NEWS

Honorary Editor: Dr Edwin Martin
Editor: Janet Fricker

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COUNCIL

THE second meeting of the 1986/87 Council of the Royal College of General Practitioners was held on Saturday 6 December 1986.

Primary Health Care - an Agenda for Discussion

Dr John Hasler said that since the last meeting of Council, the College had given evidence to three DHSS consultation meetings on the Green paper. Professor Denis Pereira Gray led a College team at the Exeter meeting on Prevention, Dr Bill Styles led a team at the Leeds meeting on Quality and Dr Colin Waine a team at the Manchester meeting on Nursing. In October College officers presented evidence to the Social Services Committee of the House of Commons.

Council considered the College's draft response to the Green paper. It had been prepared after taking into account Council discussions and faculty responses. Professor Pereira Gray, who had done much of the drafting, gave the background to how the paper had been compiled.

Council congratulated the drafters and made some suggestions for final amendments.

It was decided that the College's response to the Green paper should be sent to members in the format of a report from general practice. This is planned to be distributed with the March Journal. □

Neighbourhood Nursing - a Focus for Care

Council welcomed the emphasis that had been put on cooperation between all members of the primary health care team in the College's draft response to the Cumberlege Report. But the difficulties of defining a neighbourhood and knowing the characteristics of residents in that neighbourhood were recognized. □

Complaints Procedure

Council considered the review consultation document on the Family Practitioner Service Complaints Investigation Procedure. It decided that this was more the remit of the General Medical Services Committee than of the College and that no response should be made to this document. □

Election of Officers

Dr Bob Colville was elected chairman of the Education Division for 1986/87 and Professor John Bain was elected chairman of the Research Division for 1986/87. □

Quality Initiative

Dr Ian McNamara, the Council Quality Initiative Coordinator, reported on the Council's Quality Initiative Study Day on 5 December.

Council agreed that the faculty and Council members' responses should be circulated to the faculty boards, but that individual contributors' names should be removed from the report.

Dr McNamara said that Dr Mike Pringle, from the Vale of Trent, had agreed to take over the post of Council Quality Initiative Coordinator.

Council felt that it was important that it should demonstrate its support for the principals of the Quality Initiative through a project.

Dr Jackie Hayden and Dr Pringle agreed to submit a paper on how the Quality Initiative should proceed to the next meeting of Council.

Dr Hasler expressed Council's thanks to Dr McNamara for his work over the last three years as Quality Initiative Coordinator and for the success he had made of it. □

Other matters

Dr Styles reported that a letter had been received from the Censor in Chief of the Royal New Zealand College of General Practitioners suggesting that the two Colleges should agree some reciprocal process with regard to membership.

Council felt that problems might occur when standards and definitions of primary care varied in the different countries. A major problem in agreeing reciprocity between sister colleges would be the registration of the MRCGP diploma with the General Medical Council.

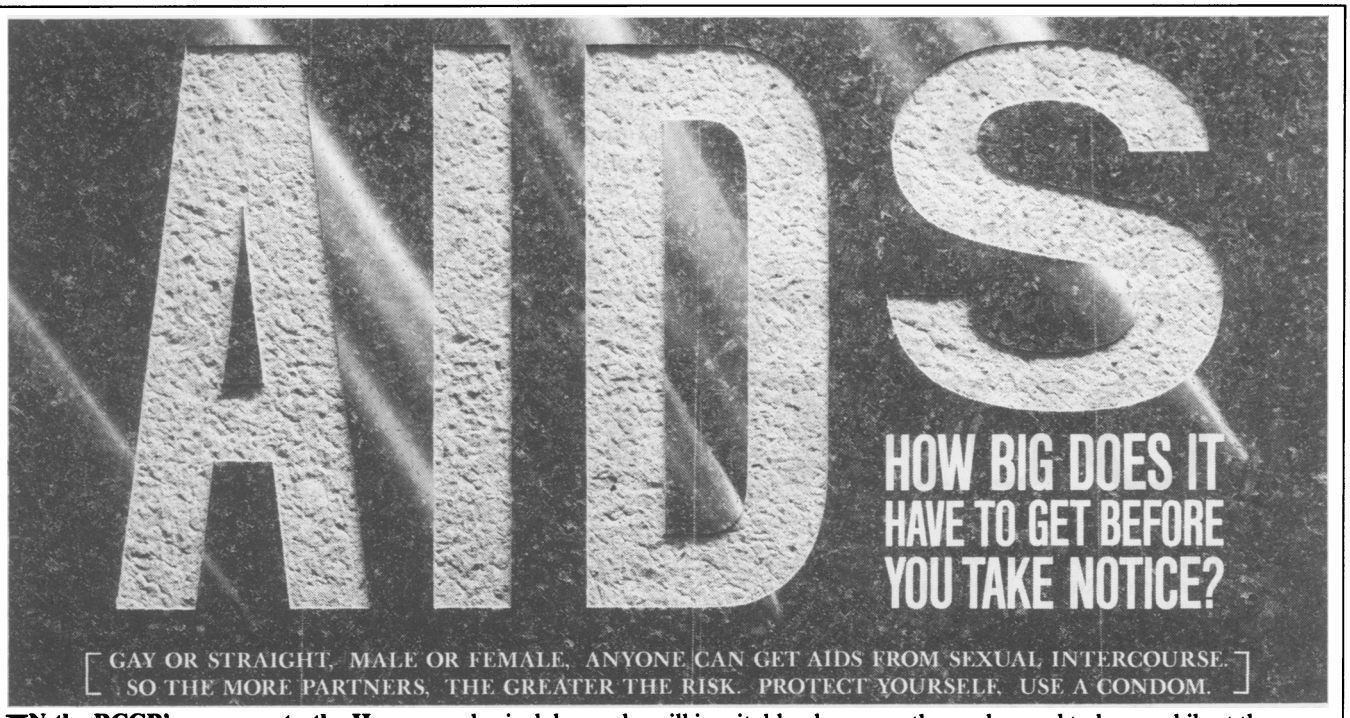
Council agreed to give written evidence to the House of Commons Social Services Committee on the problems in general practice associated with the care of AIDS patients. There was considerable discussion about the resources required in general practice to cope with the ever increasing number of people suffering from the disease. □

JOHN HASLER

THE College regrets to announce the resignation of Dr John Hasler as chairman of Council. Dr Hasler, in a letter to all members of Council, said:

> "Now we have completed our responses to the government on the Green Paper and the Cumberlege report I have decided to stand down as chairman of Council."

