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.

B. JAMES

The Doctors' House
Claremont Road
Marlow
Bucks.

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.

CHARLES B. FREER
Department of Community Medicine
University of Glasgow
Ruchill Hospital
Glasgow G20 9NB.

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.

N. SANKARAYYA

120 Wood Lane
Woodgate
Birmingham B32 4AJ.

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.

M. H. DALE

Pinfold Health Centre
Bloxwich
Staffs WS3 3JJ.

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

a means of getting effective college control of training have their expectations confirmed. Which training scheme or individual will dare gainsay the 'advisory' committee which may refuse to grant certificates of experience if its 'advice' is rejected?

I am also saddened that I have helped to increase the spurious credibility of the College by being one of "the large increase in applications for membership". Although I certainly do "care about standards", this was not my reason for seeking membership. Quite bluntly I, in common with many others, lack the moral courage *not* to be a member of a College with such prodigious prowess at manipulating the legislature. When the NHS (MRCGP) Bill arrives (as it surely will), we moral cowards intend to be safely on the right side of the fence before the test becomes even more expensive, pretentious, and erratic.

There is a need for an institution to foster, by diligent enquiry and free discussion, the search for ever better ways of caring for people. When the College sees fit to abandon its cruder political ambitions and favour persuasion rather than compulsion, then many cynical and fearful members will become proud and active participants in this search.

BRIAN M. GOSS

Heath Road Hospital
Ipswich
Suffolk.

Reference

Journal of the Royal College of General Practitioners (1976). Editorial, **26**, 631.

Sir,

A recent short article in *World Medicine,* by Breakey entitled "Have You Ever Compared the MRCGP to an Arm Balance Weighing Machine?", compels us to write. The article is, of course, referring to Appendix 2 at the end of Teaching Practices. *Reports from General Practice No. 15* by Irvine (1972).

We fully acknowledge that we should have commented on this report when it first came out and we make no excuse for our idleness.

The method of scoring advised in the report to assess the suitability of potential training practices is so manifestly absurd that the Royal College of General Practitioners is in danger of losing a great deal of its credibility. This is serious because the founder members and much of the subsequent work done by the College has improved the standards and status of general practice, but at the present time as we 'ride on the crest of the wave of education' there is a real danger that patients may be used as a means to an end in relation to education and research.

It is well for all of us—university departments, teaching practices, and ordinary practitioners—to remember that what most patients want from their doctors is accessibility, availability, and continuity. These vital aspects of primary care do not appear to feature very prominently in the criteria for good teaching practices.

Reports such as this must surely bring upon the College and general practice itself well-deserved ridicule. We are certain that many general practitioners are ashamed to be associated with such a pronouncement. Unfortunately there is a distinct danger that it has already been accepted as 'holy writ'.

JOHN STEPHEN
ALAN WOOLLEY

References

Breakey, B. (1976). *World Medicine,* **12**, 7.
Irvine, D. (1972). Teaching Practices. *Reports from General Practice No. 15.* London: Journal of the Royal College of General Practitioners.

The above letter was shown to Dr Irvine, who replies as follows:

Sir,

To make his point about academic and other teaching general practitioners, and the college examination, Dr Breakey in his article used the well known technique of selective quotation out of context. The method is the trusted friend of commercial writers who use it to evoke a response from readers when they know that reasoned argument will fail. Its successful use seems to have been demonstrated nicely by Drs Stephen and Woolley.

I cannot claim ever to have "compared the MRCGP to an arm-balance weighing machine." Six years ago I did publish a descriptive study of the premises, staff, equipment and organizational features of 190 training practices. My object then was to find out whether the significant deficiencies identified in a proportion of a sample of all general practices in England were also present in training practices. The results demonstrated that the majority of those training practices studied provided facilities which would give trainees the opportunity to practise medicine of a reasonable standard.

A rating scale based on peer group values was constructed, and correlations between the qualifications of the trainers, their professional, research and educational interests, and the general structural features of the practices were sought. No correlations were identified, a point recorded in my paper, but conveniently or carelessly overlooked by some of my critics. Since it seemed that the scored characteristics of the trainers (as distinct from their practices) were unhelpful in selection, I abandoned them. I cautioned readers that if they wanted to score structural and organizational features of practices they should do so with care since there were clear limits to the method. I also said that the check list and score could be a useful preliminary guide, but could not replace a personal assessment based on a visit to a practice.

The most disturbing feature of the letter from Drs Stephen and Woolley is its implied assumption that premises, staff, and organization are the most important criteria on which practices are chosen for training. They are mistaken. These factors are important, but we should be clear that the College (1972) and the regional trainer appointment committees have always very rightly emphasized that the personal qualities of the trainer carry the greatest weight. Furthermore, it is surely now evident that the individual criteria used in progressive schemes are being changed or are acquiring different values as standards are raised. For example, in the northern region we were anxious when we started vocational training eight years ago to see that trainees would work in a reasonable setting, and so we emphasized features of the practice. In the last five years the regional criteria have reflected our trainers' prime concern to be competent as doctors and teachers. Two years ago we moved on, like many trainers elsewhere, to take the first hesitant steps in the difficult task of trying to understand and define what we mean by 'good' patient care. General concepts like accessibility, availability, continuity, and professional competence roll off the tongue easily enough; securing even basic agreements about what they really mean to our patients and ourselves, and what we are prepared to do about them, will take years.

Yet I am also encouraged by Drs Stephen and Woolley for they evidently share with many of us the belief that good teaching and training in general practice has its foundation in good patient care. In seeking to define our objectives more clearly we who are active general practitioners may spare a thought for the Breakeys of this world, who gave it up. We are out in the field where the action is and we will discover satisfactions in our clinical work; they are bystanders who can only snipe or cheer from the touchline.

DONALD IRVINE

Redesdale
Wansbeck Road
Ashington
Northumberland NE63 8JE.