BMA AFFAIRS

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From the GMSC

GMSC to consider concept of GP budgets

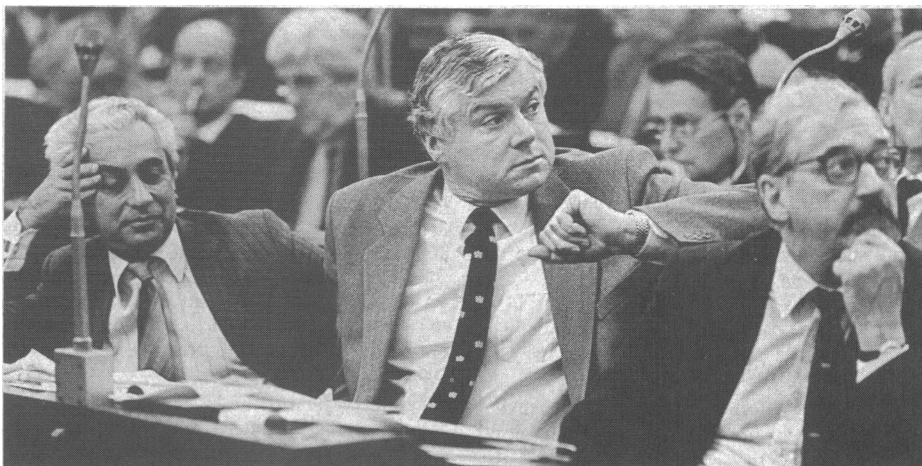
Half way through the meeting of the General Medical Services Committee on 19 January the chairman, Dr M A Wilson, gave news of the government's formal announcement that the Prime Minister's review on the NHS would be published on 31 January. So after the numerous leaks and speculations in the press weeks of uncertainty were ended and a full scale debate at the February meeting was assured. But there was still no indication about the accuracy of the leaks or how much the forthcoming white paper would impinge on the negotiations that Dr Wilson and his colleagues have been conducting in confidence (on their side) on the primary care white paper *Promoting Better Health*.

At the December meeting the chairman had promised to send an interim report to all general practitioners. The committee eventually agreed that the letter should be sent (p 260), though during a discussion on it many speakers voiced dissatisfaction, believing either that the negotiators should break their promise of confidentiality so that a more detailed report could be made or that the chairman should await the outcome of the Prime Minister's review before dispatching a letter.

The latest leak had been published in *The Times* on the morning the committee met—"GPs face cash limit on drug spending bill." The committee pointed out that it would be patients who would be cash limited, and it endorsed the criteria that the BMA had produced against which any proposals for change should be measured (14 January, p 124). And it unanimously resolved that any proposals that diminished the standard of care that doctors provided for their patients would be met with "strong professional resistance."

The Times and other papers had forecast that the review would recommend the introduction of general practice budgets. In anticipation of this the GMSC has set up a working group to consider the concept of general practitioner budgets and to report back to the February meeting. In its checklist the BMA had emphasised that the review should not introduce changes without carrying out properly evaluated studies. The GMSC reiterated this view by declaring that "participation in any pilot studies can be decided only by the individual doctor concerned, who will need to be assured that in the proposed local situation patients' interests are safeguarded."

The members of the working party are Dr J W Chisholm, Dr H I Humphreys, Dr R B John, Dr P F Kielty, Dr S Jane Richards, and Dr M A Wilson (ex officio).



On the front row of the GMSC—Dr M Hamid Husain, Dr D E Pickersgill, and Dr A J Rowe

Continued frustration

At the start of the meeting the chairman admitted that he did not know the status of the primary care white paper. Some of the negotiations would very probably be superseded by proposals in the Prime Minister's review, which would also be in the form of a white paper. He shared the distress felt by members of the committee and many local medical committee members. Dr Wilson found the present position intolerable and had told the Department of Health at the negotiating meeting the day before. Dr Wilson repeated that there had been negotiating meetings at three weekly intervals for the past nine months and despite the provocations of leaks the profession had not breached confidentiality. When the Prime Minister's review had been announced 12 months previously it had seemed that it would be seeking to improve the NHS; now all the rumours indicated that the white paper would be about cutting back on resources for the NHS, and general practitioners could be faced with having to provide the cheapest form of treatment.

