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A.R.M. Round Up

The General Medical Council, confidentiality, abortion, euthanasia, hospital staffing—despite such controversial issues on the agenda the Annual Representative Meeting at Leicester was a surprisingly placid occasion. With the last day devoted to a Special Representative Meeting on the industrial relations legislation and the proposed N.H.S. reforms, the A.R.M. itself was dispatched in a shade over three days without giving an impression of undue haste, though quite a few motions fell to the guillotine and had to be referred to appropriate committees. This was largely thanks to the agenda committee's preparatory work and to the patience and good humour of the Chairman of the Representative Body, Dr. Arthur Maiden.

The long time taken by the Government to set up a new Review Body and the consequent delay in any recommendations on pay for N.H.S. doctors in 1971-2, was deplored in a—quickly approved—composite resolution, which gave the Council a free hand to press for an early increase. Nevertheless, the fact that pay never emerged as a major issue during the debates no doubt also contributed to the meeting's peacefulness.

Hospital doctors were well represented at the A.R.M., and it was on hospital staffing that some of the liveliest debates took place. This year it was the regional consultants rather than the juniors who took most of the limelight. Critical resolutions about the constitution of the Central Committee for Hospital Medical Services calling for greater representation for regional hospital consultants were defeated, but nevertheless the strength of feeling among some regional consultants on this issue was clearly demonstrated. It was decided to hold an annual meeting of representatives of hospital staff in future. The representatives were left in no doubt about the parlous state of some accident and emergency departments—the shop windows of hospitals, as Mr. Walpole Lewin described them—and urgent action was demanded on the recent C.C.H.M.S. report on career structures for these departments. Mr. Lewin gave a progress report on the new proposals for monitoring hospital staffing. The regional hospital staff would be well represented on the monitoring committees and he saw it as "an opportunity for the profession to play a guiding part in the problem of hospital staffing. The Representative Body approved the proposal to increase consultant staff by 4% and registrar grades by 2½%, and there was a long debate on the problems caused by the registrar freeze of the past few years. A suggestion that a subconsultant grade should be introduced was firmly rejected despite a strong plea on behalf of women doctors.

The relationship between general practitioners and hospitals is a major issue in the N.H.S. at present, and debates on clinical and medical assistants' pay as well as on the controversial hospital practitioner grade naturally prompted intervention by several general practitioners in the hospital debate. The division of opinion between the G.M.S. Committee and the C.C.H.M.S. on the hospital practitioner grade was discussed without polemics, and the two committees were asked "to make strenuous efforts to resolve their differing views." The Representative Body subsequently resolved that the grade should be restricted to general practioners and part-time hospital medical officers employed for not more than five sessions a week.

One general practitioner told the A.R.M. that the happiest period of his career had been the month last summer when National Insurance certificates had not been issued by doctors. His fellow representatives obviously agreed, because they asked the Council to press for abolition of such certificates. The B.M.A. faces a hard task in the coming session to convert the Government to that policy. Vocational training in general practice, including proper payment for trainers, and an item-of-service fee for contraceptive advice by family doctors were among other items discussed in the G.M.S. Committee's section.

It is impossible in the space available to do more than touch on a few of the many subjects discussed at an A.R.M., but a disturbing report from the medical teachers demands attention. This concerned the serious shortage of medically qualified teachers in preclinical departments. One speaker blamed the shortage on the severe financial deterrent, saying that teaching in a preclinical department can cost a doctor up to £2,000 a year compared with colleagues in clinical teaching. The meeting took the point and approved a resolution asking for similar salary scales for preclinical and clinical teachers.

The Brynmor Jones report on the constitution of the G.M.C.[1] was accepted by the Representative Body, though it recommended payment of the annual retention fee only on a year-to-year basis until a satisfactory outcome is achieved about the future functions of the council. Even a message

from the G.M.C.'s registrar to the B.M.A. that the annual retention fee would have to go up—by an amount unspecified—failed to provoke the brisk reaction that might have been expected. No doubt inflation psychology had effected the representatives because they also accepted a rise in the B.M.A. subscription to £21 with barely a murmur.

In a responsible debate on medical confidentiality the speakers tried to stick to principles, and after the platform had repelled several amendments the Council's advice to doctors that they should respect the patient's wishes on confidentiality was approved. The relationship between doctors and social workers on confidentiality of patients' medical records is at present worrying the profession, and this too was debated. This matter will require careful consideration by both groups if patients' interests are not to be adversely affected.

The contribution the B.M.A. makes to scientific and social medicine was reflected in the wide range of the debate on the activities of the Board of Science and Education, a part of the meeting which, as always, attracted much press interest. Euthanasia was once again rejected, the board's proposals to reduce smoking supported, and an inquiry into A.I.D. agreed upon. Sir Ronald Tunbridge spoke about the Board's recent report on abortion and its much publicized reference to the age of consent, and he emphasized that it was not B.M.A. policy that the age should be changed. The meeting decided that the prescribing of amphetamines should not be compulsorily banned nor that these drugs should be available only from hospital pharmacists. However, a recommendation to include barbiturates under the Misuse of Drugs Bill was approved.

