NEWS

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COUNCIL

SEPTEMBER Council tried the experiment of sitting on the Friday afternoon as well as all day Saturday to get through the necessary volume of work.

Proposed Divisional Structure

Council agreed that an Examination Board should be set up and that it should relate directly to Council. According to the ordinances of the College at least 50 per cent of the members of the Examination Board would need to be Council members.

Anxiety was expressed about whether the board would be able to carry out its work as expertly when diluted with Council members who might not understand the running of the examination. The matter of the balance of examiners and non examiners was referred to GPC.

It was agreed that the chairmen of the divisions should normally be elected from the membership of Council.

AIDS Working Party

Council considered the first report from the AIDS Working Party which discussed how general practice and the College could best meet the challenge of AIDS.

It was recommended that there should be a declaration of College policy about AIDS and that the College should institute educational and research initiatives. Council re-affirmed that caring for patients with AIDS was the responsibility of all GPs and not an activity that doctors could refuse to handle.

It was agreed that the working party should stay in existence and continue to monitor AIDS from the GP's point of view.

Council felt that the Working Party should now consider the role of the College in giving a lead to the profession and public as well as ethical issues, the changing behaviour of the at-risk population, education of colleagues, cooperation with other professions, epidemiology and collection of information on the disease.

Faculty Fellowships

Council then considered a paper from the Midland faculty suggesting the establishment of five or six faculty fellowships to promote local activity in prescribing, research and practice management.

The fellowships would be funded for one year at the rate of one session per week at the hospital practitioner rate.

Council approved the idea of initiating activities in the faculties and providing protected time, and referred the matter to the new Services for Members and Faculties Division.

Request for Council Agendas to be Circulated to the Faculty Boards Prior to Meetings

Council considered a letter from Dr Dick Savage, chairman of the South London faculty, suggesting that Council agendas should be circulated to faculty board members.

Discussions centred around the fact that the faculty representative was not a delegate and it was not possible for the faculty board to instruct its representatives. No objections were raised to faculty representatives sharing papers for forthcoming meetings, although the practical difficulties of faculty boards having to meet three or four days prior to Council were recognized.

Licencing Act 1984 — Government Proposals for Reform

Council considered government proposals for reforming licensing laws and approved these with the request that the government should also consider stricter drink driving policies, increasing the price of alcohol to discourage consumption and strengthening the licensing laws to ensure that licences were withdrawn from publicans who serve underage children. The Education Division was asked to consider how they might best increase health workers' and the public's knowledge of the effects of alcohol.

Assessment During Vocational Training

Council considered the report of the JCPTGP Working Party which had been set up "to consider methods of ensuring a doctor's competence to become a principal in the NHS and to make recommendations."

The JCPTGP saw the College examination continuing to be taken voluntarily as a standard of good practice rather than as a requirement for entry to the profession.

Council felt that as well as continuous assessment a national system of assessment was required to ensure that standards were equal country wide.

Council agreed that the College, as a parent body of the JCPTGP, should endorse the principles set out in the paper.

Proposals from Committee on Postgraduate Medical Education (CPME)

As a result of the GMC recommendations on the training of specialists the CPME in England and Wales has drawn up proposals for a more formal educational administrative structure at DHA level.

Although Council thought the theme of bringing doctors together at a district level was sound, they felt the proposed model of consultants holding the executive positions was unacceptable. It was agreed that a paper putting forward the College's point of view should be written.

Maternity Services in Primary Health Care

A letter from Welsh Council expressed concern about the proposal from the Royal College of Midwives that all maternity care in the community should be the responsibility of midwives.

The chairmen of the UK and Scottish Joint Professional Committees for Primary Health Care reported that the matter was under discussion. Council agreed that the matter should be raised at a joint meeting with representatives of the Royal College of Midwives to be held in the future and that a paper should be prepared for GPC.

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Council

Waiting Lists

Council considered a resolution from the Merseyside and North Wales faculty deploring the existence of waiting lists within the NHS which had been referred from the 1986 AGM.

It was noted that a considerable amount of information about waiting lists in the hospital sector was being collected by district managers and that in order to interpret this data the College needed to collect information about GPs' waiting times and their patterns of referral.

It was agreed to invite the Research Division to look at the question and make recommendations.

Voting and Deputies

Council confirmed the present situation where faculties whose representatives are elected to the posts of chairman of Council, honorary treasurer or honorary secretary of Council are able to elect additional representatives to attend and vote at all Council meetings.

Council agreed that faculties should be able to send democratically elected deputies to Council when faculty representatives are unable to be present, but members of Council elected through the annual ballot or who are coopted have no such rights.

It was decided that in future the deputies of faculty representatives should have voting rights at the meetings they attend. It was agreed that although observers should be able to nominate a deputy they still would not have the right to vote.

Council Elections

It was agreed that Professor Denis Pereira Gray should be nominated as the 1987-88 chairman of Council, Dr David Murfin as the chairman of Services to Members and Faculties Division, Dr Colin Waine as the chairman of the Clinical and Research Division and Dr John Ferguson as chairman of the Examination Board of Council.

Dr Alastair Donald was elected chairman of the newly formed International Committee.

A.O.B.

Council expressed strong disapproval of a Home Office draft circular on the use of hypnosis during the investigation of serious crime by police.

Council agreed with the proposal that the North Wales sub-faculty should be granted full faculty status.

From October 1 1987 the faculties' grant for each of their fellows, members and associates will be increased to a flat rate amount of £4 with no optional additional extra. It was agreed that the maximum subscription for the 1987-88 College year should be no more than £125.

Council agreed to establish an Ethical Committee. □

Scottish Council RCGP

SINCE the inception of the College an attempt has been made to include the membership outside London in its affairs and administration. The first Regional Council was set up in Scotland in 1953 for the purpose of coordinating the activities of faculties and other local organizations in Scotland. The original Foundation Council was concerned that the College should be able to assist its members and associates wherever they might live and work and, in return, the members would supply information about their needs and other aspects of general practice about which Council was concerned.

In Scotland faculty boundaries have always been the same as the NHS regions. Many years later the College Council adopted a similar plan for the reorganization of the College's faculty boundaries in England and Wales in the light of the 1974 NHS reorganization plan. It is interesting to note that the recent paper 'Quality and the College' stressed the importance of basing faculties on FPC districts.

