reasons why entry into these institutions is disliked so intensely by many patients is this dependence on others. Being undressed, lying down, and being controlled by others in a strange environment is a classic recipe for dependence. When invasions of privacy, both verbal and physical, occur frequently as well, it is hardly surprising that one of the characteristics of hospital patients is passive acceptance and toleration of dependency.

Because hospital doctors mostly see patients in a state of relatively great dependency, they may become more accustomed to it than colleagues who work with patients on their own territory, such as their own homes. Hence, intensive analysis of the appropriateness or inappropriateness of each form of doctor dependency, its rights or wrongs, has become an intellectual fascination principally of primary physicians. Such analyses now suggest that many hospital activities, especially admission itself, extensive investigation and frequent follow-up, may be potent methods of creating dependency.

Future

The advent of systematic preventive medicine or anticipatory care introduced a new dimension and a new conflict to the problem of doctor dependency. While general practitioners on the one hand are making great strides in reducing doctor dependency, particularly for minor medical ills for which health care at home is both logical and appropriate, they have simultaneously started to introduce a whole new range of settings in which patients are now being trained to be more doctor dependent than in the past.

Systematic case finding for hypertension is now common, and more and more fit, middle-aged adults are finding themselves being investigated, supervised regularly, and advised to take drugs on a long-term basis for a condition for which they often have no symptoms. In sociological terms they are being made doctor dependent. The onus must be on the profession to justify this change by the harsh standard of improved outcome, that is, by demonstrating a decrease in morbidity and mortality, as indeed it is now trying to do.

An important group of patients are the middle-aged women who become emotionally dependent on their doctors. They have emerged as one of the principal challenges for primary care in Western societies. How such problems should be managed is a topic of immense concern. In the 1940s such patients' real problems were often undetected and cloaked under psychosomatic labels. In the 1960s psychotropic drugs, which produced a new set of dependency problems, were all the rage. In the 1980s the same problems are increasingly being managed by non-drug psychotherapy, sometimes by other members of the primary health care team, and particularly by doctors through the technique of counselling.

Counselling today, in its commonly used sense, has the aim of helping the patient to help himself. This seems to offer, at present, the best theoretical chance of avoiding undue dependency. Counselling, when coupled with a firm policy of never prescribing unless it is really necessary and only investigating when the results are really relevant to management decisions, can help patients to take care of themselves far more than has been usual in the past.

Doctor dependence is sometimes inevitable and sometimes appropriate. In both hospital and general practice, however, it is all too often an unhealthy aspect of the doctor/patient relationship.

Reference

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Watershed in training

THE Fourth National Conference for vocational trainees was held at the University of Exeter from 15 to 17 July 1980. Previous conferences had been held at Newcastle, Edinburgh, and Oxford.

The conference was attended by about 200 trainees, representatives of many of the postgraduate educational organizations, and several regional advisers in general practice.

The three-day meeting, reported in this issue (p.636), sought to look at some of the important aspects of British vocational training and in doing so to involve as many trainees as possible.

During the months before the conference, a lengthy questionnaire was distributed to about 3,000 trainees in the British Isles and over 1,400 were returned in time to be processed on the university computer before the conference. The presentation of the results of the questionnaire by a team of five trainees and ex-trainees formed the academic highlight of the meeting.

Only two thirds of the trainees thought that their trainer gave "value for money in terms of teaching", and trainee satisfaction correlated strongly with the amount of teaching time per week the trainees thought they were getting. Standards in the training practice were also a cause for concern. Although about half the trainees reported that they had the use of a consulting room for themselves, more than half were dissatisfied with their practice libraries and almost two thirds

reported that they had not been shown any form of clinical audit in general practice.

As for the half-day release courses, trainee satisfaction correlated with the degree of trainee participation in the course, the use of small group methods, and experience of Balint-type groups.

The impact of these findings was immediate and dramatic. The balloon of complacency was burst. Many of those responsible for training in the various regions looked with concern at the detailed regional analyses which were posted on the notice boards at the conference. In some regions, for example, more than a quarter of all trainees reported that they were sometimes left on call without back-up.

At the end of the meeting, the conference in plenary session took a number of notable decisions which are likely to influence vocational training in Britain in the years ahead.

First, it endorsed the general framework of the conference and expressed its appreciation of the high degree of trainee involvement and participation including several trainee chairmen.

Secondly, it decided to develop strong trainee representation in all the regions, so that the trainee voice would be heard more loudly in the future. It decided to break the previous pattern of triennial conferences and, in future, hold conferences at least annually. The Trent region was suggested as the venue for the next one in 1981.

Finally, the Conference was careful to avoid aligning itself either to the British Medical Association or the Royal College of General Practitioners, and moved cautiously towards an independent existence, whilst welcoming College support.

The meeting ended by recognizing the considerable personal triumph of the trainee conference chairman, Dr Clare Ronalds of Exeter, with a memorable standing ovation.

Assessment

The pleasant, good humoured discussions led to mature and productive proposals. Whilst the many defects of training were fairly faced, there were many occasions when the constraints facing vocational training organizations were recognized and the meeting understood that it too lived in a real world of limited resources. Participation was widespread. The substantial number of women trainees spoke up and spoke out. The social programme was imaginative and entertaining and included a dinner, barn dance, and barbecue, which added greatly to the enjoyment of the meeting.

This National Conference was largely designed by trainees for trainees; the three organizing committees consisted of 12 trainees, two ex-trainees, two senior lecturers from the Exeter Department of General Practice, and the Dean of Studies from the College, all with a trainee chairman. The outcome was a degree of involvement and participation not previously achieved in a national conference for vocational trainees, nor perhaps for trainees in any other medical discipline.

For historical reasons the evolution of trainee groups and trainee organizations has inevitably been slow and haphazard and has developed at different rates in different regions. Although some schemes have for years had strong and active trainee groups, others have had none at all and the trainee voice in some regions has been weak and ineffective. The achievement of this conference was the waking of the sleeping giant, the 3,000 doctors now training for entry into the largest branch of the medical profession.

This conference marked a watershed in the evolution of British vocational training, which may never be quite the same again. July 1980 may have marked the time when an era of benign paternalism, which had previously characterized vocational training, changed to an era of more abrasive but productive partnership.

From now on trainees can be expected to play an active part in the whole process of postgraduate training for general practice. Their presence as partners in committees and conferences will be greatly welcomed and will undoubtedly be a powerful pressure for improved standards in the future.

Screening for neural tube defects

OF all the seven ages of man, the first is surely the most emotive. The arrival of a new baby is almost always the happiest of events, but when that baby is born severely handicapped it becomes one of the greatest family tragedies. Anything that can lessen that possibility is of enormous importance.

When Brock and Sutcliffe (1972) reported a detectable rise in alpha-fetoprotein in the amniotic fluid of mothers bearing a child with a neural tube defect there was at last a hope that anencephaly, spina bifida, and related defects might be reliably detected, the birth of sufferers prevented, and a tragedy that affects about 2,000 families a year in England and Wales avoided.

During the subsequent eight years much further investigation has gone on and much debate has ensued about the desirability of establishing a national screening programme. It has become apparent that there are considerable technical and ethical problems. Amniocentesis is expensive, time-consuming and not without risk, and although this might be justifiable if a group of