Continuing medical education

JUDITH MILLAC

For 12 months I have been observing continuing medical education for general practitioners in the Trent region. I wish to stimulate discussion on this aspect of postgraduate education which was recognized by Wood and Byrne in an occasional paper in 1980 as having 'escaped the limelight'.[1]

Two decades have passed since the Nuffield Provincial Hospital Trust Conference in 1961 placed continuing medical education for general practitioners in the hands of hospital consultants. Since that time general practice has changed considerably. It has an active Royal College, and departments of general practice now exist in many medical schools. Vocational training has become mandatory, the discipline is supported by an increasing body of research and teachers in general practice are gaining in expertise.

Pickering suggested that 'much of the continuing learning process is derived from doctors' own experience of practice — from exchanging experience and ideas at formal and informal discussion'.[2] We have realized the importance of identifying what we as general practitioners need to learn, as opposed to what specialists think we should know. The most useful way of identifying our learning needs apart from within our clinical practice, is in a group where we can share problems, discuss ideas, ask questions and identify deficiencies,[3] and set local standards of clinical practice. The Quality Initiative of the Royal College of General Practitioners links continuing education with the setting of clinical standards.[4]

We are ready, in general practice, to take over our own continuing medical education.

Problems

Three closely linked problems of continuing medical education face all general practitioners: isolation, a reduction in job satisfaction and lack of motivation. Isolation may not only be geographical but also intellectual. This may mean that apart from the fact that we seem to be liked by patients[5] we have little feedback on our performance. Without this feedback it is hard to maintain our job satisfaction.[6] In a survey of Nottingham general practitioners, where there was a response rate of 50 per cent to a questionnaire on continuing education, 37 per cent of the respondents found their work was less than fully enjoyable with 20 per cent confessing to no enjoyment at all.[7] The same paper highlighted the problem of motivation with 82 per cent of respondents encountering obstacles to their continuing education, including lack of time, practice commitments and the need to preserve family life. Fifty per cent of respondents found difficulty in keeping their education up-to-date, yet attendance at postgraduate courses is low and declining. These courses may be unattractive because the clinical tutors, who are responsible for their planning, are hospital doctors relying on specialist lecturers whose interest is in the dissemination of knowledge regardless of whether it is applicable to general practice. The result is a shotgun effect — 'scattered, weak and unpredictable'.[1]

Educational methods

General practitioners are individuals, and there is unlikely to be one solution to our problems. However, many methods of continuing education are becoming available. They should be appropriate to the individual concerned in order to meet his or her needs, not only for continuing education, but also for professional growth, increased job satisfaction and improved clinical practice. Different methods will be required by the same individual for different needs and at different times.

Self-learning includes not only reading of the many journals available to us and the expanding literature of general practice, but also listening to tapes, watching videos, and performing computer tests and self-assessment programmes. Distance learning programmes are being developed by the Centre for Medical Education in Dundee. The advantages of personal study are that it can be carried out in our own time, we can be selective, it is a simple and cheap resource, it can include self-assessment and we can relate it to our needs. The disadvantages are that it requires motivation, we sometimes read irrelevant material, and we rely on memory.

Meetings between practices geographically linked can involve discussion on relevant clinical or patient problems; each member is a resource and the mixture of ages represented allows the younger members to impart knowledge and the older members to impart experience. These meetings allow the development of attitudes and skills, there can be examination of how other practices are organized, there can be peer review and travelling distances are short. The disadvantages are that a convenor or organizer is needed, and skilled leadership is often required. Such workshops often progress through clinical topics, consultation analysis and standard-setting exercises to research.[8]

Young practitioner groups have emerged in the last few years.[9-12] They provide a means of continuing the style of education that the doctors had experienced in vocational training. Important topics considered by these groups have been: difficulties in communication between practice partners, practice agreements, learning about the area of the practice, and the difficulties experienced in trying to bring about changes in practice organization.[13]

The advantages of these groups are those of any group-based approach — they lead to a noticeable improvement in patient care[14] and combat the problems associated with isolation and reductions in motivation and job satisfaction. The members act as their own resources and can prepare clinical material for presentation. My own observations confirm the educational value of these groups and general practitioners are emerging who are able to teach others. The groups are already involving themselves in audit and research; the main problem is that of group leadership. Even in 1979, before vocational training was mandatory, younger practitioners were rating group discussion as their preferred method of education.[15] There is no doubt that the number of these groups will increase. The groups need help in identifying others who wish to join a group, and in obtaining resources and Section 63 approval.[16] The Royal College of General Practitioners, recognizing this need, has recently produced an information pack on young principals groups.

