NEWS

Honorary Editor: Dr Edwin Martin
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Inner Cities Conference

THE RCGP and Royal College of Physicians held a joint conference in July to highlight some of the more successful initiatives developed in the inner cities.

In his opening address Sir Donald Acheson, chief medical officer of the DHSS, reminded participants that regeneration of the inner cities was a prime objective of the present administration. He identified unemployment, poor housing, crime and the high prevalence of mental illness and drug abuse as making the care of patients in inner cities difficult. He said that many of the patients seen by doctors and other professionals in the inner cities were young, mobile and without the normal support systems. The consequences were long hospital stays because of home conditions, an increased prevalence and slower recovery from illness, and a decreased expectation of what the Health Service can provide. Hospitals are used inappropriately for primary care, and the general practice system suffers from poor premises, lack of team work and professional isolation.

Sir Donald made the plea that plans for improvement should be made in response to local needs, rather than large scale reorganization which might be inappropriate in certain areas. He highlighted the need of hospitals to develop their links with local populations and primary care teams.

He commented that most teaching hospitals were in inner city areas and that the attitude of medical schools to the community and general practice would be a vital factor in improving inner city medicine.

Born in the Inner City

Professor Sir Malcolm MacNaughton, president of The Royal College of Obstetricians and Gynaecologists, described the work of his Glasgow unit in providing antenatal care to deprived areas. A consultant from the unit is attached to each health centre and antenatal clinics are conducted in health centres near the patient's home by both consultants and GPs. Dr Langan, a GP from Glasgow, said that the advantage was that care could be provided near the mother's home by a team of doctors and nurses she could get to know.

Dr Leon Polnay, a community paediatrician from Nottingham, said that the problems highlighted for inner city children in a 1905 report were much the same as for children today. He gave the example of a mother who turned up directly to hospital with a sick child. She was given a telephone book and asked to telephone her own doctor, but it was found that she was unable to read, unable to use the phone when given the number and unable to explain what was wrong with her child.

Nottingham GP John Temple said that the health visitor was often the first point of contact in child illness, and that communication was made easier if health visitors worked in the same building as GPs. Dr Temple said that one consequence of their open access child health clinic was that immunization rates had risen to as high as 85 to 95 per cent.

Tower Hamlets Primary Care Development Fund

Nancy Dennis described her work with the Tower Hamlets Primary Care Development Fund. For the last four years she has been talking to GPs about how they would like to see their services develop and what could be done about their problems. Many of the problems centred round poor premises, the need for information, poor communications with local hospitals and a need for joint planning between the health authority and the FPC. She had found GPs interested in improvements, and since beginning her project the number of practices with real primary care teams in the area had increased from five to 25.

Accidents and Illnesses in the Inner City

Dr Terry Redman, an accident and emergency consultant from Manchester, spoke of the care of violent patients and the danger to staff.

With regard to rape cases, he said that the care and investigation of patients who had been raped could become another 'assault' if it is not carried out sensitively.

Dr DJ Williams, accident and emergency consultant at St Thomas' Hospital and chairman of the Society of Accident and Emergency Surgeons, said that in inner cities where tourists, commuters and homeless people had no GP, A&E departments had a dual role. Dr Williams produced figures to show that fewer emergency admissions to hospital came through GPs than A&E departments. He said that patients choosing A&E departments for their primary care should be ensured high quality treatment.

Dr John Oldroyd told the conference that of the 1,200 London GPs who had answered his questionnaire on violence, only 30 had had no experience or threat of violence. There were 150 cases of reception staff also experiencing violence and two cases of the doctor's family being attacked.

Conclusion

It was mentioned that immunization figures and other indicators of good practice were sometimes better in the cities of third world countries such as Nairobi than in Britain. One delegate commented that if it was possible to run an efficient child health clinic under a tree in South East Asia, premises should not be considered a bar to running efficient clinics in the UK. They could easily be run in church halls and the backrooms of public houses.

One factor that became obvious during the day was that many of the projects had not been evaluated. It was decided to jointly set up a monitoring system between The Royal College of Physicians and RCGP to report back on the progress of these initiatives and decide what further steps were required. □

Edwin Martin

New RCGP Research Fellows

THE RCGP has appointed three GPs to its new research fellowships. Tyneside GP Dr Morris Gallagher will be assessing the impact of AIDS on general practice. He plans to estimate the number of new consultations GPs have with people who are worried about AIDS.

He will be trying to find out what GPs think about HIV blood testing confidentiality, giving out sterile needles to drug addicts and the provision of domiciliary terminal care.

North London GP Dr Stephen Iliffe will study the mental health of carers looking after elderly patients in the inner-city areas of Brent and Islington. He will examine the relation of the mental health of the carers to the subsequent use of health care facilities.

Leicester GP Dr Aly Rashid plans to assess the extent to which ethnic minorities feel their symptoms are understood by health care professionals.

The fellowships, which run for two years, are aimed at helping young principals pursue an original line of research and to learn about methods and design. □

RCGP Examination Passes

The following candidates were successful in the Membership Examination of the Royal College of General Practitioners in June/July 1987:-

(* denotes distinction)

