According to Dr Hart, I found a total of 169 patients from a health centre population of 14,500 identified as hypertensives. What I said was, however: ". . . I listed the names of those persons, who in 1975 had received the right to free antihypertensive medication. . . ", which means that I was not talking about the prevalence of hypertension nor even about the annual incidence but only about all those persons who during the year 1975 received the right to free antihypertensive medication in that district. Every year since 1970 some people have received and will receive these rights. The annual number depends on many things, their own activity and the activity of their doctors among others. Taking everyone who received this right during one particular year, and then these same persons again two years later, allowed an evaluation of the effectiveness of the free medicine scheme with this particular cohort of patients and an assessment of the quality of hypertension care in this particular health centre district. All of these patients had already been treated for various lengths of time before the certificates for free medicines were written by the doctors.

The mean pretreatment pressure for the whole group, which to Dr Hart seemed to be missing, was not given because the doctors had not indicated the pretreatment readings for all the patients in their certificates, from which this piece of information was abstracted. However, in this particular context, this omission is not important. Considering the free treatment programme one might even become curious about whether, in fact, the patients with missing pretreatment information (27 out of the 169) were hypertensives at all, or were merely taking their free medicines on their doctors' prescriptions.

In my article I clearly explained my criteria of the therapeutic outcome assessment and it is up to the readers to accept them or not.

Finally, I do not believe that the findings I presented discourage medical teams, as Dr Hart seems to fear. On the contrary findings such as mine should encourage doctors to study more closely what they are doing and to learn more about their daily activities. Such learning could then be used to improve the quality of care and the health status of the patients.

PERTTI KEKKI

Acting Professor of General Practice

Lapua Health Centre
Lapua
Finland.

Prison Medical Services

Sir,

There has recently been a surge in interest and controversy regarding the ill-treatment of prision inmates.

Last year there were some 2,800 complaints against the police alleging assault of prisoners. No systematic attempt to measure the prevalence of injuries in custody has been attempted, although some suggest that maltreatment in custody is far from rare and is more frequent than the public realizes or the authorities care to admit. Should these allegations be true, there is a need for closer supervision, particularly at the time of interrogation, to eliminate the possibility of assault. The fact that some injuries are self-inflicted is noteworth.

I use, by way of illustration, the example of a 43 year old, unmarried-labourer with a criminal record for offences of theft and violence. He presented himself at a night shelter complaining of severe ear ache and difficulty in hearing.

This man had an unspectacular medical history. There was no abnormality in the cardiovascular system, central nervous system or respiratory system. On examination, the ear canal was completely obscured by wax. There was a puzzling, shining object just visible, the nature of which could not be discovered because of the large quantity of wax present. The ear was syringed and it was then seen that a large, coarse, piece of tin foil had been embedded proximal to the ear drum. The foreign body was removed and it could be seen that the ear drum was severely scarred. There was increased vascularity of the whole tympanic membrane.

After some close questioning it transpired that he had inserted the piece of foil into his ear and had pushed it as far as possible into his ear with a pencil. He admitted that this process had been extremely painful and the only explanation he could offer for this behaviour was boredom while in prison.

This sort of injury is commonly considered not to be self-inflicted and I believe there is no similar report in any medical literature. I frequently encounter individuals who claim to have been assaulted by the police but it soon becomes apparent that their injuries were sustained before their arrest (usually while drunk) and later conveniently attributed to police brutality.

The prisoners' rights group (PROP), supported by the Howard League for Penal Reform, have recently called for the prison medical service to be disbanded and for the responsibility for prisoners' health to be transferred to local NHS doctors of the prisoner's choice. The fact that many such individuals are not registered with a general practitioner has been overlooked, and many doctors are unaware of the devious nature of such individuals.

N. J. SHANKS

9 Glencross Avenue
Chorlton
Manchester
M21 1NX.

We showed Dr Shanks' letter to the Assistant Director of the Howard League for Penal Reform, whose reply follows:

Sir,

Your correspondent is right to suggest that some allegations of assaults on prisoners are ill-founded, but this in no way weakens the case for abolishing the Prison Medical Service and integrating its services with the normal community health agencies.

The problem of self-injury is not essentially different from that of self neglect, and doctors have to deal with many such patients each day, whether they neglect their health through smoking, excessive drinking or overworking. It seems wrong to point to special groups as being especially neglectful.

In fairness it should be noted that homeless people frequently find that general practitioners are unwilling to take them onto their lists. I have known of many cases where homeless people and those who assist them have gone from surgery to surgery without success. I am afraid that Family Practitioner Committees are sometimes unable to rectify these problems promptly.

The questions posed by medical services are quite different again. Should doctors for prisons be appointed by the same authorities who manage the prison service? Should prisoners have the right of access to alternative medical advice when they want it? At present, this is permitted only if either the Prison Medical Officer allows it or if the prisoner is a party to litigation where medical evidence is material.

