NEWS

Honorary Editor: Dr Edwin Martin
Editor: Janet Fricker

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COUNCIL

A SPECIAL meeting of Council was held at Princes Gate at 10.30 am on February 10 following the resignation of the chairman of Council, Dr John Hasler.

The president, Professor Michael Drury, took the chair. He reported that Dr John Hasler had resigned not only from the chairmanship of Council, but also from membership of Council and its committees. Council paid tribute to the many years of service Dr Hasler had given to the College and Dr John Toby, the convenor of the Board of Examiners, reported a tribute from the Panel of Examiners.

Professor Drury then made a statement about events prior to Dr Hasler's resignation. He reminded members that at the November Annual General Meeting a motion was put forward censoring the chairman and officers of Council. After discussions a modified motion was passed, but this failed to resolve the issues. After the AGM many members and fellows communicated their unhappiness to the president and many felt that the dissatisfaction in the College had increased rather than decreased. At this stage the Presidential Working Party, which had been set up to examine the relationship between the examiners and the Council and to look at the future development of the examination, was asked to widen its remit to look at the problems that had occurred between the Board of Examiners and the College Council. During the early part of 1987 Dr Hasler and the General Purposes Committee felt that as things stood it was difficult to make any progress in the difficult tasks that faced the College, and Dr Hasler resigned.

During the discussion which followed Council considered the issues which had led to the recent problems. It was felt that lessons about communication had to be learned. Many members expressed their thanks to the president for the role he has played in troubled times.

Nominations for the post of chairman were requested. Professor Denis Pereira Gray was nominated by Dr Colin Waine and seconded by Dr Robin Steel. There were no other nominations. Professor Pereira Gray was elected and welcomed as chairman of Council.

Following his election Professor Pereira Gray spoke of the contribution Dr Hasler has made to general practice in this country. He reminded members that Dr Hasler is a leading regional adviser, that he was College secretary for five years, vice-chairman for one year and chairman for just over a year. He pointed out that with Dr Hasler's many qualities he will have much to give general practice in the future.

Professor Pereira Gray said that the College had been through a 'constitutional crisis' and that the College had collective responsibility to try and sort it out. He urged members of Council to bring their listening and learning skills into their work at the College because such talents were needed above all by those who held responsibility within the College. Professor Pereira Gray said that he would always be available to listen and asked members to telephone him about any issues of importance. He said that there was a lot of work to be done, but that he was confident that the College would work together in the future. □

Edwin Martin

FOR YOUR DIARY

PRESIDENT'S SUMMER PARTY

Tuesday 21 July 1987
7 for 7.30 pm

Exhibition, Music and Food

Tickets £10 each from Margaret Burtt at the College, 14 Princes Gate, London SW7 1PU. Tel: 01 581 3232 ext. 204.

Cervical smears

THE National Federation of Women's Institutes has just published a survey to determine the extent of their members' knowledge of cervical screening and their views.

They are concerned that 65 per cent of the women replying said that their doctor had never suggested a smear test, that 68 per cent had never received any form of reminder and that results are not automatically made available. They are now asking all members who are or ever have been sexually active to make sure they have regular tests continuing until their 60s.

The survey proved so popular that replies were received from over 9,500 women despite only 9,200 questionnaires being sent out. The majority of the women were over 40 which is particularly helpful because one of the problems of screening programmes has been an inability to attract women in the higher age groups. The reasons women gave for not attending were embarrassment about internal examinations, fears of the results and not wanting to visit a male doctor.

The Federation is asking general practitioners to recommend smear tests to all female patients, to talk over their fears with them and to be straightforward about the results.

They are saying that general practitioners should recognize that when female patients prefer to see a woman doctor this is not an adverse comment on the skill or competence of male doctors, but a way of reducing their embarrassment. They believe that it is important for the cooperation and communication between medical and lay people to become more effective because the greater the knowledge the women acquire, the better equipped they will be to play a positive role in their own health care.

In response to the survey the RCGP commented: "There is much more to be done here in educating women about the test itself so that they can be less anxious about it." □

Neighbourhood Nursing

IN its response to *Neighbourhood Nursing — A Focus for Care,* the College told the government that it believed the report's suggestions for neighbourhood nursing would impede the future development of practice based teams.