P.R. Abbott, Patricia M. Abbott, Elizabeth V. Abernethy, Mairi C. Adam, P.J. Adams, R.N. Adams, S.P.R. Adams, *Gemma Adamson, Patricia Y.A. Ahlquist, Margaret C. Ainger, Mazen Al-Bashir, Elizabeth M. Albiston, Julia M. Alexander, M.C. Aley, M.P. Allen, M.E. Allerton, Helen R. Alpin, D.J. Alston, Margaret Alty, S.J. Alvis, Fiona M. Anderson, T.J. Anderson, Rachel A. Angus, R.Y. Anthony, Helen Appleton, Gillian M. Arbuckle, M.I. Archer, Sally C. Archer, M.H. Ashley, *Charlotte E. Asquith, D.A. Astley, R.C. Attree, Mary F. Backhouse, Christine de C. Baker, Hilary A. Baker, Kanwaljit Bakhshi, H.R. Bance, S.I.G. Barclay, R.J. Barker, C.R. Barlow, Helen C. Barlow, M.H. Barnes, Janet E. Barraclough, Ian Barrow, M.P. Barry, A.D. Bartholomew, Hilary R. Barton, S.R. Barton, M.D.P. Bates, Helen J. Bayliss, W.R.J. Beales, D.C. Beattie, Helen E. Beaumont, Kathryn J. Beck, M.A.R. Beeney, G.J. Bell, Sharon M. Bell, Mary E. Belton, P.R. Bendor-Samuel, A.G. Bennett, P.F. Bennett, Janet L. Benson, Helen C. Beveridge, Maureen C. Birch, Wayne Birchall, Stephanie M.L. Birmingham-McDonagh, D.G. Black, Patrick Blackford, D.H. Blackwell, K.N. Blake, G.J. Bland, P.F. Bleiker, P.B.J. Boffa, P.F.M. Boland, Graham Bond, Margaret Bone, Colette J. Bonner, Walter Bonnici, Susan L. Boorman, Ruth Booth, G.P.T. Bourke, J.S. Boyd, Christine J. Bradley, *M.A. Bradley, M.D. Brady, Sarah E. Brear, Elinor F.M. Brew, M.D. Brooke, P.R. Brough, L.J. Broughton, Harry Brown, Mary E. Brown, Audrey Bruce, R.N. Bryant, N.H.L. Bryson, B.E. Burke, Heather M. Burke, Lorraine M. Burns, C.R. Burr, Lee Burton, G.L. Busher, Lynne H. Butcher, Fiona A.M. Buxton, Lesley L. Cadzow, Eileen M. Cahill, Catherine J. Caird, J.F. Cairney, Peter Calveley, I.L. Cameron, Gillian L. Campbell, J.L. Campbell, Jennifer A. Campbell, Susan E. Campbell, W.M. Campbell, P.J. Cansfield, R.S. Caplan, S.P. Capp, M.D. Cardwell, Nicola F. Carey, N.F. Carr, R.G. Carr, Wendy M. Carr, P.J. Carragher, Ann-Marie Carroll, M.P. Carson, Yvonne H. Carter, Andrew Cartwright, M.J. Casey, S.C. Cayre, Jane M. Chalmers, Jacqueline Chapman, P.B. Charlson, Wai Chen, Frances E.M. Childs, Kit-Oi Chung, P.J. Chuter, D.P. Clark, Alexandra J.R. Clarke, D.R. Clarke, Sarah V. Clarke, N.M. Clayton, P.R. Coghlan, Susan L. Cohen, N.S. Coleman, C.N. Collier, T.H. Collins, B.J. Conlon, J.M. Connolly, J.C. Conway, Victoria A. Cooke, J.F. Cooper, Rosemary Cooper, S.F. Cooper, Denise Cope, Pamela K.A. Copp, R.F. Cordell, Susan L. Cordiner, M.H. Corfield, J.W. Cotterill, Dilys A. Cowan, S.M. Cowles, Rachel M.G. Crabbe, Alison M. Craig, Andrew Crank, Alison Craven, M.R. Crick, Robyn D. Crighton, M.G. Cripps, Catherine F. Cronin, Sally L. Cronk, Pauline E. Crossland, P.G. Crow, Linda E. Crowder, J.J. Crowley, B.J. Cuddihy, A.A. Culhane, S.A. Cumming, G.A. Cunniffe, J.G. Curran, Ann L. Currie, M.A. Currie, C.R. Cuthbert, P.K. Dakin, J.R. Dale, W.F. Dalton, Avril F. Danczak, Marie C. Davidson, Amanda M. Davies, M.C. Davies, T.A. Davies, Judith A. Davis, R.L. De Courcy, Paolo De Marco, *Anne C. Deans, Wendy E. Denning, Gregory Denton, M.J. Devine, Vini Dewan, Penelope J. Dexter, Mario Di Monaco, Phillippa J.N. Dickens, R.I. Dickson, Eamonn Dillon, Sarah Divall, Joseph Djemal, M.J. Doherty, N.W. Doll, *J.F. Donaghy, C.A. Donaldson, M.B. Donnelly, Anna M.R. Douglas, R.W. Drayson, Joanne L. Drew, J.J. Duffy, Diane F. Duke, W.K. Dunn, K.P. Dunphy, Kamran Durrani, G.W. Durston, A.H. Dutton, Wendy A. Dyke, Mary T. Easson, D.A.H. Easton, J.M. Edwards, Sian A. Edwards, J.B. Elder, J.C. Elliman, Frances M. Elliot, *I.M. Elliott, Eunice M. Ellor, Penelope E. Elphinstone, *J.R. Emmanuel, A.J. Emslie, Hilary J. Entwistle, D.A. Evans, J.A.L. Evans, *P.H. Evans, B.J. Everett, S.J. Eyre, *Judith E. Fairweather, M.M. Fanning, Elizabeth A. Farnall, A.M. Farooqi, C.P. Farrelly, G.S. Faulkner, K.P. Fellows, A.E. Felton, S.R.J. Feltwell, R.J. Ferguson, N.J. Field, S.J. Field, Susan M. Field, Rowena D. Fieldhouse, A.S. Fielding, Simon Filose, N.G. Findlay, Hilary J. Fine, Sarah M. Finnie, Jacqueline A. Fisher, P.P.J. Flanigan, Martin Flatley, Mari Fleri, Rosemarie J. Flood, D.J.C. Flower, H.R.C. Ford, Jennifer E. Foster, N.J. Foster, Andrew Foulkes, P.S. Fox, D.C. Frank, A.W. Frankland, A.K. Fraser, M.C. Free, H.M. Freeman, S.P. Freeman, Christine U. Freytag, J.E. Gaffney, C.J. Gallagher, *Paula M. Gallagher, Caroline G. Gamlin, J.K. Garland, J.F.P. Garnett, P.J. Garrod, D.A.H. Gerson, Janet P. Gillespie, J.R. Glenfield, P.S. Goffin, J.G.S. Goldie, D.R. Gorman, Judith A. Graham, W.M. Graham, A.J. Grant, C.M. Grant, Karen L. Grant, Deborah A. Gray, I.C. Greaves, R.E. Green, Nola C. Greene, Elizabeth R. Greer, *S.N. Gregson, Hannah M. Griffiths, P.J. Griffiths, Valerie A.M. Griffiths, Robert Grinsted, *Alison R. Groves, M.A. Grubb, R.E. Grundy, Margaret B. Gunn C.C. Gunstone, Rex Haigh, D.A. Haines, I.M. Hall, K.G. Halpin, Sheila Halpin, Duncan Hambly, D.M. Hamilton, John Hamilton-Paterson, M.E. 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Tulloch, G.N. Turk, Colin Turner, M.J. Valentine, Aileen J. Van Der Lee, Kishorchandra Vasant, John Veale, A.R. Verghese, Ajaykumar Vora, J.W. Wagstyl, Claire S. Walford, E.D. Wallace, Kim D. Wallace, J.N. Walters, R.T. Walton, *D.G. Ward, Lindsay Ward, Beverley J. Watkins, Timothy Watkins, N.F. Watson, P.A. Watson, S.P.A. Watson, Ruby M.J. Watt, C.S.A. Wayte, Barbara A. Weatherill, Patricia A. Webster, J.P. Wedgwood, Clare A. Weekes, Rachel M. Weeks, I.R.J. Weir, A.J. Wells, Mary R. Wenley, Anne P. West, A.H.S. Weston, *Elen Wharton, Robin Wheatley, Katharine A.H. Wheeler, J.A.J. Whitaker, A.A.J. White, T.M. White, M.R. Whiting, Ian Whitley, P.S. Whyman, P.C. Wiehe, D.J. Wilcock, Jane Wilcock, P.R. Wilkes, A.R. Wilkinson, Janet M. Wilkinson, Andrew Williams, D.T. Williams, Dorothy J. Williams, H.G. Williams, Janet M. Williams, R.J. Williams, Lyn Williamson, G.M. Willis, C.A. Wilson, Christine S. Wilson, D.G.F. Wilson, D.L. Wilson, Elizabeth Wilson, *N.L. Wilson, N.R. Winslow, A.N.B. Winter, P.J. Wiseman, Hannah E. Wishart, Jacqueline M. Witt, A.P. Wolpe, H.W. Wong, Alison J. Wood, Hilary J. Woodhead, R.B. Woodhead, I.G. Woollands, C.T. Worth, *Sara K. Wraight, A.V. Wright, J.G. Wright, Keith Wycliffe-Jones, Angeline M. Young, D.R. Young, V.S. Zammit. □

Computer Guidelines

RCGP/GMSC joint guidelines for the extraction of data from GP computer systems by organizations external to the practice.