An increasing number of group practices, partly as a result of vocationally trained doctors becoming partners, hold regular clinical meetings within the practice. These have the advantage of being on site. We learn about each other, we are our own resources, our discussions are closely related to patient care, and we can see our ideas being implemented. However, such meetings require the support and motivation of all the partners. We can become inward-looking, and there may be a dilemma as to who leads the meeting — the senior partner or the new principal.

Medical societies still have a place in our education. The West Leicester Medical Society, which has been in existence for 20 years, has a higher average turnout to its evening meetings than the regular lunchtime meetings at the Leicester Royal Infirmary Postgraduate Centre. The advantages are that there is social interaction, the invited consultants can be regarded as people to talk to rather than as didactic lecturers, and the members participate in the discussion; in addition these meetings can be forums for the discussion of ethical, philosophical and moral issues. The disadvantages are that the audience is sometimes

passive and the educational input may take second place to the social aspect.

The postgraduate lecture, still the backbone of our continuing education, has the advantage of providing up-to-date information and is an economic use of teaching time if the audience is large enough. However, the lecturers are often talking about their specialist subject, which may be totally unrelated to practical patient care. The experiment at the Nottingham City Hospital where the general practitioners have taken over planning the programme and inviting appropriate lecturers, including their own peers in general practice, has obviously been successful, since attendance has increased from a dozen or so to 45–50.

Seminars and courses have the advantage of being topic-based and in-depth. The speakers are usually consultants and the audience passive. Attendance at the seminars at the Postgraduate Centre in Leicester is erratic even though a wide range of relevant topics including coronary care, post-mastectomy care, insomnia, clinical genetics and the painful back are covered.

There is a challenge to general practitioners to run their own courses based on the prototype five-day intensive course which took place in Eastbourne in 1980.[17]

Coordination of continuing education

In order to take the initiative in planning our own continuing education we need to think in terms of structure, personnel and resources.

The Nuffield Provincial Hospital Trust has built many excellent postgraduate centres, some of which include libraries. In recent years many practices have been built either privately or as health centres and they include facilities for continuing medical education.[18] There are rooms for holding meetings, libraries and video equipment.

It should be possible to set up postgraduate departments of general practice based on postgraduate centres. Within these departments there should be a close link between continuing education, vocational training and the college faculty. Much of general practice education expertise is in vocational training. Course organizers are becoming sophisticated medical educators and associate advisers are their counterpart in education administration.

However, additional personnel are required to run continuing education — a general practice education organizer with office space and secretarial time is needed. Their job description would include overall responsibility for organizing lectures, seminars or courses for general practitioners, the assessment of the needs of general practitioners and the evaluation of the courses. It would also include introducing performance review as part of continuing education and organizing work programmes for individual doctors. The job would include supporting a cohort of general practice education coordinators whose job description will be based on that worked out by a group of RCGP college tutors in May 1984 at Stoke Rochford.[19]

The coordinator would be responsible for all general practitioners in a small defined area, contacting new entrants, the professionally isolated, and those with special interests or skills. The coordinator would identify group leaders in the area, instigate new groups, and encourage, help and lead the groups if necessary.

The third group of people required would be the group leaders themselves. The need for them to develop leadership skills has already been stressed. The MSD Foundation Leadership Course is tackling this problem on a regional basis, but the continuation of such learning will have to be done ourselves — another job for the general practitioner education organizer.

The financial implications of these proposals are difficult to assess. It is worth noting that small groups are relatively cheap since travelling distances are short, and there is rarely a lecture fee involved. However, the personnel suggested above need to be recognized and paid on a sessional basis. This problem will need to be debated at many levels. As a first stage, I propose that the ideas are implemented on an experimental basis by one or two regions. Over a two-year period it should be possible to assess the value and the cost of the ideas, particularly if, in the tradition of our profession, we carefully evaluate and record our activities.