The RCGP believes that zoning nursing goes against the government's aim of giving people the widest possible choice of primary care services. Neighbourhood nursing would limit patient choice since the source of service would be determined primarily by where a person lived rather than by consumer preference. Doctors and nurses working to two different populations would cause confusion and only lead to duplications or omissions. The present system of patients registering with a named practitioner provides a logical basis for monitoring health problems in defined populations, for planning services to patients, and in evaluating performance and uptake of services.

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There is concern that the contribution made by practice nurses has not been properly acknowledged or understood in the Cumberlege report. The College wants to encourage its members as employers to make increased provision for the education of practice nurses both before employment and through inservice training both in the practice and on courses. The attendance of practice nurses on courses is at present hindered by the provisions for the reimbursement of the costs of the training of employed staff in the Statement of Fees and Allowances for General Medical Practitioners. The College believes that further development of the role of practice nurses is central to the future of primary care and it looks forward to appropriately trained practice nurses acquiring increased responsibility and clinical independence without supervision by nurse managers who are based outside the practice and may not have experience of practical nursing.

The College thinks the roles and responsibilities of nurse practitioners have not been defined clearly enough and that there is an overlap with the role of practice nurses. In any event the College believes that nurse practitioners should work as members of the primary care team and not in isolation from other professionals working in the community.

The College says that the only way to provide satisfactory primary care services is through the multidisciplinary primary health care team. There is a need for greater recognition of the importance of the team and for wider flexibility of the range of professions in it. The College believes that only a team approach would make it possible to extend the nurse's responsibilities so that they could prescribe from a limited range of items and use their professional judgement to alter the timing and dosage of drugs prescribed by doctors.

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It is thought that it would be inappropriate for specialist nurses working in the community to be accountable to hospital based nurse managers and to respond to hospital based specialists. Specialist nurses, such as stoma care nurses, should work closely with community nurses in advisory capacities. Any medical problems that community nurses encounter with individual patients should be referred to that person's own general practitioner for advice and management.

The College supported the Community Nursing Review's proposal for the introduction of a common training course for all first level nurses working outside hospitals. They also supported the need for local consumers to contribute their views on health needs and on health planning and agreed with the recommendation that team members should try to understand each other's roles more clearly and work together to agree and monitor the care they offer. □

Janet Fricker

New Research Posts

LIVERPOOL have just launched the country's first paid part-time research posts in a university department of general practice.

Five general practitioners are being sponsored by Stuart Pharmaceuticals to work approximately two sessions a week at the university department with the possibility of having their research accepted for an MSc degree. The new Stuart Research Associates' backgrounds range from those who have had no previous research experience to those who require extra funds to complete projects.

The topics being covered include information technology, the diabetic patient and the psychological health of mothers in pregnancy and puerperium. But they have only a year to demonstrate the potential of their work after which they will have to apply in open competition to renew their bursaries.

At the launch in January Professor Ian Stanley, head of Liverpool's department of general practice, emphasized the importance of counterbalancing university research with research in general practice.

The newly appointed Stuart Research Associates. From left to right: Dr James Read, Dr Clare Connolly, Dr Peter Elliott and Dr Neil Westhead. The fifth Associate, Dr Paul Bradley is not shown in the picture.

"Part of the credibility gap has come about because of the nature of research pursued by academic departments which are seen by many as ivory towers. We need to counterbalance this with vigorous research based in general practice addressing the 'real world problems'. But general practitioners have either to take time out of practice to pursue research or use their own free time."

He said that he was hopeful that the new approach might be the start of a different way of doing things, but added that in order for general practice recruits to fulfill their promise they needed protected space and time with easy access to computer terminals, libraries and word processors.

Professor John Bain, chairman of the College's Research Division, added his support to the project.

"There's always been a tendency for the pharmaceutical industry to give money to projects they'd have liked to carry out, but what is nice about these bursaries is that individual doctors can develop ideas in their own practices with no strings attached." □

Breaking the Sound Barrier

A plea has been made for family doctors to do more for older patients suffering from hearing loss.

