explained why Dr Lynch's views were shared by the other negotiators, but Dr Tiarks commented that those views implied that the committee thought it knew best. Committee members couldn't represent the interests of general practice if they wore earmuffs and blinkers. "We can only represent the profession if we listen."

Dr Lynch thought it was sad if members, particularly negotiators who had been elected to do a job, couldn't say in open debate what they had learnt while in office. Credibility and leadership depended on realism.

Bringing the subject back to the committee in this way was creating a precedent, believed Dr G Rae, but he welcomed the opportunity to discuss Dr Lynch's comments on conference motions, which asked for things provided that there was new money to pay for them.

Also feeling uncomfortable about Dr Lynch's remarks, Dr J Gilley pointed out how privileged committee members were in their access to documents. She had sat in the committee block at the last conference and had been disturbed at the disinterestedness and discourtesy shown by some GMSC members to the conference speakers.

The committee had to recognise that not everything that the conference voted for was attainable, Dr J G Ball, a former GMSC chairman, pointed out. Referring to Dr Rose's statement that the committee's main function was to represent doctors, Dr Ball reminded him that doctors' livelihoods depended on patients. "Politics," the former chairman told the committee, "is putting our best efforts in trying to achieve our objectives."

The chairman, Dr I G Bogle, said that he could see why there had been unease at the last meeting, but he had been a representative at the local medical committee conference for 25 years and he understood the responsibility that this meant. The negotiators intended to try to find solutions to the problems raised; the results would be brought back to the committee before going to the conference.

BRIEFLY . . .

- The GMSC plans to raise with the new secretary of state the question of GPs being paid for advising FHSAs
- The GMSC is to try to identify occasions when general practitioners face difficulties in securing time off from practice commitments
- Doctors will be advised of the importance of allowing trainees leave to attend the LMC conference and their subcommittee, which are described as trade union activities
- The negotiators were due to meet the review body on 23 November to give supplementary evidence on general practitioners' workload
- GMSC members wishing to stand in the election of 110 representatives to the annual representative meeting should apply by 30 November.

1 Beecham L. Advertising—no longer a dirty word. *BMJ* 1990; 300:1420.
2 Beecham L. Lost credibility or new opportunity? *BMJ* 1990;301: 990.

Patients' rights

The GMSC has reaffirmed "the right of the patient to accept or reject any form of treatment or preventative measure offered." This statement, which had been referred to craft committees by the BMA council, originally contained the following additional words, which the GMSC could not accept: "Doctors must not allow personal financial advantage to affect, in any way, their conduct towards patients unwilling to accept the offer of immunisation or cervical cytology."

Changes in rural practices payments

The GMSC has endorsed recommendations for replacing the rural practice payments scheme in England and Wales with a milage fund. The changes, which were negotiated in the Central Advisory Committee, come into force on 1 April 1991; the outcome will be a redistribution of the money in the rural practice scheme. The government has not provided any new money, but it has agreed to retain the advisory committee, which the secretary of state had originally wanted to disband. The remit of this committee, which contains departmental, FHSA, and professional representation, is "to examine the scheme for rural practice payments and make recommendations to the secretary of state on options for revising the present long standing criteria for payment."

- There will be no definition of rurality
- The minimum qualifying distance will remain at three miles
- The number of eligible patients required to attract payment will be increased from 10% to 20%. The aim is to remove the possibility of including urban general practitioners without having a definition of rurality
- Total partnership list will be used to determine the relevant percentage rather than practitioners' individual lists. This should tighten up the present criteria, where in a mixed rural and urban practice all the rural patients are put on to one general practitioner's list so as to qualify for the 10% criterion and enhance practice income
- The weighting of units will be changed to increase the payments for greater distances (see table)

Weighting of units for milage fund

Distance from surgery (miles)	Current units	New units (April 1991)
3-	1	1
4-	3	4
5-	5	6
6-	7	8
7-<8	9	10
For each additional mile or part of a mile	2	2

- The present provisions for walking, difficult walking, and blocked routes will be retained, although the criteria for walking and difficult walking will be amalgamated. In future general practitioners will need to confirm to the FHSA, on a regular basis, that their circumstances remain unchanged
- No new special districts will be approved pending a review by the health departments, in consultation with the GMSC and FHSA representatives, by way of the Central Advisory Committee
- A transitional payment scheme will be introduced to run for two years to reimburse any doctor who loses money under the new arrangements to the extent of two thirds of any financial loss in year 1, and one third in year 2. These transitional payments will be funded from within the rural practices payments fund
- The revised scheme will be reviewed after it has been in operation for 12 months.

The review body will determine the new unit in its 1991 award. At present the rural practices fund stands at £15 351 630. The present unit payments are £0·218 per unit per quarter for 1 April to 31 December 1990 and £0·219 per unit per quarter for 1 January to 31 March 1991.

LAURENCE PHOTOGRAPHY

Mr Duncan Nichol has agreed to open the seminar on clinical directorates, which the Central Consultants and Specialists Committee is organising at BMA House on Friday 7 December (10 November, p 1104). He will give an overview from the NHS Management Executive

BMA council election 1990-2

Mr Dick Greenwood has been elected to fill the casual vacancy on the council of the BMA for a representative of senior hospital doctors. The election was conducted by the single transferable voting system.

Number of ballot papers distributed	14 140
Number of ballot papers returned	4 310
Number of ballot papers spoilt or invalid	8
Rate of participation	30·48%

IAN T FIELD
Secretary

Correction

Doctor's stricter parking curbs

An error occurred in this article in BMA affairs (3 November, p 1051). The staged warning system for doctors' street parking refers to only the Marylebone area of London.