These guidelines are designed to ensure the confidentiality of GPs' medical records when data is supplied by GPs to external organizations, whether for commercial or other purposes. They do not, however, apply to the normal transfer of clinical and administrative data from one doctor to another or between a doctor and other appropriate health professionals; nor are they intended to restrict the statutory requirements for notification of data.

They should be viewed in conjunction with the JCG guidelines on GP dealings with pharmaceutical companies and shall be open to amendment in the light of future experience.

1 Any organization seeking to obtain data from GP computer systems should have appointed a medical officer assuming overall responsibility for the confidentiality of the data, and for maintaining the validity of its analysis. The medical officer must also provide personal and organizational guarantees to this effect.

2 Whenever a GP or group of GPs enters into a contract for the release of data to an external organization, the operation should be monitored, and the uses to which data will be put by that organization, and by third parties, should be scrutinized by an independent advisory body acceptable to the profession. Each member of this group should declare any personal interest.

3 Ownership of the data contained in the practice computer remains with the GP, who must have access to it and be able to analyse it as he/she wishes, and be able to share it for purposes such as education, service and research.

4 No patient should be identifiable, other than to the GP, from any data sent to an external organization without the informed consent of the patient. It is suggested that a link number should be used that would enable the patient to be identified by the GP only. Disclosure to any other body, of
   a) the patient's name or address
   b) the full postcode or
   c) the full date of birth
   is not acceptable. However, the electoral ward, postcode sector (provided the population of the ward or sector is not less than 100), sex, and year of birth are admissable. Studies requiring more specific data will require specific protocols which should be agreed by properly constituted medical ethical committees.

5 Before supplying data to an external organization, that organization should be required to provide the GP with a statement, which he/she should retain, of what data are to be taken from his/her records and for what purpose they are to be used. The GP must give informed consent to the use of the data by the external organization or by the third parties. The usage of the data must be defined and if the external organization wishes to change or extend this usage it must provide the GP with a fresh statement defining the new usage subject to his/her approval.

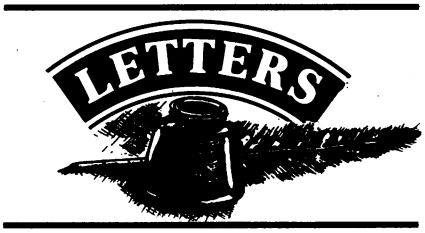
6 The automatic remote interrogation of the practice computer by the external organization's computer is not acceptable. There are, however, two acceptable ways in which data can be transmitted to an external recipient:
   a) the external organization's technicians may extract the data from the practice computer if supervised by the GP or an approved member of his staff.
   b) the GP, with appropriate training, can extract the data himself and send the verified extracted data to the external organization. This can be done by either mail or practice supervised electronic data transfer, provided the GP has full knowledge and control of what data is transferred.

   The GP must be provided with a copy of all data being sent outside the practice and must be able to examine and verify the data being sent.

7 The purposes for which data will be used, the classes of data and the sources and disclosures, must be registered under the Data Protection Act 1984 by the data users. □

Medical Women's Federation

SPEAKERS at The Medical Women's Federation's 70th Anniversary Symposium on *Women, Health and Work* include Baroness Warnock and Anna Raeburn. Programme and registration forms for the symposium, which will be held at the Royal College of Obstetricians and Gynaecologists on Thursday November 26, are available from: Mrs Aileen Goldhill, 65 Century Court, Grove End Road, London, NW8 9LD. Telephone 01 289 2060. □



Prison Medicine

Sir,

The article on prison medicine by Dr Edwin Martin in your August issue of the Journal mentioned the frequent occurrence of psychiatric illness in prison and the estimate that up to 30 per cent of prisoners could benefit from psychiatric treatment. This is an issue of great concern to the National Schizophrenia Fellowship as we are hearing of more and more people with schizophrenia who are ending up in prison either because they have broken the law as a last desperate attempt to get some care, or because they have committed a more serious offence as a result of allowing their illness to go untreated in the community. Either way prison is not a good environment for people with schizophrenia and, as Dr Martin points out, prison officers would require the skill and patience of a saint to help them, not to mention some knowledge of the serious psychoses and the kind of treatment and care they require!

Following up the House of Commons Social Services Select Committee investigation into prison medicine would it not be a good idea for the Royal College of General Practitioners to investigate the numbers of mentally ill people held in prison (including those on remand), the quality of their treatment and the training of the staff dealing with them? In our experience prison officers have been given little or no training in psychiatric medicine and we daily witness the seriously mentally ill being discharged from mental hospitals and admitted into prisons with only a varying period of deterioration in between. □

JUDY WELEMINSKY
Director

National Schizoprhenia Fellowship,
78 Victoria Road,
Surbiton, Surrey KT6 4NS

Representatives from the RCGP, The Royal College of Physicians and the Royal College of Psychiatrists are currently examining the training requirements of prison medical officers.

Practice Computers

Sir,

I think I should point out that the title given to the article about a faculty computer (Vol 37 August, 1987) was misleading.

As an honorary secretary of one of the two college faculties using a computer I felt that other college members might be interested to know the background of the faculty's computer project and how we were progressing.

Unfortunately, the title, (not my own), given to the article indicated that I was writing about computers in general practice, which I obviously was not. □

JACKY HAYDEN
Unsworth Medical Centre
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So You Think You're Safe

IN 1984 a female GP was bludgeoned to death while making a routine home visit to a patient in Leytonstone. General practice is a high risk profession and a survey by the Health and Safety Commission has estimated that one in three GPs have been victims of threatened or actual violence. The survey of 3,000 health service staff including 300 GPs showed that the risk of injury was twice that to building workers, and the problem appears to be on the increase.

But Dr Frank Wells, who represented the BMA on the Health and Safety Commission's Working Party looking at violence to health staff, believes that most GPs are underaware of the potential threat to themselves and their staff of both verbal and physical attack.

"The most important message for GPs and their staff is don't believe it won't happen to you, because it could. Forewarned is forearmed," said Dr Wells, who was himself the victim of an assault when he was a GP in East Anglia.

The case of Suzy Lamplugh highlighted this problem. Last July in broad daylight and the middle of a working day Miss Lamplugh, 25, disappeared in the course of her work as an estate agent. Although there have been plenty of theories there have been no positive reasons as to how or why she went missing.