I quote from Wood and Byrne's paper 'If organized and sustained education intervention is to reach us, it must be based around the work we do and where we do it.'[1] In the last analysis, it is up to individual doctors to learn what they need to know. Our practices can do two things to help. The first is to introduce study time as an integral part of our terms of service,[20] and within the practice contract. The second is to introduce and maintain regular clinical meetings within the practice. Perhaps, a start would be to make these standard criteria for appointment as a training practice.

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The Scientific Foundation Board

It is possible that many people are unaware of the College's Scientific Foundation Board and its place in the scheme of things. Apart from the buildings at Princes Gate much of the College's wealth is invested to endow the Scientific Foundation. The income from this investment, at the moment approximately £30 000 a year, is available to fund research. The Foundation is administered on behalf of Council by a Board appointed by Council. At present this Board meets twice a year in May and November to consider applications for funding.

In considering applications the Board is primarily concerned to satisfy itself that the proposed study is methodologically sound, that is the study offers a reasonable hope of providing an answer to the questions posed or of refuting or accepting the null hypothesis. The Board considers that research in education or social sciences is as acceptable as research into specific diseases; observational research is as acceptable as experimental research.

Thirty thousand pounds is a small sum of money compared with the funding necessary for research projects but it can nevertheless fund a large number of small and worthwhile enquiries.

At the moment the Board does not spend its total income. There are two reasons for this. First, the number of applications which the Board receives is relatively small considering the number of Members of the College and the need for research and secondly a relatively large proportion of applications are rejected.

The number of unsatisfactory applications must be a cause for concern. The Board takes the view that it cannot fund unsatisfactory studies simply to provide encouragement. However the Board is very conscious of the fact that rejection may destroy enthusiasm which is worthy of cultivation and support. The Board does return projects for revision with helpful and constructive criticisms and on occasion members of the Board have been able to meet applicants and to discuss with them their ideas. Nonetheless the Board cannot meet the need for advice and help during the planning stage from its own resources.

It would seem that academic departments, not only those of general practice, could in part meet this need; as a general rule academics are pleased to help. Faculty research committees, wherever they exist, could also have an important part to play.

It is our hope that in the very near future the Board will have difficulty in deciding which studies to fund when faced with so many high-quality applications.

Those who are interested in obtaining details of how to apply should write to: The Secretary, Scientific Foundation Board, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

Health Education Council Lectures

Dr Martin Lawrence and Dr Theo Schofield have been appointed Health Education Council Lecturers in General Practice in the Department of Community Medicine and General Practice, Oxford University. They have also both been appointed to Fellowships at Green College, Oxford.

AUTGP Executive Committee 1984–85

Professor J.G.R. Howie, Edinburgh, is Chairman of the Executive Committee of the Association of University Teachers of General Practice for 1984–85 with Dr P.M. Reilly, Belfast, as Treasurer and Dr T.S. Murray, Glasgow, as Secretary. The other members of the Executive are: Professor R. Harvard Davis, Cardiff, Professor J.H. Walker, Newcastle, Professor R.C. Fraser, Leicester, Dr D.R. Hannay, Glasgow, Dr A. Jacob, Dundee, Dr J. Cohen, Middlesex, Dr D. Jewell, Southampton, Dr H.J. Wright, Leeds.

There is also a representative of the RCGP, Dr M.A. Varnam, Nottingham, and a representative of the Association of Regional Advisers in General Practice, Dr R. Scott, Dundee.

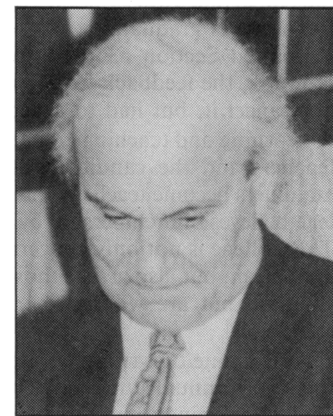
Honorary Doctorates to College Fellows

Honorary Doctorates have been awarded to two Fellows of the College.

Dr Lizbeth Hockey, a leading nurse researcher, has been made an Honorary Medical Doctor by the University of Uppsala in Sweden. Dr Hockey already holds an honorary degree in law from the University of Alberta in Canada, as well as a PhD from the City University, London.