IN February a pack specially designed to draw the attention of general practitioners to the need to identify elderly people with hearing problems was launched jointly by The Royal National Institute for the Deaf, Age Concern England and The British Association of the Hard of Hearing. The pack *Breaking the Sound Barrier* stresses that much can be done by general practitioners and that the earlier a patient with a hearing impairment is referred and properly fitted with an aid the better the chance of success.

The general practitioner is often the first point of contact for the deaf person and if they do not react sympathetically the patient will often get no further. They say that all too often doctors come up with patronizing statements like 'Well what do you expect at your age?'

With five million people in the country having some sort of hearing loss they are saying that general practitioners should be routinely screening patients for hearing. Dr Andrew Harris, the general practice adviser to the RNID campaign, believes that opportunistic screening is the answer to getting patients referred earlier. The advantages are that it is quick, cheap and reaches the group most at risk. Dr Harris says that general practitioners should take histories including such questions as: Do you want the television louder than your wife? Are there any difficulties with conversations at home? Do you always hear the door bell? Can you hear the telephone bell ring? Do you have problems hearing at meetings?

With five million people in the country having some sort of hearing loss general practitioners should be routinely screening patients for hearing.

Doctors are also being urged to ensure that receptionists are aware of the problems caused by hearing loss. Patients often wait for longer than is necessary simply because they are unable to hear their names called out. Doctors can easily ensure that patients with hearing problems are identified by marking their case notes prominently.

Another problem is that the waiting lists for ENT hospital appointments can take anything up to two years.

"For an old person of 75 this is too long because they may not be around by the time their appointment comes up," said Mr Mike Whitlam, the chief executive of RNID. One solution might be accelerated referral cutting out consultants and going straight to the audiologist. The technician would be able to identify conditions requiring medical attention and to refer these patients to the consultants.

Mr Jonathan Hazel, a neuro-otologist at University College Hospital, said that there are at present only about 40 hearing therapists in the country concerned with auditory rehabilitation and to have any real effect the number would need to be increased ten-fold. They teach the manoeuvre of getting the mould into the ear, lip reading and the use of environmental aids. He believes that fitting the hearing aid and not properly counselling the patient can lead to aids being taken home and left in a drawer.

The pack contains an information sheet on the elderly and hard of hearing campaign leaflets, a fact sheet on tinnitus, stickers to go on hearing impaired patients' records and a poster. It also includes a competition with prizes of a mains operated screening audiometer, a pocket audiometer and an otoscope for the first three correct solutions drawn on May 1 1987.

There are at present only about 40 hearing therapists in the country concerned with auditory rehabilitation and to have any real effect the number would need to be increased ten-fold.

The packs are being distributed to general practitioners through most FPCs, and those whose FPCs are not taking part in the campaign can obtain a free pack by writing to Mrs Anne Clark at the Royal National Institute for the Deaf, 105 Gower Street, London WC1E 6AH. They should enclose an A4 envelope with a 32p stamp. □

Janet Fricker

Interview with new Chairman

PROFESSOR Denis Pereira Gray, the new chairman of the RCGP Council, says that his first priority in the post will be to listen, learn and try to understand the feelings of every body involved with the College.

Professor Pereira Gray comes from a medical background: his grandfather, father and uncle were all general practitioners in the Exeter area.

"I grew up in a doctor's family and saw the system from the inside. My parents had the usual set-up of a doctor working with his wife. My mother organized everything and gave up a large part of her life to the practice."

Before joining his father's practice in Exeter he studied at St John's College, Cambridge and Barts. He still works from the room below which he was born. The practice has grown and now has four partners serving 7,000 patients.

"It is fairly typical of a city practice in a provincial town, but what is particularly nice is that many of the patients have been with us for three or four generations and we know them as families."

When Professor Pereira Gray became an Associate of the College in 1962 it was just ten years old, and still thought unusual for general practitioners to be involved with it. He became a full member in 1967.

"I decided to join when I got hold of a copy of the Journal and discovered that it was a lifeline of ideas about making general practice better."

He remembers the early sixties being 'terrible times' for general practice and that there was doubt whether it would even survive.