The Suzy Lamplugh Trust was set up in December last year by her mother Diana Lamplugh: it aims to reduce the risks involved for people who put themselves into dangerous situations through the nature of their work.

After Suzy's disappearance Mrs Lamplugh received calls from vets, doctors, journalists and accountants who had experienced feelings of fear and threat without knowing what to do.

"We hope to reduce physical, sexual and verbal abuse so as to achieve a less aggressive workplace, where everyone is able to work at the job they wish to do to the best of their ability," explained Mrs Lamplugh.

The trust recognizes that violence includes not only physical attacks but also verbal abuse and threatening behaviour. Prolonged exposure can have a serious effect on staff morale and efficiency, with both mental and physical health being damaged.

Mrs Lamplugh, a teacher and author of books on relaxation and exercise, is a formidable lady who has used her special talents for communication to mastermind the trust. She has emerged as a media figure, the 'darling' of the popular press, contradicting the stereotyped image of the grieving parent.

"When Suzy disappeared I asked a psychiatrist friend what I should do. He gave me two options, I could either put my head under a pillow or work so hard that I dropped every night."

Mrs Lamplugh believes that GPs, health visitors and social workers are particularly vulnerable to attack because of the isolation caused by visiting patients at home.

Through research, education and training the trust aims to reduce the risk of personal vulnerability. It believes that if you want to go into a dangerous situation you should be able to do so, but you should be equipped to cope.

"A doctor cannot refuse to go to a home where there may be a violent mental case, they have to go, but they should learn the techniques to deal with the situation."

But few health staff are taught the techniques of how they should avoid these situations.

"Communication skills, relaxation and avoidance techniques are all life skills which not only help people avoid potential problems, but also to work better," said Mrs Lamplugh.

She explained how when people are under stress in a stationary situation they lose their adrenalin and become incapable of performing at their best.

"If you use relaxation techniques you retain the adrenalin and can bring in your communication skills to change the level of the conversation so that you can talk to your aggressor and diffuse the situation," said Mrs Lamplugh.

The one thing that always concerned Mrs Lamplugh about estate agents was the way they took their social behaviour into the workplace.

"If it was a male client Suzy would allow him to show her into the house. Immediately she was trapped with no electricity, a telephone cut-off and a house barred up."

Mrs Lamplugh feels that it is important for people in a work situation to learn techniques where they can politely decline to sit, and that they should automatically become aware of their position in the room and their get away.

"Suzy did not take 'Mr Kipper's' name, address and telephone number, ask him to meet her at the office or inform her colleagues when she meant to return."

She says that all these points should become automatic.

Finding that the trust could not meet the enormous demand for its courses Diana Lamplugh devised the Awareness course packs which they hope will eventually become standard induction material for new staff. They are being designed as distance learning programmes and consist of four books and four videos which can either be used in sequence or taken separately. The fifth module will be about making your own

Paul and Diana Lamplugh, founders of the Suzy Lamplugh Trust, surrounded by pictures of their missing daughter Suzy.

procedures so that an organization can decide for itself which it should be adopting.

"This will enable GPs and practice staff to study together and learn to understand each others problems."

But it appears that for both doctors and nurses, policies for dealing with violence are not backed up by training. The Health and Safety Commission's *Violence To Staff in the Health Service* recommends that training in the prevention and management of violence should be available to all health staff and cover the causes of violence, recognition of the warning signs, relevant inter personal skills and details of arrangements devised by management.

The report suggests that GPs should install panic buttons in their consulting rooms, carry two way radio links when on home visits, keep detailed plans of staff whereabouts and movements and issue personal shriek alarms.

They recommend that attention should be given to the general design and physical environment of waiting rooms and reception areas, for "even small changes within a room can make it seem less hostile and more welcoming". Specific changes include glare free lighting, sufficient personal space so that patients do not feel crowded, reduction in noise levels, 'subdued' colour schemes, homely touches such as flowers and pictures, comfortable furniture designed so that it cannot be used as a weapon and access to pay-phones to enable people to ring friends and relatives.

Many more attacks occur than are reported. Mrs Lamplugh believes that GPs do not all report attacks because they feel nothing can be done or that the attack was in some way their own fault.

"People fear that the reporting will be worse than the offence itself. Women are sometimes afraid that it will affect their employer and that they may lose the opportunity to go out during the course of their work," said Mrs Lamplugh.

Some partners are now stopping female colleagues from going on night visits. Dr Lotte Newman, the president of the Medical Women's Association, is concerned that if such practices become too widespread they might lead to a reluctance to appoint female principals.

"Women going into general practice should show complete commitment and not accept such offers however kindly they may be meant," she said.

Mrs Lamplugh is hoping to interest doctors and their staff in the trust's 'Vulnerability And The Workplace' conference at the University of London on November 20 which, among other things, will be identifying ways of protecting health workers from assault.

"We will be bringing together experts involved in many different disciplines such as psychology, criminology, and architecture and will look at the issues raised by the trust. I'm only the instigator - a catalyst - I don't know the answer to these questions. I'm wanting people of calibre to go out and find them."

Further details can be obtained by writing to Diana Lamplugh at 14 East Sheen Avenue, London SW14 8AS. □

Janet Fricker

Annual Scientific Meeting of AUTGP

THE Association of University Teachers of General Practice held their annual scientific meeting at the Middlesex Hospital Medical School from July 15 to 17.

The Association was founded in 1974 with the object of promoting the development of general practice as a university discipline. An important function has been to encourage all forms of research in general practice including the development and assessment of teaching methods. The annual scientific meeting has now been hosted by most UK departments of general practice and provides opportunities for the presentation of both completed and ongoing research, and for the exchange of ideas about future directions.

One hundred and thirty doctors took part in the three day meeting which was opened by welcome addresses from both the provost of University College London and the dean-elect of the University College and Middlesex Hospital School of Medicine. Both emphasized the central role of teaching and research in a community setting and the importance of departments of general practice and primary health care in ensuring excellence.

The first paper, given by Professor Andrew Haines, provided a critical appraisal of research in general practice. He reviewed general practice papers published in the *BMJ* and the *RCGP Journal* from 1984 to 86 and looked at the pattern and design of projects, the origin of research and funding. Several authors, principally Professor Ian Mcwhinney in 1966 and Professor John Howie in 1984, proposed agendas for research in general practice and Professor Haines related his findings to these ideas and outlined the implications for future research priorities.

The papers which followed addressed some of the present preoccupations of general practice research workers in the areas of health education and health promotion, the role of departments of general practice in the continuing education of local GPs, the teaching of communication skills to undergraduates and the interface between medical and social problems. Lively discussion is always a hallmark of AUTGP meetings and this session was no exception, with particular emphasis on the utilization of different research paradigms for exploring general practice problems, and in particular the tensions between the population and the individual approach. The contributions of anthropological methods were felt to be both valuable and under used, and this was one of the major themes within both the formal and informal discussions.

