DRINKING IN ENGLAND AND WALES. ENQUIRY CARRIED OUT ON BEHALF OF THE DHSS

Paul Wilson

HMSO
London (1981)
79 pages. £8.00 (paperback)

Many people have become concerned about the steady increase in drinking problems in the UK during the past 20 years. To investigate the patterns of alcohol consumption and measure the amounts consumed within the general population, the DHSS commissioned a survey in the autumn of 1978 in which 2,000 adults were interviewed in their homes using a structured questionnaire.

The results are published here and certainly contain many disturbing and interesting findings; for instance, the remarkable extent to which the drinking/driving laws are being ignored, or the fact that one man in 10 reported feeling the effect of a hangover at work. The book has chapters on average weekly consumption, drinking patterns, demographic and occupational differences in drinking patterns, leisure, drinking before driving, influence on work, development of drinking habits and opinions on drinking problems.

This survey contains many essential statistics for anyone who is researching into or particularly interested in the problems of alcohol. However, it is solely a reference book, and whilst as doctors we are constantly being told that we should be more aware of the problem, the average doctor would not find this book a good buy.

DAVID HASLAM

GIVE US THE CHANCE. SPORT AND PHYSICAL RECREATION WITH MENTALLY HANDICAPPED PEOPLE

Kay Latto

Disabled Living Foundation
London (1981)
198 pages. £9.50 (including post and packaging. £8 if collected).

Although not intended specifically for doctors, this book must be the best source of information when it is needed. It contains detailed notes on all kinds of games and sports suitable (some with obvious modifications) for people with disabilities of all kinds. There is a list, with addresses, of a large number of organizations which can give help.

Available from the Disabled Living Foundation, 346 Kensington High Street, London W14 8NS.

REPORT

Fifth National Trainee Conference, Sheffield, 8-10 July

THE fifth National Conference of General Practitioner Trainees sparked vigorous discussion in its plenary sessions on general practice obstetrics, hospital posts for trainees and the number of general practitioners necessary to provide adequate nationwide primary care. Small groups wrestled with their thoughts about exams for general practice, computers, review of performance (audit), continuing education and obstetric training for general practice. Unfortunately the meeting had to waste one and a half sessions simply to preserve its cherished non-aligned status.

Training schemes

Again, the chance was taken to gather data on the state of vocational training, concentrating this time on hospital posts. The conference organizers, led by Barnsley trainees Dr Ed Warren and Dr Diane White, used the first afternoon to present the results of a pre-conference questionnaire sent to all UK trainees and consultants who have a junior post linked to a three-year general practice vocational training scheme (GPVTS).

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Perhaps the most telling finding was that no consultants at all in Northern Ireland were identifiable as being linked to a GPVTS. Of the rest, 50 per cent of consultants, but only 40 per cent of trainees, responded. Consultants reported room for improvement: almost a third felt that their trainees get too little outpatient experience and too little teaching of their specialty in relation to general practice. Two thirds felt they should be involved in the study release course. Most (83 per cent) thought their trainees had adequate opportunity to attend these courses, despite only 52 per cent of trainees thinking so. Seventy-four per cent of consultants, and 75 per cent of trainees, felt consultants would benefit from general practice experience; and about half (of consultants and trainees) thought consultants should receive a training allowance.

Amongst trainees, a trenchant 12 per cent felt that a three-year GPVTS would not alter the way they work as principals. Almost half reported insufficient opportunity for minor specialty experience; and while only 58 per

cent of trainees thought they had adequate opportunity for study leave, 89 per cent of consultants thought so. Half the trainees favoured working overseas as part of vocational training.

Consultants and trainees tended to agree on matters of opinion, but differed over many easily measurable matters of fact, which could be discussed locally among trainees, consultants and course organizers. It should not need a national survey to expose such discrepancies; and it certainly cannot solve them.

Representation

Thursday morning witnessed Dr Peter Ellis, the national trainee representative on the GMSC, presenting a report from the GMSC Working Group on Trainee Representation. One of its recommendations, despite last year's resolution at Exeter to avoid alignment with the BMA or RCGP, was that the GMSC trainee subcommittee be the agency for setting up future national conferences. A bizarre take-over bid followed: it was too tricky a job for a few trainees to be expected to take on each year, said Dr Ellis, and arrangements would soon founder. However, the evidence from the floor, from previous, current and future organizers, was that local groups of trainees are up to, and want, the job. Conference, refusing to endorse the GMSC documents, received them and moved on.

Are more general practitioners needed?

There followed a debate of the motion "This house believes that adequate primary care cannot be provided until the number of general practitioners is at least doubled". The motion was proposed by Dr Dipak Ray who was seconded, at short notice, by Dr Eddie Josse in the enforced absence of Dr Julian Tudor Hart. It was opposed by Dr John Fry, who was seconded by Dr John Williamson. The proposers emphasized the need for more time and more doctors: more time with patients; more time for study and family life and to tackle the increasing burden of patients discharged into the community; more doctors to raise the level of care, provide locums and take up the challenge of technology and preventive medicine. The opposers demanded hard evidence that twice the number of general practitioners would improve anything, and claimed that this was a panic measure. They felt that much of a general practitioner's present work could and should be delegated. The motion was overwhelmingly defeated, but the Chairman, Dr John Horder, concluded that the discussion had convinced him that the motion would have been carried had it read "increased" instead of "at least doubled".