Dr John Horder, a past President of the College has been awarded an Honorary Doctorate by the Free University of Amsterdam. This is the first time that a British general practitioner has received an honorary degree from a Netherlands University.

Dr Lizbeth Hockey, Honorary Doctorate from the University of Uppsala



Dr John Horder, Honorary Doctorate from the Free University of Amsterdam

Societas Internationalis Medicinae Generalis (SIMG) — Janssen Prize 1985

This prize aims to promote research in general practice. It is open to any general practitioner in Europe. Applicants should send a typed protocol of no more than 1000 words, in English, German or French to the undermentioned address. They should state the significance of their project, as well as its aims and methods. The work should be completed within two years.

An international jury will select the best work with respect to specificity, feasibility and relevance to international general practice.

The winner will receive a prize of 50 000 Belgian francs; 30 000 Belgian francs initially and the remainder when the work has

been completed. He/she should be prepared to present the results of their study at a SIMG meeting.

In 1984 the prize was awarded to Dr M. Köhle. He is a general practitioner in Grafing, near Munich. He will be assessing the efficiency of a follow-up of hypertensive patients.

Applications can be sent up to 30 November 1985 to: Professor Dr R. De Smet, Secretary of the Jury, Centrum voor Huisartsopleiding, Rijksuniversiteit Gent, Academisch Ziekenhuis, De Pintelaan 185, B-9000 Gent, Belgium.

North and West London Faculty eighth annual study day for overseas graduates

BASHIR QURESHI
Course Organizer
Faculty Communications Convenor, North and West London Faculty

Cultural differences in science are well respected. British general practitioners come from many different cultures, as do their patients. Learning behaviour, test performance and the quality of medical practice inevitably vary with a person's beliefs and training. The College promotes postgraduate education for all general practitioners, conducts the membership examination and strives to ensure high standards of practice. In medical thinking there is no place for discrimination — negative or positive — but a fair distinction between each patient's ethnic, religious and cultural needs is essential. Different needs require different answers. A provider of health care needs the appropriate education to enable him to serve all consumers. To identify such needs, the North and West London Faculty holds an annual study day for overseas graduates.

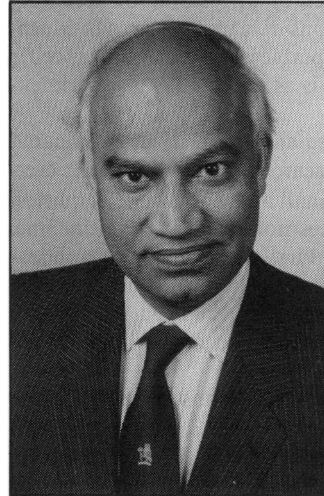
Limited Section 63 funds placed the study day in doubt. However, the feedback from past years was such that we could not cancel it, but had to accept a reduction in numbers.

Learning and teaching go hand in hand. At the study day the teachers and the candidates learn from each other. College examiners become teachers; this is a demonstration that the College believes in membership by inclusion and not by exclusion. The College is not only concerned with those who pass the examination, but also assists those who do not reach the required standard but are willing to try and achieve it by continued education.

At the time of writing we are in the final stages of planning this year's annual study day. The teaching staff consist of eight College examiners and three faculty course organizers. The examiners are Drs John Lee (Chairman, Membership Division), Andrew Bailey, Peter Burrows, Cameron Lockie, Peter Mukherji, Lotte Newman, George Taylor and John Toby. The faculty members are Drs George Melotte (Faculty Chairman), Jayant Thakkar and myself.

The programme begins with an introduction to the College and then covers various parts of the examination, dealing particularly with the problems encountered by overseas graduates — educational as well as cultural. Various talks by examiners and teachers cover most aspects of general practice, including job prospects.

The objectives of this study day are:
— To familiarize potential candidates with the format and style of the MRCGP examination.
— To identify some of the special problems of overseas graduates who take the examination, in order to help them prepare for it appropriately.
— To look at problems in communication between patient and doctor as well as between examiner and candidate, in order to encourage those with difficulties to improve their skills.
— To provide a forum for sharing experiences and an opportunity to form study groups.



