BMA AFFAIRS

From the council

Unanimous support for reduction in juniors' hours

The BMA is to seek an urgent meeting with the Secretary of State for Health, Mr Kenneth Clarke, to tell him of the association's serious concerns about junior doctors' hours of work.

This unanimous decision was taken after a long debate at the council meeting on 4 January, which was chaired by Dr J H Marks. The meeting also agreed unanimously that "an average of 72 hours a week" should be the maximum necessary for postgraduate training and saw no reason for this to be exceeded save in exceptional circumstances. The debate on the proposal that in the long term the needs of patients "may best be served by an eventual reduction to 60 hours" was adjourned and the motion "left on the table."

The decision to insert the words "average" and "save in exceptional circumstances" in the motion secured the support of the senior and junior hospital doctors as well as of the other crafts represented on the council. The leaders of the Central Committee for Hospital Medical Services could not accept the wording of the original motion, which had been passed by the Hospital Junior Staff Committee in December (17 December 1988, p 1615) and submitted to the council for approval in the following form: "That council believes that a 72 hour week is the maximum necessary for postgraduate training and sees no reason for service needs to exceed this."

The CCHMS's chairman, Mr A P J Ross, told the council that 72 was an arbitrary figure, and he proposed as an amendment that "the number of hours worked by junior hospital doctors should not exceed those necessary for their postgraduate training as recommended by the appropriate royal college or faculty. The council believes also that for the long term continuing efforts should be made by health authorities, with medical advice, to rationalise services to patients wherever possible to ensure both an improved quality of care and a further reduction in the on call duties of doctors in training."

In Mr Ross's view the way forward was through the district working parties to reduce rotas and improve cross cover between specialties. A blanket figure could not be imposed. The royal colleges should be asked what was appropriate in each specialty and grade.

Reminding the council that the problem of junior doctors' hours of work was no new one, the HJS chairman, Dr Graeme McDonald, said that the 1980s had been a decade of good ideas not put into practice: as far back as 1981 the decision to eliminate rotas more onerous than one in three had failed, and in 1987 the department had refused to institute a ban on such rotas. Instead it had been decided that district working parties should be reactivated to look at hours of work. But his committee believed that any success would be marginal.

Council's decision on hours of work

- That the council believes that an average of 72 hours a week should be the maximum necessary for postgraduate training and sees no reason for service needs to exceed this save in exceptional circumstances
- The council instructs the chairman of council to seek an urgent meeting with the Secretary of State for Health in order to convey members' serious concern about the issue of junior doctors' hours of work.

The 1988 annual representative meeting had agreed that no junior doctors should be rostered for more than 80 hours a week after 1990, and in October the HJSC had decided that legislation would be the appropriate tool to solve the problem. The committee supported Lord Rea's private member's bill

SOLO SYNDICATION

Dr Sam Everington with Dr Nicky Low (centre) and Dr Paula Hickman during their Christmas vigil outside The London Hospital to publicise junior doctors' long hours of work

This report was prepared by LINDA BEECHAM, assistant editor, *BMJ*

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to impose a maximum of 72 hours a week by 1992. In December, Dr McDonald reported, the HJSC had passed the motion before the council because no royal college had said that more than 72 hours a week was necessary for training. He was pleased that the Minister for Health, Mr David Mellor, had now withdrawn his statement questioning the veracity of the junior doctors' long hours and that the minister was now committed to reducing hours of work. The minister had said, however, that consultants and health authorities were the obstacles to reducing hours of work. This was not the case and the council should make this clear. He urged the council to throw out Mr Ross's amendment.

The majority of the members supported him, and the council unanimously passed the motions set out in the box (p 121).

The chairman of the Central Committee for Community Medicine and Community Health, Dr Eileen Wain, was concerned about the amendment's wording. She was unaware that the royal colleges had indicated any appropriate hours of training. What did long term mean? Who was to give the medical advice? It was difficult to get agreement in the district working parties, and although there was no easy solution the council must support the juniors in their attempts to improve their working hours.

