EPIDEMIC OBSERVATION UNIT

Platelet function in total albinism

Professor R. M. Hardisty of the department of haematology, The Hospital for Sick Children, and Mr D. C. B. Mills of the department of pharmacology, Royal College of Surgeons, have asked for help in tracing further patients affected by total albinism: “It has been known for several years that total albinism may be associated with a haemorrhagic tendency characterized by a long bleeding time. In two such patients whom we have studied (Hardisty and Hutton 1967), this has been shown to be due to a defect of platelet aggregation. The relation of this abnormality to the biochemical defect which results in the failure of pigmentation in these individuals is obscure, but our observations are of great interest in relation to the haemostatic function of normal platelets. We should now welcome the opportunity of studying a number of other albino patients, in order to determine the frequency of the platelet defect in this condition and its relation to haemorrhagic symptoms. We should like to obtain up to 100 ml of venous blood from patients with total albinism, with or without bleeding symptoms. As the samples would have to be taken with special precautions, it would be necessary for the volunteers to attend the Hospital for Sick Children, Great Ormond Street, for a visit of about 20–30 minutes, preferably on a weekday morning, or alternatively for one of us to visit them at home. Any travelling expenses would gladly be refunded.”

Any doctor, whether in the College or not, who attends a patient who is willing to help in this way, is invited to get in touch with the director, Epidemic Observation Unit, Corran, Peaslake, Surrey, or complete the notification form at the end of this Journal.

REFERENCE

REPORT OF COURSE

GENERAL PRACTICE AND THE POSTGRADUATE MEDICAL CENTRE

On Thursday, 12 June, the Headquarters Courses Committee held a one-day seminar at Princes Gate. Ten selected clinical tutors were brought together with the same number of invited practitioners, an observer from the Department of Health, and a regional postgraduate adviser in psychiatry. The aims were:

1. To bring together a selected group of specialists who are also clinical tutors at postgraduate medical centres, and a selected group of general practitioners who are active members of the Royal College of General Practitioners.

2. To discuss the special nature of features of general practice and the clinical opportunities in this field, and to consider ways in which suitable educational and research activities may be expanded and advanced in the centres.

3. The seminar was also an experiment to test the hypothesis that general practitioners have something to teach their specialist colleagues. This was done by pairing the opening speakers—a senior and a junior practitioner each presenting their views.

Dr George Swift, chairman of council, stressed the importance of the local postgraduate centre, as a local focus both for breaking down barriers, and disseminating knowledge. Although tutors had a large commitment to their general-practitioner colleagues, in some areas communication was minimal, and advantage had not been taken of advances in educational methods. This seminar, he said, was an attempt to help both tutors and practitioners to assist each other in finding solutions to mutual problems.

Dr E. V. Kuenssberg of Edinburgh spoke first on the nature, patterns, and future trends. The general practitioner today was more than a ‘black bag and biro’ associated with ‘grey
cells' using only clinical skills. Although a proportion of practitioners, by reason of temperament and geography, were in single-handed practice, which he regarded as a wholly-acceptable method of delivering medical care, even they had to use secretarial, nursing and other auxiliary staff to care for the present average number of patients per doctor. For many reasons the trend was toward group practice, and this seemed attractive to younger doctors who could select their future with more choice than ever before. Team work needed self-critical analysis and learning the difficult skills of communicating with colleagues. Considering the clients of the health service were in millions, and staff in thousands, it was surprising that hospital reports and letters were not sent on a N.H.S. teleprinter net, that would eliminate postal delay and could cost as little as one fifth of conventional systems. We were still responding to patient demand, often past the point of pathological no return, without evaluating sufficiently early detection, health education, preventive medicine, and the patient's ability to assimilate information. Dr Kuessburg believed we were on the fringe of a medical audit system. The future practitioner who elected to advance into practice, and not retreat from other medical careers, would have to accept responsibility for organizing and co-ordinating. Health, or group practice, centres were not magic but a physical facility to bring colleagues and patients under one roof, and this could lead to more discriminating reference to hospital, possibly returning to the older concept of consultation with specialist colleagues. Present resources were stretched due to overlapping, and the first advance was exorcising the feeling that nobody else could ever do things as well as we did.

