LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

MRCGP examination

Sir,

At a recent meeting of our local trainers group the appropriate time for setting the MRCGP examination was debated. It was strongly felt by our group that there exists in many quarters a tacit encouragement to attempt the examination at the end of the period of vocational training; indeed this is now becoming the norm. As a result many trainees have the feeling, rightly or wrongly, that the examination is yet one more prerequisite for being considered as a potential partner in a practice. This encourages an undue emphasis on studying for the examination in the training period in general practice at the expense of gaining experience for a lifetime of family doctoring.

We suggest that the examination should be split into two parts. The written part could be taken at the end of the vocational training period but the rest of the examination only after two years as a principal in general practice (or equivalent if the candidate has ultimately chosen another field). The consequence of this would be that the pressure to pass the examination as an additional entry qualification into general practice would be removed. It would also be interesting to see how many new young doctors were still motivated to complete the full examination when the pressure to find a job had been removed.

RICHARD DREAPER

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Sir,

Following the letter from Dr John Makin (April *Journal*, p.180) in which he expressed concern about the pressure on trainees taking the MRCGP examination detracting from the trainee year, I have been wondering whether the problem is more profound than the timing of the examination.

From the fourth year at secondary school education is geared towards passing examinations. Once at medical school, education is still geared towards an end point assessment. When trainees finally enter the training scheme it is hardly surprising that they see the course as yet another three-year slog for an examination.

This approach not only detracts from the scheme but could produce an attitude in the trainees that passing the examination means that the doctor is a 'fully qualified' general practitioner who has no further need to study.

To help our trainees gain the most benefit from the trainee year, we need to change their attitudes towards education which have been built up over many years. This is a considerable challenge but it is not the first time that we have had to change attitudes instilled by the traditional educational system. If we can meet the challenge the next generation of general practitioners will see vocational training, and the MRCGP examination, as the first step on the long trek towards the unattainable goal — the perfect general practitioner.

PETER L. MOORE

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Sir,

I could not help but notice an inconsistency between Dr Belton's letter to regional advisers in general practice (March *Journal*, p.138) and E.J.M's comments (p.139). E.J.M. noted that Dr Belton's letter was given dramatic coverage in the general and weekly medical press, and he implied regret that the fact that 75% of trainees pass the MRCGP examination was not taken into account in the reports. I can only suggest that it is fortunate that it was not.

Dr Belton's letter outlines several areas of deficiency in candidates sitting the MRCGP examination. The serious nature of the deficiencies he describes and his assertion that in many of these areas over 50% of candidates were inadequate (as implied by his use of 'majority'), appears to be in direct conflict with E.J.M's quoted pass rate.

The deficiencies described by Dr Belton would appear to be incompatible with both the aims of the College, and with the standards to be achieved at the end of vocational training. One is left with two possible conclusions: either the situation is not as bad as Dr Belton states or candidates are being admitted to the College who do not read, are lacking in knowledge, and cannot communicate.

The former conclusions would appear unlikely. As Chief Examiner, Dr Belton should be fully aware of current standards. In the event of the latter conclusion prevailing, this situation can only devalue the MRCGP examination and negates the 'audit of training' to which E.J.M. refers.

The College has done much to raise standards in general practice, but to enlarge College membership in the manner implied can only ultimately reduce its influence and credibility and is counterproductive to its efforts.

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Morbidity statistics from general practice

Sir,

The editorial 'the third national study of morbidity statistics from general practice' (February *Journal*, pp.51-52) describes an increase in mean consultation rates for both males and females — 2.30/3.14 (males/females) in 1971 versus 2.71/4.02 in 1981. Further, it appears that rates for home visits as a percentage of all consultations are decreasing — 14.0/15.8 in 1971 versus 11.1/12.7 in 1981. There are two interpretations of these figures. First the number of home visits has remained unchanged while a growing number of people come to see their doctor in his surgery or secondly, the number of home visits is declining. If the latter is correct this is

deplorable. If we no longer make home visits both patients and doctors should be pitied and doctors should, rightly, be blamed.

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Wheezy bronchitis

Sir,

In the editorial on asthma (February *Journal,* p.52) Dr Levy decries the use of the term wheezy bronchitis. 'Wheezy bronchitis' is a useful diagnosis and should not be disdained. Its very use indicates that the doctor considers that there is bronchospasm present and that asthma is a likely diagnosis although perhaps not certain at that stage. It almost certainly means that he has also prescribed a theophylline preparation or a beta-receptor agonist and it alerts his partners and reminds himself next time to be particularly watchful for the stigmata of asthma. In explaining the diagnosis to the patient I would always mention the possibility of an atopic origin without branding the child as a definite asthmatic.

