will have to comply with the principles of data protection which govern the acquisition, organization and utilization of personal information. The eight principles are:

1. The information to be contained in personal data shall be obtained, and personal data shall be processed, fairly and lawfully.
2. Personal data shall be held for only one or more specified and lawful purposes.
3. Personal data held for any purpose or purposes shall not be used or disclosed in any manner incompatible with that purpose or those purposes.
4. Personal data held for any purpose or purposes shall be adequate, relevant and not excessive in relation to that purpose or those purposes.
5. Personal data shall be accurate and where necessary, kept up-to-date.
6. Personal data held for any purpose or purposes shall not be kept for longer than is necessary for that purpose or purposes.
7. A data subject shall be entitled — (a) to access at reasonable intervals, and without undue delay or expense to personal data of which he is the subject and (b) where appropriate, to have such data corrected or erased.
8. Appropriate security measures shall be taken against unauthorized access to or alteration, disclosure or destruction of personal data and against accidental loss or destruction of personal data.

Having complied with the principles of data protection, data users will be required to register with the Registrar. Registration will commence on an appointed day yet to be determined, probably in September. A fee of between £30 and £60 for a three-year registration period is expected. Amendments to a data users' registration will also attract a fee.

For further general information about the Act, please contact Ms M.A. Piggott, The Information Service, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU. Tel: 01-581 3232, ext. 218.

Summary of Council meeting

The third meeting of the 1985 Council took place on 9 March 1985.

Limited list of drugs

There was widespread agreement that the most effective answer to the Government's plans would be for general practitioners to rapidly develop prescribing policies, with effectiveness as the major aim but with costs firmly borne in mind. It was conceded that the Government's proposals for laxatives, antacids, analgesics and tranquillizers were likely to receive parliamentary approval. Successful action by the profession might deter further measures. The high handed way in which the issue had been dealt with by the Government was still bitterly regretted, but the fact that about two-thirds of the membership had responded positively to the questionnaire and subsequent letter from Dr Hasler was noted with satisfaction, especially as many replies indicated that practices were already operating or developing prescribing policies. The whole issue was seen as being unsettling for patients and disruptive for the profession. The need to clarify between generic prescribing, in which the doctor takes the decision, and generic substitution, where the pharmacist decides, was emphasized, and it was also felt that several issues regarding generic prescribing still needed to be defined, not least that of liability. The fact that the DHSS is hindering the dissemination of better information to doctors by the Prescription Pricing Authority was seen as both regrettable and illogical. The close collaboration between the College and the General Medical Services Committee was noted with satisfaction. The

importance of good liaison between local medical committees and the College faculties was emphasized.

Joint Committee on Postgraduate Training for General Practice

There was a debate on a document from the JCPTGP on guidelines for trainer selection. Many speakers emphasized the importance of the clinical performance of the trainer as being central to any selection procedure. It was felt that the present guidelines, while being helpful, are perhaps not being applied stringently enough, as the reports from visitors to vocational training schemes tend to be saying the same points over and over again. It was agreed that the College review its own position on criteria for trainer selection as the comments from the Education Division on the JCPTGP document favour more stringent and explicit guidelines.

Patients' Liaison Group

Council approved that a lay person be appointed to the chair of the Patients' Liaison Group, and Ms Susan Clayton is to be invited to fill this post.

Health Visitors Association: policy statement on child surveillance

The policy statement from the Health Visitors Association on child surveillance received considerable attention, especially the proposal that doctors should be virtually excluded from all but the six-week and pre-school checks. Such a policy would neither foster good relationships between patients and professionals nor encourage team work. It was decided to seek a meeting with representatives from the Health Visitors Association. It was envisaged that such a meeting could be based on the principle that it is more important for children to benefit from a skilled surveillance programme than to specify who actually carries out the checks.

The European Community

Council considered a paper from the DHSS outlining proposals for European Economic Community (EEC) directives on specific training in general medical practice, together with recommendations from the General Purposes Committee on these proposals. The period recommended in the directive for vocational training for general practice was a minimum of two years, including six months as a general practitioner trainee. Council expressed reservations about this as the established College policy was for five years of training. The Chairman informed Council that the recommendation was the outcome of a series of long negotiations and for the present time this represented the best compromise possible. It was also recommended that the General Medical Council (GMC) be the body competent to issue evidence of formal qualifications awarded after specific training in general medical practice in the United Kingdom (article 2[iii]). The GMC was responsible to the EEC for all other specialties in the UK. Council agreed to accept this recommendation.