The original intention was that the chairmanship of the Scottish Council should rotate through the faculties, but in recent years the chairman has been selected on merit.

The guidelines on which Scottish Council has functioned have been to coordinate rather than to initiate work in the faculties — receiving reports sent from them, helping them with their projects when necessary, and acting as a liaison between the faculty membership and the Council in London. In addition the Scottish Council produces evidence or comment on medical policy when asked by government departments and other organizations. At present the College is represented on 32 separate committees in Scotland.

Whether the comparatively low profile of Scottish Council has been beneficial to the work of the College nationally remains to be seen, although a recent survey amongst trainees in North Glasgow indicated that trainees were almost completely unaware, not only of Scottish Council's existence, but of its membership. Consequently, a determined effort is being made to raise the profile of this Council for the membership, concentrating particularly on young doctors. There is no move to form a separate College in Scotland, but rather to emphasize the work of the College in London and the many activities of this regional Council. The Scottish Research Advisory Committee, which has recently developed from the old research committee of Scottish Council, has representatives from each faculty in Scotland and has an important role in coordinating research activity, giving advice and promoting new concepts.

Aspects of health care peculiar to Scotland are discussed in detail at Scottish Council meetings. The recent Gillick case, for example, highlights some of the legal differences between Scotland and the rest of the UK. There are educational, social and cultural differences which may require the consideration of Scottish Council and its members.

The time may be right for this Regional Council to reappraise its role and function within the framework of the College, perhaps initiating rather more than coordinating the work of faculties.

Over the past 30 years Scottish members have contributed greatly to the work of UK Council and there is certainly no lack of Scottish representation in the corridors of Princes Gate.

There is an enormous reservoir of expertize within the current membership of Scottish Council and this resource is barely recognized not only by the membership but by faculties generally.

The Ian Stokoe Memorial Award is the gift of Scottish Council in association with South East Scotland faculty and the Ian Dingwall Grant award is likewise administered by Scottish Council. While the monetary value of these awards is low they are prestigious and they do attract applicants of high calibre.

The current membership of Scottish Council is probably one of the youngest for many years and hopefully this may result in a new broad based strategy for promoting not only the work of the College in Scotland, but also the work of the College nationally. □

Norman Jarvie

Singapore College

THE College of General Practitioners in Singapore has recently moved to new premises.

The College of Medicine Building, which was officially opened in August, also houses the Ministry of Health Headquarters, The Academy of Medicine Singapore and a postgraduate medical reference library.

Until 1985 the block, which was previously known as the Faculty of Medicine Building, contained the pre-clinical and para-clinical departments, administrative offices, a library and lecture theatres.

For the occasion, which is regarded as a milestone in the development of the College of General Practitioners, they are preparing a commemorative issue of *The Singapore Family Physician* - the official publication of the College. □

Wellcome Museum

ONLY a stone's throw from Princes Gate, in fact just round the corner at the Science Museum in Exhibition Road, is a remarkable collection of medical paraphernalia. The Wellcome Museum of the History of Medicine is a unique three-dimensional record of man's concern with his health and an ideal place for visitors to the College to spend a fascinating afternoon.

The museum owes its existence to Sir Henry Solomon Wellcome (1853-1936), an american who settled in England and set up a hugely successful pharmaceutical business. The basis of the company's fortune was the purchase of an 1840's patent to make medicines in tablet form, a simple idea that had not previously been commercially exploited.

Although Wellcome is well-known as the philanthropist who left the future profits of his world-wide pharmaceutical business to the support of medical research, he was a polymaph and the scheme dearest to his heart was the foundation of a museum of man based on athropology.

Dr Brian Bracegirdle, the keeper of the museum, explained: "In Wellcome's life medicine was only part of the collection. Man's concern with his health is a very large part of anthropology — it is quite revealing of the state of mind of a civilization as to how it treats disease."

In 1985, after the death of his partner Silas Burroughs, Wellcome became the sole proprietor of the company Burroughs Wellcome and spent much of the profit on collecting. He became an almost manic collector using a network of agents and contacts all over the world, and at one time was spending more each year on collecting than even the British Museum.

By the time he died in 1936 he had 55 official collectors and had amassed over two million objects. Among other things his collection contained 250 pestles and mortars, 2000 microscopes, 20,000 surgical instruments and 50 shrunken heads.

Wellcome had intended that the Euston Road building be used for the museum, but the collection had not been fully installed before the company's headquarters were bombed during the Second World War and the museum displaced.

In the years after the war the museum store led a nomadic existence, being moved from Dartford to Willesden until finally coming to rest at the Science Museum. In the 1950s it became clear that Wellcome's grandiose concept of a museum of man would never be realized and other UK museums were offered the non-medical objects.

In 1977 the Wellcome Trustees placed the historical medical objects on permanant loan to the Science Museum and Dr Bracegirdle was invited to form a new department. He was presented with a storeroom the size of a football pitch heaped with boxes and crates, many of which had not been opened since Wellcome first bought them.

The process of identifying and recording was enormous. Each item had to be photographed, numbered, registered, catalogued and recorded on computer.

Many of the objects' catalogue numbers had been secured with luggage tags and during the course of 50 years the brown paper had crumbled.

"So even when there were adequate cards the numbers no longer related to the catalogue and in any case the descriptions were not those of experts," said Dr Bracegirdle.

The objects on display are a mixture of things that are exotic and totally humdrum.

"The essence of medicine is that it affects everybody and it would be totally unrepresentative if we were just to show the gorgeous items made of precious metals and ivory."

The museum curators were aware that the two functions of the museum were to provide entertainment with education for the casual visitor and to offer material for historical research. They resolved this by offering archive material, three-dimensional objects, paintings and printed books. The museum only has room to display 3 per cent of the 150,000 items they have in store at their vast warehouse near Olympia.

The objects on display are a mixture of things that are exotic and totally humdrum.

