REPORT

Research-in

FROM THE RESEARCH UNIT OF THE
ROYAL COLLEGE OF GENERAL PRACTITIONERS

There can be few attenders of conferences who have not at some time or other expressed the view that the most valuable exchanges of ideas occur, not during the set papers given by the highest in the field in the drowsy comfort of a centrally heated lecture theatre, but in the corridors, the bar, the restaurant at lunch, whenever old and new acquaintances meet and, finding common ground, really get down to the roots of the matter. Such encounters are unpredictable, subjects arise spontaneously which may—at least to some—be more interesting than those discussed upstairs. Those conferring may number anything from two upwards, and they are the less inhibited for knowing that no one is tape-recording them for transcription and publication later.

In this belief, the Research Unit has, in the past, held two or three unprogrammed meetings on defined subjects and found them useful. The next logical step was to apply the same principle on a larger scale and the joint Congress with the College of Family Physicians of Canada provided the opportunity.

In the academic world the concept of the ' teach-in ' is now established and respectable. A teach-in on research, a *Research-In*, was decided upon. It would last from 10.00 to 19.00 hours. One or two speakers would be invited in advance to give short papers on any subject they chose, with freedom of interjection given to the audience and as much discussion as time allowed. As far as possible, speakers would alternate, from Canada and the United Kingdom, drawn from the audience by the chairman-of-the-hour who might be either Canadian or British.

It was planned, too, that there would be a series of exhibits at one end of the room in which the research-in was held. These table displays were staffed by demonstrators and on the one day—Friday, 6 April—included a stand mounted and staffed by the Office of Population Censuses and Surveys at which copies of the preliminary report on the second National Morbidity Survey were available for first release to a waiting world. Other displays were of the work of the research unit, the library and the oral contraception study. It had been intended that this part of the room would be partitioned off but this was found impracticable. The visual and the auditory were of necessity merged into one, and tables had to be moved aside to make room for extra chairs.

Dr Graham Tait, Chairman of the Research Committee of Council, opened the proceedings half an hour early, introducing Professor D. L. Crombie of London, Ontario, and Birmingham, England. He described the evolution of the unit and by the official starting time discussion of ways and means had begun. Dr W. A. Falk of Victoria, British Columbia, introduced the subject of morbidity studies and showed that in Canadian hands the diagnostic index could be every bit as useful as it is at home. The issue of classification of disease was one to which we seemed fated to return at intervals during the day. The research-in had begun to take shape.

Over coffee, someone said that it was time the British and Canadians stopped being polite to one another and got down to work—more chairs, more people, and the next chairman decreed a circle of the former rather than the formal crescent rows. Dr David Metcalfe deliberately introduced the needed note of controversy and in the discussion of the different dimensions in which recording could be used the chairman had to work hard. There were those who showed a somatic bias, those who fervently espoused the cause of the psyche and it seemed at one time that the only area of general agreement was that the answers, as well as the next questions, lay in the patients whom we see in practice and that it is up to us to elicit both.

Dr Jim Collyer, of Ontario, described his adaptation of the computerised billing system, which is part of the Canadian pattern of practice, for research purposes, insisting that for this to be accurate, the doctors must be selected and convinced of the need for consistency. Mention of computers led to a description of the part played by these instruments in the National Morbidity Survey and other major studies. The love-hate relationship welled up and not two but several attitudes were revealed.

One Canadian speaker described the introduction of computerised recording in a two-doctor health centre and the extended use of the program to measure the use of medical care in the population of St. Johns, Newfoundland. The methods brought bear-growls and wolf-howls from some Canadian colleagues and support from a number of UK speakers. The honours were divided evenly.

There was a quiet interlude when Dr John Sumner, of Haney, British Columbia, showed transparencies of the distribution of morbidity in his practice as it developed, and the human and scenic background to his work with slides that showed him to be both artist and photographer. One slide of snow on a sawmill log-jam was a real beauty. He brought us back from the statistic to the person, from whom all the statistics that we were interested in ultimately derive. Dr Peter Lambert, of the Office of Population Censuses and Surveys was quietly erudite in his view of morbidity studies and there was more talk about baselines and definitions.

During all this, people came and went—breaks for refreshment were brief and no doubt the talk went on. Some stalwarts stayed the whole course including the variant on the theme provided by Dr Sydney Fogel, of Saskatchewan who showed a film illustrating the behaviour of a patient under hypnosis, a subject which had come to occupy much of his time in practice. A patient under hypnosis was ' tuned in ' to a metronome, the rate of which could be varied from zero to 180 ticks a minute. The film showed clearly how her mood, behaviour and responses varied from catatonia at lowest frequency to hyperactivity resembling mania as maximum rates were reached. This sparked off discussion of other ways in which the environment; visual, audible and, presumably also tactile, could influence behaviour. Phantom limbs, dual personalities, hyperkinesis in children all came up in discussion which brought the meeting to a close, half an hour after its scheduled closing time with 30 people still in the room.

Substantial support was given to the principle. A minimally structured semi-programme does release ideas and hold interest in a way that may not have been fully recognised. In addition to Canadian participants there were speakers from Australia, America and Holland, and it was felt that maintained informality added to the liveliness of the disputations.

Some lessons were learned. Next time, there should be more chairs from the start, and a definite physical barrier between the visual display area and that given over to discussion. A directed flow through the visual display area into the auditorium with an exit from the latter would be best of all. We did not dignify the *Research-In* as a teaching method but we believe it to be a very good way of picking the brains of others and dusting out some of the cobwebs in our own.

VENEREAL DISEASE IN TEENAGERS

If cases of gonorrhoea in teenagers continue to rise in Great Britain many general practitioners and physicians in clinics will be faced with similar problems, so it may be of interest to consider their options in relation to the law of this country. A letter dated 31 December, 1969 and sent by the Department of Health and Social Security to secretaries of regional hospital boards and boards of governors under the heading "Consent to Treatment" went as follows:

"(1). The purpose of this letter is to draw to the attention of hospital authorities those provisions of the Family Law Reform Act 1969 which affect the treatment of patients in hospitals. The Act implements *inter alia* the main recommendations of the Report of the Committee on the Age of Majority which was published in July 1967.

"(2). Section 8 of the Act deals with consent to treatment by minors. It comes into force on 1 January 1970.

"(3). The Section requires no explanation except possibly Sub-section 3. This recognises that it may continue to be possible to treat as effective a consent given by a person under 16 years of age; e.g. if that person has sufficient mental capacity to know what the consent implies."

British Medical Journal (1973). Editorial, **1**, 190.