Interdisciplinary Working Party on Perinatal Mortality Inquiries

The report of the Interdisciplinary Working Party on Perinatal Mortality Inquiries was considered, and great emphasis was made of the absolute need of a guarantee of confidentiality. The support of the RCGP could only be given when this was assured.

Nomination for election of President

The Council nomination for President to succeed Dr Lawson will be Professor Michael Drury, who is at present the holder of the Chair in General Practice at the University of Birmingham.

The Foundation Council Award

The Foundation Council Award will be conferred on Professor James McCormick.

News of the present ill health of two distinguished past Presidents, Lord Hunt of Fawley and Dame Annis Gillie was received with sadness.

Not the last word on cot deaths — Report on the DHSS seminar held on 15 March

Although 'postneonatal mortality' is a far less emotive term than 'cot deaths', the Department of Health and Social Security (DHSS) chose to use the latter in its invitations to a seminar on 15 March 1985, convened to discuss the multi-centre study coordinated by Professor Knowelden of Sheffield.

The report of the study[1] has already provoked a controversial leading article[2] which has been justly and comprehensively criticized by Professor Bain and others.[3] Unfortunately, the Government's seminar was no more in touch with general practice than Dr Valman's editorial,[2] despite the substantial input into the study from general practice, and its already much quoted recommendation for improving 'the quality of primary care'. The paediatrician member of the study team, Professor F. Harris, emphasized the finding that of the 131 children with a terminal illness identified who had had any contact with the general practitioner, 84 were judged by the case conferences to have received inappropriate treatment. Professor Harris then postulated that this represented the 'tip of an iceberg' of inadequate care of the young in primary care, not mentioning that for 25 per cent of the children dying after a 'terminal illness' in hospital, the actions of the hospital staff were also considered inappropriate.

The mud slinging extended to the pathologists, who engaged in an undignified quarrel about the relative skills and resources of forensic and paediatric pathologists, thus obscuring the important recommendation that all infants dying suddenly or unexpectedly should be subjected to a careful necropsy, and that such deaths should be certified at two levels, clinical and pathological.

Finally, the semantic problem of the term 'sudden unexpected deaths in infancy' was recognized, and, if not clarified, at least explored further in this study. The difference between 'unexpected', on clinical grounds, and 'unexplained' after full necropsy was all too obvious, since although most of the infants with no pathological evidence of disease also had no symptoms, the converse was not true. The majority of cases certified as 'sudden unexpected death' or 'cot death' were found on necropsy to have evidence of terminal disease.

The most interesting finding of the study, arising from the case-control comparisons of socioeconomic data, was that the 'true' sudden infant death syndrome cases (those with no evidence of terminal disease on necropsy) resembled their controls more closely than did those in other pathological categories, suggesting that the deaths in this (small) group might be less associated with environmental factors and therefore less amenable to preventive measures. A similar conclusion was drawn from the analysis of 'risk scores', which discriminated between deaths associated with a terminal disease and deaths without evidence of terminal disease. The latter showed similar risk scores to deaths from congenital anomalies and approached the score of the control group.

Two environmental factors associated with postneonatal death which the report identified as possible areas for preventive action were maternal smoking and artificial feeding. The study did not of course prove that either factor was causal in these infant deaths, or that changes would decrease the mortality rates, but the results do add to the evidence that family doctors should use their persuasive powers with pregnant women and families with young children, to discourage mothers from smoking and bottle feeding.

P.C.

References

1. Knowelden J, Keeling J, Nicholl JP. A multi-centre study of postneonatal mortality. London: Department of Health and Social Security, 1985.
2. Valman B. Preventing infant deaths. *Br Med J* 1985; **290:** 339-340.
3. Jewell D, Burke P, Kinmouth AL, Bain DJG. *Br Med J* 1985; **290:** 710.

Family Practice

Family Practice is now in its second year of publication. This international journal of general practice is published quarterly by Oxford University Press in association with the Royal College of General Practitioners. The journal provides a forum for the sharing of ideas and information between doctors working in different countries where not only health care systems but cultures vary considerably.