"Morale was low, hundreds of doctors were emigrating and there was a crisis of confidence. At that time the College stood out as a beacon being one of the few bodies making a serious attempt to believe in general practice and improve standards."

Professor Pereira Gray remembered that people in the South West England faculty were very encouraging to young general practitioners and that the leaders at Princes Gate went out of their way to inspire them. He has always been interested in the younger members and says that he hopes that a caring College will encourage them to play a part in the College as an organization. It was under his chairmanship that the Communications Division introduced the Young Principals and Trainee Group, which was intended to encourage young principals to become involved with the College.

Professor Pereira Gray has always been interested in writing and editing and from 1972 to 1980 he was honorary editor of the College Journal.

In the early days he had to do all the copy preparation, proof reading, coordinating publishers and authors, gathering news and correspondence on his own in his spare time and even had to handle the proofs from a holiday cottage which he and his family rented in Cornwall.

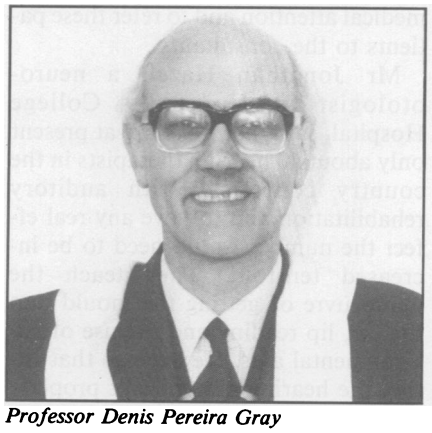
"My weekends were very full, but the mid 70s were a time of great expansion, development and optimism and it was exciting to report and chart the events as they happened."

Great headway was made in 1972 when the first English chair in general practice was created at Manchester University and in 1976 the Vocational Training Act was passed requiring all new general practitioners to undertake vocational training. This was fully implemented in 1981.

In 1976 his wife Jill was appointed assistant editor to help him. Before her marriage Mrs Pereira Gray, who has an English degree, had done editorial work for the National Union of Teachers and the Royal National Institute for the Blind where she helped with the house journals. She also edited journals for transcription into braille and was ironically unable to read what she produced.

Dr Simon Barley was appointed editor of the Journal in 1980, but at the last moment the College decided to keep the publications side in Exeter.

"There was a lot of logic in splitting because it was all getting a bit much for one person," said Professor Pereira Gray.



Dan Crowley

Professor Denis Pereira Gray

Under the guidance of Professor Pereira Gray the Exeter Publications Office has expanded rapidly. Seeing the need for a series of publications which were too long to be articles and too short to be books he started the *Occasional Papers* in 1976. There are now 35 in the series. Other ventures include *Reports from General Practice,* the *College Policy Statements* which refer to major issues of policy that have been formally approved by the Council of the College, the *Members' Reference Book* and full length books.

"We have now gone full cycle and got into complete book publishing with a small but steady stream of these books."

He recognizes that with the new appointment he is going to have to substantially reduce the time he spends in the Publications Office.

"I hope that we can find some way of keeping the show on the road without my having to put in so much time."

Professor Pereira Gray was the first chairman of the Communications Division and has won many awards including the Gold Medal of the Hunterian Society twice, the George Abercrombie Award for literature in 1978 and the 1980 Foundation Council Award. In 1977 he gave the James Mackenzie lecture stressing the importance of home visits. He is also regional adviser for the South Western Region, consultant adviser in general practice to Sir Donald Acheson and last October he became the country's first postgraduate professor of general practice when he took up a personal chair at the University of Exeter. In April, on the retirement of Professor David Mattingly, he takes up the appointment of head of Exeter's Postgraduate Medical School.

When asked how he manages to fit everything in Professor Pereira Gray said: "I enjoy work and what is work and what is a hobby run into each other because they are all to do with general practice in one form or another. Fortunately things overlap and you can get the same document wearing different hats, but I would like 24 more hours in the day."

Professor Pereira Gray said that his appointment as chairman of the College Council came very suddenly.

"It is a tremendous privilege to be asked to do this job at a time like this and it is obviously a very considerable responsibility." □

Janet Fricker

Membership Division's new Chairman

THE new chairman of the Membership Division, Dr John Ferguson, sees his role as helping to rebuild the confidence of the examiners to develop the examination.

