daily ward visits by general practitioners employed as clinical assistants in the hospital. The patients generate a large amount of correspondence including progress reports to the hospital, but there is as yet no recognition of the additional resources required, not even an elderly patient capitation fee.

General practitioners in Clitheroe are perhaps more able than most to absorb these demands — we have average lists below 2000, with good living conditions and low unemployment among our patients,[3] but we feel the strain. How will other practices, which are already severely stressed, cope? Perhaps by refusing to accept such patients.

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Safest place of birth

Sir,

Marjorie Tew's letter (November *Journal,* p.521) repeats her well known position that it is safest to give birth away from consultant obstetric units, with their increased likelihood of obstetric intervention. This position has been thoroughly argued,[1] but her method has been shown to contain important methodological and logical flaws.[2]

Mrs Tew quite rightly states that the hypothesis that 'obstetric management is especially valuable to babies who are at risk because their mothers have certain characteristics or obstetric experiences' has never been tested. However, her challenge to use the Oxford obstetric data system for this purpose is misconceived; observational data sets of this type cannot be used for this task. In clinical practice women are not assigned randomly to their treatment (or place of booking or place of delivery), and statistical analysis, however ingenious, can never make up for this deficiency. In our hospital all women with risk characteristics will have received consultant care, making a comparison with general practitioner care impossible.

Indeed, it is partly because both Mrs Tew and her critics have had to rely on observational data, that there has been such confusion and controversy surrounding the issue of the safest place of birth.

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Training for hospice care

Sir,

I would like to support the views expressed by Dr Finlay in her editorial 'Training for hospice care' (January *Journal,* p.2). However many hospice beds there are, only a small proportion of patients will spend a small proportion of their illness in them. It is well recognized that hospitals are not an ideal place to care for dying patients from the medical, social and emotional points of view. The majority of patients are going to spend most of their time at home and it is the doctor's ability to liaise closely and sympathetically with the patient's general practitioner and the whole primary care support system, and to appreciate and respond to the pressures of the home environment as well as its opportunities, which are adequately prepared for by experience in general practice. I would like to see this go beyond completing a trainee course to the inclusion of at least two or three years of active practice, with final responsibility for patients.

Dr Finlay's suggestion of a diploma in palliative medicine, well balanced between clinical, communication and management skills seems to be well worth considering.

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Timing and purpose of the MRCGP examination

Sir,

I would like to respond to Dr Robert's paper on the timing of the MRCGP examination (January *Journal,* p.30). I sat the examination two months after completing my vocational training and I learned a lot from this. The emphasis on reading current medical literature including that on non-clinical subjects such as politics, computers and screening is relevant not just to general practice but to medicine as a whole. Trainee day release courses and trainers are not necessarily examination oriented and may teach other equally, or even more valuable approaches, such as Balint type group meetings. For me, the examination was complementary to the trainee year in many respects.

I am currently a senior house officer in psychiatry and intend to make psychiatry, and not general practice, my career. If I had to gain years of further experience in general practice I would not have sat the examination. Many doctors now have more than one postgraduate membership, and it would be a pity if interested non-general practitioners were to be prevented from broadening their knowledge of general practice in this way. A hospital patient has many of the same needs as a general practice patient. Doctors in different hospital specialties may not need to talk to each other, but they all need to communicate with general practitioners and have some understanding of their work.

I hope this viewpoint will be taken into account in debating the re-scheduling of the examination.

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Sir,

It seems almost impossible to open a general practice journal or newspaper without seeing something about the MRCGP examination. Unfortunately, most articles appear to cover the same ground. The latest offering in the *Journal* (January, p.30) is no exception. However, there were one or two points on which comment should be made. The fact that many candidates devote time to modified essay questions and attempt to increase their factual knowledge appears to be anything but reprehensible, especially if you bear in mind that you cannot develop a questioning approach to general practice without first having a sound basis of factual knowledge.

The article also implied that the good practice allowance/postgraduate education allowance, should become tied to the

examination, on the basis that the examination is somehow associated with good practice. Unfortunately, there is no evidence that possession of the MRCGP guarantees a good standard of practice. Furthermore, the white paper's intention in proposing the postgraduate education allowance,[1] is to encourage a continuing commitment to education rather than a one-off attempt to pass an examination.