Dr J. B. O'Donovan, Tamworth, pointed out the dangers of forgetting the doctor's original rôle of personal physician; he welcomed Michael Balint's distinction between the patient-centered doctor, contrasting with the hospital illness-centered doctor. He felt that medicine was still fighting a last ditch battle too frequently, and more advances in screening techniques and health education would improve health care more significantly than present concentration on therapeutics in the geriatric age-group. He saw the family doctor having an increasing rôle in hospital both for his own patients and in a speciality. The present hospital hierarchy would need changing as juniors became proportionately fewer, with more patients returning to the care of their general practitioner especially with bigger hospitals further from the community they served. The hospital team of the future may have more clinical assistants, fewer trainees, and therefore, more practical experience. The harassed patient must not be overlooked in all these changes, particularly because in areas such as Tamworth it was not impossible that a general practitioner who a few years ago had a list of 2,500, may find no alternative to lists of 5,000. In postgraduate education pure hospital specialists, with narrowing fields, were replacing the older consultant with some knowledge of general practice. The formal lecture by a specialist, now the prime postgraduate educational method, could usefully be diluted with more sessions of clinical attachment, teaching on unselected cases, more discussions using the seminar techniques, and other methods applying recent research in education. Dr O'Donovan, had circulated 30 tutors to ask certain questions. A quarter said they never sought advice from general practitioners in any way when preparing courses; many expressed their preference for discussion groups and seminars, and from an excellent selection of programmes he particularly noted a middle-care course. This referred to a service where doctors and nurses in the community came regularly to see what was happening to their patients between leaving hospital and returning home.

In discussion speakers raised many points. One tutor felt that it was the same people who came to postgraduate, B.M.A., college, and all meetings, whereas it was the evaders who needed reaching. A North Country centre having the highest attendance was alleged to be wholly and successfully modelled on a working man's club; several speakers felt a social side facilitated many postgraduate centres and activities. It came again as a surprise to enlightened consultants to hear that some black areas still have no open access. The Belfast success in non-related academic courses was emphasized and a voice from Manchester stressed that over the age of 40 in education as in matrimony it was quality that counted. Several speakers hoped that with more use of open access the specialist would become a consultant again, and one person felt that in some cases patients were referred and admitted because of insufficient time for taking a good history in the consulting rooms.

Dr John Fry, Beckenham, described the thresholds of ill health ranging from death to complete health, and mentioned the wide variation between patients in deciding what needs
the doctor's attention. From his own research he demonstrated the possibility of predicting the incidence and prevalence of disease. In chronic diseases the field was led by the unglamorous bronchitis, although diseases far less numerically important often had more attention focused upon them. In the social field each year the average practice had 40 isolates, 100 patients on assistance or supplementary benefits, five to ten on probation, four juvenile delinquents, four severe alcoholics, three bastards, one divorce, and one sentenced to prison. Surveys of populations also gave reliable figures for disease that was present but not detected; in an average practice population there might be 200 anaemics, and 200 bronchitics, 110 depressives, 120 hypertensives, 100 bacteriurias, eight diabetics, and three positive cervical smears. Every two years a patient with bronchial carcinoma was picked up on M.M.R. Although hospitals dealt with large numbers, Dr Fry only referred four per cent of his patients each year. Only in general practice could acute hospital episodes be seen in the perspective of total morbidity and population at risk. He illustrated this with figures on coronary artery diseases and the timing of fatal attacks. Before deciding on selection for hospital admission and need for the cardiac flying squad, the results of surveys of coronary disease in the community were needed to provide a baseline. Although only a superhuman physician having a longer professional life span than that of his patients could study full life history, Dr Fry classified profiles of disease into five categories, measuring disability against a base of age. First, the straight line of trauma or congenital defect; second, the progression of senile disorders; third, the 'growing out' of childish ailments; fourth, the self-limiting diseases such as ulcers or hay fever, and, last, those present only at the extremes of life, such as the patient with an acute wheezing chest and good health between attacks.

