such portent. Surely the doctor should always be informed of a patient coming up to or at full dilatation in order that he may make every effort to be present at delivery and after.

The nub of the argument for general-practitioner units is combining a relaxed and familiar ambience for delivery with immediately available equipment. It is not acceptable that in 73 per cent of the confinements reported there was no medical presence. How can the practitioners concerned justify their claims for care during confinement? I might add that figures for our local general-practitioner unit last year were equally disappointing.

MICHAEL THIRLWALL
300 Meadowcroft
Aylesbury
Bucks HP19 3JA.

Sir,
Dr Richmond is to be congratulated on his comprehensive and well presented survey of the six general-practitioner obstetric units (July *Journal*, p. 406).

Although I suspect that this was not his intention, his figures present a strong argument against the continuation of separate general-practitioner obstetric units. A transfer rate of eight per cent from the general-practitioner unit to the specialist unit, presumably sometimes several miles away, seems less than ideal and an average attendance rate by the general practitioner during labour of 27 per cent does not indicate a strong inclination to participate in the management of the labours. This attendance rate could be regarded as an indication that the favourable end results were due to the good judgement and ability of the midwives of the units.

The continuing use of buccal oxytocin and the failure to use oral prostaglandins could be regarded as an indication that the general-practitioner obstetricians were out of touch with current obstetric practice.

As a general-practitioner obstetrician myself I hope that general-practitioner obstetrics will survive, but if it is to do so, then I suspect that it will have to be undertaken by general practitioners working within or closely attached to specialist units, who are prepared to be present at and take an active part in most of the labours under their care.

K. A. HARDEN
85 Milngavie Road
Bearsden G61 2DN.

LOOKING AFTER THE OLD

Sir,
Although precise indications of workload in general practice have not emerged from the various studies, there is a general impression that elderly patients are the greatest consumers of medical services. Morrell's study of patterns of demand in urban general practice (1970) showed that, while the age groups 64 to 74 and 75-and-over formed the two smallest ten-year group percentages of the practice population, they had the highest attendance rate per consulting patient, and the highest consultation rate per patient at risk.

Whilst examining at the last MRCGP examination I studied the log diaries of ten candidates, comprising 500 patients presumably seen by them in a sequential and unselected manner. Two service candidates were excluded as being unrepresentative of civilian practice.

The numbers of consultations with patients over 65 years, as they appeared in the logs, were as follows:

65–70	11
70–75	15
75–80	9
80–85	5
85–90	4
95 +	2
Total	46

We are confronted here by the surprising fact that the elderly, a group described as likely to overwhelm general practice, comprised only 9·2 per cent of the consultations. Of course, it must be said that the series is small and not significant to statisticians. However, it seems to indicate that doctors have become inaccessible to older patients, while carrying on a voluminous trade with them by means of repeat prescriptions.

In the review of Dr S. Carne's book (August *Journal*, p. 507), White Franklin was quoted suggesting that six facets of child care should provide the bases of service and the doctor's education now that the "paediatrics of sickness recedes from its historic dominance." No such recession from dominance can be expected of the sicknesses of old age. On the contrary, the magnitude of the problems arising from the care of the elderly places doctors in the front line in their traditional role. It is evident that there exists an urgent need for better training and retraining for deployment at both extremes of the life cycle.

M. KEITH THOMPSON
24 Fryston Avenue
Croydon CR0 7HL.

Reference

Morrell, D. C., Gage, H. G. & Robinson, N. A. (1970). *Journal of the Royal College of General Practitioners*, **19**, 331-342.

MEMBERSHIP EXAMINATION

Sir,
In the June *Journal* (p. 381) you kindly published my observations on the use of the college examination as a means of selection of trainers. Since that letter was written I have had further cause to question whether the examination is in reality being regarded in the way in which the College intended.

In his excellent lecture, reproduced in the July *Journal* (p. 391), Dr J. P. Horder states that the examination tests a minimal level of competence. Entrants would therefore fall into two categories: vocational trainees demonstrating that their training has achieved its desired end, and established practitioners seeking to demonstrate that their experience over the years has achieved a similar result. I find, however, both from information reaching me in the post and from advertisements in the *Journal* that courses are being offered for the examination. If either a vocational trainee or an established practitioner has reached the basic level of competence which the examination is supposed to assess, then such courses would appear to be superfluous. If, on the other hand, the examination can be more easily passed by attending a course on how to pass it, then to my mind it is not assessing a basic level of competence.

In making these observations I am not adopting an anti-college or anti-examination stance; I am simply attempting to ensure that the examination is really assessing what it is supposed to assess and to ensure also that my chosen specialty is not in danger of becoming crippled by the insidious disease of multiple diplomatosis.

M. TOWNEND
24 Fitz Road
Cockermouth
Cumbria CA13 0AD.

GOLD MEDAL ESSAY

Sir,
Dr Stevens's essay (August *Journal*, p. 455), which won him the Butterworth Gold Medal, reminds me of the television panel game, *Call my Bluff.* I am not sure whether what he says is true or false. Before reading his contribution I had not even heard of a "paradigm", which according to the *Concise Oxford Dictionary* is an "example, pattern, especially of inflexion of noun, verb., etc." and I am not clear even now what it is all about. No doubt now paradigm will become an 'in' word, just like 'Draconian' and 'existentialism'.

The article, which consists largely of stringing together extracts from 211

papers, shows that the author is widely read and it obviously impressed the examiners if it did not baffle them, but I am left with a feeling that Dr Stevens is to medicine what Tippett is to music and *avant-garde* to art.

