Training which merited a separately bound supplement (*Reports from General Practice* No. 17) to the June *Journal*.

"Our finding was that measures of intellectual processes form the bridge or catalyst between recent (and world-wide) research into the psychology of problem-solving and the operational process of diagnosis and patient management under investigation."

Re-reading these words repeatedly one searches in despair for the meaning of this modern educational jargon and wonders why it could not be expressed more clearly.

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THE M.R.C.G.P. EXAMINATION

Sir,

Dr Halle knows that no examination will answer his questions when even a year's partnership may not suffice. Why then should one take the MRCGP?

Medicine is not going to have an easy time over the next few years. We seem likely to have doctors and patients implacably entrenched in self-pity, with the doctors feeling exploited and the patients feeling neglected. The independent standards of the Royal Colleges will then be more important than ever. One should take the examination as witness to a commitment to good general practice.

Once perhaps there were two good reasons for not taking the examination. First, it might be held that the examination was brought in prematurely, unhappily isolating the College as an exclusive minority body. I held this view myself, but now the College's achievements are undeniable, the examination is firmly established, and one must accept these facts.

The second reason for not taking the examination is that experienced practitioners might fail in an academic and irrelevant exercise and no-one gains from a pointless humiliation. My experience shows this is not necessarily true.

Perhaps I should have been disguised: but I was too busy in the lunch-hour to cope with burnt cork or a hump-back. And in any case Professors of General Practice are fair game for any real general practitioner—including examiners!

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Professor of Community Care and General Practice

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REFERENCE

Wilkes, E. (1976. *Journal of the Royal College of General Practitioners*, **26**, 217–218.

Sir,

The article *Taking the M.R.C.G.P.* (March *Journal*) makes interesting reading. I cannot understand why Professor Wilkes found it "almost impossible to persuade people to take the examination", though he may be referring to doctors from other countries, as in my opinion, the M.R.C.G.P. is designed solely for doctors practising in the United Kingdom. To pass this examination, it is not enough if the candidate is competent in his work and thorough in his theory; he also has to have a firm knowledge of the National Health Service, social organisations, welfare departments, local authority services, etc., of the United Kingdom, of which foreign practitioners are ignorant.

I had cherished the ambition of taking this examination for many years. As the system of medical practice here differed from that in the U.K., I had to clear several technical hurdles before the Board of Censors would permit me to take it. They also overlooked the medical audit and log diary for the same reason.

Thus, a few years ago, I made my first trip to the U.K. (probably my last too) and to Queens Square. The questions were straightforward, though there were many which only candidates practising in the U.K. could answer. The examiners in *viva* were very considerate to the 'foreigner' but the modified essay paper was difficult because it was based on the 13-week certificate, which I had never heard of. I returned to my country soon after, contented with an Associate Membership of the College.

I agree with Professor Wilkes that "the examination needs overhaul rather than the candidate", and until such time as this is done, there is no point in doctors from other countries taking the M.R.C.G.P. examination. When it is, it would be helpful if the *vivas* followed soon after the written papers, so that busy practitioners were not forced to stay on in the U.K. longer than necessary.

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REFERENCE

Wilkes, E. (1976). *Journal of the Royal College of General Practitioners*, **26**, 217–218.

NOMINATIONS FOR FELLOWSHIP

Sir,

One only has to read the medical obituary columns to find part of the evidence that there must be many members of the College who, according to the present criteria, are well worthy of fellowship but are not receiving this honour. It can be assumed that the reason for this is that too few nominations are being made. It therefore seems strange that another obstruction is being put in the way.

The letter from the Honorary Secretary of Council (May *Journal*) indicates that for economic reasons all nomination forms which are not completed in typescript will be returned to the sender. At this stage of the College's development there must be many members who did sterling work in the formative years—work which can only be fully recognised by the offer of fellowship. By the nature of things, their nominations will come from other older members who may not now have access to typing facilities. To have a nomination form returned will not only be embarrassing, but insulting. Would it not have been adequate to state on the nomination forms that these should preferably be completed in typescript?

It is doubtful if this petty decision can be justified even on economic grounds, as fellowship fees are a source of revenue. Council should be looking for ways to facilitate nominations for fellowship whilst maintaining the standards.

I appeal for the reversal of this notice.

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REFERENCE

Irvine, D. H. (1976). *Journal of the Royal College of General Practitioners*, **26**, 357.

DOCTOR–PATIENT RELATIONSHIP

Sir

I have seldom read such a catalogue of rubbish and pseudoscientific mumbo jumbo as Dr D. M. Smith's letter in the *Journal* of June 1976.

I have never been able to diagnose acute otitis media without examining an ear. I do not know of anyone who can, and I would suggest that if your correspondent thinks he does possess this magic ability, then he should communicate the criteria on which he bases this judgment to an expectant world.

I take issue most vigorously and vehemently with Dr Smith on his contention that a recently registered neurotic elderly patient arriving from a previous doctor with a string of medications upon which he or she is allegedly dependent should have "a host of slimming tablets, sleeping pills, and nerve tablets" prescribed for him/her until a working relationship has been established.

The medical profession is not only a scientific profession, it is also a caring profession, and an authoritative profession. There is no virtue whatsoever in prescribing medicines which are known to be harmful, or at best unnecessary, and deluding oneself into thinking that a rapport is being established with the patient. The sooner physicians realise that they are being used in a fairly obvious fashion by their patients, the better.

The only way to establish a working relationship with such a patient is for a frank but not unfriendly definition of respective positions when first asked to prescribe slimming tablets, sleeping tablets, or nerve tablets. To waste one's time prescribing this form of medication in the hope that as time progresses the patient's demands will become less frequent and less onerous is a dangerous delusion. It is a clear cut failure of duty to exercise discretion in the prescription of drugs.

The only techniques that I can suggest which would enable Dr Smith to achieve long term scientific satisfaction are as follows:

(1) Examine all patients thoroughly when they present to you, suggesting that they may be ill.

(2) Refuse to prescribe medications under any circumstances when you have reason to believe that they are either harmful or unnecessary.

I can assure Dr Smith that there is a certain genuine satisfaction to be obtained from practising medicine under these conditions.

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