final six months, divided by the hospital posts. Newcastle was first in developing stricter methods for the selection of general practitioner trainers, which included considering their personal qualities, their practices (premises, records, staff, equipment, and organization), and the qualities of their partners. The selection procedure included a visit to the practice.

The initiatives for these schemes were different in each case: at Belfast it was by the Department of Postgraduate Medical Education for Northern Ireland; at Ipswich by the Postgraduate Medical Centre (making a conscious experiment to base the scheme on a district general hospital for the first time); at Newcastle by a Subcommittee of the Regional Postgraduate Organization; and at Manchester by the University Department of General Practice.

The Manchester scheme was intentionally subdivided, for research purposes, one part having a theoretical course at the start, one an extended course over one year, and the third no course at all.

All four of these early schemes submitted themselves to a large assessment study by the Department of General Practice at the University of Manchester, which aimed "to evaluate one course against another by measuring the changes effected in those taking part in terms of knowledge, skills, and attitudes, and some methods of thought and factors of intellect". The results of this study were published in 1976[42,43]. This important effort in evaluation was the initiative of Professor P. S. Byrne, who also played an important part as Chairman of the Education Committee (RCGP) from 1966 to 1970 and in producing (1966) the first course for general practitioner teachers aimed at increasing their teaching skills.

This most unfortunate mistake is very much regretted.

LETTERS TO THE EDITOR

CORONARY PREVENTION

Sir,

The coronary screening programme described by Dr J. Stuart Brown (December *Journal*, p.735) appears well planned and efficiently performed but it leaves some questions unanswered. If 22 per cent of ECGs are abnormal, is this a sensible screening test from the patient's point of view? It may be a useful baseline for the doctor but what does one say to the patient? Similarly, do the complex lipid tests performed on 20 per cent of patients really have a useful function? It is a little alarming that only 48 per cent of patients were "told that all tests were 100 per cent normal". Were the other 52 per cent reassured or frightened? The several patients who asked when they could have their next screening test may have done so through anxiety rather than enthusiasm. In other words, it seems to me that the *accent* of this programme does not seem quite right, being to "prevent coronaries" rather than lead to advice on good health in general. In our practice, we carry out a 'forty plus' examination almost identical to Dr Stuart Brown's except that we do not perform routine ECGs and do not take slight biochemical abnormalities very seriously. The accent is on reassurance and redirection. It may be that the risks of creating alarm and a demand for repeated screening should be taken more seriously than Dr Stuart Brown implies.

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Sir,

I was interested to read Dr J. Stuart Brown's article on coronary screening (December *Journal*, p.735) and congratulate him on a well thought out and executed investigation. I do, however, think that something ought to be said about his reference to ECGs. He refers to 15 patients with "ECG abnormalities, the majority being T-wave changes or the presence of ventricular extrasystoles". He then goes on to say that "most of the T-wave changes were considered to be within the normal range" and "more recently the general trend is to attribute ever diminishing significance to premature beats". If one accepts these comments, I imagine very few, if any, of the 15 in fact had ECG abnormalities.

The classical ECG changes of ST depression and T-wave changes can be produced by a large variety of other conditions and are not pathognomonic of ischaemia. Ectopic beats (even ventricular ones), as Dr Stuart Brown points out, are of very doubtful significance.

I am sure this is important to say, because there are many people walking about who are anxious about their hearts simply because doctors have told them that they have "minor ECG changes", whereas in fact these "abnormalities" are perfectly acceptable within the normal range.

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SELECTING TRAINERS

Sir,

Dr John Oakley's letter (February *Journal*, p. 117) complaining about the Oxford Region's criteria for the selection of trainers and training practices raises some important issues. He calls the requirement for new trainers to have passed the MRCGP examination presumptuous, unfair, and an insult to colleagues in general practice. Strong words indeed.

The Oxford Regional Committee's General Practice Sub-Committee is concerned that trainers should be clinically competent. It was because a number of our *trainees* felt that some trainers were not competent enough to teach clinical medicine in general practice that those from one of our vocational training schemes asked the Sub-Committee to introduce passing the MRCGP examination as a requirement for new trainers in April 1977. The members of the Sub-Committee agreed unanimously to do so. Existing trainers are not affected, although a number of them have sat the examination because they wished to do so.

The suggestions for assessing clinical competence published by the Joint Committee for Postgraduate Training in General Practice that Dr Oakley mentions are for guidance only. Passing the MRCGP examination is just one of the suggestions: in the Oxford Region we use all six. Anyone with experience in assessing and appointing trainers—and the members of our regional appointments committee and visiting assessors panel have a very great deal of experience—knows that judging a doctor's clinical ability is very difficult.