and development, health surveillance, care of the newborn, preventive health in childhood, educational medicine and management of children with handicaps. The examination consists of a multiple choice question paper, a paper of short note essay questions and a clinical examination with long and short cases. The DCH is therefore an examination suitable for general practitioners and clinical medical officers.

The MRCP(UK), on the other hand, is an examination which is designed to select candidates who wish to embark on specialist training in hospital paediatrics and community child health, and does demand a greater degree of knowledge of hospital paediatrics than is required for the DCH.

Copies of the detailed regulations and syllabus for the DCH may be obtained from the Diploma Examinations Secretary at the College.

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The MRCGP Examination—an Overseas View

Sir,

Overseas members of the College are less involved in its activities than the majority who live in the UK. However, having trained and worked in a different setting may allow them to view the College and its development in a different light. I was vocationally trained in Britain and sat the MRCGP examination before coming to live in Israel and completing my training to be a specialist in family medicine.

Now that vocational training for general practice has become mandatory should not the College examination become progressively more difficult in order to give it the prestige of say the MRCP? Now that there can be no danger that prospective entrants into general practice will not be vocationally trained, perhaps the training necessary before being allowed to take the examination should be more strictly defined to encompass the main areas of family practice instead of candidates having to complete only part of a list. At present it is possible to enter general practice holding the MRCGP without, for example, having undertaken any postgraduate paediatrics.

In Israel, to be a specialist in family medicine one has to have completed four years of a very strictly controlled list of approved jobs, apart from six months options, as well as a university postgraduate course before being allowed to complete examinations that are considerably more difficult than the MRCGP. All this is completed after full registration. The status of the specialist in family medicine compares with that of other medical specialists whose training follows a similar pattern.

Although my suggestion might be criticised for rigidity and uniformity in training for a branch of medicine that is made up of individualists, I feel that the improvement in standards that would result from harder examinations and a more clearly defined experience base would be worthwhile. If competition for posts in general practice is heavy then this could be used as an opportunity to improve standards.

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A Simple System for Monitoring Child Immunization in General Practice

Sir,

There is an obvious need for maintaining high levels of immunity in the general population, as shown by the recent whooping cough epidemic and, in the last year, by outbreaks of poliomyelitis and diphtheria. Immunization rates vary from area to area; 80 per cent for poliomyelitis, 55 per cent for measles and 40 per cent for whooping cough on average.[1] Just over half the health districts use the Child Immunization Register, but this in itself does not provide satisfactory results without good follow-up and monitoring. In non-computerized districts monitoring of immunizations in childhood is left to individual general practitioners.

Initiatives taken by individual primary care teams can obtain very high immunization rates. General practitioners are in an ideal position to promote immunizations since they hold the clinical records and are in continuing contact with the children registered with them, and with their parents.

The Cymmer Chart

The Cymmer Chart will show at a glance the immunization status of all the infants on a doctor's list. It can be constructed prospectively and does not need a filing system.

For simplicity I use graph paper sheets 70 cm × 53 cm. These will accommodate the names of 70 children over a two to three year period, assuming that primary immunizations would normally be complete by the age of two years.

The chart is divided into years and each year into quarters. On registration with the doctor, a child's name is entered on the chart up to the beginning of the quarter in which he or she was born (see illustration). Immunizations are entered in the quarter they are given, either from surgery records, or from health authority computer printouts. Hung on a wall in the office the chart is easily updated and referred to, and serves as a constant reminder.

The chart is reviewed every quarter and any child more than three months behind with immunizations can be identified (in the illustration A is up to date, B is obviously behind). If a child is more than three months overdue, the notes are tagged (and perhaps the parents' notes also) to show that this must be discussed at the next consultation. Alternatively, or in addition, reminders can be sent to the parents.

The chart can be constructed prospectively and easily at little cost, and requires little effort to update it. It is particularly suitable for the practice that does not have an age-sex register. It is easily referred to, is a constant

	1981 JAN to MAR	APR to JUN	JUL to SEP	OCT to DEC	1982 JAN to MAR	APR to JUN	JUL to SEP	OCT to DEC	1983 JAN to MAR	APR to JUN	
John Brown born 20.7.81			DPT P(0)		DPT P(0)		DPT P(0)		Meas		CHILD A
Jane Brown born 20.1.82							DPT P(0)		DPT P(0)		CHILD B

reminder to all members of the practice team and serves as a useful start to introducing the idea of practising prevention. Its use can be extended by including details of attendance for developmental checks.

