LETTERS

Section 63

Sir,
Your editorial on reforming Section 63 runs a risk of dividing the profession into hospital and general practice.

You suggest that the whole of postgraduate education for general practice is being dominated by other specialties. In fact, not only do all other specialties submit to similar scrutiny by the regional postgraduate education committees (RPEC), but general practice stands unique in being the only specialty which has separate funding.

You fail to recognize the all important role of the RPECs and would appear to imply that there is an absolute direction by the postgraduate dean, with no regard for other opinions. This we believe to be very far from the case.

We agree that general practice must be the authority on the mechanisms for teaching within its own specialty. In the South West we have seen no problem in allowing this to evolve within the present system. The regional subcommittee in general practice has just formally and unanimously supported a memorandum on this very point, accepting that general practice is a major clinical discipline in its own right and feeling that it can only suffer by separation from the university and medical school. The role of the regional general practice sub-committee is seen as preeminent in the management of the problems both of vocational training and of continuing education in general practice. However, it was felt that it should not become autonomous but should remain as a sub-committee of the main RPEC, where its views could influence and be influenced by those of the postgraduate tutors and the regional advisers in the various specialties who have already over the years contributed on such a large scale to the success of postgraduate education in both hospital and general practice.

Section 63 activities in our region evolve from the districts, which are almost all represented by general practitioner tutors as well as hospital tutors, and reach the office of the postgraduate dean only through the regional advisers in general practice. Since this routine was adopted, there has been no example of a clash of opinions between the medical postgraduate dean and his regional advisers, who are seen as the authority on matters of education in general practice.

We plead that the alternative case be considered most carefully—that both general practice and hospital practice should submit themselves to a final common educational pathway which will allow ideas to be pooled and the risks of specialization to be minimized. Mutual respect and a realization that each branch of the profession can learn from the rest, has, we believe, been the reward won by the present system.

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Membership

Sir,
I write in reply to the letter from Dr Norell (November *Journal,* p. 697). It is a pity that he can only use the contemptible ploy of character assassination to answer the points raised by Drs Mitchell and Rankin. At the risk of raising the age rule yet again, may I as a young (33 years old) principal enter the argument?

There is no doubt at all in my mind that MRCGP by formal examination must remain the sole basic entry criterion for the College. This College, of which I am proud to be a member, has fought long and hard to establish itself as a reputable academic body representing general practice. This long process was carried out against a background of hostility from general practice itself and from some of the other learned Colleges and Faculties. The MRCGP diploma is now recognised as the only truly representative, registrable qualification for postgraduate general practice. I have no doubt that it is the production of this fair, but rigorous examination that has raised the status of our College in the eyes of both the other Royal Colleges and amongst our specialist colleagues.

The Working Party Report "What sort of doctor?" published in the same issue of the *Journal* (pp. 698-702), condemns itself in one telling phrase, namely, "we rapidly discovered that making value judgements was inescapable" (paragraph seven). In ordinary layman's language, the assessment is a matter of personal opinion.

The proposed new method of assessment may have some merit for assessing continuing competence in practice, or as a route to fellowship (the present route to fellowship certainly baffles some of my colleagues!), but as a basic test of postgraduate competence in general practice it is a non-starter.

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Sir,
To me the crucial issue is the standard of primary care offered to patients by all general practitioners, accepting that not all general practitioners' standards are what they should be.

I agree, any system which tries to improve standards will work only by voluntary means; so passing the MRCGP examination must not be a formal requirement to be a principal; but we should use the examination as a test of minimum competence:

1. For all vocational trainees; it should become the norm to take it, and it should be expected that most applicants to become principals will have wanted to pass the examination. It will therefore be difficult for those who do not pass it to become principals; and those who fail must be properly advised and further assessed. If the examination is working properly, it should detect those who should not become principals.

2. For all other doctors who choose to take it, and there must not be any alternative route to membership. If it is a test of minimum competence, then all general practitioner principals should be capable of passing it; if older doctors take it, they will do so voluntarily; if they then fail, they can resit; if they still fail, then (if the examination is working properly) they must have some weaknesses, and again there should be counselling to help the doctor in a positive way. This will serve a valuable educational purpose.

There is of course no reason why surgery assessments as proposed should not be used.

1. To broaden the examination or improve it.
2. To assess a candidate for fellowship.
3. As an alternative means whereby older doctors could assess their work if

they chose not to take the MRCGP examination—perhaps because they may be afraid of failing. This would be a valuable alternative way for doctors who felt they were behind the times helping themselves without embarrassement.

