Psychotropic Prescribing

Sir,
I was interested to read Dr Varnam's account of his self audit of psychotropic prescribing, flattered at his referral to my own efforts, but dismayed that it was so inaccurate.

He states "Wilks in his two articles (1975, 1980) has shown that while his barbiturate fell by over 80 per cent by 1976 he was still issuing prescriptions at a rate (sic) of 2,120 a year. In the light of this, my two prescriptions over a period of five weeks seems a more satisfactory result."

In fact 2,120 (Table 1) referred to the number of tablets prescribed, and of these 1,920 were phenobarbitone 30mg, the majority given for epilepsy. The barbiturate prescription rate per 1,000 registered patients was 10 (Table 3).

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References

Varnam, M. A. (1981). Psychotropic prescribing. What am I doing? *Journal of the Royal College of General Practitioners,* **31,** 480-483.

Wilks, J. M. (1980). Psychotropic drug prescribing: a self audit. *Journal of the Royal College of General Practitioners,* **30,** 390-395.

Asthma

Sir,
Your leading article (June *Journal,* p.323) poses the question of whether the general practitioner or the hospital should provide the long-term care for asthma.

There are many similarities between the long-term management of asthma and that of diabetes. Both require, at an early stage, detailed explanation to the patient of the nature of their disease and the qualities and uses of the drugs used in management: what to do in an emergency; when to seek medical help; how to use the devices to administer the drug; how to monitor the progress of the disease (urine testing or peak flow meter).

To achieve all these requires a considerable amount of time on the doctor's part and perhaps should be undertaken by the practice nurse or attached community nurse, holding regular monitoring clinics. In the clinical trial situation in asthma, this company has found it immensely useful to employ a nurse to undertake this type of work (Hogg, 1980). I feel that the experience learnt could easily be transferred to long-term clinical practice.

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Reference

Hogg, B. (1980). *Asthma and Intal: the Nurse's Role.* Loughborough: Fisons.

Section 63

Your editorial on reforming Section 63 (September *Journal,* pp. 515-516) welcomed the motion passed by the Conference of Local Medical Committees and the Annual Representative Meeting of the BMA that

> "in future regional general practice subcommittees for postgraduate medical education should i) determine the educational policy for both vocational training and continuing education in general practice; ... and iii) together with the regional adviser in general practice control the regional allocated Section 63 funds for general practice to carry out these educational policies."

It would be naive and foolish to expect, however, that an organizational change of this kind will necessarily lead to the reform of Section 63 activities. Your editorial notes some of the achievements of Section 63 activities—their number has multiplied in the last ten years; progressive policies have been followed in most regions and the majority of general practitioners have been enabled to attend courses. While all this is true, those who have read the Occasional Paper on the topic (Wood and Byrne, 1980) will know that this description conceals the real problems.

Although there have been exciting innovations here and there, it would be difficult to support the claim that the dominant character of Section 63 activities has undergone any dramatic change in the last decade. The bulk of activities continues to be built on the old didactic model which has not been shown to be effective in changing behaviour. There are marked geographical inequalities in provision; many activities are poorly supported and few appear to meet the needs of practising GPs as well as they meet the needs of the teachers. In addition, very little effort is made to evaluate the outcome of the time, money and effort that is spent on these activities.

There is no doubt that Section 63 activities are in need of drastic reform. The proposed change provides an opportunity to do things differently but does not go far enough. There are many forces resisting changes in the traditional pattern of Section 63 activities and their strength should not be underestimated. It remains to be seen whether this organisational reform will result in a pattern of local activities which are popular and can be shown to be effective in maintaining and improving standards of care.

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Reference

Wood, J. & Byrne, P. S. (1980). *Section 63 Activities. Occasional Paper 11.* London: *Journal of the Royal College of General Practitioners.*

Training Trainers

Sir,
In your editorial 'Reforming Section 63' (September *Journal,* p. 515) you state: "Some Deans and Clinical Tutors remain sceptical about educational theory and are fully entitled to their views". There are many practising general practitioners, including myself, who share this scepticism. Later in the same sentence you make the point that the vast majority of trainers have systematically prepared themselves for a teaching role. This proves absolutely nothing about educational theory or the amount of support for it, as those trainers have had no alternative but to attend trainers' courses, etc. in order to be selected as trainers.

This becomes a self-filling prophesy, i.e. you cannot become a trainer without attending a trainers' course and, therefore, all trainers have attended such courses. However, where is the evidence of any benefit for the trainer, the trainee, or, most important of all, ultimately the patient? I would very much like to become a trainer but feel extremely reluctant to spend a week being video-taped talking to other doctors pretending to be patients and learning jargon. Life is too short. I have no objection to others doing so, but should it be obligatory?

It is a salutary point that one can become a fully vocationally trained general practitioner without *any* paediatric experience, yet one's trainer *must* have attended a trainers' course.

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