Dr Ian Gregg, Roehampton, discussed his contacts with the postgraduate courses at the Brompton Hospital, where he worked. Subsequent discussion mentioned the helpfulness of the Brompton courses, and emphasized the value of a general practitioner in a postgraduate teaching institute when running courses for general practitioners. Dr Gregg saw a dilemma between too much time spent on stimulating new advances, against the more mundane matters of everyday concern to the general practitioner. Too familiar material was boring as was too much high powered esoteric detail. He made a plea for courses to have a theme, to have a course tutor feeling the pulse and especially for courses to rethink fundamentals. Too much medicine was contingency-doctoring often enhanced by pushing advertisements, of which he exhibited examples, linking expensive drugs with symptom complexes regardless of basic physiology or scientific rationale. As an example of this view he gave a brief description of his approach to airway disease. He described the pathology and then demonstrated the benefits of measuring pulmonary function over the years in a cohort of his patients. The varying course, the effect of infection, the hazards of smoking, the critical level of steroids were all demonstrated as were the implications of hospital inpatient therapy and relapse at home. At the same time the remorseless measured deterioration appeared in some patients who would otherwise appear similar to those remaining static. The whole lecturette on one respiratory disease was an outstanding example of how precise clinical surveillance of a group of patients monitored by regular tests of function could be carried out in general practice.

In the pre-lunch discussion, the need for specialized outpatients clinics was discussed. Skills at handling disease vary with experience, but if one consultant, or general practitioner sees, for example, all diabetics, the others soon will lose touch and not know how to deal with an emergency. The specialized doctor also reduces his range outside his subject. The question arose how much less would be the outpatient load in medical outpatients if all general practitioners had had three years hospital experience, full access, and a desire to investigate and treat their own patients. Several speakers raised their problem of how to involve the general practitioner in teaching and this was answered by describing various local arrangements, including alterations after regular surveys with questionnaires. Again and again the discussion returned to the problem of the apathetic minority. One consultant, with his tongue in his cheek, said he felt the initials R.C.G.P. stood for 'Royal College of Good Practitioners', and asked what active steps the College was taking to widen its membership and influence amongst the unconverted who were three times as many as members. Several felt a good social programme, especially with alcohol, reached an important subgroup who could imbibe knowledge as well as other matters once in the postgraduate centre. A speaker from New Zealand described how they were actively experimenting and it was a
refreshing change to hear medical postgraduate education discussed as a matter for scientific research and not for anecdotes and inspired guesswork. He felt it was not unless one saw the British health service in comparison with another how evident was the gap between the potential service that a trained general practitioner with enough time and facilities could give and the present brief hurried consultations which of necessity lead to sorting procedures. A clinical pathologist gave heartening support to the concept of family doctoring and indeed during the whole day no one questioned that we should adopt the American or Russian approach, nor that of any other organized health service.

In the afternoon, leaving general practice and disease behind, attention was focused on the postgraduate centres, the future opportunities, and the need for an educational programme. Dr George Swift, Winchester, introducing himself from the chair, described his pioneer work as a regional adviser in general practice. He foresaw a central council for postgraduate education delegating to the regions as a second tier. Each region corresponding to a university medical school, regional board, and faculty area, would have a postgraduate dean who would have a number of paid advisers, one for each specialty, including general practice. These advisers would meet under the dean's chairmanship, to discuss the balance and co-ordination between the specialties and the centres. Each adviser would be supported by his committee, having representation from that specialty from several of the postgraduate centres. At the grass roots, or third-tier level, would be the local postgraduate centre run by the tutor, who in turn would be supported by a committee representing the various specialties with particular emphasis on active support, and consultation with general practice. The regional postgraduate adviser in general practice, Dr Swift felt, should be a doctor in active practice, and not a sinecure for the retired. He should speak for general practice at a regional level on educational problems, having links upwards with the central council, the royal colleges, BMA, etc., and also links with the general practitioners at the peripheral centres. He listed nine major functions which he had found important, but in a developing field this was not exhaustive, and further ones would be formed as each region appointed paid advisers in general practice on the Wessex model.

1. Careers advisory. Many young doctors in preregistration posts were unaware of training facilities, or whether they had the temperament or stamina for practice. Medical manpower was precious for pure trial and error, leading to frustration and emigration.

2. Designation of hospital posts for general-practitioner training. Although many hospital posts, especially in surgery and gynaecology required service establishment, hours spent in theatre did not prepare for practice, whereas dermatological out-patients, that at present had few junior staff, needed to be developed.

