1. As might be expected, visiting is maximal in the 65-plus age group. More than half the visits made were to elderly people (3,109 out of 5,975). This was the only group in which doctor initiated follow-up visiting exceeded those visits requested by patients. There was a wide variation among doctors, ranging from the five who made no follow-up visits in this age group to one who made 68. The problems surrounding practices in scattered communities lead to increased visiting, but this is less important than the behavioural variation among doctors because there is greater variation in the results for follow-up visits than for new visits.

2. Eight hundred and sixteen visits were made to the youngest two age groups (i.e. less than 15 years), and 718 of these were in response to patient requests, leaving only 98 doctor initiated follow-up visits. Follow-up visiting among children was not undertaken to any great extent. Only six of the recorders made a follow-up visit to a baby (under 12 months) in the study fortnight, and 17 to a child (1 to 14 years).

Acknowledgements

The Birmingham Research Unit in association with the Department of Engineering Production of Birmingham University thank recorders for sending in their returns, and Messrs Reckitt and Colman, Pharmaceutical Division, who sponsored the series.

National Conference of Postgraduate Advisers in General Practice

THE thirteenth meeting of the National Conference of Postgraduate Advisers in General Practice of the UK was held at the College on 1 December 1977. Dr Alistair Donald took over as Chairman from Dr John Hasler. Dr Hasler was warmly thanked for the authority and distinction he had brought to the task of Chairman of the Conference.

The Conference continues to perform a useful function in providing a medium for exchanging ideas about the different ways of resolving the problems which beset all advisers. For example, there is concern about the future of training for women doctors who want to enter general practice but cannot work for more than half the usual time. The NHS (Vocational Training) Act (1976) requires that provision should be made for such trainees and the present regulations already allow for this. Implementation, however, depends on the availability of funds for training posts in hospitals. It is rarely possible for two women to cover one established post, though this has occasionally been achieved. It also depends on the willingness of trainers to accept them. The amount of time and reorganization of the practice required for part-time traineeships is similar to that for full-timers, yet at present the trainers' grant is spread over two years, which means that there is little incentive.

The advisers are also concerned about the present regulations covering the appointment and reappointment of trainers. There are several aspects of Paragraph 38 of the Statement of Fees and Allowances (NHS General Medical Services, 1972-8) which are regarded as unsatisfactory. The General Medical Services Committee is, of course, represented by an observer at the Conference, and several advisers are also members of that Committee, which gives them the opportunity to put forward the advisers' views to those negotiating on the profession's behalf.

Another problem aired at the Conference was that of overlap of trainees in teaching practices. Many of those involved in organizing vocational training schemes consider that a splitting of the 12 months' traineeship into two, not necessarily equal, parts is educationally desirable. This may involve one trainer having two trainees for a few weeks, one completing his training and the other beginning. Furthermore, with the absence of women trainees on maternity leave or any trainee on sick leave, rotations can sometimes get out of phase. Women may return to join their traineeships after having their babies later than originally planned and this again can give rise to clashes. At present the Department of Health and Social Security allows only three weeks' overlap but the advisers are of the opinion that the length of overlap should be entirely dependent on educational considerations and that such decisions should be left to regional postgraduate committees and their general-practice advisory committees.

Visits by teams from the Joint Committee on Postgraduate Training for General Practice again formed a major subject for discussion, and for this the Conference was joined by members of the Joint Committee and visitors who were not themselves regional advisers. Some advisers are concerned about the time taken in preparing for, and reacting to, these visits. They advocate that, at the most, they should occur at two-yearly intervals, or possibly even three. They have also been critical of the relatively minor impact of the Joint Committee on the content of hospital posts. In view of the imminent tabling of regulations for implementation of the Vocational Training Act, it is vital that the posts used for training

OCCASIONAL PAPERS

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A System of Training for General Practice

The fourth *Occasional Paper* by Dr D. J. Pereira Gray is designed for trainers and trainees and describes the educational theory being used for vocational training in the Department of General Practice at the University of Exeter. **Price £2.75.**

future general practitioners should be seen to be educationally sound. Although much of the burden of the task of ensuring this will fall on the regional postgraduate committees, the advisers are insisting that the Joint Committee has a national role to play as well.

The advisers have urged the Joint Committee to circulate documents which show some of the different mechanisms by which they have achieved success in vocational training. They have also pointed out that when visits are made to schemes there is a danger that those doctors who are on self-constructed programmes, particularly in districts where there are no schemes, may be overlooked. Their needs are, if anything, greater than those who are on organized schemes.

DOUGLAS PRICE
Secretary of the Conference

Reference

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Responsibilities of consultants in psychiatry within the NHS

The legal, professional, ethical, diagnostic, and prescriptive responsibilities of the medical profession cannot be delegated to a multidisciplinary group when treating an individual patient. Each doctor (consultant) must formulate his own opinion, whether assisted in this process by others or not. Multidisciplinary in this context, from the medical point of view, is a process of consultation, the final decision resting with the consultant on matters where he has the final responsibility. Similar conditions may apply to other professions when the central responsibilities germane to these disciplines are involved. However, with patients the medical role is the prime mover for the whole process of treatment and care. In the multidisciplinary team model that is being put forward, a standardized pattern centring on a regular meeting on the ward of all disciplines is recommended. This model is being transmitted throughout the Service to the extent that there is an implication that if meetings are not held, there is some failure of those involved. It must be stated that communications at ward level and the formation of the team spirit are important to the care of patients, but it does not necessarily follow that there is only one method (through a meeting) by which communications can be achieved. Nor does it follow that if meetings were held widely throughout the Service they would necessarily achieve the expected results. Age, experience of participants, personalities, local factors, professionalism, structure of disciplines within the hospitals, and administrative policies of all militate both for and against relationships and communication.

Reference

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