should deter general practitioners from referring women for the abortions to which they are entitled.

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TEACHING MEDICAL SUBJECTS TO SOCIAL WORKERS

Sir,
The Liaison Committee between the British Association of Social Workers and the Royal College of General Practitioners is currently considering the requirements for teaching medicine and related subjects during social work training. We realize that medical subjects are taught to a varying extent in most courses of social work training. We have made limited soundings of opinions on the subject among doctors and social workers, but we would like to know more about what actually happens in training courses.

It would be much appreciated if doctors who teach on social work training courses would write to us and let us know what happens. In particular we would like to know what is taught, by whom, and the amount of teaching time that is involved. We would also appreciate a brief assessment of the value of such teaching.

Correspondence should be addressed to the Secretary of the Committee, Miss D. G. Dedman, BASW/RCGP Liaison Committee, Department of Social Work, The London Hospital, Whitechapel, London E1 1BB.

G. KEELE
Chairman

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MEDICAL EVIDENCE OF INCAPACITY

Sir,
In the January issue (p. 44) there is an unsigned 'snippet' entitled "Medical evidence of incapacity" which deserves comment because it appears to carry great authority.

However, it fails to distinguish between advice and certification. Of course a practitioner must advise his patient on the time and extent of resumption of all forms of activity, including naturally resumption of work.

Certification, on the other hand, is a process of advising a petty bureaucrat of the DHSS for the security of the public purse.

That employers so frequently use sight or copy of Med 3 is probably not a breach of confidence in that the patient hands the certificate to the employer and incurs the full responsibility himself. It is, however, a breach of the practitioner's copyright and fraudulently deprives the practitioner of his fee. This custom is now contrary to the policy of the Conference of Local Medical Committees and of the British Medical Association.

The suggestion that serious disease may be detected early because of the need to attend early for a certificate is probably vastly offset by those who do not attend with serious illness because the doctor is always "so busy"—issuing certificates and necessarily examining, and probably treating, large numbers of patients with straightforward self-limiting illnesses and minor injuries.

DERMOT LYNCH

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SELECTING TRAINERS

Sir,
It was with astonishment that I read Dr Oakley's stirring defence of the Kent Trainer Selection Committee's method of selecting trainers (February *Journal,* p. 117). It is good to see that they adhere to the criteria laid down by the Joint Committee on Postgraduate Training for General Practice (1976).

Why then was I deferred for a year by the self-same committee because I had not been a principal for *five* years when those criteria of which Dr Oakley writes clearly state three years?

It seems that whilst Oxford and the North of England areas are to be soundly condemned by Dr Oakley for not adhering to the criteria in asking for the possession of the MRCGP, Kent are to be admired for altering a far more arbitrary criterion.

Experience rules OK, Dr Oakley?!

JOHN F. GRACE

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Kent.

Reference

Joint Committee on Postgraduate Training for General Practice (1976). *Criteria for the Selection of Trainers.* London: JCPTGP.

Sir,
I could not agree more with Dr John C. Oakley (February *Journal,* p. 117) about the selection of trainers. I would add that a trainer does not need to be trained to be a trainer, as some members of the profession would have us believe. Surely, teaching and 'putting things over' to people is an art and one is either capable of communicating ideas or not. This is something we should have learned by now from our school and student days; that is, that you are either capable or incapable of teaching, and that is an end to the argument.

I would like to disagree with Dr M. Modell (December *Journal,* p. 759) who suggested that the MRCGP examination should have a 'clinical' unit; I suggest that he not only insults the young doctor who has already qualified and who has passed several clinicals in his finals, but also insults his distinguished panel of examiners by imputing that they were not capable of determining whether the student before them was capable of conducting a clinical examination.

M. E. GLANVILL

Jocelyn House Mews
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Somerset.

BUTTERWORTH MEDICAL DICTIONARY

Sir,
I hope you will allow me space to redress the effect of your curt dismissal of the *Butterworth Medical Dictionary* in your recent review of its second edition (December *Journal,* p. 762). Your complaint was that it contained none of the newer terms used in general practice. Although you did not specify any of the terms for which you had sought in vain, it is likely that most of them are defined in standard dictionaries of the English language. Terms such as 'psychodrama', 'role play', and 'behaviour modification' can be understood in this way. Other hybrid terms such as 'collusion of anonymity' and 'standardized residuals' are better worked out in discussion with a tutor.

Since receiving this fine work as runner-up to the Butterworth Gold Medallist I am perhaps the only other general practitioner to possess a copy. It seems to me a great landmark in medical publication, a marvellous example of the lexicographer's art, and a work without which few medical authors could now make their contributions. In anatomical nomenclature the NA (Paris) terms are incorporated where appropriate without marching ahead of the education of doctors who are still more familiar with the Bir-