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

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Leamington Spa
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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

those aspects of the examination concerned with general practice. If the College really wants the examination to assess standards in general practice, why not give these areas increased weighting?

For all his rhetoric, Professor Walker does nothing to refute the uncomfortable conclusions on the timing of the examination reached by Dr T. N. Griffiths.[1] In my opinion it is supporters of the examination, not its opponents, who hold a 'restricted view' of training. Of course we want to produce clinically sound doctors but the main areas of vocational training are in personal development and creative thinking or, in John Stevens' terms, shifting from a closed to an open system.[2] Preparation for an examination hinders such an attitudinal shift and generates unnecessary anxiety, even if it may not 'divert *intellectual* energy from training' (my italics).

There is mounting opposition to the examination both from outside the College and from trainees, including those on our scheme.[3] Perhaps the College would listen more to a concerted approach from some of us involved in vocational training. I should be interested to hear from colleagues supporting this idea.

PAULSACKIN
Course Organizer,
Peterborough Vocational Training Scheme
Peterborough District Hospital
Thorpe Road
Peterborough PE3 6DA.

References

1. Griffiths TN. Why time the MRCGP examination at the end of vocational training? *J Roy Coll Gen Pract* 1983; **33:** 249-50.
2. Stevens J. Brief encounter. *J Roy Coll Gen Pract* 1974; **24:** 5-22.
3. Bond T *et al.* MRCGP examination. *J Roy Coll Gen Pract* 1982; **32:** 642.

The Canadian Alternative

Sir,

I read with interest the letter of Dr Michael Cohen (July *Journal,* p.461), concerning the MRCGP examination as viewed from Israel.

To join the College of Family Physicians of Canada it is not necessary to pass an examination. One merely has to pay the fee, declare one's sympathy with the aims of the College and dedicate oneself to a minimum of 50 hours continuing medical education each year.

For those who wish to demonstrate their skills in general practice, the CFPC holds a certification examination. the candidate must answer factual and pictorial questions, be interviewed formally and conduct simulated consultations with actors role-playing the patients. As one who has taken both the British and Canadian examinations, I found the latter a more realistic test of my skills.

Members of the CFPC undertake a minimum time for their continuing medical education each year. The CFPC is now introducing a scheme whereby members can be periodically assessed, and advised of areas where they seem to be falling behind.

I am sure the RCGP will be wise to consider these developments in another College.

GRAHAM WORRALL
Medical Clinic
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Newfoundland
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DATES FOR YOUR DIARY

National trainee conference 1984

This conference will be held at St Mary's College, Twickenham, on 18 to 20 July 1984. Topics will include 'Quality of care in general practice' and 'Medical manpower', and it is hoped to present the results of a questionnaire which is designed to discover whether those who have recently completed vocational training have had difficulty in finding partnerships.

The coordinator for the conference will be Dr Ian Kelly, 78 Crown Road, Twickenham, and bookings will be accepted from April/May 1984.

Project work in teaching and learning

A one day workshop to explore the practical aspects of project work in continuing general practitioner education is being held at the College on Thursday 23 February 1984. It will have relevance for all who are involved in continuing education whether as teachers or as learners. The convener is Dr Peter Stott.

Approval under Section 63 for 2 sessions has been gained. For further details and an application form, please apply to Mrs Sue Smith, Education Division, The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

British Computer Society

The theme of 'Current Perspectives' has been chosen for the first annual conference of the British Computer Society because the advent of many stand-alone systems for specific applications has begun to produce groups of people with great expectations from health computing.

Conference fees will be £95 (nonmembers £100) including the Proceedings and fullboard accommodation. Day visitor rates will be available. The conference will take place at Birmingham University from 28-30 March 1984.

Further information is available from Mrs D. Scott, Management Services, Division, NETRHA, St Faith's Hospital, London Road, Brentwood, Essex CM14 4QP. Tel: 0277 228470 x 27.

Clinical Research Nurses Association

The CRNA conference is to be held at the Royal Society of Arts, London, on Friday 10 February 1984. The cost of admission inclusive of coffee, lunch and tea is £14 for members and £16 for nonmembers.

Further information may be obtained from Veronica Bishop, Research Department of Anaesthetics, Royal College of Surgeons, London WC2A 3PN. Tel: 01-405 3474.

MRCGP Courses

For further details of the MRCGP Courses listed here please apply to the names and addresses that are given. Elizabeth Monk of the Education Division at College Headquarters, 14 Princes Gate, Hyde Park, London SW7 1PU (Tel: 01-581 3232) is endeavouring to keep an up-to-date list of these events. Course Organizers are requested to send her details when planning new MRCGP Courses.

Sidcup, Kent—January/February
Dr R. May, 42 High Street, Chislehurst, Kent.

Galway—January/February
Dr James Kent, Direen, 33 Threadneedle Road, Salthill, Galway, Eire.

Exeter—extended course—January-March
Dr K. Bolden, Dept of General Practice, Postgraduate Medical School, Barrack Road, Exeter EX2 5DW.