As far as the end point assessment is concerned, although there is nothing inherently wrong with a system of assessment based on personal reporting, the main worry is the lack of standards. At least the MRCGP examination has a reasonable standard which is based on the collective wisdom of the panel of examiners.

The timing of the MRCGP examination is a subject that many, including myself, have commented on in the past. But, on balance, I do not think it matters all that much when the examination is taken. In fact, the strongest argument for continuing with the present arrangement is the flexibility that it offers to the potential candidates. Indeed, a candidate can take the examination at a time which is most suitable and convenient to him.

Finally, it must be about time to acknowledge the excellence of the MRCGP examination and its tremendous contribution to raising the status of general practice. This self criticism will do nothing but discredit the examination and undermine the confidence of our trainees in vocational training and the College.

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1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Promoting better health (Cm 249).* London: HMSO, 1987.

Funding for continuing education

Sir,

As a course organizer who has an interest in continuing medical education, I was pleased to see Professor Pereira Gray's mention of the need for higher degree courses in university departments in his report to the annual general meeting (News, December *Journal,* p.575).

As a participant in the new masters degree course in medical education, I would welcome any suggestion of sources of funding to cover the necessary expenses. This course is part-time, constructed in short modules that span two years. This format allows me to maintain my practice responsibilities and my commitment to my day-release course. However, my request for study leave funding has been declined by the Department of Health on the grounds that applications are only approved for full-time study completed within an upper time limit of 12 months. Similarly, a local medical school trust has also declined any assistance, stating that clinicians are expected to make 'some personal sacrifice'.

While not totally disagreeing with the above, I feel that lip-service is paid by the health service to the concept and importance of professionalism in continuing medical education, but its acquisition is, as usual in medicine, dependent on the will and resources of the individual.

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AIDS and the future general practitioner

Sir,

Sibbald and Freeling in their paper 'AIDS and the future general practitioner' (November *Journal,* p.500) make an array of statements about doctors from a comparison of trainers and non-trainers. Their work was based upon postal questionnaires with response rates which seem to me to be pretty dismal, 67%, 54% and 52%. I wonder below what level of response is it unwise to draw conclusions? And, how close should the response rates for the two groups be for reasonable comparisons to be drawn? Surely if the samples may not be representative of the populations, the conclusions and the statistical tests of differences might well be incorrect?

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Sir,

Dr Garson is concerned that low response rates invalidate the findings of this study. As discussed in the first paragraph of the discussion of the original paper, we believe the response rate of 67% among trainers is high enough to ensure this is a representative sample. Certainly the sample is large enough to give, for example, a confidence limit of ± 4% on a prevalence of 20%. The response rate among non-trainers was low (52%), but the findings were remarkably similar to those obtained in three other contemporary surveys. It is of no statistical importance that the response rates of the two groups differed. It is likely therefore that our findings and conclusions are valid.

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A car with flat tyres?

Sir,

In his editorial 'A car with flat tyres' (December *Journal,* p.535), Dr Richards states that the familiar medical record envelope originated with the health insurance act of 1911. Certainly the capitation system of payment and the self-employed status of general practitioners can be dated from that time, but there were no medical record envelopes until 1 January 1921. As far as I can ascertain, the state made no arrangements whatsoever for providing stationery for recording medical notes before 1921.

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Ultra nappy rash

Sir,

We wish to draw attention to a problem which we have recently observed. Between us we have seen 12 children attending surgery, health visitor or casualty department who have developed a rash in the nappy area following the use of various ultra-absorbent disposable nappies. The rash invariably settled when the type of nappy was changed and recurred in two cases when the nappies were reintroduced. These nappies, only recently introduced into the UK, contain a polyacrylate polymer (said to be non-allergenic), which increases the absorptive power of the nappies and reduces their bulk with obvious advantages for both parent and retailer.

Professionals should be aware of the existence of this problem which we have called 'ultra nappy rash', as most mothers we spoke to had initially used the nappies because their children had sensitive skin. These nappies may not be the best choice for such children.

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