

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 Glasgow Eastern District and Grimsby Vocational Training Schemes. These schemes are recog-

nized by the Royal College of General Practitioners for the purpose of the MRCGP examination.

SYMPOSIUM ON EPIDEMIOLOGY

A one-day symposium will be held at the Royal Hallamshire Hospital, Sheffield, on Tuesday, 18 November 1980 when

seven invited speakers will present applications of epidemiological methods appropriate to clinical research and practice. The closing date for enrolments is 31 October and the programme and full details may be obtained from Dr R. A. Dixon, Department of Community Medicine, University of Sheffield Medical School, Beech Hill Road, Sheffield S10 2RX.

LETTERS TO THE EDITOR

ASSOCIATION OF GENERAL PRACTITIONER HOSPITALS

Sir,

The Association of General Practitioner Hospitals was founded a little over 10 years ago. In the early years our chief activity was to assist hospitals threatened with closure where that closure did not seem to be in the interest of the communities concerned. More recently, as the Association has gained more status, we have been consulted by Government, by the Royal College of General Practitioners, and by other bodies, for information and advice on the present state and future prospects of general practitioner hospitals.

Part of the problem was the lack of information about what actually went on, and Cavenagh's (1978) paper has been an important milestone.

In Lichfield recently we invited a group of trainees from the North Birmingham Training Scheme to spend the afternoon in our own general practitioner hospital. This was clearly a major eye-opener for them as previously they had believed that cottage hospitals were for the long-term care of elderly people requiring near-permanent stay in hospital. Dr Gerard Vaughan's recent statements make it clear that small hospitals are going to play an increasingly important role in the development of the NHS and we feel it important that all trainees should at least be aware of what happens in general practitioner hospitals and what the possibilities for the future are. Ideally we would like all vocational training half-day release courses to include a visit to a general practitioner hospital and I would be most grateful if you would bring this to the attention of your course organizer readers.

I would be very happy to act as a resource in finding a geographically ap-

propriate general practitioner hospital and interested host general practitioner for as many training schemes as possible.

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Honorary Secretary

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Reference

Cavenagh, A. J. M. (1978). Contribution of general practitioner hospitals. *British Medical Journal*, 2, 34-36.

DEFINING AN EPISODE

Sir,

A pilot study was carried out in this practice to compare the patients and the types of illness presenting to the senior partner and to the trainee. We categorized the illnesses we saw as follows: new illness (including new patient); recurrent illness, but a new episode presenting for advice; short-term follow-up, up to six weeks from first contact; long-term follow-up (concerned with monitoring chronic disease).

We found it difficult to categorize many patients' illnesses. It was difficult to decide when something was genuinely new, and not in some way related to previous or current disease. It was also unclear at times what was meant by recurrent illness.

Some of the ideas for this pilot study were taken from the two National Morbidity Surveys, done in 1955 and 1971, and in particular we drew on their use of the term 'episode of illness'. This term was introduced in the second survey to cover a period of illness during which there may have been a number of consultations. This was done in order to

prevent a large number of consultations for one condition distorting the survey. The conclusions drawn from a comparison of the two surveys (Crombie *et al.*, 1975) indicate that the 'episode of illness' rate per person has risen although total consultation rate has remained static. This has been taken to imply a real increase in workload.

However, examination of the two surveys show that the term episode was used with different meanings. In the first survey 'episode' is a construct obtained from the total number of consultations for a particular diagnosis in a patient throughout the year. In the second survey distinct episodes of the same illness were recorded separately. Although the authors do mention this discrepancy, they go on to draw conclusions about the changing workload of doctors which seem to be implicit in the differing definitions of 'episode of illness'. We do not think that any such conclusions can be drawn when such ambiguity surrounds what is being compared.

Indeed, drawing on our experiences during the pilot study mentioned above and the difficulties we had in categorization, it is questionable whether any definition of 'episode' can be more than arbitrary. In fact, the greatest difficulties in categorization occurred in those patients with psychological symptoms and it is patients in this group who show the greatest increase in episode rate over the period of the two surveys.

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S. A. HULL

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Reference

Crombie, D. L., Pinsent, R. J. F. H.,

Lambert, P. M. & Birch, D. (1975). Comparison of the first and second national morbidity surveys. *Journal of the Royal College of General Practitioners*, 25, 874-878.

COMMUNITY MEDICINE AND GENERAL PRACTITIONER SERVICES

Sir,
The Faculty of Community Medicine and the Royal College of General Practitioners have set up a Working Party to promote effective co-operation between general practice and community medicine by a study of ways and means of developing information systems useful to general practice with emphasis on practical applications.