The contents include:

— original articles: most of which report the results of research but some discuss ideas and beliefs without data.

— educational material: for example, a recent series of three papers on health economics.

— leaders: ranging from 'anticipatory care' through 'classification of disease' to the World Health Organization and 'Alma-Ata'.

— correspondence.

— review articles.

The review articles aim to be longer and more comprehensive than are published in most journals of general practice, running to as long as 5000 to 6000 words and containing as many as 100 references. Reviews have covered themes as diverse as diabetes and its management, epilepsy, problems of world population, and continuity of care. General practitioners or other workers in related fields who have reviewed the literature on a subject as part of a thesis for a higher degree or an application for research support often find that their reviews are interesting in themselves but difficult to publish because of their length and format.

Family Practice sees its review section as an expanding service to both readers and writers. Authors who think they might wish to prepare such articles are encouraged to discuss their ideas with: The Editor, Professor John Howie, University Department of General Practice, 20 West Richmond Street, Edinburgh EH8 9DX.

Members of the RCGP can become subscribers at the half-price rate of £16.00 per annum. Any reader wishing to take up the reduced rate subscription for either this year (1985) or last year (1984) should complete the form below:

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The Ian Stokoe Memorial Award

The Scottish Council of the Royal College of General Practitioners invites applications for the Ian Stokoe Memorial Award.

Dr Ian Stokoe was killed in a road accident in February 1974. An outstanding family doctor, scholar and teacher, Dr Stokoe made a special contribution to the work of the College. A former provost of his faculty, he was, at the time of his death, Honorary Secretary of the Scottish Council. He is probably best remembered for his pioneering work in launching what was to become the College Abstract Journal.

One of his special interests was in medical illustration and its use in teaching, research and publication.

An appeal was launched on a College-wide basis to establish a memorial to Dr Stokoe and it was decided that the funds so raised would be used to promote an award for original work done in the context of general practice.

The award is open to any Fellow, Member or Associate of the Royal College of General Practitioners. The competition is to encourage high standards in the preparation of material for publication. The award will be made with special reference to the quality and aptness of illustrations, graphs, figures, line drawings, tables or photographic material. Priority will be given to the submission of material which has already been published, but consideration will also be given to material which has been used in a lecture given under the aegis of the College or of a faculty of the College. Other material on a theme which has not yet been published or used in a lecture will also be considered.

To enter for this competition, applicants should submit their material either in the original form or as a copy of a reprint of an article. If a reprint is not available, a complete detailed and precise reference will be accepted. The candidate should be the author, but not necessarily the sole author, of the article.

Where photographic or other illustrated material is being presented, candidates should have undertaken the original photographic or drawing work, but can have received professional help in its development and final production.

The applicants may submit their own name and material. Alternatively, any Fellow, Member or Associate of the College who has been attracted by particular articles or lectures may encourage the authors (provided they are eligible) to submit their material for adjudication.

The material should be sent by registered post to: Dr H.D.R. Munro, Honorary Secretary, Scottish Council, The Royal College of General Practitioners, 2 Hill Square, Edinburgh EH8 9DR, from whom further information may be obtained.

The closing date for the competition is 31 July 1985.

The Mike Crawford Memorial Fund

The Executive Committee of the Liverpool Division of the British Medical Association, together with the Liverpool Local Medical Committee and the Board of the Merseyside and North Wales Faculty of the RCGP, consider that there should be a permanent memorial to the late Dr G.E. (Mike) Crawford. They have decided that it would be appropriate to identify a section of the Library in the Liverpool Medical Institution with his name.

Mike Crawford served the profession for over 20 years and was active on all three committees supporting this memorial fund. He was President of both the Liverpool Division and the Mersey Regional Council of the BMA and Chairman and Provost of the Faculty Board of the RCGP. In addition he was a member of the Council of the BMA for 15 years. His greatest achievements were as Chairman of the Private Practice Committee of the BMA, an office he held at the time of his death even during the painful stages of his terminal illness. The improvements in pay which he obtained considerably enhanced the basis on which subsequent increments have been made. As a result doctors in all disciplines have benefited from his efforts.