The Special Representative Meeting, which followed the A.R.M., broadly approved the Council's reports[2] on the Industrial Relations Bill and on N.H.S. reorganization. On the first subject Dr. Ronald Gibson reported the B.M.A.'s success in persuading the Government to make special provision for the professions in the new legislation, and the Council was given a free hand by the S.R.M. to apply for the B.M.A.'s admission to the special register under the Industrial Relations Act at the appropriate time. This can now be done without change in the B.M.A.'s status or character, and it seems likely that negotiations for doctors in the N.H.S. will continue along established and well-tried channels.

There were no real surprises in the debate on N.H.S. reform, the Representative Body strengthening the Council's proposals here and there but not altering the main lines of policy. On the subject of finance, the S.R.M. wanted the Government to provide "large amounts of extra money forthwith" to rectify some of the Service's more "glaring defects." The representatives deplored the absence from the Consultative Document of any reference to improving the standard of care of the patient. As in the Council and its standing committees the emphasis on management caused much anxiety among speakers, and this understandably prompted the request for full professional representation in the regional and area health authorities and for strong statutory professional advisory machinery at these levels.

The timetable set by the Government for receiving comments on its proposals was criticized, but Sir Keith Joseph had assured the B.M.A., Dr. Gibson said, that the views of the Representative Body would be "taken fully into account" in preparing a White Paper.

1 *British Medical Journal Supplement*, 1971, 1, 55.
2 *British Medical Journal Supplement*, 1971, 3, 1.

Temporal Lobe Epilepsy

Though the term temporal lobe epilepsy was first used by W. G. Lennox,[1] it was derived from Kinnear Wilson's earlier concept of "temporal epilepsy".[2] The temporal lobe is the part of the brain which lies below the Sylvian fissure, and its most medial and deep portion includes the hippocampal region with the uncus, the hippocampus itself (Ammon's horn), and the amygdala. This area is concerned not only with smell but also with the autonomic nervous system, visceral sensation and motor activity, and possibly certain aspects of memory. S. Currie and his colleagues[3] at the London Hospital have recently reviewed a relatively unselected group of no fewer than 666 patients with temporal lobe epilepsy followed for an average of seven years. Since our knowledge of the natural history of this illness is scanty, this thorough study is particularly welcome.

Currie and his colleagues found that attacks with nocturnal fits—which is often thought to be characteristic of temporal lobe epilepsy—occurred in only 5%. Viscereal symptoms were the commonest type, occurring in 40%, while déjà vu was reported in only 14%. Though it is often held that abnormal sensations of smell and taste are common in this condition, they found that visual (18% of all cases) and auditory (16%) symptoms occurred much more frequently than olfactory (12%) or gustatory (3%) symptoms. Moreover, there was also a relatively low incidence of psychiatric disorders compared with other series[4-6]—probably reflecting the relatively unselected nature of their series. Abnormal physical signs occurred in only 3% of patients; 92% had definite foci on the electroencephalogram and 6% ill-defined foci. Finally, 11% had a family history of epilepsy, 7% a history of a birth injury or an abnormal birth, and 5% had had seizures in infancy.

The London Hospital group's conclusion that temporal lobe epilepsy is a disorder with a later age of onset (average 28 years) than has previously been recorded is probably influenced by the fact that very few children were referred to them. In their series those whose epilepsy began under the age of 10 years were not seen for the first time until an average of 15 years later, and when epilepsy began between 10 and 15 the first attendance was not until roughly 10 years later. This is important as children may have epilepsy for several years before the attacks become typical of temporal lobe epilepsy and before the electroencephalogram shows a definite focus in the temporal lobe.[5 7 8]

Follow-up of the 666 patients showed that 73% had improved and that 40% were free from attacks. Of those of working age, 88% were in employment, while most of the remainder had psychiatric disorders and were not disabled by epilepsy. Hence Currie and his colleagues concluded that temporal lobe epilepsy has a relatively good prognosis. Moreover, their findings suggest that surgery is not often needed for this type of epilepsy because the main indication for surgery is the failure to control the attacks by medical means sufficiently for the patient to lead a relatively normal life. In fact, only 62 patients underwent lobectomy, most of whom had had epilepsy from before the age of 15. Fifty-four of the 666 patients died; in 42 death was related to the epilepsy, being due to an underlying cerebral tumour in 30 patients, but only seven died during or as a direct result of a seizure.

It is of special interest that only one patient examined at necropsy had mesial temporal sclerosis (that is, loss of nerve cells and glial scarring affecting not only Ammon's horn but