tive medicine. Some people turn to osteopaths, homeopaths or acupuncturists only when orthodox medicine has failed them, others become interested in the more positive aspects of health promotion that they offer. The medical profession, being as conservative as any other, has been a good deal less enthusiastic about acknowledging the contribution of alternative medicine than it has that of self-help groups. By the same token there is a tendency among adherents of the alternative health movement to adopt an anti-NHS stance. The College of Health will encourage bridge-building between the two medicines, conventional and unorthodox, and greater awareness of what each has to offer.

Membership

It is hoped that in time local branches of the College will be set up by groups of members interested in promoting health care and education in their own communities. A number of people with whom we have had preliminary discussions have expressed an interest in helping to promote local activities. We hope too that people who already belong to local groups such as self-help groups and community health initiatives will join the College. Membership will be open to anyone with an interest in health promotion and care, and medical as well as lay people will be encouraged to join. The initial subscription could be £10 per annum. In return members will receive the quarterly magazine and have the right to buy booklets, hire videos and participate in courses at a reduced rate. They will also have the right to elect a national committee.

Advisory services

In general the College of Health will concentrate on building up links with existing organizations and networks so that wherever possible people could be referred to the most appropriate source of help near their homes. Where a national organization has particular expertise we would seek to work closely with it.

Reference

1. Pendleton D. Patients' views of general practice. *J Roy Coll Gen Pract* 1983; **33:** 5-7.

LETTERS

Letters are warmly welcomed as an important feature of News and Views. Contributors may wish to express opinions about previous articles or letters in the Journal. In addition, ideas, experiences and (clinical) observations about patients or practices may be very relevant and of interest to other members.

Editor, News and Views.

Doctors and the Pharmaceutical Industry

Sir,

Only if you believe that the post-marketing surveillance of drugs is an unimportant activity can Professor Howie's letter be justified. It is certainly a very difficult enterprise and it might be reasonable for him to say that it is so difficult and so unlikely to give benefit that we should not embark upon it. Of course, I disagree, but that would be a tenable view for him to express. He has, however, expressed neither of these points, and his letter could only be considered constructive if he had suggested better ways of carrying out post-marketing surveillance.

I know that Professor Howie takes a rather narrow view about epidemiological studies in general, and that he is much more comfortable with a tightly controlled clinical trial. I can understand and respect that view, indeed I would probably feel more comfortable myself in that situation, but it has not fallen to my lot to conduct that type of study.

The object of the early studies is to get a feedback in a comprehensive way, about the experience of general practitioners and their patients when using a new drug. In this particular case (Suprol) it happens to be a drug from a group which has given rise to perhaps more problems than almost any other, and so there is a particular need to monitor it. No, it is not naive to record the clinical indications for which the drug is used. Given that a doctor has agreed to use it, it is entirely valid to collect information about the conditions he has felt were appropriately treated with the drug. Professor Howie's view that 'efficacy, safety and overall acceptability' cannot be assessed outside a double-blind controlled clinical trial is negated every time he sees a patient and assesses the response to treatment. Of course the assessment is subjective, both on the part of the doctor and the patient, but it is that subjective response which it is valuable for us to collect. He implies that that would give an inevitably favourable view of the drug under investigation. There is absolutely no justification for that opinion. An adverse impression is equally likely to be obtained.

He has completely misunderstood the third objective 'to record the incidence of clinical events'. The whole point of this exercise, which has been termed event-monitoring, is that everything that the patient reports to the doctor should be recorded without any presupposition that it is causally related to the treatment being given.

I hope Professor Howie will now read my paper in the July issue of the *Journal*. If he has any comments on this, I should be delighted to have them.

Finally, he speaks in his last paragraph about the 'launching of unnecessary and otherwise unsellable new products'. Now he is being naive. Does he really think that any company would spend nearly £50 million on launching a drug which it believed was unsellable, or which was in fact unnecessary? We would not be having another nonsteroidal anti-inflammatory agent if any of the existing ones were really effective.

CLIFFORD R. KAY
Executive Director
Medicines Surveillance Organization Limited
8 Barlow Moor Road
Manchester M20 0TR.

Rural versus Urban Parasuicide

Sir,

Dr Hughes' paper (October *Journal*, p.637) presents some interesting facts but leaves some questions unanswered.

Confining a study of parasuicide to patients resorting to drug overdose alone probably underestimates the total rate in a community by about 10 per cent. It is hard to see why other forms of deliberate self harm should have been excluded.

The distinction between urban and rural patients seems tenuous. Some study patients must have lived close to

the city of Bath, where a 999 ambulance call would be likely to lead to their immediate removal to a city hospital. For patients living many miles away to the east, early involvement of their general practitioners would be likely to occur more often and a decision about psychiatric referral would follow.

