

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.

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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 Davies¹, 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 initial 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?

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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.

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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