By these means the status of the examination would be maintained and raised, and no-one could call the College hypocritical for having a test of minimum competence and then allowing others to obtain MRCGP status by the back door (no matter how secure the back door).

Further, the level of minimum competence can be slowly raised as the general standards of practice rise. As the years go by, the number of general practitioners with MRCGP will rise, putting more moral pressure on the remainder to face the challenge of good standards (even minimum ones). Those general practitioners who do not work to raise their standards will, hopefully, be slowly diluted out; some may be netted by the newer powers of the GMC and helped to improve.

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Sir,

There is scope for improvement, as we all know, in the methods used to assess potential members. At the moment there are two groups of members: those who paid their money early on and those who have passed the examination. Let me put up a plea to Princes Gate: please do not introduce a third group of members—those who are admitted after appraisal of their day-to-day work.

I do not wish to suggest that any one of these groups of members is better than another, but the following facts remain: many of those who helped to get the College off the ground have subsequently chosen to take the examination; trainees and younger members (including myself) would, I believe, choose the examination as it stands as being a much softer option than having our day-to-day work appraised. We are on safe ground remembering facts and saving what we 'would' do.

Yes, Drs Rankin and Mitchell (August *Journal* page 505), like yourselves I got in the easy, non-threatening way. How much more difficult it would be for many of us actually to be obliged to 'do' rather than simply to 'say' or make "multiple guesses". I do not wish my Membership to be devalued by comparison with those members whose mode of entry was tougher and more realistic. There must be only one route of entry into the College; there must be only one door—the front door. If there are two doors the argument will be endless as to which one is the front and which the back and an irreparable schism would develop in our College.

Clearly, the examination must be made more relevant to the realities of practice, and this means that a clinical component (perhaps appraisal of day-to-day work) must be introduced. If and when this happens I wonder if I will be tempted to re-classify my membership by taking this new tougher more realistic examination?

There is another question—should members be obliged or encouraged to re-take the examination every five years or so, and if so, should it be with or without the risk of losing one's right to membership?

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Sir,

My failure in the MRCGP viva last December, essentially because of a clash of personalities, convinced me that passing the examination is pretty valueless.

Thank God for Dr Norell's good sense (November *Journal,* page 697). Of course there should be other methods of entry for established GPs.

I wonder how many of the successful candidates are in any way involved in the promotion of standards in general practice, for which the College stands?

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Sir,

With reference to a letter from Drs Rankin and Mitchell (August *Journal,* p. 505), and subseqent correspondence, surely, if the MRCGP Examination is one which an experienced GP who is up-to-date, cannot pass, then the examination itself is at fault, and should be restructured forthwith.

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Sore Throats

Sir,

The letter from Michael Whitfield (July *Journal,* p. 442) confirms my experiences with the conservative use of antibiotics in sore throats.

Taking up a practice vacancy in 1959 enabled me to observe the effects of the limited use of antibiotics in URT infections, especially in children. My indications for giving penicillin were the toxic cases, when patients had high temperatures, severe pain on swallowing and felt quite ill.

Most cases were not like this. My peers were genuinely concerned about the possible occurrences of rheumatic fever or nephritis in my patients, though these problems have never yet occurred. In children not receiving penicillin a hearing loss rarely occurred, and when it did so it returned within two months. Very rarely did these require tonsillectomy, adenoidectomy or middle ear drainage.

In 1963 I was joined by an assistant who had 15 years of ENT experience in hospitals. She introduced full antibiotic cover for all these cases, mild to severe. However, this regime produced the very complications and sequelae she had hoped to avoid and three years later I was witnessing children who had had up to a dozen recurrences of otitis media; one had had 15 episodes. It is my impression that two-thirds of those receiving penicillin had a recurrence within four months.

My assistant then left and I resumed a conservative regime. Recurrences of URTs returned to modest levels, and so it has remained.

In 1972 I spent a Sabbatical year working on a kibbutz in Upper Galilee where, at that time, whole classes of children would receive antibiotics, often three in succession, including chloramphenicol, to help overcome recurrent URT infections and the feared sequelae, though none had occurred so far. Most of the recurrences petered out within several months of dicontinuing this intensive therapy.

There is overlap between impressions and statistics, and I believe that my non-statistical impressions are valid. The criticisms formerly proferred by ENT consultants may be because they saw only referred patients and none of the many mild home cases.

It is for those who advocate the use of antibiotics to justify their advocacy, not for abstainers to justify their abstention.

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