means of assessing *one aspect* of professional competence—the cognitive field of knowledge.

2. The use of lantern slides was compared with the more orthodox method of sitting the examination. The slides introduced an additional stress factor, the effect of which was to impair slightly the performance. It is considered that this is undesirable in any examination.

3. The item analysis of questions previously used in Australia correlated well with the results obtained in this examination.

4. The relevance of the MCQ examination to assessment of professional competence in general practice is briefly discussed.

Appendix

Item analysis of sample question (see example 1)

		(Correct=A)				
		A	B	C	D	E
Number (above median) correct	34	34	3	8	1	1
Per cent	72	72	6	17	2	2
Number (below median) correct	17	17	8	6	6	3
Per cent	43	43	20	15	15	8

Percentage mean 57
Discrimination index 29
Difficulty index 61
= 270 (Standard errors x 100)
In this analysis a value > 196 is required to assume that it is non-random.

Acknowledgements

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NEW IDEAS FOR A NEW DECADE

Thirteenth annual scientific assembly of the College of Family Physicians of Canada.

One of the most appreciated 'new ideas' was that of making this a joint meeting with the Royal College of General Practitioners as guests! Over 150 members and their families braved the transatlantic flight to attend the convention—a flight made memorable by the lavish helpings of champagne provided by Air Canada, and the unexpectedly clear views of the Greenland and Labrador coasts.

The convention proper did not begin until Monday 29 September—six days after our arrival. However, a series of 'happenings' was laid on by our hosts to fill the gap and help us to readjust our rather shattered circadian rhythms! These events included a visit to PROFESSOR IAN MCWHINNEY'S department of family medicine at the University of Western Ontario in

London—set in a most attractive, but, one gathers architecturally controversial, modern campus. On Friday 26 September the United Kingdom delegates and their Canadian hosts were guests at a reception given by the Lieutenant-Governor of Ontario, the HONOURABLE W. Ross MACDONALD, at Government House, Toronto. On the following day we were invited to an all-day tour of Niagara Falls culminating in dinner at the Skylon restaurant as guests of the Canadian College. In addition many of us had opportunities to visit the individual practices of our Canadian counterparts and, indeed, to see them 'from the inside' as house guests of Toronto practitioners who had generously offered hospitality to our families and ourselves.

The convention opened on Monday 29 September, in the Royal York Hotel, and proceedings lasted four days—four days of intensive activity. Papers were read at half-hourly intervals from 8.30 am to 5 pm with intervals for coffee (combined with question time) and lunch. Lunch on each occasion had a medical speaker or choice of speakers. The final item on each days programme was a summary of the proceedings seen through British eyes—a function successively performed by Drs LAWSON, SWIFT and SLATER, with a masterly summing up by DR PAT BYRNE on the final day.

A variety of entertainments and functions took place each evening, the highlight being the annual college dinner and dance on Wednesday. This was marked by an academic ceremony at which the first fellowships of the Canadian College were awarded as well as certificates in family medicine to successful candidates in the first examination organized by the College. Following this came the presentation of the Victor Johnson Medal of Honour, the College's highest award, to MADAME VANIER, widow of a former Governor-General of Canada and founder of the Vanier Institute of the Family.

Scientific and trade exhibits were on view in the rooms adjoining the Convention Hall. The latter ensured their share of our limited time by the simple but ingenious method of issuing raffle tickets—one for each exhibit visited—for a prize of 1,000 dollars to be spent on a post-graduate course in Canada.

A medical 'film festival' ran concurrently with the convention. The programme appeared attractive but, as it continually clashed with the 'live' speakers, few certainly of the United Kingdom visitors, managed to attend.

Those doctors staying in the Royal York Hotel were, if their stamina allowed, able to watch a special medical programme on closed circuit television from 7–9 am and again in the evening until 1 am.

