problems with a doctor, nor had they sought other methods. Clearly widespread prescription of the pill is not a panacea and an efficient follow-up and advisory service is essential.

Of the patients given terminations almost one-fifth were sterilized or their partners underwent vasectomy. Of the remainder three-quarters received contraceptive advice from their general practitioners or from local authority family planning clinics. Unfortunately nine patients returned to their daily lives after termination without arrangements being made for regular contraceptive advice. This is disturbing.

HEALTH SERVICE AND PRIVATE MEDICINE

All consultations with general practitioners in our survey took place under the N.H.S. Altogether arrangements were made for 88 specialist consultations, of which 70 were Health Service and 18 private. A private sector in Somerset of just over 20% of referrals is slightly smaller than that reported in Hertfordshire (25%) by Eames *et al.*[2] Not unexpectedly the partners of these women were drawn exclusively from the top three social classes. Only six patients actually chose private consultations for themselves, however, and in the remaining 12 cases the decision was taken for them by the general practitioner. The reasons given to justify these general-practitioner decisions were varied and included: speed and efficiency (3 cases), grounds for termination were minimal and referrals to a private clinic guaranteed termination (2 cases), and case for termination was not sufficient to justify the use of an N.H.S. bed (7 cases).

The replies indicated that some general practitioners act on the belief that the Abortion Act is operated with a lower threshold in the private sector than in the N.H.S. The protection of Health Service resources is interesting, especially as it influenced the direction to private medicine of 10% of all referrals. Such considerations surely do not arise as often in any other kind of Health Service consultation in general practice. Some minor redistribution between private and public sectors was carried out by the consultants. Four women referred privately were transferred to the Health Service, and seven of the 12 who were refused N.H.S. abortion subsequently obtained it privately, often by another consultant. Only once was the lack of an N.H.S. bed given as a reason for refusal.

As there can be no waiting lists for termination some rationing of the demands on N.H.S. resources is being exercised by the profession. It is curious that this is being performed mainly by general practitioners, for the consultants should be better able to judge the pressure on N.H.S. beds at any point in time. On the other hand, the inference is clear on the availability of resources between the two sectors—no one was refused a private abortion by a consultant in this survey, whereas the refusal rate was 19% under the Health Service.

We thank the Somerset Local Medical Committee, the participating general practitioners, and the consultant gynaecologists for agreeing to this exercise of self-analysis.

Requests for reprints should be addressed to Dr. A. Parry Jones, Health Department, County Hall, Taunton, Somerset.

References

[1] Cartwright, A., and Waite, M., *Journal of the Royal College of General Practitioners*, 1972, Suppl. No. 1, 22.
[2] Eames, J. R., Jamieson, J., and Hall, J., *Practitioner*, 1971, 207, 227.

Gazetteer of General Practices in the Aylesbury Area

B. L. E. C. REEDY, E. ROSEMARY RUE

British Medical Journal, 1973, 3, 92–95

Summary

One reason for defects in communication between hospitals and general practitioners may be that hospital staff lack information about local practices. We compiled a handbook giving information about 55 (86%) of the practices which use the district general hospital group in Aylesbury. This included biographical details about each doctor in each practice, when he was available on the telephone, what ancillary staff worked in the practice, and so on. The handbook was given to 500 staff in all grades and departments in the group. It seems to have been effective in improving communications, relationships, and morale within the area.

Medical Care Research Unit, University of Newcastle upon Tyne, NE2 4AA

B. L. E. C. REEDY, M.B., M.R.C.G.P., Lecturer in Community Medicine

Oxford Regional Hospital Board, Oxford OX3 7LF

E. ROSEMARY RUE, M.B., M.R.C.P., Senior Administrative Medical Officer

Introduction

The National Health Service's undoubted problems of communication have been the subject of exhortation, measurement, and attempted remedy ever since its inception—and they have been mentioned in a variety of publications.[1-9] In discussion about the relations between hospital and general practitioner or hospital and local authority there has been a tendency to make the hospital the whipping boy in the controversy. Lefever and his partners[10] aired their disquiet in public recently, but also showed their awareness of the wider issues underlying their problem. In part they attributed it to lack of appreciation by hospital staff of the organizational and clinical problems of general practitioners. They also assumed that " . . . the hospital doctor usually does at least know whom to telephone or write to . . . "—but this was an assumption which, with its implications, had already been challenged by Loudon[11] who questioned junior and senior members of the staff of the hospital in which he carried out his survey. Repeatedly he found that for all aspects of clinical organization and administration in general practice "these (questions) showed an almost total lack of any knowledge of present trends in general practice by a majority of the staff."