Arrangements are being made for a new chairman to be elected at the next meeting of Council. In the meantime, Dr Robin Steel, vice-chairman of Council, and the other officers will be conducting College affairs. □



IN the RCGP's response to the House of Commons Social Services Committee Enquiry into AIDS, last month, the College predicted that AIDS would increasingly become a primary health care problem.

The College believes that general practitioners, with their unique contact with patients, will be of fundamental importance in the management of AIDS and foresees that their role will develop as the epidemic spreads. The College said that general practitioners should be able to provide health education for those most at risk, diagnose the condition and contribute to its management by providing terminal care.

The good relationship developed over the years between general practitioners and their patients provides an excellent basis for persuading adults to change their behaviour in delicate areas of promiscuous sexual behaviour and drug abuse since general practice is the largest single supplier of family planning advice it is logical that doctors should be involved in any national educational campaigns. Doctors are also in a good position to advise patients going abroad, who come for immunization and malaria prophylaxis, to avoid sexual intercourse (particularly with prostitutes) and if possible to avoid blood transfusions in countries where blood testing is not yet secure.

The College believes that plans need to be made now for caring for AIDS patients in their own homes because it has predicted that the number of AIDS patients will rise to a level exceeding the entire number of acute beds in the hospital service. The terminal care of AIDS patients, with its special emotional and physical demands, will inevitably place a heavy burden on the primary care team. The College recognizes that AIDS presents special home nursing problems since surroundings are often not ideal, specimens can be infected and there is a social stigma attached to the disease. As the number of people with AIDS increases additional resources will be required in the community to provide for extra nurses and counsellors.

More common than the patient with AIDS will be the patients who are worried that they have contracted it. Since the College is committed to the principle of caring for the physical, psychological and social aspects of patients' problems it is logical that members should become involved in the psychosocial aspects of AIDS early on. General practitioners will need to have direct access to laboratories providing HIV antibody tests and should be aware of the devastating effect this can have on a person's life. Patients diagnosed as HIV positive face rejection by society, they may have to make a commitment to refrain from sexual activity, they become a bad insurance risk and are often unable to get a morgage or take a job. They have to learn to live with the fact that there is a three in ten chance of a person who is HIV positive developing the full AIDS disease and dying from it.

The advent of AIDS introduces important new ethical dilemmas for the general practitioner and the College is now calling for guidelines to clarify the situation. The disease poses the question of confidentiality and whether all members of the primary health care team have the right to know which patients are HIV positive. The problem arises of how this information can be made available to those who need to know while at the same time maintaining confidentiality within the team. Then there is the problem of whether the ethic of confidentiality should be overtaken by a precedent ethic to avoid the harm that one individual can do to another if an HIV positive patient refuses to disclose information to his or her sexual partner. The College believes that the trust between doctor and patient must be ensured as far as possible, but that at the same time the responsibilities of individuals and their doctors to society must be recognized.

Postgraduate education is urgently needed to inform general practitioners. Postgraduate deans and regional advisers should now be considering how the educational needs of general practitioners and their teams can be met so that informed and sensitive care is readily available.

Doctors can go a long way towards helping to overcome the prejudice and stigma of AIDS. The College believes that a better informed public is likely to be less prejudiced and more responsible in its attitudes to the disease, its prevention and the people who have been unfortunate enough to acquire it. □

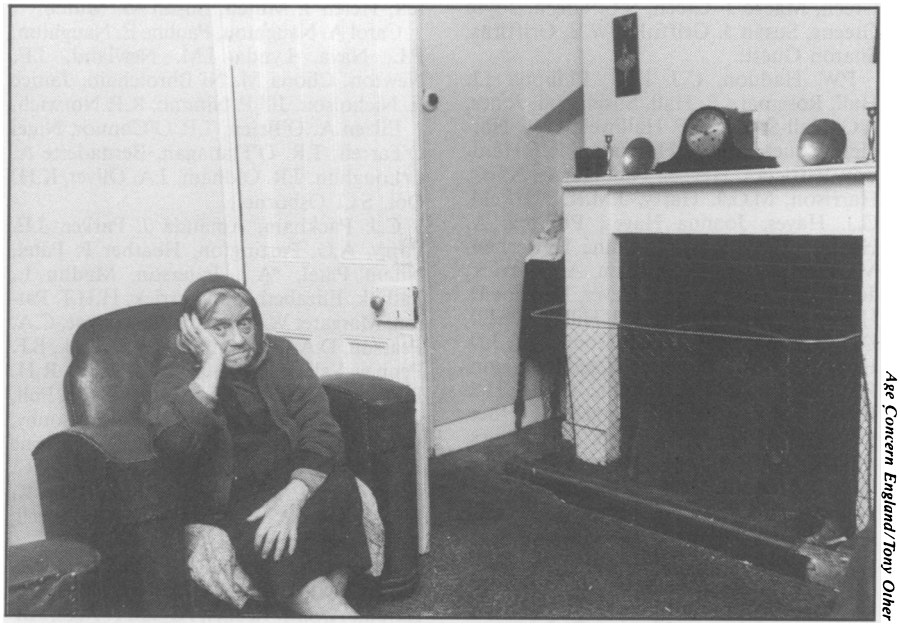
Janet Fricker

THE News editors welcome members articles and ideas.

We recognize that events important to general practitioners often occur locally and so we'd like to hear what's happening from the faculties.

