tion system which, to the user, appears as a coloured screen in 'video arcade' type box. There are about 100 topics of health information and over 900 screens of information. Information has mainly been abstracted from leaflets supplied by the Health Education Board for Scotland and has been edited by health professionals in the Glasgow Institute of Public Health.

Between March and September 1991 six *Healthpoint* units were moved between 14 sites in and around Glasgow. Like the system described by Stanley and Tongue, *Healthpoint* included internal monitoring of the screens viewed. We also observed users, carried out interviews with users and conducted a questionnaire survey of potential users.[2] The five topics most frequently selected by the public were contraception, alcohol, the acquired immune deficiency syndrome (AIDS), women's health and sexually transmitted diseases. Unlike Stanley and Tongue, there was a similar selection of topics at each site.

Trying to put a value on such a service is difficult; there is no intention to charge for use but the 'willingness to pay' approach provides one estimate. Each unit costs approximately £3000 and assuming a conservative estimate charge of 10 pence per user, the approximate time needed to recoup the value of *Healthpoint* at each site was calculated. This took into account a 'discount' for abuse by children under 12 years and the number of days available during the week on average. Nine of the 13 sites would recoup the cost within the likely five year life of the machine.

In the second phase of evaluation, 10 *Healthpoint* units were moved to Clydebank, a town on the outskirts of Glasgow and placed in a chemist, post office, library, two in a health centre, social security office, public house, technical college, sports centre and housing office. After being in place for six weeks a street survey of an opportunistic sample of 300 people in the shopping mall on weekday mornings were interviewed (100 aged under 30 years, 100 aged 30–49 years, and 100 aged 50 years and over; 50% male). Only people who had been to at least one of the 10 sites were included in the sample. They were asked, for each site, if they had been there, if they had seen *Healthpoint* and if they had used it. Seventy four per cent had seen it and 25% of the 300 respondents had used it.

Both the report by Stanley and Tongue and our own experience show that the use of computers is a good method of making general health information available to the public.

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Detection of colorectal cancer

Sir,

David Mant and colleagues have discussed the importance of screening for colorectal cancer and the difficulties involved (January *Journal,* p.18).

Colorectal cancer is the commonest cancer in non-smoking men and second only to breast cancer in women, survival is related principally to the stage at which the disease is diagnosed and deaths from colorectal cancer outnumber those from cancers of the breast and cervix combined.[1,2] Since most colorectal cancers probably arise from benign adenomas, the case for population screening to detect these is strong but the methodology remains uncertain and cannot be recommended until randomized controlled trials have demonstrated a decline in mortality rates.[3] The best chance of influencing outcome therefore depends on early detection of symptomatic disease. In practice this means responding appropriately to patients with lower bowel symptoms, in particular to rectal bleeding.

In a recent questionnaire study of functional bowel symptoms in 1620 subjects registered with eight general practitioners, 20% had experienced rectal bleeding, 15% in the previous 12 months.[4] Only about one third of these patients had consulted a general practitioner. Rectal bleeding was found to be commonest in younger patients (30% in men aged 20–29 years, compared with 15% in men aged 50–59 years). Consultation rates rose with age and were generally higher in women. It is of concern, however, that 14% of people aged 40–69 years had experienced rectal bleeding and yet only 34% of these had sought medical advice.

In patients referred to hospital with a diagnosis of rectal bleeding, as high as 10% may have malignancies and 30% a neoplastic condition.[5] However the prevalence of these disorders in general practice is much lower and the proportion of patients with local ano-rectal conditions correspondingly greater. General practitioners have to tread a narrow and potentially hazardous diagnostic path between overinvestigation and inappropriate reassurance. With increasing age, the likelihood of malignancy rises and middle-aged and older patients deserve an adequate and well considered explanation for their symptoms.

A serious obstacle to early diagnosis is highlighted by Mant and colleagues: it can only be achieved if people accept the offer of a health check or consult their general practitioner. The major stimulus to consultation is concern about the potential seriousness of symptoms[6] and there is evidence to suggest that this may also influence the response to an invitation for a general health check.[7] Until the effectiveness of faecal occult blood screening in reducing mortality from colorectal cancer has been proven, there is a case for a sensitive initiative aimed at raising public awareness of the significance of rectal bleeding.