The money raised will be used to purchase books, predominantly, but not necessarily, related to general practice. Contributions of not more than £5.00 are invited and should be sent to: The President, BMA Mersey Regional Council, 22 Oxford Street, Liverpool L7 7BL. Cheques should be made payable to 'The Mike Crawford Memorial Fund'. To reduce costs individual acknowledgements will not be sent unless requested.

DIARY DATES

34th International Congress on General Practice of the SIMG

The 34th International Congress of the Societas Internationalis Medicinae Generalis (SIMG) will be held from 16–21 September 1985, at Klagenfurt University, Austria.

The topics to be covered will include: psychosomatically ill patients in general practice, 16 September; Diagnostic problems in general practice, 17 September; The patient overcoming disease and the help of the family doctor, 18 September; Research in general practice, 19 September; Quality of life, 20 September and The methodology of drug research in general practice in various countries, 21 September.

The languages spoken at the congress will be German on 16, 17 and 18 September, English-German on 19 September and English-French-German on 20 and 21 September, with simultaneous translations.

The registration fees for the congress are as follows:

	SIGM Members and hospital doctors	Non-members of the SIMG
September 16–21	AS 800/£31 Sterling	AS 1400/£54 Sterling
September 16–18 or 19–21	AS 500/£19 Sterling	AS 800/£31 Sterling
One day card	AS 200/£8 Sterling	AS 300/£12 Sterling
Entire congress for speakers	AS 200/£8 Sterling	
Entire congress for students	AS 100/£4 Sterling	

Relatives of the participants have free entry. In case of registration after 15 August 1985, there will be a 10 per cent surcharge. AS = Austrian Shillings.

For further information on this congress please contact: Mrs Sigrid Taupe, Secretariat of the SIMG, A-9020 Klagenfurt, Bahnhofstrabe 22, Austria. Tel: (0 42 22) 55 4 49.

A new sort of Annual Symposium — a shift to active learning

The 1985 Annual Symposium, to be held at the Barbican Conference Centre on Friday 8 November 1985, is entitled 'Quality: what is it and what stops you providing it?' It will be based on small group work in which members will use their own practice experience to work out ways in which to define quality and identify those factors which inhibit its achievement.

Remember the great Northern dictum 'Nowt's for nowt': members attending will be expected to have done two preparatory tasks as a basis for their group work. The morning is to be on 'quality of care in arthritis' and for that participants will be asked to write a description of their goal in the care of patients with arthritis and review the care of two patients with arthritis to see if their goals were achieved. The afternoon is to be on 'quality in prescribing' and participants will be sent a simple encounter form for recording very simply 50 consecutive consultations in terms of type of drug prescribed. These will be collected at registration, computer analysed on site and fed back to groups as a basis for their afternoon's work.

It will not only be group work; short opening talks by appropriate experts will provide a stimulus, and each session will be summed up by another distinguished doctor who will have circulated among the groups.

So if you do not like sitting, arms folded in serried ranks, being lectured at, but do like learning from your peers, and are prepared to invest a bit of preparatory effort, this is the meeting for you.

For further details and an application form please write to: Mrs Sue Smith, Education Division, The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

OBITUARY

Dr M.J. Mitchell

Dr M.J. Mitchell, a general practitioner in Crieff, Perthshire and a member of the Royal College of General Practitioners of many years standing, died suddenly on 27 January 1985 aged 54 years.

Malcolm James Mitchell graduated from Aberdeen in 1953 and then held house appointments in Aberdeen Royal Infirmary and the City Hospital before a two year spell as a medical officer in the RAF. He moved to Crieff in 1956, as assistant to the late Dr A.H. Rintoul, and quickly became a well-known and respected figure in the town. He was a keen golfer and angler and a much sought after companion by his fellow sportsmen. A member of the British Medical Association he maintained a constant interest in the association and regularly attended meetings. He also served for several years on the local medical committee.

Jimmy Mitchell was a general practitioner of the highest standard and his example inspired his partners, trainees, students and all who worked with him. His quiet character was a rare mixture of tolerance, modesty and high professional integrity and he was greatly loved by all his many patients in Crieff. His colleagues have lost a great friend and his readiness to lend a helping hand will be sorely missed. He is survived by his wife Tibby, daughter Shona and sons Graham, Andrew, and Alastair who is a medical graduate of Aberdeen.