Contact Janet Fricker by writing to the College or ringing 01 581 3232. □

OLD AND COLD



Age Concern England/Tony Other

AGE Concern are appealing to doctors to help prevent a tragic repetition of last February when an estimated 7,000 pensioners died of cold.

They believe that general practitioners are in a better position than most professionals to help elderly people by giving advice on how to avoid hypothermia and other cold related problems.

David Hobman, director of Age Concern England, said: "In consultations, leading questions such as how are you managing through the cold weather .... are you worried about the bills .... are you keeping warm .... can help general practitioners establish if patients are at risk."

Dr Keith Thompson, a general practitioner with a particular interest in the elderly, said that doctors should be able to easily identify patients at risk by using their age/sex registers.

"Then before the winter starts it's a good idea for the social worker to visit the old person's home to see what heating it has, how much there is to spend on heating, and whether they have warm clothing and means of heating hot food," said Dr Thompson.

Dr Thompson added that when the cold weather sets in it should be perfectly feasible for the Practice to make frequent home visits because there are not usually more than 20 people on the 'at risk' register. He warned that doctors should be especially vigilant of patients on phenothiazine drugs such as chlorpromazine, prochlorperazine and trifluoperazine which make them particularly susceptible to cold. Also those with a thyroid deficiency were at greater risk.

Age Concern say that every surgery should keep a supply of leaflets for older people with tips on how to keep warm. Sensible advice on clothing and eating to keep out the chill and referral to relevant organizations for practical help can also save lives.

Local branches of Age Concern should be able to provide helpful information on benefits. Age Concern have just published a fact sheet *Helping with Heating* which gives information about fuel problems and what to do about them. It outlines the financial help available to elderly people on housing or supplementary benefit. There is also advice on how to apply for insulation and draughtproofing grants and useful energy saving tips.

"Age concern say that every surgery should keep a supply of leaflets for older people with tips on how to keep warm."

People aged 65 or over who receive a Supplementary Pension are automatically entitled to a weekly heating addition of £2.20, and people over 85 to £5.55. Other additions are available if people have heating systems which are particularly expensive to run or if homes are hard to heat.

In very cold weather people on Supplementary Pensions or Housing Benefit who have savings of £500 or less may be able to claim an Exceptionally Severe Weather Payment. Payments are fixed at £5 a week and will only be paid if the average temperatures for a seven day period running from Monday to Sunday is zero degrees celsius or less.

"Severe weather should be declared over the whole country when it's cold rather than relying on scientific data which will be grossly unjust in its operation. The government claims its new system is fairer. Age Concern believes it will simply be cheaper," said Mr Hobman.

Age Concern and the Health Education Council have produced *Warmth in Winter*, a free leaflet with advice on how to claim benefits, insulation and other fuel saving tips and how to eat for warmth. It is available from local Health Education Units. General Practitioners can also obtain free copies of the factsheet *Helping With Heating* by writing to the Information Department (FS1), Age Concern England, 60 Pitcairn Road, Mitcham, Surrey CRA 3LL and enclosing a large sae. Postage is charged on bulk orders. □

Janet Fricker

PSYCHIATRY MEETING

A JOINT meeting "Psychiatrists and General Practitioners: The Working Relationships" is being held at the Royal College of Physicians on 20 February, 1987. The meeting, which is in conjunction with the Annual General Meeting of the Section of Social and Community Psychiatry of the Royal College of Psychiatrists, will be dedicated to the topic of psychiatrists working in primary care.

In the morning there will be three principal speakers including Dr Geraldine Strathdee, from the RCPsych, who has completed a survey of psychiatrists working in general practice and also Professor Paul Freeling from the RCGP.

In the afternoon there will be a series of smaller presentations in which psychiatrists and general practitioners will talk about the schemes they have been involved with.

Doctors interested in attending should contact Mrs Jean Wales at The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Telephone 01-235 2351-5. □

RCGP Examination

THE following candidates were successful in the membership examination of the Royal College of General Practitioners in December 1986 (* denotes distinction):

R.J. Abbatt, Gail M. Addis, Joanna C. Ainsworth, G.M. Allan, A.S.C. Allison, Jane E. Alun-Jones, Angela A.S. Anderson, Helen E. Armstrong, J.D. Arnold, Sohail Ashraf, Jeanne S. Asirwatham, M.T.C. Atherton, P.J. Atkinson.

Mary P. Bacon, Kathryn A.E. Baddock, Heather E. Baker, J.R. Balazs, N.A. Ball, M.G. Bamber, A.S. Bansal, Michael Barnfield, D.A. Barrett, Isabel A.C. Bartlett, Eithne M. Batt, Jeanette Bayon, Catriona A.S. Beard, Sara C. Beattie, J.H. Beaven, G.C. Beggs, Elizabeth A. Beling, M.P. Bell, David Bellamy, C.J. Bensemann, F.A. Beresford, Gabrielle L. Berman, Tessa M. Bevan-Jones, V.B. Bhatt, Fiona M. Birrell, K.C. Bishop, J.R.C. Blackburn, Jane E. Blackmore, C.G. Blanshard, B.J.J. Blayney, A.J. Blunt, Alyson A. Bowhay, Nigel Brennan, J.C. Bromly, Susan M. Brown, J.M.C. Browne, Elaine C. Brownie, R.M. Brynes, Joan M. Bryson, I.Y. Buchanan, A.R. Bull, A.M. Burch, Munira Butt.

Ann M. Campbell, C.W. Campbell, Jane C.E. Campbell, Christine A. Caren, P.G.M. Carlin, A.S. Carr, K.P.C. Carroll, Deidre A. Cashin, P.S. Chahal, Felicity A. Challoner, Catherine A. Chalmers, J.S.M. Chan, H.M.J. Charles, Maria G. Charmantas, Farakh R. Chaudury, J.S. Cherry, D.F. Chesover, Anil Chopra, R.B. Church, J.D. Churcher, P.F.F. Clarke, B.J. Cloak, Carole A. Clouter, G.W. Collins, D.F.M. Connolly, D.P. Connolly, Christine Cook, Anna L. Cooke, A.M. Cooper, C.W. Cooper, Phillipa J. Coppock, B.V. Court, A.S. Coutts, Amanda L. Cox, D.C. Cox, S.R. Cox, Alexis Craig, P.J. Craven, Jillian M. Creasy, Patricia A. Cresswell, A.W.B. Crockett, Gillian M. Crooks, M.P. Crooks, I.B. Cross, L.J.W. Cruickshank, P.R. Cundy, *Sarah F. Cunningham.