Several other papers excited intense interest. Dr Roger Jones, of Southampton, outlined a review of recent work in decision making theory and then presented preliminary data and ideas for work on the nature of uncertainty and its effect on clinical decision making for individual doctors. Dr George Freeman, from the same department, took the opportunity to discuss the classification and choice of appropriate outcome measures for assessing the effect of continuity of care in the management of epilepsy. In addition to long term clinical outcome measures, the use of psychological and social outcomes such as changes in the degree to which a patient feels in control of himself in relation to his epilepsy and levels of perceived stigmatization, again demonstrated the importance of drawing on the work of other related disciplines.

Poster presentations and workshops were an important part of the meeting with the workshops offering a wide choice for participants including: the OSCE — a method of medical student assessment, new technology in teaching, diagnosis, medicine in a multicultural society, and primary care development projects.

The social programme included an opportunity to see Les Misérables and a trip down the Thames with food, drink, a jazz band and, for some, a chance to let their hair down and dance a little! This was a successful and stimulating scientific meeting which demonstrated that academic general practice is alive, well and engaged in relevant and productive research. □

John Cohen and Lesley Southgate

The Best Kept Secret

THE RCGP Museum is currently holding an exhibition of historical obstetrical and gynaecological instruments which have been donated to the College.

These coldly metallic objects acquire much more interest when you consider their fascinating history, full of intrigues and shady dealings.

Forceps were kept secret by the Chamberlen family for one and a quarter centuries in one of the most supreme acts of selfishness in the history of medicine. This deprived countless women of assistance in childbirth, with many babies being lost and women dying undelivered or developing fatal injury or sepsis.

The Chamberlen family came to Britain in 1569 as refugees from the Hugenot rising. The father William, and two of the sons, referred to by historians as 'Peter the older' and 'Peter the younger' set up practice as barber surgeons despite repeated altercations with the authorities about their qualifications to do so.

'Peter the older' acquired such a reputation that without even a medical degree he became surgeon to Queen Anne, and when thrown into Newgate Prison by the Royal College of Physicians for the practice of 'physick' he was released by Royal order.

Dr Peter Chamberlen, son of 'Peter the Younger' was the first member of the family to obtain medical qualifications. He graduated from Padua in 1619, from Oxford in 1620, from Cambridge in 1621 and in 1628 became a member of the Royal College of Physicians. He had a large obstetrical following and it was rumoured he had special instruments with which he assisted women in labour.

His son Hugh, a doctor in London during the plague, visited Paris in 1670 and offered to sell the 'family secret' to Mauriceau, physician to the king of France, for 10,000 crowns. Mauriceau tested his boast that he could deliver any woman in 15 minutes by giving him a dwarf with an impossible pelvis. After three hours he admitted defeat and returned to England with the secret intact.

He eventually sold the idea some 20 years later to a Roger Roonhuysen who was able to maintain an obstetrical monopoly over Amsterdam for the next 60 years. He formed a corporation and sold the instrument to each member for a fabulous fee, and by 1747 forceps had become so popular that a municipal law was passed making it obligatory for every obstetrician to possess them. One doctor became so angry when he was refused a licence to practice that he managed to obtain a look at the instrument and published the design.

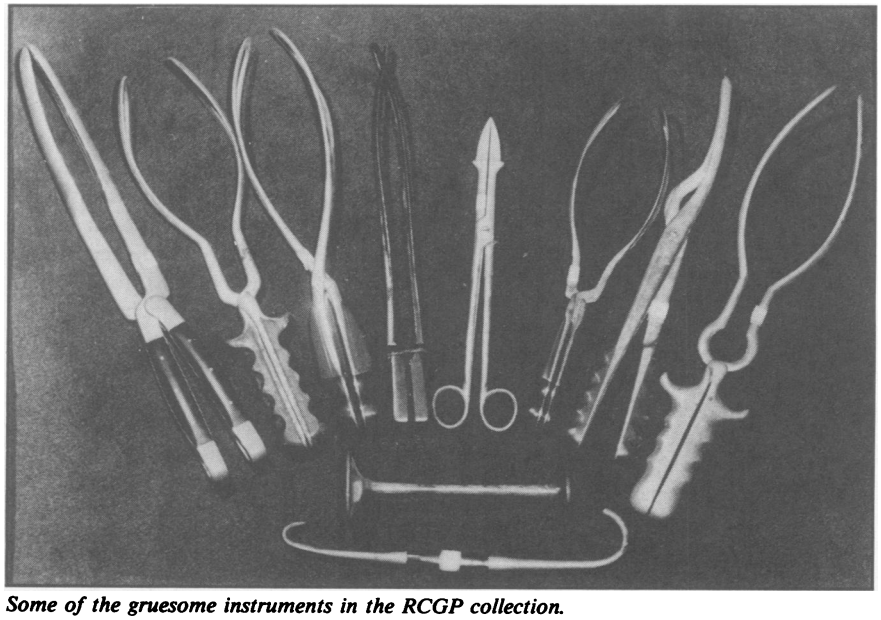
But the full secret was only uncovered in 1813 when examples of the Chamberlens' instruments were discovered beneath the floor boards at Woodham Mortimer Hall in Essex, the last home of Peter Chamberlen who died there in 1683.

Although the Chamberlen family invented the forceps, William Smellie (1697-1763) was largely responsible for the British pre-eminence in midwifery and refinements to the design.

The Chamberlen forceps had a cephalic curve and were only effective for outlet deliveries. Smellie introduced the pelvic curve which allowed the blade to grasp the head high in the pelvis and avoided perineal damage. Smellie's other contribution was the lock, known as the 'English lock' abroad and 'Smellie's lock' at home, which helped steady the blade.

The delivery room acquired such an air of Victorian proprietary that for the sake of modesty births took place under the cover of a sheet that stretched from the mother's shoulders with its ends tied round the doctor's neck; the idea being that the only part he ever saw of her was the head. But forceps became a strictly male domain. For many years only doctors could use forceps and only men could be doctors.

Nineteenth century obstetricians were reluctant to use forceps unless absolutely necessary.



Some of the gruesome instruments in the RCGP collection.

J. Siegmund, *Die Königl. preussische und churbrandenb. Hof-Wehe-Mutter,* Berlin, J.A. Rüdiger, 1723. ch. 4 pl. 20.

William Hunter would frequently pull his own from his pocket saying: "Where they save one, they murder many". This attitude was carried to such extremes that in 1819 Princess Charlotte, the daughter of the Prince Regent, was left in labour for 52 hours without intervention. As a result the mother and baby died and the doctor, Sir Richard Crofts, shot himself.

"In the past obstetrical and gynaecological instruments only tended to be used if the baby was dead in a last effort to save the mother," said Professor Bryan Hibbard from the Royal College of Obstetricians and Gynaecologists.

The RCGP collection contains some gruesome objects. There is a decapitating hook with a sharp blade that was passed into the vagina and round the foetus' neck to enable the head and body to be removed separately.

"Poking inside the pelvis caused mayhem, with the danger of making holes in the mother's bladder and rectum," said Professor Hibbard.