Before communication is possible the respondent must be identifiable and something known about him, and it is perhaps the assumption by general practitioners that hospitals have this information about them which is partly at the root

of the problem. In fact the boot may be on the other foot so far as the availability of information is concerned. Nearly all general practitioners have worked in hospital as postgraduates as well as undergraduates, and many hospitals make information available about themselves in yearbooks and annual reports, outpatient timetables and staff location charts, duty rosters and telephone directories, and these are usually available free of charge to general practitioners and their staffs.

Possibly hospitals (and local authorities and now social services departments) have never had enough information about practice organizations to achieve rapid and effective communication with them and with individuals in the organizations. However, there is no record of any systematic attempt to present a consensus of information about general practices in a functional area, such as the catchment of a hospital group, nor any attempt to measure the perceptions and attitudes of hospital staff in relation to a group of practices.

A new edition of an information handbook published by the Glasgow Division of the B.M.A.[12] gives a comprehensive and detailed account of hospitals, local authority health services, social services, and voluntary services, but completely omits general practices, which reinforces our supposition that they are seen as being unapproachable for this purpose.

One of us had already done research involving all the general practitioners in the Oxford Region[7] and the other had been an established principal in general practice in the locality for 10 years. The climate of general practice in the Oxford Region seemed right for us to try to produce a compendium of information about general practices—and the whole project was given impetus by the growing discussion about integration of the National Health Service.

Method

In April, 1970 discussions were begun with the Oxford Regional Hospital Board on the form for a project of this kind. We aimed to produce a handbook giving essential and accurate information about each one of the practices using a district general hospital group, for distribution to hospital staff and also the staff of the local authority and social services department. Three kinds of information would be included.

(1) Purely utilitarian, such as address and telephone number, working hours, names and appointments of lay and professional staff, and the hours at which each doctor made himself available during the day to receive telephone calls and conduct consultations and discussions over the telephone.

(2) Some idea of the size and degree of complexity and sophistication of the organization. Thus appointment systems, special design features of the building, the degree of attachment and capacities of local authority staff, unusual instrumentation, hospital appointments, teaching and research capacity would all be indicated.

(3) That which would encourage the formation of personal relationships, particularly on a first name basis. Thus, wherever possible, staff of all kinds would be encouraged to to give their usual first names for inclusion in the handbook.

We next consulted the B.M.A.'s Central Ethical Committee, and after a sympathetic discussion of the project the committee recommended the exclusion from the handbook of many of the more contentious items in category (2), to which we agreed, recognizing the expedience of doing so. Another obvious requirement was the limitation of the handbook's circulation, and this was secured by a personal distribution and a note on the title page "Circulation restricted —not to be made available to the public." In the nine months since its distribution we have not heard of any problems in relation to this.

The project also had three research opportunities. (1) The ability to identify and describe the anatomy of the general practice organizations forming the de facto "district" of a district general hospital. (2) Measurement of the actual use of the handbook by hospital personnel. (3) A study of some of the perceptions and attitudes of hospital personnel towards general practices and their staff. The results of these studies will be published later.

We decided to use the Aylesbury district general hospital group (Royal Buckinghamshire and Associated Hospitals Management Committee) for the experiment, partly because the group's area was geographically well defined and relatively small, and partly because many of the general practitioners were known to one or both of us. There were the added advantages that the area corresponded roughly to the North Buckinghamshire areas of both the County Council health department and the newly formed social services department, both of which were to be involved in the distribution, though only marginally in the research for methodological and practical reasons.

