Table 1. Reactions of trainees to the videotaping and viewing of their consultations.

Score[a]	Simulated consultations				Real consultations (Oxford group only)	
	Being recorded		Viewing recorded		Being recorded	Viewing recording
	Glasgow	Oxford	Glasgow	Oxford		
1	2	0	2	0	0	1
2	9	12	5	2	4	2
3	15	12	9	16	15	10
4	10	6	16	12	12	18
5	3	2	6	2	1	1
Total	39	32	38	32	32	32
Mean	3.08	2.94	3.50	3.44	3.31	3.50

[a] 1 = very unpleasant, 2 = unpleasant, 3 = neutral, 4 = pleasant, 5 = very enjoyable.

perience were also determined. The results obtained are shown in Table 1.

Even in supportive and carefully controlled situations, approximately one third of the trainees involved found it unpleasant to be filmed in a role-played consultation in unfamiliar surroundings. However, only four out of 32 trainees in the Oxford group who were filmed with real patients in their own surgeries found this experience to be unpleasant. The same group also found it more pleasant to view these recordings than their role-played consultations.

All the trainees involved were inexperienced at being filmed, and it would be expected that the number continuing to find this experience unpleasant would be smaller. However, it must be appreciated that no matter how often they are filmed, some people continue to find this experience unpleasant.

G.D. ROBERTS
37 Upper Gordon Road
Camberley
Surrey

References

1. Brooks D, Sepher B, Hayden J. Teaching the consultation with audiovisual recording. *Trainee* 1981; 55-59.
2. Davis RH, Jenkins M, Smail SA, *et al.* Teaching with audiovisual recording and consultations. *J R Coll Gen Pract* 1980; **30**: 333-336.

Quality control in the National Health Service

Sir,

The reason why quality assessment and quality control should be applied to the National Health Service (NHS) is that the quality of the service would be substantially improved. Moreover, improved efficiency and better utilization of resources will result.

Some assessment and control of quality already exists in the training and promotion of doctors. Continual scrutiny, accompanied by criticism and advice is *de rigueur* for junior doctors. Why does this scrutiny suddenly cease upon appointment as a general practitioner or consultant? Both groups make errors and good and bad practice do co-exist. However, at present the two jobs do not receive even occasional outside assessment. Quality checks are mandatory for aeroplane pilots, and commodities such as food and cars, yet NHS doctors, concerned with the physical and mental wellbeing, life and death of humans and financed by the tax-paying public, have no quality assessment or control beyond their junior ranks.

Doctors treat medical mistakes with silence and patients who know or suspect that they have been the victim of a mistake usually see no point, or are too upset or timid, to enlighten the medical establishment. Thus both doctors and patients tend to suppress errors. This is no way to pursue excellence and errors and misjudgements highlighted by a third party are educative — this is a major component of the training of students and junior doctors.

Once the notion of quality assessment and quality control has been recognized, the next step is how best it may be implemented. In the USA quality in medicine is often assessed by a lawyer. However, the best equipped persons to assess doctors are doctors in a group drawn from a variety of disciplines. It has been suggested that these doctors should make assessments under four headings — clinical competence, accessibility, ability to communicate and professional values.[1]

It is hard to dispute that such an assessment would be a forward step. However, quality assessment in medicine is new and for many a threatening concept. By pursuing it under the above headings it might prove prone to accusations of subjectivity and this would set back the successful implementation of a system of quality assessment.

A better starting point would be the identification of errors of direction and judgement. In general practice examples of such errors are found in referral letters to hospital — the man referred to a surgeon who removes a rectal carcinoma; six months previously the man had presented to his general practitioner with rectal bleeding and was treated for resumed piles. Whether such errors are one-off or indicative or overall poor practice, they should not pass without remark. It is precisely because bad practice may be uncovered that these errors should come under scrutiny. Hospital errors, perhaps more difficult to identify, should for the same reason be sought. Further, consultants should be called upon to account for the content and duration of bed occupancy and waiting lists.

Quality assessment, rather than more money, is the immediate need of the NHS. The question of how to exact quality control may be left in obeyance for the time being. Quality assessment can be expected to raise overall standards; this desirable effect is, in itself, quality control.

WILLIAM G. PICKERING
7 Moor Place
Gosforth
Newcastle upon Tyne NE3 4AL

Reference

1. Anonymous. What sort of doctor? *J R Coll Gen Pract* 1985; **35**: 317-318.

Preventive care of pre-school children

Sir,

I understand that both the General Medical Services Committee of the British Medical Association and the RCGP wish to encourage the preventive care of pre-school children within the setting of general practice and that training practices should encourage young doctors to develop the skills for this work.

I have been a part-time trainee in general practice since June 1984 and feel that six months as a senior house officer in a hospital paediatric department is insufficient training for paediatric medicine. In July 1984 I answered an advertisement for a course on developmental examination at the Institute of Child Health. I have now been told that I have a place on the 10-day course that begins on 29 January 1986. However, my pleasure at receiving this long-awaited news was shortlived as it was followed by an invoice for £240. I am asking my family practitioner committee to pay this course fee but

assume that, in view of the £22 annual limit, I will receive little finance from that source. While preventive care of children under five years of age is a service provided from belief in its importance, without financial reward, it seems unjust to charge exorbitantly for acquiring the necessary skills.

