cheaper for the state to treat an average illness than it is to service a washing machine. In view of this, one would disagree with Dr Richards's stated conclusion that "Services provided by doctors are expensive to the National Health Service."

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Reference

Richards, C. W. (1976). *Journal of the Royal College of General Practitioners,* **26,** 823-827.

PRESENTATION OF CLINICAL DATA

Sir,

As the complexity of medicine increases it is becoming increasingly important that individual clinicians are capable of weighing the evidence critically for themselves rather than swallowing holus-bolus the opinions of others. To develop this capability in medical undergraduates is an uphill task, often discouraged by much of the contemporary curriculum. It is sad, therefore, to find the *Journal* occasionally doing the same for its readers.

Two recent examples will perhaps suffice. The first concerns the use of abstracts. In the October *Journal* under the heading "The Treatment of Vaginal Candidosis" appears the sentence "Of the three preparations, miconazole was found to be the most effective."

Now, it is true that you provide the relevant reference, enabling those who will to read the original paper and consider the evidence on which this statement is based. But, in the knowledge that most of us do not do so, this is precisely the method of presentation relied on by the commercial 'glossies'. Moreover, the journal in question does not happen to be available in at least one, well-stocked university library.

Should we not agree, therefore, that bald conclusions should be included in abstracts only if there is also some brief comment on the methodology used and/or the validity of the argument?

The second example is Fry's article on "The Natural History of Angina in General Practice". Here clinical data are presented, but presented in such a way as to defy independent conclusions.

For example: "The incidence during the 20-year period . . . is shown in Table 2" (page 644). This table appears to show, amongst other things, that there were 76 males aged 40 to 49 and 104 females aged 70 or over presenting as new patients with angina per year per thousand at risk. Do these figures refer to incidence or to prevalence, and are they being expressed per thousand at risk, or per thousand age-related at risk?

Secondly, throughout the paper, the author does not indicate whether he is dealing with incidence (and prevalence) or with *reported* incidence (and prevalence); nor is his method of follow-up defined. Thus, it is not possible to know whether the heading "Angina Goes" (Table 3) means that these patients had been recently reviewed and found asymptomatic, or whether they simply did not contact the doctor (although still registered with him).

Thirdly, "many associated clinical features were anaemia, a bleeding peptic ulcer . . . " (page 644). Now these clinical conditions are either important to the outcome or not important. If they are *not* important why mention them (any more, say, than mention corns or osteoarthrosis, which doubtless in some instances must also have been associated conditions)? If they *are* important then plainly Table 4 becomes meaningless. Further, in spite of Table 4, the advice given in the final two paragraphs of the paper pays no attention to age or sex.

If there are indeed valid lessons which the reader can learn from a published paper all well and good, but if he has no means of assessing the validity of what he reads it were better not to add to the mountain of paper under which he is already buried.

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References

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THE ARTS AS AIDS TO LEARNING

Sir,

Your Editorial and theme in the August *Journal* bearing on cultural factors in medicine have been commented on by Professor I. M. Richardson (November *Journal*) in encouraging tones. However his last paragraph suggests, unhappily I believe, "that the arts should be given an educational place in the preparation of most medical students."

Many doctors have written about, and practised 'whole-person' medicine; fewer have realized, until recently, our need to be 'whole persons' ourselves, and the contribution to this aim which an interest in and study of the arts in their widest sense can make. There are two aspects implied in this statement which have, as it were, disadvantageous side-effects; first, that one can *make* a doctor a whole person by giving the arts an educational place. Surely the best that a medical school or university can do is to avoid positive discouragement, for example by a curriculum not unduly overloaded and by the example of the teachers themselves as educated and sensitive people.

Secondly, there are implications for our work as general practitioners with the emphasis now on team work. I do not wish to develop this argument here, but would merely point out some conflict between the aims of the doctor with his patient (each to develop as a whole person) and the nature of team work as currently discussed, which shows some danger of detracting from the responsibilities and fulfilments of each individual member of the team.

I hope that, in spite of this caveat, you will continue to provide in the *Journal* opportunity for your readers to be as aware of their artistic needs as of their scientific nourishment.

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MEDICAL COMPUTING

Sir,

I think a note of caution should be raised on this topic since medical computing has been an actively pursued subject for many years in many countries and some of the systems which have been introduced have been expensively abandoned. There is obviously a great application for dedicated computers for the analysis of numerical data, for example the EMI scanner, but the normal mode of entry to the data bank is via a keyboard and most general practitioners are particularly loath to use a typewriter.

