the former, parents may be inadvertently increasing the likelihood of the latter.

The advice that 'the infant should be kept in the parents' room at night' may not be necessary. I am not aware of any evidence that the room in which the child sleeps makes any difference to the rate of sudden infant death syndrome. In contrast, having the infant in the parents' bedroom may contribute to parental anxiety by obliging parents to respond to every noise and movement in the cot, a feature which is likely to increase as the child gets older. Perhaps it would be less frightening to suggest that parents, for their convenience, consider keeping the infant in a cot by the bed while the infant is still being breast or bottle fed. This would probably cover the age of maximum risk of sudden infant death syndrome.

The greatest short-term benefit in the prevention of sudden infant death syndrome is likely to come from advice which attempts to reduce the following: infants sleeping in the prone position; maternal smoking; bottle feeding (by encouraging mothers to breast feed). Much evidence demonstrates that the prone sleeping position is associated with increased risk of sudden infant death syndrome.[2,3] This is also supported by evidence that sudden infant death syndrome rates are relatively low in groups which normally let their infants sleep in the supine position, for example, Hong Kong Chinese and Pacific Islanders in New Zealand.[4,5] Many studies have shown that maternal smoking is associated with an increased risk of sudden infant death syndrome, indeed in one extensive epidemiological study, maternal smoking gave the highest odds ratio of any risk factor for sudden infant death syndrome.[6] One study has demonstrated a dose response relationship between the number of cigarettes smoked by the mother and the relative risk of sudden infant death syndrome.[7] The evidence supporting breast feeding is not as strong as that of the other two factors, although case control studies have shown that sudden infant death syndrome cases are more likely to have been bottle fed at one month than the control infants.[8]

Practitioners need to give a great deal of thought to the advice they give parents and prospective parents regarding the prevention of sudden infant death syndrome. It should be clear and consistent, as over-complex advice may serve only to confuse at a time of high anxiety.

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Patients' and doctors' sex and ethnicity

Sir,

Ahmad and colleagues recently reported that Asian patients were more likely to consult a doctor of similar ethnic origin, whereas for non-Asians, the sex of the general practitioner was more important.[1] However, other factors not studied by the authors may have contributed to this difference, such as the age of the doctor, his or her personality and his or her ability to deal with specific complaints, such as psychosocial problems. Such qualities are irrespective of ethnicity and may have influenced whom the patient consulted.

No account was taken of availability of appointments for different partners — perhaps the woman doctor's appointments were fully booked so the consulting patterns may not reflect the patient's 'first' choice of doctor. This clearly would have some bearing on the results. Although the numbers studied were adequate (1633 consultations were analysed), the duration of the study was short, lasting for four weeks. This may not accurately reflect consulting patterns throughout the year. It is important to know individual general practitioner policy in terms of patient review — could different review policies have caused this apparent difference in consulting patterns? This difficulty could be overcome by studying only those patients attending for their first consultation about a new problem.

It is important to appreciate that there may be other, more subtle but important, factors influencing patients' choice of doctor, not just sex and ethnicity.

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Side effects of influenza immunization

Sir,

I was interested to read the letter from Drs Robinson and Rayani (November *Journal,* p.476) concerning the side effects of influenza immunization.

Four patients in my practice who had been given influenza immunization (MFV Ject® , Merieux) in 1991 each developed acute gout approximately 10 days after the injection. These four patients had a history of gout, had raised urate levels, were taking diuretic medication but were not taking regular uricosuric medication owing to the infrequency of acute episodes (less than one episode of gout per year). One patient said she noticed that her last acute episode of gout had taken place at a similar time during the previous year — 10 days after the influenza immunization. I have reported these cases to the Committee on Safety of Medicines but would also be interested to hear from other general practitioners who may have noticed a similar trait.

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Working in partnership with nurses

Sir,

In his editorial (October *Journal,* p.398), Dr Salisbury discussed the role of community nursing and, in particular, its organization and development. A meeting was convened for members of the Royal College of General Practitioners in the Burnley area to discuss the editorial.

