CHAIRMAN: It's often said that patients have great difficulty in formulating their complaints—do they need some help here?

MR. KLEIN: We will have to wait for the report of the Davies Committee on any changes in hospital procedure. But the introduction of a Health Commissioner should help a great deal. He will only investigate complaints after the hospital authorities have been given a chance to deal with them. The trouble is that many laymen are going to find it hard to articulate complaints—again this could be a role for the community health councils.

Stimuli by Outside Organizations

CHAIRMAN: What are your reactions to the type of questionnaire investigation that the Consumers' Association has recently been undertaking. This asks such questions about doctors' surgery arrangements and the patient's experience of his practice, about clinical problems ("which of the following would you consult your doctor about: for no particular reason, feeling tired all the time—for over 3 weeks; depressed for 3 weeks or more; being overweight; difficulty in sleeping for about a week; giving up cigarette smoking; travel sickness before going on holiday; skin problems; family problems.")

DR. SMITH: I've no objection to it: it could provide useful information for patients and G.P.s. We've had our own trainees asking patients some of these questions already. The answers are exactly what we want to know about where our organization goes wrong.

DR. PYKE: I'm very suspicious about the clinical questions—you can't stratify things in this way: "Have you consulted your doctor about depression or sleeplessness, how sympathetic and helpful was he about this? very sympathetic; sympathetic; not particularly; not at all sympathetic." Somebody will pick up some result like "Thirty-five per cent. of patients going to this hospital or doctor are not satisfied." What does it really mean?

DR. SMITH: There's still too much mystery behind medicine; this approach isn't a bad thing.

DR. PYKE: It's risky to start asking selective questions. There's

certainly a need for management studies, but it's extremely difficult to sort out the multitude of answers to clinical questions.

MR. KLEIN: My doubts are about the technical design of the whole exercise: chiefly about the size of the sample and asking these questions by post. General practitioners ought to do this sort of thing themselves.

DR. SMITH: I'm sorry the Patients Association hasn't been more effectual; their pronouncements seem terribly muddled.

DR. PYKE: I agree: the standard of their evidence to Mrs. Renee Short's committee was very poor. But, again, conceivably the association's existence has had a catalytic effect.

MR. KLEIN: On using patients as teaching material?

DR. PYKE: I think that the question of using patients for teaching has been greatly exaggerated as a problem; provided doctors treat their patients with ordinary courtesy, everything is all right. If asked, patients are almost always happy to be used in this way. Indeed, I find it often quite moving that patients are so helpful. Incidentally, medical students are now much more sensitive than they used to be of patients' feelings. Most complaints have related to poor communications, but remember that even when doctors have told patients something three times over, they may still be reproached for "not telling you anything."

DR. SMITH: We don't get complaints about teaching in general practice, perhaps because it's in the G.P.'s own interest not to antagonize his patients. This is presumably why the Patients Association has never complained about this.

MR. KLEIN: I should have thought there was a strong case for the B.M.A., say, subsidizing a new, more efficient type of patients association. To make sensible criticisms is expensive and time-consuming and it would be in the doctors' interests to help patients make suggestions which would improve the standards of care all round.

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Contemporary Themes

Relation between Radiographic Categories of Coalworkers' Pneumoconiosis and Expectation of Life

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Summary

A 20-year follow-up of the male population of the Rhondda Fach, examined in 1950-1, has been completed. Survival rates for miners and ex-miners appear independent of the x-ray category of pneumoconiosis except for category B or C, where survival rates are much reduced.

Introduction

In 1950-1 the epidemiological section of the M.R.C.'s Pneumoconiosis Research Unit completed their first radiographic survey of the Rhondda Fach. The population was described in 1952.¹ To assist readers who are unaccustomed to the specialized terminology of coalworkers' pneumoconiosis, the classification in use during the survey is shown in the figure. This was later incorporated in the international classification. (International Radiographic Classification of Coalworkers' Pneumoconiosis, Geneva 1958). The population has been followed up and studied on many occasions. From the point of view of this paper the most important study was that on a six-year follow-up of the males over 15.² The results of that paper can be summarized as follows.