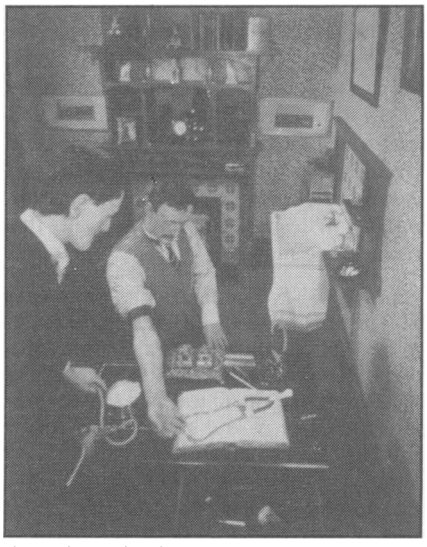
The lower gallery illustrates the evolution of modern medicine by putting the past and present side-by-side. The full scale 1980 open heart operation with the patient being kept alive by a heart-lung machine acts in sharp contrast to Lister's 1895 operating theatre where surgeons are using instruments treated with carbolic acid to kill germs.

There is the life-sized recreated scene of a consulting room at the turn of the century showing an advanced Midland's GP taking a patient's blood pressure with a sphygometer. Although he has an up-to-date binaural stethoscope, a leach jar can still be seen tucked away on a shelf.

"This shows the very essence of general practice. Here is a forward looking GP in a very ordinary room, sorting out the trouble in domestic surroundings," said Dr Bracegirdle.

The beautiful reconstruction of a nineteenth century pharmacy came to the Wellcome Museum quite by chance.

"I happened to buy a copy of the *Hexham Courant* when passing through Newcastle in 1977 and to read that a pharmacist was retiring and selling off his shop which had been established before Victoria came to the throne and last modernized at the turn of the century," recalled Dr Bracegirdle.



Consulting the doctor in 1900

He immediately travelled to Hexham and made the owner, Mr Gibson, an offer for the entire contents of his shop. The interior of the pharmacy with its mahogany drawers and rows of drug jars and bottles has been erected with great attention to detail in the lower gallery and the pharmacist behind the counter was meticulously modelled on portraits of the present Mr Gibson's grandfather.

The upper gallery entitled *The Science and Art of Medicine* emphasizes the importance of the scientific basis of modern medicine.

It is almost impossible to convey an impression of the breadth of this remarkable collection. They have the silkworm cocoons that Louis Pasteur used to investigate fungal disease and the family sherry glasses that Lord Lister resorted to in 1877 when there was no suitable equipment available for his experiments. It was as a result of this work using ordinary domestic vessels that he developed his revolutionary antiseptic techniques for operating theatres.

But perhaps the most interesting objects for the College visitor are the original dudgeon sphygmograph and polygraph that James Mackenzie used for his important cardiology investigations.

"We display some anthropological items because you can't hope to understand people's medical practices without knowing something of the context in which they live," explained Dr Bracegirdle.

One of the strengths of the collection is the large number of similar ordinary items that have proved invaluable to historical research. Specialists can make appointments at the Olympia store to view entire rooms devoted to objects such as hypodermic syringes and scalpels.

Plans are now underway for a new 'Forward Looking' gallery containing phar-

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Dr Jordi Gol i Gurina

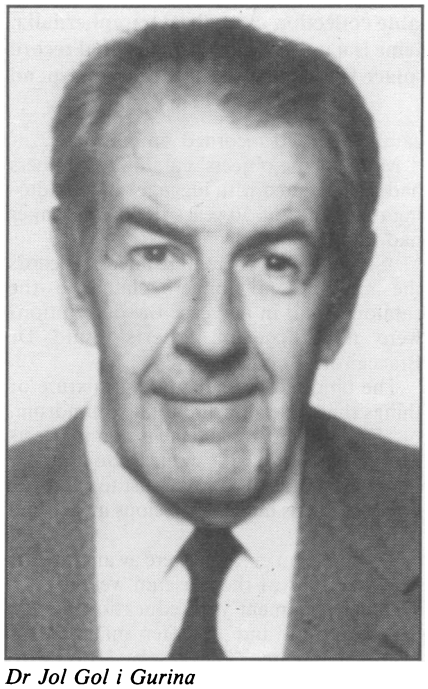
ALTHOUGH in his life time Dr Jordi Gol i Gurina was little known abroad he is now regarded with the same admiration in Spain as Will Pickles and James Mackenzie are in this country. Here Dr Julian Tudor Hart, who has attended a number of primary care conferences in Spain, writes an appreciation of this remarkable man.

In 1983 I went on the first of what later proved to be a series of journeys to Spain to speak at various meetings and conferences on primary care in the new Spanish National Health Service. Spain was in a state of sustained excitement and serious hope for its future which I could only compare with the atmosphere in Britain in 1945, and this was very apparent at medical meetings.

A curious feature of these meetings was the youth of the doctors attending. The middle-aged doctors, who seem to dominate many of our College meetings, hardly seemed to exist. Some doctors prospered under Franco, but they were not acceptable models to young doctors, nor were they interested in plans for a people's health service. One elderly man stood out as an obvious exception: a tall, gentle lion of a man, with a tanned, creased face topped by a white mane; and obviously held in great affection by everyone. This was the legendary Dr Jordi Gol i Gurina.

His sudden death in December 1985 ended a contribution to medicine that stretched from his student days in the ashes of Spanish democracy and Catalan cultural autonomy, to the death of Franco and nine years of huge creativity in the early days of the new Spanish Health Service. Progressive ideas in Spain have tended to start in Catalonia, and Barcelona is the undisputed pioneer of the still struggling service. For young Catalan doctors, Jordi Gol was as heroic a figure, as James Mackenzie and Will Pickles are to us, but with an added dimension as a folk-hero of a persecuted language and culture. His pioneering work and ideas deserve a wider international audience than they have so far achieved.

Jordi Gol was born into a medical family in Barcelona in 1924. He graduated with honours in 1949 and, even as a student, set himself the aim of being a doctor of people rather than of illnesses. As an active Christian intellectual he co-authored a book in reply to the 1969 Vatican encyclical *Humanae Vitae,* addressing the role of Christians in a technologically advancing society. The book was banned, the beginning of a series of difficult encounters with the Catholic establishment which were hard for a loyal and naturally shy Christian believer. He increasingly found himself drawn to problems of the relation between science and ideology, between ends and means, and the social functions of medicine. In 1970 he was appointed head of the department of internal medicine at the Red Cross Hospital in Barcelona, where he was involved in research and undergraduate teaching. The then incorrigible narrowness of the teaching hospital become intolerable. He finally resigned, together with many of his team, in 1976 (ironically, Franco died the same year) and became a GP in the social security system, bringing the clinical team concepts he had learned in hospitals to primary care. In Spain at that time this career decision was equivalent to moving from the highest level of teaching hospital consultancy to work on the Lloyd George panel before the Second World War; a defiance of established attitudes to medical hierarchy and an exceptional act of social courage and altruism.