Perhaps before plans to devolve responsibility for developmental checks from clinical medical officers to general practitioners are too far advanced, greater provision needs to be made for training or refresher courses in developmental examination, since I have seen no other such courses advertised in the past 18 months. Equally important is adequate funding for such courses, without which even enthusiasts will not be able to attend.

JENNIFER MINDELL

Chalkhill Health Centre
Chalkhill Road
Wembley HA9 9BQ

General practice record folders

Sir,

Policy statement I. Evidence to the Royal Commision on the NHS, recently published by the College is of the opinion that the present folders for record keeping in general practice are 'out of date', but cautions that simply to change the form of the printed record could be a temporary yet extremely expensive palliative, and favours a computerized system.

Policy statement 2. Quality in general practice, goes further, saying that the NHS medical record envelopes are 'inadequate', and that the NHS A4 record folders 'provide a better opportunity to extend the patient data base and to improve the quality of record keeping'.

I have not been able to find a reference which justifies the damnation of the Lloyd George envelope, or offers a significant advantage of the A4 record folders, apart from 'being larger, with more room to store information; in addition letters and reports can be filed flat'.[1] The data base of a patient can be put comprehensively in one summary card of the Lloyd George envelope,[2] and an additional card can contain the repeat prescriptions, and all other information desirable for computerization.[3]

I am sure there are advantages and disadvantages to both systems, but to make a policy point of it seems to me a vain pursuit of elitism, making an accidental feature a distinguishing aspect of quality in general practice.

A.A. PIERRY

57 Hampton Crescent West
Cyncoed
Cardiff

References

1. Bolden KJ. Record systems. *Update* 1984; 15 October.
2. Moulds AJ. Putting your records in order. *Update* 1985; 15 April.
3. Collins I. Choosing a computer system. In: *The Royal College of General Practitioners 1985 Members' reference book.* London: Sabrecrown Publishing, 1985: 399-401.

Letter to regional advisers in general practice

Sirs,

The Panel of Examiners have been considering the performance of candidates in the latest MRCGP examination. The following is a selection of points, most of them old and well-established, which continue to be a source of anxiety.

1. The majority of candidates gave the impression that reading is so far down their list of priorities as to be virtually out of sight. It is not so much the lack of relevant reading or the inability to critically evaluate appropriate articles but rather the total absence of any reading whatsoever.
2. As part of the general lack of reading, most candidates appeared unable to demonstrate any critical appreciation of drug trials, whatever their source. Basic statistics appeared to be a language from another world.
3. The Panel once again expressed deep anxiety about the standard of training received by some candidates in some practices; the actual number seems to be increasing. Such candidates appeared to have a service commitment higher than any of the principals in the practice, to receive no teaching of any sort, and to be allowed no opportunity for self-education and given no encouragement to take the opportunity of critical appraisal of the delivery of health care within the practice or the surrounding community. Members of the Panel have found themselves on many occasions in the difficult position of feeling that the candidate has received a very raw deal in his training, and that his performance reflects his training practice to such an extent that the examiner is marking the practice rather than the candidate. In an attempt to mitigate this, the Panel would seriously urge that every trainee should be given, and should take the opportunity to gain, as wide an experience as possible in different types of training practice, rather than having his 12 months' general practice attachment concentrated in the one practice.
4. A surprisingly high number of candidates gave no indication of any logical thought behind the management of common chronic diseases such as hypertension and chronic obstructive airways disease. A protocol for diagnosis and management appeared to be unknown, and the ability to justify any planned regime was totally lacking in many cases. A specific example is that of the level at which to start treating hypertension, when candidates seemed to pluck figures out of the air with no rational basis for the decision. Again in this area the evidence to support actions was missing (no appropriate reading) and there was an additional lack of rational prescribing in management.
5. In the first oral examination most candidates appeared to have neither the inclination nor the opportunity to demonstrate any evidence of quality control in day-to-day practice. Existing habits whether good or bad were accepted without question. Use of the term 'audit' produced an air of cynical disbelief, and the very idea of monitoring performance appeared to remain at a totally subconscious level.
6. The Panel remains concerned by the inability of the great majority of candidates to construct a logical argument verbally; this concern is increased many times over in the written papers, where English grammar appears to be a thing of the past in educational terms. The Panel feels that this must represent a continuing inability to communicate at any level with anybody else.
7. While the mean score on the multiple choice questionnaire (MCQ) paper on this occasion was approximately the same, concern must be expressed about the 50 or so candidates who scored below 25% on this paper. Lacunae of ignorance reflected in these marks must in turn inspire lack of confidence in colleagues and patients alike. One candidate — an existing principal in general practice — even managed to score less than 5% on this paper.
8. Many candidates showed a surprising lack of knowledge about the organization of the health service in the United Kingdom, especially those areas of direct concern to primary care, for example, the relationship between local medical committees, family practitioner committees, district health authorities, and the independent contractor.

While this list could be increased, particularly if idiosyncratic responses by individual candidates are taken into account, the above represent the features of a more global frequency which caused most concern to the Panel on this occasion.

A. BELTON

Chief Examiner
The Royal College of General Practitioners
14 Princes Gate
Hyde Park
London SW7 1PU

Footnote: This is the text of a letter which has been printed in the *Journal of the Association of Course Organisers.*