

The student will no doubt play the game of deciding which chapter was written by which author. Right or wrong he will reach the last chapter as well informed, in some matters at least, as some of the principals with whom he may subsequently work. He will have begun to think of patients as people

with problems rather than bodies with pathology, and have some insight into the element of probability. He will learn, too, that he has to organize his own practice in his own way because medicine is still an art, though a good deal of science is now attached to it.

Those who may benefit most from

this book are the students who will go into some other branch of medicine when they graduate and qualify. For providing an understanding of general practice to the career hospital worker the authors deserve our thanks.

R. J. F. H. PINSENT

REPORTS

GP INFO 80

THE advent of the microcomputer has seen a rapid and fundamental change in the way we regard information, both in its acquisition and its application. The medical profession is not immune from the changes that this new technology will bring, and in a recent symposium, the Royal College of General Practitioners demonstrated that the primary health care team could and would be involved in this technological revolution. GP INFO 80, a national symposium on computing in general practice, was held at 14 Princes Gate, London from 13 to 15 March 1980 and combined a detailed exhibition of current equipment with a chance for the profession as a whole to meet the men whose machines will reshape their practice.

The exhibition

The exhibition was open for nearly a week with the College building turned into an Aladdin's cave of shiny new machines strung on a spider's web of white plastic covered wire, the whole effect seeming somewhat incongruous as the buzz of cooling fans and the clicking of paper printers broke the calm normally associated with the building. Nonetheless, the atmosphere was friendly and only a few early gremlins prevented the smooth demonstration of the modern machines, which varied tremendously in their technical complexity and intended application. The skill available varied in the same way, from the dedicated professional who offered package deals of readily available equipment to the even more dedicated enthusiast who was prepared to demonstrate his own solution to the programmers' problems.

A detailed description of the exhibition would be tedious so I shall mention just a few of the exhibits which caught my eye. The most impressive was certainly the system displayed by the Southampton Project, which showed how the application of the microcomputer to general practice problems could generate a research tool of formidable power. Not only could this machine hold data for a practice population and recall particular items on demand but it could also cross refer

and produce searches of the data held to help in both research and management. For instance, I watched it search and produce a list of all the diabetics held on file in less time than it takes to write about. The system was designed as a research tool and no doubt the time will come when it is offered commercially but since the current price is about £20,000 that time is clearly not yet here.

Mickie is a well known micro system which is unusual in that it is not so much concerned with practice record keeping but more with the patient/machine interface. This machine can question a patient on a simple basis and arrive at some decision about management; in other words it can screen symptoms and decide whether a medical opinion is required. Not, I hasten to add, that it is designed to replace a doctor but rather to act as an extension of the doctor in order to reach more people more effectively.

My favourite system was Patrius, which is based around a currently available micro, the well known Commodore PET, but it is not available as a package. I liked it because it represented for me the direction in which the computer will have to go before it becomes widely accepted: the need is for a single individual or practice to be able to define the problems in their own practice and then apply a readily available machine to them. In effect Patrius is a computerized age/sex and disease register of limited capability but it is designed to fit particular parameters rather than to create problems that only it can solve.

The Conference

So much for the machines: what of the Conference? In the opening sessions five discussion groups were formed and introductory papers given by Professor David Metcalfe, Department of General Practice, University of Manchester, and Mr D. Reid, IBM UK Laboratories Ltd. Professor Metcalfe speaking on "Information needs of general practice" stated that a revision of record keeping systems in general practice was long overdue. The little brown Lloyd George folder, first used in 1911, had changed little since then. Further-

more, the average practice could be compared with a business with a turnover of about £200,000, and a business of this size would have an accurate knowledge of their customers, their orders, their throughput, their suppliers, and their financing. The average practitioner could give no concrete information about his consulting rate, surgery visit rate, old/new ratio, case mix, who had defaulted from care, and so on. Certainly on that basis alone the arrival of the microchip in general practice could not come soon enough.

The next day began with the presentation of four short papers by general practitioners which were received with enthusiasm: Dr P. J. Fell, Oxford spoke on the choice between mainframe or mini; Dr P. Sprackling, Nottingham, on the Nottingham system; Dr Robin While, Chippenham, spoke on how to persuade partners and ancillary staff that computers are a good idea, based on his experience with the Chippenham project; and finally, Dr Gareth Emrys-Jones, St Columb Major, Cornwall, told a cautionary tale of computerized disaster and described a hitherto unknown social group, the computer widow.

In the discussion groups that followed, the real work of the Conference took place. Each group was given a specific topic to consider and was asked to describe how the use of a micro would fit in with their solution of the problem. The groups reported their conclusions at a plenary session later in the afternoon. Certainly it seemed that there were many benefits to be gained in the fields of record keeping, prescribing, practice finance, and preventive medicine, largely through the computer's immense data handling capacity which made the control of the record easier. The completely electronic patient record was not accepted, mainly for fear that the elimination of paper records from the consultation would subtly alter its nature. Indeed, the effect of the computer on the doctor/patient relationship was noted to be of primary importance. The computer could help enormously with preventive medicine since not only could it recall and sort records for such procedures as cervical cytology and immunization but also, in conjunction with a patient/computer interface, be used for health education. Sadly, the fifth group, whose brief was to define how computerization could benefit audit, failed to agree even what audit was, much less whether they wanted it or whether a computer could help.