Sarah M. Dauncey, I.G. Davidson, Christine E. Davies, M.E. De Bhulbh, Simon De Lusignan, R.K. Dempster, Jane R. Dewar, P.R. Dickens, J.M. Dirckze, N.W. Dixon, C.J. Dobbing, P.F. Downey, S.M. Drage, W.A. Ducharme, M.G. Duerden, P.A. Dunachie, Katherine J. Durrant.

Eileen A. Eeckelaers, *Anne E. Eldred, Krystyna Ellenger, P.M. Ellis, Sally J. Elphick, Farhad Emad, Karen J. Emms, P.R.A. Ettlinger, C.J. Evans, J.G. Evans, *Sarah A. Evans, Siwan G. Evans.

A.R. Ferris, Kim P. Fewell, P.R. Fink, Fiona Y. Firth, P.N. Fitzgerald, Geraldine C. Fleming, K.D. Fletcher, Mary E. Fletcher, D.L. Fone, Jill L. Foot, C.D. Ford, P.S. Foreman, Julie H. Forsey, *Susan M. Foster, T.R. Foster, Kathryn M.A. Fowler, Sally E. Fox, J.R.C. Francis, A.E. Furniss.

S.M. Galey, M.H. Gallagher, *Alison O.P. Gardiner, C.S. Gardner, Andrew Garner, G.C. Gibson, Keith Gillespie, John Glass, S.B. Glen, R.H. Goddard, Susan M. Goldberg, Geraldine A. Golden, Peter Goldstein, Isobel A. Gow, Kathryn B. Grady, Susan J. Grant, Melanie K. Gray, Jonita M. Green, Maeve J. Green, S.L. Green, Joyce Greene, Susan J. Griffiths, W.E. Griffiths, Sharon Guest.

P.W. Haddon, C.J. Hall, Philippa J.I. Hall, Rosemary E. Hall, Susan Hall-Jones, R.G. Hall-Smith, R.P. Halliwell, D.M. Hardie, Jacqueline M.A. Hardiman, R.J. Hardway, Patricia I. Harper, Paul Harris, N.S.C. Harrison, M.G.J. Harty, J.M.R. Hatfield, G.J. Hayes, Joanna Hayes, Philippa A. Hayes, G.P.G. Hays, Suzanne Heffernan, Maureen E. Hehir, Annam A. Herrick, Juliana M. Heslin, N.M. Hever, Julianne D. Hewitson, J.H. Higham, K.J. Hill, S.A. Hill, D.G. Hobson, *Patricia M. Hoddinott, J.D. Hodgson, C.A.J. Hodson, W.A. Hollington, P.R. Hollis, Keith Holtom, Diana H.J. Hood, Sally L. Hope, Angela T. Hore, Susannah V. Howard, Ann J. Humphreys, Jennifer A. Humphry, Christina Hunt, J.T. Hunt, Anne S. Huson, Katherine F.C. Hutchinson.

Jill Insole, Wanda I. Iskrzynska.

N.C. Jackman, B.K.D. James, C.M. James, Susan J. Jarman, Helen A. Jefford, Caroline A. Johnson, Debra C. Johnson, Pauline A. Johnson, Fiona A.B. Johnston, D.M. Jones, J.R. Jones, Julia A. Jones, K.D. Jones, *K.P. Jones, N.A. Joshi.

Dipak Kalra, G.M.H. Kanagasooriam, T.J. Keane, D.S. Kennedy, Jill E. Kent, L.G. Kersh, A.M. Khan, Denise Kinch, C.G.J. Kinchin, B.W. Kinsella, Lesley A. Kirkpatrick, N.I. Konzon, Ravinder K. Kooner, Vedala K. Krishnakumari, Meena Krishnamurthy.

T.E. Ladbrooke, M.J. Laird, M.K. Laker, R.S. Lall, Sally C. Landau, J.M. Lavric, Jennifer E. Law, E.N. Lawn, Margaret A. Lawrence, Alison J. Leahy, A.D. Lee, Elizabeth C. Lee, Jane S.A. Lees, G.J. Leese, P.J. Lefley, Antonia M.G. Lehane, John Leigh, G.D. Lewis, G.H. Lewis, Sian E. Lewis, J.H. Lieberman, A.J. Lister, Madeline A. Litchfield, Deborah Lloyd, Rosemary M. Logan, Rachel M. Long, J.M. Lough, Anne J. Lowes, P.M. Loxton, Denise C. Lucas, Kim Lumley, Harriet A. Lupton, C.J. Lyons.

R.M. Macfarlane, Lucy H.E. Mackenzie, Ian Maclure, T.D. Macpherson, J.C. Madoc-Jones, Linda M.E. Mahon-Daly, Karen A. Major, S.R. Manapragada, K.J. Marsden, Victoria M. Marsh, C.D.W. Marshall, J.S. Marshall, G.D.R. Martin, L.T. Martin, Vipul Masharani, M.J. Maslen, A.E. Matthews, D.F. Maxted, C.J.G. McArthur, Marie T. McCarthy, P.G. McCarthy, *Carol K. McCaugherty, J.W. McCorkindale, J.A. McCrohan, Fiona E. McDougall, J.P. McGeehan, Christina M. McGourty, *W.P. McGucken, Geraldine T. McHugh, Russell McInnes, Anthony McKenna, A.J.W. McLauchlan, P.J.G. McNamara, J.J. McPeake, T.J. McVey, *J.G. Mellor, R.H. Mennie, Lyn M. Miller, Mary F. Miller, F.C.A. Mills, Gillian P. Mines, N.P. Minett, Mukesh Mistry, Anne C.S. Mitchell, B.D. Mitchell, R.D. Mitchell, Catherine A.K.Y. Mok, Doreen J. Moles, G.F. Molloy, M.J. Moor, P.I.M. Moran, Debra S. Morgan, P.K. Morley, N.G. Morris, *A.M. Moulson, J.P. Mounty, R.F. Muir, Melanie F. Munro, Mary B. Murphy, J.W.I. Murray, Helen M. Murrell, Helen J. Mutch, Susan M. Mutch.