And are the residents of Devizes, Chippenham and the other market towns truly rural citizens? To imply that they are, and to infer that this shows a uniform parasuicide rate in town and country, may be a premature assumption.

Dr Hughes found that patients managed by their general practitioners were not affected adversely when compared with those seen by psychiatrists. This corresponds closely to my own findings.[1] It provides further evidence that general practitioners, especially when working in a team with other professionals, are able to select from among patients who harm themselves those who can be helped and supported without the need for the involvement of psychiatric services.

RODNEY TURNER

49 Wansunt Road
Bexley
Kent.

Reference

1. Turner RM. Parasuicide in an urban general practice. *J Roy Coll Gen Pract* 1982; **32:** 273-281.

Colour Coding of Medical Records

Sir

One of the early improvements in medical records in practice was the College's idea of tagging medical record envelopes with a colour code, to mark and remind of past and present disease. This was acceptable because it was easy to introduce. Only a small number of colour codes was adopted, marking diseases such as hypertension, epilepsy, diabetes and tuberculosis, and longterm maintenance therapy. Some colours were left free for individuals to adapt for their own purposes. Colour tags with the disease superimposed on them are now available as a service from one of the pharmaceutical companies.

With the current emphasis on better records, especially in training practices, there is now a good case for moving forward and introducing a greater range of standard codes.

Many practices see the value of tagging as a reminder to partners, locums and trainees and are developing their own individual codes. Would it not be better if an extended standard code were devised?

We have all at some time written a prescription for, say, penicillin, only to be reminded by the patient or by a call from the pharmacist that a reaction has previously occurred. A red sticker could save much embarrassment.

As we move into an era of better continuing care and of preventive medicine, with the development of recall systems, the need for reminders becomes greater. Colour tagging could help in at least two of the aspects of care identified by Scott and Davies[1], namely review of existing conditions and opportunistic health education. A colour code on the medical record would help to focus one's attention on these fields.

Reminders for continuing care would be useful in such conditions as malignancies (often diagnosed some years before), alcohol problems and asthma. A reminder of the presence of a pacemaker at the time of death and before cremation would be helpful. Further examples are cervical smears, hysterectomy, rubella immune state and smoking habits.

In the field of social medicine, at-risk families of various sorts could be identified—an 'at risk' overprinting of existing codes such as diabetes would be helpful. The longterm therapy code could well be broken down into smaller categories.

The possibilities are endless. The intial scheme was right in restricting the number—perhaps now a modest increase to 15 or so would be in order and would be welcomed.

As a positive and very cheap means of improving patient care why does not the College extend its code?

IDRIS HUMPHREYS

2 Penrhyn Isaf Road
Penrhyn Bay
Llandudno
Gwynedd.

Reference

1. Scott NCH, Davies RH. The exceptional potential in every consultation. *J Roy Coll Gen Pract* 1979; **29:** 201-205.

Otitis Media in Children

Sir,

I should be interested to know whether any readers of the *Journal* are planning or engaged in follow-up studies of children with otitis media. Together with an ENT colleague I am pursuing a small study of some children with this condition presenting in one practice. There are also very tentative discussions regarding the possibility of a future multi-observer study in the Midlands. In order to avoid duplication of effort, I should be most interested to hear of any such studies being planned or actually in progress.

J. F. WILMOT

16 Clarendon Street
Leamington Spa
CV32 5SS.

The MRCGP Examination

Sir,

Professor J. Walker's detailed defence of the MRCGP examination (September *Journal,* p. 545) seems inconsistent in many areas:

'The prime purpose of the MRCGP examination is the admission of members to the College', we are told. Yet the majority of established principals must be excluded since even of the highly motivated few who sit the examination, only 60 per cent pass.

Professor Walker tells us that the MRCGP examination results prove that 'training works'. Certainly the statistics suggest that training (mainly in hospital) improves performance in the MRCGP examination. Unfortunately he presents no evidence to show any correlation between success in the examination and performance as a general practitioner.

I agree that 'some form of evaluation' is necessary to 'determine whether standards are being achieved and maintained'. An examination that, on Professor Walker's evidence, is most easily passed with minimal experience of general practice can play no part in evaluating standards. Would it not be better if the enormously hard work done by the examiners were diverted to refining a technique that *does* evaluate standards, for example using the criteria produced by the 'What Sort of Doctor' working party?

Trainees are not allowed to sit the examination until they are within eight weeks of completing their training. It is difficult to believe that a few weeks' training either way makes much difference to performance in the examination. Instead one cannot help wondering if the rigid application of this rule is to prevent trainees at a *far earlier* stage of their training from embarrassing the College by passing the examination.

Figure 11 in Professor Walker's paper has a very curious scale on the horizontal axis which makes the decreasing pass rate in the examination with length of general practice experience less apparent than it is. Healthy controversy—by all means—but not deliberate distortion of facts.

It is revealed that not surprisingly, candidates do relatively badly in