"We have found the department to be intransigent," Dr Wilson told the GMSC. Departmental officials seemed to regard statements in *Promoting Better Health* that began "it is the government's intention" as being holy writ. When it was suggested to him that the negotiators should break confidentiality the chairman pointed out that there was no direct evidence that any of the leaks had come from ministers or officials at the department.

GMSC decisions

- That any proposals from the government which diminish the standard of care which doctors provide for their patients will meet with strong professional resistance
- This house has full confidence in the chairman of the GMSC and the negotiators and recognises the difficulties experienced by them in conducting discussions on the white paper
- That the GMSC should set up a group to consider urgently the concept of general practice budgets and to report back to the next meeting
- That participation in any pilot studies can be decided only by the individual doctor concerned, who will need to be assured that in the proposed local situation patients' interests are safeguarded.

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

Dr George Rae from Whitley Bay and Dr E D M Deeny from Belleck, County Fermanagh, exchange views

And when a motion that the negotiators should break confidence and issue a full and detailed report at the March meeting was proposed committee members decided to move to the next business.

Letter to profession agreed

There was a long debate on whether Dr Wilson's letter should go to the profession, but eventually the committee gave its approval by 39 votes to 15. Among comments made during the debate were the following:

This letter does nothing to relieve the frustration we feel about the lack of information (Dr Lotte Newman)

Kent and East Sussex local medical committees want a special conference because they feel we have reached a watershed for all parts of the profession (Dr D J D Farrow)

Events have overtaken us and we cannot make a sensible response to the review without knowing how far we have got with the present negotiations (Dr P J P Holden)

We are in a no win situation and this letter will not placate our members (Dr George Rae)

This letter is no longer appropriate; the committee can no longer maintain confidentiality; the chairman should come back to the committee with a full explanation (Dr D E Pickersgill)

The letter will be no consolation to general practitioners; you should tell the department that general practitioners have had enough (Dr M Hamid Husain)

We should persuade the profession to keep calm and let the negotiations run their course in secret. We will not help our cause by asking for progress reports (Dr J D Watts)

This government is mandated to change society and is prepared to do so without consulting us. The ordinary general practitioner will not understand this letter; he will say that we have been taken to the cleaners (Dr Arnold Elliott)

I urge you to withdraw this letter. It will be recognised as a placebo (Dr C O Lister)

The department would laugh if it could hear this debate when more than ever there is a need to be united. If you want us to break confidentiality do so but this letter is meant for 30000 general practitioners not just for the committee. It explains what is going to happen and it is the committee's job to put the message across. (Dr J B Lynch)

A shorter letter should go to general practitioners attacking the leaks; a special meeting of the GMSC should be called to discuss the Prime Minister's review; local medical committees should be urged to call meetings so that doctors can be told of the implications for general practice in 1989 (Dr Lionel Kopelowitz)

Whatever we do with this letter we should send out a statement that any interference with standards of care will meet strong professional resistance (Dr P F Kielty)

This letter is first class and should go out. We should stick to the original timetable until we have got the best deal (Dr John Callander)

This letter will give strength to the department because it will give an indication that we cannot do anything to stop the government's intentions (Dr S A P Jenkins)

The government sees the health service as being overcostly, inflexible, and unmanageable, and it intends to sort it out. We must recognise change, see that the doors are battened down, and protect the most valuable parts of the cargo. This is a damage limitation exercise and things are changing so rapidly that this letter will be misunderstood (Dr J G Ball)

It is not good enough to issue a full report in time for the June conference. We need to know what our constituents think (Dr H E Godfrey)

If we want to have a revolt we can stop the confidential discussions. If we want to limit the damage we can keep confidentiality. We should back the negotiators and let them decide whether the letter should go out (Dr D L Williams)

This is the letter that you asked us to prepare; we do not want your sympathy, we want your support (Dr M A Wilson).

Chairman's letter to GPs

In January Dr M A Wilson agreed to send an interim report on the negotiations on the white paper *Promoting Better Health* to all general practitioners in the United Kingdom (7 January, p 53).

