examination, on the basis that the examination is somehow associated with good practice. Unfortunately, there is no evidence that possession of the MRCGP guarantees a good standard of practice. Furthermore, the white paper's intention in proposing the postgraduate education allowance,[1] is to encourage a continuing commitment to education rather than a one-off attempt to pass an examination.

As far as the end point assessment is concerned, although there is nothing inherently wrong with a system of assessment based on personal reporting, the main worry is the lack of standards. At least the MRCGP examination has a reasonable standard which is based on the collective wisdom of the panel of examiners.

The timing of the MRCGP examination is a subject that many, including myself, have commented on in the past. But, on balance, I do not think it matters all that much when the examination is taken. In fact, the strongest argument for continuing with the present arrangement is the flexibility that it offers to the potential candidates. Indeed, a candidate can take the examination at a time which is most suitable and convenient to him.

Finally, it must be about time to acknowledge the excellence of the MRCGP examination and its tremendous contribution to raising the status of general practice. This self criticism will do nothing but discredit the examination and undermine the confidence of our trainees in vocational training and the College.

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Reference

1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.

Funding for continuing education

Sir,

As a course organizer who has an interest in continuing medical education, I was pleased to see Professor Pereira Gray's mention of the need for higher degree courses in university departments in his report to the annual general meeting (News, December *Journal,* p.575).

As a participant in the new masters degree course in medical education, I would welcome any suggestion of sources of funding to cover the necessary expenses. This course is part-time, constructed in short modules that span two years. This format allows me to maintain my practice responsibilities and my commitment to my day-release course. However, my request for study leave funding has been declined by the Department of Health on the grounds that applications are only approved for full-time study completed within an upper time limit of 12 months. Similarly, a local medical school trust has also declined any assistance, stating that clinicians are expected to make 'some personal sacrifice'.

While not totally disagreeing with the above, I feel that lip-service is paid by the health service to the concept and importance of professionalism in continuing medical education, but its acquisition is, as usual in medicine, dependent on the will and resources of the individual.

JOHN PITTS

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AIDS and the future general practitioner

Sir,

Sibbald and Freeling in their paper 'AIDS and the future general practitioner' (November *Journal,* p.500) make an array of statements about doctors from a comparison of trainers and non-trainers. Their work was based upon postal questionnaires with response rates which seem to me to be pretty dismal, 67%, 54% and 52%. I wonder below what level of response is it unwise to draw conclusions? And, how close should the response rates for the two groups be for reasonable comparisons to be drawn? Surely if the samples may not be representative of the populations, the conclusions and the statistical tests of differences might well be incorrect?

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Sir,

Dr Garson is concerned that low response rates invalidate the findings of this study. As discussed in the first paragraph of the discussion of the original paper, we believe the response rate of 67% among trainers is high enough to ensure this is a representative sample. Certainly the sample is large enough to give, for example, a confidence limit of ± 4% on a prevalence of 20%. The response rate among non-trainers was low (52%), but the findings were remarkably similar to those obtained in three other contemporary surveys. It is of no statistical importance that the response rates of the two groups differed. It is likely therefore that our findings and conclusions are valid.

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A car with flat tyres?

Sir,

In his editorial 'A car with flat tyres' (December *Journal,* p.535), Dr Richards states that the familiar medical record envelope originated with the health insurance act of 1911. Certainly the capitation system of payment and the self-employed status of general practitioners can be dated from that time, but there were no medical record envelopes until 1 January 1921. As far as I can ascertain, the state made no arrangements whatsoever for providing stationery for recording medical notes before 1921.

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Ultra nappy rash

Sir,

We wish to draw attention to a problem which we have recently observed. Between us we have seen 12 children attending surgery, health visitor or casualty department who have developed a rash in the nappy area following the use of various ultra-absorbent disposable nappies. The rash invariably settled when the type of nappy was changed and recurred in two cases when the nappies were reintroduced. These nappies, only recently introduced into the UK, contain a polyacrylate polymer (said to be non-allergenic), which increases the absorptive power of the nappies and reduces their bulk with obvious advantages for both parent and retailer.

Professionals should be aware of the existence of this problem which we have called 'ultra nappy rash', as most mothers we spoke to had initially used the nappies because their children had sensitive skin. These nappies may not be the best choice for such children.

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