*President's Press**

The fecundity of committees is a never-ending source of wonder. These form sub-committees, joint committees and liaison committees, so that joining one usually leads to others. As I have already mentioned, Presidential office means membership of the Joint Consultants Committee, and as a result of this I have recently become one of the JCC representatives on the Joint Committee for Postgraduate Training in General Practice. This represents roughly the equivalent of the Joint Higher Training Committees in the various hospital-based medical specialties, such as our own JCHPT. Now that the necessary Act has been passed and general practice requires mandatory training before acceptance as principal in the Health Service, the JCPTGP has become very important. In its background, of course, is the work done for some years by the Royal College of General Practitioners with regard to their own Membership examination. Like us, they have their problems in organizing Approval Visits. Their numbers are enormous compared with ours, and the training practices are scattered over wide geographical areas. The GPs, of course, have on the whole been much less exposed to working in an academic atmosphere than many of our consultants, so that it has been important to make the visiting appear as unthreatening as possible. This is also complicated by the fact that vocational training for general practice involves two years of hospital work, and only minimal contact with general practice, followed by a year's full-time work in general practice. It has been agreed that the hospital posts the trainees will occupy will have already been approved for their own purposes by the appropriate Royal College. As RCGP posts are obviously in medicine and surgery, and certain sub-specialties, it is as yet uncertain what influence the JCPTGP can exert on the way these posts satisfy the GP trainees, as opposed to specialist trainees, and yet fulfil service needs of the hospital.

What comes out very clearly are the difficulties in the relationship to our own College training scheme. We tend to approve rotational schemes involving a number of posts in sub-specialties like psychogeriatrics, rehabilitation, alcohol, child psychiatry, etc. The GP trainee clearly wants to get a bird's-eye view of many aspects of psychiatry, but particularly experience in dealing with the management of acute disorders (and all in a maximum of six months), so there may be problems in accommodating the large number of trainees who will go into general practice.

Another striking and obvious omission of all Approval Visits is that none of us ever interview patients on our visits. We tend to judge the training post to be a good one when the trainee gets what we regard as good supervised experience. The relationship between this and what actually happens to the patient may not be straightforward. However, there are obvious and almost unsurmountable difficulties in getting a representative sample of patients. In our own subject, we have a sort of feedback that comes from patient groups, therapeutic communities, etc., and we are much more in touch with patients' relatives routinely than are most physicians and surgeons.

Clearly, mortality and even morbidity statistics are no real guide to the quality of general practice. I suppose it would not be impossible to arrange a survey of the treatment of common conditions in different sorts of practices, rather like Professor Jerry Morris did some years ago in teaching and non-teaching hospitals on appendicectomy, but I am not sure how relevant that would be to most of the qualities of general practice I would like to evaluate. GPs can obviously be good at particular aspects of their multifarious work. Some may be good at medical diagnosis; others at family crisis intervention and handling the psychosocial as well as the medical complications of life events; others may be good at the organization of practice; and yet others with particular patient groups such as children or marital problems.

In our own special relationship with general practice, a striking thing is the tremendous variation in the use of the hospital service by the primary care-givers. Some GPs almost proudly declare that they can do everything and need the psychiatric services only for long-term institutionalization or management of acute behavioural disturbance. Others want nothing to do with anything remotely psychiatric and hope that the psychiatric services can take all such patients off their hands. We have hardly begun to think about ways of assessing the value of different approaches. The general practice-hospital dichotomy noticeable in training continues into practice, and the Department of Health's enthusiasm for trying to shift work into the community is in some way causing a bit of a backlash.

It is obvious from several studies going on at the London Hospital by Colin Parkes, Stephen Wolkind and others that the traditional out-patient referral type of practice is not appropriate for many problems. There is a Catch 22 situation when little or no money is available for new resources. People then resist depleting already understaffed hospital-based services for the sake of community-based services which sometimes merely seem to unearth more patients rather than deal more effectively with those who might otherwise have to be in hospital. One example of the difficulty is seen in the role of the community psychiatric nurse, who is increasingly regarded as a most valuable member of the psychiatric services. She is our main ally in the community for patients discharged from residential care. In some places, however, she is primarily attached to general practices and may be the first person in the psychiatric services to be turned to by the GPs for many problems, thus enormously

*See also 'General Practice Trainees in Psychiatry' on page 93 of this issue.