(1) Those whose original radiographic categories showed

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X-ray classification of coalworkers' pneumoconiosis.

progressive massive fibrosis (P.M.F.) (category A, B, or C) had high standardized mortality ratios (S.M.R.s).

(2) There appeared to be no differences in the S.M.R.s of those with original x-ray category 0 and those with categories 1, 2, and 3 combined.

(3) The S.M.R. of the non-miners was lower than those of the miners and ex-miners with categories 0 or 1, 2, and 3 combined.

The number of deaths on that occasion was not large enough to be certain of the interpretation of these findings, so it was decided to attempt a 20-year follow-up of all the males in the original survey. The objective, so far as this paper is concerned, was to confirm or refute the previous findings.

Technique and Results

The x-ray coverage of the male population, aged 25 or more, of the Rhondda Fach in 1950-1, as redefined later, is shown in table I, together with the extent of the 20-year follow-up. The main technique was our usual one of home visiting and letter-writing. At approximately the 97% level of the follow-up we started co-operating with Mr. D. J. Smale, of the Office of Population Censuses and Surveys. The results of these studies will be published separately. The end result is that we believe that we have traced and determined whether they were alive or dead 20 years later all but 10 of the original population. Death certificates were obtained for all the deaths and coded by the Registrar General's department. We agree that there is always the possibility of residual error, but we believe that it must be very small. We therefore claim that the possible biases introduced by low radio-

graphic coverage (except for those over the age of 75 in the original population) or poor follow-up are so small as to be negligible.

The material has been analysed by means of life tables. The numbers in each age category available for follow-up are given in table II. The associated high incidence of pneumoconiosis was, of course, not typical of British mining areas in the 1950s. The incidence in the Rhondda Fach was probably one of the highest. The 20-year survival rates are shown in table III. The results, in the first place, confirm our previous results in greater detail that the S.M.R.s for category 0 and categories 1, 2, and 3 were much the same. The new point to emerge is the similarity of the survival rates for As to those for simple pneumoconiosis. This is important, as some believe that all cases of P.M.F. are associated with a high case-fatality rate. These findings suggest A shadows progress so slowly that expectation of life is the same as that of 0s, 1s, 2s, and 3s for at least 20 years.

TABLE II—Distribution of Pneumoconiosis Category of Miners and Ex-miners by Age Group in 1950-1

Age Group (Years)	Radiological Category							Total
	0	1	2	3	A	B, C	Not x-rayed	
25—	719	146	119	82	47	26	5	1,144
35—	668	157	174	120	89	132	6	1,346
45—	696	187	128	70	98	152	6	1,337
55—	565	165	105	46	78	186	25	1,170
65—	329	99	70	25	59	129	54	765
≥75	123	29	13	4	13	41	72	295

TABLE III—Mortality Experience related to Pneumoconiosis Category, omitting Industrial Accidents (that is, omitting I.C.D. 910-916 of 6th, 7th Revisions). Percentage Surviving 20 Years

Age Group (Years)	Non-miners	Miners and Ex-miners according to Pneumoconiosis Category					
		0	1	2	3	A	B, C
25—	93	95	96	94	90	96	81
35—	82	81	75	76	78	75	47
45—	64	50	54	55	67	53	29
55—	31	22	25	24	30	15	12
65—*	19	20	18	16	12	24	12
≥75†	16	18	7	(15)	(0)	(23)	7

*Percentage surviving 15 years.

†Percentage surviving 10 years.

Numbers in parentheses refer to groups with fewer than 25 subjects.

Discussion

The results confirm our previous finding that the non-miners in the valley had a lower S.M.R. than the miners and ex-miners. This difference did not appear in the nine-year follow-up of the Staveley community.³ It has been suggested that the difference between the Rhondda and Staveley might be due to the massive migration out of the former in the 1920s and 1930s.⁴

These data on survival rates also fit in remarkably well with the M.R.C.'s data on lung function in random samples of mining communities.⁴ No evidence of decreased average pulmonary function in categories 0, 1, 2, 3, or A was found. The National Coal Board's surveys of large numbers of working miners^{5,6} do suggest small differences between the average values for various categories, but the effect is very small compared with that of age and smoking habit. One can therefore now quite reasonably put forward the suggestion that there is no appreciable disability or loss of expectation of life (in 20 years) associated with any category of coalworkers' pneumoconiosis except categories B and C.

