What impact is the Cumberlege Report likely to have? The recommendations are certainly radical — the Report envisages a neighbourhood nursing service for communities between 10 000 and 25 000 people and the eventual removal of the demarcations between district nurses, health visitors and school nurses by integrating the training of the different groups. The logic of the proposals is attractive were it not for the difficulties of implementing radical changes in primary health care in the United Kingdom. The fundamental difference in management structure between general practitioner and nursing services means that progress towards teamwork in primary health care is painfully slow. Where teamwork does operate it is often based on the development of trust between individuals rather than arrangements between organizations.

Nevertheless there are changes which can take place to facilitate the development of effective primary care teams or networks. For example, practices in urban areas could restrict themselves to smaller geographical areas through local and informal agreements between practices without creating monopolies which deny choice to patients.

From the point of view of general practitioners, the accountability of community nurses is a key issue which needs to be addressed. The Report places great emphasis on the role of neighbourhood nursing managers. With notable exceptions, the tendency of nursing managers in the United Kingdom has been to take a bureaucratic approach to the provision of services, with decisions delayed while consultations take place within the nursing hierarchy. Such an approach restricts the clinical role of nurses, preventing them from adapting to new circumstances and new approaches to care. The adaptability and flexibility seen by the Report as essential for providing primary health care is lost unless the actual providers of care can become individually accountable for their clinical decision-making.

The growth in the numbers of practice nurses in the last 10 years is related more to this issue of accountability then to the subsidizing of nurses salaries which the Report condemns. General practitioners take responsibility for the actions of the nurses they employ and this has enabled many practice nurses to carry out a wider range of activities than would be permitted by nursing managers and health authorities. Perhaps the solution to the problems of accountability and clinical responsibility for community nurses is to make them more independent in their decision-making and this in turn would make the debate about who employs them less contentious.

The National Health Service seeks to provide a uniformly good standard of care throughout the country. But despite schemes to equalize the resources for health care between different parts of the country, the 'inverse care law' coined by Julian Tudor Hart still applies. The struggle to achieve a uniform service means, however, that the professions and the Government have been reluctant to sponsor experiments in the organization of health care. It should be possible to set up an experiment by organizing health care in some districts along the lines recommended in the Cumberlege Report and evaluating the effectiveness of the services provided — only then can rational decisions about the future of community nursing in the UK be made.

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Family conciliation services

ALTHOUGH neither family conciliators nor doctors would endorse the headline 'Divorce doctors' in the *Daily Express* last year, it serves to draw attention to the possible relationship between the two.

Local out-of-court family conciliation services are growing rapidly throughout the country, their growth coordinated by the National Family Conciliation Council (NFCC). There are now more than 30 affiliated services operating and the NFCC is in touch with a further 40 at different stages of development. All these services are run as voluntary agencies with charitable status and employ professional staff. In some areas conciliation is carried out within the courts by divorce court welfare officers. Conciliation is becoming a popular concept and is recommended to clients by an increasing number of solicitors.

The NFCC defines the aim of conciliation as 'to help couples involved in separation and divorce to reach agreement, or to reduce the area of intensity of conflict between them, especially in disputes concerning their children. In the short term the objective is to reach a workable settlement which takes account of the needs of the children and the adults involved. The longer term objective is to help both parents maintain their relationship with their children and achieve a cooperative plan for their children's welfare'. It has been predicted that on current trends, one in three marriages is likely to end in divorce and 20% of children are likely to experience the divorce of their parents before reaching the age of 16 years.[1] At the time of separation couples are so caught up in their own distress that they may find it difficult to recognize distress and confusion in their children. Conciliation offers them help in reaching decisions without abdicating parental responsibility.

Conciliation, though performed by people with a training and background in social work or marriage counselling, is not a therapeutic or a welfare activity. Staff do not treat or advise; rather they invite couples to negotiate. As the Booth Committee[2] puts it, 'we are firmly of the view that the primary decision-making responsibility should rest with the spouses themselves and that they should be given all necessary help in deciding for themselves what should happen to their children, their property and their marriage'. Although conciliation does not aim to be therapeutic, it can have healing effects. The process of communicating with each other in conciliation appointments actively helps couples to balance their needs with those of their children. About 10% of couples reconcile as a result of this opportunity, including spouses who had not previously sought marriage counselling. For the remainder, research at Essex University for the NFCC reports that a high proportion reach agreement on issues of custody and access.[3] The Government has now funded a major piece of research at Newcastle University which will further examine, among other things, the effectiveness of conciliation. Studies have shown[4-6] that continuing contact with both parents and clear conflict-free communication between them can do much to mitigate the harm done to children by their parents' divorce. Interviews involving the children can sometimes assist in this process.

