examinations for membership of the Royal College of General Practitioners. It is often proposed that the examination is a suitable end-point for judging competance to practice as a general practitioner. At the end of the day I came to the following conclusions about what the MRCGP examination does and does not achieve.

The examination did demonstrate which of the candidates had something extra, by which I mean those who read about their work, care about it and above all have a willingness and ability to think about and even advance their discipline. The examination thus achieves its aim of identifying doctors who one would like to see as members of the College. It also picks out the doctors who will be able to lead and inspire future trainees. None of the oral examinees, however, appeared to be in any way unsafe to practice as principals. A proportion of the candidates get such low marks on the written papers that they are not invited to the orals. Obviously, I am not able to say anything about these doctors beyond noting that they have failed tests which concentrate mainly on knowledge rather than performance.

The conclusion is that as a measure of satisfactory albeit pedestrian competence as a general practitioner the membership examination is not appropriate; some other criterion of assessment needs to be found. To this end both the Joint Committee on Postgraduate Training in General Practice and the Association of Course Organizers are looking at continuous end-point assessment of vocational training.

My thanks are due to the examiners in general for having me and especially to Tom Dastur for all his kindness to me during the day.

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Marriage guidance counselling

Sir,
In her article on marriage guidance counselling in general practice (September *Journal*, p.424), Dr Corney states that many studies have indicated a decrease in the number of visits to the doctor by patients after cessation of counselling in comparison with the period before referral. She also comments on studies that have found a reduction in the prescribing of psychotropic and other drugs. I would agree that the papers that she lists do in fact come to these conclusions.

My recent survey, however, using a one-year follow up period, detected no major change in the number of prescriptions for psychotropic drugs or consultation rate during the years that counselling was available in the practice.[1] In the year after counselling, the number of psychotropic drug prescriptions actually increased, though this was accounted for by a small number of patients. A recent review of literature on counselling in general practice[2] came to the conclusion that it has yet to be proved that meeting patient's needs by counselling is better, cheaper, or in the long run more effective, than these needs being met by consultation with the doctor and the prescription of psychoactive drugs.

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Primary care services

Sir,
We note that in the September *Quality in Practice Bulletin* College Council has issued a statement of the basic range of services that should be made available to patients by every practice in the United Kingdom. We assume that any resemblance between this list of services and our list published in the *Lancet* in February[1] is purely coincidental.

Nothing we have seen or heard in the debate about primary health care services, before or since the publication of the Government's green paper[2] has led us to change our views. We believe that a guaranteed minimum service comprising traditional demand-led service, continuity of care, care of certain common chronic conditions and specific preventive programmes, would give general practice a much needed sense of direction. We believe practices rather than individual practitioners should be made responsible for providing such a basic range of services. Furthermore, the development of a computerized information system for the activities of anticipatory care would allow health authorities, family practitioner committees and practices to concentrate their efforts on areas of need such as inner cities. Local medical committees would have the major constructive role of advising on appropriate annual targets for the care of specified chronic conditions, and for the various preventive measures.

This approach to the provision of primary health care follows the World Health Organization's philosophy of 'health for all', and could be the basis of a new contract for general practitioners. It could go some way to solving the major difficulties that beset general practice — namely, lack of direction, relative lack of accountability, poor measurement of outcome, inconsistency of service provision and difficulty in marrying the salaried community health service with the independent general practitioner service.

We welcome the College Council's statement.

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2. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care — an agenda for discussion (Cmnd 9771).* London: HMSO, 1986.

Fees and allowances

Sir,
The College has rejected the government's proposal to shift remuneration from basic practice allowance to capitation fees. This is understandable as we would not want a return to the oversize lists of the past. However, in some areas patients have difficulty getting a doctor to take them on even though lists are smaller than in the past.

The structure of our fees and allowances means that the highest rate of pay per patient is for the list of 1000 patients. Below that level basic practice allowance is cut, but once over 1000 patients the extra for each patient registered falls from over £20 to about £8. This leads to a dual population of general practitioners. Those with outside commitments with lists just over 1000, who are reluctant to take on extra patients, and full timers with lists of 2000 or more.

I would propose different thresholds for