This chart was developed and used at the Cymmer Health Centre, West Glamorgan. I am grateful to the staff there, and particularly to Jean Williams, receptionist.

PETER GODFREY

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Reference

1. Smith T. Our national resistance to immunization. *The Health Services* 1983; **March 11:** 12.

Psychiatry in General Practice

Sir,

In an editorial (April *Journal,* p. 195) Dr Anthony Clare described three possible approaches to improve psychiatric management in primary care. More involvement by psychiatrists at one end and by social workers at the other, and strengthening the general practitioner's own skills.

Valuable as the first two suggestions are, I do not see them as a substitute for improving our own skills.

The actual techniques of interviewing can be improved by role play, video-recording and analysis of the process of consultation, but if we are to progress from his depressing analysis that our major form of treatment is by psychotropic drugs, something more is needed.

Patients come to doctors with emotions that are often intense and wrapped up in ways that are peculiar to the general practice setting, which is often 'gift wrapping' to those doctors who try to see beyond the presenting complaint to what lies beneath it. All this is lost when the patient is referred to someone else. Awareness of the general practitioner's own involvement in the consultation, and how this may reflect the patient's other relationships, are best learnt slowly in a group setting.

As a dedicated member of the Balint Society two things encourage me in the present state of general practice. Vocational training implies half-day release courses, where trainees naturally gather in small groups for case discussion. The problems that they wish to discuss are nearly all concerned with management of emotional and family problems. I hope that many trainees are now learning the value of sharing such problems in a group, and that they will wish to take such learning further when they are established.

The other encouraging thought is that I believe doctors are choosing to go into general practice because they are interested in such psychosocial matters. I hope that this may filter back to influence the selection and training of medical students. When I left hospital for general practice in 1953 I thought that everything that was not hospital-style medicine was nonsense. The present generation of trainees is much more sophisticated.

Dr Clare rightly suggests more intense investigation of the whole problem of psychiatry in general practice. An important part of this would involve assessing how trainees are changed during their training, both by groups and by individual supervision.

Assessing the value of our efforts with patients is even more difficult, since orthodox psychiatric classifications have little bearing on the rich variety of human problems that are brought to us all the time.

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Training in Geriatrics for General Practice

Sir,

A report by the British Geriatric Society and the Royal College of General Practitioners in 1978 on training general practitioners in geriatric medicine[1] suggested that 'all vocational training must provide training in geriatric medicine', yet in 1981 only 26 per cent of schemes approved by the College had a compulsory appointment in geriatrics for three or six months, and only a further 25 per cent had a voluntary appointment available.[2] This position has not changed significantly in the last two years.

This apparent reluctance to include geriatric medicine in vocational training schemes is surprising. The reason for this omission is not clear but perhaps the organizers of vocational training schemes consider that the experience gained in hospital practice is not of direct relevance to the management of the elderly in the community.

Whilst one of us (M. B. J.) was working as a senior house officer in geriatric medicine as part of a general practice vocational training scheme recently, we compared the medical and social problems of a group of 68 patients admitted to the geriatric assessment unit of a district general hospital with a similar group of elderly patients under the care of general practitioners in the same area.

Our results showed that the patients seen in hospital differed from those seen in general practice only in being older and more dependent and were otherwise very similar both medically and socially. This strongly supports the view that experience gained in managing patients whilst under the supervision of a geriatrician and obtaining first-hand experience of the organization of a geriatric service relates directly to the management of elderly patients in the community.

In view of the rapid increase in the elderly population in the country it is of great importance that general practitioners are competent in supervising the care of the elderly. The provision of more hospital geriatric training posts in vocational training schemes would help to ensure this.

M. B. JACKSON
G. D. WALKER

References

1. British Geriatric Society and Royal College of General Practitioners. Some aims for training in general practice. *J R Coll Gen Pract* 1978; **28:** 355-357.
2. Council for Postgraduate Medical Education in England and Wales. Vocational Training Schemes for General Practice. 1981.

An MD from General Practice

Sir,

It is never easy to attempt an MD from general practice, and to be unsuccessful in the end can be shattering. Those of us who act as examiners for the London University degree have been concerned about many of the theses with which we have been presented and hope that the following suggestion will be useful to anyone thinking of becoming a candidate.

In this University there is no supervisor for the work, since it is held that anyone fit for the degree does not require one. Help from appropriate academic quarters is encouraged, but when the adviser is an expert in a specialized field, the help that he or she can offer may be more limited than the candidate really needs. It seems, from a number of recent submissions, that advice is also needed from someone who is familiar with the problems both of general practice and of doctoral research.

Senior members of the departments