In the letter approved by the committee Dr Wilson has told general practitioners that when the Prime Minister's review was announced in January 1988 the profession was told that the "principal emphasis" was to be on the hospital service and that discussions on the primary care white paper could proceed. The GMSC was warned, however, that "should the outcome of the NHS review impinge upon the general medical services, it will be necessary for the discussions to take account of the new circumstances."

Negotiations on the white paper did not start until March 1988, and Dr Wilson and the negotiators aim to produce a full report for the conference of representatives of local medical committees to consider in June. But this, he said, would depend on progress with the department and on any impact that the Prime Minister's review might have on the deliberations.

Dr Wilson said in his letter that he shared the impatience and frustration felt by many doctors. "The result has been an illusion of progress but a reality of blocked developments and delayed improvements." But the negotiators were determined to see the discussions through to a conclusion. He emphasised that no contractual changes had been agreed to terms of service or in the method of payment.

There had been parallel talks on the privatisation of the General Practice Finance Corporation, the new prescribing information system, and the complaints procedure.

Future role of Medical Practices Committee

In the light of the proposal in the white paper *Promoting Better Health* that the government would discuss with the Medical Practices Committee (MPC) how account could be taken of local information in determining the distribution of doctors the negotiators had suggested amendments to some of the recommendations made by a GMSC working group in 1985 and endorsed by the annual conference. The committee approved these changes, which are set out below.

It its paper to the GMSC the negotiators pointed out that the success of the MPC had been considerable and gave the following examples:

In 1974, 13% of the country was classified as designated and 17·7% of principals practised in such areas. Now there were no designated areas. Intermediate or restricted areas had risen from 64% of the country to 95·2%.

In 1974, 40·5% of patients lived in an area that was classified as intermediate or restricted; in 1986 this figure was 91%. In other words, over 90% of the population had access to adequate or well doctored services and therefore a choice of doctors.

The number of appeals against non-selection in advertised vacancies was minimal. In 1986 there were 121 out of a total of 4818 applications.

The chairman pointed out that although the MPC did not always get things right it was more likely to be successful than if the appointment system was devolved to family practitioner committees. Any change would require primary legislation and could not be done by regulations.

Although he agreed that primary legislation was fraught with problems, Dr P R Baker thought that singlehanded vacancies should

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be dealt with by family practitioner committees.

Dr G D H Shephard agreed and quoted an example of where an unsuitable doctor had been appointed by the MPC and the local recommendation disregarded.

Dr D E Pickersgill had chaired the original working party on the MPC but supported the proposed amendments to the recommendations. The world had changed since 1984-5 and it was right to change the policy. The working party had been critical of the way that the MPC collected information and gave out advice, but it had changed many of its working practices.

Although the members were predominantly doctors, the present chairman of the MPC, Dr J G Ball, reminded the GMSC that his committee was an independent public body which was mindful of the views of the profession, the department, and family practitioner committees. If mistakes were sometimes made the reason was usually the quality of evidence provided to the committee. The MPC dealt with 120 vacancies a year and accrued a lot of skill at its twice weekly meetings. He believed that it was much better for decisions to be taken by an organisation "one removed," so avoiding local bias, and he told the GMSC that the new recommendations would help to establish a baseline.

MPC classification areas

Open area: less than adequately doctored with an average list size of between 2101 and 2500.

Restricted area: more than adequately doctored with an average list size of less than 1700.

Intermediate area: adequately doctored with an average list size between 1701 and 2100.

Designated area: none exist—average list size of more than 2500.

Revised recommendations

- That functions of the MPC should remain as at present, including the statutory duty to determine whether and how to fill a vacancy caused by the withdrawal, removal, or death of a singlehanded practitioner

(Original recommendation: We believe that as family practitioner committees will become health authorities in their own right, and as they enter into contract with the singlehanded practitioner, they should be the appointing authority, acting on the advice of a joint vacancy committee.)

- That the GMSC seek agreement with the Society of Family Practitioner Committees and the Society of Family Practitioner Committee Administrators to a code of procedure and constitution for joint vacancy committees for implementation by all family practitioner committees and local medical committees

(Original recommendation: That the constitution of joint vacancies committees is nationally standardised and that shortlists are drawn up by at least two lay and two medical members of a committee.)