Monday 29 September. The theme of the opening day was 'New prescriptions for old organs'. Contributions, perhaps inevitably, included two speakers with practical experience in the heart transplant field, DR I. DYDRA of Montreal and DR M. DEBAKEY of Houston, Texas. Two main conclusions emerged; the operation of heart transplantation is considered 'justifiable but experimental', and the main factor determining long-term survival after operation is—luck!

More down-to-earth problems were dealt with by DR THOREK of Chicago who gave two papers, on 'The acute abdomen in the aged' and 'Diseases of the breast'. He pushed home his points with a flow of witticisms which must make him much in demand as an after-dinner speaker. Thorek's triads—both original and revized versions—are likely to be retained in our memories after more erudite information has vanished from recall.

'Worn out joints', 'End stage renal disease', 'Chronic lung disease' were the subjects of other papers together with (rather unexpectedly in such company) 'Childhood and adolescent gynaecology' by DR R. KINCH of McGill University.

Tuesday 30 September. 'New doctors for old practices'. Education and training for general practice was the theme of the day and matters discussed included internship and residency, medical computing systems, examinations and medical record-keeping. The latter subject was covered in a dynamic and provocative talk by DR LAWRENCE WEED of Cleveland. He attacked conventional methods of record keeping and diagnosis in such terms as 'medical roulette', 'sustained muddle-headedness', and 'a mixture of guesswork and facts'. He prefers to record the results of history-taking and clinical examination on a patient in terms of 'problems' (often multiple) rather than 'diagnosis'.

PROFESSOR IAN MCWHINNEY—so recent an export that we almost counted him a member

of the United Kingdom team—spoke on postgraduate education for family medicine. The concept of family practice as an amalgam of all the specialties, but prepared for by multi-specialty rotation in training, was now out-moded. Family medicine was a specialty in its own right, and its skills and techniques were best taught within the setting of family practice. On the other hand mere apprenticeship to established practitioners would not suffice as the future family doctor would need the capacity for independent critical thought, and for learning from experience which a liberal university education could alone provide—"our concern is not only what a man is doing tomorrow, but how he will be thinking in 20 years time".

DR PAT BYRNE'S paper—'The stage we're at'—described the arrangements for teaching family practice in Manchester and explained some of the problems in defining the rôle of the general practitioner in the present state of medicine and society. His own definition "the general practitioner provides personal, primary and continuing care to individuals and families". He thought that the separate provincial health services in Canada gave useful scope for experimentation.

DR P. NEWELL, one of the first batch of certificants in family medicine of the Canadian College, spoke on 'The relevance of family practice teaching'. He made the interesting point that many doctors who left family practice for other areas of medicine did so, not because of the supposed traditional difficulties over pay or status, but because they found themselves ill-prepared to deal with the psychosocial problems they encountered.

DR R. KINCH was again odd man out with a paper on 'Doctor-patient relationships in pregnancy and the puerperium'. He sketched the various emotional changes that women may undergo during pregnancy and the puerperium, with special reference to the unmarried mother. He laid stress on the need for what he called "anticipatory guidance"—not only should we be aware of the psychological changes likely, but we should be prepared to warn the patient about them in advance.

The annual business meeting of the Canadian College also took place during the morning session.

Wednesday 1 October. 'Medical communications'—a somewhat irrelevant title for a mixed and interesting day. The morning session was devoted to a series of elective hospital rounds. Of the six choices available most opted for rounds in the Toronto Hospital for Sick Children followed by a visit to the Toronto General Hospital across the road.

In the afternoon DR A. C. BARNES of Johns Hopkins University gave his somewhat controversial views on 'Management of the postmenopause'. He advocates the administration of hormone therapy to all postmenopausal women on the grounds that they are suffering from an endocrine deficiency comparable to myxoedema or Addison's disease. Benefits claimed include not only a more youthful appearance and the avoidance of hot flushes, but also the prevention of atheroma and of senile osteoporosis. He recommends a mixture of 5 mg methyltestosterone and 0.625 mg conjugated oestrogens taken daily except for the first five days of each calendar month. His original advice to take the hormones 'for ever' has been modified to 'until aged 86' as he found that 'for ever' was being varyingly interpreted as between three weeks and four months!

