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?

K. M. MACK
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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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