Dr Gabriel Scally, a chief administrative medical officer in Northern Ireland, wondered whether the consultants had been reading the daily press or watching the television over the past few weeks. The same tactics of trying to halt the juniors had been tried at the annual meeting but the profession had to take the issue on board. In his view 72 was not an arbitrary figure, it was reasonable.

The amendment was too bland, according to the chairman of the Medical Academic Staff Committee, Dr Colin Smith. It did not accord with the BMA's policy that no junior should work more than 80 hours. The problem, he said, could not be solved by bland promises, and the juniors and seniors should go forward together.

Legislation would be illogical

Dr E B Lewis, the former chairman of the CCHMS negotiating subcommittee, said that he shared the juniors' frustration that it had taken so long to achieve anything, but to use legislation would be illogical. The negotiation procedures had to be used. He suspected that junior doctors would spend their "spare" time working for locum agencies and be just as tired. A reduction to 72 hours would spell the death knell of small hospitals as there would not be enough junior staff to do the work. There would also be an increase in the size of the subconsultant grade, which would please the government.

The chairman of the occupational health committee, Dr W M Dixon, referred to the survey his committee was undertaking on the effects of long hours of work and fatigue. The literature on the subject showed that junior doctors did not fail in making diagnoses but they did fail when it came to explaining things to patients. A pilot study on junior doctors was about to start.

Dr W J Appleyard, a consultant paediatrician, was once chairman of the juniors' committee, and he warned that the juniors' motion would not help their cause. The royal colleges were responsible for postgraduate training and each post had to be approved by the colleges. He urged the council to pass Mr Ross's amendment, to gather information from the district working parties, and to take this to the Department of Health.

"This amendment is not on," Dr R A Keable-Elliott, chairman of the journal committee, told the council. It would do the BMA no good to put out such a "watered down piece of bumpf."

One of the doctors who had kept a day and night vigil outside The London Hospital over Christmas, Dr Sam Everington, reported on the great support from doctors and the public that he and his colleagues had received. Mr Mellor had blamed consultants and management for the long hours, and if the juniors and seniors did not act together the public would believe that the minister was right.

Urgent meeting required

Liking neither the amendment nor the juniors' original proposal, the chairman of the Joint Consultants Committee, Sir Anthony Grabham, suggested that the council should note the views of the juniors and seek an urgent meeting with the Secretary of State.

Dr Ruth Gilbert is a research registrar in paediatrics and a deputy chairman of the HJSC. She believed that the consultants had been appeased long enough. The profession could not deny that 84 hours—a one in three rota—made for tired doctors and risked standards of patient care. The council would lose credibility if the juniors' motion was lost.

The amendment from Mr Ross had to be rejected, declared Sir Henry Yellowlees, a former chief medical officer, because it contained several indictments. Nothing had been done in 1981, he said, because the royal colleges had not recognised the problem. When meetings had been arranged between the department and the colleges the latter had not sent the people with authority. The people concerned at the time—and he included himself—had not created a big enough row with ministers or health authorities to get something done. Although he did not support the wording of the juniors' motion, he did support their aims.

Dr Jeremy Lee-Potter, chairman of the CCHMS negotiating subcommittee, had seconded Mr Ross's amendment. His committee supported a reduction in hours but not to 72 hours at the moment. This would mean virtually a one in five rota and he believed that the hospital service would collapse.

During the debate the chairman of council told members that the motion as finally passed would provide him with a clear policy to take to the Secretary of State.

After the meeting the secretary wrote to the Secretary of State, who agreed to meet representatives of the BMA on Monday 9 January. The outcome of the meeting is reported at p 74.

BMA's gold medal

UNIVERSAL PICTORIAL PRESS

The BMA has awarded its gold medal for distinguished merit to Sir Douglas Black for his distinguished services to the medical profession. Sir Douglas was president of the association, 1984-5, president of the Royal College of Physicians, 1977-83, and chairman of the BMA's board of science and education, 1985-8. The gold medal will be formally presented by the president of the association at the adjourned annual general meeting in July.

