Election of the President

Sir,
Dr Irvine Loudon's brisk condemnation of the electoral process of our College President (July *Journal*, p.301) provides an impetus to clarify some of the myths surrounding this process.

As the Council members are the decision makers it may require restating that they are elected partly by a general vote and partly by the faculties, which in turn represent the body of the College by geographical area. This could be seen as an example of the democratic principle, entrusting the final choice of the President to these elected members.

As to the osmotic process attributed to Council in electing the President, this one-sided description does no justice to Council's well-chaired and thoughtful procedures (quite apart from the life-sustaining osmotic diffusion in our cell physiology).

When considering the electoral process further it may well be necessary to redefine the position of the President. As Dr Loudon so correctly states the President represents the total membership of the College. This representation cannot be achieved effectively by a vote (annual or otherwise) involving electioneering or pressure group action, but depends on the President being in touch with all levels of the membership during his term of office.

There is another important aspect in this consideration of the position of the President. The Speaker in the House of Commons maintains an impartial balance and the President likewise, though not in the party political sense, is at times required to stand between the interest of Council and its Chairman, and the needs of the membership. The Speaker too is not elected at a general election, but by Members of Parliament. This is hardly undemocratic.

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Sir,
Dr Loudon's editorial (July *Journal*, p.301) demands a reasoned contradiction. Genuine democracy can be a foolish way of trying to choose the right man.

Our Council is elected democratically. Most of those who vote know something and often quite a lot about those for whom they vote. The result is satisfactory.

Members of Council are well acquainted with each other, and know who is likely to be a good President. Most of us have neither the skill nor the initiative to undertake the dedicated work which they do for us. Of course there is some verbosity, pomposity and self-aggrandizement but these are qualities which members of Council are well able to assess in each other. They are not so easily detected by the rest of us in a curriculum vitae circulated for self-advertisement.

I have been a member of Council and I would rather let the informed and critical Council choose my President than have a vote myself.

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MRCGP examination

Sir,
Three experienced general practitioners, whom I know personally, have recently failed the MRCGP examination. One is a 'would be' trainer, another a trainer and the last a past trainee course organizer and trainer. The latter is a conscientious, concerned, compassionate and dedicated doctor. I just do not believe that he failed to come up to the standards for which I have always believed the College stood.

It must be that the wrong parameters are being tested. I suspect that more importance is given to the measurable than to the unmeasurable items. If the examination continues in this vein it will become divisive. In view of my suspicions, it does not surprise me that candidates have been criticized for lack of knowledge about practice management and lack of reading (March *Journal*, p.138). Neither of these seem to me to be what makes a good general practitioner and this makes me sceptical that we can be assessed for quality.

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The Cumberlege Report — another view

Sir,
Members of the College will have read with interest your reasonable and carefully argued editorial relating to the Cumberlege Report on the future of Community Nursing[1] (July *Journal*, p.299). Attention should be drawn to this document, for it makes proposals which, if accepted, would have fundamental implications for the future of nursing in primary care. However, we feel that you may have been overly generous in your consideration of the report's views and recommendations.

The Vale of Trent Faculty recognized the importance of considering the report properly and we are the members of a working party appointed to consider the document. The contents of this letter reflect our board's submission to the Secretary of State.

There is much in the Cumberlege Report with which nursing and medical colleagues will agree:

— That community nurses are most effective when working in a primary health care team, and that this concept is rightly promoted by the College, and on vocational training schemes.

— That the best place for much patient care is in the community, and that such an increase in workload needs to be recognized and accompanied by a consideration of the resources required.

— That good planning, appropriate management and audit of nursing activities is appropriate, and to be encouraged.

— That nurses can be directly accessible to patients, and be involved in some clinical decisions, including the prescription of certain medications and dressings, when properly supervised, and with clear lines of responsibility.

However, there were a number of features of the report with which we felt uneasy and we found the report's frequent failure to document the evidence upon which its views were founded disturbing. Statements such as 'The needs of communities ... become ... obscured when nursing services are organised solely around general practice' or (of new roles for nurses) 'nurses could develop such interests without abandoning their more general workloads' should have been accompanied by references.

The report refers to the nursing difficulties associated with small locations served by many general practitioners. The problems of this arrangement are clear, but it must be remembered that for the patients concerned this might represent continuity of medical care over many years and different addresses. The rationalization of such patients with two or three general practitioners may have an attractive administrative simplicity, but this would not necessarily guarantee better care.

You rightly pointed to the tardiness with which teamwork has been adopted in many areas. The report suggests that part of the solution to this is to have a written

contract between the proposed neighbourhood nursing unit and the practices whose patients such units would serve. We are told that 'doctors who preferred not to negotiate such an agreement would receive only those nursing services which the neighbourhood nursing managers themselves decide to provide'. We find it hard to believe that such an approach would be uniformly successful, and can evisage a hardening of attitudes among colleagues which would do little to promote teamwork.

