lend medical books!

H. K. FORD

Group Surgery
Poplar Avenue
Heacham
King's Lynn
Norfolk PE31 7EA.

MEDICAL JOURNALISM

Sir,
The quality of medical journalism needs to be improved. Doctors and journalists need to understand each other. That is why there are general practitioners who focus on such matters by being involved with faculty publications. However, newcomers still have to start from scratch, and new faculties like Essex, or Beds and Herts, have no guide as to what the College considers to be a minimum standard with respect to size, distribution, style, or cost of producing newsletters and sending them to local members. Issues are not often timed to coincide with hot news from board meetings, or general or open meetings. There is little liaison with calendars from medical centres in the region. Inefficient use is made of free postage available for less urgent mailings of general interest to general practitioners from the faculties to their own area—through the family practitioner committee 'bundle'.

Your *Journal* has only a limited amount of space for College matters, and must accommodate articles and news from a wider catchment than members only. But you also have an opportunity to co-ordinate the processes and tasks of communication within the College itself, whether for the benefit of members or outsiders.

The medical journalist is a fairly new breed of doctor and a new European Association is about to be formed through the initiative of Mr Ronnie Bedford, Science Editor of the *Daily Mirror,* and Mr Jerry Cowhig, Editor of *General Practitioner.* If our College is setting standards for the profession on medical matters, it must also keep abreast of developments in standards of communication in medicine: doctor-to-doctor, doctor-to-journalist, doctor-to-patient, journalist-to-patient, patient-to-patient . . . A conference of news-sheet editors might well study this without losing their independence; on your initiative.

MICHAEL JAMESON

Beds and Herts Faculty News
21 Upper Lattimore Road
St Albans AL1 3UD.

MRCGP EXAMINATION

Sir,
I have been uneasy for many years about the lack of a 'clinical' in the MRCGP examination. Examining skills are as important in general practice as in hospital medicine, surgery, paediatrics, or any other discipline, and the present examination encourages the idea that we practise a less clinical type of medicine.

For the past week I have been examining in the DCH which has reinforced my belief that the 'long' case in the clinical examination is the most sensitive indication of a candidate's ability to relate to a patient and, for example, to extract information which would enable him to assess and manage a chronic illness. The candidate was also shown three to five short cases so he could demonstrate his skill in eliciting abnormal physical signs. This is as important in general practice as hospital medicine—more so perhaps as the patient has usually to rely on one doctor discovering what is amiss whilst in hospital practice usually several doctors examine each patient.

There are enormous difficulties in reorganizing the examination in this way. The patients would have to come from practices within a few miles of the examination centres, transport would have to be arranged, and presumably patients would come mainly from the practices of the examiners.

Perhaps the time has come to debate this thorny problem once again.

MICHAEL MODELL

Kentish Town Health Centre
2 Bartholomew Road
London NW5 2AJ.

WHAT KIND OF COLLEGE?

Sir,
Dr A. T. H. Glanville's letter (September *Journal,* p.571) raises two points of interest:

1. He states that many doctors have given up community commitments, such as the St John's Ambulance and the British Red Cross Society.

A glance at Appendix 3, page 27 of the Twenty-sixth Annual Report 1978, under the heading "College Representatives on other Organizations and Committees", shows that the College is not represented on either of these organizations. Perhaps Council should consider those community commitments which involve general practitioners, and make haste to plug this gap.

2. He suggests that some aspects of the College seem to be run "by a selected hierarchy who have little touch with general practice".

I do not feel this is true, but perhaps members of Council and those holding important office in the College should be expected to undertake a certain minimal amount of hours of consultation sessions in general practice during the week.

RONALD LAW

9 Wrottesley Road
Willesden
London NW10 5UY.

LEARNING FROM OUR PRESCRIBING

Sir,
Dr Norell's report of the symposium held jointly by the College and the *Drug and Therapeutics Bulletin* (September *Journal,* p.574) occupied only half a page. This is barely room for an adequate summary or itemizing of points.

In the condensation I detect a four-and-a-half line sentence devoted to my contribution and a further unnecessary innuendo of " . . . therapeutic nihilism and stinginess . . .". My prescribing might be characterized parsimonious, but I think 'economic' or 'relevant' are preferable.

Semantics aside, I *have* obtained the staggering results to which Dr Norell refers, but not, as he suggests, by "substitution from the chemists shop". I did say that the local chemist, my patient for 20 years, initially did 'substitution business' because of my inexperience, but this is largely history for I am now better able to get a concept over to a patient. (Do other doctors' patients never visit a chemist shop?) Furthermore, my patients very rarely change their doctor, nor do they play my partner against me; and should they get extra incentive to visit the off-licence as Dr Norell, no doubt whimsically, suggests, the patients' spouses, consorts, family, or neighbours have yet to bring this to my notice. Understanding a patient, though a skill slowly acquired, is not a limited talent.

I have a postulate: "A doctor's prescribing costs are reciprocal to his grasp of the problem and his understanding of the patient". My approach reflects this. Am I wrong?

DAVID RYDE

56 Anerley Park
London SE20 8NB.