- That appeals against appointments for singlehanded vacancies continue as at present to the Secretary of State

(Original recommendation: That for singlehanded vacancies the MPC acts as an appellate body.)

AIDS and drug misuse

The GMSC has endorsed a commentary from its practice organisation subcommittee on the report from the Advisory Council on the Misuse of Drugs. The commentary will be reproduced in the committee's annual report, and some of the conclusions are set out here.

General practitioners cannot be expected to provide care and advice to patients misusing drugs without adequate community based and hospital based support services.

Free condoms should be available at appropriate outlets, including general practitioners' surgeries if the general practitioners so wish.

Certain practices accept an extra workload as a result of managing drug abusers and people infected with HIV. Extra principals and extra ancillary staff may be required. Employed counsellors are needed.

Substantial further expansion of drug misuse services with protected funding is required.

Short term attachments of general practitioners to local specialist drug services should be encouraged so as to create a pool of general practitioners experienced in dealing with the problems of drug misuse.

Experience with syringe exchange schemes and with sales of injecting equipment by community pharmacists should be fully evaluated before such schemes are implemented elsewhere.

From the JCC

Call for more pump priming posts

The Joint Consultants Committee has decided to ask for more pump priming consultant posts because of the failure to achieve an adequate increase in the numbers of consultants. Several times ministers have committed themselves to ensuring that a 2% expansion is maintained. This expansion had clearly not happened, Sir Anthony Grabham told the JCC on 17 January. He was chairing the meeting, which was hosted by the British Dental Association at the Royal Society of Medicine.

The pump priming initiative agreed in *Achieving a Balance: Plan for Action* was part of the wider aim to increase the number of consultants in the NHS in England and Wales. The government agreed to provide central funds for the appointment of 100 new consultant posts over two years—45 for 1987-8 and 55 for 1988-9—in general medicine, general surgery, and traumatic and orthopaedic surgery. The central funding covers the new consultant's salary and £15 000 a year support money for a limited period, after which the funding is built into the health authority's budget. Posts are allocated on condition that other resource implications of a new appointment—for example, anaesthetic services for surgery—can be accommodated within existing budgets.

In 1986-7 the expansion rate of consultants in England and Wales had been on average 1·5%, although the figures for 1987-8 might be better. The profession and the Department of Health were, Sir Anthony said, hampered by inadequate figures. Three regions were unable to give figures for their consultant expansion. It was those specialties with the greatest manpower problems that had achieved the lowest rate of expansion. Without the 100 pump priming posts, which had been agreed as part of the *Achieving a Balance* package, the average increase in the number of consultants in general medicine had been 1·2% but in general surgery it had been only 0·37%.

The representatives of the royal colleges and the Central Committee for Hospital Medical Services supported the idea of seeking more pump priming posts. These would have to be extended to anaesthetics, Sir Anthony said, and not confined to medicine and surgery.

Unless money was put in at the top, the chairman of the CCHMS, Mr A P J Ross, said, he could see no hope of a proper expansion in general medicine and general surgery.

The chairman of the Central Manpower Committee, Dr G H Hall, criticised the lack of support among health authorities for early and partial retirement of consultants. In South West Thames 30 requests had been turned down. In Trent 160 doctors had been discouraged from even applying. "This passive resistance must be stopped," Dr Hall declared.

Mr R T Marcus, a consultant surgeon in Stratford upon Avon, explained the difficulty of trying to get an extra consultant. His district wanted a fifth surgeon, but by closing down the surgical ward over Christmas the district had saved £27 000. Surgery was always the first specialty to suffer, and whenever an extra consultant was requested numerous arguments were deployed as to why the appointment should be in another specialty.

New moves to reduce waiting lists

The JCC has suggested sending in experts to make recommendations for reducing wait-

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ing lists. This would be on an experimental basis and would be entirely voluntary. The idea is that about five teams comprising representatives from the CCHMS and the royal colleges would be invited to those districts where long waiting lists had been identified and were causing problems. Sir Anthony Grabham hoped that the teams would be able to recommend improvements.

