MRCGP COURSES

Sir,

Unfortunately Dr Freeman's letter (March *Journal,* p. 185) does little to allay my fears about courses for the MRCGP examination. I have long believed that one of the chief attributes measured by an examination is the candidate's ability to pass examinations and Dr Freeman's remarks about familiarization with examination techniques during courses suggest that this may be true of the MRCGP.

A multiple choice question is a test of factual knowledge and if well constructed is self explanatory. A modified essay question is designed to assess a candidate's ability to handle a developing situation such as might be encountered in everyday practice, and if well constructed should be able to do so without any prior familiarization. As far as *viva voce* examinations are concerned, all practitioners have encountered these in their final MB and should in any case be well used to accounting for and justifying their views and decisions in such diverse circumstances as talking to patients and making referrals to consultant colleagues. 'Familiarization' in this context smacks of being coached in what the examiners like to hear, an approach well known to candidates in many other medical examinations but surely not one which encourages assessment of the candidate's competence or usual mode of practice.

I can conclude only that the written part of the MRCGP examination is so ill constructed that many 'competent' practitioners require instruction in its methods before their competence can be assessed or that, with the viva, it is assessing the candidate's skill in examination techniques rather than his or her basic level of competence. Either of these conclusions lead me to agree with Dr Freeman that courses became inevitable when an examination was introduced.

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AREA MEDICAL OFFICERS

Sir,

In a recent issue (March *Journal,* p. 179), you said that Dr D. T. Jones is the first member of the Royal College of General Practitioners to be appointed as Area Medical Officer. I think there are at least two others. Dr J. Salem has been Area Medical Officer of Trafford Health Authority since 1974 and Dr N. M. Bailey is Area Medical Officer of Powys Health Authority.

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THANK YOU

Sir,

I should be glad if you would allow me to use your columns in an unconventional way, which is to thank so many of my friends for their expressions of goodwill on my retirement.

It seems that when my intention became known there began a conspiracy of benevolence in which my friends and colleagues took part. This developed quietly and steadily until at the last Council dinner my wife and I received the lovely carriage clock which now holds pride of place on our mantelpiece.

Many letters were forwarded to our new address to which I was able to respond personally, but I cannot thank in this way everyone who contributed to the culmination of the plan at the Spring General Meeting. Here we were presented with a silver coaster and salad servers by the members of the Birmingham Research Unit and those colleagues in medicine and science, at home and overseas, with whom I have been privileged to work on research projects. Finally, at the Faculty Dinner we were given a beautiful silver rose bowl with the coat of arms of the College worked into the design. For this we wish to thank the members of the Midland Faculty.

Few have been fortunate enough to take part in the birth of a College and its growth from adolescence to maturity. I am grateful that this has brought us so many good friends the world over beneath whose generosity we are now all but submerged. We hope that those whom we cannot thank individually will accept this indication of our gratitude.

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A SYSTEM OF TRAINING FOR GENERAL PRACTICE

Sir,

I am most grateful to Professor Richardson for his detailed study of my *System of Training for General Practice.* He invites a response.

Specified behaviour at the end of training is of course what educational objectives are and I agree that the Leeuwenhorst Working Party (1977), which I quoted, went only as far as to delineate aims. These are, however, most valuable, and the starting point from which detailed objectives can be derived.

While Professor Richardson disagrees with my "dogmatic statement" that it is important that those teaching general practice should do a minimum amount of clinical work, I remain unrepentant! I believe that general practice, like all the other clinical branches of medicine, is best taught by those who practise it. Quite how much has to be done to ensure that the teacher, lecturer, or trainer is a 'real' general practitioner is not yet known, but in the meanwhile I support the policy of the Royal College of General Practitioners that the minimum clinical commitment should be five sessions a week. In the recent words of Dr Freeling (June *Journal,* p. 329), teaching should be done only by "those who can".

I also agree that the conflict between training and service occurs as much in training practices as in hospitals. However, I am afraid medical schools have not changed as much as he hopes: our experience in Exeter with over 60 trainees from many different medical schools is that, especially in their first year, they *do* seek to be taught by 'experts' and are at first reluctant to accept responsibility for determining their own needs, defining their own objectives, designing their own programme, and arranging any systematic self-assessment.

I accept that anecdotal evidence is unsatisfactory. However, again in our experience vocational trainees are still often 'taught' in hospital through anecdotal evidence including anecdotes of bad general practice. I hope Professor Richardson will campaign equally vigorously against anecdotal teaching in all branches of medicine.

The amount of time trainees spend with their general-practitioner trainers is increasing steadily and two hours a week indivdiual tuition is, for example, now expected of all trainers in the Oxford region (June *Journal,* p. 352) and a growing number of trainers in other regions. Has Professor Richardson evidence of any comparable commitment to *individual* teaching in other branches of the profession?

I am sorry if the multiple choice question quoted is unsatisfactory and I hope Professor Richardson will explain to me privately how we can improve it.

I welcome constructive criticism and hope that we can all work together to

improve the quality of vocational training.

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NUMBER 15 PRINCES GATE

Sir,

I completely agree with Dr Ellis (March *Journal,* p. 185) regarding the headquarters of the Royal College of General Practitioners. I have long felt that property in the centre of London is not the best investment for the College's money nor the best meeting place for College members.

There are many large country houses between London and Birmingham and in common with many other organizations one of these could be purchased and turned into a magnificent headquarters and conference centre. It may be an advantage to keep a small building in the centre of London as a convenient place for members to stay overnight, but a country headquarters would be much more accessible to the vast majority of members in the UK as long as it was situated close to a railway station and motorway network.

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THYROID DISEASE

Sir,

The recent article, "Unusual presentations of thyroid disease in general practice" (March *Journal,* p. 170) prompts me to describe a patient who presented in June 1976.

The patient, a woman of 32, complained primarily of severe itching. This had started 15 months earlier, about three months after the birth of her first child. It had been mild at first but had recently become more severe. She also volunteered an additional symptom that she had lost weight (her pre-pregnancy weight had been 311 kg (10½ st) and now her weight was 277 kg (9 st). But pruritus was her main symptom. She was a new patient in the practice and this was her first visit. A month earlier she had been treated by her previous doctor for scabies but with no improvement.

Physical examination revealed numerous excoriations covering her body and on closer inspection an urticarial rash was present as well. She had fairly obvious exophthalmos and her thyroid was slightly enlarged. Her hands were moist and warm and she had a slight tremor. Her pulse rate was 132 per minute. The diagnosis of thyrotoxicosis was confirmed by thyroid function tests: total thyroxine 305 n mol/l (normal 70 to 185); free thyroxine index 430 (normal 60 to 175); thyroid hormone uptake test (T3 uptake or THUT) 71 (normal 92 to 117).

She was treated with carbimazole 10 mg three times daily and trimeprazine 10 mg three times daily and within a few days the itching settled. She was completely free from pruritus when she returned for her follow-up visit after two weeks. She has remained well and her symptoms of hyperthyroidism have completely disappeared. She takes only 5 mg daily carbimazole now and is about to stop the drug. She stopped the trimeprazine after only a few days.

Pruritus as a presenting symptom of thyrotoxicosis is rare. In 1904 Sir William Osler described pruritus in hyperthyroidism as "an early and most distressing symptom".

More recently it has been described by Barrow and Bird (1966) and Ellakin and Rachmilewitz (1959). The mechanism is unclear.

Pruritus is also known to occur in hypothyrodism. Here it is thought to be related to the dry scaly skin. It is relieved by the administration of thryoxine.

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