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The health of the nation from a local perspective

Sir,

Can general practitioners influence the health of the nation? When the Cambridge and Huntingdon Royal College of General Practitioners group discussed *The health of the nation,* the government's green paper,[1] it was concluded that what general practitioners do is not enough in isolation; we can only have some influence as part of an integrated policy for change.

When we considered smoking, one of our members described how his practice

had spent time and effort arranging an anti-smoking clinic. This was advertised well in advance and a time was chosen in the evening when people would be able to attend. However, only three people attended. It is difficult to see how primary health care teams can achieve targets for the reduction of smoking when tobacco products are still widely advertised and smoking is permitted in public places. People turn to smoking when they are under stress and find it easier to give up smoking when things are going well. It is arguable that if the government were able to reduce unemployment and improve housing, people might be under less stress and doctors might find it easier to help people give up smoking. However, the group recognized that it was important to do what we can and a start would be to have an accurate record of the smoking history of all patients.

The group felt that the green paper had overlooked musculoskeletal disorders, which not only cause considerable morbidity in the population, but also result in many days lost from work. We agreed that immediate access to practice based physiotherapy would be likely to make a big impact on the disability caused by musculoskeletal disorders, particularly back pain.[2]

We discussed mental health and felt that this was another area where social problems could be easily disguised as medical problems. Closing mental hospitals has to be matched by more resources in the community, both medical and non-medical, so that former patients have somewhere to go during the day.[3] We would like to see more practice based services with psychologists, counsellors and community psychiatric nurses taking an active part in every primary health care team.

We conceded that primary care is often inward looking, focusing its attention quite naturally on those patients who attend the surgery. It would be useful to have the resources to send members of the team outside the surgery, to talk in schools or work places for example. Family health services authorities could fund an educator who would educate teachers about asthma, diabetes and epilepsy and talk to children about the human immunodeficiency virus, drug abuse and so on, making it clear that they would be treated sympathetically on these matters at the practice. The district health authorities might also consider enhancing the role of the community medical officers in this respect.

The group felt that it was important that trials should be done to ascertain the usefulness of any new interventions.[4-6] The public seem to want screening and check ups (General manager, Cambridgeshire Family Health Services Authority, personal communication) and the government has an interest in providing the public with what they want. However, doctors would like to know that health promotion clinics for example had been shown to be successful in terms of reducing morbidity and mortality as well as being financially rewarding. There is no doubt that we are much happier advocating screening procedures such as mammography[7] which are of proven benefit.

The emphasis on teamwork and preventive care, together with inducements to increase list sizes, places more pressure on general practitioners to become managers and to offer less personal care themselves.[8] If this leads to more and better services for patients, then this is not a bad thing, although it was generally agreed by the group that we enjoy being good doctors. Whether this is an old-fashioned concept, or whether the definition of a good doctor is changing remains to be seen.

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Vocational training

Sir,

Dr Styles' interesting review of the training experience of doctors certificated for general practice (December *Journal,* p.488) relates only to the requisite number of hospital posts that a trainee has to complete in order to gain the Joint Committee on Postgraduate Training for General Practice statement of satisfactory completion. It is possible that some applicants may have had more hospital experience than recorded on the computer. However, the pattern of training has been disappointingly stereotyped and trainees have not taken full advantage of the flexibility offered by the vocational training scheme regulations. The majority do not wish to undertake any more training than is necessary and of course, there may be many reasons for this including the trainee's anxiety regarding the job market, career progression and social or domestic factors.

Too much cannot be read into the apparent rise or fall in the number of trainees gaining experience in a specialty as a particular training post does not predict the trainee's future behaviour as a general practitioner. Despite the staggering rise in the number of trainees acquiring experience in obstetrics, few show a high level of involvement in, for example, intrapartum care.[1] Therefore, a closer examination should be made of the type of training that each post offers, the attitude of the consultants, the core curriculum of training and the effects of training upon the trainee in terms of his/her attitude towards the specialty.

A well designed rotation allowing two-month attachments to a range of specialties with 18 months' training in general practice may be the best way forward. Those wishing to spend longer than two months in a specialty should also be able to do so but, perhaps, outside the scheme and as part of their higher professional training. In addition, assessment should be made of the effectiveness of some of the historical components of vocational training, such as half-day release and trainers' workshops.

Styles' study, in parallel with others[2-4] highlights an urgent need to take a fresh look at vocational training. The changes in society, particularly with regard to the role of general practitioners, give added urgency for such an appraisal.

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