The final day was bravely entitled "Computing Tomorrow". Of several papers given in the morning session, one delivered by Mr Hugh Fisher, Systems Analyst, Institute of Biometry, Exeter, well known for his work on the Exeter project, was of particular interest. He analysed the levels at which a practice might be computerized:

1. No computer at all
2. Age/sex register
3. Level 2 + diagnostic index
4. Level 3 + prescribing summary

5. Level 4 + clinical screens + current episode summary + other potential modules.

This scheme makes it easy to see where the most serious problems will arise, namely in the interlinking of separate practice systems, for how will a practice at level 2 be able to transfer data to a system at level 5 when the current trend is for large numbers of separate and different systems to be used? Clearly, there is scope for family practitioner committees to become computerized to aid the transfer of information between each other and the practices for which they are responsible, and also to act as intermediary between separate practices.

The final session was, perhaps, the most exciting of all as it featured a demonstration of how the micro might be used in general practice. Dr Alastair Malcolm, General Practitioner, Durham, presented a paper in which he described the kind of machine he felt would be most suitable for practice use and development. This led him on to the evolution of a role play situation which was meant to show how a surgery might be run with a desk-top computer. The role play revolved around a counselling session where a patient on a particular therapy might be able to discuss his future management with his doctor. This was not an attempt to devolve responsibility from the doctor but a demonstration of how the computer could give the general practitioner rapid access to vast banks of data held in a central store and relayed to his desk-top console by land line—the newly-developed Prestel system run by the GPO. Not only did we see this system run on a real time basis as a demonstration but also the wider implications of intercontinental communications which are run in exactly the same way. The role play was developed to show how a German diabetic might present to a British general practitioner clutching only an unlabelled (and empty) bottle of insulin. Clearly to a non-German speaking doctor this situation might be catastrophic. However, he can simply telephone the German Prestel system, ask for a list of German insulins, and the new patient points out his drug.

Conclusions

In conclusion, certain features of the symposium stand out. First, we were constantly reminded of how much like the industrial revolution the coming of the micro had become. Where the industrial revolution gave society more powerful muscles in the form of servo machinery, the micro would give us more powerful minds, not in terms of thinking machines, but in terms of devolution of all the data-processing functions to free our mental capabilities for more innovative thought. Secondly, we saw in just three days just how much the computer could do for the practice of medicine and thirdly, that, like it or not, the computer *is* here to stay and it will be so much better if we can accept it now, so that when it becomes a commonplace item of practice

equipment it will do the kind of things we *want* it to do rather than impose on us the things it wants us to do. Finally, it became clear that for the next few years the computer will be under a continuous evolutionary process and we should regard it perhaps not so much as a practice investment such as the bricks and mortar of the surgery but in the same way as our car, a machine with a

specific and useful function, to be used for a time and then discarded in favour of a newer model.

JOHN POYSER

Addendum

The proceedings of the symposium are to be published at a later date, with a directory of those who attended it.

Assessing the quality of training

A ONE-DAY conference organized by the Royal College of General Practitioners was held at 14 Princes Gate on 21 March 1980, with Dr A. G. Donald, Chairman of Council, in the chair. It brought together a number of people concerned with providing or evaluating vocational training with a view to looking at some of the problems encountered when trying to monitor the standards of training for general practice. The two interests were in many cases combined in the same individual because the majority of the participants were postgraduate advisers responsible for organizing postgraduate training in their regions; they also served on the panel of visitors of the Joint Committee on Postgraduate Training for General Practice and so were involved in the inspection of training schemes outside their own regions.

In the morning there were brief accounts of the recent growth in the numbers voluntarily undertaking vocational training, the implications of the new Vocational Training Regulations, and the role of the Joint Committee. The conference then turned its attention to the peculiar frictions which external appraisal can give rise to. These were illustrated by reference to inspections that had taken place where the visitors' subsequent reports had met with a less than rapturous reception.

The afternoon was devoted to a review of the individual components of visitors' inspection procedures, looking in turn at assessments of the structure, process, and outcome of training schemes. In connection with outcome, the conference heard of the possibility that with the increasing numbers of trainees sitting the MRCP examination, analysing the results by region and by topic might reveal trends which those responsible for providing training locally would wish to know about. So long as vocational training was not then subverted to feeding the examination, this could be a most reliable source of feedback.

Feedback proved, in fact, to be the liveliest of all the issues raised in the conference. Many of those present, including the trainees' representatives, believed that every individual being assessed had perhaps a moral right—and certainly an educational one—to receive the subsequent report or at least those sections of it referring to him. There was unanimous agreement that the adverse effects of these visits were largely attributable to failure to separate clearly the regulatory function of a statutory body from the educational and advisory roles also required of the Joint Committee's visitors.

J. S. NORELL

Psychotropic drug prescribing in general practice

A TWO-DAY meeting organized by the Dependence/Addiction group of the Royal College of Psychiatrists and supported by the World Health Organization was held in London recently. Its theme was "The use and misuse of psychotropic substances", and one of the sessions was devoted to the problem in general practice.

In the last 10 years there has been a steady fall in the prescribing of barbiturates and amphetamines but this has been more than compensated for by the rise in prescriptions for non-barbiturate hypnotics, antidepressants, and minor tranquillizers. In particular, the prescribing of diazepam by general practitioners is at a very high level and increases each year.

The meeting heard about the wide prevalence of

anxiety in the community and of the peculiarly exposed position of general practitioners whose attempts to stem the tide seem like Canute's, to have been unavailing. However, some general practitioners appear to have discovered how to reject this particular sort of patient demand without rejecting the patient, and how to instil in their patients a new confidence, and perhaps pride, in being able to stand on their own feet. As possible alternatives to automatic medication, accounts were given of the use of hypnotherapy, and of successful referrals within practices to counsellors and to nurse behavioural therapists. Simply monitoring one's practice's prescribing could itself have a salutary effect.

J. S. NORELL