a range of different patients and physical illnesses, and the various services available to them within the community. A handbook with supporting information is available with this section.

Mental Illness and Handicap. Seven case-studies examining the care and treatment provided by community based services for mentally ill and mentally handicapped people in a way that reflects modern nursing techniques and complements existing teaching material. A handbook is available with this section (note—the original broadcast series consisted of eight case studies but Programme 6 is not available for copyright reasons).

Centres for Special Care. Five documentary programmes looking at the work of a number of centres which provide specialist services and care within the community.

All the above recordings are available through the normal services of the Medical Recording Service Foundation on standard tape and cassette. A summary of each type and a booking form is obtainable from: Community Care Series, Medical Recording Service Foundation, Kitts Croft, Writtle, Chelmsford CM1 3EH, Telephone: Chelmsford (STD 0245) 421 475.

VOCATIONAL TRAINING SCHEMES

Vocational training schemes have been approved for the purposes of the M.R.C.G.P. examination at the following centres: Hereford, Hull and Swansea.

CORRESPONDENCE

UNDERGRADUATE CURRICULUM

Sir,

Members of the College with an interest in medical education may like to hear of an important venture of the British Medical Students' Association.

The intention is to devise an undergraduate curriculum which will be clearly related to the professional needs of doctors of the future. It will start from first principles: what society will want from its doctors must determine the goals of medical education. There must be ways of measuring the achievement of these goals, and of correcting failure to achieve them.

To attempt this enormous task, a national organisation is being forged, and a timetable has been constructed to keep the organisation under pressure.

So far, the activity has been based on medical schools, where groups of medical students, often working with students of other health professions and with medical teachers, have been preparing papers for criticism and development. From October, these local groups will be looking at specific problems in the community—road accidents, ischaemic heart disease, chronic depression, the effects of poverty on health, to name but a few.

In this work the BMSA is aware that it needs help, and that much of this help can come only from general practice.

The Royal College of General Practitioners has given its support to the undertaking, and I represent our Education Committee on BMSA's Advisory Panel. I would ask two things of members of the College: that they help in any way they can if approached individually; and that anyone especially interested contact me so that I can pass his or her name on to BMSA.

The venture is an exciting one. To think in these constructive terms is a challenge we would avoid to our own cost.

CONRAD M. HARRIS

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DIFFICULTIES WITH DEPUTIES

Sir,

I was gratified to read your second editorial in the September issue entitled *Difficulties with deputies.*

I hope that gradually our profession can come to a more reasoned approach to deputisation in general practice.

I would be very interested to know the origin of this editorial which, in content, was very similar to my introduction of Motion 245 at the Annual Representative Meeting of the British Medical Association in Folkestone this year. This motion was met with either fear or horror at the meeting and a motion to pass to the next business was rapidly carried.

I am pleased to hear that the cause is being taken up in other quarters.

DERMOT LYNCH

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REFERENCES

Journal of the Royal College of General Practitioners (1973). *Editorial*, **23**, 612–613.

Lynch, D. (1973). *British Medical Journal Supplement*, **2**, 142.

All the editorials in the Journal *are written by general practitioners in active practice. Most are*

written by the Editor or a member of the Editorial Board and a few are requested from invited leader writers. The Journal *is editorially independent and editorials should not be taken to represent the policy of the College unless this is specifically stated.—Ed.*

LOOKING AFTER THE OLD

Sir,

Perhaps I might be allowed to comment on Dr Norman How's interesting article on *Caring for the Elderly at Home*. He uses our effective health group concept of functional ability in old age and it is interesting to see that his figures of the number of patients falling into each group are roughly in line with our own findings.

However, he goes on to state that we imply a *status quo* in our groups and not a changing situation. Perhaps this was so in our original paper but subsequent research has shown that effective health can change either one way or the other. Many factors can cause this alteration, but an important one is active intervention by the health team. The device of placing a patient into an effective health group does provide a method of monitoring the usefulness of such procedures as early diagnostic clinics for the elderly.

An article has been accepted by you for publication in the *Journal* on a follow-up of our original survey. As it will be some time before it appears, I would suggest that although measurement of effective health in the elderly gives a good guide to the patients' immediate needs, it should in no sense be regarded as static.

E. IDRIS WILLIAMS

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Bolton.

REFERENCES

How, N. (1973). *Journal of the Royal College of General Practitioners* (1973), **23**, 627–37.

Williams, E. Idris *et al.* (1972). *British Medical Journal*, **2**, 445–448.

PROBLEM-ORIENTATED MEDICAL RECORDS

Sir,

Dr Ronald Law in his letter about our article on the problem-orientated record in general practice (August *Journal*) criticises the idea that information about our patients needed to establish a data base could be collected by questionnaire. He bases this argument on the fact that if a doctor were to conduct an interview in order to gain this information then a great deal more could be learnt about the patient. This is not in doubt, but it does not answer the essential problem which was our concern; namely how can we gain at least some of this information without using a great deal more of the doctor's time?

Our suggested use of a questionnaire is merely to gain an agreed minimum of important information about all our patients. This can of course be added to by the doctor himself at any time. The kind of interview envisaged by Dr Law in which he explores the patients' 'life material' is just not going to be carried out by most doctors, for most patients. We were aiming to provide a method that not only could be, but would be used by the many rather than the few.

Professor Byrne in his letter on the problem-orientated record (September *Journal*) points to the difficulty in devising suitable methods for constructing the data base. What to include and what to leave out is indeed a difficult problem, but we feel that an agreed minimum collected by questionnaire would at least be a useful start.

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REFERENCES

Byrne, P. S. (1973). *Journal of the Royal College of General Practitioners*, **23**, 645–655.

Law, R. (1973). *Journal of the Royal College of General Practitioners*, **23**, 586–587.

CONTINUITY OF CARE

Sir,

Your Editorial on the *Continuity of Care* (November *Journal*) is an important one. As you point out, most patients prefer their "own" doctor rather than a succession of "medical strangers". You imply that patients of a large group practice are likely to be faced with many medical strangers.

With eight partners, a part-time assistant and a trainee, we are very conscious of this problem. The trainee, necessarily, can only provide short-term continuity of care. The part-time assistant has over the years gained her own following but helps all partners on their days off. Between the partners we run a pairing system, Dr A. being paired with Dr B., and Dr C. with Dr D. The rota is organised so that during the daytime at least one of each pair is available. This means, for example, on Dr A's day off, Dr B. will see any of his patients who cannot wait until the next day, and vice versa. In this way we cut down the number of doctors a patient is likely to see to a minimum.

The system breaks down partially at nights and weekends, when only two doctors are on call and, during holidays. Patients seen by one's partners are handed back the next day or after the weekend. It is not perfect, but it does aid continuity of care.

If one takes part in teaching and committee work these activities also affect one's availability, and a new threat in this direction is looming. The number of doctors, from both hospital and general practice, that are going to be needed to sit on the large numbers of committees under the reorganisation of the National Health Service is quite alarming. Some individuals could be so involved that their patients will seldom be able to see them. I hope my fears are exaggerated, but I am sure this aspect also "needs watching".

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