Bashir Qureshi, organizer of the study day

RCGP Online Search Service

ROGER FARBEY
RCGP Online Search Manager

The RCGP Online Search Service has been operating for over a year now and has answered enquiries on a vast range of subjects, from abdominal pain to primary care in Zimbabwe. Together with the straightforward computerized literature searches the service performs on subjects like audit in general practice or various aspects of prescribing, there are also exceptional searches. For example, it was discovered that there are some apparently beneficial effects of cannabis for asthma sufferers — in a search on this subject, there were several articles found on the bronchodilator action of tetrahydrocannibol. Another notable search on acquired immune deficiency syndrome (AIDS) revealed that there were 80 references on AIDS in the *British Medical Journal* and *Lancet* in 1984 alone.

Online searching is not without problems. Surprisingly these problems are not caused by the hardware or the software. Simple human error is the cause of most mistakes. A recent search for rugby football injuries in schoolchildren disclosed 44 such references. They seemed remarkably apposite until, on closer examination, two incongruous titles were noticed — 'The incidence of migraine in schoolchildren' and 'A survey of public knowledge and beliefs on food'. An explanation? These two titles had been retrieved because their respective authors practised medicine in Rugby, Warwickshire. This kind of ambiguity is normally avoided since online searches usually utilize approved subject headings (or controlled terms) taken from the database publisher's dictionary or thesaurus. However, in certain instances it is more appropriate to conduct the search using free-text language (uncontrolled terms — using virtually any word or phrase without reference to any manual). In this case, the search was undertaken on a free-text basis because there was no approved index heading for rugby football. It would have been 100 per cent accurate had the search also included the approved search term sports medicine, but as there are other approved headings that might have been used in indexing these rugby football articles (such as athletic injuries) it was deemed expeditious to circumvent this stage — a move which promptly backfired.

A much rarer hitch occurred early in the life of the Online

Search Service, when a request was made for a list of references on diseases in the Bible. Since there is an approved heading for Bible, it is reasonable to assume that there could be no misunderstandings. However, the simple addition of a truncation symbol after the term Bible which has the effect, when used appropriately on free-text words, of expanding the search range to look for that word alone or with additional characters appended to that word (such as Bibles) — revealed 26 biblical references, of which six were written by Bible M!

Surma campaign

The traditional practice in Asian communities of decorating children's eyes with surma, a black powder containing sulphides of lead, has both cultural and religious significance. However, this powder often contains large amounts of lead, frequently causing eye irritation and in some cases lead poisoning. It is illegal to sell surma containing lead in the United Kingdom, but it is brought back from the Indian subcontinent by relatives and therefore it is difficult to cut off the supply.

The Department of Trade and Industry with the full support of the Department of Health and Social Security have mounted a widespread awareness campaign where they will test surma and demonstrate to parents that it is harmful to their children. They will be writing with leaflets and posters to 1600 ethnic organizations, ethnic churches, local authorities, health authorities and public libraries. Airlines flying to the Indian subcontinent will be asked to place these leaflets on their aircraft and in their flight magazines, and Customs and Excise will be asked to display the posters in arrival halls in order to increase awareness of the dangers of surma to children.

The campaign, which started on 3 May 1985, depends heavily on the support and cooperation of those working in and with the National Health Service. Those who are interested in the campaign or who have any comments or suggestions should contact: Mr R.A.P. Coupe, Health Services Division 3B, Department of Health and Social Security, Hannibal House, Elephant and Castle, London SE1 6TE. Tel: 01-703 6380.

Spring General Meeting

Cambridge 31 March 1985

Report of Chairman of Council

The report from the Chairman of Council was published in full in the Quality Bulletin distributed with the May issue of the *Journal.* Dr Irvine presented his report on the day before limits were imposed on the prescribing of drugs by general practitioners within the National Health Service. The Spring Meeting Symposium was organized by the Essex Faculty and had as its theme, 'The patient's choice'. At the Faculty dinner in Churchill College, Dr David Owen spoke of the challenge being made by Government to primary health care in the United Kingdom with the possibility of fragmentation by privatization.

It was in the context of increasing expectations of primary health care by patients and by Government that Dr Irvine spoke of the pressing need for general practitioners to undertake performance review and produce information about the services they provide. The response of College Members to the Chairman's letter concerning the limited list controversy had shown that many doctors already undertook a regular audit of their prescribing and many doctors were also introducing practice formularies. Dr Irvine warned that unless the profession as a whole actively supports the programme for responsible prescribing which the College is promoting, further restrictions in prescribing are likely to be imposed by the Government.

