morbidity. The Civil Service have found it to be a reliable indicator. Regional differences are known to occur, with Wales and the North of England having higher levels than the South East. McKeown and Furness in 1984 examined the absence records of two separate Health Authorities, and they found a 50% difference in overall absence between the two authorities and this was paralleled by a 20% difference in the morbidity of the population as a whole as measured by serial SMR. These differences in absence rates applied to one day, short and long term absence. Whilst it may be argued that long term absence might reflect the health of that population, this would be unlikely to apply to one day absence, implying that other factors are likely to be involved. A similar conclusion was reached by Taylor in the context of Post Office employees and he implicated a wide range of social, economic and industrial factors. Thus morbidity, while being a factor particularly in long term sickness absence, is not the only one, and sickness absence, as has been noted by many authorities in the past, is multi-factorial in aetiology.

The analysis of the problem should nevertheless be considered to be worthwhile, as it may reflect the health and welfare of the workforce in a wider context. The NHS provides a unique opportunity to undertake such an analysis where all one million employees can be standardized for age, sex and occupation. Caution should be exercised in the use of indices. It is, as with other indicators in the NHS, misleading to rely on the use of one index alone. The average number of episodes of absence in one authority was one which was the same as found in Barr's survey of 1957, but had this index been used alone, it would have concealed the dramatic change that has occurred in the nature of absence, with the shortening of the duration of absence and the greater proportion of the population taking multiple episodes. The NHS is an industry concerned with the community as a whole, but it is important that it is more closely involved with the health and welfare of its own workforce. The analysis of sickness absence might provide some insight; the social, economic and medical benefit of such an analysis might well be rewarding.

K D McKeown
Department of Occupational Medicine, Friargate Hospital, Northallerton, Bishop Auckland General Hospital, Co. Durham

References
13. Clark J. Time out - a study of absenteeism among nurses. London: Royal College of Nursing

Wind of change. III.
The Royal Colleges

Several years ago, I was asked to translate into German The Short History of The Royal College of Physicians of London by Dr Alec Cooke I accepted the request and to my surprise, I found myself immediately up against a fundamental difficulty. What is the correct translation of 'The Royal College of Physicians' into any language? I remember that those days, be a tough university exam. To further lose an MD bestowable by the Royal College of Surgeons of England, and the Royal College of Physicians of London and a degree of the University? At my hospital, and others, the diploma could be obtained some months before the degree and was looked upon as a kind of insurance policy as one could be already safely in a house post before tackling what might, in those days, be a tough university exam. To further my confusion there was always, as long stop, the licence obtainable by examination at the Society of Apothecaries and, finally, a pathway to practice through Lambeth Palace, and MD bestowable by the Archbishop of Canterbury of all people!

It was accepted that for those who intended to follow a hospital career heading to honorary status and a lucrative private practice it was more important to pass eventually the very difficult postgraduate
diploma examinations of the Royal Colleges than to obtain the higher degrees of the universities, and possession of a qualifying diploma absolved the holder from the payment of back fees, etc. in the event of gaining the higher diplomas. The university appointments at teaching hospitals even in the clinical departments were a full time and relatively penurious self denying commitment, the holders being regarded by colleagues with a mixture of fear and disdain, in contrast to the Continental habit where professors of medicine and surgery had large private practices and dominated the hospital scene (the 'Geheimrat image'). In one of the major teaching hospitals in London up to the end of the 1960s the Senior and dominant surgeon was an FRCS who had never taken a university exam. On the Continent, the only access to medicine was the universities since the beginning of the 19th century (Napoleon having closed the College of Physicians in Venice in about 1801).

A lot has changed since then but whether for the better I would not dare to say. Admission to medical school and qualification are now university dominated, the non-university qualifying diplomas being anathema to most Deans, the University Grants' Committee and, by implication, the taxpayer. There is, incidentally, no room for chronic students as there was in my day.

Diminished by university influence in undergraduate education the purpose of the colleges today has been directed more to the maintenance of standards of specialist practice and strict regulation of postgraduate training in the respective disciplines, devising better and better training schemes with higher and (it would seem) even higher diploma examinations for those aspiring to, and even in, consultant grades. The colleges are also getting round to encouraging audit of clinical performance; in the case of the Royal College of Surgeons some 120 years after it was suggested by Florence Nightingale. She had already established the bite of statistics in the corridors of power after the Crimean War. To an increasing extent the colleges assumed greater influence in postgraduate affairs than the universities although the Professors are now more powerful and can easily justify the need for a budding consultant to have obtained a higher university degree as a result of research.