All doctors working in prisons in England and Wales are appointed by the Home Office's Prison Medical Service. Most work full time in prisons, although a few are NHS doctors, who work part time for the Home Office. It is wrong in principle that the Home Office, which is responsible for managing prisons, should also have the responsibility to appoint doctors. When there are not infrequent allegations of brutality and when living conditions

are often appalling, medical evidence is sometimes most relevant. A prisoner may deny the doctor's diagnosis of self-injury or malingering: here there should surely be a right to a second opinion.

On the question of prisoners suspected of being injured by prisoners or staff: here too there are obvious objections to the present practice, which denies the prisoner access to any doctor independent of the prison.

Whether complaints are well founded or not, the provision of medical services to prisoners is not independent, and is not seen to be independent by prisoners, their families or the general public. We contend that it would be much better for the local Area Health Authorities to provide the medical services in their local prisons. If this and many other services in prisons were provided by the normal agencies in the community, then perhaps there would be more interest and more well-informed public discussion about penal policies. Surely that is good for all concerned, including the doctors and prison staff.

ANDREW ERLAM
Assistant Director
Howard League for Prison Reform
169 Clapham Road
London SW9 0PU.

Membership

Sir,

We all know that August can be a difficult month for an editor of a medical journal, but making every allowance for the silly season I still think the letter from Drs Rankin and Mitchell (August *Journal*, p.505) takes a lot of beating. Flushed with success in an MRCGP examination, two self-confessed middle-aged practitioners rally to the defense of the supposedly threatened examination, expressing their righteous indignation with a protectionist fervour which would not have disgraced Colonel Blimp.

Ostensibly, they are writing about entry to membership of the College. In reality, they consider the examination to be an end in itself and that its monopoly over entry must be preserved at all costs and in the face of any progressive proposal. Their 'concern' at the idea of directly assessing a practitioner in his or her own surgery is incomprehensible. As loyal members of a College dedicated to raising standards of care, they should be putting their backs into the enterprise—not making snide comments about 'second-rate' membership. Which is the more relevant: appraising doctors where they do their real job, or asking them to write down what they remember or what they might or might not do in hypothetical circumstances and with patients they have never seen?

Drs Rankin and Mitchell give the game away when they cite the plight of academic departments of general practice in support of their argument. Can it really be true, as they allege, that the professors will become shifty-eyed as the result of the College developing methods of direct assessment rather than relying on a classroom exercise? True or not, our academics must solve their problem in other ways than by persuading the College to retain a second-best system of assessment.

Ultimately, it is the talk of 'status' and of 'insult' which will prove the more damaging. Never mind the prestige of the examination—it is the credibility of the College itself which is threatened by such reactionary protests.

J. S. NORELL
Office of the Dean of Studies
Royal College of General Practitioners
14 Princes Gate
London SW7 1PU.

Sir,

I refer to the letter from Drs Rankin and Mitchell, in which they call on the Council to state that the MRCGP exam will be the only means of gaining Membership of the College. Without commenting on their hurt pride, I would like to point out where their attitude is based on a misconception.

A questionnaire, which is to be submitted for possible publication in this journal, circulated amongst all 100 general practice trainees in Devon and Cornwall by their Regional Trainees Group, showed that they did not hold the exam in high esteem. Although a majority intended to sit the exam (75 per cent) nearly all were sitting it 'for the wrong reasons'. Only two gave as reasons that they wanted to become members of the College. The most common reasons were: "to help get a job" (19 people); stimulus to study (16); fear of the exam becoming compulsory or, more important, of conferring certain rights at present not foreseeable (16); self-assessment (14); and various personal reasons such as 'masochism', 'reflex conditioning', 'pride' and 'egotism' (14). Only one thought the exam made general practice parallel with other specialties, and one other thought it "obtained recognition for general practice".

The misconception is that learning to jump through a hoop will prepare one better for walking when one lands on the other side. Since most trainees are likely to take the exam under sufferance and for very personal reasons (including stimulus to study and self-assessment), there is little prospect that merely taking it will produce a commitment either to practice good medicine or to maintain a good reputation for the next 35 years in clinical practice.

If the letters MRCGP are to mean anything then some radical alternative criterion for conferring Membership must be considered for both young and mature GPs.

T. N. GRIFFITHS
Chairman, Devon and Cornwall Regional Trainees Workshop

10 Burniston Close
Plympton
Plymouth
Devon.

Sir,

I was very interested to read the letter written by Drs Rankin and Mitchell in the August *Journal* (p.505).

I agree with them entirely. It is open to any doctor to become an associate member of the College without passing the MRCGP examination. Full membership of the college should be reserved for those people who have taken and passed the examination.

I too am a middle-aged doctor, who in 1980 passed the examination. I would now take a very poor view of any attempt to cheapen the entrance qualification. In fact, I would no longer consider it worthwhile remaining a member of the College. I am sure I am not alone in thinking in this way.

I could have entered the College in the 1960s without examination. I chose not to do so and so presumably did the middle-aged doctors who now wish to enter without examination. Didn't they miss the boat? They should now gird up their loins, take and pass the examination. The MRCGP is a sensible practical test which any experienced GP, who has kept himself up-to-date by regular reading should pass without difficulty.

H. G. NICOL

Rother House Medical Centre
Alcester Road
Stratford-upon-Avon.