Diabetes mini-clinic

Sir,

Dr Ivan Benett (Letters, February *Journal,* p.76) describes the diabetic mini-clinic run by his practice for the last 15 months. His practice population is 13 000 and yet there are only 56 diabetics on the practice diabetic register. The prevalence of diabetes in the general population is variously stated as being between 1% and 2%. Taking the mean of 1.5% suggests that there are likely to be another 139 diabetics in his practice, the majority presumably undiagnosed (he does say that not all known diabetics have yet been included on the register), and not only unable to take advantage of the excellent facilities offered by his clinic, but not being given any care at all.

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Sir,

I note the comments made by Dr Griffith but I should point out that the audit was made only on diabetic patients registered for the mini-clinic. There are of course many who do not attend simply because they live closer to the district general hospitals or prefer going there.

It was not my intention to comment on known or unknown diabetics within general practice, as much has been written regarding their care. Dr Griffith is right of course in his assertion that as many as half of the diabetics are undiagnosed. Further, those diagnosed and being followed up in hospital clinics or under shared care do not receive optimum treatment. This is indeed my point. In general practice mini-clinics patients can be given personal, continuous and comprehensive care with particular attention to the identification of complications.

Since writing the letter more diabetics have been added to the mini-clinic register. There are now about 70 patients and I feel this is optimum; any more would result in a hurried hospital-like clinic with the loss of all the benefits I have mentioned.

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Non-steroidal anti-inflammatory drugs

Sir,

In view both of the numbers of prescriptions written for non-steroidal anti-inflammatory drugs and of the availability over the counter in pharmacies of the newer types, the leading article by Steele and Gilliland (February *Journal,* p.49) appealing for caution in prescribing these preparations strikes a welcome note.

It was disappointing, however, to find no reference to the part this category of drugs may play as trigger factors in asthma, leading to severe acute asthmatic attacks in susceptible patients. Asthma should therefore be added to the list of conditions in which great caution is indicated and this is referred to in the section on non-steroidal anti-inflammatory drugs in the *British national formulary.*

B.E. MARKS

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Diconal research: help wanted

I am working on a research project investigating the pharmacokinetics of the drug dipipanone. As part of this study I would like to analyse blood and urine samples from patients who are using Diconal (Calmic) to control pain. I would therefore be pleased to hear from doctors who are treating patients with Diconal and who might be willing to help.

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Incidence of otitis media

Sir,

The excellent paper by Ross, Croft and Collins (February *Journal,* p.70) has undoubtedly contributed greatly to our knowledge of otitis media in infancy. However, two of their observations deserve comment.

They discount the importance of self-selection, on the basis that parental concern and treatment expectations are high for children in this age group and with this condition. This would only be valid if the parents could reliably know that the condition was present. The basis of the study is that otitis media is under-diagnosed by doctors, and there is no reason to expect that parents are any more proficient at making the diagnosis.

The second observation is that the incidence of otitis media is higher in the two to three years age group. As I understand it, children were recruited at under two years of age, and therefore the only children who fall into the two to three years age group are those whose third birthday fell within the study year. These children were therefore not at risk for a full calendar year, and would be clustered preferentially towards the final phase of the study. Since seasonal factors are known to operate in this condition, the incidence in the older age group would therefore be artificially high if the study finished in winter or spring. A strict comparison with the data for the children up to two years old is not possible.

The authors' points about the diagnostic criteria and predictive value of subtle eardrum changes are well made, and I fully agree that further research is needed in these areas.

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Random analysis

Sir,

Random analysis is a regular feature of present day training. The cases discussed are usually those seen quite recently. As a variation our practice has found it instructive to discuss 'six month' random cases. In this instance the notes of patients seen six months (or any other agreed period of time) previously are produced for discussion. The aim of this audit is to check the outcome of arrangements made for patient care and it has demonstrated the need to look at the quality of written notes and the use of follow-up.

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Priorities in medical education

Sir,

In an article entitled 'Priorities in medical education' (News, November *Journal,* p.521) I suggested that the College has its priorities wrong when considering the contribution of general practice to the education of students and postgraduates. I have waited in vain for a response. Is there no one in the College Council or Education Committee who wants to tell me where I have got it wrong? Is there no one in the university departments who

wishes to support me? Are there no trainees who feel that a lot of their time as clinical students was ineffectively and inappropriately spent? Apparently not. And yet I am convinced that the contribution of general practitioners to education at pre-qualification level is now by far the largest challenge facing us.