Other papers were read on 'Project head start' by DR J. B. RICHMOND describing a US programme, of which he had been director, to help deprived children; on 'Medical communications in dermatology' by DR A. KOPF, who discussed various ways of coping with the 'knowledge explosion'; and by SIR IAN HILL of Dundee on 'Must we wear out'. Sir Ian concluded that we must, but the process can be delayed.

Thursday 2 October. 'New patterns in the old society'. DR S. J. HOLMES of Toronto opened the proceedings with 'Keeping perspective in chemical comforts'. Alcoholism was probably ten times as common as addiction to non-narcotic drugs and 100 times as common as addiction to narcotics. He gave guidance to doctors consulted over the increasingly common problem of the worried parent and the suspected teenage drug taker. His main points were that one should be careful not to regard normal mood changes of adolescence as evidence of drug-taking, and that if there seemed to be reasonable grounds for suspicion then it was essential that the doctor have an accurate and up-to-date knowledge of the drug and its effects and possible dangers. Emotional or moral attidudes on his part were less likely to be successful than an objective explanation of the facts. He was doubtful if the evils of marijuana were any

greater than those of alcohol but any youth involved in taking it should be aware of his risk of incurring severe legal penalties. Following his paper Dr Holmes discussed various points in a telephone link-up with speakers in Montreal and Halifax.

A further technical ploy came later in the morning when DR N. P. EPSTEIN of McMaster University showed a videotape followed by discussion on 'Family interviewing and family psychiatry'.

United Kingdom speakers were prominent on this final day and contributions came from DR MAX CLYNE (Problems of adolescents), DR C. A. H. WATTS (Suicide and depression), and DR C. KAY who described the research work being currently undertaken by our College on oral contraception. Other papers were read on 'Psychosomatic disorders of infants and young children' and 'Management of the rh patient', and the Victor Johnson Oration was given by DR JOHN CORLEY, chief examiner of the Canadian College on 'The evolution and evaluation of the family physician'. Finally, Dr Pat Byrne completed the session by courageously attempting 'A summing up'—a formidable task which he performed with efficiency, humility, fluency and wit.

Following the convention there was a general parting of the ways. Some went westwards to explore the delights of the Rockies and Western Canada, some to friends and relations in Canada and the United States. Nine of us embarked by coach on a somewhat ambitiously labelled 'Study tour of the U.S.' This took us via Niagara Falls, Buffalo and rural Pennsylvania to Washington, Philadelphia and finally New York. Visits were laid on *en route* to the Clinical Centre of the U.S. National Institute of Health at Bethesda just outside Washington, and to Temple University School of Medicine in Philadelphia. In both centres we were most hospitably received, taken for comprehensive tours and shown many features of medical and sociological interest.

General impressions

When we all finally met together on 13 October for the return flight—this time by Aer Lingus from the John F. Kennedy Airport in New York—there was general agreement that the whole venture had been a success both medically and socially. We felt we had learned much from Canada and also hoped that, through our participants in the convention proceedings, we had also been able to contribute something.

Overall impressions of the tour must of necessity be individual. The main one, rather surprisingly, was that of similarities rather than differences; similarities, both in the day-to-day practical problems of general practice met with by the individual, and also in the more complex field of vocational training and assessment for family practice.

Attempts at solving the problems show differences of detail. The low visiting rate in Canadian practices was one such difference. Some doctors claimed to do no visiting at all but usually admitted to exceptions under cross-examination. The overall picture in city practices seemed to be somewhere between less than one to four visits daily. The greater availability of cars and telephones and easier access to hospital beds are all factors favouring a low visiting rate, but finance cannot be excluded as the approved fees for visiting *vis-à-vis* office consultations do not show sufficient difference to compensate for the time involved. While we undoubtedly do too much visiting in this country it may be that the pendulum has swung too far in Canada, and it will be interesting to see if there is a reversal of trend when the new generation of family physicians with specialized vocational training emerges.