Dr Jol Gol i Gurina

Starting from the Congress of Catalan-speaking physicians in Perpignan in 1976, which he helped to inspire, Jordi Gol became the standard-bearer for democratic, team concepts of primary care in Spain, producing many publications (mainly in Catalan) on the social functions of medicine and the role of the GP in a democratic health service. With a committee of GPs and representatives of small hospitals he developed the practical applications of his progressive ideas, which were applied by the rapidly developing Spanish National Health Service, and included diagnostic and treatment protocols and a Catalan pharmacological index similar to the British *National Formulary.* His death interrupted important work on a model for A4 primary care records whose development is being continued by his team. Copies of these records, and details of Jordi Gol's many publications, may be obtained from Dr Eulalia Masachs-Fatjo, Commission for Medical Records in Primary Health Care, Department of Health and Social Security, Government of Catalonia, Travassera de les Corts 131-159, 08028 Barcelona. □

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Wellcome Museum

macology displays — with a scientific treatment of the development of new molecules; a modern medical technology section with special reference to body imaging; and space for medical charities to provide stands to increase public awareness of the research they are undertaking.

A special feature of the medical research display will be a choice of video commentaries catering for different levels of understanding with advanced videos for scientists, another version for adults and a third for children.

"We see this as a 'cutting edge' which could be used by scientists at the frontiers of research wanting to see what their colleagues are up to, and on a simpler level by the public," said Dr Bracegirdle.

But what was Wellcome, the megalomanic collector, like as a man? The famous 'chestnut' story illustrates both his obsessional approach and the awe he was held in by his staff. Wellcome wanted a door in the Euston Road Building to be painted the exact colour of a conker he had in his pocket, but the next day he found that it didn't quite match. The door was painted again to match the conker and still it wasn't quite right. In all the door had to be painted 11 times.

"What Wellcome didn't realize was that as the conker dried in his pocket it changed colour and nobody dared tell him."

Perhaps the most revealing assessment comes from Wellcome's secretary, Doris Jones, who first joined him in 1926.

Dr Bracegirdle recalled a meeting with her: "She was a delightful lady and it has got to be said that she would never criticize anybody. But at our second meeting she did confide 'Mr Wellcome was never very easy', which was the most devastating criticism you could imagine her uttering of anybody." □

Janet Fricker

Life on the Ocean Wave

HAVE you ever considered an alternative holiday using your skills as a GP to work your passage on a luxury liner?

The practice of ship's medicine conjures up images of *Love Boat* or *Doctor at Sea,* with medical men living a life of indolence interrupted only by an occasional bout of petty illness. But the truth is far from this. With ships' surgeons having to be 'Jacks of all trades', totally reliant on their own resources and on call 24 hours a day, they need to be doctors of exceptional calibre.

The work of a ship's surgeon is similar to that of a single-handed GP, combining the skills of anaesthetist, surgeon, gynaecologist, orthopaedic surgeon and specialist in tropical disease.

A number of cruise lines have found that the GPs' broad medical experience makes them ideal candidates for the posts of relief doctors.

"Essentially the GP is the only medical animal who has seen it all before, and in a situation where there are no advanced hospital facilities he can tackle most things in a way that is extremely difficult for the specialist," said Dr John Brittain, the medical officer of Fred Olsen Lines.

But before you start getting too excited with visions of running your own practice on a floating hotel, be warned that opportunities to take a short working holiday have declined in the last decade. Spaces are now scarce, with doctors tenaciously holding on to existing jobs and competition for new posts is fierce.

On the rare occasions companies do appoint they tend to look for people in their 30s with at least five years post-registration experience and a casualty job. They prefer candidates who have worked abroad or in the armed forces. Middle aged married doctors are most popular because they are thought less likely to entertain romantic liaisons with passengers.

Selecting suitable candidates from the hundreds who write in is difficult.

"We have found that common sense and self-reliance are the most important things to look for since there is no referral at sea," said Dr Peter Oliver the medical director of the Cunard Steam-Ship Company.

Fred Olsen Lines have found it essential to use a referee who knows the candidate personally and can speak up for his 'seagoing' capacity.

"It's very easy to find someone whose qualifications and general background look good on paper, but it can be a very different matter when they're in a force eight gale," said Dr Brittain.

Since relief doctors can be required at short notice GPs from single handed or small partnerships are at a disadvantage when it comes to selection because they might not have time to arrange adequate cover.

Remuneration varies, some companies allow the wife and family to go free in exchange for the GP's services, while others pay salaries and have strict rules about not allowing wives on board.

The type of people who go on cruises are determined to enjoy themselves and won't be put off by illness.

"Passengers don't come on cruises to be ill. You see people staggering on board with sticks and frames, but the life is incredibly rejuvenating and they're soon up and about," said one College member who for the last 25 years has spent his summer vacations as a ship's doctor on various cruise lines.

But medical problems can be exacerbated by being at sea.

Sea sickness may provoke gastrointestinal bleeding and aggravate existing disorders such as gall stones and diverticular disease. In diabetics electrolyte imbalance and hypoglycaemic coma may occur.

The convivial life, the freely available alcohol and the absence of any problems of getting home at night has always attracted alcoholics, but happily passengers these days appear more serious and intent on enjoying where they are going.

Confined accommodation, air conditioning systems and large numbers of people living at close quarters combine to make upper respiratory tract infection the most frequent illness.

Cardiovascular emergencies are not uncommon since many of the passengers are elderly. Most ships now carry ECG and defibrillation equipment, while some even contain a small ITU with a cardiac monitor.

"With all this equipment immediately to hand passengers often stand a better chance of survival than if the attack occurred at home," said Dr Oliver.

Although some ships have sophisticated operating theatres, surgery is infrequent and only abdominal operations such as appendicectomies are ever considered.

"We prefer to manage patients medically until we reach port," explained Dr Oliver.

Dr Oliver warned doctors considering working for some of the cheaper foreign package cruises to take extra care because the medical standards they are used to may not always apply.

"You may get poor accommodation, poor equipment, a hospital with no nurse and you may not even be accorded the status of a senior officer."

He advises doctors to make careful enquiries about the conditions of service and to find out exactly what they will be expected to do.