In memoriam: Lord Amulree

It is now more than a year since Sholto Mackenzie, Lord Amulree, died. Canon Dunstan paid a most eloquent and detailed tribute to him in his memorial address (St. Margaret's, Westminster, 22 March 1984). This has been recorded in the *Journal of Medical Ethics* (1984; **10:** 209-210).

Lord Amulree had been an Honorary Fellow of this College for 21 years. I wish to remind readers of the *Journal* of this lovable man and his connections with the College before more time passes.

Those who met him will remember his tall, stooping figure, handsome face and glowing smile. His stammer betrayed a sensitive, diffident shyness, but also his determination, since his great achievements depended on social contact, public speaking and public advocacy for the old, the chronic sick, the development of a special branch of the medical profession and a number of other valuable causes.

Adding life to years — the title of the book which he wrote about the time when he relinquished an established career in the Ministry of Health for a clinical crusade — reveals the idea that the elderly should be encouraged to lead independent lives in their own homes for as long as possible.

This principle, linked with the broad coverage which geriatrics and general practice share, goes some way to explaining the loyalty of Lord Amulree to our College. His clinical work at University College Hospital started just before this College. It was then too that I, as a general practitioner working in the neighbourhood of University College Hospital, began to witness the development of the first geriatric department in any teaching hospital. I benefited by his active concern for the elderly in their own homes in Camden and Kentish Town.

Lord Amulree was the nephew of James Mackenzie. The College owes to Sholto Mackenzie its possession of a number of documents, instruments and photographs commemorating James Mackenzie's life and work. It also owes to him a generous endowment in the Mackenzie prize.

He inherited a peerage, but earned a knighthood and the affection of many people in many walks of life.

J.H.

Dame Annis Gillie

A memorial service will be held for Dame Annis Gillie at St. Columba's Church, Pont Street, London SW1, at 12 noon on Friday 7 June.

COLLEGE SECTION

The third report of the Maternity Services Advisory Committee to the Secretaries of State for Social Services and for Wales is now available *(Maternity care in action part 3: care of the mother and baby [Post-natal and neonatal care] — a guide to good practice and a plan for action).* Mrs Alison Munro and her colleagues are to be congratulated on producing reports which are practical, realistic and achievable, and, one might add, eminently readable. In her foreword Mrs Munro rightly makes the point that for the mother postnatal care is as important as the birth itself but, unfortunately, in many maternity units it has had the lowest priority, and the mother's joy and satisfaction in the birth of her baby have been marred by inadequate care, by confusing and conflicting advice and by poor communication between the hospital and the community staff who will care for her and her baby at home. If the recommendations contained in the report are translated into action, this will no longer be the case. Members might like to know that the College was represented on the Maternity Services Advisory Committee by Dr M. McKendrick of Hexham.

• Self-examination of the breasts is often advocated as a strategy for the early detection of carcinoma. Sadly, there is little evidence that the high mortality from the disease can be much influenced by this or indeed any other action. There may, however, be some benefit to be gained by advocating self-examination of the testes. The results of surgery combined with chemotherapy on testicular cancer are beginning to look very promising indeed. It is one of the most common cancers to occur in men between the ages of 20 and 40 years, and there is some evidence that it is being found with increasing frequency. A significant rise in its incidence has been noted by the Medical Research Council's Ludwig Institute for Cancer Research, which found that there was a rise in incidence from 2.3 per 100 000 men in 1970 to 3.8 per 100 000 10 years later. Admittedly, these figures only apply to East Anglia.

• The quality initiative is, I hope, gathering momentum. Perhaps complaints against doctors could provide food for thought. In his book *Complaints against doctors,* (London: Charles Knight, 1973) Kline reviewed the data for 1949 to 1971 and found that the principal causes of all complaints (not just those of medical service committees) were bad manners by the general practitioner and staff (35 per cent), inadequate examination and treatment (16 per cent), failure to visit at home (14 per cent), and failure of the appointments system or an inability to contact the general practitioner (14 per cent). There remained an amorphous group of 21 per cent. Fairly basic, when you think about it.