The five options put forward by Dr Salisbury in his editorial were examined. The majority of members felt that the ideal model would be for the community nurses to be managed by a large

independent trust, which could be responsible for providing nursing care on a named practice basis. This arrangement would be most acceptable to the nursing profession, as they would have a greater input in a community trust. Out-of-hours nursing care and holiday care, as well as specialized nursing care, for example paediatric nurses, would be better provided for from a community trust.

However, a number of members felt that the fifth option, in which all community nursing services would be controlled by the primary health care team, was the most appropriate. The general practitioner would have a greater say in the choice of nurse he or she employed and would also provide the necessary funding for postgraduate training. They would also be in a position to offer facilities for training student nurses with an interest in community/practice nursing.

All members rejected the concept of a multidisciplinary partnership. The general practitioners applauded the concept of the primary health care team and extensive liaison with all members within it and felt that it had contributed enormously to the progress of general practice. However, general practitioners are normally the most consistent people in the lives and continued care of many of the patients and they are best placed (in consultation with the other members of the primary health care team) to make the decisions which affect their patients. While this may be regarded by many as a step back in the progress and development of general practice, we feel that it is a valid point and should be considered before further changes in the structure and management of the primary health care teams are made.

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Fellowship of the RCGP

Sir,

I trust that Dr Dowden (letters, November *Journal,* p.481) is incorrect in his suggestion that the Royal College of General Practitioners is intending that all honorary fellows will eventually undergo assessment. As an honorary fellow without a medical qualification I should have a problem. Nevertheless, I take his point about distinguishing honorary fellows from fellows by assessment. On the very few occasions when I have used FRCGP after my name I have always used the prefix 'Hon'.

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Membership of the RCGP

Sir,

The number of members leaving the Royal College of General Practitioners, particularly in the under-35 year old and the 50–60 year old age groups, has reduced the overall rate of increase of new members. This was reported in the RCGP annual report of Council 1990/91,[1] but no reasons were given for their leaving.

A decade ago membership had just passed the 10 000 mark, opinion from the College was increasingly being sought by outside bodies and by government, and College organization seemed to be outdated. While the pyramidal structure introduced by Dr Donald and Dr Hasler met immediate needs it created a balance of power which had previously been eschewed: the greatly increased influence of the general purposes committee and chairman of council. I do not challenge the good intentions of the various people who have wielded this influence since then. However, the outcome of their efforts suggests that the checks and balances which should operate in a good constitution have somehow been lost.

As chairman in succession to Dr Donald, Dr Irvine promoted the quality initiative with the laudable intention of encouraging clinical self-criticism. This led, unsuspectingly, to a position where quality was equated with a consensus of 'good'. In turn, mismanagement of the discussions preceding *Quality in general practice*[2] led, in 1986, to the green paper[3] which revealed a College leadership out of touch with its members. At the same time there was division over the conduct of the College examination, with the departure of the chief examiner and the subsequent resignation of Dr Hasler. In 1988, Dr Gray and Dr Styles had to resolve problems over relationships with the Joint Committee on Postgraduate Training for General Practice.

In an attempt to correct a discernible trend, the next annual general meeting approved a motion to examine the powers of the general purposes committee. The result, however, was a further concentration of power at the top of the pyramid, the general purposes committee being succeeded by the council executive committee, which was one third smaller, to 'adapt to the ever-increasing pace of change'. Some of this ever-increasing pace of change is of our own making. Our political naivety invited the government to exploit the differences between the College and the British Medical Association, and, while we have belatedly repaired relationships, the General Medical Services Committee has been left to cope with the changes that have been made to the health service.

With luck, we will have learned from the mistakes of the past decade but members will continue to be frustrated by the sense of impotence engendered by these events and which I suspect prompted those of our colleagues who have decided to leave us. Checks and balances existed prior to the past decade in the form of a president who carried weight in council as the representative of the membership (rather than as the outside representative of council on behalf of the College), and a body of fellows of great diversity available at all levels (in a smaller College) as a sounding board of senior opinion when wise decisions had to be made. The balance represented by these influences will not be recovered.

How then do we remedy matters to reduce future risk from centralized power and human error? Finding new checks and balances is of greatest importance to young members. Currently the membership examination is very sophisticated. However, doctors have little idea of the workings of the constitution of the College they are applying to join. If the membership examination were to contain one compulsory question on the College constitution, new members would find their feet more quickly. We might then lose fewer of these new members.

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