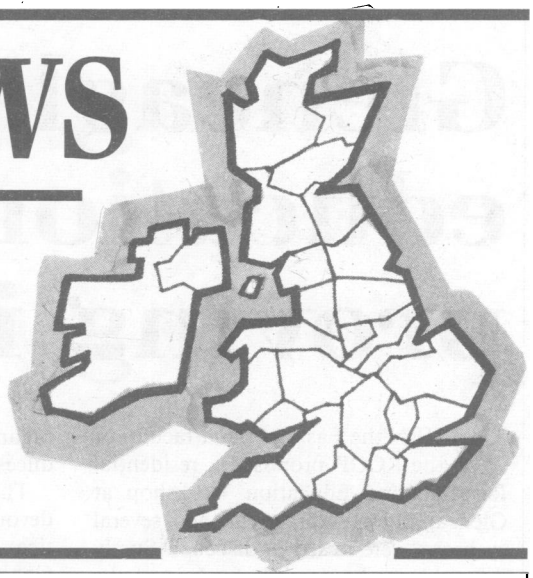
There is a perforator which was used on hydrocephalic babies to allow the fluid to drain and so assist delivery; and a set of bone scalpels which were used before caesarean sections to cut through the pubic symphsis and splay the pelvis to increase the capacity of the birth canal.

One of the older instruments in the College's collection is a whale bone fillet, which Professor Hibbard believes dates from the seventeenth to early eighteenth century. "Before the development of forceps, fillets were hooked over the back of the neck or under the chin and used like a lasso to drag the baby out," he explained.

The case displays a number of more common instruments like Simpson's long forceps, Anderson's forceps and Braithwaite's forceps, which were especially designed to be carried by GPs in their overcoat pockets and are shaped to fit easily together. □

Janet Fricker

FACULTY NEWS



Contents

A First for Scotland?

LAST year six practice managers from the North East Scotland faculty met to share ideas and discuss problems. A number of common issues arose and they recognized the need to initiate a training course.

In November 1986 they approached Dr William Reith, the chairman of the faculty board, who was also enthusiastic about the idea. The appointment of Mrs Morag Balchin as the faculty's administrative secretary allowed for appropriate organizational support. They decided to arrange a three day course, with a different theme for each day.

The organizers, who had felt they would be pleased if as many as 20 practice managers expressed an interest, were delighted when 50 people attended. The delegates came from Tayside and Highland Regions, as well as Grampian, with some travelling as far as 138 miles.

It was hoped that the theme for the first day of administration would set the course off on a practical note. Completion of the various NHS claim forms was discussed, as was the importance for GPs and the Health Board in submitting claim forms promptly. The final speaker of the day was Mrs Susan Bates, the secretary of the LHC. Many practice managers knew only vaguely of its existence and were unclear of its function. Following a resumé of the History of Health Councils, Mrs Bates went on to highlight some of the recurring problems and complaints that she had encountered. Issues such as the length of consultation times, being kept waiting without an explanation, and hospital waiting lists were all raised. The possibility of an informal complaints procedure and the need for closer liaison with patients were also discussed.

The second day was on the broad theme of management. Mr George Reid, a senior lecturer in communication studies at Aberdeen College of Commerce, gave a thought provoking presentation of the principles of management. He asked participants to complete a questionnaire which highlighted their management style — whether it be people or task orientated. Then Mrs Merrill Whalen, a practice manager from Edinburgh who is joint author of *Management in General Practice,* covered time management and communication. She introduced members of the group to role playing which was designed to improve assertiveness and the handling of difficult situations. The afternoon finished with the video *Behaviour Breeds Behaviour,* a lighthearted but pointed look at how our behaviour can affect others.

The third day was taken by Mr Peter Graves, the national sales training manager for Ciba-Geigy Pharmaceuticals who sponsored the event. He covered interviewing and selection and stressed the need for effective staff training and appraisal. Most of the managers went away intent on incorporating some of his ideas into the day-to-day running of their practices. They thoroughly enjoyed his delightful sense of humour and wide variety of teaching methods. One participant later wrote: "I would have liked to take this man home in my case, and let the rest of the staff share his enthusiasm."

The general feeling coming from the three days was one of renewed enthusiasm. For many it was their first opportunity to meet other practice managers and, as always, the informal discussions proved just as valuable as the formal programme. Several managers from Tayside and Highland are now hoping to develop groups in their own areas. We are sure that this course will become an annual event and look forward to further training opportunities.

Maureen Campbell, Esther Greig, Edna Ledingham, Eleanor McLeod, Joan McKenzie, Hermione Youngs.

Trainees' Social Evening

THE Leicester faculty's Education Committee organized a trainees' social evening at the Leicester Royal Infirmary at the end of April.

The aims were to publicize the areas in which the College helps GPs, and to get feedback from those we hope will soon become members. Members explained the organization of the College centrally and locally in small group discussions, and then opened the floor to the trainees. Inevitably, many questions relating to the exam and its recent troubles were asked, and trainees were able to hear the differing opinions of 'grass root' members.

After the discussions a buffet supper was served.

Allan Thomas, the faculty liaison officer, was present throughout the evening with his display and a wide range of College publications. This input from central College was most welcome and informative.

Over 30 doctors attended, and we hope that as a result the trainees will have gained useful information about the College. □

Dick Hurwood

Gleneagles '87 — an educational initiative proving its worth

WHEN the East Scotland faculty of the RCGP proposed a residential Research and Education Workshop at Gleneagles Hotel three years ago, several eyebrows were raised in disbelief. Surely it would not be possible for one of the College's smallest faculties to successfully generate a programme from its own members' work that would be sufficient to sustain a weekend meeting.

Despite such scepticism Gleneagles '85, the first Spring Workshop of the East Scotland faculty, was held with over 50 GPs attending. It was so successful that it was decided to attempt the venture again this spring. This was a test to see whether such workshops were sustainable and educationally worthwhile.

Three main sessions were organized for Gleneagles '87: 'Drugs and Abuse', 'Collaborative Research in General Practice' and 'The Problems of Continuing Medical Education'. A draft programme was drawn up nine months in advance, with 14 speakers, all of whom worked in Tayside and came from the East Scotland faculty.

Dr James Dunbar has developed a national reputation for his work on drinking and driving. His paper, contrasting his experiences in Scotland and Finland, highlighted the need for random breath testing.

Dr Andrew Orr presented an exceptionally neat piece of research on the effects of alcohol on the foetus at the time of conception.

The problems of heroin addiction with its medical and social consequences were described in a study from the Dundee department of general practice, by Dr Ronald Neville.

Dr Albert Jacob's multiple publications reflect the acute intellectual enquiry that general practice can generate. His ability to sustain a unique approach to an exhaustive computer analysis of multiple variables in home visiting problems, exemplified the man and his work. It was a contribution not to be missed.

The problem of leg ulcers plagues us all. In his study on alternative ulcer therapies Dr James Laird demonstrated that an organized, simple approach usually produces the best results.