Apart from running the medical department, doctors on some lines are expected to entertain passengers at their table, and although this has lapsed on others they are still expected to play a vital role in the ship's social life.

"Doctors have a real duty to mix with the passengers so that anybody who is anxious, worried or depressed is emboldened to unburden themselves," said Dr Brittain.

Other duties include showing the crew health education films on subjects like AIDS and regularly monitoring the standard of food hygiene in the kitchen and the ship's water.

"One of the nightmares of a ship's surgeon is having an organism in the water that leads to an outbreak of gastroenteritis," said Dr Brittain.

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Life on the Ocean Wave

Most of the ship's water comes from a 'desalinization' plant but on occasions it proves necessary to take it on board at a port of call. The recent introduction of a mobile lab on Fred Olsen's Black Prince is helping to solve this problem.

The mobile labs, developed by Surrey University for third world countries, weigh just 13 kg and using hand-held digital meters doctors can measure pH, conductivity, temperature, turbidity and free and residual chlorine. The system gives an immediate and accurate indication of the condition of the water supply with a means of ascertaining the bacteriological count of suspect samples.

The Black Prince now has the option of refusing the water or knowing precisely how to treat it.

With so many different passengers on board there are inevitably amusing incidents of the stuff Richard Gordon novels are made.

One doctor recalls the death of the cherished budgerigar of a duchess and since there was an epidemic of psittacosis in England the captain asked for an autopsy.

"Unfortunately the *Ship Captain's Medical Guide* contained no allusion to this disease, and my experience of carrying out post-mortems on birds was confined to carving a turkey.

"Having sized up the comparative diameters of the cage and the porthole I jettisoned the cage and contents into the Indian Ocean, and announced to the anxious group waiting outside 'natural causes'"

Fortunately no one subsequently developed signs of psittacosis. □

Janet Fricker

RCGP Folders

THE RCGP has produced a new information folder on the management of Parkinson's Disease which aims to increase GP awareness of the problems facing sufferers and their families.

There are about 100,000 people with the disease in Britain and although there have been advances in the last 20 years it remains a considerable challenge to the primary care team. The folder is the fourth title in a series on the management of chronic disease in general practice and has been produced with the help and cooperation of the Parkinson's Disease Society. It costs £7 for members and £8 for non-members.

The folder — *Entering General Practice* has been revised and now includes the article "Job sharing in general practice" by Dr Sue Jones. This folder retails at £3 to members and £4 to non-members.

Both folders are available from the Central Sales Office at the RCGP. □

SIMG: Prague 1987

THE 36th International Conference of the Societas Internationalis Medicinae Generalis (SIMG) held in Prague this year, provided a rare opportunity for GPs from both East and West Europe to meet.

Altogether there were more than 700 doctors present representing nearly every European country, together with a few from North America and Japan. Topics discussed ranged from education in general practice, where the varied experiences in the countries reporting were demonstrated, to prevention of heart and vascular diseases, where similarities seemed more striking. As usual, discussions outside the conference setting were equally rewarding. It was fascinating, for example, to learn that the Russians, plan to dismantle the polyclinic system of 'specialoids' and replace it with generalist doctors, and also to hear about Czech patients' expectations of primary care.

At one of the formal sessions Dr Lotte Newman, who has done so much for SIMG, was presented with the Purkinje medal of the Prague Medical Society.

The social activities included a dinner at the Konopiste Hunting Lodge in central Bohemia. This was the last home of Archduke Ferdinand d'Este, whose assassination at Sarajevo precipitated the First World War, and was remarkable for the decoration of every square foot of wall space in the corridors with the antlers and tusks of the hundreds of animals slaughtered by the family in the surrounding forests. On another occasion the Prague Male Voice Choir, with organ and trumpet, gave a dramatic concert in St Nicholas' Cathedral whilst thunder and lightning crackled overhead. Prague is a fascinating city of fifteenth to nineteenth century buildings, which have escaped the depredations of war and post-war developers. There is an extensive renovation programme and it must soon become one of Europe's most beautiful cities. The 1987 conference underlined the value of a visit to an SIMG meeting for any GP. □

MICHAEL DRURY

SIMG is organizing a research contest - the KD Haehn Award - open to vocational trainees and established GPs working on their first research projects.

The award is in memory of Professor KD Haehn, who died in 1986 and held the first chair of general practice in Germany.

The paper has to be written in either English, German or French and describe a completed research project which has not previously been submitted for publication. The work should have been performed in general practice and based in at least one of the following areas: the structure, management or practice organization of primary care, epidemiology, patients' expectations and beliefs and the family.

Applications have to be submitted before March 31, 1989. Further details can be obtained from Professor Dr C van Weel, Department of General Practice, University of Nijmegen, PO Box 9101, 6500 HB Nij-megen, The Netherlands. □

Free Milk for Pregnant Women

THE Maternity Alliance and the National Dairy Council are asking GPs to help boost the up-take of welfare milk by pregnant women and nursing mothers.

Expectant or nursing mothers and young children in families receiving supplementary benefit, family income supplement or who are on a low income are currently entitled to tokens which they can exchange for seven pints of cows' milk per week. As an alternative babies up to the age of one can get two packs of dried milk per week.

But Lyn Durwood, the policy and information officer at The Maternity Alliance, said that enquiries coming to them suggest that many pregnant women do not hear about their right to free milk until a few weeks before the birth. As a result women in the lowest income groups lose the benefit of additional nutrition at a time when they most need it.

Miss Durwood feels that GPs can play an important role in informing pregnant women on low incomes about their entitlement to free milk.

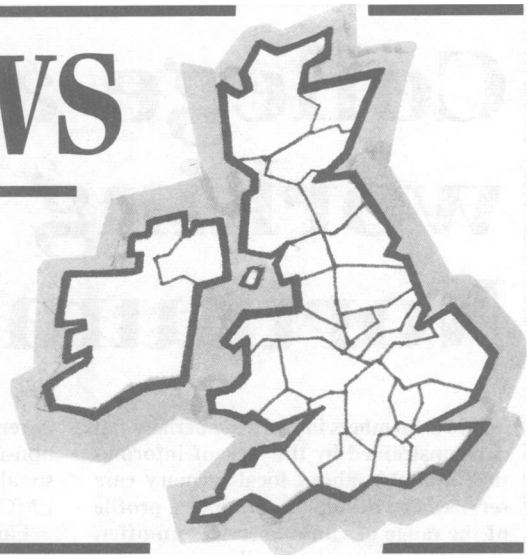
"The GP is often the person who tells the woman she is pregnant and may be the only health professional she sees early in the confinement," she said.