If it were not for the fact that Sir George Godber rang me to say that he thought the article made a lot of sense I should fear that no one opened the *Journal* to read what I had written.

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Trainee representation

Sir,

As participants in the College's second annual trainee conference (News, December *Journal,* p.573) we support the College's view that two way communication between trainees and the College is vital. However, we wonder whether the conference achieves this aim? While the meeting gave the College an opportunity to inform those trainees present of some of its major preoccupations, communication in the other direction was poor. Since many of the trainee faculty representatives were meeting for the first time, the group lacked the necessary cohesion and sense of purpose to identify and represent national trainee issues to the College. We feel this is symptomatic of the poor representation of trainee's views at all levels of the College.

At the last national general practitioner trainee conference (Durham, 1987) trainees expressed their dissatisfaction with their representation through the College and the General Medical Services Committee. As a result, the GMSC has undertaken an internal review of trainee representation. We wonder whether the College should undertake a similar review so that trainees will be able to make their full contribution to the College?

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The College: academic or political?

Sir,

Professor McCormick and colleagues. (January *Journal,* p.30) deserve praise for their article discussing the College's objectives. In effect, they call for debate on the question of whether the stated objectives of academic excellence and educational achievement are compatible with the College as a political and representative organization, and if so, where the balance should lie.

The College's founding fathers had no doubt. The *British Medical Journal* supplement of 27 October 1951, in its report of a meeting of the British Medical Association's General Medical Services Committee, states: 'Dr G.F. Abercrombie [Chairman of College Council] said he could speak for the whole of his Council when he stated that they were not interested as a Council in medical politics. Their sole object was the education of the general practitioner and the improvement of general practice.' Also: 'Dr J.H. Hunt [Honorary Secretary of the College] repeated that they were interested only in the academic side of general practice.' And later: 'It would be their aim to refer all matters to do with medical politics to the BMA.'

A few months later the College suited the action to the word when it submitted evidence to the Cranbrook committee and sedulously refrained from giving advice on administrative topics.

Times change, but as far as I can recall, the College has never formally altered its policy, nor sought the membership's consent to extend its activities to the political field. There has, however, been a sea change and I believe that the effects have been detrimental to patients and profession alike. The only beneficiary has been the Department of Health and Social Security: ministers and civil servants have repeatedly been able to divide the profession and defeat its officially elected representatives.

Such political activity has begged the question of whether the College can act as a representative organization. If, in pursuit of high standards it seeks to exclude from membership those with lower ones, how can it claim to represent those it excludes? There are also some people who, rejecting a seemingly patrician approach to the politics of practice, refuse to join, even when cajoled with the offer of honorary membership.

Some members I have met would be glad to see the College expand its political activities. I am not sure if they are consciously seeking a means to impose their own views on their non-member colleagues, and it is a cause for concern that they might use their right to comment on standards as a cover story for political activity. As a democrat I would be happier if they took part in the local medical committee/GMSC system which represents every general practitioner in the National Health Service.

Besides, is there not something in a royal charter which forbids political activity?

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Fellowship by assessment

Sir,

I am becoming increasingly concerned at what appears to be a concerted campaign by some, mainly younger, members of the College to abolish the present method of fellowship by election.

Fellowship never has been some sort of 'long service and good conduct medal'. I was a member of the fellowship committee for five years and any experienced member could spot an 'old boy' nomination, and it was usually rejected if that was its only merit.

The task of the nominator is onerous and time consuming and no one would go to the trouble unless he felt strongly that his candidate had outstanding qualities. The nominator also has to find two sponsors. The nomination is then sent to the provost for his support and he consults two fellows not associated in any way with the nomination. Finally, copies of all the papers are sent to each member of the fellowship committee before it meets to consider its recommendations to Council. The fellowship committee may make its own enquiries. All this is done in complete confidence and any candidate attempting to canvass his own nomination is not considered.

I have no objection to a parallel route to fellowship when a member feels he has been overlooked and wishes to be assessed. The only difference from the existing method would be that the candidate would nominate himself.

I have been involved with the nomination of several members over the years both directly and as a provost and I feel the process is a thorough assessment by at least four people — the nominator, two sponsors and the provost. Fellowship is an honour that the College should be able to confer as at present, an honour that depends entirely on the candidate's standing among his peers. I am proud to have been elected under this system.

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