3. Selection of training practices. Even if the Royal Commission's recommendations were partially implemented, Britain would need 1,000 training practices, or one for every 22 practitioners; this meant a ten-fold increase, and some suitable but reluctant practices would need first persuasion, and then advice.

4. Courses for trainers. Although some medical schools felt the skills of imparting medical knowledge were inherent and not learned, the College had vigorously campaigned for tuition, especially using the expertise of those working full time in educational training. Courses were running at Princes Gate and in Manchester, and soon each region and faculty would need them.

5. Courses for trainees. The Wessex scheme of a 30-day, year's course spread over three university terms by releasing trainees all day Wednesday was described; the seminar approach was all important. Continuity was necessary and numbers must be balanced between having at least 12 present for the grant, but preventing too many leading to the large class disadvantage. Professor Scott of Edinburgh ran a similar scheme. Other new ones were being developed at Canterbury, Thames Valley, and Birmingham.

6. Supervision of doctors in training. Without constant feedback the suitability of posts and progress of trainees cannot be improved, or steps taken to improve the training.

7. Organizing co-ordination. The continuity between posts and the overlap of pro-
grammes or nearby centres, all require integration so that the regional plans run smoothly.

8. Arranging courses. In addition to everyday clinical programmes of the centres and the training courses each region needs experimental courses and innovation. A central faculty register of good speakers on special aspects, such as practice organization, is necessary.

9. Arranging clinical attachment. In obstetrics especially, but also any practical subject, no amount of theory can replace experience in theatres, wards, or clinics. For this type of experience the post has to be carefully selected to match the teacher to the doctor learning and the amount of clinical material available that must be sufficient without overwhelming. Dr Swift stressed the evolution of posts such as his, and the variations that will occur should academic departments of general practice exist but each postgraduate dean needed his adviser now.

Dr Robin Steel, Worcester, said he was a member of the local hospital postgraduate committee. Worcester, where the BMA was founded in 1832, and whose medical society had been amongst the first ten to be founded, had long experience of postgraduate activities. There was only one hospital, and the hospital staff, local authority, and family doctors were on Christian name terms. He saw a different atmosphere to that of large city practice, although Worcester was in its fourth year of designation, and his group practice had 15,000 patients between four partners. He gave examples of the local postgraduate programme for winter evening meetings, which had average attendances of over 50. The average breaks down into 31 general practitioners out of a total of 99; seven consultants out of 40; and eight residents out of 46. At the two weekend courses applicants had to be turned away. One was organized by the postgraduate tutor in psychiatry on depression and suicide, having five psychiatrists, the physicians, pathologists, as well as two general practitioners, the Samaritans, welfare officers, etc.; the other organized by the Midlands faculty had seminars on emergencies, and investigations, again with both consultant and general-practitioner speakers, and an afternoon brain’s trust on the difficult patient. He described the plans for a new centre, named after Sir Charles Hastings, and gave details of the Midlands course for trainee assistants 'orientation towards general practice'. He saw more small groups self-monitored, possibly starting with college tapes, and for vocational training, which had to provide for 4.8 new entrants a year per 100 established general practitioners to stop lists rising.

In the final discussion Dr Crombie made a plea for each postgraduate centre to choose a specific item of operational research, and to make observations as a group whose results could be compared with those from another region. Other speakers emphasized the centres must be a nodal point for as many activities as possible, and that in the present phase of rapid change, experiment was essential, with success leading to imitation elsewhere.

The day had thrown up many difficult problems that had been discussed with thought, and good humour. Much of the isolation that existed had been seen to have been illusionary, and that the aims of the seminar have been well achieved. In conclusion the following points seem to have emerged.

1. That clinical tutors are isolated unless strongly supported on their committee by active general practitioners.

2. That the College has not succeeded in keeping in touch with local tutors, some of whom asked for information which they should have had distributed to them by the College.

3. Each region needs a paid active general practitioner as adviser to the postgraduate dean, and the adviser must be supported by a small committee.

4. That a similar meeting between clinical tutors and interested college members could well be held in each region being supported, if necessary, by speakers from headquarters.

Robin Steel.