Carol A. Naughton, Pauline E. Naughton, P.L. Nava, Lynda J.M. Newland, J.E. Newton, Cliona M. Ni Bhrolchain, Janice E. Nicholson, Jill P. Nimmo, R.P. Norwich.

Eileen A. O'Brien, T.P. O'Connor, Nigel O'Farrell, T.R. O'Flanagan, Bernadette A. O'Loughlin, J.R. Oldham, J.A. Oliver, K.H. Ooi, S.C. Osborne.

C.J. Packham, Amanda J. Parker, J.E. Parry, A.G. Partington, Heather F. Patel, Nilam Patel, *A.J. Paterson, Madhu L. Pathak, Elizabeth A.S. Patrick, H.H.T. Patton, Margaret W. Patton, J.M.V. Payne, C.A. Pearson, D.A. Pearson, Audrey B. Peck, B.F. Penney, Valerie J. Philip, R.C. Phillip, R.H. Piggott, M.H.J. Pimm, D.J. Plews, D.J. Poll, C.T.S. Pollock, Christine E. Ponsonby, *Rosamund M. Pope, J.P. Portelly, Christine A. Porter, D.H.T. Powell, K.J. Pressley, R.C. Price, S.D. Price, J.J.A. Pringle, Jane K. Pringle, Grazyna Z. Pudlowska, R.T. Purcell, A.J. Pyper.

Dolores A. Rafter, V.K. Raichura, D.B. Rance, W.T.M. Ransom, Ruth E. Ray, A.P. Rayani, A.G.M. Reader, Alyson F. Rees, Anna M. Reijnierse, J.M. Reilly, M.J. Richards, A.H. Riley, *J.W. Rivers, L.J. Roberts, E.W. Robertson, I.R.S. Robertson, A.A. Robinson, M.B. Robinson, P.W. Robinson, David Roche, Gertrude T. Ronan, J.S. Rose, C.W. Rufford, *A.N. Rughani, D.R. Rutherford, E.A. Rybinski.

C.D. Saitch, M.K. Saksena, Susan A. Salkeld, N.K. Sandy, P.R. Sanville, A.N. Sawyer, I.R. Schofield, Gillian M. Scragg, S.B. Selby, Janet E. Self, Debasish Sen, Jerome Sender, Nina M. Senior, H.R. Shah, Mark Shapley, Elizabeth J. Shaw, D.M. Sheldon, D.A. Sheppard, Catherine M.E. Shire, G.S. Shuster, D.C. Simpson, H.C. Simpson, M.J. Simpson, Surinder Singh, R.I. Smallman, Alison Smith, Martin Smith, Patricia A. Smith, Clare L. Smithies, M.G. Smyth, Kevin Snee, Velaiuthar Sooriakumaran, J.R. Spain, J.F. Spelman, J.M. Spokes, E.B. Staunton, M.A. Staunton, Helen C. Steel, A.J. Stewart, Mary W. Stewart, Fiona W. Stirrat, D.N.H. Stone, C.J. Strang, G.S. Streeter, M.R. Strudley, J.M.G. Stupple, A.J. Sykes.

J.W. Tankel, Deborah M. Taverner, D.I. Tayler, A.D. Taylor, Janet E. Tempest, Y.K. Teo, P.R. Thomas, Sara A. Thompson, Hilary A. Thomson, Julie Thomson, *T.J. Thurston, I.L. Torrance, Sally A. Tothill, *J.P. Turner, Theresa M. Turney.

Elizabeth Vaughan-Williams, Ray Vella, P.W. Vincent.

Susan J. Walker, D.S. Walsh, K.G.M. Walshe, Audrey M. Walters, Carol P. Ward, W.A. Warin, Elizabeth Waterston, M.I.L. Watling, Martin Waugh, *Jennifer N. Webb, R.A. Wells, Susan M. Wells, D.P. Werry, Jane M. Western, Penelope M. Weston, D.H. White, Sara L. Whiteside, G.T. Whitham, A.D.C. Whitton, A.J. Williams, J.P. Williams, S.R. Williams, D.J. Williamson, Helen F. Willsdon, C.B. Wilson, Fay Wilson, June Wilson, P.P. Wilson, Sarah J. Woropay, A.T.S. Wright, T.J.W.A. Wright. □

Antique Drug Jars

ANTIQUE drug jars with their pleasing shapes and attractive blue designs are probably the historical medical objects of most interest to collectors.

The College is fortunate enough to possess two such jars which were presented to the Museum by Dr John Horder, a past president. Dr Horder was given the jars over 20 years ago by a patient who was a director of Sotheby's.

Dr Roger Price, a curator at the Wellcome Museum, said: "There is now strong competition for buying these jars. Retired general practitioners especially seem to like to collect them."

"Apothecaries often commissioned sets of vessels from potters solely with the intention of impressing their customers.""

Dr Price dated the College's jars as being English and belonging to the early eighteenth century. He said that glazed earthenware drug jars, commonly known as delftware, with their familiar blue painted decorations on a white background, did not make their appearance until the middle of the seventeenth century. He added that they had most probably been made at the Lambeth pottery centre in London.

He said that after making and firing the pots they were cooled and then dipped in oxides of tin to produce the white background. The blue used for decoration was prepared from cobalt salts and after the design had been painted the pots were fired for a second time.