While the university is a whole body of teachers and students, the medical Royal Colleges are bodies of Fellows and Members. The Royal College of Physicians of London has developed a new policy concerning its number of Fellows. Under the presidency of the late Lord Rosenheim in 1968 a report of a committee under his chairmanship was accepted by Comitia on 25 April of that year. It recommended that the number of Fellows should be increased by electing at least 200 annually. Accordingly, the Fellowship would be achieved at a much younger age.

The situation is made clearer when comparing the numbers of Fellows and Members in 1938 and 1988.

<table>
<thead>
<tr>
<th>Year</th>
<th>Fellows</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1938</td>
<td>581</td>
<td>1690</td>
</tr>
<tr>
<td>1988</td>
<td>5511</td>
<td>16048</td>
</tr>
</tbody>
</table>

Concerning the membership, it must be stated that the number given for 1938 covers the old MRCP London, whereas the number given for 1988 refers to all MRCP(UK) in England, whether or not they are Collegiate Members of the London College. The number of Licentiates was about the same as those of the Members of the Royal College of Surgeons of England in 1938, also in 1988.

The Royal College of Surgeons of England have not until now changed their policy concerning the Fellowship nor their examinations. Their figures are given as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Fellows</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1938</td>
<td>2480</td>
<td>20689</td>
</tr>
<tr>
<td>1988</td>
<td>11157</td>
<td>26000 (over)</td>
</tr>
</tbody>
</table>

The increase in number of Fellows (by examination) is explained by the College Secretary firstly by the immediate post-war expansion with the introduction of the NHS and the growth of specialization in surgery, and secondly by the great influx of overseas doctors in the 1950s until a few years ago, with a consequent sharp rise in the numbers wishing to take a British Fellowship.

Pari passu with the increasing numbers of fellows each belonging to a specialist association or society has come a proliferation of Colleges and Faculties. Each seeks varying degrees of independence from the parent colleges, sometimes fiercely, each clamouring to be watchdogs for maintaining high standards in their specialty.

There are, at present, seven medical Royal Colleges in England and three in Scotland. The Royal College of Physicians in London has attached to it a semi-independent Faculty of Community Medicine and a Faculty of Occupational Medicine. The Royal College of Surgeons of England has similarly attached the Faculty of Dental Surgeons, the Faculty of Anaesthetists (about to become a college within the parent college structure) and also the Hunterian Institute (partly from the ashes of the Institute of Basic Medical Science). A College of Ophthalmologists is now being added to the growing list. Which specialty will be next in this wind of change?

At present, there is a movement afoot to found a College of Paediatricians (Lancet, 1988, i, pp 1030-31).

The reason given is as follows:

"How a major specialty governs itself and admits to its ranks is a matter for wider interest within the profession, not least because that specialty claims an interest in the welfare of a vulnerable and valuable section of the society. Concern about such developments is not confined to the profession, nor is it new: 21 years ago a non-medical commentator noted that "the fiercest guardians of medical tradition, and the core of the medical establishment, are the Royal Colleges in London". The medical novelist John Rowan Wilson complained, through a fictional minister of health: "What groups of men had such a bewildering variety of representative bodies?" One might well ask whether fewer, not more colleges would serve doctors just as well."

And the final conclusion of the leader writer in the Lancet was that the paediatricians could have their wishes achieved within the present framework 'and the further balkanisation of the medical Royal Colleges would be avoided. In other words, it would be a good thing, were the universe of medical colleges to expand no further'. (see also Davis JA. Who needs a college of Obstetrics and Gynaecology? Lancet 1987;i:1465).

One is reminded of a parody taken from W S Gilbert in relation to the proliferation of professors that occurred in the 1960s and 1970s - 'Professors in their funny hats, as plentiful as tabby cats, in point of fact too many.'
This proliferation relates to my final point in the wind of change. In recent years, noticeably in recent months, there has been a new development. We have seen colleges enter, or perhaps been drawn into, the political arena. Being very old fashioned, I am afraid of politics, even when they are disguised as economics. The field of politics always appeared to me a minefield. I may be wrong, but I have felt compelled to confess my misgivings. I have always remembered Goethe's dictum: 'Political song - a nasty song', and the old Roman warning: 'Caveat consules, ne quid res publica detrimenti capiat.' (Indeed, since writing these lines, I have read Dr Elizabeth Shore's article 'Politics and the Royal Colleges' Br Med J 1988;297:1068–9.)

The Continent of Europe is bereft of its many old medical colleges. They are diminished and destroyed, I believe, by politicians and dictators. We are so proud of being able to retain our own free institutions, but I am concerned that divisions and subdivisions will weaken these. I am concerned for their charitable status (their strength and their Achilles heel).

I am reminded again that Napoleon closed the College of Physicians in Venice in 1801. He was only the age of a middle grade registrar at the time, not much less than aspiring Ministers of State.

V C Medvei
38 Westmoreland Terrace
London SW1V 3HL