Trainees and training

DRAMATIC phrases like a "watershed in training" and "the waking of the sleeping giant" *(Journal of the Royal College of General Practitioners,* 1980) might safely be put down to exuberance once, but not twice: that would be rash. Since last autumn the giant has woken and is walking. With the publication of *Occasional Paper 18,* the National Conference of General Practice Trainees, now an annual event organized by trainees themselves, shows itself to be a potent forum of opinion and debate, a hitherto untapped organ for research, and a force for change.

The paper is in two parts. The first reports the results of a questionnaire circulated to trainees (as many as could be traced by the astonishingly inefficient methods available to regional advisors and course organizers). The second describes the 1980 conference itself. The heart of the paper answers the question "What do you think of it so far?" But to whom should those answers matter? And who must change as a result?

Advisors

Regional advisors will be profoundly affected by the results of the questionnaire. Ninety-nine per cent of trainees who had done a short attachment in general practice as an introduction to their three-year scheme thought it was a good idea. Yet, in three Scottish regions no such attachment was even offered, while 87 per cent of trainees did one in South-West Thames. Why are so few trainees in West Midlands, Wessex and North-East Scotland, and none at all in North Scotland, provided with a general practice study release course in their hospital jobs? What is going on in Mersey and Northern Ireland, where less than half the trainees think their scheme is well organized? And what does the JCPTGP plan to do in the North-West and in Devon and Cornwall, where the unmet demand for obstetric jobs is, respectively, four and three times the national average of 7 per cent; or in Northern Ireland, where the unmet demand for paediatric jobs is over twice the national average and where there is no integration of hospital jobs and the general practice year?

Regional study days are sporadic and patchy. Yet regional advisors can stimulate such activity and have the funds to support regional trainee groups, which can meet regularly and can act in an advisory capacity. And for course organizers, here is clear evidence that if trainees are encouraged to select their own topics for the release course, and are exposed to small group work and behaviour, they are more likely to consider their course worth attending.

Value for money index

A simple index is formulated to predict the likelihood of a trainer providing value for money for a trainee. The amount of teaching time spent with the trainee is decisive, and highly valued by trainees. But the most discriminating single piece of information about a trainer would be whether or not he or she was an MRCGP, so heavily do members score on the other elements of the index.

Regional General Practice Sub-Committees (of the Regional Postgraduate Education Committee) now have in *Occasional Paper 18* a widely representative statement, from trainees at least, of what trainers should be offering. Is there a practice library, containing general practice literature? Do the practice notes contain summary cards? Will the trainee be invited to partners' practice meetings?

The 1980 conference

The rest of the paper reports on the conference itself, and includes a manual on how to run a national conference. Appendices cover a lengthy analysis of the novel statistical methods applied to the questionnaire results. Some of it is daunting, but all of it is important: these data stimulated recruitment of a new technique—a demonstration of the vibrant co-operation between mathematicians and doctors which must flourish if research is to progress. The idiot's guide to the trainee parts of the DHSS's Statement of Fees and Allowances (The Red Book) is also particularly welcome.

Trainees marshalled themselves to produce this feast of information, some of which reveals restlessness and discontent. The paper treads the middle ground between some of the aggressive complaint and blinkered self-congratulation of the conference to produce constructive, valid criticism. Those involved have now to respond by change. The changes required are not radical, nor even new; but they require thought, work and a deal of diplomacy, not least from trainees.

The huge regional variations in training and the crucial part to be played by regional advisors stand out glaringly. It may be symptomatic that trainees in Mersey

and Northern Ireland volunteered so keenly to host the 1983 National Conference at the end of this year's conference in Sheffield. The floor scarcely considered the third offer from North-West Thames region, centred on the Hammersmith. Although the 1982 conference will be in Cambridge, perhaps trainees are now attaching more relevance to holding future conferences in regions of demonstrable need than in centres of excellence or even somewhere pretty, by the sea. If so, this decision is an admirably unconventional departure by the members of a caring profession.

References

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Fourth National Trainee Conference, Occasional Paper 18, is available from The Royal College of General Practitioners, 14 Prince's Gate, Hyde Park, London SW7 1PU, price £3.75 including postage. Payment must be made with order.

Suicide and deliberate self-injury

FAMILY doctors see many types of self-destructive behaviour, some of which, including tobacco and alcohol addiction, are excluded from the traditional definition of deliberate self-harm. Yet suicide and parasuicide (non-fatal deliberate self-harm) are problems of growing importance, the former as an indicator of potentially treatable depression, the latter as an expression of interpersonal stress, especially amongst young females. In a practice of 2,300 patients, a doctor could expect five self-poisonings a year and one suicide every four. Doctors themselves are at increased risk of suicide.

The incidence of suicide has been rising again, by 3 per cent per annum, since 1975, having dropped substantially in the late 1960s (OHE, 1981). Self-poisoning, which accounts for nearly all parasuicides, has increased at a dramatic rate in the last 20 years and now accounts for at least 15 per cent of acute medical hospital admissions (Matthew, 1975). An Office of Health Economics pamphlet, *Suicide and Deliberate Self-harm* (1981), has now examined which patients are at high risk and current methods of management.

Patients at risk

Although it has become clear that in many parasuicides the patient does not wish to die—hence the term 'attempted suicide' has been dropped—there is a big overlap between the two types of disturbed behaviour. Almost half of all suicides have a history of parasuicide, and about 1 per cent of parasuicides will kill themselves in the following year.

Self-poisoners, 'repeaters' and suicides are heterogenous groups. Personality disorders, alcoholism, drug abuse and unemployment are common in all three. However, self-poisoning most often occurs in females from social classes IV and V, who are under 40 years old, live in overcrowded conditions, have a history of divorce and have received violence from relatives, and who lost a parent in early childhood. A common precipitating event is a quarrel with a key person. Repeaters have often had previous psychiatric treatment, a criminal record (if male) and multiple previous attempts. Self-poisoning is usually impulsive; those young women who do it are not as a group of hysterical personality (Goldney, 1981).

By contrast, suicide occurs most commonly in men over 40 years old who are socially isolated and suffer from depressive or serious physical illness, or bereavement. They are most frequently from social classes I and V, and their acts are premeditated. Ovenstone and Kreitman (1974) subdivided suicide into the 'chronically disorganized' and the 'acutely disrupted'. The former often had a long history of psychiatric illness and social disruption, including repeat parasuicides. The latter had comparatively stable lives without previous parasuicides; the loss of a key figure or physical disability precipitated the suicide.

Parasuicide

Two thirds of parasuicides see their general practitioner shortly before the event and three quarters of self-poisonings involve 'prescription only' drugs. The drugs used reflected the prescribing trends in general practitice away from barbiturates and towards benzodiazepines.

A general practitioner may write 2,000 prescriptions for psychotropic drugs in one year, so that some method of identifying patients at high risk of self-poisoning is necessary. One way is to indicate this clearly on the front of the medical record with a coloured sticker which can alert doctors who are unfamiliar with the patient. Such a system needs a quicker method of transferring notes between general practitioners than we have now. Once the risk recedes, the sticker is removed.

When high-risk patients present with interpersonal problems, drug treatment should be avoided unless there is a specific indication, such as anxiety, which grossly impairs the patient's ability to cope (Hawton & Blackstock, 1977). Patients should be asked if they have considered taking an overdose. If drugs are used, sublethal doses only should be issued at any one time: 100 nitrazepam 5 mg are relatively harmless, whereas as little as eight amylobarbitone 200 mg (Sodium Amytal F33) can be lethal (Simister, personal communica-