BMA's proposals for no fault compensation

Mr David Bolt chairs the BMA's no fault compensation working party, and on 12 and 13 January he was due to put the association's views at a conference organised jointly by the Royal Society of Medicine and the BMA. Mr Bolt outlined the working party's views. It believed that if no fault compensation was introduced all patients who suffered unforeseen injury during their medical care would be reasonably compensated for the damage and, when appropriate, dependants would be compensated for financial loss. At present those few individuals who were able to establish that the care that they had received was negligent were awarded large sums in compensation. There should, Mr Bolt said, be no relation between no fault compensation and litigation. The working party did not see the proposals as inhibiting people from going to the courts.

Eligibility for compensation

The working party had looked at the Swedish regulations for eligibility and made similar proposals modified to take account of the position in the United Kingdom. Patients would qualify for compensation under the following conditions:

- The nature of the complaint should not relate to the progress of the disease
- Compensation would cover exclusively physical damage resulting from medical care
- A claim would be permissible if a diagnostic error could not be regarded as reasonable in terms of current medical practice
- A claim would not be admissible if an

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injury could be regarded as having arisen from a recognised risk of a procedure competently performed for valid medical reasons
- Injury resulting from infection would not be considered if the infection arose after a procedure involving organs or tissues that were naturally infected or of diminished vitality; after prolonged catheterisation or drainage; after more than one year after the introduction of prostheses or other foreign material; or in a patient with reduced immune resistance as a result of disease or necessary treatment
- A claim would not be accepted if the injury resulted from the use of a drug in accordance with the manufacturer's instructions
- Injuries resulting from events not relating to treatment—for example, equipment failure or mishap during transport—would be admissible.

Compensation, Mr Bolt said, should be related to actual identifiable loss or additional expense. The working party believed that to qualify for compensation a person would have to prove that he or she had been off work for 30 days or in hospital for 10 days. The scheme would take account of income from other sources, such as insurance payments.

Mr David Bolt, who chairs the BMA's working party on no fault compensation

When an individual suffered temporary loss of earnings and received only National Insurance payments this would need to be raised, and the working party suggested a ceiling of twice the national average wage. Provision would need to be made for dependants, such as providing extra help if a housewife was injured. If a child suffered injury any additional costs for the period of the child's education beyond the provision made by the health service and the social services would be a charge on the scheme.

The working party was not clear about awarding capital sums, but in Mr Bolt's view there would have to be provision in certain circumstances. Another uncertainty was over payment for pain and suffering as this spread into possible compensation for psychological damage.

There was, Mr Bolt said, no indication of how much a no fault compensation scheme would cost.

During the debate Dr Colin Smith drew attention to the difficulty of getting suitable people to sit on the panels that would adjudicate on the claims. He also thought that it might be hard to exclude psychological damage. He cited the case of an attractive woman who had a nasal procedure that went wrong even though there was a recognised risk.

Dr Jane Richards did not like the suggestion of having to prove 30 days off work, and Dr R A Keable-Elliott agreed that general practitioners would be put under pressure, particularly if cases were brought retrospectively.

Dr A J Rowe was sceptical about the one year allowed for claiming for damage caused by a prosthesis or other foreign material.

On the question of panels Mr Bolt said that he believed that most of the work would be done by officers of the scheme, who would call on other experts if necessary. As the staff built up experience the number of people going before a panel would fall. He reminded the council that a plaintiff would not have to prove the fault. If an individual had been harmed and his claim came within the terms of the scheme he would be compensated.

Mr Bolt hoped that the scheme would be self supporting. There would be difficulties at the beginning, but if such a scheme proved successful he envisaged that within three or four years the bulk of claims would be dealt with by the scheme.

Strengthening the BMA in the regions

The council has approved nearly 30 recommendations from a working party set up in September 1987 "to investigate and report on the effectiveness of the regional services and their relationships with the local craft committees and divisional structure and with the individual members." Some of the recommendations are set out on p 124.

The report will now go to the finance and general purposes committee for costing, and it will be published as an appendix to the annual report of council.

