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.