doctors to go out to Nigeria to help in the general practice training centres and in providing primary medical care.

I went to Nigeria in 1956 to organize and run the General Outpatient Clinic at the new University College Hospital, Ibadan, the first teaching hospital in the country. The clinic was organized on the lines of a large—very large—general practice health centre and became known as the GP Clinic. There were six house officers, in present day terms trainees and assistants, and medical students attended at different times in their clinical course. While this set-up was useful as a start it was not, of course, adequate training for primary care in the rural areas and we had to get additional facilities away from the hospital.

In 1961-62, in conjunction with the Departments of Medicine and Social and Preventive Medicine, the expansion was planned of an existing clinic in a suitable area by the addition of a small community hospital, quarters for senior medical staff, trainee medical officers, medical students and also health visitors, nurses and midwives. I left Nigeria in 1962, so to my regret I did not see this scheme completed, but after nearly twenty years it appears to have borne fruit. It is good, too, to see that there is now a separate Faculty of General Practice which is, I think, essential for GP training. It is an exciting prospect.

As far as the individual doctor from this country is concerned, I am sure that he or she will never regret a spell of work in West Africa. The clinical experience is vast. Though facilities are often inadequate and shortages of all kinds are frustrating, there is the satisfaction of trying to cope with the large numbers needing help—and on returning the GP will appreciate the facilities of our much criticized National Health Service.

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Patients who Change Practices

Sir,

Patients who leave the practice can be divided into many groups. The group I wish to consider are those who leave for "the practice around the corner" without obvious cause. The possible causes are legion, probably multiple in many cases and may even be difficult for the patient to define.

I am prompted to write now by such a transfer of a woman patient; the motivation for it is a complete mystery to me and indeed somewhat wounding. A letter from the consultant to whom I had referred the lady recently came complete with a copy for the neighbouring doctor and was the first indication I had had of the existence of a problem between us. A review of her notes and those of her family failed to bring to mind any clues; indeed they are for the most part infrequent attenders.

It is not my intention to complain in these august columns, but rather to suggest that a form of audit applied in these circumstances might be of use to patient and doctor alike. I suggest that when a patient transfers "round the corner" both the patient and the doctor be invited, diplomatically, to comment on the events leading to the transfer, such comments to be considered by an independent third party, perhaps the Family Practitioner Committee. This would lead I believe to much useful and perhaps even critically important information being unearthed about mismanagement, negligence, malpractice, unrealistic expectations and so on.

The present situation lacks utility or virtue in any respect and should be changed. There is an opportunity here to make a worthwhile contribution to the standards of primary care, and I look forward to hearing the views of others on this topic.

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The College as Host

Sir,

I was very pleased to see the note (July *Journal,* p.447) describing the dinners held at the College by the St. Mary's and St. Charles' vocational training schemes. The College house in Princes Gate almost always receives compliments from those who visit it for the first time. The more it is used by Members and others the better—whether for medical or social occasions.

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POSTGRADUATE EDUCATION

TOWARDS THE MRCGP

A course held at the Royal College of General Practitioners, February 8—12, 1982

THE four Thames Regions were asked to provide tutors for this course, which had first been successfully held one year previously. In the event, Dr James Scobie from the South London Faculty and Dr John Dymond from the S.W. Thames Faculty volunteered to run the course together.

Introduction

This was a residential course, held at the College, for those candidates who had failed the MRCGP examination and wished to prepare for it again. All those candidates who failed the exam in 1981 and who wrote asking for details of their marks, were sent details of the course and eventually 19 attended. The organizers invoked the help of several other tutors: Dr Gregor Bartlett, Dr Andrew Belton, Dr Ben Essex, Dr Graham Hornett, Dr Alistair Moulds and Dr Douglas Price.

The aims of the course were for the participants to attempt to identify the areas in which they were weak and unprepared, and to compile a strategy for filling these gaps. It was not intended that the five days spent at the College would in itself do anything more than set the candidates on the right lines for future work. When the course began, inevitably a degree of anger was expressed by many course members against the whole concept of the College, the exam. and the examiners. The members were allowed to bring these anxieties and conflicts out into the open and to express their anger.

The Participants

It was apparent that there was a wide range of knowledge and ability among the 19 course members. Some doctors

had taken the exam at least four times and it was unfortunately clear that they could go on taking it many times in the future without hope of success. The lack of knowledge of some candidates was indeed disquieting; for instance, one doctor was unable to name a single beta-blocker. The purpose of this report is to describe the various teaching methods which were used in the course of the five days.