The chairman of the working party was Dr J A Ford, who explained that evolutionary rather than radical changes had been proposed. He and his colleagues had not tried to be prescriptive but to set out guidelines. He hoped that there could be a planned programme whereby the council looked at the services the BMA provided for members on a regular basis. The working party had concluded that the services were value for money but that there needed to be continued planned investment.

Since the last review of regional services the Griffiths report on NHS management had been implemented, Dr Ford pointed out. So it was more important than ever to strengthen the divisional and regional council executives so that general managers knew who to consult and the profession could speak with one voice.

The report proposed that inactive regional councils should be revitalised, and this was supported by speakers from regions such as the West Midlands where these were successful. Others, however, reported the difficulty in getting people to travel long distances to attend their regional councils. One major weakness, according to Dr Lionel Kopelowitz, was that regional councils could not submit motions to the annual representative meeting or send representatives.

Dr Lindsey Stroud supported the proposal to continue to provide back up services for industrial relations officers. No one should underestimate the service that they provided to members.

Dr Mervyn Goodman pointed to the difficulty in persuading doctors to take part in local BMA affairs and to sit on local committees. He welcomed the proposal that regional office staff should attend regional craft committee meetings.

But Dr Jeremy Wight, deputy chairman of the HJSC, criticised the failure to attack the apathy among members. Mention was made of the difficulty in recruiting place of work accredited representatives among junior staff. Why was this so? Some responsibility must lie with senior colleagues and teachers, many of whom gave the impression that participation in medicopolitical affairs was detrimental to juniors' careers.

Implementing some of the recommendations would cost money, Dr M Hamid Husain pointed out, but the regional structure was cost effective and members had to be made to believe that the association existed for them.

The chairman of the General Medical Services Committee, Dr M A Wilson, welcomed the recommendation that communications between the peripheral and central structure of the BMA should be improved, but how was this to be done? The extension of the regional structure had been one of the BMA's success stories, but he believed that there should be much more feedback to craft committees from the industrial relations officers.

Mr W I Jones chairs the Welsh council, and he thought that the document repre-

Briefly . . .

- Dr Jeremy Lee-Potter has been elected unopposed to fill the vacancy created by the resignation of Dr J S Happel as the representative of the Wessex region
- Mr Mark Calloway, the chairman of the associate members group committee, becomes an ex-officio, non-voting member of council for the current session
- Mr Keith Reid, the associate member elected to the council, has been appointed a trustee to the British Medical Students Trust
- The BMA will meet representatives of the Association of Directors of Social Services to discuss the Griffiths report *Community Care: Agenda for Action*
- The council will recommend to the annual representative meeting that the Central Committee for Hospital Medical Services should change its title to Central Consultants' and Specialists' Committee
- As part of an overall package to raise the profile of the associate members group committee it will be recommended the name be changed to BMA medical students group committee
- The council has agreed to continue to provide financial and secretarial help for the Commonwealth Medical Association until July 1989.

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sented a step backwards. The BMA had to recognise that the strength now lay in the craft structure and not in the divisions.

Dr Lionel Kopelowitz agreed that doctors would attend the craft committees but not division meetings. Divisions would not be successful until they followed the federal structure of the council and all disciplines were represented.

It was important that as many place of work accredited representatives were recruited as possible, Dr J D J Havard, BMA secretary, told the council because only they could take action under trade union legislation. The BMA was a registered trade union and if sufficient numbers of POWARS were not in post the BMA could be in difficulty. The representatives had certain privileges under the Employment Protection Act and the BMA provided training courses for them.

Future of child health services

In 1987 the annual representative meeting endorsed a report from the child health forum, chaired by Dr George Duncan, on the difficulties which had arisen between the crafts on the future provision of child health services and to suggest solutions. Later that year a joint craft working party was set up to produce proposals for implementing the strategy drafted by the forum. The working party was also chaired by Dr Duncan.

The council agreed to look at the working party's report again after it has been considered by the craft committees. Thereafter the negotiating committees will be invited to negotiate the agreed proposals with the health departments.