We wish to start with a review of existing models of co-operation and through the courtesy of your *Journal* I would request any readers who know from their own area of examples of co-ordination between community medicine and general practitioner services to let me have a brief written summary of such schemes.

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GENERAL PRACTITIONER OBSTETRICS

Sir,
Mrs M. Tew's interpretation of the Oxford General Practitioner Obstetric Unit figures (August *Journal*, p. 502) is original to say the least! Her implication that we should have done better had we transferred fewer patients to consultant care in pregnancy during the last triennium seems to be a complete non sequitur. The facts, comparing the first and last triennia, are these:

1. The overall perinatal mortality fell from 15.3 to 9.1 per 1,000.
2. The perinatal mortality for patients transferred to consultant care in pregnancy fell from 54.9 to 28.6 per 1,000.
3. The perinatal mortality for patients not transferred in pregnancy (but including those transferred in labour) fell from 3.4 to 2.0 per 1,000.

In her second main paragraph she seems (conveniently perhaps) to have excluded perinatal deaths from patients transferred in labour. Thus, the variations in perinatal mortality rates for the two triennia for those transferred in pregnancy and those not transferred are represented by factors of 16 and 14

respectively, not 30 and 40 as she maintains, that is there was some improvement, not 25 per cent deterioration.

I maintain, therefore, that re-examination of our figures by comparing the first and last triennia reveals an improvement in performance of 40 per cent over the 10-year period and is, I believe, further justification of our style of general practitioner obstetric practice which combines teamwork and collaboration with specialists with continuing education and audit.

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THE JOURNAL

Sir,
Dr Sackin's outcry was perhaps a trifle excessive but he does raise an important point (May *Journal*, p. 306). Articles published in the *Journal* often carry the germ of an idea or suggest a promising line of thought, but why have they to be blown up into 'originals'? Is there no place nowadays for the humble 'medical memorandum', or the modest 'communication', or even simply a letter through which to transmit our thoughts and findings?

I constantly hear complaints about *Journal* articles being dead boring, and it does seem rather pointless to wade through pages and pages of dull, but no doubt impeccable, material merely to discover the null hypothesis confirmed, or some such. That sort of exercise surely serves nobody's interests—except possibly perhaps the authors'.

Here, I am afraid Dr Sackin could be right in implying that this unwelcome trend may be associated with the advent of academic general practice and the consequent need for career advancement. General practice has so far been spared the more pernicious effects of a hierarchical career structure, but this could change. Nowadays one comes across quite slight articles bearing the names of four authors, among them the professor and his reader; and I remember an article in the *Journal* boasting no fewer than seven authors. I ask you, Sir, how can seven individuals write one paper? Is it that important to be numbered amongst the 'et al.'?

One can sympathize with the plight of aspiring academics, gloomily pondering the stark message, 'Publish or perish!': the higher the reputation of the *Journal*, the greater the incentive to be seen in it. Keeping a proper balance between articles of equal merit must be an editorial headache, but the *Journal* is after all the journal of the College, not of the university departments.

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WOMEN GENERAL PRACTITIONERS

Sir,
I was interested to read the latest somewhat coy instalment of your long-running "woman claws woman" saga (May *Journal*, p. 305).

Dr Hayden suggests several reasons why male partners are preferred—women may 'have more time off', 'have been unreliable partners', or be 'less clinically competent'. Such charges are serious. However, she does not produce any evidence to back these assertions, nor indeed discuss how the reliability or clinical competence of general practitioners might be measured. It is therefore impossible to judge whether her hypotheses are valid.

Moreover, even if it were found that, as a group, women did have more time off work because of their family commitments (perhaps the most plausible of Dr Hayden's theories), this would hardly be surprising. It is nowadays a commonplace that married women enter the job-market with one hand polishing the furniture, if not actually tied behind the back. Those with children are required to be mothers, housekeepers and home nurses as well as paid employees. Although many men now participate in domestic duties, these are rarely as arduous or as sustained as the tasks undertaken by women.

Female medical students are at least as academically able as their male counterparts. When the opportunities, in the form of part-time training and career posts, are available, women are able to fulfil their potential, even when their success is measured on the traditional parameters—the attainment of hospital consultant or general practitioner principal posts and the achievement of post-graduate qualifications. However, it is not enough merely to ensure that women can avail themselves of these opportunities for part-time work. All those who wish to see women treated equally, and one must assume that Dr Hayden is among these, should press for future changes which ensure that men are able to play a fuller role in the domestic round.

Dr Hayden's suggestion that, by protesting, women have "frightened" their male colleagues, seems rather naïve. Without the efforts of such women, she would not have been able to reach her present position, and it ill becomes her to attack them. It may be tempting to