The second session of the meeting was devoted to collaboration in general practice. Dr Alastair Wright's work on the General Health Questionnaire is well known, having recently been presented at the European Conference of the International Society of General Practice (SIMG) in Austria. This work has been the main stimulus behind what is hoped to be the development of a faculty research project.

Humour was provided by Dr John Mackay, who had looked at the effects on a large country practice of a migratory fruit picking population. A neatly conceived piece of work which contrasted well with the other speakers.

After suffering years of neglect the GP hospital is becoming much more topical. Dr James Grant has spent five years looking at all aspects of these hospitals in Scotland. He gave a thought provoking description of the outcome of myocardial infarctions over a five year period in Scottish GP community hospitals. His presentation challenged GPs to give further thought to this important aspect of care.

It was appropriate that Dr Frederick Proudfoot, provost of the faculty, should present a paper on his own research work. His study on the value of throat swabs provided the meeting with a challenge which was met in a good humoured and enjoyable way.

The work of the East Scotland faculty's Diabetic Group and its protocols for the management of type II diabetics in practice was presented by Dr Sandy Young and Dr Robin Scott. The use of a planned record insert and the need for adequate skills in fundoscopy were highlighted.

Free Standing Papers were presented on varying subjects including 'Management of Gout', 'Significance of Consultation Times', 'Diabetic Management Protocols' and 'Laboratory Investigations — An Unnecessary Expense?". It was felt that this was a very valuable part of the programme since it provoked stimulating discussions between the delegates.

Dr Jeremy Gillingham confronted the meeting with the crisis as he saw it in Continuing Medical Education. Will the developments in this field alleviate this crisis in the future? Only time will tell.

A paper from Dr James McKellican on 'The Problems of Organizing Drug Trials in General Practice' illustrated the work he had been involved in with antihypertensive agents in multi practice drug trials.

A lesson on how to conduct 'Audit and Research' in an organized and methodical way was given by Dr Sandy McKendrick who analysed six annual projects which he and his trainees had conducted. He showed both the positive and negative aspects of such a systematic approach.

The last presentation was given by Dr Alastair Shaw. His use of clinical photography is well known locally and his technical expertise provided a humorous and educationally useful end to the proceedings.

Conclusions

From the academic point of view, the workshops have been widely regarded as successful because of the number of GPs presenting work, the quality and variety of research, and the interest shown by both members and non-members.

One problem of GP research is lack of confidence as well as content. Given the facilities and the venue, GPs rise to the occasion and see it as a means of presenting work which might otherwise be left unseen. The East Scotland faculty's ability to run such a meeting, twice, suggests continuing support even though the faculty is one of the smallest within the College. The East Scotland faculty has a total of 250 GPs within its area, 63 of whom attended Gleneagles '87. Surely the East Scotland faculty is not unique? Should GPs continually under-rate their work and think it inappropriate for a conference?

There have been problems, organizational and presentational, but these were inevitable given the number of speakers and the size of the meeting. Despite these we concluded that research and the educational process can be legitimately and profitably combined in such working weekends. With families able to enjoy the

Continued on page 432

The Retired College Member and his Faculty

WHEN I retired it seemed unthinkable not to remain in touch with a College that I had been involved continuously with since joining in 1953. So I paid the extra subscription to remain a life fellow of the RCGP. This means I receive the College Journal, news from my faculty, and an invitation to attend the faculty's AGM.

I have at times contributed to the correspondence columns of the Journal, and I was asked to write this article by the honorary editor of the News section, so it must be presumed that the College continues to show interest in ideas put forward by doctors who are no longer working. I still represent the College on Age Concern and The Parkinson's Disease Society, and I have been invited on to the Medical Advisory Committee of the latter organization. But why should I continue? Perhaps because I now have more time to serve on these bodies than I had when I was in practice.

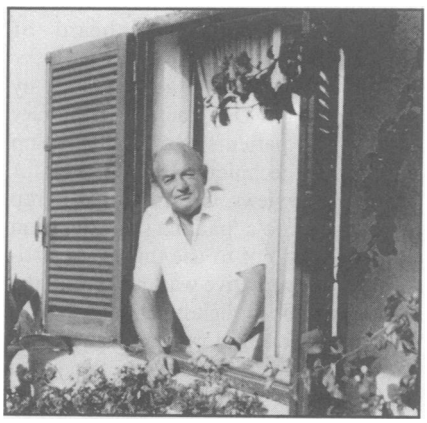
What about the faculty? To find how I should now relate to the faculty I attended the AGM. At least I made up a quorum as it seems there were more apologies than attenders, due perhaps to it being held in the first week of July rather than in November. Although I had not attended for two years I did not feel a stranger, having been a former provost during a period of rapid development. At least I felt among friends until I found myself filling my glass next to a senior fellow I have known for many years and with whom I have lectured. Since he is a sage, able and willing to offer opinions on anything, I put my question to him about what place a retired member might have within the College and the faculty.

His answer was forthright: "No place, if he is not working". I then asked about fellowship and keeping in touch with one's colleagues. "Fellowship is not for the faculty" came the brusque answer. It was now that I felt an intruder, regretting that I had accepted the invitation to attend. I could see that he was right, and usually respected his opinions which are rarely given so plainly.

When the AGM began my old friend the provost welcomed me as his predecessor. This failed to console me, so that when a vote was taken on a proposed change I abstained feeling that I had no right to influence matters for others. However, later in the meeting I put forward the following proposal which I had prepared:

"I was disturbed to see it stated recently that 70 per cent of the major offices within the College are held by academics or regional advisers who account for less than 1 per cent of College members. This is because of increasing commitment involving time, travelling and effect on partners and patients. May I suggest an idea that may reconcile the problem. Retirement at age 60 and even 55 is considered increasingly, while some Council members are well over 60. How does this Faculty view the idea of one or two recently retired doctors with a suitable record of involvement in the Faculty being asked to serve on Council for a limited term, free as they might be of other commitments. Such an opportunity might be an inducement to retire early."

Does the College owe any obligation to long serving members beyond the use of club facilities at Princes Gate, or information and library services for those who, like myself, consider continuing in medical journalism. Increasingly educational and administrative functions are being delegated to the faculties and it seems clear to me that it would be difficult for retired doctors to be useful unless they are working. On the other hand the experience of such men as advisers could be invaluable. I have little doubt that young practitioner groups could benefit from older men with experience on LMCs, FPCs, and with experience on other matters such as practice management, research and publication.



Dr Keith Thompson at his retirement home in Sitio de Calahonda, Spain, where he now spends half the year.

In some ways we are faced with something like an old boy's association, although in other fields these are often more concerned with sport and socializing than academic functions. It might be argued that a doctor who wants to remain active in the College should not retire. Indeed, successful retirement is based on continuing development and cultivating new interests. While doctors may want to give up consulting, they nevertheless retain an interest in general practice and medicine, the advancement of which may owe something to their individual contributions. It is often thought that fertility of ideas is lost with advancing age, and while this is true of creativity, old spectators can give useful tactical advice. No one can yet say if successful retirement might not depend on further development of an old interest since we find patients occasionally who loved travel but never had time to indulge until retirement when they became great travellers, photographers and sometimes authors.