The report is also critical of directly employed practice nurses. Apart from the report's assessment of the cost of such staff, which is inaccurate as has been explained by Dr Arnold Elliott of the GMSC, what reason could there be for reducing the number of nurses working in the community, given the report's earlier acceptance of the need for greater provision? The answer to this question, and perhaps a clue to the proposal for written contracts, may lie in the sympathy expressed with the view, ascribed to the Royal College of Nursing, that 'as a matter of professional principle, nurses should not be subject to control and direction by doctors over their professional work'.

Although it is not made clear where clinical responsibility would rest, the report suggests that the provision of appropriately trained practice nurses, under the supervision of the neighbourhood nursing unit would reduce the need for general practitioners to employ their own nurses. We suspect that this is the reverse of the experience of many doctors, who find that the only solution to managerial restrictions of the role of nurses employed by the local health authority is to employ and train their own.

Is the main need of the community nursing services a better managerial structure? Are not most of the nursing and medical problems in the community more to do with resources than chains of command?

The implication of the report is that the proposed managerial changes could be introduced at minimal financial cost. Therefore, it is argued, because they are free, any such improvements must be worth having. The increase in the level of personnel required by the report's recommendations is estimated at 1.5% which, it is claimed, could be paid for by reductions in the cost of paperwork and travelling.

Can they seriously suggest this? The National Health Service has recent painful experience of the expense and difficulties associated with managerial reorganization. If the implementation of the report's recommendations does have a significant cost then an important area has not been addressed: whether such money would be best spent in that way.

By all means let us support the establishment of an experimental trial of the neighbourhood nursing model, but we shall require much firmer evidence than this report provides before accepting its proposals.

Perhaps the final word should be given to a nurse quoted in the report as saying that any further fundamental changes in organization were needed 'like a hole in the head'.

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Reference

1. Department of Health and Social Security. *Neighbourhood nursing — a focus for care (The Cumberlege Report).* London: HMSO, 1986.

Practice profiles

Sir,
Dr Thompson writes (August *Journal,* p.381) to challenge the findings of Frances Hanson and myself about claim rates for items of service and other characteristics of elderly doctors in Kensington, Chelsea and Westminster (April *Journal,* p.165); his grounds are that they do not apply to himself and his practice.

Unfortunately one case proves nothing, particularly as Dr Thompson's practice is in Croydon. We did say that we had no idea how far our findings might hold in other areas, and of course we know how lightly he carries his own years. He suggests that the low rates we reported were due to lack of clerical staff, absence of team work, poor premises and a mobile population rather than to the doctors' age. Our tables show that many of these features were in fact especially strongly associated with single-handed elderly doctors; moreover, in the two-doctor practices, those with at least one partner aged 65 years or more had lower rates than the rest. We can assure Dr Thompson that we do not believe that doctors automatically make fewer claims when they reach the age of 65 years, but he should not dismiss the findings as no more than a coincidence. The underlying reasons are almost certainly complex and may be unique to the area.

Our surprise with regard to maternity services was at the large number of doctors who made no claims at all, even for referring patients to an antenatal clinic. His account of his nocturnal obstetric activities misses the point.

It would be useful if Dr Thompson or anyone else could demonstrate that elderly doctors in areas less unusual than Kensington, Chelsea and Westminster behave differently. The necessary data are sitting in the files of family practitioner committees all over the country waiting patiently to be analysed.

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A 'herald wave' of type A influenza of the H1N1 sub-type

Sir,
It appears that recent outbreaks of influenza A in Singapore and Kuala Lumpur and also more recently a single isolate in England were caused by the H1N1 sub-type of the virus which shows considerable antigenic drift from previous strains.[1] Influenza A of the H1N1 sub-type has been prevalent since 1977 when it caused 'red flu' epidemics. Since then its activity has been on the decline, the majority of infections being caused by the H3N2 virus (derived from the 'Hong Kong' influenza virus). It has been noted that new viral strains isolated in the northern hemisphere in late spring do not cause epidemics in that hemisphere during the succeeding months, but affect the southern hemisphere during this period returning to the northern hemisphere six months later.[2,3] The Public Health Laboratory Service noted a single isolation of the A/England/42/72 strain in England in 1972 which caused outbreaks in the southern hemisphere in succeeding months and was responsible for winter influenza in Britain in 1972/73.[4] This so called 'herald wave' of influenza A has been observed in several long term studies[2-4] and it is reasonable to assume that it is a true phenomenon inherent in the nature of the virus or its epidemiology.

The recent isolation described above may therefore indicate that the northern hemisphere will be plagued next winter with moderate to large epidemics caused by this new H1N1 virus. It would therefore seem prudent to ensure that this new viral strain is incorporated into influenza vaccines given in the next few months in order to reduce influenza morbidity and possible mortality in the northern hemisphere next winter.

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