October 1980.

This six-day meeting will have as hosts the American Academy of Family Physicians, and will feature joint lecture presentations with instantaneous translation services.

In addition to lectures and other educational activities, there will be clinical seminars, 'live' teaching demonstrations, and closed-circuit television.

In addition to the medical meeting the Academy is planning a wide variety of medical activities for the spouses and children of participants. The tone of the meetings is expected to capture the flavour of 'old New Orleans' including the famous Mardi Gras and world-renowned New Orleans Jazz.

Further information can be obtained from the Director of Planning, 1980 WONCA/AAFP Meeting, 1740 West 92nd Street, Kansas City, Missouri, USA, 64114.

WONCA NEWSLETTER

The *WONCA Research Newsletter* is now being published by the *Journal of Family Practice* and is available from Dr Peter Curtis, MRCP, MRCGP, Department of Family Medicine, UNC School of Medicine, 711 Clinical Sciences Building 229H, Chapel Hill, North Carolina 27514, USA.

NATIONAL HEALTH SERVICE IN SCOTLAND

Elderly patients aged 65 and over occupied 57 per cent of the beds used daily in non-psychiatric and non-obstetric hospitals in Scotland in 1976. This is the first time the percentage has exceeded 50 per cent.

Community nursing staff made a substantial proportion of their home visits to the elderly; 20 per cent of home visits were made by health visitors and 77 per cent by district nurses. Nearly 10 per cent of the population aged 65 to 74 were seen by health visitors, compared with 21 per cent of those aged 75 and over. Home nurses visited 8·5 per cent of those aged 65 to 74 and 23 per cent of the over 75s.

Nearly a quarter of a million women in Scotland received contraceptive advice from general practitioners, and just over half as many were advised by family planning clinics.

The number of abortions rose slightly and 29 per cent were performed on girls aged 19 and under, compared with 18 per cent in 1970. Abortions for single women had risen from 38 per cent in 1970 to 48 per cent of all abortions in 1977.

The average number of patients on a general practitioner's list was 1,905.

ATTENDANCE OF PATIENTS AT HOSPITAL

The numbers of discharges and deaths, outpatient attendances, and new accident and emergency attendances at 31 December each year in NHS hospitals were as follows:

	Inpatient discharges and deaths	New outpatient attendances	New accident and emergency attendances
1970	6,028,000	9,279,000	8,877,000
1973	6,158,000	9,353,000	9,717,000
1977	6,391,000	9,053,000	10,323,000

Reference

House of Lords (1978). Quoted in *British Medical Journal*, 2, 1723.

HEALTH SERVICE IN WALES

The number of positive cases of cervical cytology detected per 1,000 cases examined rose from 4·7 in 1974, to 7·0 in 1977. The number of positive cases detected from general practitioners has also risen from 88 in 1974, to 201 in 1977.

Of the 842 total positive cases 48·5 per cent were under the age of 35.

On 1 October 1977 there were 1,204 unrestricted general practitioner principals in Wales with an average list size of 2,175. Eighteen per cent of principals in Wales have list sizes of more than 2,500 and an additional seven per cent have list sizes over 3,000.

The number of vocational trainees in Wales has risen as follows: 1974—42; 1975—56; 1976—56; 1977—66.

Reference

Welsh Office (1979). *Health and Personal Social Services Statistics for Wales.* Cardiff: HMSO.

EEC COMMISSION

The Plenary Assembly of the Standing Committee of Doctors of the EEC met on 1 and 2 December 1978 in Copenhagen with the Danish Medical Association acting as hosts.

The assembly agreed the following motion:

"That a specific postgraduate training for general practice is essential; that such training must include elements of postgraduate training both in hospital and in general practice itself; and that it must be of a minimum of two years' duration. The Standing Committee of Doctors recommends that by 1985 such a specific postgraduate training for general practice, whether obligatory or voluntary, be established in all member states of the European Communities and that any doctor migrating to a member state in which such training is obligatory must be required to fulfil the obligation in order to practise as a vocationally trained general practitioner in that country."

Reference

EEC Plenary Assembly (1978). Declaration on health costs. *British Medical Journal*, 1, 65.

JOINT COMMITTEE ON POSTGRADUATE TRAINING FOR GENERAL PRACTICE

The Joint Committee on Postgraduate Training for General Practice and the Royal College of General Practitioners have approved the Monklands, Airdrie, and Lanarkshire vocational training schemes, and have re-approved the schemes at Salisbury and Rotherham.

These schemes are recognized by the Royal College of General Practitioners for the purpose of the MRCGP examination.

CORRECTION

In the article on the history of vocational training for general practice by Drs Horder and Swift (January *Journal*, p.24), a half-page column was omitted in error.

This should have appeared at the bottom of page 29 under the heading 'The first local vocational training schemes'. The missing section was:

The first local vocational training schemes

The first four local initiatives to begin the expansion of the three-year training schemes, which has continued throughout the 1970s, were at Belfast[39] in 1964 (a two-year scheme changing to a three-year one in 1967), Ipswich[40] in 1969, Newcastle[41] in 1969, and Manchester[42,43] in 1969. All followed the general pattern of two years in hospital and one year in a teaching practice.