Representatives of the JCC have twice met the department to discuss ways of reducing waiting lists since the waiting list initiative was launched in July 1986. In 1987-8 the waiting list fund was £25m; this was increased to £30m for 1989-90.

Dr E B Lewis criticised the quality of information available—not only on waiting lists—as well as the calibre of the people interpreting the information. One document that he had seen quoted 80 operating theatres in Trent and 960 in the West Midlands; these figures had not been queried.

The Royal Society of Medicine, where the JCC met on 17 January as guests of the British Dental Association

Support for reduction in juniors' hours

The committee gave wholehearted support to the stance that junior doctors, backed by the BMA council, have taken to try to reduce their hours of work and suggested that a small group should meet representatives of the juniors to draw up proposals for changing work patterns.

The chairman of the Hospital Junior Staff Committee, Dr Graeme McDonald, told the JCC that his committee was dubious whether the district working parties which had been reactivated last year would achieve the desired effect of abolishing all rotas more onerous than one in three. That was why the HJSC had supported legislation in the shape of Lord Rea's bill, due to have its second reading on 25 January. Dr McDonald reported that the BMA council had agreed "that an average of 72 hours per 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 had asked for and achieved a meeting with the Secretary of State for Health, Mr Kenneth Clarke. Although sympathetic to the problem, Mr Clarke had not acceded to the BMA's request for a ban on rotas more onerous than one in three (84 hours) and a move towards a ban on 72 hours by 1992. The Minister for Health, Mr David Mellor, had called for reports from district working parties as a matter of urgency and had agreed to meet representatives of the BMA again in a month's time.

There were, Sir Anthony said, several practices that could be changed that would help to reduce hours of work. For example, covering for colleagues was not always necessary, and nurses often called junior doctors out for tasks that they could perform themselves.

Dr G H Hall pointed out that there was no uniformity among doctors that they wished to work fewer hours than they did now. Furthermore, a reduction in hours would mean a reduction in the amount of work done or more junior doctors.

Mr Russell Hopkins, a part time unit general manager in Cardiff, asked that if a group was to look at ways to improve working practices it could look at the amount of work that junior doctors did for locum agencies and deputising services, which had an effect on the overall number of hours worked.

Mr Stanley Simmons from the Royal College of Obstetricians and Gynaecologists pointed out that cross cover with his specialty was not appropriate because the junior doctors would not have the necessary training. There were no preregistration house officers, and about 100 districts employed only two intermediate doctors or fewer. If all rotas were reduced to one in three many small sites would disappear, but that would have to be a political decision made by the Department of Health.

Threats to clinical responsibility

The committee continues to be concerned about examples of the erosion of consultant's clinical responsibility. At its last meeting it had discussed a paper prepared by the secretariat on the subject, and for the January meeting the secretary of the conference of royal colleges and faculties, Mr W M Ross, had prepared a paper.

The concept of consultants' responsibility for patients had been set out in several documents since 1948, and as recently as last autumn a draft circular on the discharge of patients had stated:

> Only a consultant (or principal in general practice responsible for general practitioner beds) can accept medical responsibility for patients admitted to NHS units. No patient may be discharged from hospital without the authority of the doctor holding responsibility for that patient.

Despite this there had been occasions, Mr Ross pointed out, when the principle had been questioned. Multidisciplinary teams had been developed in paediatrics and psychiatry, and the consultant's clinical decision could be overruled by other members of the team. Mr Ross set out further examples:

- A letter from the Department of Health and Social Security to the Royal College of Psychiatrists in 1985 stated, "there is no legal requirement that every in-patient should be the responsibility of a consultant, or even of a medically qualified practitioner"
- In 1988 a statement by the Chartered Society of Physiotherapists referred to physiotherapists as "clinicians in their own right"
- General managers had directed the movement of patients between wards or between hospitals without reference to the responsible consultants
- In some medical laboratories there had been attempts by laboratory technicians to control the tests available to clinicians without the agreement of the consultant pathologists
- During the past two years there had been examples in draft health circulars where the responsibility of the consultant had been in question.

There had also been important changes in the relationships between doctors and nurses and doctors and midwives.

