Until these matters are put right by the Department of Health and Social Security general practitioners will find that inevitably there are local medical libraries which do not match up to the proper standards.

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TRAINING GENERAL PRACTITIONERS

Sir,

The article by Dr Murray and colleagues on "Evaluation of Structured and Unstructured Training for General Practice" (July *Journal,* p. 360) exposes some of the flaws of this type of study.

The two groups chosen are not comparable. One is a group of trainees presumably with a reduced workload, who are compared with a group of principals. This must have a bearing on the preparation for, and hence performance in, any type of examination.

The authors state that "it is surprising that the principals did not score higher than the trainees in the initial test as most of them had been in practice over a year and the examination was biased towards general-practice knowledge and skills." This is not necessarily so surprising since MEQ and MCQ techniques can be as important as the factual content of the test and rather like techniques in the driving test I suspect are produced on the day.

It would be easier to assess the value of structured training if the same group were to be tested, say, five years later.

I suggest that the true conclusion of this paper is to demonstrate the value of structured and unstructured training as a preparation for a specific test—no more and no less. Vocational training has many advantages for future general practitioners, but critics are only likely to be more critical if this type of evidence is produced in support.

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Sir,

The paper by Dr Murray and colleagues (June *Journal,* p. 360) adds more weight to the opinion held by Professor Byrne and his colleagues that structured training is of considerably more value to a trainee than unstructured. All those contributing to this paper are to be congratulated.

I am still not happy! Do I want as a partner a young man whose structured training sends him through four house jobs in the same district general hospital and one year in a teaching practice, or do I want an unstructured partner such as one who, when he applied to us, revealed he had been in Biafra for Save the Children Fund; been a ship's doctor for P & O; acquired a DCH from Portsmouth and a DRCOG from the London Hospital; been a medical registrar in London, and undertaken numerous general-practitioner locums up and down the country?

So little in general practice is MEQ and MCQ on paper: so much is sensitivity. Some have it as a gift: most of us have to acquire it. Every trainee must do a vigorous period of in-service training, working alone, and with an experienced partner, and no structure will alter the need for this.

There is still much to be done on deciding who is a good general practitioner. Attention to 'customer satisfaction' is rarely mentioned, and yet it must be one of the most important of general practice aspects because we are all patients! I have found visits to waiting rooms recently most revealing.

That training for general practice is necessary there is little doubt, but rigid structuring in these early days may inhibit many young men from seeking knowledge where they know they can find it, and this must be to the detriment of our challenging branch of medicine.

Let us make it possible for trainees to jump from scheme to scheme, county to county, and perhaps country to country. Only in this way will high standards be maintained.

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ETHICS

Sir,

A recent issue (June *Journal,* p. 367) announced that Council had set up a working group to consider the best method of examining ethical issues within the College. The decision arose after a "major debate" in which the need for an ethical committee was challenged by Professor J. S. McCormick. He felt that the essential feature of an academic institution was tolerance and that there was no need to accept that individuals had to subscribe to universally accepted beliefs. Many ethical beliefs, however sincerely held, did not depend on evidence and it was not appropriate for the profession to judge them especially when a regulating function was exercised by other bodies.

Dr D. J. Pereira Gray took a contrary view. He doubted whether existing regulations were adequate and referred to the suggestion that the Ombudsman should be involved with clinical decisions which could be interpreted as dissatisfaction by society with existing mechanisms. He felt that ethics were another form of standards and that it was appropriate for the College to have an active ethical committee. Other speakers queried the wisdom of confining ethical considerations to an ethical committee, or pointed out that the College was always making ethical statements.

The situation is clearly confused and I wonder whether all the speakers were talking about the same thing. Häring (1972) pointed out that because they represent concepts that overlap, the words 'ethos', 'ethical code', 'medical ethics', and 'morality of the physician' are often confused. He suggests that ethos comprises those distinctive attitudes which characterize the culture of a professional group, or subgroup such as general practitioners. It includes a sharing of customs and common experiences and a commitment to a particular hierarchy of values. It originates within a profession and is formulated more particularly by those who typify it in an outstanding way.

Ethos is to be distinguished from ethical code which consists of a studied effort to foster and guarantee ethos but is meant to go beyond it by assuring to physicians, to patients, and to the public a professional standard of human relationships. In other words, it draws its vigour from ethos, but goes beyond it. Ethical codes may be a guideline, such as the Hippocratic oath, or may be used to warrant a minimum of self-control within a profession, such as that laid down by the General Medical Council. It sometimes wards off the necessity for the state to legislate in medical questions.

Medical ethics represents a systematic effort to illuminate ethos and to establish the perspectives and norms of the medical profession. It takes into account the existing ethos but intends to strengthen the morality, the moral discernment, and the decisions of both doctor and patient.

The morality of the physician lies in his own perception of the proper approach to his profession. It is his way of living within the ethos of his profession and concerns his capacity to make