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.

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References

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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.

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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.

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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.

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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.

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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

team work and led eventually to the premature termination of the experiment.

These factors were: problems with communication, faulty expectations of roles, problems with status, and a failure to achieve a cohesive team structure.

Paramount in the team's failure in communication was the absence of an integrated patient's record. Other communication difficulties were the failure to establish formal methods of referral between team members and the difficulty of obtaining feedback after referral. Many of these difficulties could have been avoided had detailed consideration been given to formal methods of communication and record-keeping at the outset of the experiment. This failure was due mainly to ignorance as a large amount of time was spent on discussing research methodology in great detail, but the more important aspects of team management were not touched on.

Reilly and his colleagues also mention the expectations and perceptions of the various workers. We found out too late that a proportion of the blame for the failure of the Liverpool project rested on faulty expectations of the roles of the various team members by colleagues and failure to understand adequately the various skills of the individual team members.

Finally, unspoken and unresolved problems of status and status hierarchy led to difficulties which were never anticipated and which contributed to the breakdown of the experiment.

The multidisciplinary primary care team has been compared to a football team in which the player with possession of the ball determines the play at that moment but, at the same time, all the players are collectively responsible for the result of the match. It follows that a good team must train together for a considerable time. It seems that where primary care teams have been unable to overcome the difficulties and stresses of the novel situation they have not spent sufficient time together in practice and training before getting down to the business of caring for patients.

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JOURNAL STYLE

Sir,
I note with horror that the word 'analyse' has been spelt 'analyze' in the *Journal* since January 1977. I dislike this repellent word because it is an example of unnecessary literary bastardy. As a product of this I know it has no pedigree and can only hope that it has no posterity.

The word 'analysis' is derived from two Greek words *ana* (up), and *lyein* (loosen), (Greek *analysis*). The Greeks spelt this with an 's' and not with a 'z'. Thus the verb 'analyse' has an unimpeachable pedigree, and retains both its meaning and its roots—a splendid example of felicitous adoption.

How did the 'z' appear? I suspect that some pernickety scholar, insisting on the classical way of making a verb out of a noun by adding the Greek (and Latin) suffix 'ize', produced 'analysize' which pedantically correct horror later became falsely contracted to 'analyze'.

I fear that in changing from a house style which used all -ise endings to all -ize, you are jumping out of the frying-pan into the fire. Please do not argue with your colleagues; just ask a straightforward question and demand a straightforward answer. "Why do you think analyze is correct?" Ask them also how they would spell haemolyse and electrolyse.

Authorities are legion and include *Chambers' Twentieth Century Dictionary,* the *Oxford Dictionary of English Etymology,* Fowler (indirectly) and *The Times.*

My kindest regards to your sub-editors and proof readers. I await their counter-barrage with confidence and a complete lack of trepidation. I hope these few observations may help to 'catalyze' the situation.

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EMPLOYMENT OF MENTALLY HANDICAPPED PEOPLE

Sir,
In reply to Dr Raphael's criticism (June *Journal,* p. 380), my report (January *Journal,* p. 53) was based on the findings of a two-day workshop held at the King's Fund Centre in December 1974, which was reported by the Centre in a paper entitled *Employment of Mentally Handicapped People.*

Whether Remploy's intake of mentally handicapped is applied to the analysis of primary disablement categories served or to the number of mentally handicapped suitable for sheltered workshops throughout the land it still appears to remain "a tiny percentage".

Page 15 of the above report reads: "The number entering sheltered employment, widely thought to be more appropriate for mentally handicapped individuals than is open employment, reveals a surprisingly lower figure. This can best be explained in terms of low availability of places, for only about 12 per cent of area training centres reported that sheltered work places were available for their trainees. This may not be surprising in view of the small percentage of mentally handicapped people reported to be employed in Remploy, for example. Figures for the years 1963 to 1973 show only a five per cent increase (from four per cent to nine per cent) during the period (Department of Employment, 1973).

"This figure is desperately low, and appears to reflect the Department of Employment's policy of allocating no more than a small percentage of places to 'mentally disordered' people. Wide-ranging enquiries reveal that there is a low expectation of the ability of mentally handicapped people to attain entry requirements for sheltered employment. Indeed, the figures show that it is approximately ten times more difficult for a trainee to obtain a place in a sheltered workshop than it is for him to obtain a place in open employment."

In the same paper Dr Edward Whelan, Director of the Habilitation Research Project, Hester Adrian Research Centre, Manchester, and Joint Director of the Workshop, shows that it seems easier to get a job in open employment than in a sheltered workshop (p. 14). Referring to this the paper goes on to state: "Remploy, as it operates at present, seems to be inappropriate to, and not particularly interested in, the needs of mentally handicapped people" (p. 52), and further on: "Remploy seems to be an industrial organization which employs handicapped people on a selective basis, but which seems to consider itself inappropriate for mental handicap. Perhaps we are wrong. It would be helpful if Remploy would lay down a clear and unambiguous policy on this issue" (p. 55).

On government involvement, the paper has this to say: "There seems to be a lack of co-ordination, for example, between the Department of Health and Social Security (responsible for area training centres) and the Department of Employment (responsible for sheltered workshops)" (p. 54).

It seems that a major concern of the two-day workshop was that better education and training for the subnormal and severely subnormal should not, and cannot, be an end in itself. There is great need of much more sheltered employment. Can there really be the slightest doubt that central and local government have failed lamentably in this? To train young subnormals, and then have so little suitable employment for them to move on to, makes neither socio-economic or moral sense.

To quote further from the King's