She added that it would be helpful if GPs could keep supplies of the DHSS leaflets MV11 and FW8 explaining how to claim the milk.

GPs who want to display the National Dairy Council and Maternity Alliance leaflet about obtaining free milk in their surgeries should write to B Mannock, E Christian and Company, Peckham Grove, 191-195 Southampton Way, London SE5 7EF.

A copy of a poster drawing attention to free milk for display in GP's surgeries is enclosed with this month's Journal. □

FACULTY NEWS



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The Cost of being a Council Faculty Representative

IN 1984, the sub-faculty of Cumbria metamorphosed out of its parent in the North East to become the Cumbria faculty. One of the great attractions was that we would have direct representation on the College Council, and hopefully have some say in the ideas and policies emanating from Princes Gate. At the outset we decided that whoever represented the faculty on the Council would have a three year term of office. This would share the workload and ensure that our representative did not become too 'establishment' in his thinking. I have now completed my term and, as I step down, I thought it might be interesting to make some observations on the costs of being on Council.

For those who don't know, Council meets four times a year on a Saturday in London. In addition, most Council members are asked to serve on one of the College divisions (during my time four although another reorganization is in the offing) which requires a further four whole days of meetings in London, usually on a weekday. As well as these purely College based meetings it is usual to ask Council members to represent the College on a variety of bodies from government quangoes to national voluntary bodies. The time commitment is infinite and the first weapon in the survival kit of any budding councillor is the ability to say 'no' nicely to the honorary secretary! I, in fact, represented the College on two bodies, each of which met three times a year in London.

So the cost in time is substantial. The weekend meetings are a cost to be borne by one's family. Four Saturdays a year does not sound a lot, but add this to an on-call rota and it can cause problems. I have always tried to bring my wife down to London for the day as part of our personal deal. Those experienced in marital matters will recognize the financial implications. Meetings during the working week represent a loss of time from the practice and have to be paid for either in reciprocal time for other partners or by financing a locum from practice profits. No College Council member is reimbursed for locum expenses unless he or she holds one of the major offices.

Travel and subsistence are reimbursed. To bring me down to London cost the College about £130 in road, rail and sleeper charges. I tended to use the sleeper because it meant I only lost one working day, with home to London taking about four and a half hours. I became quite a fan of British Rail's sleeper system and in three years I was never once let down. However on occasions where an overnight stay had to be made I was out of pocket financially. I lost time from the practice, and the accommodation allowance paid by the College is less than the section 63 limits and certainly less than an overnight stay in a reasonable hotel. It is of course possible to stay in Princes Gate, but it gets booked up quickly.

What about the other hidden costs. Anybody who has had sight of the Council agenda will appreciate the time required to read through all the papers. I estimate that it takes about three hours to read an average agenda bundle and longer if you intend to speak to an item where further background reading may be necessary. Papers for division meetings take a similar amount of time, not 'protected learning time' but unprotected family time. During my stint on Council we had the deputizing furore, the limited list, the quality initiative and the green paper. I leave to your imagination how much paper these generated.

There are other more subtle hidden costs. As with any national representative body which gets involved in medico-political issues, colleagues can at times be suspicious of your motives. There have been times when it has been difficult to defend a Council decision in the face of criticism even when I have been convinced by the arguments at Princes Gate. I firmly believe that the only way to avoid these problems in what are often close personal friendships, as well as professional ones, is to be open and honest in discussing Council business within the faculty. I therefore always refused to recognize the red stamp on my mail from Princes Gate which marks Council papers 'strictly confidential'. Its only purpose has been to assist me in pretending to my children that I am really a spy who goes off on mysterious trips to London! It is this mentality which I believe led to our most recent difficulties and no amount of reorganization will cure the problem if fellow GPs feel that discussions in College are top secret.

Have the costs been worth it? I think they have. It has given our faculty a closer link with Princes Gate. It has allowed me to meet and talk with some stimulating colleagues and bring back ideas to both practice and training. It has shown me a lot that is good within our College and has reinforced my continued membership. It has however convinced me that there is more personal satisfaction to be gained from clinical general practice than from medical politics. That alone has been worth it.

Remember that running Council and its offices costs you, the members, some £360,000 a year. It costs more to run Council than the membership division which includes all the costs of the MRCGP examination. Perhaps you should take an interest in its work and in the work Council members in your faculty are doing. After all it's your money! □

Robert Walker

College and LMC — working together in Northumberland

LMC members in Northumberland felt constrained by the lack of information available about local primary care services and decided to produce a profile of the range of clinical services on offer.

In 1984 we set up a small working party called the 'Review Group' to conduct a survey on the services local practices provided.

Confidentiality was seen as an important issue since Northumberland is a large rural county with a south-eastern corner containing old industrial towns, making many practice profiles instantly recognizable. Even before the questions for the survey were finalized it was obvious that some information about the doctors themselves might be considered confidential, and publication of comparative data about neighbouring practices was not considered ethically acceptable. These problems were resolved by deciding to publish data in a non-attributable form by aggregating it into six areas which were more or less coterminous with local authority districts within the county.

Despite the 'allergy' doctors seem to have to questionnaires, we decided to use them to collect information from all 162 principals in Northumberland. Three things favoured the LMC questionnaire. First, it was self-generated and approved by the committee. Second, feedback of the results to every practitioner was an integral part. Third, we agreed that non-responders could be 'followed-up' by the deputy chairman of the LMC, who alone knew their identity.

Recognizing at an early stage that we would need assistance with the management and analysis of data we were fortunate to employ Jane Smyth to undertake the analysis and to have the back up facilities of the Health Care Research Unit in Newcastle.

In March 1986 a postal questionnaire was sent to each principal in Northumberland seeking information on qualifications and postgraduate training, professional commitment, patient care, professional appointments outside the practice and clinical services offered by the practice. Questionnaires were identified by a confidential number, with the key only being available to the deputy chairman. A reminder was sent after two weeks to non-responders and in nine cases a personal reminder followed from a local LMC member.

Early analysis showed that confidentiality was harder to preserve than we had at first thought and we had to further aggregate the results into five areas containing populations of between 40,000 and 60,000 people.

