Membership

Sir,

The logical answer to those who decry the MRCGP and an alternative assessment within practice environs must be a combination of both, which is a belief I have held from the first discussions about having an examination as a criteria for membership.

The simple problem is that a passed examination says nothing about future competence. Equally, competence in passing an examination says nothing about actual practice and treatment of patients. Failure equally says something about the preparation for the likely questions, but little about character, concern, and many other desirable attributes.

On the other hand, seeing a doctor at his practice when he knows he is going to be assessed is unlikely to be necessarily truthful. Being on show means a few hours of trying to produce what you think the assessors will want to see. This too, therefore, is not a very good method of fact finding.

However, both methods together might provide more than either alone. So, have the MRCGP, and confirm it after a practice visit three years later. Those who can provide sufficient experience or for other reasons could claim exemption, can just endure the latter. Other professions have a period of apprenticeship; members gain full recognition some years later, after passing a preliminary qualifying examination. Then there is a full recognition of their status, as members of the body concerned.

I recommend we do the same if we are going, as presumably we feel we should, to try and provide some measure of our standards.

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Terminal Care

Sir,

In their article on terminal care in the home (September *Journal* pp. 531-537), the authors commented that there were considerable differences between the general practitioners' and the carers' perceptions of the patients' problems. This would be a highly significant statement worthy of further study, as finding the reasons for this discrepancy would be of benefit to general practitioners caring for the terminally ill at home. However, the presentation of this information on Table 3 renders any comparison between the two groups invalid, as the doctors and carers are referring to the same patients in only 49 cases. It would not be an unreasonable conjecture that in the 26 cases where a reply from the general practitioners was forthcoming, but not from the carers, the problems of the dying were less; conversely, in the 29 cases where a reply was forthcoming from the relatives and not the general practitioners, the problems of the dying may have been greater.

It would be interesting to compare these findings in the 49 cases.

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REPORT

Association of University Teachers of General Practice

The Association of University Teachers of General Practice held their 1981 Annual Scientific Meeting in Belfast. The attendance was similar to previous years, but the academic programme and the social aspects surpassed that of previous years. The delegates were surprised how quiet Belfast was, despite the deaths of two H-block detainees just before and during the meeting.

The meeting began on Wednesday, 8 July with a tour of Dunluce Health Centre where the University Department of General Practice is situated. The party of almost one hundred was divided into small groups for demonstration of the computer facilities and the closed circuit television. (See September *Journal,* pp. 557-560.) The computerized record system is at present being developed and will complement the existing manual system. It will be used for service work and research and will eventually provide each GP with a problem summary and data base, encounter data, drug medications and the facility to print out repeat prescriptions. There was no doubt during this two-hour demonstration that the facilities in Dunluce Health Centre are second to none.

The scientific papers for the remainder of the morning looked at contrasting teaching techniques, with Neil Carson describing the undergraduate course at Monash University, Melbourne: this was very structured but extremely well thought out. Dean Southgate from the Flinders University of South Australia then described a course of teaching on alcohol and its effects. Chris Donovan described the general practice teaching at the Royal Free.

The afternoon session began with two papers on assessment: firstly Jim Bamber (Queen's University) described the value of the MEQ in the assessment of learning in final MB, then Jack Marshall (from Adelaide) spoke on the value of the patient management problem in measuring problem solving. Both these papers raised a number of issues and useful discussion. Stuart Wood (Glasgow) ended the day with a description of his attachment to a university department and a hay fever study which he had carried out.

The following day the morning was taken up by clinical research papers: David Metcalfe (Manchester) on verbal behaviour in the consultation, Michael Drury (Birmingham) on monitoring for adverse effects of drugs, James McCormick (Dublin) on some practitioners' criteria of hypertension, George Lewith (Southampton) on a trial of acupuncture in shingles and post-herpetic neuralgia and, finally, two papers from Queen's: Cameron Ramsey on aspects of the care of epileptics and Margaret Cupples on the use of digoxin in general practice. This group of papers produced lively discussion and the morning session passed quickly. The afternoon was taken up by the social programme: firstly, a visit to Mount Stewart House, which had magnificent gardens, and secondly, a reception at Stormont, the former Houses of Parliament, Northern Ireland. The hospitality at both these visits was outstanding.

The last day of the meeting was again filled by a series of scientific