None of the participants previously knew each other. Their reasons for joining the course were quite diverse. Nobody said how much they admired the RCGP or wished to join such a fine and exalted body and to take part in the avowed work of the College, which is to improve the standards of general practice in this country. Doctors wished to pass the exam. because, for example:

"I thought I ought to pass it before the trainee gets it".
"My wife has got it".
"My partners have got it".
"The writing's on the wall".

Before coming to the course the doctors had been advised to start reading the medical press, if they did not already do so, and not to neglect the medical newspapers, such as *Doctor, General Practitioner,* or *Pulse,* in which appear a lot of general information relevant to the work of a general practitioner.

One of the course tutors devised a short quiz to test the up-to-date and topical knowledge of the doctors. All the answers could have been gleaned by reading the papers even briefly over the past two weeks. Apart from one or two exceptions, the scores were universally low, and this was the first indication that the participants had not really taken seriously the advice which had already been given.

The Course

Group Work

Course members had also been asked each to prepare a four-part Modified Essay Question, together with their suggested answers. Four groups were formed in which the participants were invited to discuss one of these MEQs per group and to come up with their ideal answer for each question. This was their first introduction to group work and it was gratifying that they rapidly began to enjoy the exercise and to grasp the concept that between them they did in fact know a great deal. They were able to see that the deficiencies which one of them might have could be plugged by the knowledge of the others.

An MEQ prepared by one of the course tutors was set to the whole group. They were given similar time to that which they would have in the exam to answer the questions. Again, they then divided into groups to try and polish up their answers so that they could compare these answers with those prepared by the other groups. The four groups reconvened in the main group and again worked together to produce a final answer. It was emphasised to them that this was the way in which the examiners prepared a marking schedule for the answers to MEQs Some of them began to see how difficult it was in fact to produce examination questions.

Preparation and Following Instructions

A visiting tutor came to talk to the group. He was an experienced practitioner who in mid-career had decided to sit for the exam. He had failed the exam twice but had subsequently modified his strategy and had taken the exam and passed. This was a very stimulating and very encouraging lesson for the group. Many of them subsequently said that it was at this point that they began to feel less pessimistic. The doctor was able to give a lot of sensible advice about how to begin to prepare for the examination. What came out of his talk—and the tutors constantly reaffirmed this throughout the week—was that the examination did need to be prepared for carefully and almost certainly would involve a lot of hard, detailed work. Some of the course members began to see that the anger they had expressed against the examiners might in fact be misplaced, and that part of the problem was that they, the examinees, had not fully understood either the questions or the full implications of the questions.

Can you follow instructions? A simple three-minute test comprising 20 questions was set to the examinees. The test was designed to see if they could read and follow simple instructions. The majority of them failed miserably. This was a very good lesson and a very powerful exercise and far more important than merely having the tutors repeating several times a day the old advice about reading the question.

The Multiple Choice Question

This, being the most factual part of the exam, is the one which demands least attention, except insofar as it is important to look at the possible strategies for gaining maximum marks from the paper, given that no candidate is likely to know all the answers. It was stressed that it is important to fill in those answers which the candidate thought were unequivocally correct and possibly to go through for a stab at those about which the candidate had a reasonable idea, but that straight guessing was a fruitless occupation.

Statistics and Epidemiology

The philosophy of the course organizers was totally against the didactic lecture, but it was thought appropriate to introduce the candidates to these two subjects by a carefully prepared lecture, since it was relatively difficult to gain information relevant to general practice from an easily obtainable source.

Evening Discussions

The course tutors and course members went out together for an evening meal and returned to the College at about 9 p.m. They then reconvened in groups for discussion of general topics, which had been selected through the course members writing out a list of possible topics on the blackboard during the day. The idea of these informal discussions was to suggest to the potential candidates that questions in the exams could be wide-ranging and that general practitioners would be expected to have knowledge and opinions about a broad range of medical topics outside the strictly clinical and outside the consultation. Topics covered in the discussions included: "What do you understand by audit?"; "Doctors and the Bomb"; "Is your pharmacist really necessary?"; "Moral attitudes to the Pill and abortion"; "Computers in general practice"; "The collapse of the NHS".