The project was accepted on this basis by the Nuffield Medical Centre for Combined Research at Aylesbury and funded by the Oxford Regional Hospital Board. The consultants, the senior nursing and administrative staff of the hospital group, the County Medical Officer of Health, and the Director of the Social Services Department were enthusiastic and helpful. The Buckinghamshire Local Medical Committee found the project to be unexceptionable with the proviso of confidentiality in relation to the general public. In view of this approval the Executive Council did not feel that it need be formally consulted.

The principle adopted was to include all general practitioners and practices making any use at all of the inpatient, outpatient, or service department facilities of the group's hospitals—most of which are in the immediate vicinity of Aylesbury. It was obviously out of the question to use the same criterion, for the three regional units in rheumatology, plastic surgery, and dental surgery, and the national spinal injuries unit at Stoke Mandeville Hospital. These were, however, included in the distribution of the handbook. Strangely, there was no formal record at that time of the practices using the hospitals, nor any analysis of the kind of use made by each one. Practices were identified for us by the chief records officer, using the list of towns and villages in the local medical list and the H.M.C.'s own map of its assumed catchment area (delineated by a perfect circle on the map), which included parts of some neighbouring counties.

For the general practitioners and practices identified as using the Aylesbury hospital group, three sets of questionnaires were prepared to elicit the following: (1) information about the whole practice organization (address, telephone number, appointments system, staff details, etc.); (2) information about each principal and assistant (names, qualifications, date of registration, medical school, etc.); and (3) information about branch surgeries. (Later this was felt to be of marginal interest and was omitted from the handbook.)

After a control period of observations on incoming communications in seven group practices and health centres in Aylesbury, the handbook was distributed in mid-July, 1972

Response to Questionnaires

	Principals	Partnerships	Main Practice Premises
Total No. circulated	181 (100%)	64 (100%)	75 (100%)
Usable response (after a reminder and re-circulation)	156 (86%)	55 (86%)	66 (88%)
No reply after reminder	14 (8%)	5 (8%)	(5)
Asked to be excluded from handbook	11 (6%)	4 (6%)	(4)

as follows: Hospital Management Committee, 500 copies; County Council Health Department, 250 copies; Social Services Department, 100 copies; Executive Council (for all practices), 175 copies.

A second period of observations was carried out in the seven practices in November and December, 1972 and a questionnaire was sent in January, 1973 to all the hospital staff who had received a handbook. The results of these observations and their implications are also being analysed, and will be included in a later publication.

General Practice Response

The response to the questionnaires is given in the table. In addition to the principals there were eight assistants and two trainee assistants. With one exception none of these was included in the handbook. No branch surgeries are included, but eight partnerships had two main surgery premises and one partnership of three general practitioners had three main premises. All these were staffed and "at risk" at all times for a list of patients and were therefore treated as separate systems for communication purposes.

Most of the partnerships who failed to respond probably did so because they felt that they made insufficient use of the Aylesbury hospitals to warrant their inclusion in the handbook. Nevertheless, one partnership of doctors is known to make fairly extensive use of the hospitals and its absence from the handbook was remarked on in the hospital questionnaires by several staff from various departments. Four partnerships asked to be excluded, at least temporarily, from the handbook mainly for the reason that they were undergoing various organizational changes in the near future.

The degree of co-operation from the general practitioners and their staffs could be judged from the generally scrupulous way in which the questionaires were completed. In addition 95% (142) of the doctors committed themselves to a range of times each day during which they would be available by telephone for discussions with colleagues and 71% (106) gave their home telephone numbers, some of them ex-directory, for use in the handbook. Though this information was not needed for the handbook itself 80% (44) of the partnerships disclosed their total list size—traditionally regarded by general practitioners as sensitive information.

Format of Handbook

The information about each practice was typed by the Regional Board's staff on A4 paper. During photolithography the size of the printed pages was reduced to give a $4\frac{3}{4}$ by 6 in. (12 by 15 cm.) pocket book in which 88 pages were formed by centre-stapling and surrounded by plastic-surfaced soft covers. A total of 1,500 of these cost £260 to print and make.

