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.

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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.

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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.

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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.

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