Among the working party's proposals are the following:

- Consultants in community child health should operate under hospital terms and conditions of service
- All those in training should be in recognised training posts
- There is a need for a career grade entry in primary child health care after completion of general professional training. This could be either the staff grade or be achieved by continuing the clinical medical officer grade
- Non-consultant appointments in secondary child health care in the community should be in either the associate specialist grade or the staff grade
- Detailed recommendations are made for the review of senior clinical medical officer posts and for reclassifying those posts deemed to be of consultant status
- Senior clinical medical officers who are not regraded as consultants after review should have security of tenure in their existing posts.

On training for general practitioners, the working party has recommended that for those already carrying out child health surveillance their own experience will have provided the necessary training. For trainees who wish to pursue child health surveillance when fully trained the vocational training schemes or personal programmes should be structured to provide experience. For principals without previous experience in child health surveillance arrangements will need to be made to enable them to undertake the necessary training.

The working party noted the importance that the child health forum attached to the need for a close exchange of information between the preschool and school health services and the general practitioner. It envisages that the details of the health surveillance programme will be agreed locally in consultation with the appropriate health professionals.

Ten Years On: proposals on BMA's regional services

Communications should be improved between divisions, local craft committees, and district health authorities; between regional councils, regional craft committees, and regional health authorities; and between the peripheral and central structures of the BMA.

Regionally elected members of the council should have access to all BMA committees and craft committees in their regions.

The industrial relations service should be strengthened by the continued appointment of administrative assistants.

A major recruiting drive for senior and junior place of work accredited representatives should be instigated.

The division should be the point of contact with the district health authority chairman and general manager for communication regarding trade union matters affecting the profession locally.

The division executive should include BMA representatives from each of the craft committees locally.

Inactive regional councils should be revitalised.

The regional council executive should be a point of contact with the regional health authority chairman and general manager.

BMA checklist for government's NHS review

The BMA has produced criteria against which any proposals for change in the forthcoming review of the NHS should be measured.

The chairman of the BMA council, Dr J H Marks, told a press conference on 5 January that the BMA was well aware of the need for resource control and for maximum efficiency in the NHS and that value for money must be achieved, but the checklist would enable people to decide whether the proposals in the review benefited them or not. The list took account of the fact that doctors must continue to safeguard high standards and provide high quality care. Dr Marks emphasised the association's firm belief in the basic principles on which the NHS was founded—that is, that the service should be free at the time of delivery and available equally to all according to need and not the ability to pay.

The BMA believes that the outcome of the review must

- Ensure a full range of services within reasonable geographical reach of all patients
- Provide the public with information so that people can understand how the NHS works and the services which are available
- Ensure that district health authorities have the resources to maintain and improve equipment and buildings, to install new technology, to recruit the necessary staff, to provide management training for doctors, nurses, and others directly concerned in the delivery of health care to enable them to participate in resource management exercises tailored to individual hospital and district requirements
- Encourage general practitioners to continue to develop services to their patients
- Ensure that any proposed structures for providing health services outside the NHS model are subject to legislation to safeguard patients and staff and ensure that these services are appropriately and regularly audited
- Ensure that financial considerations are not used to overrule responsible clinical decisions
- Undertake a programme of hospital rationalisation on one site in districts where this is appropriate thus avoiding unnecessary duplication of resources
- Assess implications of new technology and medical and scientific advances and evaluate their contribution to the future health care needs of patients
- Deal with instances of alleged professional misconduct in hospitals quickly, fairly, and efficiently
- Create an environment in which individuals are encouraged to take responsibility for developing healthy lifestyles
- Ensure that adequate resources are provided for community services and in particular where a response is required to policy changes.

The BMA is adamant that the government must not introduce changes without carrying out properly evaluated pilot studies.

AIDS factsheet for MPs

The BMA's AIDS Foundation has sent the first of its series of parliamentary factsheets to MPs and selected members of the House of Lords. This explains the tests for infection with HIV or AIDS. It points out what a positive and a negative result would mean to individuals and emphasises the importance of counselling before deciding whether a test should be done. People should be told that a negative result is no guarantee of not being infected and does not prevent future infection, but a positive result does not mean that a person has AIDS.