The College has as its first priority the implementation of the programme referred to as the Quality Initiative. Individual Council Members have committed themselves to report by the end of May on the services they provide in their own practices. Before the next Annual General Meeting a one day symposium will be held at the Barbican in London on Friday 8 November, entitled, 'Quality: how to go for it and what holds it up'.

While central College activities are important, in his report Dr Irvine spoke of the crucial role of College Faculties in ensuring that sensible prescribing policies will be achieved.

Dr Irvine's report demands close scrutiny. In comparison with other countries, general practice in the United Kingdom has a protected and privileged position. In one of the debates in the symposium preceeding the Spring General Meeting the motion was 'British primary care is second to none'. The opponents to the motion accepted that British primary care is cheap, but they challenged the quality of service provided. Dr Irvine's report demonstrates that the College is not only concerned about the present quality of British primary care, it has a positive programme for improving the quality and has a sense of urgency about implementing it.

RCGP Schering Scholarships for trainers in general practice

The President of the College, Dr John Lawson presented the RCGP Schering 1984 Scholarships to Dr R. Edmunds, Dr R. Hunt, Dr A.Hutchinson, Dr M.S. Lawrence, Dr G. Smerson. These scholarships enable teachers in general practice to enhance their knowledge and skills by visiting other practices.

Affiliateship

The Midland Faculty of the College had submitted the ordinary resolution 'That this meeting congratulates Council on its initiative in developing affiliateship to the College'. The motion was proposed by Professor V.W.M. Drury and seconded by Dr R. Steel. There was a lengthy debate with opposition to the resolution coming from Scottish Council. It was accepted that the affiliateship had been proposed with the laudable aim of strengthening the primary care team, but critics feared that affiliateship would damage the relationship of the Royal College of General Practitioners with the other Royal Colleges.

At the end of the debate, Chairman of Council Dr Donald Irvine suggested that a vote in favour of the motion would be taken as a reference back to Council of the proposal for affiliateship so that Council could review the plan and undertake further consultation. This was agreed too.

Access to hospital beds

An ordinary resolution from the Midland Faculty, 'That this meeting supports the view that all general practitioners should if they so wish have access to hospital beds in which they may look after their own patients', was proposed by Dr R.J.D. Brown and seconded by Dr A.J.M. Cavenagh. The meeting agreed to this resolution.

William Pickles Lecture

Sir George Godber gave the Pickles Lecture on 'Change and continuity' and this will be published in the July issue of the *Journal.*

OBITUARY

Dame Annis Gillie

Dame Kathrine Annis Calder Gillie (Mrs Peter Smith) died at her home in the Cotswolds on 10 April 1985 aged 84 years. She was President of this College from 1964 to 1967, the only woman so far to hold this office. She had previously been Chairman of Council (1959–62) and in 1954 was President of the Medical Women's Federation.

Her husband died two years before her and she did not recover from his loss nor from the great change in her life which this

entailed, since his disablement, first manifest at the start of their long marriage, had in recent years required her constant presence and devotion.

Annis had a rare combination of personal gifts. The most striking was her ability to find the right words for any public occasion. This ability never failed. She clothed ordinary matters with a dignity and style which were hers alone. Never ruffled, she could draw success from the least promising situation. In personal encounters she was memorably courteous and thoughtful. With these qualities she excelled as a chairman, but she also brought to this role a quick grasp of complexities, a firmness of purpose and a detachment which was not distracted by personal allegiances. It is sad that neither of the portraits in the College's possession do justice to her charm. But one of them does suggest the immense self-discipline which she maintained at all times — never so obviously as at the time of her daughter's death.

Her father was a presbyterian minister — the Reverend Dr Robert Calder Gillie. She was proud to be a daughter of the manse and equally proud of her family which included a number of distinguished journalists. She herself was educated at Wycombe Abbey, University College London and University College Hospital (to which she pays a notable tribute in her James Mackenzie Lecture of 1961).