TABLE I—Population of Non-miners and Miners and Ex-miners

Age Group (Years)	Non-miners			Miners and Ex-miners			
	No. Defined	No. Traced in 1971	% Response in 1971	No. Defined	% x-rayed Originally	No. Traced in 1971	% Response in 1971
25—	737	737	100	1,146	99	1,144	99.8
35—	447	446	99.8	1,346	99	1,346	100
45—	223	222	99.6	1,337	99	1,337	100
55—	148	147	99.3	1,173	97	1,170	99.7
65—	64	62	96.9	765	92	765	100
≥75	32	32	100	295	75	295	100
Total	1,651	1,646	99.7	6,062	97	6,057	99.9

I report this preliminary account as the results appear relevant to the work of the Industrial Injuries Advisory Committee.

I am deeply indebted to many hundreds of people for help in the original survey and the follow-up. I cannot thank them all by name. I would, however, like to thank the people of the Rhondda Fach once again, all the medical officers of health who answered so many of my queries, Mr. Jonathan and Mr. Moore, who played important parts both in the original survey and the follow-up, and Mr. David Hole for the statistical analysis.

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General Practice Observed

Diabetic Clinics Today and Tomorrow: Mini-clinics in General Practice

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Summary

In the belief that there was need for diabetic clinics in general practice, 14 of them have been started in the Wolverhampton area. Provided that patients with diabetes that is difficult to control, or who need extra care, remain the responsibility of the hospital diabetic department, this system is an advantage for the hospital department, general practice, and the patient. We believe that many patients are now getting better care in general-practice clinics than they were in the hospital department.

Introduction

Diabetic clinics were started to deal with insulin treatment and were among the first hospital special clinics. There are now about 500 of them in Britain. Although papers on diabetes are numerous, assessment of the place of diabetic clinics is unusual.¹⁻⁴ In many areas a diagnosis of diabetes is regarded by all concerned as an indication to attend the hospital clinic for ever. The result is that diabetic clinics have such a large clinical load that they are unable to devote sufficient time to difficult cases. Medical manpower to deal with the growing work load is usually met by increasing use of junior staff,⁵ and the situation is well described by Wilks.⁶

Diabetes is an all-embracing disorder, so whoever looks after the patient's diabetes tends to look after the whole patient. After 50 years of insulin and 15 years of oral treatment, surely many diabetic patients should be looked after by their own

practitioner. We believe that the best way for a general practitioner to look after his diabetic patients is to organize a special session for that purpose. A practice with four partners may well have 80-100 diabetics on the list, so a monthly session is worth while. Starting such clinics should be a combined operation between the practitioners and the consultant who runs the hospital clinic, and we believe that these clinics—which we call mini-clinics—should continue to be run in co-operation with the hospital clinic.

Malins² wrote that "most physicians who run diabetic clinics would be glad to know of any satisfactory method by which patients could be returned to the care of their own doctors." We think that the scheme we describe here is satisfactory but we do not think that the experimental clinic described by Malins and Stuart⁷ goes far enough in establishing an autonomous clinic run by the general practitioner.

Diabetic Population Studied

This hospital diabetic clinic started in 1924 and the mini-clinic scheme in 1970. The total number of patients concerned in this report is 2,136. This includes every patient who attended either the hospital clinic or a mini-clinic during 1970-2. Each patient has a punch card on which is recorded year of birth, age at diagnosis, year of diagnosis, general practitioner, and type of treatment. All long-term attenders and new attenders in 1970 and 1971 had their treatment assessed at the end of 1971, whereas new attenders in 1972 were assessed at the end of that year. Patients known to have died during the survey are not included as they are no longer a follow-up problem. The type of treatment for all these patients is shown in table I and age at diagnosis related to type of treatment in fig. 1.

Mini-clinic Practices

By the end of 1972 14 practices in the area had started mini-clinics. The distribution of those practices with mini-clinics among all the practices on the list of the Wolverhampton Executive Council is shown in fig. 2. There are two four-partner practices, six with three partners, four with two part-

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