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He gives out-of-date and partial figures in support of his criticisms of Remploy which he made in his article (January *Journal,* p. 53).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.

PAUL O'FLANAGAN

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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.

Our weekly discussion sessions were terminated largely because Dr O'Flanagan preferred to spend the time elsewhere. These sessions are initially of value in introducing a trainee to a practice and discussing any problems arising during the preceding week, but may prove tedious as time goes on, when there are fewer topics for informal discussion. For this reason my partners co-operated in arranging some evening tutorials as an alternative.

We both attended weekly seminars organized by the Derby Vocational Scheme, and of course had case discussions after each surgery. Our trainees also spend some time with the various members of the primary health care team.

Since Dr O'Flanagan took his half day on the day of the practice antenatal clinic, this must account for the very few obstetrical cases recorded. To compensate for this, he was able to attend a consultant antenatal clinic, although these cases are not mentioned in his statistics. He was also able to attend a family planning course, dermatology and other clinics during his general practice year.

I agree with Dr Gilchrist (July *Journal,* p. 441) that the comparison of Dr O'Flanagan's 1,000 consecutive cases seen in general practice with my own 500 cases is somewhat misleading, since we used rather different diagnostic criteria, and I recorded, where appropriate, several diagnoses per patient. The purpose of my study was purely to verify my own suspicion that the established general practitioner tends to see more chronic illness, psychiatry, and gynaecology, than the 'new' doctor in a practice.

This is inevitable, but in this practice we can overcome the problem to some extent since we have a communicating door between the two surgeries and can therefore invite the trainee in to see anything of interest or importance, providing the patient is agreeable.

Constructive criticism of a trainee's work is perhaps the most difficult, and most important, thing a trainer has to do. In many ways this is most easily done patient by patient and visit by visit. We are now experimenting in Derby with assessment forms for both trainee and trainer. Indeed, my last trainee and I filled in the appropriate forms and neither of us found the experience too painful.

Regarding the article as a whole, I would agree with Dr O'Flanagan that obstetrics and paediatrics are the two essential hospital posts, but the insistence on a further year in hospital is open to debate. Most trainees have already spent six months doing a general medical job, and a further six months medicine may not be of value unless the firm concerned is geared to the needs of general practice and is able to teach the diagnosis, investigation, and long-term follow-up of chronic disease from the general practitioner's point of view.

There is a great deal to be said for the introduction of psychiatry, geriatrics, and gynaecology into the trainee's hospital posts, but perhaps even more to be said for additional time in general practice.

I hope this will help to clarify the problems raised.

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BOOK REVIEWS

CHILD CARE IN GENERAL PRACTICE

Cyril Hart (Ed.)

Churchill Livingstone, Edinburgh (1977)

442 pages. Price £6.50

Dr Hart and 32 contributors, 29 of whom are practising general practitioners, have co-operated to produce this book. In his succinct preface Dr Hart makes these important points:

1. Child care accounts for 25 per cent of general practice, thus justifying a work exclusively devoted to this aspect.
2. The book is designed to complement rather than supplement standard textbooks of paediatrics.
3. Books on general practice are best written by general practitioners.

To a large extent the work justifies these last two statements.

The work is sensibly divided into six sections namely: The Organization of Child Care; Child Care and Preventive Medicine; Clinical Care in Acute Illness; Continuity in Clinical Care; Clinical Care in Long-term Disorders; and Essays in Family Care. The multiauthorship has not prevented a natural flow of the text but has led to a variable standard in the contributions.

Section 1 is, on the whole, well written and it is interesting that, although the Court Report was not available to the contributors, some of their conclusions are in broad agreement.

I particularly commend the chapters: "The Quality of Child Care", by Dr Hart and "The Social Services and the Practice", by Elspeth Colebrook, who was herself a social worker. This is written with a good deal of tact and a deep appreciation of the problems of both disciplines. The chapter by Dr Pearson, "Child Care Legislation", is valuable for reference.

Section 2, Child Care and Preventive Medicine, is more patchy. The initial chapter, the "Fetus at Risk", reads like a knowledgeable student's answer to an examination question. It is a comprehensive treatise but requires modification.

The other chapters: "Development Screening", "Immunization", and "The Child Health Clinic", are quite adequate but that on "Ill-treated Children", by Dr Pereira Gray, is of a very high standard. Happily this carries with it the approval of the Royal College of General Practitioners as its policy towards the problem of child abuse.

The quality of the chapter "Clinical Care in Acute Illness" varies throughout. The chapter on "Acute Infection of the Respiratory Tract", by Dr Gregg, from whom we have come to expect so much, is disappointing. The chapters "Some Common Viral Infections", by Dr Hart, and "The Acute Abdomen", by Dr Hooper are of a high calibre. In the latter the author begins with a sensible review of the symptoms and signs, but I must take issue with his implied statement that diarrhoea is absent in acute appendicitis (p. 190).

Section 4, Continuity in Clinical Care, is by and large well written but is surpassed by Section 6, Clinical Care in Long-term Disorders, which includes an excellent and practical chapter on congenital heart disease, by Dr Sykes.

Both in this section and that which follows, Essays in Family Care, the authors write as general practitioners