• The district, as the functional unit of the National Health Service (NHS), is certainly sensible, yet when district health authorities meet, agendas are rapidly dominated by concern with bricks and mortar rather than with the delivery of care, with prevention and with progress. It would be easy to lay the blame on the membership of health authorities, yet in my experience

such people are highly motivated and eager to improve health. One reason for the authorities being ineffective is that we have failed to provide the necessary medical advice. Regional medical committees are a motley assortment of representatives of each specialty group and have not been capable of delivering coherent recommendations. Is vested interest proving to be a barrier to progress? Community physicians, who should be leading this field, often seem to shrink from facing the real issues and defining the priorities. Maybe this is what the Griffiths report is all about. Unless the profession can unite we will have to accept rule by managers.

● Harvey Marcovitch, in *BMA News Review,* March 1985, argues for the removal of the so called financial incentive for a domiciliary visit by a consultant. There is much in his article which makes sense. I would like to focus attention on another aspect: the domiciliary visit without the attendance of the general practitioner. The domiciliary visit offers the unique opportunity to merge primary and secondary care. It is devalued by the absence of the general practitioner who, thereby, is abdicating responsibility. The physician with whom I did my first house job would never contemplate carrying out a domiciliary visit without the presence of the family doctor. When he retired he was given a rather splendid greenhouse by his general practitioner colleagues. Not for him the 'fast buck' — rather the shared experience. Domiciliary visits offer unique opportunities for increasing mutual education, respect and understanding. They should not be dismissed lightly.

● Polio will soon be only a memory in developed nations. My own memory is of sleeping on alternate nights for six weeks in a room next to one in which a sufferer was being nursed in an iron lung. There were usually three to four calls each night to attend to the tracheostomy tube or other details of his care. Sadly, he died, but his memory lingers. In our virtually polio-free society it is all too easy to forget that every year polio strikes 500 000 people, killing 50 000. As part of their contribution to health for all by the year 2000, Rotary International are to be congratulated on their intention to raise $5 million annually for polio vaccine and to provide advisory teams to plan, implement and evaluate campaigns for mass vaccination. They are to be advised by Dr Albert Sabin, developer of the oral polio vaccine.

● 'Projects with local input and support are more likely to be successful in improving health care than schemes imposed from above.' Acheson D. . . . Whither the limited list?

● If I were a diabetic I would certainly use disposable syringes. The argument against their being provided on the NHS used to be that of cost, but now that it has been shown that such syringes and needles can be re-used (sometimes for several weeks) without any risk of infection, the argument no longer holds true. In fact, disposable syringes could even be cheaper. In addition, they are lighter and more easily carried, have smaller dead space and the needles tend to be sharper, resulting in less painful injections. Disposable syringes and needles do not need to be kept in spirit, merely the needle covered and the syringe kept in a refrigerator between injections. It is to be hoped that the pressure from the British Diabetic Association for disposable syringes and needles to be provided on the NHS will continue and that the whole medical profession will support the use of disposable syringes.

DOCTORS TALKING TO PATIENTS

Doctors Talking to Patients, by Professor P. S. Byrne, a distinguished past-President of the Royal College of General Practitioners, and Dr B. E. L. Long, an expert educationalist, was first published by HMSO in 1976.

This well-known book has made a major contribution to the understanding of the consultation in general practice and illustrates the potential for using modern methods of recording for analysing the problems of doctor-patient communication.

With permission of HMSO, the Royal College of General Practitioners has now reprinted *Doctors Talking to Patients* and so made available this classic work to a new generation of trainees and general practitioner principals.

Doctors Talking to Patients can be obtained from the Publications Sales Office, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £10.50, including postage. Payment should be made with order.

PRESENT STATE AND FUTURE NEEDS IN GENERAL PRACTICE

The sixth edition of this well known book by John Fry gives numerous facts and figures about general practice and is a basic reference for all those interested in primary medical care.

Dr Fry has again summarized key information such as the average number of patients, patterns of allowances, and numbers of trainers and teaching practices in a series of tables and charts which are supported by a clear commentary. Particularly useful is the conversion of current rates for illness and services in relation to population units of 2,500 (about one general practitioner) and 10,000 (a typical group practice).

Present State and Future Needs in General Practice has been published for the College by MTP Press Limited and is available from the Publications Sales Office, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £5.50 including postage. Payment should be made with order.