The question of multidisciplinary teams had been discussed in the liaison committee with the General Medical Services Committee, Mr A P J Ross reported. The general practitioners had agreed to ask their colleagues to refer patients to named consultants. If they referred patients to physiotherapists or psychologists they would retain clinical responsibility for their patients.

Junior Members Forum

The BMA's occupational health committee is looking for a junior doctor (under 40 and within 12 years of qualification) working in the specialty who would like to represent the committee at the 1989 Junior Members Forum. This will be held on 1 and 2 April in Newcastle, County Down, Northern Ireland. There will be a symposium "Promoting the People's Health" on the first day, and the second day will be devoted to medicopolitical issues. Applications should be addressed to the secretary of the occupational health committee at BMA House.

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Notes

Extra £5·2m for MMR vaccine

The government has announced that a total of £7·8m will now be allocated to regional authorities for 1989-90 to purchase the measles, mumps, and rubella vaccine. One million doses of the vaccine have been ordered and distributed during the first three months of the new programme.

Needs of the elderly in the 1990s

Nick Bosanquet, professor of health policy at Royal Holloway and Bedford New College, University of London, is to investigate the future health care needs of elderly people for the National Association of Health Authorities. There will be half a million more people over 75 before the end of the century and the association is concerned that there are no detailed or accurate forecasts about the health care consequences of this demographic change. The research, which will cover district health authorities and family practitioner committees, will assess the impact on health care expenditure of changes in the population, innovations in medical technology, and treatment regimens.

Kenneth Clarke with two friends when he opened the new shopping mall at Addenbrooke's Hospital, Cambridge, earlier this month. Under the terms of an agreement with British Airport Services Limited Cambridge Health Authority is guaranteed at least £100 000 a year income from the refurbished mall, which includes nine shops surrounding a piazza style café

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Dangerous bus doors

Unlike underground trains and lifts the automatic exit doors of one man operated buses are not fitted with safety devices which allow them to spring back if someone or something is trapped. On several occasions this has caused serious accidents; the driver moves off unaware that he is dragging along an ex-passenger. Dr P M Dunn of the University of Bristol believes that there are hundreds of these kinds of accidents a year and he wants doctors to join him in urging members of parliament to insist on safer doors. He would like to receive information of any such accidents. Dr Dunn's address is Department of Child Health, Southmead Hospital, Bristol BS10 5NB.

NSPCC supports child assessment orders

If social workers had been able to use child assessment orders, which would ensure that a child was medically assessed without delay, the National Society for the Prevention of Cruelty to Children believes that some of the recent tragedies could have been avoided. The society wants child assessment orders to be introduced into the Children Bill, which is in the committee stage in the House of Lords. The order would be less severe than the proposed emergency protection order as the child would remain with the parents and visit his or her usual doctor but it would allow social workers increased access to children who may be at risk of abuse.

New computers to handle patients' records

A contract worth £4·5m has been awarded to IBM (UK) Ltd for computerising the NHS's central register. The system will be developed over the next two years and will become operational in November 1990. It will provide an accurate central record of everyone registered for NHS purposes in England and Wales, showing which family practitioner committee holds each patient's current or most recent registration with a doctor. The Department of Health believes that the new system will speed up tracing and transferring of medical records between family practitioner committees when a patient moves.

People in the news

- Dr Roger Williams, director of the liver unit at King's College School of Medicine and Dentistry, has been appointed honorary consultant in medicine to the army.
- Mr Tony McSean has succeeded Mr Derek Wright as librarian of the Nuffield Library, BMA House. Mr McSean was formerly at the British Library.
- Dr Lewis Johnman, a general practitioner at Rutherglen Health Centre, has been appointed Territorial Army adviser to the director general of the army medical services in the rank of brigadier with effect from 1 April.

COMING EVENTS

Institute of Psychiatry—Details and copies of the programme of conferences to July are available from the short course organiser at the institute, Nadine Morgan, De Crespigny Park, London SE5 8AF. (Tel 01 703 5411 ext 3170.)

University of Birmingham Centre for Postgraduate Psychiatry—Course "Individual work with children and young people and with their families in varied settings: a psychodynamic approach," commencing September, Birmingham. Details from Christine Neal at the centre, Uffculme Clinic, Queensbridge Road, Moseley, Birmingham B13 8QD. (Tel 021 449 4481.)

