Training in appraisal skills is required. One of the best ways of learning is to experience a skilled appraisal oneself. This can also give some insight into why junior doctors find appraisal helpful.

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Is the MRCP(UK) examination a dinosaur?

Sir—The risk of the long-term demise of the MRCP(UK) examination, envisaged in *News & Views* (January 1995, Issue No. 8, page 2), might be augmented by the perception prevailing amongst some candidates that this diploma represents the culmination of the acquisition of clinical skills in general medicine. The reality is that, even at MRCP level, a substantial content of medical knowledge and craft might be overdue for re-evaluation, not least because the methods which underpin our clinical skills have themselves so far escaped validation for sensitivity, specificity, and productive power. In essence, what is overdue is a continuous process of defining, refining, and redefining of the areas of certainty as well as uncertainty in the craft as well as in the science of medical practice.

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CPR: doctors and nurses expect too much

Sir—I read the study by Wagg *et al* (January/February 1995, pages 20–4) with interest. One conclusion seems to have been overlooked. From the data on respondents' estimates of survival to discharge following a CPR attempt, all the groups (except the US nurses) estimated a greater survival nationally compared to the survival of the patients who had CPR that they themselves participated in. This difference of estimates was not borne out by the most experienced doctors who estimated similar survival figures both locally and nationally. It would seem that the less experienced participants in CPR attempts either do not have the same confidence in the ability of their local resuscitation team, do not feel that a sufficiently adequate attempt is made, or feel that the group of patients they are attempting to resuscitate are in some way different from those nationally. In any case it would seem that an opportunity to discuss the feelings of the participants should exist. After all some CPR attempts can be psychologically traumatic for the staff intimately involved in the care of the individual patient.

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From medical apartheid to siyazamile

Sir—Dr Haviland (November/December 1994, pages 567–8) gives a depressing but accurate account of her experiences as a medical student in a provincial hospital in South Africa during the last days of the apartheid era. She contrasts the collapse of hospital-based medical services with the promise of nursing-based primary health care in the community. I have recently helped to implement the Perinatal Education Programme at Settlers Hospital which has greatly improved staff morale. Based on a very successful US model [1], the Programme is a self-help, problem-orientated correspondence course in maternal and newborn care which enables local health authorities to improve the standard of perinatal care provided by both doctors and nurses. In a field trial being used for a doctorate thesis we are hoping to document not only a change in the knowledge, skills, attitudes and behaviour of the Settlers staff, but also an improvement in the quality of care received by the people of Grahamstown. This innovative method of cheap outreach eductaion is currently being launched throughout southern Africa and promises to correct many of the problems identified by Dr Haviland.

I hope that concerned doctors in Britain will consider working in the new South Africa to assist with the reconstruction and development of a health service which will bring appropriate care to all communities [2].

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Endoscopy: throat spray or sedation?

Sir—We read with interest the study by Pereira *et al* (September/October 1994, pages 411–4). The objective of sedation, as defined by the *Guidelines for sedation by non-anaesthetists* [1], 'is to help patients accept uncomfortable and distressing diagnostic and therapeutic procedures while easing technical difficulties for the operator'. Clearly if sedation is not needed then its associated risks are best avoided but we feel this study may not answer the problem addressed.

Over one third of the patients (76) had previously had an endoscopy. These patients are likely to have different expectations of endoscopy. They probably know their diagnosis, which was