Dr Ferguson, who is himself an examiner, believes that the fact that seven examiners are now on the Membership Division Executive and that the convenor of the panel of examiners is an observer on Council can only act to strengthen and improve communication between examiners and central College.

"We have all got to learn from the problems that have occurred in the last few years. The examination is not a static thing, it's dynamic and needs to be resourced, improved and developed," he said.

There is now provision in the division's budget to employ someone to do research on the development of the examination.

One important project that Membership Division is involved with is the working party on fellowship by assessment. Tamar, Beds and Herts, South East Thames, and North West England are at present testing the draft protocol to see if the College can find an improved method of assessing members for fellowship.

Dr Ferguson is a senior lecturer at Edinburgh University, and a principal and trainer in a practice that is entirely staffed by members of the department of general practice.

He says that he is more interested in teaching than research, but that clinical audit and developments in education are his special areas. This was not always the case. Dr Ferguson started out studying physiology at St Andrews, but his professor recommended that he should change to medicine.

"It was the best piece of advice I've ever been given. My real interests lie more on the clinical side than the academic. General practice is a rewarding career because you're dealing with people on a continuous basis and learning what makes them tick."

The department at Edinburgh has recently been involved in a project to help doctors from Saudi Arabia and Kuwait to understand the British system of general practice. In Kuwait they are developing a form of general practice similar to that in Britain, but in Saudi each individual

Dan Crowley

Dr John Ferguson

ministry has developed its own health service to deal with employees and their dependants. Last summer an Arab primary care physician from the Military hospital in Riyadh, who had never worked in the NHS, passed the College's examination.

"Perhaps his example will lead to a few more Arab doctors using the MRCGP examination as an end point in training."

When I spoke to Dr Ferguson he had just returned from three weeks holiday in Hong Kong where he had been standing in for an army practitioner and helping serving doctors prepare for the MRCGP examination. He is a lieutenant colonel in the territorial army and in his spare time commands a field surgical team based in Aldershot. □

Winter's Tale

Margaret Hammond, the Stuart librarian, describes her first practice visit.

MY first official Stuart Librarian visit in January happened to coincide with the winter freeze. Dr Douglas Garvie invited me up to Stoke on Trent to look at the library at his practice. I was interested to visit the practice and to see how a part-time professional librarian organized her time and stock.

At first the snow appeared minimal and I was just thinking how quick the journey from Euston to Stoke was compared to my daily journey across London, when the train stopped. We sat for an hour, then crawled into a siding at Rugby Station, crawled out then in again and out like a yoyo. By this time people were talking to one another and a general air of bonhommie spread over the compartment, aided by the fact that the buffet had run out of everything except alcohol. A defective carriage removed, we sped on and arrived at Stoke two and three quarter hours late. But my hosts were waiting and the warmth of their welcome made up for the coldness of the carriage.

I spent the following morning with Mrs

Betty Bell, the practice librarian who works two hours every second week. The library was small, about 200 books, a dozen periodicals and various pamphlets and reference books. I couldn't fault the organization, but the basic setting up had taken 60 hours which might prove difficult to organize in other practices.

Later I looked round the general practice section at North Staffordshire Medical Institute's Library. I think that it is very important for general practitioners to turn first to their local libraries for help and advice. Many postgraduate medical libraries produce 'lists of recent additions', or 'periodical holding lists' which are available to general practitioners. The Institute library produces a daily press cutting service of topical items copied from the main national newspapers. The service is available to local general practitioners, as well as the usual services of loans, photocopies and on-line searches.

I left the Institute library at lunch time and caught a train to Birmingham. In view of the blizzard conditions I wondered if I was being too optimistic in pursuing my plan of visiting the Barnes Library. However, I continued and plodded up the hill through quite thick snow to the university. Stan Jenkins was waiting for me. For a number of years he has been involved in speaking to groups of general practice trainers about setting up practice libraries. I had a lightning tour of the library and set off for my return to London.