There is little doubt that this is a new question. There must be many who joined the College in the early 1950's when general practice existed at a very low ebb and who fought to establish the structure of our speciality, and feel justly proud at the way it stands now. Some of them may consider their work has been done; others envisage further objectives.

As I drove home from our AGM, one thing dominated my thoughts and that was the variable view members had of the role of the GP. Our new provost had pointed out that central College agreed that we should focus in future on clinical work. Some younger members disagreed with this view, and a senior member declared that their business was that of health promotion. I heard others say that we were in the business of caring, and leaders of the primary health care team. Anything, it appeared, other than clinicians.

Yet in the latter part of my professional career, having developed an interest in examining crystals aspirated from knee joints, I should have liked to have asked some of these colleagues to name the conditions which can be associated with pseudo-gout. Years ago this would have been seen as a specialist problem, but I have seen general practice evolve until it is now within our remit. The reason I believe we should focus on clinical work is because, unless we do, we could be replaced by counsellors dealing with anxiety, opticians screening eyes, nurse practitioners treating a large amount of trivial illness still brought to doctors, social workers, health visitors, and midwives. Unless we can clearly define our role the cost of training and maintaining doctors in our speciality may lead to great reductions in our numbers.

Perhaps these ideas will encourage retired members to enlarge on my thoughts. Does the College still need us? Can we still be of service? Or are we an embarrassment as worthless 'has beens'? We cannot all be Mackenzies and Pickles, honoured and glorified. Perhaps we are just in limbo. What do you think and want? That is what matters. Write in with your views, honest and unsentimental please. This is not a minor question since there were 1,072 retired life members in January this year, and a further 240 retired doctors contributing annually at one quarter rate. This will increase quite considerably by September, so we are talking about 9 per cent of a total membership of 15,198. □

Keith Thompson

Meeting the Candidates

I KNOW if I see a large animal with big ears and a trunk that it is an elephant. And, however many statistics the zoo keeper might produce to prove it was a giraffe, I would still be left with the feeling he was wrong. I have seen an elephant before, even if I cannot prove it with accurate figures.

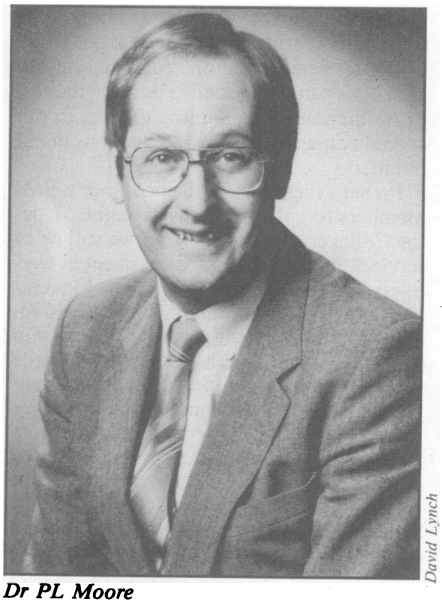
In the recent election I had the same feeling about the health service. Every day I see how it works. And watching all the politicians debating the finer points I began to wonder whether this was the same organization.

But I was in a position to voice my doubts. Using my regular medical column in the local paper I decided to interview the candidates. As a local paper I knew that I must not show political bias — if I supported one party I would alienate two thirds of my readership.

On the day the election was announced I wrote to the three candidates asking for an interview for the paper.

I received two immediate phone calls and one letter by return of post. Although our receptionist recognized the name of the Conservative candidate she mistook him for a fellow GP.

The next step was to ring the chairman of the LMC to make sure that I was not going to upset his plans. He was delighted. The GMSC had asked all LMCs to meet their candidates. Suddenly I was also the LMC representative. But I was cautious. My role as a reporter was to gain information and not to provide propaganda for the candidates. However I was lent the GMSC booklet 'Who Cares' which gave useful advice.



David Lynch

Dr PL Moore

I taped each of the interviews. You did not have to look at the rosettes to see which party each candidate was from.

The Labour man was a pleasant postgraduate student — probably gaining experience in a 'no hope' seat before being offered a more realistic chance. But he was interesting. We had a long discussion about the role of the Labour movement in the social history of the early twentieth century. Fascinating, but not a major vote winner in the Torquay of the 1980s.

The Liberal was a keen, young, local man. He knew the community well, but I did wonder whether he had ever travelled beyond Exeter.

I was met by the Conservative at his door with a huge glass of wine. We had a superficial chat with the phone ringing every few minutes and his wife and agent reminding him about a dinner engagement.

My aim was to ask about primary care. Only one of the candidates claimed to have heard of the green paper — although he hadn't heard of any of its contents — and none of them had heard of Cumberledge.

I found that I could achieve most by avoiding 'Robin Day' tactics. In surgery I try to help patients relax and open up and the same techniques seem to work for political interviews. Only once did I trap a candidate into a 'banana skin' situation and I decided not to use this in the article. The Conservative was explaining the success of his policies: "And we have managed to bring down GP list sizes."

"So you don't agree with the green paper when it suggests that there is no evidence that lower list sizes improve patient care?"

"Are we talking locally or nationally?" I am still not sure quite how that is relevant.

The other aspect I found disconcerting was the way they had to look up their opinions in the manifestoes. I felt that if I had offered them a cup of coffee they would have had to consult about whether they took sugar.

I liked them all as people and could not understand why they wanted such a dreadful job. When the tape recorder was off they all talked in a much more relaxed way. If I was really mean I would have had a second hidden recorder.

With the help of the sub editor I produced a full page headlined 'Doctor consults candidates'.

After the debate and the detailed analysis in the media a patient came into the surgery. She has two Down's Syndrome children, both of whom are now over 18. "Please could you sign the form so that they can have a postal vote?"

They certainly met the criteria on the form. And it was not up to me to decide who should be entitled to vote. They are delightful children but I felt that I must express my reservations.

"Isn't that a bit irresponsible. How do they know who to vote for?"

"Oh, they know who looks the nicest," she said.

I suppose they can recognize an elephant as well as any other voter. □

PL Moore

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Gleneagles '87 — an educational initiative proving its worth

facilities of the hotel, no GP needed to feel guilty about leaving his/her spouse and children for yet another weekend. This is an important factor in the continuing success of the Gleneagles Workshops.

When the idea of a workshop was first suggested, it was hoped that it might be possible to constructively discuss traditional and modern techniques for researching problems in general practice.

We further hoped that individual GPs might see ways of adapting some of the ideas and techniques presented, to their own practice.

It is, as yet, too early to say whether we have succeeded. However, the signs are encouraging. It appears that holding such an event every two years is acting as a stimulus to continuing faculty research and education, as well as establishing an important focus for faculty identity which can only benefit future faculty activities.

It would have been premature to have made any such claims after Gleneagles '85 but the success of a further workshop this year leads us to believe that what has been created in the East Scotland faculty is sustainable and a continuing source of educational potential for the future. □

James A Grant