The computer has the ability to retrieve and collate a great deal of information at high speed so that the age-

sex and disease statistics of a practice can be rapidly extracted, furthermore it could be connected via a data link with information stores all over the country. Such a system is in world-wide use by international airlines for booking and management purposes, but before it can work for medical purposes the vast amounts of data, which are at present recorded in long hand on patients' records all over the country, must be laboriously typed in by hand into computer memories at enormous cost, using money which can be applied with better effect elsewhere.

Most diagnoses are made by pattern recognition, and in this field the average doctor is immeasurably better than the best computer one can imagine at present.

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PAEDIATRIC CARE

Sir,

Dr Curtis Jenkins's article on developmental and paediatric care of the preschool child (November *Journal*) presents a timely and interesting overview of the subject but I would like to raise two points.

While the 'Delphi' technique may be valuable and commendable and may indeed be more relevant than the "statistically median opinion" he should demonstrate consistency and not introduce statistics by quantifying the responses of a miscellaneous group of doctors chosen by unstated criteria. Their anecdoctal opinions may be of value and interest but the numerical strength of the responses is meaningless.

Secondly, the article makes no clear distinction between developmental screening, developmental assessment, and well baby care and this may have led to at least one astonishing statement, namely that one of the respondents doubts the "efficiency in diagnosis" of the health visitor. If this particular doctor really believes that the aim of screening is to make a diagnosis he is clearly no expert and must weaken the case for the 'Delphi' technique. Furthermore I feel that Dr Curtis Jenkins has misrepresented the conclusions of Roberts and Khosla on the use of paramedical staff in developmental screening, as they state in the conclusion (with regard to developmental screening) "the small number of observations that are effective are of such a nature that they could probably be made equally well by lay personnel."

Nevertheless, Dr Curtis Jenkins rightly stresses the urgent need for the evaluation of developmental screening programmes, and I would agree that rather than nationwide surveillance local problems demand local solutions depending on local needs and resources.

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References

Curtis Jenkins, G. (1976). *Journal of the Royal College of General Practitioners,* **26**, 795-802.

Roberts, C. J. & Khosla, T. (1972). *British Journal of Preventive and Social Medicine,* **26**, 94-100.

ILL-TREATED CHILDREN

I found the College's evidence on ill-treated children both interesting and relevant. However, I would like to make one or two points.

Firstly, it is my impression that in any family it is usually the same child that is 'battered' while the siblings are at considerably less risk. Secondly, I think traumatic alopecia may be an occasional physical finding.

I agree that a causative factor in battering is stress in the family environment, be it financial, the crying infant, or intermarital. I think in some circumstances when these stress situations are resolved, it is certainly possible for the family relationships to return to normal. Obviously a watchful eye must be kept on such families, but equally it is important that a prejudice against these families is not perpetuated. It is a pitfall that should be guarded against by the general practitioner when accepting a family with a past history of child battering on his list.

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Reference

Royal College of General Practitioners (1976). *Journal of the Royal College of General Practitioners,* **26**, 804-815.

EXAMINATION FOR MEMBERSHIP

Sir,

Exactly why I took the college examination—fellow that I am, and within a year of retirement to boot—is not the point at issue, but having taken this pretty threatening pastime I have no regrets. I now view most of my friends' pre-examination attitudes towards me that I was mad with less resentment than before, but would most certainly not dissuade anyone else from sitting with the other 'grey-heads' at Queens Square if they felt so motivated.

I now feel better qualified to speak with greater authority on what the examination is for, and it has given me cause to think more accurately on the question of competence to practise and what role the College has in offering assessment of competence to its members, and this is a much more important point of issue than: why take the exam?

At the moment the college examination seems to be aimed directly at the UK vocationally trained graduate, and is, for this purpose, a remarkably fine-honed tool, and the more one knows about the examination process, the greater is one's respect for those general practitioners involved in its organization.

In addition to this vocational assessment examination, what to my mind is becoming needed is a trainer assessment examination, which would be taken not less than five years after the first assessment.

If such a two-level assessment was to be offered, then consideration should also be given to the relationship of the granting of MRCGP and FRCGP qualifications with this assessment for those wishing to subscribe to the college aims and finances.

For those who still doubt a market for the examination commodity in general practice, Queens Square, with its top room filled with faces lined and unlined, should provide the answer; and for those grey-heads who feel too threatened, I would assure them the examination is fair, and not least of the threats is fourth-floor dyspnoea.

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WHAT KIND OF COLLEGE?

Sir,

The first editorial of the first *Journal* I received as a member of the College was a sorry welcome (September *Journal*).

This College must have the dubious distinction of being the first erstwhile academic institution in the free world to need to resort to legislation in order to propagate its views. As the editorial openly admits, those who expected that the 'advisory' Joint Committee on Postgraduate Training would be used as