The day had been very interesting. I believe that the Stoke practice library is successful because they have made one person responsible for looking after the collection. It is a bonus if the librarian has professional training but unless the work involved in the care of the library is identified as one person's job, the library will fail to realize its potential. □

Medicine Chests

THE College Museum contains an extensive collection of eighteenth and nineteenth century medicine chests of all shapes and sizes.

The earliest medicine chests were probably those used by army surgeons in the time of Elizabeth I, but massed produced chests for private households and travellers didn't really become popular until the last few decades of the eighteenth century. At a time when doctors were scarce, roads poor and transport slow medicine chests rapidly became an essential part of a gentleman's home.

Medicine chests, with their thinly partitioned pigeon-holes containing handmade stoppered glass bottles and finely dovetailed drawers for accessories, demanded fine craftsmanship. They were made by the same cabinet makers who produced portable writing desks, dressing tables and tea caddies. Mahogany was the most popular wood, although some chests exist with veneered satinwood or rosewood to match home decors.

There are two distinct designs of medicine chests. They can either open from the front in a cupboard-like fashion with racks of bottles inside the doors as well as in the main section, or they are fitted with a lifting lid as in a trunk with drawers beneath the main compartment containing accessories in fitted trays and boxes. Accessories included a mortar and pestle for grinding and pounding the ingredients, hand-held scales with brass pans and a set of apothecaries weights, and pill making equipment. Medicine chests equipped with leech cages and leech tubes were not uncommon, suggesting that people may well have been applying leeches without medical advice.

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Heads of households were often reminded of the importance of having remedies available in the home. There was great emphasis on chalk anti-diarrhoeal preparations reflecting people's concern about gastro-intestinal problems among which cholera was a frightening example. Fever remedies were also necessary for until well into the first half of the nineteenth century in addition to typhus and typhoid, malaria was rife in Britain. The only pain killer available was opium and most chests contained tincture of opium or laudanum.

Leonard Malcolm

Mahogany medicine chest donated to the College by Dr Philip Hopkins.

Fitted medicine chests often came with domestic remedy booklets giving details for diagnosing the sufferer's complaints, the names of preparations to use and the appropriate dosage. Some even gave information on first aid treatment for poisoning and on methods for resuscitation in cases of drowning. Some guide books were written specifically for clergymen who played a significant role in rural medical practice until well into the nineteenth century.

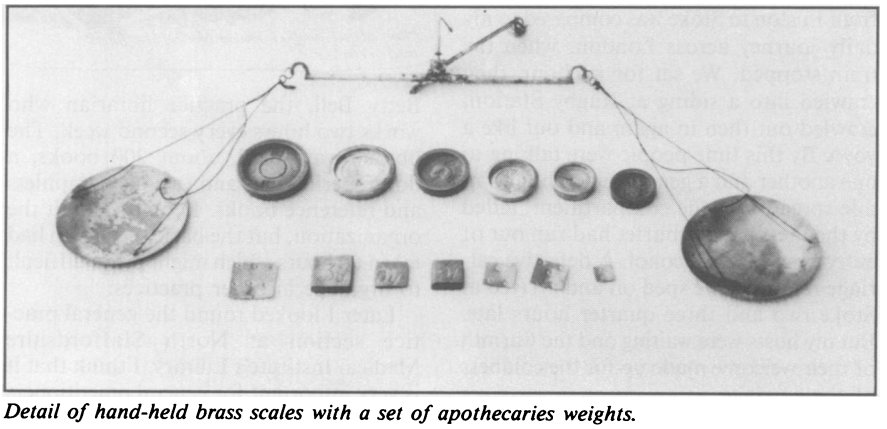
Dr Roy Porter, from the Wellcome Institute for the History of Medicine, believes that the expansion of professional medicine in the eighteenth century stimulated rather than suppressed lay medication. Doctors tended to favour the increased popularity of medicine chests because they felt that people who had some medical knowledge would be able to recognize when summoning of medical aid was vital. A William Buchan warned that people would only fall victim to 'cunning women, quacks and nostrummongers' if they were kept ignorant of medical matters.

After Hahnemann revived the doctrine of 'like cures like' a new homoepathic type of medicine chest was reproduced containing dozens of bottles of liquids or pilules in different dilutions. They had none of the apparatus found in the orthodox chests, merely a bent glass rod for dropping the tinctures or a small metal scoop for measuring out pills.

