but this is a far cry from being completely unavailable to patients except from nine to five.

C. A. H. WATTS

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Asby de la Zouch,
Leicestershire, LE6 567

Sir,

I was most interested to read your two articles about out-of-hours calls side by side in the January *Journal*.

Two interpretations could be placed on the results. In one article, an experienced family doctor claimed that 50 per cent of calls were genuine emergencies and only seven per cent were totally unnecessary. In the other article, a hospital doctor (Dr Gabriel) working for the emergency call service, claimed that only 14 per cent of calls were medically justifiable.

From these reports, it seems to me that vocational training which turns a 'hospital doctor' into a family doctor is fully justified. In one case, the hospital doctor needed further education as to the meaning of 'emergency calls' with all their implications.

The alternative is that the practices which he was serving were so badly organised that the patients had no training in the proper use of facilities by the principals concerned. In either case, the figures in both studies would have been much more comparable if Dr Gabriel or the principals of the practices using emergency call service had been vocationally trained.

K. J. BOLDEN,
Senior Lecturer

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Postgraduate Medical Institute,
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Sir,

Your editorial of January 1976 states that " the triple interests of patient, profession, and government are likely to be best served by some variation of the system of extended cover ".

As is often the case when this view is expressed, no evidence is offered to support this. The statement that deputising services are " inevitably often provided by doctors with no experience of general practice " is not evidence, as it is inaccurate. The view that the " service " has no personal knowledge of the patient is irrelevant, as this often applies to the extended cover system.

How long will the College take to remove its blinkers of tradition, and realise that the only rational system in all but the most rural of areas is the deputising service? Then perhaps we can get on with the relevant debate about how (not if), these services should be organised.

If the College continues with its present attitudes it will be in no position to influence the standards of these services and it will alienate a good many of its members and other general practitioners.

It is worth noting that approximately 80 per cent of general practitioners in areas where deputising services exist, use them. Are 80 per cent wrong or uncaring?

R. E. FITZWATER

67 The Avenue,
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Kent, ME20 7LQ.

Editorials in the *Journal* should not be taken to represent the policy of the College unless this is stated.—*Ed.*

Sir,

It was with interest that we read your two articles on emergency night calls one by Dr Lechston and the other by Dr Gabriel (January *Journal*) each of whom reached opposite conclusions from their individual experiences.

We felt that perhaps the general practitioner's involvement with a night visit would be regarded as part of his total care of a family unit, and thus make him more likely to consider a visit as urgent or necessary because of this, rather than a purely clinical view, as might a deputising service doctor who will never be acquainted with the patient again.

Having said this, we would like to compare the experiences of these two doctors with our own. We form part of a large group practice of ten doctors in a mixed urban rural community of 30,000 patients, and at weekends we employ a commercial deputising service.

We have found that the incidence of night calls does not alter from weekdays to weekends, nor does the degree of urgency of the visits requested.

From our records of the weekend visits by the deputising service, we note that of 56 visits over 52 nights, approximately nine were felt to be unnecessary (15 per cent), by us, not the deputising service doctors.

During weekday nights when members of our practice were on duty covering the same six month period, 14 per cent of the calls were deemed totally unnecessary, and of the rest 50 per cent were necessary and 50 per cent urgent.

Finally, we do not feel that a small charge would deter " trivial " night calls, more likely to do this would be the removal of the bedside telephone to a spot down the cold wet road.

DAMODAR B. NEGANDHI
ROGER C. LONGBOTHAM

The Health Centre,
Horse Fair,
Rugely, Staffs.

SEEING OF THE SAME DOCTOR

Sir,

I read Dr Aylett's article (January *Journal*) with great pleasure and interest, and I would like to add a short comment.

Dominance and dependence are two extremes of roles played by people when they interact, so that some people, depending on their needs, will try to establish more close, affiliative associations than others. Thus, some patients will prefer separate list practices, and some combined list practices. A doctor's leaning to one or the other type of organisation may result from his own attitude to roles in his relationships with patients.

It is the patient's attitude which is the more important, and ideally he should be allowed to find in the group the kind of doctor/relationship which suits him best. In this way, a doctor will tend to attract to himself those patients who will be satisfied with the sort of relationship which he provides, and these are the patients for whom he is most likely to be able to provide the best service.

Although, for the sake of continuity, a patient should be encouraged to remain with the same doctor during any one episode of illness, in my view he should be free to choose to stay with one doctor indefinitely, or to see any other doctor in the group as he wishes. One of the aims of group practice organisation should be to allow the patient to make this choice without bias in favour of one sort of relationship or the other.

K. H. PICKWORTH

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REFERENCE

Aylett, M. S. (1976). *Journal of the Royal College of General Practitioners*, **26**, 47–52.

ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

Sir,

Further to my previous correspondence concerning the statement in the March 1975 issue of your *Journal* about admission to the Royal Australian College of General Practitioners of persons who have passed the examination of your College. I wish to advise that I have had discussion with both the Administrative Secretary, Mr Wood, and the Honorary Secretary of the Board of Censors, Dr Burden of the Royal College of General Practitioners.

It appears that there could have been some misinterpretation of the Royal Australian College of General Practitioners' regulations and that possibly these could have been a little misleading.

However, the situation remains that members of the Royal College of General Practitioners who wish to join the Royal Australian College of General Practitioners must fulfil the following criteria:

(1) Be a registered medical practitioner,
(2) Have undergone a rotating residency (internship) of not less than two (2) years in an approved hospital,
(3) Have undergone at least a further one year's approved training in general practice,
(4) Have been in general practice not less than five (5) years,
(5) Be sponsored by two Fellows/Members of the College.

Where an applicant is unable to provide satisfactory sponsors, provision is made for an interview by the Faculty Censors.

Persons who have been in general practice for less than five (5) years may be eligible for admission as Associates.

The Royal Australian College of General Practitioners' examination now leads to Fellowship but the fact of having passed the Royal College of General Practitioners' examination does not confer any automatic privileges and/or exemptions. However, our Censors are examining this situation.

F. M. FARRAR

Secretary General,
Royal Australian College of General Practitioners

WORKING PARTY ON WOMEN IN PSYCHIATRY

Sir,

I should be grateful if you would allow me through your correspondence columns to inform our readers of the existence of the recently formed Working Party on Women in Psychiatry. This small group is seeking information and contributions from all doctors with an interest in women in psychiatry. A high proportion of psychiatrists are women, but their distribution between the training and career grades shows that a relatively few have been appointed to consultant posts.

The working party will be considering employment opportunities, with particular reference to types of post available and part-time employment, and the availability of training. We shall be looking at the experience required for specialist accreditation at higher professional training level. We particularly wish to look at the experience of women training in personal posts set up under HM(69)6 and hope to set up a register to monitor the eventual outcome.

Many women working in psychiatry are employed as clinical assistants for up to nine sessions weekly, and have considerable experience in the specialty. They are not eligible for the hospital practitioner grade, as this is restricted to principals in general practice. We would welcome the views of these doctors and others on an acceptable service grade contract.

The Working Party hopes to prepare a report for the Education Committee of the Royal College of Psychiatrists by the end of 1976. We should welcome contributions of personal experience and opinions relevant to our task.

PAMELA ASHURST,
Chairman of the Working Party

The Royal College of Psychiatrists,
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