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.

Training and the quality of care

THE debate about the quality of care in general practice, how best to measure it and its relation to prior training, has its counterparts in other developed countries. We would do well to consider the results of studies carried out in other countries, such as this audit study of 120 randomly selected family physicians in Ontario.

Research nurses abstracted data from patients' records about social information, prevention and diagnosis and management of selected common conditions. Samples of patients were surveyed regarding accessibility, preventive procedures and quality of communication. The criteria for good care had previously been agreed by panels of (mainly non-academic) family doctors. Individual scores for the dimensions of care were combined to produce an overall 'quality assessment score'. This was highest for family physicians who had undergone residency training before taking the certificate examination of the College of Family Physicians of Canada and lowest for non-members, with intermediate scores for those entering the College by other routes. Younger doctors, those in large cities and women also had higher scores.

It is gratifying to see evidence for some benefit from training programmes, and the methods used in this project might have some relevance to the Royal College of General Practitioners as it considers how to implement practice based assessment for prospective fellows.

(J.W.)

Source: Borgiel AEM, Williams JI, Bass MJ, *et al.* Quality of care in family practice: does residency training make a difference? *Can Med Assoc J* 1989; **140:** 1035-1043.

Serious injury by abbreviation

ALTHOUGH doctors have failsafe measures to prevent damage and injury to patients, these are not foolproof and catastrophes can result from misunderstandings and poor communication. Ignorance is rarely a cause of tragedy.

This report in *South African Family Practice* describes the case of a three-week-old baby girl who was still jaundiced. Her general practitioner decided to check serum bilirubin and wrote TSB (total serum bilirubin) on the request form. The phlebotomist was unsure what this meant, and phoned the doctor to find out. The doctor was unavailable so the phlebotomist contacted a paediatrician who felt that it might be a request for thyroid function. The phlebotomist inserted a needle to get a large sample of blood. The baby screamed with pain, vomited, aspirated the vomitus, and had a cardiorespiratory arrest. Fortunately skilled help was available and the child was resuscitated and discharged from the intensive care unit three days later. The relieved general practitioner reflected ruefully that he had almost killed her with his pen.

Near misses are more common than disasters but are rarely subjected to statistical and critical analysis. Perhaps doctors would be more objective and less defensive if near miss rates were analysed.

(C.D.)

Source: Ellis C. A series of misunderstandings. *S Afr Fam Pract* 1989; **10:** 447.

Contributors: Valerie Oates, Glasgow; Frank Sullivan, Glasgow; John Wilmot, Coventry; Charles Daly, Co. Waterford.

INFECTIOUS DISEASES UPDATE

Listeriosis

Listeria monocytogenes has emerged as a bacterium of public health significance owing to the nationwide increase in cases of listeriosis (170 to end of June 1989 compared with 136 for the same period in 1988). Ubiquitously distributed, in soil, water and vegetation, making exposure unavoidable, it has the unusual property of multiplying in foods at domestic refrigerator temperatures. Fortunately it is killed by adequate cooking.

Up to 5% of the population are symptomless gastrointestinal carriers but there is no clear evidence of person to person spread except at birth. Rarely does an uncompromised member of the public become ill with listeriosis. Those principally affected are pregnant women, their fetuses or newborn offsprings, the immunocompromised, and the elderly (predominantly those aged 75 years and over). The incubation period is uncertain. Clinical presentation can be septicaemia, meningitis or a non-specific febrile illness. Cases among pregnant women commonly present as premature or spontaneous labour with the fetus or neonate being infected. The organism is usually ampicillin sensitive but mortality is around 30% as a result of the underlying clinical conditions.

The majority of food related case reports highlight foodstuffs eaten without further cooking or a failure in processing or heating. Foods implicated include coleslaw, soft cheeses, pate, chicken and turkey sausages. Chief medical officers have issued advice to all doctors on the importance of observing food hygiene precautions and on following manufacturers' instructions for storing foods in refrigerators, and on the use of microwave cookers.

(D.C.)

Pertussis

It is anticipated that the next whooping cough epidemic will occur soon and notifications and laboratory confirmed cases suggest that numbers of cases are already increasing. Traditionally, in a partially immunized community epidemics occur every three to four years and last for 12 to 18 months. However, as immunization rates increase the peaks and troughs become less well defined. It may be timely to note that monovalent pertussis vaccine is available for children who missed out on primary vaccination as infants and whose parents may have had second thoughts.

Whooping cough can still occur in those immunized but the illness is usually mild. It may then be confused with other causes of a persistent cough. Isolating the organism using pernasal swabs remains the most definitive method of diagnosis (a carrier state is unproven) but some regional laboratories can now look for immunoglobulins M and G in serum which are useful tests, especially in older children and adults, from whom isolation of the organism is less reliable. Antimicrobial drugs give little or no benefit after the first five days of the illness but sometimes they are used later to try and cut down infectivity. For example, they can be given to older ill siblings if a newborn child is about to return home, at the same time as attempting to arrange isolation of the infected child. There is no placentally transferred protection against this disease and children under six months of age tend to have a more severe illness.

(E.W.)

Contibutors: Dr D. Campbell and Dr E. Walker, Communicable Diseases (Scotland) Unit, Ruchill Hospital, Glasgow G20 9NB (041-946-7120), from whom further information about the current topics can be obtained.