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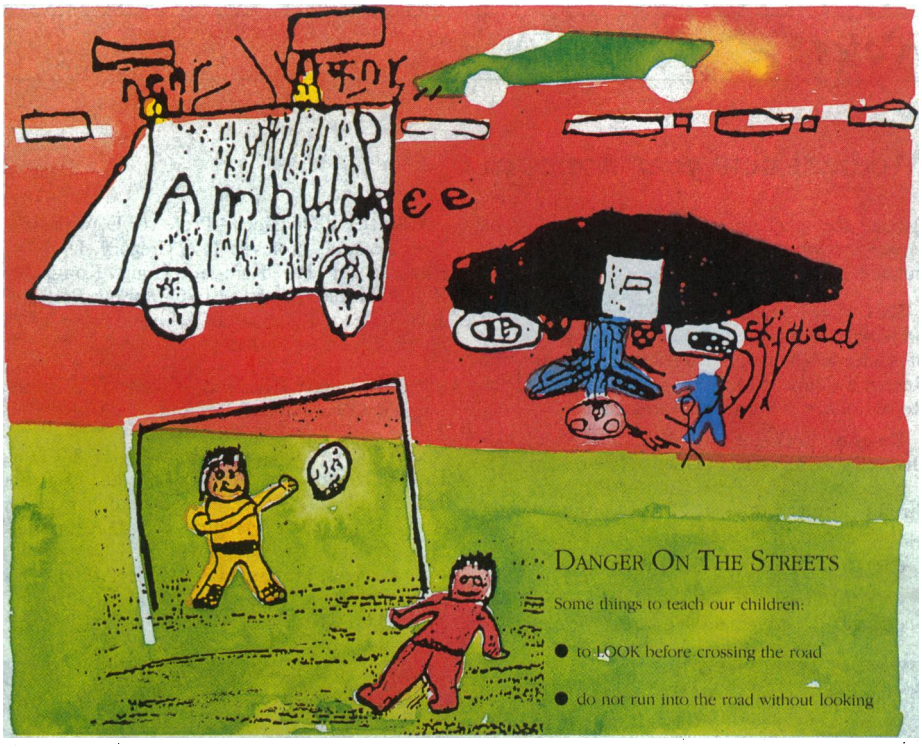
new national service is run by the Womens National Cancer Control Campaign and women who are experienced in health work will be available from 9 30 am to 4 30 pm, Monday to Friday, on 01 495 4995 to answer questions about the tests available, who needs them, where to go, and what happens. They will explain about further investigation and treatment if the result is not normal. People who require information and emotional support about living with cancer will be referred to other agencies—for example, BACUP, Cancerlink, and the Breast Care and Mastectomy Association. Two 24 hour lines will also operate. These will provide taped information on breast screening (01 493 6060) and cervical screening (01 493 8878).

Reducing accidents in the home

The National Association of Health Authorities and the Royal Society for the Prevention of Accidents have joined forces to look at the problem of accident prevention. At present the cost of fatal and non-fatal home accidents to the NHS is £325m a year and home accidents account for one third (over two million) of all accidents treated in hospitals. General practitioners deal with another million home accidents. The two organisations have set up a group including health authority representatives and health care professionals to

- Outline the scale and nature of the problem for the NHS
- Look at health authorities' current preventive knowledge, attitudes, and activities
- Review the case for individual health districts' participation in accident prevention activities
- Develop suitable policies and strategic options and identify examples of good practice.



The picture for November from the "Bright and Healthy Calendar '89" produced by the Palesa Foundation, 15 Arundel Street, Brighton BN2 5TG. Each month has a picture that raises a health theme. The idea for producing such a calendar grew from a similar, highly successful one produced in Lesotho by Dr Sam Ramsay Smith, who now works in Eastbourne. As happened in Lesotho the calendar will be distributed to all schools in east Sussex and is being used to spearhead a new health promotion campaign being mounted by the health promotion units in Brighton and Eastbourne. Copies are available from Brighton Health Authority, Health Promotion Unit, Resource Centre, 12-14 Wellington Road, Brighton BN2 3AA (price £2.99 plus 30p postage and packing).

