NORTHERN IRELAND GENERAL HEALTH SERVICES BOARD

The following postgraduate courses for general practitioners have been arranged:

General courses

March 29–April 10	Belfast City Hospital
May 3–8	Altnagelvin Hospital, Londonderry
May 10–15	Lurgan and Portadown Hospital, Lurgan, Co. Armagh

Residential maternity courses

March 18–20	Royal Maternity Hospital
March 22–April 3	and Jubilee Hospital
May 3–15 and 17–29	Belfast

Application forms may be obtained from the **Postgraduate Education Adviser, Northern Ireland General Health Services Board, 27 Adelaide Street, Belfast 2.**

Correspondence

Some afterthoughts on the mental illness survey

Sir,

The mental illness survey has now been completed. It has been written up into two long papers, one of which has appeared in the *British Medical Journal* (1964) **2**, 135. The second paper will follow in due course, probably in some other journal.

This survey was a tremendous undertaking, and would not have been possible without the full support and the machinery of the College Research Committee. Looking back one can always see things which could have been done better, questions which have been left unanswered, and also possible projects for the future.

One of the main difficulties of such a large survey was to keep tags on the participating doctors, and to keep the project on a personal basis, and not some remote form filling ploy. When the participating practices run into hundreds, the liaison has to be maintained by way of contact doctors. Each of these should have an index card of his own, with the names of his colleagues below, and plenty of space for additions or alterations. The whole index should be maintained at a central point. In this survey there were two collecting points and it was found to be most difficult to keep an accurate list of participants. The final list was in the region of 437 doctors, but we were never happy about its accuracy, as with such numbers, over the year, addresses can change. In order to achieve a high level of efficiency with such a big team, and to increase the personal element the whole time, a liaison officer is really an essential. Every practice should be visited at least once, and the whole project discussed with the various doctors. We feel sure that in this way more uniform collecting would be encouraged, and many useful ideas would emerge. This sort of scheme would mean that the liaison officer would have to be freed from practice work for a time, to go on such rounds,

and his travelling and maintenance expenses would be considerable. To some extent this would be offset by fewer cards having to be sent back for completion at the end of the surgery, a procedure which was costly in time and postage. Unfortunately, the Research Adviser of the College was not appointed until well on in our survey, otherwise he might well have been the ideal co-ordinator of this survey.

While we think that general practitioners taking part in a scheme of this nature should be encouraged to contribute of their time and knowledge without any monetary reward for their labours, every possible step should be taken to see that no expenses are accrued by them. While prepaid postcards were enclosed in our survey, and certain expenses were covered from headquarters, the ideal of no financial loss to the collectors was not achieved. In the future, consideration must be given to this aspect, especially as so often it is the same practices who offer their services to so many of our surveys.

A number of items were missed from the survey which could have been most useful. A more extensive and critical analysis of a pilot survey might have avoided this. Examples of such omissions are listed below.

(1) Was the patient living alone?

(2) Has the patient any under school age children living at home?

(3) Were they affected? If so, in what way?

(4) How many severe but short-lived depressions occurred during the year which were not recorded by our methods of collecting?

(5) The records of 'other helpers' and 'other reporters' were incomplete, and I am sure that with better wording of the card or the instructions, we could have achieved better results.

To write up the findings of such a survey takes up an inordinate amount of time. The one to do this work should again be freed for a time from practice work, to write, and at the same time to be able to visit his co-recorders to discuss the final layout and so on. This extraordinary workload leads to long delay before the results of surveys are available, and much of the interest of the participating doctors may have cooled or shifted to other schemes.

This survey has shown a way in which a very useful prospective study of suicide and attempted suicide could be studied. Our figures showed that a group practice with 10,000 patients at risk would have about one suicide a year and some nine attempts, a case load of only ten patients in all, and with a well-prepared *pro forma*, such a task would cast no great burden on the collecting doctors. Many practices would be needed, but the work for each practice would be minimal.

To summarize

Surveys by a large number of general practitioners (437) are a practical possibility, when carried out by the organization built up by the College of General Practitioners.

Certain of the defects could be overcome by making available full-time co-ordinators or recorders, possibly general practitioners on sabbatical or research leave from their practices. More might have been achieved

in the final survey had a longer period been allocated for the pilot survey.

The writing up of communal research projects and surveys by large numbers of general practitioners, becomes an unduly laborious and delayed effort, and again should ideally be entrusted to general practitioners temporarily or partially freed from their general practice duties.

Applications for financial grants for such projects must, in future, consider the need to cover the recorders for such eventualities.

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Line and graph case records

Sir,

It was most interesting to read in the College *Journal* of November, 1964 of the method of line and graph case-recording developed by Dr Döhrn of Düsseldorf. I have found such a method of great value in studies of an epidemic, in obstetric antenatal case-notes, and, more recently, for Total Development Graphs using the College Classification of Disease (1963).

The method has the obvious advantages of encouraging accuracy of recording and allowing rapid assessment of progress. It also promotes the state of mind which neither takes the traditional pathological view of disease in a rather anonymous patient, nor the more recent statistical view of disease in a social group, but the family doctor's view of the individual under the influences of growth, environment and disease.

The accompanying illustrations show:

1. *A Total Development Graph*, using initially a scale of ½ inch to 1 year, followed by an exploded scale of 1/10 inch to 1 day to record a respiratory infection. This case is more complicated than the average and in practice the graph is clarified by the use of ball-point colours: black for diseases and symptoms, red for numerical graph lines, screening tests and prophylactic procedures, and green for treatment, which is noted more fully than shown in this example.

2. *An Antenatal Graph.* The height of the fundus is measured by obstetrical calipers. The foetal sketches represent presentation, position and degree of engagement of the presenting part. Colours used are black for B.P. and weight gain, red for foetal heart sounds, fundus and blood group.

The graph paper used is 10 squares to the inch. The page for total development graphs is quarto size, that for antenatal graphs 8½ inches by 6½ inches.

Waiuku, New Zealand S. R. WEST

Acknowledgement

I wish to thank the editor of the *New Zealand Medical Journal* for permission to republish "Graphic Recording of Antenatal Casenotes" (Correspondence, June 1961).