We were fairly confident that we would achieve a reasonable response rate, but we did not anticipate that we would get a 95 per cent return. Replies were received from 154 of 162 principals and from at least one doctor in each of the 51 practices. The profile of the doctors is one of a fairly recently qualified group, with slightly over half having qualified since 1970, and just over half having undergone vocational training. Some 58 per cent of respondents were members of the RCGP and only 17 per cent had no postgraduate qualifications.

"We were fairly confident that we would achieve a reasonable response rate, but we did not anticipate that we would get a 95 per cent return."

As a result of the widely scattered population there are a number of community hospitals in Northumberland and it is estimated that 42 per cent of doctors hold hospital appointments as part of their clinical work. Among the wide variety of professional appointments held outside the practice were 'well baby' clinics, teaching and industrial medical adviser posts.

Our aim in asking about clinical services was to develop a picture of the range of clinical activities being offered in the county and which professionals were providing them. Rather than looking at what skills were being used in consultations we asked about services which had needed an element of planning, not least because there is increasing consumer pressure. All of the practices offered antenatal care, immunization programmes, family planning services, and cervical cytology, while 82 per cent offered 'well baby' care. In addition more than a fifth of practices were offering special clinics for such things as blood pressure screening, diabetic care, weight control and marriage guidance. Many of the services were offered both at clinics and in consulting sessions by doctors, practice nurses, community nurses, health visitors and midwives, sometimes separately and sometimes together. In general, the practices least likely to offer special sessions were rural or single-handed or both.

Special sessions can have advantages including the 'mini-specialization', the involvement of other health professionals, administrative convenience, the maintenance of skills and the possibility that the discipline of a clinic session leads to a better adherence to clinical protocols. On the other hand, there are disadvantages such as lack of flexibility, inefficient use of time if only a small number are catered for, the difficulty some rural patients have in getting to sessions at set times in the day, lack of confidentiality and loss of skills in doctors who are not involved in providing the special sessions.

It has been interesting to see the effect of this exercise on LMC members. Far from being reluctant to let others see the results, members have been keen to promulgate both the report and the concept of LMCs seeking information on which to plan family doctor services. Although it is important not to under-estimate the workload and resource implications involved, these difficulties are not insurmountable. Offers of help came freely from the FPC and the DHA officers and we used local resources to contain costs wherever we could.

Even if this exercise in information gathering was a once-only undertaking we would regard the resources of time, effort and money as well spent. Our colleagues are not letting us off so lightly. Already there is talk of collecting process data from information already available from sources such as FPC and DHA while long-term plans involve measuring the quality of care. By working together we are ensuring that Northumberland general practice will live through interesting times! □

Allen Hutchinson

Organizing the faculty

JANET Norton Bruce, the administrative assistant of the Midland faculty, describes her work with the RCGP.

In October 1986 I returned to the Black Country and applied for the new part-time post of administrative secretary to the Midland faculty of the RCGP. I had enjoyed working as a receptionist, medical secretary and practice manager and was pleased to retain links with general practice, though I missed the hubbub of surgery life.

Initially most of my work came from the honorary secretary, and I spent the first three weeks setting up the faculty office and making contacts. I had to sort through files which had previously been kept by the honorary secretaries, to varying degrees of efficiency.

Once I was introduced to the faculty board and they had discovered there was someone with time and energy to do the background work, ideas came flooding in.

Since then, I have begun work on dividing the faculty into 22 informal districts, in the hope that this will encourage better contact with the local faculty board/postgraduate centre representative, encourage attendance at local meetings and facilitate local mailings. The Board appointed convenors responsible for education, research, ancillary staff (including practice nurses), CHC's, LMC's, GMSC and Young Practitioners. There is also a newsletter editor.

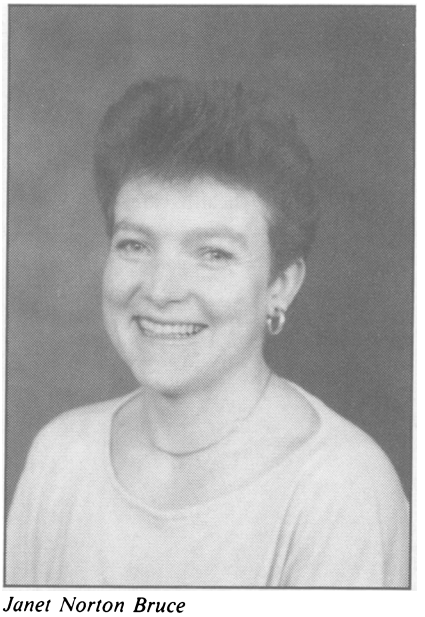
My work now comes from officers, local representatives, convenors, and from any faculty member requiring administrative support for College work or meetings. It can be divided into three main categories. For the faculty board meetings I am responsible for copying incoming correspondence and distributing it to the appropriate members, preparing and circulating the agendas, organizing a venue and informal meal, follow-up correspondence (usually initiated by the honorary secretary), preparing and circulating minutes and action reminders to officers, representatives and convenors.

I receive work directly from local representatives and convenors, which may include the organization of meetings and symposia, preparation of circular letters, receipt and transfer of relevant information, and general provision of administrative and secretarial support. Recently an exciting part of my work has been helping to facilitate the formation of the West Midlands Practice Nurses' Association on behalf of the faculty. As far as the faculty newsletter is concerned I am required to channel information, liaise with prospective contributors and maintain contact with the publisher.

Finally there is the day-to-day administration of the office, tasks like dealing with correspondence, maintaining my 'who's who' lists and keeping in contact with Princes Gate (usually the registration department or the faculty liaison personnel).

The faculty office is located in a Regional Health Authority building, so I have access to facilities such as telephones, franking, and photocopying, for which the faculty is invoiced quarterly. I share the office with the staff of the regional adviser's department and there is also good liaison with Birmingham University's department of general practice.

I see my role as facilitating communication between local members and the faculty board, the faculty board and Princes Gate and between faculties. In addition I maintain contact with DHA's FPC's, LMC's, CHC's, and such other health professionals and patient groups as the board directs. My presence has allowed ideas to germinate and I provide the information, skills and time to put them into action.