SOCIETIES/LECTURES

Monday 30 January

St George's Hospital Medical School Department of Obstetrics and Gynaecology—At Lecture Theatre A, 12 30 pm, grand round, speaker Dr Strangeways: The microbiology of the vagina.

Tuesday 31 January

University of Oxford ICRF Cancer Epidemiology and Clinical Trials Unit—At Ida Green Seminar Room, Observer's House, Green College, 5 pm, Duncan Thomas: Some applications of Bayesian methods in epidemiology.

Wednesday 1 February

Institute of Neurology Queen Square—At Wolfson Lecture Theatre, National Hospital, Sandoz Foundation advanced lectures on clinical and experimental neurology, 6 pm, Dr T W Robbins: Brain dopamine and the mental chronometry of action. 7 pm, Mr R Brown: Cognition in Parkinson's disease.

Royal College of Surgeons of England—4 45 pm, Arnott demonstration by Mr C S Sinnatamby: The anatomical basis of the surgery of the parotid gland.

Royal Postgraduate Medical School—At Stamp Lecture Theatre, 10 15 am, medical staff round.

Thursday 2 February

Institute of Laryngology and Otology—At the Royal College of Surgeons of England, 5 30 pm, guest lecture at an advanced level by Mrs V Moore Gillon: Smell.

Friday 3 February

Nuffield Department of Orthopaedic Surgery, Oxford University—At Lecture Theatre, Nuffield Orthopaedic Centre, 6 30 pm, Professor A D Care: Control of calcium metabolism: early life.

Saturday 4 February

Nuffield Department of Orthopaedic Surgery, Oxford University—At Lecture Theatre, Nuffield Orthopaedic Centre, 8 30 am, Professor A D Care: Control of calcium metabolism: the adult. 9 30 am, Dr J Mott: Calcium and hypertension.

BMA NOTICES

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

Division Meetings

Aldershot and Farnham—At Civic Hall, Camberley, Friday 3 February, 7 30 for 8 15 pm, joint dinner with lawyers attended by the Lord Lieutenant, speakers include Mrs Brahams, Mr Bernard Hargrove, and Dr Wall.*

Great Yarmouth and Waveney—At Burrage Centre, James Paget Hospital, Friday 3 February, 8 pm, debate with members of local dental and legal professions "What price professional indemnity? (Is protection becoming a racket!)"* (Preceded by buffet supper 7 pm. Spouses and guests welcome.)

Leeds—At Littlewood Hall, Leeds General Infirmary, Wednesday 1 February, 8 for 8 30 pm, joint BMA/Medicolegal Society meeting, speaker Mr Rodger Pannone: "Medicolegal aspects of American litigation versus English litigation."

Northern—At Postgraduate Centre, Ballymena, Tuesday 31 January, 7 30 pm, special meeting.

North Warwickshire—At Griff House Hotel, Nuneaton, Tuesday 31 January, 7 30 pm, Dr Gordon Wood: "The ABC of hepatitis."*

Shropshire—At Medical Institute, Shrewsbury, Friday 3 February, 7 30 for 8 pm, joint BMA/BVA meeting, speaker Mr J E Cooper: "Surgeons, snakes, and psittacosis: a veterinary approach to comparative medicine."* (Followed by buffet supper. Guests welcome.)

Solihull—At Gloucester Suite, St John's Hotel, Wednesday 1 February, 7 30 for 8 pm, dinner meeting, speaker Joy Woodall.*

Somerset—At Marsh Jackson Postgraduate Centre, Yeovil District Hospital, Wednesday 1 February, 7 30 pm, reception for new doctors to East Somerset.*

Regional Meetings

South West Regional Hospital Junior Staff Committee—At Postgraduate Medical Centre, Musgrove Park Hospital, Monday 30 January, 7 pm.

South West Thames Regional Committee for Hospital Medical Services—At Postgraduate Medical Centre, Royal Surrey County Hospital, Monday 30 January, 5 30 pm.

Wessex Regional Committee for Community Medicine and Community Health—At Reception Room 2, Old Manor Hospital, Salisbury, Thursday 2 February, 10 am.*

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