But towards the end of the nineteenth century discoveries were being made into the cause of disease which led to the development of specific treatments for a range of illnesses. Drugs were manufactured in tablet form and there was no longer a need for families to keep chests of substances from which symptomatic remedies could be prepared. □

Janet Fricker

Leonard Malcolm



Detail of hand-held brass scales with a set of apothecaries weights.

Management in Practice

IN the last 30 years general practice has moved from single-handed to group practices and the emphasis has shifted from a doctor-led hierarchy to the team concept of organization.

Such dramatic changes have led to the trend of doctors delegating more tasks to their staff and growing recognition of the need for management skills.

To meet this need the College launched its *Management Appreciation Programme* in January 1986 for general practitioners and senior practice staff to come together and learn the fundamentals of management. The course has proved immensely popular and so far 230 people have benefitted from it.

They aim to change attitudes rather than teach specific skills and stress that management is neither a chore nor an erudite science. It is just a common sense way of simplifying the complex. Many people think management is to do with cold efficiency and counter to the concept of general practice as a caring profession, but the course demonstrates that in order to develop general practice needs a solid management basis.

"Management is not a mysterious black box of principles and it's up to the participants to take the array back from the College to their practices and try them on for size," said June Huntington, the course tutor who is also a fellow in Organizational and Professional Studies at the Kings Fund College.

Sally Irvine, the programme director, discovered that modern general management could help general practice when she joined the College as general administrator in 1983, and visited members' practices. What had started out as a purely fact-finding exercise soon extended to serious discussions about the difficulties of running a practice. Mrs Irvine, with her management consultancy background, quickly recognized the need to extend the awareness of the benefits that good management could bring to patient care.

People come on the course for a variety of reasons and from a wide range of practices from the single-handed to those with 14 partners or more.

"Most of the doctors come because they are wanting to focus on change and the College's Quality Initiative. They wish to provide better clinical care but are coming up against the barrier of getting staff to see their vision of general practice," said June Huntington.

The mix of doctors and practice managers on the course leads to a stimulating interchange of views and allows problems to be seen from different perspectives. The wide range of activities consisting of small group work, plenary sessions, films and discussions provides continuous interest throughout the course.

Sally Irvine (left) and June Huntington.

The first day concentrates on 'managing ourselves and others'. After an opening plenary on 'What is Management' participants learn about staff recruitment, are lectured on the purpose of a job description and then write one themselves. This exercise is designed to allow them to think through the job structure and then decide which characteristics are essential and which are only desirable. They then have the opportunity to practise mock interviews on guinea pigs who are real practice managers especially bought in. They subsequently discuss key principles in managing staff and managing an organization that is increasing in size and complexity.

The second day is about managing change. Amongst other things participants look at the external factors affecting general practice and the obstacles to adapting to meet these. On both days there is great emphasis on small group work because it provides peer group solutions rather than solutions imposed by the teachers and helps ensure that the less confident have the opportunity to talk about practice problems in relative privacy.

Everyone seems to get something out of the course. One practice manager even went as far as to say it had changed her life and a doctor said that it had had a significant effect on his development as a general practitioner. Participants are all given comprehensive study sheets to take away with them to help in day to day management.

"We hope course members will go away with enthusiasm, plenty of ideas and new approaches. At the end of the course we ask them to write down an action plan of a few ideas that they intend to carry out and six months later we follow this up and ask them how they've got on," said Sally Irvine.

If practices are still experiencing specific problems and need someone from outside to articulate them, Sally Irvine and June Huntingdon can visit to encourage the team to explore the problems among themselves and facilitate them to develop.

To complement the course the College, with the resources of the MSD Foundation, has produced *Management in Practice,* a video and accompanying course book which has been specifically designed for general practice and will be launched in April. It is the first College distance learning project that involves all members of the practice team in coming together and analysing their work. The purpose of the package, which has been created by Sally Irvine, June Huntington and Marshall Marinker, is to increase awareness in the primary care team of the practical applications and principles of management.