This new training, with its accent on sociological and psychological aspects, and on the family as a unit, is not as yet universally approved by the old generation of Canadian practitioners. This applies especially to those practising in the more remote areas where there is still felt to be a need for the old type of truly 'general' practitioner, able to turn his hands to a variety of special skills. Improved transport facilities will, no doubt, play their part in changing the picture but can hardly completely overcome geographical facts.

As visitors we were overwhelmed from the moment of arrival by the helpfulness and hospitality of our Canadian colleagues. They have indeed set a high standard for us to attain when they pay a return visit for another joint meeting in this country in 1973. Apart from our individual hosts—and their tolerant families—a special word of thanks must go to DRS MASSON and RICE of the convention committee who did much to smooth our path and to MRS STRUAN ROBERTSON, chairman of the ladies' convention committee. Appreciation should also be recorded

of the efforts of those members of the Royal College who by their active participation did so much to make the convention a success. Dr Slater in addition to doing his stint on the convention rostrum and his liaison with the convention committee, was responsible for much of the pre-conference arrangements in the United Kingdom. Mrs Swift was always on duty at an early hour to see that we got due credit on this side of the Atlantic for our postgraduate study sessions. Our president, DR JOHN HUNT, was always on the scene both at the scientific sessions and on the social occasions, when he ably represented us at various top tables particularly at the annual dinner of the Canadian College, when he made a witty and well-received speech.

Finally, the Proman Society who were responsible for our travel arrangements, both on the charter flights and for much of our internal travel in North America, are to be congratulated on the success and efficiency of its arrangements.

W. G. KEANE.

Correspondence

The continuing story of human brucellosis

Sir,

I thought it might be of some interest to record that, since you published my paper on *Brucellosis in general practice* in 1966, a further 12 cases have been diagnosed—bringing the total number since 1957 to 28.

Six of these 12 cases occurred in farmers or farm workers: two in members of farm workers' families; three in families unconnected with farms (apart from living in a rural community) and one in a slaughterman.

Six of the cases were considered to be acute, four chronic and the remaining two equivocal. The clinical features and diagnostic difficulties have been adequately described elsewhere, and no new features were presented, except that one patient was unfortunate enough to have brucellosis and farmer's lung at the same time. (Incidentally, it seems likely that the incidence of this latter condition will increase, and this increase could conceivably be related to modern methods of harvesting when tightly baled moist hay quickly becomes mouldy. Another source of pulmonary irritation is the dust from pulped sugar beet.)

As a result of correspondence with Dr D. J. N. Payne of the public health laboratory service, Portsmouth, and conversations with Dr Barrow of the public health laboratory service, Truro, the treatment of these cases consisted of streptomycin 1 gm IM daily for two to three weeks with tetracycline 2 gm daily for three weeks; then a week's rest, followed by tetracycline 2 gm daily for a further three weeks. This regime appears to be effective in the acute cases (the infection should be hit hard before it becomes intracellular) and also of considerable benefit in the chronic cases.

There is no doubt whatsoever that human brucellosis will continue to cause problems in diagnosis and treatment, quite apart from more than a little personal suffering to those infected, for quite a long time to come, especially in view of the fact that the so-called eradication scheme will probably take many years before it meets with any success. One reason for this lack of success is that it is common, or almost accepted practice, for infected cows to be sold in the open market, so that a farmer attempting to replace stock lost, for example, from foot and mouth disease, will almost certainly get a herd infected with brucellosis, and as long as bovine brucellosis exists so will human brucellosis.

I should like to conclude with some positive suggestions:

1. Human brucellosis is a preventable disease, but this involves eradication of the disease in cattle.
2. Until this ideal is attained the disease should be made notifiable so that an accurate assessment of the incidence can be made and this might stimulate the appropriate authorities to accelerate and modify the eradication programme.
3. The difficulties associated with the diagnosis and treatment of chronic brucellosis make it