There was no day release course in Belfast in the first years, but this was developed strongly at Newcastle and Ipswich. At Ipswich the day release course concentrated particularly on psychiatry and its application to the problems of general practice. At both Newcastle and Ipswich this course continued through the period in hospital posts as well as that in training practices. A particular difference at Newcastle was the division of the trainee year into an initial six months and a

final six months, divided by the hospital posts. Newcastle was first in developing stricter methods for the selection of general practitioner trainers, which included considering their personal qualities, their practices (premises, records, staff, equipment, and organization), and the qualities of their partners. The selection procedure included a visit to the practice.

The initiatives for these schemes were different in each case: at Belfast it was by the Department of Postgraduate Medical Education for Northern Ireland; at Ipswich by the Postgraduate Medical Centre (making a conscious experiment to base the scheme on a district general hospital for the first time); at Newcastle by a Subcommittee of the Regional Postgraduate Organization; and at Manchester by the University Department of General Practice.

The Manchester scheme was intentionally subdivided, for research purposes, one part having a theoretical course at the start, one an extended course over one year, and the third no course at all.

All four of these early schemes submitted themselves to a large assessment study by the Department of General Practice at the University of Manchester, which aimed "to evaluate one course against another by measuring the changes effected in those taking part in terms of knowledge, skills, and attitudes, and some methods of thought and factors of intellect". The results of this study were published in 1976[42,43]. This important effort in evaluation was the initiative of Professor P. S. Byrne, who also played an important part as Chairman of the Education Committee (RCGP) from 1966 to 1970 and in producing (1966) the first course for general practitioner teachers aimed at increasing their teaching skills.

This most unfortunate mistake is very much regretted.

LETTERS TO THE EDITOR

CORONARY PREVENTION

Sir,

The coronary screening programme described by Dr J. Stuart Brown (December *Journal,* p.735) appears well planned and efficiently performed but it leaves some questions unanswered. If 22 per cent of ECGs are abnormal, is this a sensible screening test from the patient's point of view? It may be a useful baseline for the doctor but what does one say to the patient? Similarly, do the complex lipid tests performed on 20 per cent of patients really have a useful function? It is a little alarming that only 48 per cent of patients were "told that all tests were 100 per cent normal". Were the other 52 per cent reassured or frightened? The several patients who asked when they could have their next screening test may have done so through anxiety rather than enthusiasm. In other words, it seems to me that the *accent* of this programme does not seem quite right, being to "prevent coronaries' rather than lead to advice on good health in general. In our practice, we carry out a 'forty plus' examination almost identical to Dr Stuart Brown's except that we do not perform routine ECGs and do not take slight biochemical abnormalities very seriously. The accent is on reassurance and redirection. It may be that the risks of creating alarm and a demand for repeated screening should be taken more seriously than Dr Stuart Brown implies.

C. P. ELLIOTT-BINNS
31 Church Street
Cogenhoe
Northampton.

Sir,

I was interested to read Dr J. Stuart Brown's article on coronary screening (December *Journal,* p.735) and congratulate him on a well thought out and executed investigation. I do, however, think that something ought to be said about his reference to ECGs. He refers to 15 patients with "ECG abnormalities, the majority being T-wave changes or the presence of ventricular extrasystoles". He then goes on to say that "most of the T-wave changes were considered to be within the normal range" and "more recently the general trend is to attribute ever diminishing significance to premature beats". If one accepts these comments, I imagine very few, if any, of the 15 in fact had ECG abnormalities.

The classical ECG changes of ST depression and T-wave changes can be produced by a large variety of other conditions and are not pathognomonic of ischaemia. Ectopic beats (even ventricular ones), as Dr Stuart Brown points out, are of very doubtful significance.

I am sure this is important to say, because there are many people walking about who are anxious about their hearts simply because doctors have told them that they have "minor ECG changes", whereas in fact these "abnormalities" are perfectly acceptable within the normal range.

WILLIAM BENSON
Cardiac Department
Royal Devon and Exeter Hospital
(Wonford)
Barrack Road
Exeter EX2 5DW.

SELECTING TRAINERS

Sir,

Dr John Oakley's letter (February *Journal,* p. 117) complaining about the Oxford Region's criteria for the selection of trainers and training practices raises some important issues. He calls the requirement for new trainers to have passed the MRCGP examination presumptuous, unfair, and an insult to colleagues in general practice. Strong words indeed.

The Oxford Regional Committee's General Practice Sub-Committee is concerned that trainers should be clinically competent. It was because a number of our *trainees* felt that some trainers were not competent enough to teach clinical medicine in general practice that those from one of our vocational training schemes asked the Sub-Committee to introduce passing the MRCGP examination as a requirement for new trainers in April 1977. The members of the Sub-Committee agreed unanimously to do so. Existing trainers are not affected, although a number of them have sat the examination because they wished to do so.

The suggestions for assessing clinical competence published by the Joint Committee for Postgraduate Training in General Practice that Dr Oakley mentions are for guidance only. Passing the MRCGP examination is just one of the suggestions: in the Oxford Region we use all six. Anyone with experience in assessing and appointing trainers—and the members of our regional appointments committee and visiting assessors panel have a very great deal of experience—knows that judging a doctor's clinical ability is very difficult.