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Original pack dispensing

Sir,

The editorial on prescribing (April *Journal,* pp.146-147) stated that changing to original pack dispensing might result in pharmacists becoming undervalued. This is a strange reason to attempt to undermine the development, particularly as the Pharmaceutical Society of Great Britain has joined with the Association of the British Pharmaceutical Industry in stating that original packs should be the normal method of dispensing.

I fail to see how a defence of 'traditional dispensing skills' can be taken seriously — the counting of tablets or measuring medicines from bulk containers, often to cater for requests for irregular quantities by the prescribing doctor, can hardly be in the best interests of patients. Dispensing using original packs should make the job much quicker, and allow the pharmacist more time to talk to patients, a role that the editor of the *Journal* is obviously keen to support.

The question of flexibility in dosage or length of a course of treatment has been much discussed — directives on how long a medication should be taken should surely primarily be made by the manufacturer. The Association of the British Pharmaceutical Industry circulated advice to all its members in February 1986. Chronic treatment packs should contain treatment for 28 days, while short-term treatment packs should contain the quantity required to meet the manufacturer's recommendations for a course of treatment. The chronic *pro re nata* treatment pack should not deviate from the principle for chronic packaging, containing multiples of 28 tablets or capsules. This avoids the breaking of bulk to meet prescriptions.

The College has been obsessed with discussions on quality in practice over recent years — the *Journal* should support our pharmacist colleagues by supporting original pack dispensing with its many advantages.

DAVID E. MURFIN

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Patients' attitudes to generic prescribing

Sir,

Generic prescribing is recommended by the College to the profession. A review of the literature reveals little information on patients' attitudes to this change.

A survey of 50 consecutive patients who had had one drug changed from a brand name product to a generic equivalent on repeat prescription was carried out by questionnaire in a suburban teaching practice in February 1985. For the purpose of the study a repeat prescription was defined as a drug which the patient had been taking regularly for more than three months.

The aims of the study were to assess: patients' awareness of the change to generic prescribing; patients' education as regards generic prescribing and its origins; and patients' attitudes to generic equivalents.

The results showed that only 39 of the patients (78%) were aware of any change in their prescription; of these, approximately two-thirds (24) became aware by observation and less than one-third (12) recalled receiving information from a professional person (doctor or pharmacist). Twenty-nine patients (58%) recalled receiving an explanation as to why there had been a change in their prescription. These results imply a poor level of patient education; the patient either did not remember or understand the information given, or was not given any information.

Only 12 patients (24%) received a generic equivalent preparation. Analysis of the drugs involved in the study showed that for 70% a generic equivalent preparation was available to the pharmacist. Three of the patients receiving a generic preparation felt that the medication was similar to the brand product and nine felt that it differed in its effectiveness — eight patients felt it was less effective and one felt it was more effective. Four patients expressed dissatisfaction with the generic equivalent.

The advantages and disadvantages of generic prescribing will continue to be a point for debate but as from April 1985 generic prescribing, in some therapeutic areas at least, is compulsory. Therefore, the impact of generic prescribing on patients and on general practice gains increasing relevance.

This small survey illustrates two unresolved points about generic prescribing. The first is that by prescribing drugs generically the doctor leaves the choice of actual preparation dispensed to the pharmacist. The second point is that a high proportion of patients receiving the generic equivalent drug doubt its effectiveness and are dissatisfied with the change from a proprietary preparation.

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Arthralgia from parvovirus infection

Sir,

I was interested to read the letter from Dr M.T. Everett (November *Journal,* p.540) about two adult females with arthralgia from parvovirus infection during an outbreak in children in Plymouth. I have recently seen a similar case, but in a male and unassociated with an outbreak of fifth disease.

A 37-year-old marketing director presented on Christmas Eve 1985 with a 24-hour history of joint pains. He felt tired and lethargic but had no fever and no rash. The pains were localized to his neck, back, wrists and knees; there was no joint swelling. He took ibuprofen (400 mg) three times daily with no benefit. The arthralgia later spread to his hips and the proximal interphalangeal joints of his