## EMPLOYMENT OF MENTALLY HANDICAPPED PEOPLE

Sir,

Mr Orriss, in his letter (July *Journal,* p. 443) chooses to ignore my information (June *Journal,* p. 380).

He gives out-of-date and partial figures in support of his criticisms of Remploy which he made in his article (January *Journal,* p. 53). He cites also long, critical quotations from the Kings Fund Centre report. However, these criticisms are not necessarily correct and, in my experience, not relevant to Remploy.

Providing productive and gainful employment to some 8,484 severely disabled persons, of whom at least 1,706 are mentally disabled, is surely deserving of some praise.

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## EDUCATING PATIENTS

Sir,

I am attempting to assess the efficacy of a cassette-slide unit for educating patients in general practice. I would like to correspond with any of your readers who have attempted to educate their patients by means of audiovisual technology (especially using a tape-slide unit) and should be grateful if they could write to me at the address below.

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## VOCATIONAL TRAINING

Sir,

Dr Gilchrist's letter (July *Journal,* p. 441) raises some points of interest with regard to my article published in the April issue of the *Journal* (p. 227). I would be grateful for the opportunity to reply and to attempt to elucidate some of the points raised by him.

He begins the discussion by observing that only one diagnosis was recorded for each disease episode and he wondered what happened if a patient had more than one complaint? I should like to point out that in such a case more than one diagnosis *was* recorded.

His criticism of the excluded 135 cases is valid; I should have included more information on these cases. He is also correct in drawing attention to the disparity between 500 and 609 trainer consultations. In fact, the figure for 500 consultations is correct but more than one diagnosis was recorded on each occasion, giving rise to 609 diagnoses.

Dr Gilchrist wonders what my justification is for saying that the results of the study "challenge arguments that psychiatry can be learnt in general practice". My answer is that my experience was limited and excluded such cases as schizophrenia or organic dementia. Further, Dr Bain (1969), commenting on his experiences as a trainee, reports that most psychiatric and social cases were seen by his trainer. Finally, a joint working party, representing the Royal College of General Practice and the Royal College of Psychiatry, gave as one of its conclusions the following: "Yet critical analysis of the data presented, including accompanying letters and essays, indicates that the special relationship between psychiatry and general practice, which should aid and support general practitioners in the exercise of their psychiatric skills, is not yet reflected in the training of family doctors. Many of the clinical attachments offered in psychiatry are ill-suited for future general practitioners; some training schemes plainly ignore the importance of psychiatry". "If uniformity of standards is to be achieved, then some form of predetermined teaching will have to be arranged. It is likely that this will be taught by means of seminars" (Royal College of General Practitioners, 1975). Thus I would reiterate my point that it is doubtful if psychiatry can be learnt in general practice.

I think Dr Haire (July *Journal,* p. 442) misunderstood the aims of the article. His heart might not have been broken if he had realized that it was intended "to provide details of the *clinical* experience". However, let me reassure him that there was a lively half-day release scheme in which the trainees played a large role in the planning. In addition there were videotaped simulated interviews (using actors) and other educational activities such as visits to the Research Unit at Birmingham, the Royal College premises in London, and various schools for the blind and handicapped, to name but a few.

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**References**

Bain, D. J. G. (1969). *Journal of the Royal College of General Practitioners,* **17**, 29-35.

Royal College of General Practitioners (1975). *Journal of the Royal College of General Practitioners,* **25**, 609-615.

Sir,

It has been drawn to my attention that the acknowledgement at the end of my article (April *Journal,* p.227) might be a misrepresentation. I would like to say that this was intended as a true tribute and vote of thanks to those who had helped me. The facts are:

1. In the latter part of 1976 I submitted an article to the *Journal* which was 18 pages long.
2. This was seen by my trainer, who sent me a critical analysis four foolscap sides in length.
3. The *Journal* subsequently suggested that I shorten the article and supplied comment asking whether "any technique such as 'random case analysis' was a regular feature" of my training.
4. The article was considerably shortened and two sentences in reply to the above question were added. These led to a change in emphasis in the relevant section.
5. The sentences were: "I found 'tandem' surgeries very tedious" and "Apart from an abortive attempt to have a discussion once a week there was no other tuition."
6. None of the people mentioned in the acknowledgement saw this shortened version.

I would therefore like to apologize to them for any misunderstanding caused and extend this to the *Journal* and its readers.

PAUL O'FLANAGAN

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Sir,

I understand that there has been some misunderstanding following the article written by Dr O'Flanagan (April *Journal,* p. 227) concerning his experience as a vocational trainee. I have already replied privately to the letter written by Dr Haire (July *Journal,* p. 442).

Although my name was mentioned in the acknowledgements, I did not see the final article and was therefore surprised at one or two statements, notably those regarding his lack of tuition during his general practice year.

Although Dr O'Flanagan found "tandem surgeries" (i.e. trainer and trainee together) tedious, neither of my subsequent trainees found this to be so. This is obviously a subjective reaction which will vary from trainee to trainee, and each trainer will have to make the appropriate decision if and when to stop them.