In brief

A laboratory devoted exclusively to research into meningitis has been opened in the John Radcliffe Hospital, Oxford. Headed by Professor E Richard Moxon, professor of paediatrics at Oxford University, the Meningitis Trust Laboratory will receive funds totalling £600 000 from the trust over the next five years.

People in the news

- Professor Peter Armstrong, at present professor and vice chairman, department of radiology, University of Virginia Medical Centre, Charlottesville, Virginia, United States, has been appointed to the Mercers' chair in diagnostic radiology at St Bartholomew's Hospital Medical College from June 1989.
- Mr Roderick Pickis will succeed Mr Frank Whitehill as registrar of the Council for Professions Supplementary to Medicine in the autumn; he will become registrar designate in July. Mr Pickis has held posts in the Department of Health since 1961.

COMING EVENTS

Royal National Institute for the Deaf—Seminars "What future for hearing aid services?" 27 February, Birmingham, and 13 March, Manchester. Details from the institute, 105 Gower Street, London WC1E 6AH.

Royal Aeronautical Society—Meeting "Aviation emergency planning and its management," 2-3 March, London. Details from Carole Parr at the conference office of the society, 4 Hamilton Place, London W1V 0BQ.

Age Concern Scotland—Conference "Rights, risks, and responsibilities," 10 March, Glasgow. Details from the conference secretary, 7 Sandyford Place, Glasgow G3 7NB. (Tel 041 204 1829.) Closing date for applications 27 February.

Royal Society of Medicine Forum on Clinical Pharmacology and Therapeutics—Meeting "Drug formularies: the way forward," 17 March, London. Details from Barbara Komoniewska at the society, 1 Wimpole Street, London W1M 8AE. (Tel 01 408 2119.)

International Society for Prosthetics and Orthotics United Kingdom National Member Society—Annual scientific meeting, 12-13 April 1989, Nottingham. Details from Miss C Van de Ven of the society, 19 Seaforth Lodge, Barnes High Street, London SW13 9LE.

Balint Society—Balint weekend for general practitioners and trainees, 19-21 May, Ripon. Details from the honorary secretary of the society, Dr David Watt, Tollgate Health Centre, 220 Tollgate Road, London E6 4JS.

International Society of Technology Assessment in Health Care—5th annual meeting, 5-6 June, London. Details from Christine Davies, King's Fund Centre, 126 Albert Street, London NW1 7NF. (Tel 01 267 6111.)

Royal Free Hospital—XIVth international update on liver disease, 13-15 July, London. Details from Professor Neil McIntyre in the academic department of medicine at the hospital, Pond Street, London NW3 2QG. (Tel 01 794 0500 ext 3969.)

International Federation of Automatic Control—Workshop "Decision support for patient management: measurement, modelling, and control," 31 August-2 September, London. Details from Bell Howe Conferences, Gothic House, Barker Gate, Nottingham NG1 1JU. (Tel 44 0602 410679.)

London School of Hygiene and Tropical Medicine—"Fourth seminar on health economics and health financing in developing countries," in association with the London School of Economics and the World Health Organisation, 4-22 September, London. Details from Anne Mills at the evaluation and planning centre of the school, Keppel Street, London WC1E 7HT. (Tel 01 636 8636.)

UK-USSR Medical Exchange Programme—Specialist tour in oncology, radiology, and associated research topics, 9-24 September. Details from Professor J W Boag, Flat 1, 40 Overton Road, Sutton, Surrey SM2 6QR.

Institute of Physics—4th conference "Sensors and their applications: S & A IV," 25-27 September 1989, Canterbury. Details from the institute, 47 Belgrave Square, London SW1X 8QX. (Tel 01 235 6111.)

