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!

PETER I. VARDY

109 Moughland Lane
Runcorn
Cheshire WA7 4SG.

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.

I. S. L. LOUDON

Health Centre
Garston Lane
Wantage
Oxon OX12 7AY.

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

provided by trainers and trainees. There is still too little information about this, and about the results of different forms of training. Further information is still required.

IAIN GILCHRIST

Broomfields
Hatfield Heath
Bishop's Stortford
Herts CM22.

References

Hodgkin, K. (1973). *Towards Earlier Diagnosis.* 3rd edition. Edinburgh and London: Churchill Livingstone.

Royal College of General Practitioners (1972). *The Future General Practitioner —Learning and Teaching.* London: *British Medical Journal.*

VOCATIONAL TRAINING OVERSEAS

Sir,

I would like to praise Drs Brown and Holland (February *Journal,* p. 97) for their concern about the health of the people of the Transkei bantustan of South Africa. However, I would like to question the wisdom of sending vocational trainees there to work.

During a psychologically and physically hard year in West Africa, it became clear to me that western curative medicine has little to offer the closely linked political, socio-economic, and health problems of the Third World. Vocational trainees are undergoing appropriate primary care training for the UK and have no training for the formidable and completely different problems of the Third World. By transporting western, curative medicine to the developing world, the growth of these inappropriate ideas is encouraged with disastrous results.

Dr D. Morley and his colleagues in a recent letter to the *British Medical Journal* have raised the question of the role of British doctors working in the developing world. It is a serious question that should be answered before the College makes the suggestions of Drs Brown and Holland official policy.

I am sure that six months abroad would be a 'growing period' for the trainees, but it would be 'malnutrition' for the countries they would be serving. Let us show concern for the developing world by giving them the skills and technology that will enable them to pursue their socio-economic development in a way that is appropriate for their needs.

ALEC STYLE

Division of Family Medicine
Department of Family and Community Health
1,005 Eighteenth Avenue North
Nashville, Tennessee 37208.

Reference

Morley, D., Reed, T., Sanders, D., Sloan, D., Vaughan, J. P. & Winkler, F. (1977). *British Medical Journal,* **1,** 572-573.

Sir,

Dr O'Flanagan's article "One Trainee's Clinical Experience" must have broken the heart of the average vocational training scheme organizer. Was this a real account of the total learning experience of a three-year scheme? Was there no introductory course in which the trainee was introduced to, and spent several days with, the various practice nurses, the social services, the community health services and the other trainers in the scheme? Was there no academic day release each week of the three years, when psychiatry and all other relevant subjects were studied and visits were made to relevant centres? Were there no weekly trainer/trainee lunchtime meetings to discuss clinical and organizational topics? The less said about the year in general practice the better.

The purpose of vocational training is to improve general practice. This can only be done by the trainee being involved with several trainers so that he can gradually mould himself through their advice, by accepting or refusing the various parts of his experience. Two years' hospital work and one year as an individual 'face-to-face' trainee cannot achieve this as the trainee cannot become more than a copy of his trainer 'warts and all'.

The first vocational trainee conference at Newcastle tried to end the hospitals' abuse of the scheme and the second conference at Edinburgh tried to deal with the trainers' abuse. It appears that neither were successful. There is still time to scrap the dull and unimaginative programme for the third conference at Oxford and instead hold a real conference for all those involved: one or two general meetings and then separate ones for organizers, advisers, trainers and trainees so that broad guidelines for a basic syllabus can be hammered out by those actively involved in the schemes.

I. R. HAIRE

St Francis Hospital
Haywards Heath
Sussex.

CONTRACEPTIVE RECORD CARDS

Sir,

Dr Froggatt's contraceptive record card (February *Journal,* p. 107) was timely. I have prepared an alternative card in which the information is arranged so that the front of the card records the history and provides a data base, and continuation examinations are shown on the back.

The card is white, which I believe is important in that it is unobtrusive. Mothers receiving contraceptive advice can become aware if their daughters have acquired distinctive coloured cards similar to their own, especially when they accompany their daughters and see the notes on the doctor's desk. Similarly, I do not recommend having 'contraceptive record' printed on the card, which might project from the notes and be seen.

RICHARD GARDNER

The Surgery
1 Stevenage Road
Knebworth
Herts.

Sir,

I was delighted by the response which followed publication of my paper on the contraceptive record card. The letters published by the *Journal* from Dr Smail (May *Journal,* p. 317), and from Dr Creme (June *Journal,* p. 378) reflect some of the comments which I received from other general practitioners direct.

The card has now been modified and referred to the Practice Records Committee for consideration. The modifications have taken note of all Dr Smail's suggestions and have included modifications suggested from other sources.

I have not, however, left space on the card to enter details of claims submitted for contraceptive services and cervical smears. Details of claims can be recorded where appropriate in the "Clinical Details" column. Creating a special column for this would constitute a waste of valuable space, as it would remain blank in the majority of consultations.

CLIVE FROGGATT

129 St George's Road
Cheltenham
Gloucestershire GL51 7AQ.

COMMUNICATIONS BETWEEN DOCTORS AND SOCIAL WORKERS

Sir,

Drs Reilly, Patten and Moffett are to be congratulated on a neat though limited examination of the difficulties in communication between doctors and social workers in general practice (May *Journal,* p. 289).

In a three-year study in this dockside practice in Liverpool we identified several factors which prevented the establishment of true multidisciplinary