difficult, some county councils routinely produce unemployment rates to this level. We used these rates and showed their association with morbidity. The main issue in respect of the denominator is not that it is difficult to construct but that if comparisons are to be made between localities care needs to be taken to ensure that the method of construction is consistent.

Jarman points out that his index was developed as a measure of general practitioners' opinion of what influenced their workload. If that was all the index purported to measure we would have no quarrel with it. He goes on to say, however, that the objective in developing the measure was to concentrate general practice resources more into underprivileged areas. The assumption that general practitioners' opinion of their workload equates with underprivilege in a locality is a great leap.

Our reason for carrying out our study was health authorities' increasing use of the Jarman index as a measure of deprivation influencing their allocation of resources. It is not clear from his letter whether Jarman agrees that this use of the Jarman index is inappropriate.

We agree with Jarman that this issue is not an academic exercise and has real implications for resource allocation. We disagree with his view that the index used is less important.[3] It is important that the appropriate measure is used in the appropriate context. This makes a real difference to resource distribution.[4]

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2 Campbell DA, Radford JMC, Burton P. Unemployment rates: an alternative to the Jarman index? *BMJ* 1991;**303**:750-5. (28 September.)
3 Jarman B, Townsend P, Carstairs V. Deprivation indices. *BMJ* 1991;**303**:523. (31 August.)
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RCGP approaches 40

SIR,—In his editorial celebrating the fortieth anniversary of the Royal College of General Practitioners Andrew P Haines refers briefly to the need for the college to widen its horizons beyond the United Kingdom.[1] The international committee has the remit: "To promote health care internationally...." Several current activities support this remit, including the appointment of fellows, of whom there are currently four assisting governments and general practitioner bodies in Kuwait, Malta, Portugal, and Saudi Arabia to develop systems of primary care appropriate to the country's needs.

The college has responded to requests from the World Health Organisation, the Department of Health, and the British Council to advise and give practical assistance to several central and eastern European countries that are attempting to reorientate their systems of primary health care. This month a conference entitled "General Practice in the New Europe" was held at the college.

The college is supporting Action in International Medicine in establishing district health systems in Third World countries and is also helping the Voluntary Service Organisation to promote its work in underdeveloped countries. Through international scholarships the college has supported general practitioner exchanges and assistance to and from developed and underdeveloped countries in all parts of the world.

Many governments are looking to Britain for advice and assistance in the provision of a cost effective and appropriate system of primary health care. I believe that the college can help. Its members have much to offer and much to learn from international activities.

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1 Haines AP. The RCGP approaches 40. *BMJ* 1991;**303**:1213-4. (16 November.)

Special representative meeting and the political process

SIR,—The pussyfoot approach is about as effective in medical politics as treating appendicitis by fanning the umbilicus with a wet straw hat.

Having been elected in accordance with the Trade Union Act of 1984, the BMA's council has decided to hold a special representative meeting next year.[1] This will inform the public of the effects of last spring's drastic changes in the NHS, but there are now signs of an attempt to reverse that decision. Tony Keable-Elliott fears that a special representative meeting "will involve the BMA in taking a political stance" and that unpleasant consequences will follow.[2]

Fears of being accused of taking a political stance did not noticeably inhibit the BMA from expressing the profession's opinion in the days of David Lloyd George (Liberal), Aneurin Bevan (Labour), Dennis Vosper (Conservative), Kenneth Robinson (Labour), Richard Crossman (Labour), Barbara Castle (Labour), and Kenneth Clarke (Conservative). It is difficult to work out why anyone would wish to suppress information that only the profession can provide, particularly in respect of the quality of the care that the public receives.

Doctors are in a unique position to observe the work of the NHS, seeing the effects of both success and failure on each patient. Over the past few months they have also seen the results of administrative change on the patient, on the organisation and efficiency of the service, and, much more importantly, on the effectiveness of the service. Doctors, both individually and collectively, have a compelling duty to report, accurately and explicitly, their observations to the public.

Recently antipathetic sections of the press have made one or two attempts to accuse the BMA of misrepresenting its members' views. This accusation falls flat in the light of the BMA's democratic structure even if there is not going to be a referendum. Every member has the right (and, dare I say, duty) to provide his or her representative with facts, figures, observations, and opinions; the representatives can then speak and vote accordingly.

The council should have the moral courage to avoid the pussyfoot approach, eschew vacillation, and stick to its decision.

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2 Keable-Elliott T. Special representatives meeting and the political process. *BMJ* 1991;**303**:997. (19 October.)

Behind the speaker

SIR,—The late Professor Dick Scott would surely have warmed to Tony Smith's remarks on the art of lecturing.[1] Scott, the first person in the world to hold a chair of general practice and himself never entirely at ease on the podium, would often proffer the following advice to would be speakers. "If you're asked to speak for an hour you could probably manage at a pinch with two or three days preparation. For a half hour lecture you would need at least a couple of weeks' notice to be on the safe side; for a 15 minute talk a month is required—and if anyone ever asks you to speak for a shorter time than that, refuse."

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1 Smith T. Behind the speaker. *BMJ* 1991;**303**:1207. (9 November.)

The health of Europe

SIR,—The successful negotiation of a new European treaty at Maastricht last month marks another important step in the creation of (in the words of the treaty), "an ever closer union among the peoples of Europe."

It also ushered in a new period in cooperation between the 12 member states of the European Community in health matters. The treaty contains a new chapter on public health in which the 12 commit themselves to cooperate and to coordinate their policies and programmes to prevent disease, particularly the major health scourges, including drug dependence. I warmly welcome this development.

This is not an entirely new departure. For some years the community, with the strong support of the United Kingdom, has implemented health programmes, including those on AIDS and cancer and projects to help the elderly. But this has been done on an ad hoc, uncoordinated basis. The new treaty chapter provides an opportunity for member states to develop a framework within which they can help each other through sharing ideas, exchanging scientific information, providing early warnings of the outbreak of disease, and implementing concerted efforts to inform the people of Europe how they can promote their own health and wellbeing.

This does not, of course, mean that member states will no longer remain free to pursue their own policies. They will—but through coordination of their efforts; and the European Commission will have the role of promoting closer relations between member states. Together states should be able to achieve more than they can separately. Indeed, it should be a test of the value of any community activity that it achieves more than member states can on their own.

Nor does the enhanced role of the community mean that member states will have to tailor their health care systems to a European blueprint. European health care systems are richly diverse, and each country rightly values the benefits of its own system. The public health chapter therefore excludes any power to harmonise the laws and regulations of member states, so the funding and structure of the NHS will not be altered by the treaty.

In responding to the new health chapter the community needs to recognise that other international organisations of which the United Kingdom is an active member, especially the World Health Organisation, have a record of achievement in international health. The community should build on and complement those achievements—not seek to duplicate them. For that reason the United Kingdom pressed for and obtained a provision in the health chapter that the community should foster cooperation with international organisations working in public health.

The treaty signed at Maastricht offers an important opportunity for all of us in the community to develop an effective framework for cooperating in public health between member states, supported by the European Commission. I look forward to the United Kingdom playing its full part.

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