examination. Clearly the College is entitled to lay down whatever criteria it wishes for those wishing to take the examination; equally clearly, in the absence of supporting evidence, it can do no more than offer an opinion about the best training for general practice.

The more that the examination is felt to assess accurately the knowledge, skills and attitudes required for good general practice, the more likely is it to be accepted by entrants to practice. Our examiners, while certainly not complacent, seem happy that the examination is well on the way to providing such an assessment. If this is so, it becomes difficult to see why some combinations of training experiences are deemed acceptable, and others rejected. If a candidate can show that his knowledge, skills and attitudes are such that he must be allowed to pass the examination, the way in which he achieved them should not be our concern. If he fails the examination, his vocational history is of no interest to us. To doubt this is to doubt the validity of our examination; to accept it would free the vocational training sub-committee from the arduous chore of judging hundreds of programmes, and programme organisers from many of the difficulties of assembling them.

If the post-registration posts are not relevant to candidacy for the examination, what is their point? We suspect that it concerns the other issue—appropriate training for practice itself. The unwritten premise upon which our list of 14 specialties relevant to general practice is based is that some years of residential post-registration hospital experience are essential. It then follows that we should offer advice as to the most useful or least useless ways of spending these years. Since there may be no posts which are totally useful, and none totally useless, our list must try to pick out those at the more useful end of the range. Given the unwritten premise, our selection may be of value, but we should like to hear the evidence for the assumption. *Does proof exist that any amount of residential hospital experience is an essential part of preparing for general practice*?

The hospital offers a situation in which certain clinical experiences may be concentrated into a fairly brief space of time, but perhaps this is also true of part-time detachment to hospital from a programme set firmly within general practice. We do not know the answer, and we believe that no-one else knows the answer either. Certainly the supernumerary nature of a trainee within the practice makes the idea practicable, and the major considerations against it are political rather than educational. While sympathising with a hospital service bereft of half its junior staff, the College surely has a duty to state clearly what it believes to be best for general practice.

It will be asked if we have enough suitable teachers in general practice for such a system. The answer is that we have no idea—but then we have no idea if there are enough suitable teachers for our trainees in hospital either, and we have not allowed this to affect our unwritten premise. At the very least we should be setting up three-year experimental programmes with no residential hospital component in order to compare the results with those of the conventional system.

The MRCGP examination, with whose validity and reliability the College is satisfied, would then be in a position to compare three groups of trainees:

1. Those without post-registration hospital experience,
2. Trainees whose experience is of the sort approved in our list,
3. Trainees who have experience of posts such as we currently find unacceptable.

In time we might have a rational basis for college policy on vocational training.

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G. LLOYD

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HOW MANY PATIENTS?

Sir,

It used to be said that medicine was the perfect way of life if it wasn't for the patients. Now your *Journal* (August) has shown, through that indefatigable author, Dr John Fry, how those tiresome appendages can be avoided.

He modestly assures us that he and his partner give "a good standard of care" to 9,000 patients, and who is to question him? Not lesser mortals who strive to give reasonable care to 2,500 each. Not apparently the executive council who do not pay ordinary doctors for looking after more than 3,500. Possibly the patients, but Dr Fry sees so little of them that they could hardly let him know.

His comment that "there is a partnership with two other practitioners with relatively small lists" is unusually obtuse from a pen normally as lucid as his. Is he in a partnership with two or four? Or is this a subterfuge for gaining payment for responsibility (one hesitates to say care) for more than the notional limit.

With visiting reduced to such miniscule proportions, who attends the terminal patients in his practice? Or having dispensed with care of the geriatrics has he by organisation abolished death?

It is noticeable that he has apparently abandoned the care of old age, rheumatic, cardiovascular, neurological, dermatological and gastro-intestinal illnesses which usually demand the care of a physician, and increased his activities in immunology, antenatal care, cervical cytology and child welfare, all of which can be carried out by ancillary workers, no wonder he is finished by 1800 hours, the wonder is he still considers himself a 'personal family doctor'.

It used to be said that we cured sometimes,

relieved more often, and comforted always. Perhaps the patients in Dr Fry's practice get little comfort, but then I doubt if he considers comforting patients a medical job.

J. R. CALDWELL

Newick Lodge,
Newick,
Sussex.

REFERENCE

Fry, J. (1972). *Journal of the Royal College of General Practitioners*, **22**, 521–8.

Sir,

Dr Fry is, as we all know, one of the most quotable sources of information on general practice work. I find his most recent article fascinating and quite breathtaking. His description of his practice is so radically different from what I know to be the majority of practices in suburban London.

One or two statements in his article must I am sure be clarified. For example: "it is now a two-man practice . . ." A little later he says "Two general practitioners can care for almost 9,000 people, as there is a partnership with two other practitioners with relatively small lists and therefore there is a maximum allowance of up to 4,500 per doctor". What does this mean?

Dr Fry also mentions an assistant and a time in 1963 when three doctors worked in the practice.

Really the description of the practice is so confusing as to make the interpretation of the figures doubtful. The situation is more confused by reference to a rota system with another group for night and weekend work.

I wonder if it would be possible for Dr Fry to let us know precisely how many doctors are involved and to include in this figure all partners and assistants, whether full-time or part-time? Dr Fry must have been aware of the controversy that such an article would arouse and it is a pity that such elementary facts were not precisely stated.

B. J. BROOKS

Bourne Hall Health Centre,
Ewell,
Epsom,
Surrey.

REFERENCE

Fry, J. (1972). *Journal of the Royal College of General Practitioners*, **22**, 521–8.

STERILIZED PATIENTS

Sir,

Might I suggest that another label be produced for sticking to the corner of medical record envelopes? The purpose would be to denote whether: (i) the male partner had been sterilized, (ii) the female had (a) been sterilized or (b) undergone hysterectomy.

There are occasions when an unguarded question about the possibility of pregnancy escapes one's lips, and the resulting embarrassment could easily be avoided by the sight of a distinctive tag.

J. D. WIGDAHL

20 St Nicholas Street,
King's Lynn.

TRAINEES AND THE COLLEGE

Sir,

Most teachers in general practice encourage their trainees to join the College as associate members. Some teaching practices pay their trainees' application fee (£5) which covers the first annual subscription.

I have been asked to bring this interesting fact to the notice of all general-practitioner teachers.

Application forms for associate membership can be obtained from the membership secretary, 14 Princes Gate, Hyde Park, London SW7 1PU.

STUART CARNE

14 Princes Gate,
Hyde Park,
London SW7 1PU.

Book reviews

A survey of general practice in Northern Ireland (1972). Belfast: H.M.S.O. Price: 80p.

In examining the present state of general practice, it is unfortunately true that Northern Ireland tends to be overlooked by researchers examining the position in Britain[1,2]. This study, undertaken by Officers of the Department of Health and Social Security in Northern Ireland, sets out to remedy such a notable omission. It aims to furnish basic data about family doctors, and more especially their practices, and has the advantage of being based on the whole population of practitioners, coupled with an extremely high response rate.

In presentation, it is likely to appeal to those interested in the study of the characteristics of general practice, and to planners, rather than to the casual reader. There is a wealth of tabulation; however, comparisons with other parts of the United Kingdom, which would have been helpful, are not abundant.

As expected, some trends common to general practice in other parts of Britain are recorded. Thus, there has been an increase in group practice; an increasing number of doctors practise from health centres; the use of secretarial staff, and of nurses and health visitors has also increased subsubstantially in recent years. Area variations occur, as they do in Britain.[1]

More interesting are the differences between Northern Ireland and other parts of the country. Thus, for example, the proportion of general practitioners practising from health centres is higher in