What is envisaged is co-operation between the health centre staff and the patients, rather than confrontation, the aim being to involve as many patients as possible and to use the unique and varied experience of as many of the 10,000 patients as possible to assist the practice team of 15 to provide a better service.

Our local Patients' Committee is an example of grass roots democracy in the NHS which is, more and more, being controlled at all levels, by appointed, not elected, bodies.

Our relations with the Community Health Council are excellent; the Community Health Council Secretary has already spoken to one open meeting of the patients.

Is there any good reason why this cannot also happen at every other health centre?

At a Valleys' Community Project Conference held at Aberfan on 8 February 1975 on *Health in the Valleys* at which I reported on the discussions at the primary care group, the following recommendations were made:-

(1) There should be more community participation in the primary care service.

(a) Community Health Councils could ask local doctors for appointments to visit their surgeries or health centres—in this way barriers between doctors and the Community Health Councils can be broken down.

(b) It was considered that the appropriate Community Health Council could "associate" with the patients' committee.

(c) There should be increasing democratic local control of the health services.

(2) There should be central exchequer control of health service finances, but with a larger and wider distribution of funds particularly to areas of greatest need.

(3) It should be an essential part of primary care that general health education should be provided for the community particularly at health centres.

A final remark in this discussion from the Secretary of the Patients' Committee was:

"If doctors are prepared to discuss the provision of health services with their patients this could benefit both doctors and patients and could provide a better service for the community."

Pritchard (1975) has a community participation group at Bennfield Health Centre. I am sure that many forms of patient participation will develop. Soon I hope the College will arrange a meeting of the doctors involved so that we can discuss our experiences.

A. WILSON

REFERENCES

Journal of the Royal College of General Practitioners (1974). Editorial, **24**, 1–3.

Paine, T. (1974). *Journal of the Royal College of General Practitioners*, **24**, 351.

Pritchard, P. M. M. (1975). *British Medical Journal*, **3**, 583–84.

INVESTIGATIONS IN THE PRACTICE

Sir,

At a recent meeting of the Wessex Faculty on the Isle of Wight the question of the future pattern of general practice and the function of the MRCGP examination came under discussion. If one salient point emerged it was the fundamental importance of clinical excellence. One aspect of this is what might be termed "office procedures," i.e. procedures which can be performed for the patient in the surgery. As a contribution to this discussion I would like to enumerate those procedures which I regard as desirable for the modern general practitioner to have at his command and that his ability in them should be demonstrable in the MRCGP examination.

(1) The use of the opthalmoscope for diagnostic purposes.

(2) The use of the electrocardiogram.

(3) The use of the sigmoidoscope for diagnostic purposes.

(4) The ability to perform Eustachian catheterisation.

(5) The ability to perform indirect laryngoscopy, for diagnostic purposes.

(6) The ability to perform minor surgery under local anaesthetic.

(7) The ability to fit IUDs and to arrange the fitting of the contraceptive diaphragm.

(8) The knowledge of the indications and techniques for the intraarticular injections of cortisone and also its injection into soft tissues.

(9) The injection or rubber band treatment of haemorrhoids.

(10) The injection treatment for varicose veins.

These desiderata will no doubt evoke protests from the 'behaviourists' in our ranks. They are however, with the exceptions of numbers (4) and (5) techniques which have been in regular use in this practice for the last ten years or more without any detriment to the other aspects of general practice and it is my view that in the 1980s no one should become a principal in general practice without having mastered them.

Furthermore, they ought now to be available amongst the different members of a group practice.

P. D. HOOPER

The Dower House,
27 Pyle Street,
Newport, Isle of Wight.

LETTERS TO AND FROM HOSPITALS

Sir,

I read with interest the article in the July *Journal* by C. J. Durkin and A. Edwards on referral letters from general practitioners.

I agree that such letters are important, although on occasions I have had it reported back to me that my careful letter has been brushed aside by a busy doctor, who only wants to hear what the patient has to say.

I would now welcome a follow-up research project on letters from the hospital to the general