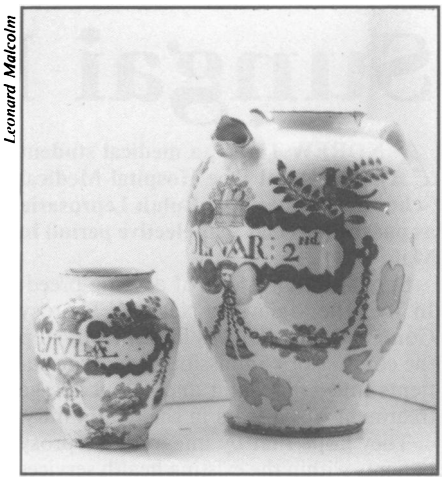
The shape and size of the jars varied in accordance with the user's requirements and the vessels were often closed with parchment membrane or wax seals to guard against the evaporation of volatile substances.

The College pots are of the 'songbird' design. The picture depicts a basket of fruit placed above the label and birds facing outwards perch on top of each end of the panel. Under the panel is an angel (sometimes called a cherub) with outstretched wings and, suspended from its mouth, a tassel. Tassels are also suspended from the ends of the label panel while decorative loops link the ends to the centre.

The smaller jar is labelled as containing a conserve of Luiula or wood-sorrel. According to the *New London Dispensatory,* published in 1682, the cordial of 'juyce' of wood-sorrel "Cools fevers, quenches thirst, and stops vomiting, being also a great Friend to the Liver."

The larger jar is inscribed with the words "O. Olivar 2nd", which Dr Price said most probably referred to the second pressing of olive oil that was often used by apothecaries to prepare medicines. The remains of the olives that have been pressed to provide the finest quality olive oil are mixed with hot water and pressed again to give a second quality of oil. If

Leonard Malcolm



the residue is allowed to fermit it can yield a third or even a fourth quality of oil.

Dr Price said that such olive oil jars were quite rare and that even the Wellcome Museum with its large collection of drug jars did not own one like this.

"We should not assume that simply because a drug jar bears the name of a drug that it contained or was ever intended to contain that drug. Apothecaries often commissioned sets of vessels from potters solely with the intention of impressing their customers. They did not necessarily keep on hand all the drugs for which they had jars," said Dr Price.

Tin-glazed earthenware drug jars continued to be manufactured until the end of the eighteenth century when they began to be replaced by the more prosaic creamware vessels which were generally without decoration. □

Janet Fricker

British Geriatric Society Honours GP

DR Keith Thompson, a general practitioner pioneer in the development of geriatric medicine, had been invited among the first to be placed on the British Geriatric Society's Archive of those who have made an outstanding contribution to geriatric medicine.

The British Geriatric Society plans to keep the information on file to use in future publications about their history.

Dr Thompson chose to study geriatrics in general practice, despite the offer of a hospital consultant's post.

"94 per cent of elderly people live in the community and I preferred to work with them rather than with people who only formed a community because they were ill," said Dr Thompson.

In 1984 Dr Thompson was instrumental in the setting up of a diploma in Geriatric Medicine, which he then examined.

In an article in the December issue of the *Journal of the Royal Society of Medicine* Dr Thompson said that the time had come for a complete change in general practitioner education. He feels that after nine years in hospitals the trainee year comes too late to achieve "the reconceptualization that is required". He recommends that instead of students spending their time studying in hospitals those opting for general practice should enter it after a basic first year.

Dr Thompson has written articles and books and been involved in the making of a video. His publications include *The Care of the Elderly in General Practice and Caring for an Elderly Relative.* He was awarded the 1986 Ian Stokoe Award by the Scottish Council of the RCGP for original work done in the context of general practice, with specific emphasis on the quality of illustrations.

Dr Thompson, who retired this summer, plans to spend half the year living in his apartment in Sitio de Canahonda, Spain. He said that he intends to spend his time writing articles on geriatric medicine and giving lectures. □

NEW YEAR'S HONOURS

FOUR College members were named in the New Year's Honours Lists.

Dr Donald Irvine, immediate past chairman of Council, was awarded a CBE.

"I was delighted and particularly pleased for the College and my partners, the unsung heroes who kept things going while I was away," said Dr Irvine.

Professor Peter Higgins, the professor of general practice at Guy's Hospital Medical School, University of London, who set up the Thamesmead Health Centre becomes an OBE.

Dr Thomas Gardner, a former chairman of Cumbria's LMC, a former member of East Cumbria's Hospital Management committee and chair of his local BMA branch, becomes an MBE, as does Dr Donald Cameron, the Borders' representative on the Scottish General Medical Services Committee.

Our congratulations go to them all. □

Sungai Buluh Leprosaria

ANDREW Tinker, a medical student at the Royal Free Hospital Medical School, visited Sungai Buluh Leprosaria as part of his final year elective period in Malaysia.

Sungai Buluh is one of a dying breed. In 1969 the Malaysian National Leprosy Control Campaign was launched to stop the compulsory admission of leprosy patients into Leprosaria and to encourage treatment of patients in the community.

They hope that by integrating leprosy patients within the existing health services they will break the barrier which has separated victims from the general public and so ease the problem of rehabilitation.

Leprosy has always been greatly feared. In the past it was considered a dreadful and highly infectious disease which caused progressive and severe deformity to the sufferer. Victims had to be segregated in the Leprosaria for prolonged periods without any hope of being discharged and accepted back into society. Tragically the stigma of the disease meant that patients, once admitted were unable to leave the Leprosaria.

Research has since proven that leprosy is only slightly contagious and easily cured. Deformity can be prevented if treatment is given early enough and the patient can be rendered noninfectious within two weeks.

The National Leprosy Control Programme aims to control the incidence of the disease and treat the 'human reservoir of infection' in the community. In rural Malaysia the programme moved the treatment of leprosy away from the Leprosaria and into the primary care setting of local health centres and small hospitals. The combination of specially trained paramedics and nurses and follow up of cases and contacts has led to a steady decline in the incidence of leprosy. Now less than one sixth of all cases are treated in institutions.