If he wishes to convince other people of the truth of his philosophy, he must learn to explain his ideas in terms which ordinary people can understand. "I were fair flummoxed", to use a Lancashire expression, so will someone please explain in a few simple paragraphs what Dr Stevens really means?

H. W. ASHWORTH
Darbishire House
Upper Brook Street
Manchester M13 0FW.

Sir,
I approached the Butterworth Gold Medal Essay (August *Journal,* p. 455) with considerable interest, combined with respectful curiosity, about what goes into the making of an essay worthy of such distinction. However, to my dismay, what I found was that passages of otherwise lucid and interesting writing erupted at intervals into such a rash of little numbers that for me the words became unreadable and the narrative sense completely lost.

As on those occasions when, listening to a lecturer or preacher with an unfortunate manner of speech, one may begin to count the repetitions instead of concentrating on the material, so I found myself compulsively adding up the number of references relative to the number of words in the sentence. There are instances where the ratio exceeds 1:2. For example. "there is an extensive relevant literature: on creativity 38, 46, 47, 48, perceptions, 49 memory, 50 the concept of mind 51, 52, systems thinking 6, 53 mechanisms of reasoning 54 and decision theory 55." Indeed, it even reaches 1:1—"Other studies have since been reported 71, 78, 79, 80, 81, 82". Altogether over 260 references are made to the 211 listed sources; the text fills 9¼ pages, the reference list, 2¾.

I appreciate that such a list must be submitted to the judges of the competition, but I do wonder whether its inclusion in the *Journal* with all the numerical indices is really necessary. The general reader may be suitably impressed (and some potential contenders for the medal possibly deterred) by the awesome evidence of the author's diligent preparation. But might there be a case for dividing the references into two groups—a short list of major references for those interested in pursuing the subject, printed with the essay, and a detailed list available on application, giving chapter and verse for all the quotations and supporting evidence? This would release two pages of the *Journal* for other material. Alternatively, could some less obtrusive method be used to relate acknowledgement to source?

In raising this matter it is not my intention to detract from the scholarship, industry, or achievement of the author. On the contrary, my fear is that his valuable contribution to "the current ferment of ideas", as he puts it, and especially his central "Concept 5" on setting clinical standards, may fail to achieve its full impact because of the intrusion of the reference indices between the reader and the text.

MARIE R. CAMPKIN
24 Hermiston Avenue
Crouch End N8 8NL.

MEDICINE IN THE EEC

Sir,
I should like to comment on the article by J. W. Tanner, "Prolonged Study Leave in Hamburg and Vienna" (July *Journal,* p. 436).

On page 436 the author writes: "Finance is through several private insurance companies or *Krankenkassen.* Membership of a *Krankenkasse* is compulsory below a certain income level".

In the Federal Republic of Germany we have indeed very few private *Krankenkassen,* because the majority of employers and employees have access to the government health insurance bodies and very nearly 100 per cent of our citizens belong to a government health insurance scheme. We have the so-called RVO and *Ersatzkrankenkassen.*

On page 437 the author writes: "The *Krankenkassen* were responsible for all items of service and paid the doctor who actually did the work." This is incorrect. No *Krankenkasse* pays a doctor; actually the doctor is under no obligation whatsoever to deal with a *Krankenkasse.* He has his *Kassenärztliche Vereinigung,* who is in charge of all administrative and financial matters for all licensed doctors in its district. The Federal Republic has 18 such bodies. This organization is responsible for all agreements regarding fees for the doctor and his licensing, and examines his *Krankenscheine* (sickness certificates which he in turn receives from his patient). This examination takes place every quarter year and the doctor receives payment from the *Kassenärztliche Vereinigung,* not from any *Krankenkasse.* The former then sends all sickness certificates to the various *Krankenkassen* and receives reimbursement. Membership of a *Kassenärztliche Vereinigung* is compulsory for all licensed doctors, that is, doctors working under the Governmental Health Scheme.

I should also like to stress the point that it is by no means typical for a German general practitioner to have a staff of six. The typical German general practitioner employs a receptionist and a laboratory technician, and he survives!

It would be interesting to know with whom Dr Tanner spoke in Hamburg, because the very last sentence of his report regarding German conditions is rather misleading. Illnesses are not being "spun out" on account of the item-per-service payment. If this statement is being made it should be substantiated by strict statistical evaluations. Otherwise German doctors could appear in a very "dim" light.

ANNEMARIE LEMPELIUS
Assistant
Kassenärztliche Vereinigung
Nord-Wurtemberg
Haus der Arzte
Jahnstrasse 30
7 Stuggart 70
W. Germany.

PRE-SCHOOL DEVELOPMENT SCREENING

Sir,
As a general-practitioner member of the Health Care Planning Team (Child Health), Rochdale, I have been trying hard during the past two years to put forward a plan for general practitioners to run their own pre-school developmental clinics, and I strongly support Court, who also recommends general-practitioner clinics.

I wish Dr Freer (July *Journal,* p. 428) had read my article in *Update.* Dr Freer did not say in his article what assessments were being carried out on the pre-school children and whether the doctors who were doing the assessments had any training in developmental assessment. Mothers will bring their children to a clinic if they feel they are getting a good service, and they must be told what the doctor is looking for in this age group, because it is natural for mothers to assume that their children need no further supervision once they are walking and talking.

I can show from my figures that attendances at the clinics are nearer to 100 per cent than 40 per cent and that there are many conditions which can be detected in pre-school children if they are looked for: conduction deafness, squint, inco-ordination, dyslexia, and orthodontic problems.

I sincerely hope Dr Freer's article will not discourage general practitioners from running their own comprehensive