Janet Norton Bruce

In the last three years the number of administrative assistants has more than trebled and I am sure this has been welcomed by the faculties nationwide and the College centrally. It must be of benefit to members that there is better College contact and increased local activity. The availability of administrative assistants produces a more professional image and probably a more active faculty, with improved communication in all directions. I am delighted that Princes Gate held a national meeting for administrative assistants to enable us to pool and exchange ideas and has also set up a working party to define and develop the role of the administrative assistant.

I feel it is essential that faculties considering the appointment of an administrative assistant seek advice from faculties with an assistant in post, as well as from Princes Gate.

I enjoy the diversity of the tasks I am asked to perform and appreciate the opportunity to meet such a variety of interesting people. I would not claim that everything in the garden is rosy or that I am a panacea for all 'ills'. The job is however interesting, challenging, sometimes difficult but never dull. There will of course be similarities and differences between my role and that of other faculty administrative assistants, but I hope they all find their jobs as rewarding and enjoyable as I do. □

Management in General Practice

THE North and West London faculty held the second of three meetings on *Management in General Practice* on Tuesday, 9 June at Princes Gate.

Previously the organizers, Drs Oliver Samuel and Eddie Shaoul, had considered the problems of employing staff using the fictitious situation of a receptionist who decided for herself what the partners and patients wanted, rather than servicing their actual needs.

This time attention was focused on the practice accounts. And not very satisfactory they proved to be for the 20 odd doctors and employed staff present. A partnership of four plus trainee were earning well below their potential, missing out on staff reimbursements and item of service payments. Their expenses were excessive for the volume of work being done. The surgery premises were inadequate for doctors, staff and patients, and where were the plans for the future with a senior partner approaching retirement, council housing and office developments scheduled for the area, and two large schools in the vicinity?

The immediate solutions were not necessarily the most suitable. Dr Shaoul was able to demonstrate that testing out a hypothesis can be used to solve management as well as clinical problems. Asking the right questions facilitates conclusions being drawn — and not always those expected.

Monitoring the practice accounts both from the FPCs' returns and the audited income and expenditure account can reveal more about your practice than just how much you are earning. Perhaps, as someone remarked, this practice was content to receive pennies from Heaven for not trying very hard. Most of those present, however, seemed to prefer to make a planned input for a financially rewarding return. □

Helen Sapper

Isolated General Practice

WE travelled by land, air and sea to Berneray, one of Britain's most remote inhabited islands in the Outer Hebrides, for a meeting on the problems of providing primary care services to isolated communities.

Geographical isolation has been seen in the past as a reason for being unable to provide adequate training in the North of Scotland and Western Isles. But three years ago members responsible for organizing training in the North of Scotland set about trying to overcome some of the problems of geographical scatter. One solution has been the setting up of local trainer/trainee groups under the guidance of local trainers. These meet regularly and supplement the centrally organized training which takes place in residential courses held in Inverness each January, May and September.

Invitations to attend the meeting at Berneray were extended to trainees from the mainland, several principals from the Isles and an imported principal from Shetland. The fact that the rest of Britain was experiencing its wettest June on record only served to heighten the pleasure of meeting on a sun drenched isle at the height of summer. The highlight of the day was a seafood luncheon prepared by the local ladies using lobsters fresh from the sea. It would have graced any five-star hotel and had to be experienced to be believed.

The meeting had a mixed audience with local principals and trainees, students from the US and Liverpool, members of the local primary care team, and a consultant psychiatrist from the Western Isles. A reporter from London and camera crew from Inverness attended and last, but by no means least, several patients added an extra dimension to the meeting by describing the management of their conditions in isolated circumstances.

GPs in such areas face the challenge of providing both traditional family and frontier medicine, placing high demands on their individual resourcefulness. Speakers carrying out primary health care in the area outlined the problems they face in their own fields.

Dr Ian Clark, consultant psychiatrist for the Western Isles, discussed the effects of isolation on both the doctor and his family and the unusual circumstances under which an isolated GP works. Does the doctor, for example, adapt to the local community or remain true to his own views! The longer periods of time spent in consultations provide a way of working that is often not possible in busy urban practices.

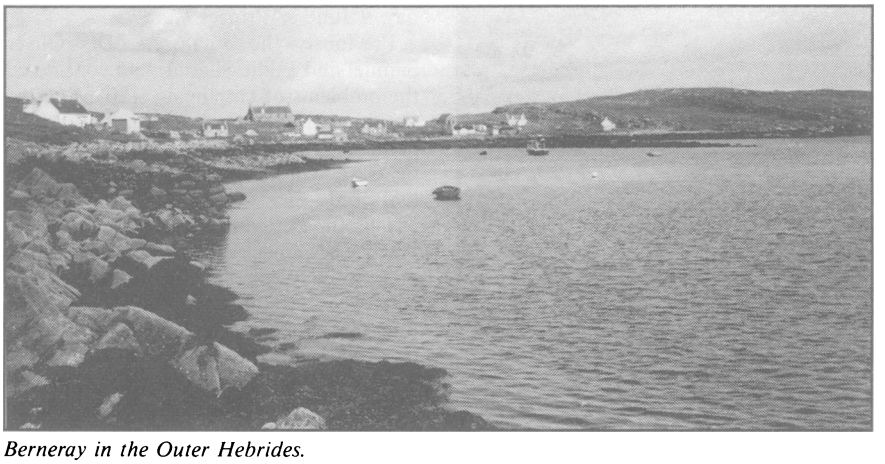
The need to keep up-to-date was highlighted by several speakers. Distance learning material and emerging technology should help overcome these problems. However all GPs need professional contact and it is notable that it is often the isolated GP who makes it to the local postgraduate centre when their mainland colleagues are unable to reach the meeting for a variety of reasons.

The College recently announced that it will help with the travel expenses of doctors travelling long distances to attend faculty meetings. For doctors in remote areas this should be a considerable boon.

Some question whether it is justifiable to send trainees to remote practices. Given that it takes a special type of GP to work in them, then surely it is right that trainees should find out if the lifestyle suits them. Those involved in training in the region feel that despite the problems of distance and geographical scatter, trainees get as good an education as anywhere else in the UK.

The final word is left to the wife of one of the doctors who has worked in the islands for 20 years: "There are bound to be drawbacks, but there are numerous advantages - not least being able to tell a red shank from an oyster catcher, and being able to sleep at night with the front door unlocked!" □

Ian McNamara



Berneray in the Outer Hebrides.