MetaPhor Conferences and Meetings—Details of symposia on gynaecological endoscopy, dysfunction of the temporomandibular joint, and total knee replacement are available from MetaPhor, 21 Kirklees Close, Farsley, Pudsey, West Yorkshire LS28 5TF. (Tel 0532 550752.)

Royal Postgraduate Medical School Institute of Obstetrics and Gynaecology—Details and copies of the programme of symposia, teach ins, and workshops to July are available from the institute, Queen Charlotte's and Chelsea Hospital, Goldhawk Road, London W6 0XG. (Tel 01 740 3904.)

University of Dundee—Details and copies of the spring term programme of postgraduate medical education are available from Professor R M Harden, Ninewells Hospital and Medical School, Dundee DD1 9SY. (Tel Dundee 60111 ext 2181.)

SOCIETIES/LECTURES

*For attending lectures marked * a fee is charged or a ticket is required. Applications should be made first to the institutions concerned.*

Tuesday 17 January

UNIVERSITY OF OXFORD ICRF CANCER EPIDEMIOLOGY AND CLINICAL TRIALS UNIT—At Ida Green Seminar Room, Observer's House, Green College, 5 pm, Godfrey Fowler: GP's views on smoking and their own smoking habits.

Wednesday 18 January

INSTITUTE OF NEUROLOGY QUEEN SQUARE—At Wolfson Lecture Theatre, National Hospital, Sandoz Foundation advanced lectures on clinical and experimental neurology, 6 pm. Professor Colin Blakemore: What can neuroscience offer to neurology and psychiatry? 7 pm, Professor W A Lishman: Organic versus functional.

INSTITUTE OF ORTHOPAEDICS—At Courtauld Lecture Theatre, Middlesex Hospital, 6 pm, Professor T S Worthington: Imaging of the IV disc. 7 pm, Mr J Crawford Adams: Correction of spinal flexion deformity in ankylosing spondylitis.

SOCIETY OF APOTHECARIES OF LONDON FACULTY OF THE HISTORY AND PHILOSOPHY OF MEDICINE AND PHARMACY—At Apothecaries' Hall, 6 pm, John Locke lecture by the Viscount Hailsham FRS: John Locke, the glorious revolution, and the Bill of Rights.*

ROYAL POSTGRADUATE MEDICAL SCHOOL—At Stamp Lecture Theatre, 10 15 am, medical staff round.

Thursday 19 January

ROYAL SOCIETY OF TROPICAL MEDICINE AND HYGIENE—At Manson House, 6 pm, Professor Andre Capron (Lille): Immunity in schistosomiasis. (Followed by buffet supper.)

Saturday 21 January

NUFFIELD DEPARTMENT OF ORTHOPAEDIC SURGERY, OXFORD UNIVERSITY—At Lecture Theatre, Nuffield Orthopaedic Centre, 8 30 am, Dr S Apte: BrdUrd immunohistochemistry in skeletal research. 9 30 am, Dr H Saibil: The cell cytoskeleton.

BMA NOTICES

Members proposing to attend meetings marked are asked to notify in advance the honorary secretary concerned.*

Division meetings

Eastbourne—At Sandhurst Hotel, Thursday 19 January, 8 30 pm, talk by Dr R J Rew.* (Preceded by dinner 6 45 for 7 pm.*)

Rotherham—At Moat House Hotel, Thursday 19 January, 7 30 for 8 pm, dinner meeting, speaker Sir David Innes Williams.* (Guests welcome.)

Wakefield and Pontefract—At Wentbridge House Hotel, Wentbridge, Friday 20 January, 7 30 for 8 pm, annual dinner dance.* (Guests welcome.)

West Sussex—At Beach Hotel, Worthing, Thursday 19 January, 7 for 7 30 pm, medicolegal dinner, speaker Mr J A Turnbull: "The Bradford Stadium fire."*

Regional meeting

West of Scotland Hospital Junior Staff Committee—At TV Room, 1 The Square, University of Glasgow, Thursday 19 January, 5 45 pm.

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