Sir,
Dr Brown (Letters, March *Journal*, p.128) is right to point out that three years is a short time to prepare to become a principal in general practice, a problem exacerbated by the fact that two years are spent in the educational vacuum that represents the hospital component of training for many trainees. He is wrong however to attack the diploma examinations of the royal colleges as being purely income generating duplications of the MRCGP examination and to advise trainees to avoid them as detrimental and disruptive to their training.

I believe that the active promotion of these examinations and the closer involvement of the Royal College of General Practitioners in their future development offers a way of improving the educational experience in hospitals for general practitioner trainees. The diploma offers a curriculum to be covered in each post and provides a clear focus around which protected teaching time can be built. The diploma examination gives a framework around which the trainee can develop a greater knowledge of a specialist subject than can be covered by the College membership curriculum and it can turn a hospital post into a fertile educational opportunity rather than a service commitment wasteland. This is what the examination for the diploma in geriatric medicine did for me. Far from being a disruption to our traineeship diploma examinations can be an enhancement.

TIM HUGHES

40 Wyndham Road
Silverton
Devon EX5 4JZ

Sir,
I read Dr Brown's letter on the subject of diplomatosis with great personal interest (March *Journal*, p.128). I have suffered two severe bouts of the disorder and envisage another before I enter general practice as a principal. I have noticed that, as for many chronic diseases, it is not the illness itself which bothers me, but other peoples' attitudes towards my misfortune.

How often have I heard general practitioners say to me 'What a dreadful malady diplomatosis is. I strongly advise you not to admit to the illness on your curriculum vitae — no one will want to employ you.' But I will not be downtrodden. I want to climb to the top of Princes Gate and shout proudly 'Look at me. I've got diplomatosis but I feel great; I feel competent; I have a wonderful sense of personal satisfaction'.

The MRCGP examination should be retained as an excellent assessment of a competent generalist approach and those of us who, at considerable personal expense and disruption, simply enjoy studying a variety of subjects to greater depth should not be criticized.

MARTIN MARSHALL

Mount Pleasant Health Centre
Mount Pleasant Road
Exeter EX4 7BW

Standardized patients in general practice

Sir
We were fascinated by the articles on assessment of the performance of general practitioners by the use of standardized (simulated) patients (March *Journal*, p.94,97). Looking at Figure 2 in the second paper we were surprised that actions outside the suggested management would be described as superfluous. No appreciation is indicated of the possible public health implications of a woman with diarrhoea of three days duration who works in a butcher's shop. It is essential that anyone with symptoms of a possible gastrointestinal infection is asked what they do for a living. A food handler with diarrhoea must not continue to work. Giving the patient this advice is an essential, not a superfluous, action.

In the UK it would also be usual in these circumstances to notify a case of suspected food poisoning to the health authority department of public health medicine and/or to the environmental health department of the local authority. Clearly, this would create difficulties with a simulated patient. If this method is to be developed the researchers must decide how to handle actions which go beyond the immediate management of the general practitioners.

HILARY PAGE
DOROTHY BIRKS

Sheffield Health Authority
Department of Public Health Medicine
Westbrook House
Sharrow Vale Road
Sheffield S11 8EU

Complaints and patient expectations

Sir,
Caution against complacency over the remarkably low complaint to consultation ratio in the UK is rightly emphasized by Owen (March *Journal*, p.113) as the complaints submitted by patients are likely to represent only the tip of an iceberg of dissatisfaction. In addition the next decade may witness a sharp increase in complaints against the medical profession if the UK is influenced by the patterns of medical litigation currently prevalent in North America. A third factor which may increasingly enter the complaints equation is the conflict between maximizing the health of a defined population within resource constraints and securing the best care for an individual patient. The former which is the remit of public health physicians entails a formal assessment of the health needs of a population and developing priorities based upon this assessment. However, mechanisms are being introduced whereby the individual clinician is expected to partake in developing priorities for groups of patients, for example, introduction of resource management in hospitals, indicative prescribing budgets and fund holding practices. The trust component of the doctor–patient relationship, based largely on the premise that the doctor will strive to achieve the best care for the individual patient, may well be undermined by these mechanisms.

Action at the national level is required to address patient expectations if this conflict is to be prevented from being transformed into complaints against the medical profession.

ZAFAR IQBAL

Clwyd Health Authority
Preswylfa
Hendy Road
Mold, Clwyd CH7 1PZ

The family history and the family doctor

Sir,
I read with great interest Peter Tomson's thoughtful editorial on family history (February *Journal*, p.45). While agreeing with most of what he has to say I was a little surprised that he used the American example of genograms but did not refer to possibly more accessible work published earlier[1,2] which might be of relevance to British doctors interested in this subject.

J J C CORMACK

Ladywell Medical Centre
Edinburgh EH12 7SN

References

1. Cormack JJC. Family portraits — a method of recording family history. *J R Coll Gen Pract* 1975; **25:** 520-521.
2. Zander LI, Bereford SAA, Thomas P. *Medical records in general practice. Occasional paper 5.* London: RCGP, 1978.