standardized mortality ratios for the Western Isles of Scotland are lower than those for the mainland of the United Kingdom. This gives rather more support to the conclusion that true rural communities with extended families and good social support in fact have lower suicide rates.

Crombie's so called 'epidemiological fact' gives us useful insight into how poor science can be readily assimilated into common belief without question. I have subsequently heard several radio programmes and seen several newspaper articles which assume this epidemiological fact to be correct. This reinforces the importance of the critical reading paper in the MRCGP exam. Indeed Crombie's paper and the subsequent correspondence are used to discuss critical reading with medical students at the University of Glasgow (G Watt, personal communication).

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References

1. Crombie IK. Suicide among men in the highlands of Scotland. *BMJ* 1991; **302:** 761-762.
2. Carstairs V. Suicide among men in the highlands of Scotland [letter]. *BMJ* 1991; **302:** 1019.
3. Douglas JDM. Suicide among men in the highlands of Scotland [letter]. *BMJ* 1991; **302:** 1019-1020.

Fellowship of the RCGP by assessment

Sir,
The Royal College of General Practitioners has launched a new initiative to promote fellowship by assessment, hoping to have 250 new fellows by this route by 1996. The experiences of these pioneers who are prepared to develop their practices and allow scrutiny by their peers should be recorded, for they will be making a major contribution to the development of general practice. Such experiences may not always appear in the official records, however, and would therefore not be available for the benefit of later applicants, or for the history of the profession.

I am keen to gather material on the experiences of those who proceed to assessment and am also interested in the attitudes and opinions of those who have given thought to the principle of fellowship by assessment but who decide not to proceed, perhaps because of difficulties, obstacles or inhibitions. I am also keen to hear from anyone who, for whatever reason, is not in favour of the principle. I hope to publish the results of this research in a book which would be a companion to my book on the MRCGP examination.[1] The project has the approval and support of Professor Mike Pringle, chairman of the RCGP fellowship by assessment working group.

I would be very grateful if anyone who has a view on fellowship by assessment could write to me at the address below. References to such views or experiences in any eventual publication would, of course, be anonymous.

RICHARD MOORE

6 Mayfield Park
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Reference

1. Moore R. *The MRCGP examination: a guide for candidates and teachers.* London: Royal College of General Practitioners, 1994.

Paperless medical records — approval still awaited

Sir,
Computer systems have been capable of storing general practitioner medical records since the mid-1970s,[1] yet to date this does not have the approval of the Department of Health. The statement of fees and allowances requires that general practitioners keep records on forms provided by the family health services authorities and some authorities persist in trying to enforce this position. To quote from a recent article by the chairman of the primary health care specialist group of the British Computer Society, 'this is clearly anachronistic nonsense' (Royal College of General Practitioners south west Thames faculty newsletter 1994; autumn: 6). Information stored on paper is bulky, time-consuming to file and almost impossible to retrieve and analyse.

For several years interested general practitioners have been under the impression that the National Health Service Executive was working to modernize the rules. However, to date no announcement has been forthcoming. The new rules should state that medical records may be stored on general practice computer systems provided that such systems are confidential to general practitioners and staff, regularly backed up to prevent accidental loss of data, and include an audit trail or other system to show details of any alterations and deletions. Computerized records should be copied or transmitted (either electronically or on paper) when patients change to a different general practitioner so that the new doctor has access to them.

Having dealt with medical records perhaps the NHSE might urgently address the problem of doing away with general practitioner's signatures on electronic claims and prescriptions. It has, after all, been possible for many years to draw cash from a bank autoteller without signing for it.

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Reference

1. Bradshaw-Smith JH. A computer record-keeping system for general practice. *BMJ* 1976; **1:** 1395-1397.

Non-verbal communication: the lip-reading sign

Sir,
I would like to describe a new sign in general practice. This has come to my notice after using a computer over some five years.

When patients are deaf but unaware that they lip-read, they rely on seeing the doctor's face and lips. During a consultation, the computer screen may be turned to face the patient so that both parties can read it. The result can be a doctor talking to the patient, but facing the computer screen during part of the consultation. If the information is essential and the patient cannot deduce what the doctor is saying, the patient gradually moves position so as to 'lip-read' the doctor. This can become so strong an urge that the patient ends up interposing himself or herself between the doctor and the screen. Perhaps the sign deserves a better name? Any suggestions?

General practitioners who think that patients may be hard of hearing should always ensure that the patient can see the general practitioner's face clearly before the doctor starts to speak, especially if the doctor is about to impart important information.

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