side of the Atlantic. It seems that the proposals are unnecessarily restrictive and other drawbacks have been noted by Drs Wall and Houghton in their editorial (August *Journal,* p.311).

The Royal College of General Practitioners should review the American Academy of Family Physicians' guidelines for postgraduate education. Membership of the Academy is similar to College membership but in order to maintain membership the Academy requires 150 hours of postgraduate education every three years. These hours may be obtained by attending convention type courses and lunchtime lectures, and from home study courses, case study reviews, teaching and research projects. Over half of the hours must be 'prescribed' credit, that is, the course, or organization providing it must be approved by the Academy in order for the educational content to be considered for 'prescribed' hours.

This approach is fairly flexible. The acquisition of hours, rather than days avoids the tedium of marathon educational sessions (unless that is your preference) and credit is given for personal endeavour. Other specialist organizations have similar guidelines and these are accepted by all the states in the USA which require continuing education as part of their licensing requirements.

Perhaps the College could adopt similar proposals for continuing membership. The College, rather than the government, would then have an opportunity to determine the direction of the future educational activities of its members.

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Torture of prisoners

Sir,

I read with great interest the appeal by Dr Beryl Dennis (April *Journal,* p.174). She referred to the strong stance taken by the Turkish Medical Association against torture or maltreatment of prisoners and appealed to doctors to write to the Turkish Medical Association expressing their support for this stance.

At a meeting of the federal council of the Medical Association of South Africa (MASA) in June 1989 two important resolutions were discussed and accepted unanimously.

1. A policy statement by MASA on civil unrest, the state of emergency and detention without trial. This statement expressed the deep concern felt by MASA regarding the unrest situation. It deplored violence from whatever source and deplored the concept of detention without trial.

2. A policy statement on the detention of children. This statement expressed the abhorrence which MASA felt at the misuse of children to attain certain aims and which could as a consequence lead to their arrest. MASA further expressed its opposition to the torture or abuse of children for whatever purposes and again stressed its opposition to the concept of detention of children without trial.

It should be stressed that MASA is a free and independent association of medical practitioners and that membership is entirely voluntary. Membership is open to any registered doctor regardless of race, colour, sex or creed. It has no connection whatsoever with any government or state authority.

It would certainly strengthen our stance if members of Amnesty International could write to MASA (428 King's Highway, Lynnwood, Pretoria 0081, Republic of South Africa) expressing the same support as has been suggested for the Turkish Medical Association.

NORMAN LEVY

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New contract

Sir,

We now have a clear idea of our new terms of service. They confirm that the contract is not only going to be very tough but is going to be strictly enforced.

Unfortunately many general practitioners have not read through the new contract and many practices have not carried out a costing exercise to see how well off they will be when the contract is introduced. In my practice, if targets which rely on the patient's cooperation are not achieved, if minor operations in clinically approved rooms are not carried out, and if the doctors who presently carry out paediatric assessments are not credited to do so under the new system, then we will be worse off despite carrying out the same clinical work and having to take on more administration and health checking. We will have to take on more staff without guaranteed reimbursement, we will have to see many more patients most of whom will be perfectly well, we will have to visit elderly patients for what is basically a social assessment or pay someone else to do this, and we will also have to keep more records in order to write our annual report on prescribing habits, visiting records, hours worked, time off, referrals and so on.

By accepting the new contract we are subjecting ourselves to unnecessary work without reward. We will be told what to do and how to do it which is not how professional people should be treated. Without action we will be condemning our patients to a poorer service which does what is necessary badly and offers a great deal of unnecessary activity which many patients do not want.

We must stand up for ourselves and give our patients a properly run, well financed system of health care even if this is at an initial cost to patients. By resigning we would be taking the National Health Service out of the political arena and resignation would not be unpopular with patients if all general practitioners resigned. It would signal our total opposition to the government's proposals, and if we continued to work as we do now but with additional services which patients want such as in-house physiotherapy, patients would support us. The government would have to reimburse patients as it would be politically damaging for them to stand back and do nothing.

In recent press reports the General Medical Services Committee have suggested an annual capitation fee of £75 per patient, but if all patients had to sign with their doctor privately, the actual capitation fee required to provide exactly the same service as at present would not need to be much more than £35 or £40. To that could be added small additional fees to cover physiotherapy, in-house biochemistry and other services useful for patients and provided on the premises. We would be maintaining our independence, and pricing our services appropriately, leaving the level of reimbursement up to politicians who would have to address themselves directly to their electorate, rather than negotiating the level of financing for health services with doctors and health academics.