On a course such as this, a lot of the work in changing attitudes goes on during informal discussions at mealtimes, in the bar, in walking to the restaurant and late at night. At this stage a lot of the course members were beginning to see how they had seriously under-estimated the scope of the examination and began to realize that in order to approach it with a more reasonable chance of success the next time around, they were going to have to change their whole attitude towards their work. This indeed was the message that the course tutors were trying to promote: that is, to take the individual consultation between the doctor and patient as the basis for learning; to try to uncover all aspects of the patient's problem. In arriving at a management decision, doctors should be reasonably confident that they know what they are doing, why they are doing it and if it is relevant. If a drug is prescribed, the doctor should know as much as possible about it. If he or she does not know much about it, then that is the moment when it might be sensible to look it up and learn more about it.

The Traditional Essay Question

The candidates were shown the essay papers from the last ten years, asked which question they would least like to answer, and then asked to answer it. All the course members were also asked to answer the same question within 15 minutes instead of the usual 30 minutes allowed in the exam. They then got together in groups, as they had previously done, to polish up their answer.

The final result produced by all the groups working together was, as far as the course tutors could tell, as near perfect as one could wish.

Strengths and Weaknesses

The course members had brought with them a list of what they considered to be their strong and weak points when going in for the exam. These were analysed in some detail and collectively presented to the participants. The two areas which came top of the list of strengths were paediatrics and obstetrics/gynaecology. This tended to reflect the fact that many of the doctors had done house jobs in these areas. A problem which the course members had not recognized is that feeling confident in, say, paediatrics as a hospital specialty will not necessarily carry over into paediatrics in general practice, where so many other factors have to be taken into account. It can therefore be a pitfall to rely on a feeling that one is strong in a certain way.

Knowledge, Skills and Attitudes

The course tutors had stressed at the beginning of the course the importance of looking at each area of general practice under the three headings of knowledge, skills and attitudes. In order to bring this home to the participants they were asked to divide into three groups, take a broad subject—contraception was chosen—and to make a list of the knowledge needed as a general practitioner, the skills needed as a general practitioner, and the attitudes involved in practising as a general practitioner when discussing contraception. This was a powerful exercise as, for instance, the members of the group were able to see that the knowledge needed to prescribe the Pill for morning-after contraception was quite different from the attitude which governed whether or not the doctor would indeed prescribe the Pill for this purpose.

Problem Solving

Another visiting tutor conducted an exercise with the group in which he presented them with hypothetical problems and asked for their solution. Different groups, not unnaturally, came up with different solutions to the same problem. The tutor then showed that by looking at the problem in a structured way most of the groups would have in fact have come up with the same solution; in this particular case the message was not to change the patient's medication without first checking compliance.

Videotaped Mock Vivas

Throughout the five days the two course tutors and one visiting tutor conducted personal mock vivas lasting 15-20 minutes with each of the course members in turn. After the viva the candidates were asked how they thought the viva had gone. The candidate and the tutor then watched the playback together and had a further discussion about it. All course members were keen to take part in this process and they watched the playback video recordings with intense interest.

Many of them were able to see some of their more obvious faults, ranging from minor personal ones of presentation, such as holding the hand over the face, to the ones which are more difficult to modify, such as having their thoughts come out in a torrential jumble. One candidate allowed his interview to be shown to the whole group and this was particularly instructive in that it showed that it was still possible to retrieve a pass standard from a seemingly irretrievable situation when a question had been asked to which the answer was not immediately obvious. For instance, this candidate finally dredged up from the deep recesses of his memory the fact that in his surgery there was displayed a certificate of insurance for his ancillary staff.

Where do we go from here?

The final session of the week was devoted to looking at the ways in which the potential candidates could prepare themselves for the next examination. This involved reading-lists, both of medical books and books relating to the wider scope of general practice; attending medical meetings; perhaps joining an audit group or a young practitioners' group; selective reading from the journals and the medical press, learning from the individual consultation and from other members of the primary health care team; and doing mock examination questions. The candidates were strongly advised to contact their local College Tutors to see if they could offer any help. For instance Tutors might be able to put a candidate in touch with a like-minded person so that they could work in pairs, which always tends to strengthen learning. Many candidates thought that more mock video-taped vivas would be helpful nearer the time of the exam.

In summary, this was a comprehensive course, and the organisers felt that they could detect a shift in the attitudes of many of the members attending it. This in itself would almost certainly be a justification for running the course. However, it is likely that the success of the course will come to be measured in terms of the examination results of those course members who sit it again. We believe that the College examination is now a rigorous, comprehensive and testing evaluation of a general practitioner's overall performance and we think it is worthy of the College to show some concern for those candidates who have not been successful.

James Scobie and *John Dymond*