DEPUTIZING SERVICES

Sir,

Your article on deputizing services (April *Journal*, p. 209) concludes that the use of a deputizing service is incompatible with good general practice because the continuity of care is disturbed. But how much continuity is really provided?

I work in a six-man group practice which does not use a deputizing service, but which organizes its own 'extended cover service'. In 1976 I made 25 visits between 24.00 hours and 07.00 hours out of a total of 9,747 doctor/patient contacts. This is 0·26 per cent of my total work. On average, only a sixth of my night visits will be to my own patients, so the amount of continuity I am supplying to my own patients during the night is just 0·04 per cent of my total work.

If instead I used a deputizing service and was guaranteed a night's sleep every night, I should be fresher to make my 50 to 60 daily consultations, which are mainly to my own patients. This would no doubt improve the quality of the care I could give them. Perhaps, on balance, I ought to use a deputizing service for night work!

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RECORDS IN GENERAL PRACTICE

Sir,

One of the least enviable jobs, it seems to me, would be membership of the Royal Commission on the NHS. Judged by published extracts, the Royal Commission has been presented with a mass of evidence some of which is dull and banal, some absurd, much that is contradictory, and some that is clearly influenced solely by narrow political or sectional interests. In contrast, the evidence of the Royal College of General Practitioners, published in the April *Journal* (p. 197) is outstandingly good. It is well written, comprehensive, vigorous, self-confident, realistic, and notable for its self-criticism. Its enthusiasm and confident optimism are indicators of the change that is taking place in general practice, and the working party that produced the evidence is to be congratulated on a document that may well prove to be one of the most important statements about general practice since the NHS began.

It is therefore only with hesitation that I make one minor criticism and that is with paragraph 5.6 on the subject of records in general practice. The meaning of this paragraph is not clear but it seems to suggest that a change from the medical record envelope to an improved but conventional written record, such as an A4 record, is not worthwhile.

My own interest in A4 records began over ten years ago. Even then there was a vague belief that reform of the medical record envelope was not worthwhile because "we would all be using computers soon". It may be true that computers will play an increasing part in information systems in general practice, but there is no more evidence now than there was ten years ago that computers will replace traditional written records in the foreseeable future. On the contrary, there is evidence from hospital trials, where the problems are much less formidable than in general practice, that computers are an unsatisfactory substitute for written records. Changing the standard record in general practice from the dangerous and outdated medical record envelope to an A4 record system would not be a temporary palliative nor would it be extremely expensive. Most of us who are fortunate enough to have extensive experience of A4 records believe that they are a vital part of present day standards in general practice and are one of the most important advances in patient care that has taken place in the last 20 years.

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VOCATIONAL TRAINING

Sir,

I was interested to read Dr O'Flanagan's contribution to our great educational debate (April *Journal*, p. 227), especially as it is the record of a trainee's clinical experience. It is useful to compare the reality achieved with the aims, goals and objectives expressed in the blueprint, *The Future General Practitioner* (RCGP, 1972). In this way the standard of vocational training may improve.

It is a pity therefore that Dr O'Flanagan's paper contains a number of flaws that detract from its value. Some are due to faults in the method. Only one diagnosis was recorded for each completed disease episode. As some patients will undoubtedly have had more than one complaint, some information must be missing. Who decided which diagnosis should be recorded—patient or doctor—and on what basis? It is also stated that 135 cases were excluded because of incomplete information. As this is almost ten per cent of all patients seen by the trainee, it is possible that their exclusion might affect the conclusions drawn from the study. To know this, one would have to know the reasons why the information was incomplete.

Further difficulties arise in the section on results. In introducing Table 4, the author draws attention to the discrepancy between the trainee's results being expressed as "episodes", and the trainer's results as "consultations". Each column is a mixture of numbers and percentages, which increases the problems of interpreting the data. The trainer's "consultations" total 609, although in the section on method it is stated that 500 consultations were recorded. Does this discrepancy mean that the trainer recorded more than one diagnosis for some consultations, or is there some other explanation?

It might have been safer for no comment to have been made on the basis of the figures presented. Dr O'Flanagan, however, makes comments on the number of cases recorded as "diagnosis unknown", and the seemingly few psychiatric episodes recorded. As only 2·5 per cent of the episodes recorded were psychiatric, he states that "these results challenge arguments that psychiatry can be learnt in general practice". What is the justification for this statement? The author may have felt that only 32 psychiatric episodes were too few to provide adequate experience. However, we do not know how many psychiatric episodes were not recorded owing to defects in the design of this study. Even if no episodes went unrecorded, perhaps the aim of a trainee's year should be to let him deal adequately with a small number of representative problems rather than being preoccupied with numbers *per se*. Finally, should numbers be the overriding consideration, and psychiatry cannot be learnt in general practice, where can the trainee gain experience which will be relevant to his future as a general practitioner?

Dr O'Flanagan has pointed to the distribution of experience between hospital and general practice in different specialties. In his book, *Towards Earlier Diagnosis*, Dr Keith Hodgkin has shown the differences between hospital and general practice in psychiatric illnesses. To my mind it is doubtful that psychiatry learnt in a setting other than general practice would be appropriate for general practitioners, and the arguments marshalled by Dr O'Flanagan against hospital training in specialties other than obstetrics and paediatrics apply with equal force to psychiatry.

In his article, Dr O'Flanagan refers to a paper of which I was a co-author, which ended with a plea for more information about the quality of care