She practised for 38 years from her London home in Connaught Square, near Marble Arch. It was here that she brought up her son and daughter, while her husband practised as an architect (he was also an accomplished painter). She had joined in partnership with Dr Christine Murrell, herself a well-known figure in medical politics. In mid-career she was single-handed but she was later joined by two other lady doctors. The family moved temporarily to Berkshire, but Annis kept in contact with many of her patients by travelling long distances to see them. Although she was later in partnership again, she always had the personal sort of practice which might be expected of such an impressive personality whose particular clinical interest lay in family relationships.

During the periods in which she was Chairman of Council and President, the College became incorporated, was granted the Royal prefix, moved its headquarters from Cadogan Gardens to Princes Gate and decided to hold an examination for membership. Her Chairmanship coincided with a time of great anxiety for the future of general practice and during her Presidency there was concern over the College's relationship with the British Medical Association. However, she was admirably prepared for this since she had served on the Council of the British Medical Association for 14 years, on the Medical Practices Committee for 12 years, and on the Central Health Services Advisory Council for 14 years. Her long association with the Medical Women's Federation represented a concern particularly close to her heart.

Annis might not have claimed to have new or original ideas, but rather to have encouraged, promoted and related those of others — particularly ideas of a practical sort. In her Mackenzie Lecture, she confined herself to a description of Mackenzie's career and thinking, quoting frequently from his writings, but scarcely referring to her own ideas or experience. Nevertheless she published a number of papers. They reveal her particular concern for the problems of middle-aged and elderly people.

Her name will always be associated with the report of the Central Health Services Advisory Council, 1963, *The field of work of the family doctor.* She was Chairman of the Working Group and the main author of the report — the first Government report to be wholly devoted to this subject. It anticipates most of the important changes in general practice and primary medical care which have come about (or are still anticipated) in the 22 years since it was written. It can now be seen as a statement of confidence in the future, which was scarcely warranted at the time as 1963 was a year when this branch of the profession was particularly threatened; recruitment was dropping; under-doctored areas were increasing in number; and all advantages, particularly financial advantages, lay in medical careers other than general practice. This was one year before the threat of resignation of general practitioners from the National Health Service and one year before the Charter agreed by the British Medical Association with a Minster of Health agreed the Charter predominantly concerned for the welfare of the Health Service. The Gillie report provided a strong factual basis and stimulus for implementing both the Charter and the report of the Royal Commission on Medical Education (1968), which opted for the restoration of general practice and gave pride of place to its special postgraduate training.

Annis Gillie was a founding member of this College. She passed a membership examination of the Royal College of Physicians in 1927, became a Fellow in 1964. She was awarded an honorary MD by the University of Edinburgh in 1968 (never previously given to a general practitioner) and the Fellowship of University College London in 1969. She was the first woman to be elected a vice-president of the British Medical Association and she was honoured by the Queen in 1961 (OBE) and again in 1968 (DBE).

J.P.H.

DIARY DATES

Symposium on Accidents in Childhood—call for papers

The Child Accident Prevention Trust is organizing a one-day meeting for medical practitioners with an interest in children's accidents. It will be held on 3 October 1985 at the Kings Fund Centre in London. It will provide a forum for doctors from different branches of medicine who share a common concern for this topic, enabling them to exchange views and to present the results of their own research.

Abstracts of papers for presentation are now invited. They should not exceed 400 words and should be sent to Dr R.H. Jackson, Child Accident Prevention Trust, 75 Portland Place, London W1N 3AL, as soon as possible. Authors of papers selected for presentation will be notified by the end of June. It is planned to publish the proceedings of the symposium.

Further details of the meeting can also be obtained from the above address or by telephoning 01-636 2545.

International Society for Quality Assurance in Health Care

A new international society concerned with quality assurance in health care has been proposed. This society would encourage international cooperation in the spread of good quality assurance studies. The society is to be known as the International Society for Quality Assurance in Health Care (ISQA), and is to be launched at a seminar on Quality Assurance in Hospital Care to be held in Udine, Italy on 29 June 1985, following a WHO working group on training for quality assurance.

For further details please contact: Secretariat, Professor Franco Perraro, Divisione di Medicina Generale d'urgenza, Stabilimento Ospidialiero S. Maria della Misericordia 1, 33100 Udine, Italy. Tel: Udine 499239.