In order to be affiliated to the NFCC the family conciliation services have to satisfy a number of criteria: they should be

managed by a committee which includes members of the social work and legal professions; they should ensure proper selection, training and supervision of staff, who as well as having professional qualifications in social work or marriage guidance counselling, should also have experience in marital and family work and training in law and conciliation skills; they should liaise with other professions but ensure that their dealings with clients are confidential. There is a code of practice worked out with the Law Society which clarifies their relationship with solicitors and the courts. It is the view of the NFCC that the role of conciliator cannot be combined with other roles, like that of doctor, social worker or marriage counsellor, because of the risk of compromising the conciliation by partiality or concern with other matters and because the process requires adherence to very clear rules in relation to the law.

General practitioners will not be surprised that a study of divorce petitioners conducted in Bristol from 1972–75 found that 20% of the men petitioning and 42% of the women had consulted their family doctor in the process.[7] In order to be effective in helping these people, general practitioners need to be aware of the services such as the family conciliation service which are available. Couples identified by general practitioners as likely to benefit from conciliation can be referred to the local service. Although both partners will need to be seen, a doctor may refer one of the partners and leave the conciliation service to involve the other. The Citizen's Advice Bureau will have information about the local service and the NFCC (34 Milton Road, Swindon, Wilts SN1 5JA) can provide a list of local services with guidelines on referral. If there is no family conciliation service in the area general practitioners can play a part in stimulating the creation of one.

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The election of the President

INSPIRED by a new sense of corporate identity and optimism about their future, our predecessors, the general practitioners of the 1820s and 1830s, felt they were the new men of the profession, the doctors for nearly all the people on nearly all medical occasions. They were, however, aware that they alone among the profession had 'no head, no body', no institution which could represent their views; and they looked to the Royal College of Surgeons to take them under its wing.

Many of the general practitioners not only thought of themselves as surgeons, but held the same diploma (MRCS) as those giants of early nineteenth century medicine, the rich and influential surgeons who dominated the teaching hospitals of London. General practitioners, therefore, believed they should be allowed to take part in the election of members of Council and the President. But the ruling elite of London hospital surgeons never had the slightest intention of allowing general practitioners to take any part in the governance of their College, although the College was financially dependent on the examination fee which, in terms of average medical incomes, was the equivalent of not less than £1000 today.

General practitioners, who formed well over 80% of the membership, were allowed no rights or privileges even when the introduction of the new charter of the Royal College of Surgeons in 1843, provided the opportunity for democratic reform. Indeed, the introduction of the FRCS in 1843 established two grades and widened the gap between the 'pure' surgeons and the general practitioners. It was this which led to the establishment, in a mood of frustration and anger, of the National Association of General Practitioners on 7 December 1844. The Association immediately began negotiations with the government and medical corporations in order to create a College of General Practitioners. After many setbacks the plan was finally on the point of success when Council of the Royal College of Surgeons had a last minute change of heart and withdrew their consent, leading to the collapse of the plan in February 1848.

This brief but necessary summary of the first attempt to establish a College of General Practitioners brings me to the subject of the election of the President of the Royal College of General Practitioners. If a College had been founded in 1848, whether it would have been a success and changed the face of British medicine is an open question; but if it had been established there is little doubt that elections to office would have been on the basis of the votes of the entire membership. In the age of parliamentary reform and increasing support for democratic procedures, anything else would have been unthinkable. That was what membership of an institution meant to our predecessors, and ought to mean to us today.

Since its foundation, the present Royal College of General Practitioners has been in the peculiar position of having two leading officers, the President and the Chairman of Council. It is reasonable that the election of their Chairman should be in the hands of Council. But the specific role of the President is to represent the views of the membership as a whole. It is therefore both extraordinary and indefensible that the President of the Royal College of General Practitioners is still, today, elected by a process that was described by a member of Council as one of 'osmosis'. A name (or names) is quietly circulated among members of the Council until the name of the successful candidate emerges. There is no vote by the membership. It is no defence to argue that the system has worked well so far; nor that it may be in line with the custom of other medical colleges. The present system is one that inevitably tends to make ordinary members feel divorced from their College and its President, and it is not surprising if some of the younger general practitioners perceive the College as an organization run by an elite of middle-aged fellows.

Future historians of the medical profession will wonder why the College which represents the largest branch of the profession tolerated such an undemocratic method of electing its President. The admiration and debt of gratitude felt by myself and others towards the present and many of the past Presidents who have done so much to raise the standard of general practice in Britain is irrelevant. What matters is that the election of the President should be genuinely democratic.

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