Sungai Buluh, the only remaining Leprosaria in Malaysia, is fascinating to visit. It has a worldwide reputation for leprosy research and is the only referral hospital in Malaysia for the treatment of difficult cases. Sungai Buluh coordinates the National Leprosy control programme and all field workers are sent there for training.

The centre, which is surrounded by jungle, covers over 500 acres and includes a palm oil production plant and a rubber plantation, both of which are worked by patients.

A settlement of over 1000 leprosy patients remain. They are longstay institutionalized patients who can no longer cope with the world outside. Their tragedy is that they were often admitted for reasons as trivial as a foot ulcer. They seem somehow reminiscent of psychiatric patients in the UK.

Most of the arable land surrounding the settlement is farmed by the patients. They live in small chalets and supplement their incomes by growing flowers and produce on small plots of land. The settlement is a self contained village with its own school, village hall and cinema. At one time the fear of catching the disease was so great that the Leprosaria had to coin its own currency. Examples of this are still on display in the museum.

Staffing remains a problem, and at least half the nurses are leprosy patients. Even medical people with their inside knowledge are prejudiced against lepers.

I was shocked by the deformity that the ravages of leprosy can bring. But even more striking was the settlement itself. Its bricks and mortar are a testament to prejudice and ignorance. In some ways it echoes the hysteria now surrounding AIDS. The disease confronting the West may be different but the human prejudice seems the same. □

Sungai Buluh

Culpeper microscope

Sir,

I read with considerable pleasure the article on my grandfather's Culpeper microscope. Like all of us, he had his faults, but above all he was an incredibly able self-taught scientist. The coal owners of County Durham made use of his geological expertise to solve some of their mining problems. At 92 he gave a lecture in Gloucester. Some 25 years later a geologist referring to this talk, stated that it had made them rethink the geology of the area. The Culpeper microscope may have been his first instrument of that kind. In 1873 he attended a course for science teachers organized by Thomas Huxley. Over 400 students applied to go on the course, but only 136 were accepted. My grandfather was one of the top two members of the course and for this he was awarded a modern compound microscope which is one of my prized possessions. He made good use of the instrument, studying foraminiferae and pollen grains. In 1895 he published a paper on the latter with over 400 drawings of pollen. I submitted this article to Professor Anne Tutin, who is a world authority on the subject and she told me he was an original investigator and ahead of his time. His diagrams of pollen grains were very accurate indeed. I feel that these achievements far outweigh any of his eccentricities.

Arthur Watts

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GP ROOTS

IN his new book *Medical Care and the General Practitioner 1750-1850,* Irvine Loudon gives a fascinating account of the daily lives of the surgeon-apothecaries of the eighteenth century and the general practitioners of the early nineteenth century. Until now histories of the medical profession have tended to neglect the rank and file practitioners, concentrating on the minority of famous doctors and their discoveries, but at last this account helps redress the balance.

The term 'general practitioner' came into common usage in the second and third decades of the nineteenth century, but it was initially confined to the medical profession and novels in the 1850s still referred to family doctors as 'apothecaries' or 'surgeons'.

The book covers the transition period in which the rank and file practitioners advanced from positions of tradesmen to membership of a unified profession. In the eighteenth century there was no system of formal education, registration and licensing and no real dividing lines existed to distinguish the trained and honest doctor from the untrained fraudulent quack. Some doctors held University degrees or were members of the Company of Surgeons (the predecessor to the Royal College of Surgeons), others had served full apprenticeships, but there were those who had started out as grocers selling drugs as a sideline and then simply changed the board over their door to 'surgeon' or 'apothecary'.

Loudon, a fellow of the Oxford Wellcome History of Medicine Unit, says that in the eighteenth century the typical surgeon-apothecary was a grammar school boy who had left school between the age of 12 and 15, with a smattering of Latin and Greek, to become an apprentice. From the mid eighteenth century increasing numbers proceeded to further medical education which often included a year at a provincial hospital as a pupil of one of the surgeons, followed by a year in London attending lectures and 'walking the wards'. There was however still no official syllabus or examination.

"There were those who had started out as grocers selling drugs as a sideline and then simply changed the board over their door to 'surgeon' or 'apothecary' ".

Tyrannical masters often shamelessly exploited their apprentices. The common image of the medical apprentice was of a downtrodden aproned lad whose life was spent endlessly washing bottles and making up medicines. In William Chamberlaine's account of apprenticeship in 1813, *Dissertation on the Duties of Youth apprenticed to the Medical Profession,* he says that the apprentice was placed in a delicate position somewhere between that of family and servant. At night he was not supposed to sit sociably with the family, but he was at all costs to keep out of the kitchen.

Provincial practitioners like Edward Jenner, famous for developing the smallpox vaccine, were able to raise themselves to the status of physicians through the MDs of Aberdeen or St Andrews without ever setting foot in Scotland. All that was required for the MD to come back through the post was a modest fee and a recommendation by two colleagues.

By the end of the eighteenth century the expansion of hospitals had helped the image of medicine to improve and parents were increasingly tempted to put their sons through a comprehensive training. A new breed of medical students evolved who were as proud of being a 'Guy's' or a 'Thomas's' man as subalterns were of being in the Guards or undergraduates at 'Balliol'.

The 1815 Apothecaries Act helped reform the medical profession by setting up a Court of Examiners to consider candidates for the Society's licence. Candidates had to be 20, to have served a minimum of five years as an apothecary's apprentice and to produce testimonials proving they had received a 'sufficient' medical education.

The Act made the career so popular that by the 1830s medicine had become a grossly overcrowded profession. By the 1840s an all time peak of the ratio of general practitioners to population was reached. Competition for jobs became intense, fees for treatment were drastically reduced and many general practitioners were forced to take on poorly paid jobs such as poor-law medical officers or medical officers to factories or mines. Employers and poor-law authorities exploited the situation by lowering medical fees and playing off candidates against each other for posts.