The pages were arranged alphabetically by the names of the towns in which the main surgeries are situated, with the details of one practice on each page. (The illustration below gives false names, address, and telephone numbers, but is otherwise a replica of a typical page.) This arrangement seemed to justify the title "Gazetteer of General Practice in the Aylesbury Area" which appears on the front cover in black on orange over an outline map of the district. A short foreword is followed by a longer introduction in which the purpose of the gazetteer is set out. The proscriptions of the Central Ethical Committee were legitimately avoided here by making general statements about the extent of local authority staff attachment, access of general practitioners to pathology and radiology services, cottage hospital beds, and maternity hospital beds. An index of main surgery premises by towns is followed by an index of doctors' names, and then by a list of the standard abbreviations used throughout the body of the gazetteer, as follows:

T	... ...	Telephone number
HTN	... ...	Home telephone number
FAS	... ...	Full appointment system
NoAS	... ...	No appointment system
SOS	... ...	Surgery open and staffed
DNS	... ...	District nursing sister
TRS	... ...	Treatment room sister
MW	... ...	District midwife
HV	... ...	Health visitor
SocW	... ...	Social worker
AVT	... ...	Available for telephone consultation/discussion
OD	... ...	Off-duty

AYLESBURY

DRS JONES WHITE AND SMITH

Meadowfield Surgery 216 Meadowfield Aylesbury Bucks
T Aylesbury 21960 Appts 21888 FAS

SOS 0800-1900 M Tu Th F 0800-1700 W 0815-1200 S
Sec/Recep Mrs Gillian O'Brien Mrs Pamela Storey
Miss Hilda Armstrong

DNS Mrs G Maxwell Aylesbury 20504 Mr E Dudley Aylesbury 23279
TRS Mrs G Maxwell 1100-1200 M Tu Th F

MW Miss N Lloyd Aylesbury 27641 Mrs Logan Aylesbury 23560
Miss J Harper Aylesbury 80152 0900-1000 daily
SocW Mr M Stone Aylesbury 54261

Dr John JONES MB BS MRCGP DObstRCOG Guys 1950
AVT 0900-1100 M-F 1600-1730 M Th
HTN Aylesbury 84590

Dr Sheila WHITE BM BCh MRCGP DCH Oxford 1956
AVT 0900-1230 M Th 0900-1100 W 1700-1800 M Tu Th F
HTN Aylesbury 50292

Dr Kevin SMITH MA BM BCh DObstRCOG St Mary's 1962
AVT 0900-1100 M Tu Th F 0900-1100 W

OD between partners and with Drs Long and James

Discussion

After the handbook had been distributed several appreciative letters, particularly from consultants, made it seem as though it might fulfil its purpose. Moreover, a preliminary analysis of the first 170 returns from hospital questionnaires shows that 74% of all grades of staff from all departments are claiming to use the gazetteer "occasionally" (54%) or "frequently" (19%), while 26% "never" use it or did not receive it. Of those that claim that they are using it, 74% do so as much now as when it was first distributed, while 15% use it less now than they did at first.

Even without formal experimental proof of the gazetteer's effectiveness at this stage, it is still possible and reasonable to suggest that area health authorities should make the production of a directory of the health and social services facilities in the area an early objective. Keeping this up to date will be the central problem and there is anecdotal evidence that many of the practices included in the gazetteer have already changed considerably since the information on which it is based was first obtained.

As for the practices involved, each one knew exactly the purpose of this gazetteer when it gave the information asked for, and it is interesting to speculate how far a kind of "double bind" or coercive effect was operating on them. Certainly the

absence of some practices from the gazetteer has been generally noticed, and equally there were some complaints subsequently from a few general practitioners that they were not included (they had not returned the questionnaires) and that it was their reception staff and attached nurses who had demanded to know why.

Of equal interest perhaps are the developments in general practice which the production of the gazetteer implies. An exercise of this nature and displaying this kind of information about virtually all the practices of an area would have been unthinkable a few years ago. It shows that general practitioners may be less defensive than they were and more outward-looking and reinforces the recent observation concerning ". . . the increasing readiness of general practitioners to provide data about their work and their readiness to discuss its quality and significance."[13] Moreover, though general practices are traditionally isolated and suspicious of each other, consensus of a sort must always have existed in some degree to allow medicopolitical bodies and postgraduate training programmes to function. The fact that it has been possible at all to create a handbook of information given about themselves by most of the general practitioners in a "natural district" shows that an embryonic consensus of the kind needed can be created by collaborative effort. We were only the catalysts in this enterprise and any credit for it belongs to all the general practitioners whose willingness to co-operate made the gazetteer possible.