Obstetrics

Two papers were presented on Thursday afternoon, the first by Professor I. D. Cooke, consultant obstetrician in Sheffield, the second by Dr P. W. F. Lane, general practitioner in Nottingham. Professor Cooke outlined a system of shared antenatal care pioneered in Edinburgh. It uses a problem check-list whose scoring system gives hospital and general practitioner obstetricians alike clear cut-off points at which to act. He saw intelligent co-operation between general practitioners and consultants, with intrapartum obstetrics playing a minor, even anticlimactic role, as the only way forward. He believed that the fear of maternal and perinatal mortality was now fading, and that the emotional aspects of childbirth were now uppermost in mothers' minds.

Dr Lane described his experience of delivering his own patients in a consultant unit. He believed that the ensuing advantages—an improved family relationship and greater trust—had been profitably combined with the extra safety and back-up of a hospital unit. But, he asked, does the present climate encourage general practitioner obstetrics, why is obstetrics so feared or disliked, and does every general practitioner want a 24-hour commitment? In response to this last question, a show of hands from the floor confirmed that 80 per cent of the trainees present intend to deliver babies.

Practice in the EEC

On Friday morning Dr A. J. Rowe described his work as Chairman of the EEC commission on postgraduate training for general practice. He outlined the latest recommendation to member countries: "Where a member state has a specific diploma or certificate of general practice, a migrant doctor coming there should be required to do in whole or in part the training of that country—but previous experience would be taken into account."

Trainee views

Reports from the wide-ranging small group discussions highlighted some important views:

Obstetrics should be available to all trainees, but a six-month obstetric post should not be compulsory.

Consultants should spend more time teaching trainees, particularly in outpatients.

Planned examination of medical care (audit) is necessary and desirable for doctors and their patients.

Computers will be important in streamlining repeat prescribing, immunization programmes, research and management of groups of patients needing regular monitoring and recall, but could and should not replace an individual's written record, ideally A4.

Medical schools should become more orientated towards general practice.

Continuing education for general practitioners must improve, with small groups playing their part.

Passing the MRCGP exam must not become necessary

for entrance to general practice, either by common usage or statute.

Organization

Future conferences can learn from Sheffield. Thursday's ceilidh and pea-and-pie supper were more fun than Wednesday's dinner and jazz band, and people would have mixed earlier had the evenings been swapped. The hall where the plenary sessions were held was an acoustical nightmare: speakers from the floor at a conference of only 250 people should not have to walk to a microphone at the front. The small groups might have been smaller: 12, rather than 20 to 30. The detailed organization, however, was exemplary, indeed astonishing: the Barnsley trainees had worked efficiently and hard for several months.

Yet some questions remain. What should be the role of such a conference? It must be primarily educational: it is approved under Section 63. But what of its brief? Until now, the choice of programme has been left to the people organizing each particular conference. Should at least some of the topics for the following year be chosen the previous year? If the Conference is a national forum for trainees, should not a spot be available for an academic report from each region, for a planned pooling and exchange of information and opinion? Should not each national trainee representative on each particular body be invited formally to report on his or her activities during the year? And surely the Conference, as the only national gathering of trainees, is the logical time and place to elect those representatives?

There should be ample scope for conferences to remain idiosyncratic and whimsical, and yet see to such simple but important business. Some was done this year: the 1982 Conference will be in Cambridge where a group of trainees is already making plans. Mersey will host it in 1983. Now that self-propagation is assured, the Conference—once an end, now a means—can develop its confident, extrovert contribution to general practice and vocational training.

NICHOLAS BRADLEY

OBITUARY

Dr Lionel Cordery

LIONEL CORDERY, who did so much for his patients, general practice, the Medical Association and the Royal Colleges of General Practitioners in the UK and New Zealand, died on 28 February 1981.

Born in Christchurch, he was educated at Christchurch Boys High School and Otago University. He graduated in 1928, spent two years as house surgeon at Christchurch Hospital and three years in England, where he gained his postgraduate experience. When he returned to Christchurch he began his general practice, to which he devoted himself for the next 40 years, interrupted only by five years as a Medical Officer in the 2nd NZEF in the Middle East, where he served with the 25th Battalion and the 3rd New Zealand General Hospital.

Apart from his patients, his great interest was in the organization of the profession. He was Secretary and later President of the Canterbury Division of the BMA, and served for five years on the New Zealand Council of the BMA. His contribution to the Medical Association over many years was recognized when in 1976 he was elected a Fellow of the New Zealand Medical Association.

His great love, however, was the College of General Practitioners. He was a Foundation Member of the Canterbury Faculty of the RCGP when it was established in 1955 and was Honorary Secretary of the New Zealand Council of the RCGP between 1956 and 1959. This was a very active period in the establishment and growth of the four regional Faculties of the New Zealand College: much co-ordination was required and there was considerable correspondence with the parent body in London. During this period Lionel Cordery as Secretary, assisted by Clive Sheppard as Chairman and other members of the Council, worked assiduously in promoting the College of General Practitioners in New Zealand as an institution in its own right. In recognition of his contribution, in 1960 he was elected to the rare honour of an Honorary Fellow of the RCGP.

He continued his interest in the College as Chairman of the Canterbury Faculty for two years, and contributed to the discussions that led to the foundation of the New Zealand College in 1974. Even in his retirement, forced by ill health, he never missed an Annual General Meeting of his Faculty.

Throughout his working career he was regarded in the highest esteem by his patients and colleagues. As a solo practitioner he took a wide and deep personal interest in his patients, and could with humility acknowledge treating seven generations of one family. He had a high sense of professional responsibility and showed great warmth and pleasure in assisting younger colleagues entering into general practice. His passing takes from Christchurch a good doctor and a great stalwart of general practice. Our sympathy goes to his widow, Trixie, and two children, Raymond and Margaret.