Unlike their rivals, the physicians and surgeons, the general practitioners of the 1830s and 1840s were actuely aware that they had no official body representing them. In the 1840s an attempt to establish a College of General Practitioners nearly succeeded, but was vetoed at the last minute by the Royal College of Surgeons who feared a loss of prestige and examination fees if the plan succeeded.

"The common image of the medical apprentice was of a downtrodden aproned lad whose life was spent endlessly washing bottles and making up medicines."

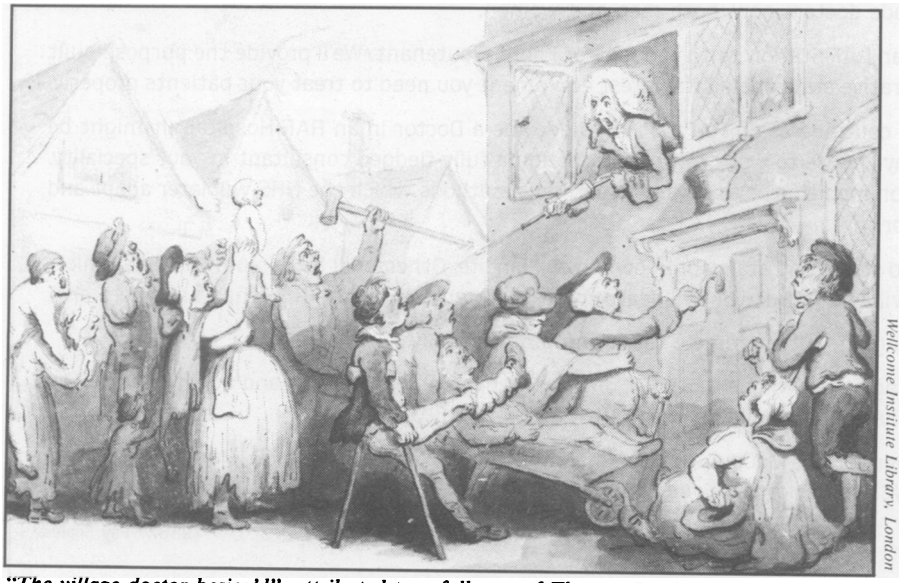
The position of general practice within the medical profession became clearer during the second half of the nineteenth century when physicians and surgeons were increasingly perceived as consultants and specialists. Before 1850, with the exception of a minority in London, surgeons and physicians did not practice in the modern sense as specialists or consultants. Doctors who specialized were looked down on by their colleagues who saw them as men who had failed in the fields of physic or surgery and had been forced to set up as specialists to attract business. From 1820 to 1850 general practitioners were much admired for the quality and breadth of their education.

Loudon believes that the structure of medicine in Britain today was not the logical result of advances in scientific medicine in the nineteenth century, but the outcome of an intense intra-professional struggle for patients, prestige and power.

Loudon said: "It was the struggle of general practitioners not only against the diseases for which they had so few remedies, but against each other, against the irregular practitioners or 'quacks', and above all against their bitter rivals the physicians and surgeons, which makes this such an interesting period in the history of general practice." □

Medical Care and the General Practitioner, by Irvine Loudon is published by the Clarendon Press and costs £27.50.

Janet Fricker



Wellcome Institute Library, London

"The village doctor besieg'd"; attributed to a follower of Thomas Rowlandson.

Library Acquisitions

THE following are some recent acquisitions to the College's Geoffrey Evans Library.

AGE CONCERN
The Law and Vulnerable Elderly People. Surrey: Age Concern, 1986.

ASGARD PUBLISHING COMPANY
1986/87 Handbook of Community Nursing. Petersfield (Hants): Asgard, 1986.

BEIGHTON P. and BEIGHTON G.
The Man Behind the Syndrome. Berlin etc: Springer Verlag, 1986.

BRODIE M.J. and HARRISON I.
Practical Prescribing. Edinburgh etc: Churchill Livingstone, 1986.

BROOKS D. and DUNBAR E.M.
Infectious Diseases. Lancaster etc: MTP Press, 1986.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Neighbourhood nursing - a Focus for Care. Report of the Community Nursing Review (Chairperson: J. Cumberlege). London: HMSO, 1986.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Primary Health Care: an Agenda for Discussion (Cmnd 9771). London: HMSO, 1986.

DRURY M. and COLLIN M.
The Medical Secretary's and Receptionist's Handbook. Eastbourne: Bailliere Tindall, 1986.

FRANCE R. and ROBSON M.
Behaviour Therapy in Primary Care: a Practical Guide. London and Sydney: Croom Helm, 1986.

FRY J., GODFREY M. and PRICHARD B.
Prescribing - What, When and Why? Edinburgh etc: Churchill Livingstone, 1986.

FRY J. and HASLER J.C.
Primary Health Care 2000. Edinburgh etc: Churchill Livingstone, 1986.

MARTIN A. and GAMBRILL E.
Geriatrics. Lancaster etc: MTP Press, 1986.

MAYNARD A. and BOSANQUET N.
Public Expenditure on the NHS: Recent Trends and Future Problems. Institute of Health Services Management, 1986.

PIETRONI P.
Holistic Living: a guide to self-care. London: Dent, 1986.

SHEFFIELD HEALTH AUTHORITY
Health Care and Disease: a Profile of Sheffield. Sheffield: Sheffield Health Authority, 1986.

SPILLING R. (ed)
Terminal Care at Home. Oxford etc: OUP, 1986.

STREET S.H. and BURCH K.W.
Essential Primary Care. Oxford: Blackwell Scientific, 1986.

TUCKETT D. et al.
Meetings Between Experts. London: Tavistock, 1986.

TURNER R.M. and WILLIAMS P.
Psychosocial Disorders. Lancaster etc: MTP Press, 1986.

WALTON J.
Partnership or Prejudice. London: Nuffield Provincial Hospitals Trust, 1986.

WHARTON C.F.P. and ARCHER A.R.
Cardiology. Lancaster etc: MTP Press, 1986.