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expanding her role. As usual, there is a tendency to evaluate these services in terms of how well they are received by the professionals rather than whether the patients get any better!

Some members of the RCGP have recently started interesting pioneering work on patient participation groups in relation to practices. The April issue of their College's *Journal* contains an account of a meeting at the beginning of this year showing that on the whole these groups are of great value, though there have obviously been problems on how to recruit the right sort of person into them. If medicine is seen as a service to the community, those who would be interested in how good it is need not necessarily be patients, or even relatives of patients. As a sort of general practice equivalent to the Community Health Council, they may well have more value than the hospital-based groups which, as is well known, have had a very mixed reception.

I, personally, have been very stimulated by contact with these new advances in community health care, and for once have not been sorry to find myself on yet another committee. I wrote this just before leaving for a trip around various countries in the Far East, from which I will have returned by the time this is in print. I expect my trip may give a different slant to my thoughts on medicine in the community.

Desmond Pond

A Case for Clinical Research

By Ming T. Tsuang

My psychiatric orientation is deeply rooted in my student days at 'The Maudsley', and my study at the then MRC Psychiatric Genetics Unit under Eliot Slater moulded my 'British approach' to psychiatry. My understanding, (with which the reader may not agree) of this approach is that it is *clinical, empirical and practical.* After I left Britain in 1965, I participated in the International Pilot Study of Schizophrenia (IPSS) as an investigator from Taiwan, and I firmly believe that the study could not have been done without the British group's contribution, for the success of IPSS was due to the application of these same clinical, empirical and practical approaches.

In 1971, I moved to the United States, but 'British orientation' has continued to dominate my psychiatric work ever since. I have found that the day-to-day practice of treating patients is the best source of new ideas for clinical research. In my own experience of running an in-patient service of the University of Iowa Psychiatric Hospital, I have learned much from my patients, medical students and colleagues. Medical students sometimes ask questions which seem naive or simple, and which we often answer without serious consideration; in fact we may mislead them with answers based not on facts but on our own 'experience'. Often we search the literature only to conclude that we cannot answer their questions without conducting some pilot research of our own, and it is when a pilot study is initiated out of such clinical necessity that residents feel it to be useful and not merely of academic interest. There is a misconception among some clinicians that research has to be perfect and highly sophisticated and that detailed knowledge of methodology and statistical analysis is always essential, and many are consequently scared away. We are not all born to be mathematically minded. Many interesting and important clinical observations based on small numbers of cases have been made without the need for statistics. Obvious results do not need any statistical test to show a 'P level of significance'. In fact a significance level may give results a misleading air of authority, by which clinicians may be blinded and fail to pay attention to sample size, or to the characteristics of the population from which the sample was drawn.

Another misconception is that to carry out good research one has to have an adequate grant for a full-time job. That is not true: many good pilot studies have been conducted by busy clinicians who did not seek additional funds. Of course, to confirm or refute the results of clinical pilot studies, to test some hypothesis, or to look at aetiological problems on a large scale, time, money and sophisticated research methodology are certainly needed.

But every clinician can be a researcher too, depending on whether he is interested in solving his own clinical problems or satisfying his own curiosity. If research is combined with clinical activities, much time and energy can be saved. It should become a habitual pattern of his daily clinical practice to ask and try to answer questions, even if he is working with a small sample.

Practical and clinical considerations apart, I feel that clinicians who are involved with patients have a responsibility to identify problems and carry out pilot studies for non-clinicians who conduct basic scientific research, because we cannot afford to let our non-clinical colleagues take over completely research dealing with clinical problems. We cannot criticize them for doing studies with no clinical relevance, if we do not tell them about our own clinical problems and provide them with new ideas for research. We should continue to collect clinical, empirical and practical data, even