The course has proved so popular that an extra series is being arranged. The new course costs £175 for members and £200 for non members, including meals and accommodation at Princes Gate. Applications for places on the courses should be sent to Mary-Anne Piggott at the College. The proposed dates are August 7 and 8, August 21 and 22, October 2 and 3 and November 6 and 7. Early booking is advised. □

Janet Fricker

Art and Anatomy Revisited

by Anne Darlington

RENAISSANCE artists, such as Leonardo da Vinci, Michelangelo and Raphael are known to have dissected cadavers in order to further their knowledge of anatomy. Da Vinci became known as the 'artist-anatomist' who spearheaded a new creative approach to anatomy. He treated the human body as an instrument of movement that was governed by mechanical laws.

Sir Joshua Reynolds, in his first presidential address to the Academy in 1768, said that the academies of art on the continent did not teach the correct method of anatomical study. He stated that 'students never draw exactly from the living models which they have before them' and because of this, the drawings 'resemble the model only in attitude'. With this in mind, the choice of a medical practitioner who could combine professional expertise with an appreciation of the arts fell on Dr William Hunter.

Hunter was appointed the first professor of anatomy at the Royal Academy of Arts in 1768. He immediately engaged painters and sculptors in anatomical studies and the Academy became the main centre where artists studied human anatomy. Hunter wrote that he 'welcomed the opportunity to enter the different world of painters and sculptors', and of enlarging his 'knowledge of those arts which formerly had been only his amusement and not his study'.

Hunter delivered his inaugural lecture to students at the Academy in 1769. Johann Zoffany embarked upon a painting (which he never completed) depicting this scene. It shows the audience of students and academicians watching the professor of anatomy demonstrate the muscles of the human body. At the Royal Academy's Council meeting in March 1769 Hunter said that he proposed to give three lectures on the skeleton and others on the muscles at such times 'as a body can be procured from the Sherrifs to whom application should be made'.

Hunter obtained his cadavers illegally for art students to draw from, but the Royal Academy chose to overlook this for the sake of good education.

It was not until 1832 that the Anatomy Act legalized dissection. Hunter obtained his cadavers illegally for art students to draw from, but the Royal Academy chose to overlook this for the sake of good education.

When dealing with the skeleton Hunter encouraged students to put their anatomical knowledge into practice, and to draw the bones in order to receive 'clear and indelible impressions upon their minds'. A syllabus of the anatomical lectures given by him in London can be found in the *European Magazine,* 1782, which displays in full the courses of anatomy, physiology and surgery that could be undertaken by artists and anatomists alike. The courses were illustrated by 'a great number of elegant and curious anatomical preparations' that had never been used before in any school of anatomy. Also advertised was a 'school for practical anatomy' where 'students dissect with their own hands', and make for themselves 'many preparations'.

There was also a need for artists and anatomists to have some means of studying the 'superficial muscles' of the body at leisure. This was partly met by the production of the écorché figure which was made from a variety of materials, such as bronze, ivory, wood, wax or plaster.

The most popular type appears to have been the écorché figure modelled in wax and in his writings Hunter refers to his own methods of producing wax anatomies of the human form which he used constantly in his teaching. During the early eighteenth century the painter and anatomist Ercole Lelli executed a number of life-size écorché figures, using the modelling technique of polychromatic wax and incorporating glass eyes and real hair.

Too much energy had been devoted to drawing and painting 'death-like dissected figures' instead of life-like forms.

It is not known whether all artists were in favour of the bias towards anatomical instruction, especially as the Academy devoted a large part of the curriculum to studying the human figure. During the 1850s Dr Robert Knox, the Scottish anatomist, scathingly attacked 'The Anatomical School' where he believed too much energy had been devoted to drawing and painting 'death-like dissected figures', instead of life-like forms.

Hunter's own medical education was helped by knowing and interacting with artists who were interested in representing and interpreting the human form. Investigations show that in the eighteenth century anatomy and art education were very much dependent on each other. □

The article derives much of its material from the author's research that is to continue for a Ph.D thesis entitled The Teaching of Anatomy at the Royal Academy of Arts and the Government Schools, 1750 to 1850.

William Hunter giving an anatomy lesson by Johann Zoffany. From the collection of the Royal College of Physicians.