We need to act together, and general practitioners must discuss with their partners and local colleagues what they consider to be best for their future and that of the health service. We must lobby local medical committee and British Medical Association representatives so that feedback from the grassroots reaches the negotiators. We must be united, otherwise a two tier system will result as many doctors leave the health service and the remaining doctors have the patients with the greatest needs. We must not despair but must do what we know is best for

ourselves and our patients, which is to oppose these government measures that will mean a deterioration in the standard of living of doctors and in patient care.

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Future of the College

Sir,

At the council meeting of the Royal College of General Practitioners on 22–23 September 1989 there was discussion of College financial strategies for 1990–95. It was clear that the College's need for more and more money to do what some members believe is necessary and important is going to outstrip resources by a considerable amount. It is even suggested that an annual subscription of £500 may become necessary to control deficits. It is clear that the College will have to decide on priority 'needs' to match available 'resources'.

This is an appropriate time to think again about what the College is doing and what it should be doing.

When I joined the College at its foundation in 1952 it was a relatively small club of self-selected and motivated enthusiasts from a general practice that was referred to as 'a cottage industry'. Now general practice is entering the era of big business with annual budgets of over £1 million in larger practices, and the College too has become larger and more professional. Unfortunately, in the same way that some general practitioners are ceasing to be long term personal doctors, so the College is in danger of becoming remote from its members.

At its inception, the aims of the College were fairly modest and precise. We wanted to improve the image and standards of general practice through more research, more education and better organization. This we have achieved. Now our leaders seem to be heavily involved in the grey morass of national medical politics. This may be right, but it is rather remote from the original aims. Such politicking is expensive, and reappraisal of our needs is necessary.

The College offers various services for members, but I wonder how many doctors will be prepared to pay £500 a year for them?

The Council did not come to any firm decisions, and the matter is likely to be referred to faculties and members. My hope is that the opportunity is taken to consider and discuss these issues.

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What happens in hospices

Sir,

What a curious quotation with which to start the digest article on the work of hospices (September *Journal,* p.384). 'They paved paradise/and put up a parking lot' is taken from a Joni Mitchell song (*Big yellow taxi*) which also has the words 'Hey farmer farmer/put away that DDT now/give me spots on my apples/but leave me the birds and the bees'. It is clear that the song is against the paving of paradise and the spoiling of the environment, but the article seems to say that hospices are showing medicine the way in many areas and that this is the equivalent of paving paradise. Surely not — surely hospices are showing us that planning permission will be denied for the paving of paradise.

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DIGEST

This month • cutaneous melanoma • pre-registration posts • training • abbreviations

Risk of cutaneous melanoma

THE incidence of cutaneous malignant melanoma is rising and this has led to public education campaigns to encourage earlier diagnosis. However, if individuals at high risk for melanoma could be identified, the disease may be prevented.

This study sought to identify the relative importance of clinically recognizable risk factors which may identify those individuals at greatest risk of developing a melanoma. It was found that the four strongest risk factors were total number of naevi, freckling tendency, number of atypical naevi and number of episodes of severe sunburn. From these variables, a flow chart was constructed such that personal relative risks could be estimated and graded on a scale of one to four — from marginally increased risk to worryingly high risk.

A doctor can use this flow chart to assess an individual's personal risk factor and, if necessary, give appropriate advice to the patient.

(V.O.)

Source: Mackie RM, Frendenberger T, Aitchison TC. Personal risk-factor chart for cutaneous melanoma. *Lancet* 1989; **2:** 487.

Pre-registration posts in general practice

SINCE the Merrison report and the subsequent medical act of 1978 it has been possible for newly qualified doctors to spend four months of their pre-registration year in general practice. Few medical schools have risen to this challenge with only St Mary's running a regular rotation which has been well described (*Br Med J* 1985; **200:** 1797-1799). In a recent article in *Medical Education* Oswald and Kassimatis describe another model. They acknowledge that careful planning and case by case supervision allowed their programme to work well.

The pre-registration doctor spent a small proportion of her week seeing patients in surgery (two sessions per week) but the rest of the time assessing patients who requested home visits (including night calls) and following up hospital referrals, visiting them in hospital and after discharge. Other sessions were spent in child health and antenatal clinics as well as seeing patients with chronic diseases. Of the 208 home visits made during the four-month period 16 patients were admitted to hospital immediately and 19 were admitted later in the course of their illness. The authors felt that a wide range of clinical problems were dealt with during the attachment.

The main feature of this model was the work at the interface between general practitioner and hospital which allowed the junior hospital doctor a unique insight into patients' problems.

(F.S.)

Source: Oswald N, Kassimatis M. A house officer in general practice: a different experience. *Med Educ 1989;* **23:** 322-327.