We are very grateful for their encouragement and help to Dr. J. A. Oddie, Dr. J. J. A. Reid, Miss P. Clowes (Director of Social Services, Buckinghamshire), and the consultants and administrative staff of the Aylesbury hospitals. Dr. J. McLuskie and the Buckinghamshire Local Medical Committee were very co-operative. In particular, our thanks are due to Mr. K. H. Robbins (Group Secretary) and Mr. K. W. Clarke (Clinical Services Officer), and to Mrs. Waterworth and Mrs. Wilson for considerable secretarial help. The project would have been impossible without Mrs. S. O'Neill, who acted as secretary, co-ordinator, liaison officer, and research assistant in addition to her usual duties in the practice.

References

1 Ministry of Health, *Communications between Doctors, Nurses and Patients: An Aspect of Human Relations in the Hospital Service*. London, H.M.S.O., 1963.
2 King Edward's Hospital Fund for London, *Working Together: A Study of Co-ordination and Co-operation between General Practitioner, Public Health and Hospital Services*. London, K.E.H.F.L., 1968.
3 Ministry of Health, *The Field of Work of the Family Doctor*. London, H.M.S.O., 1963.
4 McLachlan, G., *National Health Service Twentieth Anniversary Conference*. London, H.M.S.O., 1968.
5 Hockey, L., *Care in the Balance*. London, Queen's Institute of District Nursing, 1968.
6 Wessex Regional Hospital Board, *What Do They Really Want?* Oxford, Alden Press, 1964.
7 Rue, R. E., and Golding, D. E., *The General Practitioner and the Hospital Service in the 1970's*. Oxford Regional Hospital Board, 1969.
8 Rhodes, P., *British Medical Journal*, 1968, **4**, 509.
9 Maxwell, R., *British Medical Journal*, 1973, **1**, 160.
10 Lefever, R., West, J., and Trevelyan, T., *The Times*, 23 September 1972, p. 15.
11 Loudon, I. S. L., *The Demand for Hospital Care*. Oxford, United Oxford Hospitals, 1970.
12 British Medical Association (Glasgow Division), *Doctor's Handbook*, 3rd ed. Glasgow, B.M.A., 1972.
13 *Journal of the Royal College of General Practitioners*, 1972, **22**, 205.

Outside Europe

Regionalization of Medical Education at McMaster University

W. B. SPAULDING, V. R. NEUFELD

British Medical Journal, 1973, 3, 97–100

Since confederation in 1867 the Canadian provincial governments have been responsible for education and, in recent years, for most aspects of health. With nudging and financial inducements from the federal government, in the last decade each province has provided universal health insurance, and once the provincial departments of health became responsible for the adequacy of medical care they naturally became concerned about medical education.

Ontario occupies 412,582 square miles, an area more than four times that of Great Britain. The population reached 7·7 million in 1971, four-fifths of whom live in the southern one-tenth of the province (fig. 1). Abundant ore, lumber, and fertile land are valuable natural resources. People live under varied circumstances: from lonely isolation in northern areas to urban crowding in populous Toronto (two million).

In 1959 the Ontario government sponsored comprehensive hospital insurance; 10 years later the government introduced insured medical services. At each stage the government wisely enlisted planning help from industry—both labour and management—and from the professions—medical, legal, and other. The Ontario Council of Health was formed in 1966 as the senior advisory body to the Minister of Health and, through him, to the Government of Ontario. The Council submits recommendations to improve medical services and to ensure effective employment of the necessary human and physical resources. Its members are selected to reflect a reasonable balance of public interest, expert knowledge and experience, as well as geographic distribution,[1] and it has already published an impressive series of reports (see Appendix).[2]

Early in its history the Ontario Council of Health recognized the need for an organization which could respond to distinctive regional needs and allow efficient use of health personnel and

Department of Medicine, McMaster University, Hamilton, Ontario, Canada
W. B. SPAULDING, M.D., F.R.C.P.(C.), Professor
V. R. NEUFELD, M.D., F.R.C.P.(C.), Assistant Professor