2. The analysis of a rôle-play in which a consultation was enacted by members of the group and a student or trainee was taught from that situation.
3. The analysis of a 'live tutorial' in which teacher and trainee discussed before the group, a current clinical problem.

The demonstration opened with a video-tape recording of one of the workshop's rôle plays. The patient was a girl who might have had a deep-vein thrombosis associated with the taking of an oral contraceptive: the first minute or two of this film was accompanied by gales of laughter as members of the conference acclimatized themselves to the sight of Dr Bill Styles in the role of the girl. As the interest of the clinical problem, and the problems of teaching, became more apparent, the laughter gave way to genuine interest and involvement.

This was then followed by an unrehearsed rôle-play in which a patient presented with chest pain; a tutorial between the teacher and the trainee ensued and the workshop then discussed the teaching, and the lessons that might be learned. Finally, there was a 'live' tutorial between Dr Jack Norell and his trainee Dr Keith Dunbar which was also examined by the workshop.

There was a lively discussion on the problems and perils of workshop techniques. Many doctors at the conference felt that each group of teachers should develop its own programme for learning to teach, and the members of the London Teachers Workshop constantly reiterated the importance of learning by teaching, in contrast to learning by studying the theories of educationalists. Dr Playfair described the experience of the Plymouth Workshop where teachers sat in on each other's surgeries and case histories were later discussed by the group.

The session was concluded by Dr John McKnight, who thought that the challenge presented by the papers, the demonstration and the discussion that followed, had made a fitting conclusion to a stimulating conference.

Correspondence

Episodes of Disease

Sir,

I was most interested to note that in the article "Symptoms in General Practice" by Morrell, Gage and Robinson (*Journal*, January 1971), consultations were divided into three types depending upon whether or not the symptom or disease had been presented to the doctor before. This introduction of the idea of considering episodes of disease has not been common in British studies of morbidity or work load. It has, however, been a basic consideration in morbidity studies in Australia where, without the advantage of a defined practice list, the episode of disease has often had to be the basic unit of measurement. This has advantages, as the authors of this article have pointed out. However, it also introduces the problem of not only defining disease—difficult enough as we all know—but of defining episode of disease. The authors' definition of a new symptom as one which had not been presented to any doctor in the previous 12 months is, as they state, easily interpreted and may be uniformly applied. It will inevitably include some chronic conditions, deformities and disabilities which have not needed treatment in the previous 12 months as new episodes and will underestimate new episodes of common acute conditions such as tonsillitis and gastro-enteritis which may occur in the one patient more than once in a year. In the Australian Morbidity Survey, acute conditions are counted as new episodes when they first present and chronic and recurrent conditions such as diabetes, osteoarthritis or migraine, are counted as new conditions only when the patient has never previously received treatment for them from any doctor. These examples of slightly differing approaches merely illustrate some of the problems associated with the concept of 'episode of illness'. However, because it is important in relation to behaviour of patients in seeking help for illness, I am glad to see it is being discussed.

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Research Fellow,
Royal Australian College of
General Practitioners

Traralgon,
Victoria.

Juggling with dates

Sir,

I wish to report a method of juggling with dates. Birthdays, dates of arrival and departure from the list, etc., are available to us for research, but the difficulty has been to know what to do with them to get the results. A Megaunit of time has therefore been chosen to represent 1,461

days. Each Megaunit, four years, is then given a number starting from the year of Our Lord. This means that the Megaunit for 1920–23 is No. 480, and that for 1924–27 is 481, etc.

Tables of conversion are used to find the exact number of each date within the four-year period, so as to number them from 000·7 (day 1) to 1000·0 (day 1,461).

Each unit is 35 hours 10·34 minutes long, or about a day and a half. Either by using the conversion tables manually, or by using them to programme a computer, any dates may be used as mathematical units for calculation. It is then possible to produce quarterly statistics for the practice which cover details such as the average age difference between spouses on the list, joining the list, leaving etc., or the average age range of children of families on the list,[1] or average age of patients in any category.

For desk use the new Olympia calculator with an "N" key is useful for donkey work with averages.

M. J. JAMESON.

St. Albans.

REFERENCE

[1] Jameson, M. J. *Journal of the College of General Practitioners* (1966), **9**, 336.

Rising sickness absence

Sir,

I would not dream of suggesting that "Scottish RMO (*Journal* May 1971) should be done out of a job. My point was that it is not necessary to create more elaborate 'control' procedures because the existing system is quite adequate. Dr David Morrell's recent paper (*British Medical Journal* 1971, **2**, 454) where 2,008 NHS certificates were issued in a year, i.e. under 40 a week, in a practice of 4,455 patients shows that sickness certification by the general practitioner is not especially onerous.

I agree entirely with Scottish RMO's point that married women looking after a home and doing a job are especially vulnerable in sickness absence terms. Most employers are, or ought to be, aware of their vulnerability and I think their higher sickness absence rates ought to be accepted with good grace. They are seldom doing anyone else out of a job—in fact the part-timers, the office cleaners and so on, are working hours that no one else would think of doing—and if the community needs their labour it should be prepared to pay the price for it, including that of increased sickness absence.

Finally, as he points out, the fact that 42 per cent of 536,000 cases referred to the RMO ceased to claim benefit after being referred does not prove anything about the effect of the medical referee system. Only the Department of Health and Social Security could provide an answer.

A. M. SEMMENCE.

Abingdon.

The Horder centres for arthritics

Sir,

The Horder Centres for Arthritics is a National Registered Charity founded in 1954 by an arthritic sufferer.

The first centre, at Crowborough, Sussex, has been purpose-built with the needs of the badly disabled arthritic always in mind. It is not a holiday home, but a place to which arthritic patients are admitted for a minimum stay of three months with the idea of increasing their independence. At present, it can take no more than 22 patients but will shortly expand. The object of this letter is to bring the centre to the notice of consultants and general practitioners who may wish to send patients there. Every patient is approached individually and helped to come to terms with problems arising out of this illness and to face the responsibility which comes with increased independence. A system of special exercises is used, designed to bring about mental and physical co-ordination. Every day patients are fully occupied having treatment and pursuing creative work or training for a new career.

Since the opening in 1966, over 100 patients have passed through the centre. The results are most encouraging. All patients gain something and most of them learn at least to take a more positive view of their illness and to try to get the utmost out of the range of movement they have. Some return to work and others go home able once again to undertake household duties which they may not have done for many years.

Patients between the ages of 16 and 60 are accepted. Those in the lower age groups derive the greatest benefit. The younger arthritics, looked after by their parents, often lose their incentive to do anything for themselves or to work. They manage on social security grants and sickness benefit and eventually, while still quite young, they may have to be admitted to a home for the elderly, or even a geriatric ward. These are the patients who should be referred to the Horder Centre before it is too late.

The response to treatment in the centre depends not only upon age as measured in years but on youthfulness of outlook and receptiveness to new ideas. Some middle-aged people make good progress at the centre; they will do anything to regain some of their independence.

The South-East Metropolitan Regional Hospital Board has five rooms in the centre for patients whose homes are in the board's area. Patients come from all parts of the British Isles as the centre is the only one of its kind in the country. For most of these, special financial arrangements have to be made with their local welfare departments. Almost without exception these authorities are willing to pay for part III accommodation. These grants do not cover the cost of treatment. The Charity's general fund is used to make up this deficit amounting to over £6,000 a year. At present only about one-fifth part of the centre has been built but futher building will begin