'married families', as the Ministry of Defence delightfully calls them, are different in many ways from non-military families.

First, the military politics governing the career and responsibilities of the serviceman come first, with health coming second. Referral for psychotherapy (and perhaps for psychiatry also) may be detrimental to the promotion prospects of the patient. It may result in transfer of job within the unit or, where intensive work with the family is required, in posting back to the serviceman's home area.

Secondly, military families have no extended family system locally to support them in times of psychological or social distress. Apart from cases of child abuse, where there are usually clear referral procedures to the local authority, routine support of such families is often left to the military themselves, as it is difficult for a local authority to become involved. There are relatively few people like myself around, who know the military system and respect it, and as Major Vincenti points out, it is left to organizations like Soldiers, Sailors and Airmen Families Association to offer their professional help.

Finally, military security prevents personnel talking about their work at home and this can be a psychological strain, as they may also be unable to express their feelings in a tight command system. The fact that I have signed the official secrets act, makes it easier for some personnel to share their feelings with me. However, repression of feelings is the more common coping strategy, with resultant somatization. Further pressure, for example from family problems, could cause the patient to be insubordinate or take leave without permission, which may result in charges and courts martial. Military families often remark that they prefer the civilian medical referral system because personal, intimate matters can be discussed privately, without the line of command system getting too much information.

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MRCGP and palliative medicine

Sir,

In recent months there has been correspondence in the *Journal* about the future of the MRCGP examination and about the close relationship between the specialties of general practice and palliative medicine. There is a link between these issues.

Dr MacLeod (November *Journal*, p.477) writes of the physician in palliative medicine as having training in both that specialty and in family medicine. This is not true of all palliative medicine specialists but it is a possible combination. The Joint Committee on Higher Medical Training in its criteria for entry to training in the specialty includes possession of the MRCGP as a permitted alternative to holding the MRCP.

However, the eligibility of such alternative higher qualifications is due to be reviewed in 1992. Dr Ford (September *Journal*, p.392) hopes 'the College will act to preserve the value of its qualification to its members', a view we share. Whatever its defects, the examination is unique in testing both factual clinical information and doctors' attitudes. These attitudes are relevant not only to primary care but also to other areas of medical practice, not least palliative medicine.

In the case of palliative medicine the MRCGP functions not so much as a seal of training but as a qualification for entry to it, with up to four years of selected experience to follow prior to accreditation. Alterations to the MRCGP may mean the effective disbarring of doctors from entry to palliative medicine who have received what is arguably the most appropriate early preparation for the specialty. Such an event is unlikely to promote the collaboration on which Dr MacLeod and Dr Charlton (August *Journal*, p.347) rightly place such emphasis.

The MRCGP can have importance beyond the boundaries of general practice itself. We hope that nothing will be done to jeopardize the role it can play and hence the greater influence general practice can exert.

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Academic general practice

Sir,

I am constantly astonished at the implication that academic general practice is remote from the daily activities and problems of the rest of the profession (letters, March *Journal*, p.126). Almost without exception departments of general practice are staffed by active general practitioners, often of considerable experience who alas have not only general practice problems but university or medical college ones as well.

Dr Holden suggests the *Journal* should carry an unreviewed short reports section. As I understand it papers are frequently rejected because of methodological flaws rather than 'academic flaws'. This is right and proper; conclusions which are drawn as a consequence of research which is poorly designed or executed are not only misleading but may prove dangerous not only to patients but to readers who may be bored into extinction.

The Royal College of General Practitioners has a reputation to uphold and does this relatively well — although there is always scope for improvement. Are the keenest doctors discouraged from research by the *Journal?* I doubt it; they increasingly turn to departments of general practice for help with their projects and as a consequence the standard of papers in methodological terms is improving. I wish I could say the same for the 'interest' element — the boredom index remains remarkably uniform.

If doctors feel the need to have their flawed articles published there are always the 'freebees'. I confess I find some of the articles riveting and with these, who cares about methodological flaws?

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Iron deficiency and sources of iron

Sir,

Dr Grant's study (March *Journal*, p.112) showed a high prevalence of iron deficiency in rural pre-school children in Northern Ireland. The author concluded that the main cause of this was an inadequate dietary intake of iron, and suggested that education should cover the fact that iron absorption from foods of animal origin generally surpasses iron absorption from foods of vegetable origin. This may be misleading. Meats, and particularly liver, are rich in iron which is well absorbed, but the iron in eggs is poorly absorbed and dairy products are not rich in iron.[1] Beans and dark green leafy vegetables are good vegetable sources of iron, and fresh fruits and vegetables are good sources of vitamin C which has a very important