the year average attendance was seven doctors.

Before the clinical club was started, the feeling of co-operation in the health centre was marred by professional and administrative problems, partnership and business difficulties. However, when we were all brought together on common clinical ground, relationships and a high degree of mutual respect developed. At last each doctor was able to display his individual talents to his colleagues, who were willing to listen with open minds.

We believe that we have demonstrated adequately through the continuing success of the club that College members can and should splinter off from official College functions to develop the original ideology of the College amongst non-MRCGP colleagues.

REPORT

Joint Committee for Postgraduate Training in General Practice

SOME organizations (WHO, UNICEF) strike lucky in their acronyms. No such memorably euphony has come the way of the Joint Committee on Postgraduate Training for General Practice, but the initials are now nevertheless very well known to most of those in vocational training, and they will be interested in the committee's Annual Report for 1981. One of the best-known names in general practice—Dr Jack Norell—disappears from its list of officers, and he is replaced by Dr Douglas Price, who is in practice in Surrey and who was formerly Regional Adviser for the South West Thames region; he became Medical Executive Officer in February 1982.

In January 1981 the Committee began its task of issuing Certificates of Prescribed or Equivalent Experience; hundreds were processed every month, the total reaching just over 2,500 by the end of the year. Nearly all were for Prescribed Experience, with only 341 decisions being made in respect of Certificates of Equivalent Experience. Of these, 202 (60 per cent) were refused, and the applicants usually advised to take a further short (3–6 months) traineeship as additional experience. The Committee reports that although it was feeling its way at first, it has steadily acquired case-law that is now enabling it to reach decisions promptly and authoritatively.

A major part of the Committee's work is visiting the regions to inspect schemes. An increasing number of these visits are reassessments, and the policy is now for the visiting to be done in a single day by a single person, who tends to concentrate on the features of the scheme that are known to require particular attention. The visitors are tending to focus on the training practices, since they feel that it is no longer possible to assess the schemes as entities if the majority of doctors are choosing to construct their own programme. In the practices, an increasing amount of attention is being paid to medical records, since the quality of these is attracting so much adverse comment from visitors.

The single most important part of the visit, the Committee says, is always held to be the private meeting with trainees, and the visitors make special efforts to hear and read the views of as many trainees as possible.

In 1981 there were 21 visits which resulted in 12 schemes being given unqualified approval and nine being approved with reservations (none was not approved).

Many other important discussions took place with other bodies having an interest in vocational training and in the implementation of the Regulations. In particular, the Committee voiced its concern over the Department of Health's decision to withdraw funding from two experimental vocational training schemes containing 18-month components in general practice.

Copies of the report are available from the Administrative Secretary, JCPTGP, 14 Princes Gate, London, SW7 1PU.

CONFERENCE REPORT

Sixth National Trainee Conference—Churchill College, Cambridge, 19-21 July

BY a clear and substantial majority, the Sixth National Conference of GP Trainees carried the motion of the centrepiece debate, that "Doctors have a duty to oppose the Nuclear Arms Race." It was a conference of alternatives: a discussion on the opening afternoon of "alternatives to the MRCGP" overwhelmingly produced a resolution for a change in the current exam system of gaining membership of the RCGP; and the second day saw a wide-ranging symposium on alternative, or complementary, medicine systems.

Not until the last few minutes of the final morning did a single real spark fly at what has in the past been a gathering of firebrands. The 250 doctors who attended—mostly trainees, some trainers, some delegated, some representative, about half women, half men—seemed uncharacteristically calm and quietly spoken; happy to listen and content to chat over coffee. Contributions from the floor were unspectacular. It was too late when, just before lunch on Wednesday, some began to grumble that there had been too little discussion of trainee affairs, too little heard from national and regional representatives about the year's activities, and too much by way of lecture about herbalism. It was an unfortunate way of thanking the organizers Dr Peter Kaye, Dr Peter Bailey and Claire Downham, who had worked so efficiently throughout the year to produce a conference without hitches. The social programme was perhaps the best ever: King's College Hall and Choral Scholars take a lot of beating.

The conference began with an untabled plea from Dr Amanda Howe (Sheffield trainee) for consideration during the conference of the current industrial action in the NHS.

The main item of the first day was a discussion about membership of the RCGP, three papers being presented.

Dr Nick Bradley (Exeter trainee) pre-

sented the findings of a number of surveys of trainee opinion. He showed that, while about 80 per cent of trainees plan to sit the MRCGP exam, only a quarter actually want to take an exam at the end of professional training. The huge majority take it in order to get a job—it is a convenient currency in the market-place—and less than 2 per cent take it in order specifically to become a member of the College. He questioned whether the exam could fulfil its present multiple roles of the College's membership criterion; a useful qualification for the individual; a minimum national standard-setter; a long-term means of raising standards; an assessment of vocational training; and a sort of spot-check quality control. And what about the 40 per cent who fail?

Dr Trevor Griffiths (Plymouth trainee) then put forward a discussion proposal which would introduce a new bipartite level between Associate and Member: the grades of Registrand and Licentiate. After obtaining the vocational training certificate, an Associate would elect either a) to sign on as a Registrand and submit to five-yearly self-assessments at a fee, with the results fed back but no pass/fail declared; or b) to take an exam to become LRCGP. After a suitable minimum interval Registrands and Licentiates could choose to move on to the higher qualification, Membership, by further examination, thesis, published work, a practice visit or some other proposed method.

Dr John Hasler, Honorary Secretary of Council, then spoke on the College's behalf. He too was concerned that the MRCGP exam was becoming a meal ticket and reaffirmed that the College recommends that MRCGP must not become a statutory requisite for admission to a medical list. He felt that the present old-boy network system of conferring FRCGP was unsatisfactory. He outlined how the College sees its function: to provide an end-point to vocational training, if that is what it demanded; to provide a way for established principals to see how they are getting on; to contribute to continuing general practice education; to provide some externally assessed standard of general practice—the public are beginning to look for measures of quality; to provide a qualification; to provide a body to stimulate and fund research; and to provide a mechanism of acknowledging achievement in FRCGP.

He did not accept Dr Griffiths' proposal as a viable or registerable alternative, but felt that the alternative of a practice visit is well suited to established principals. He defended the exam as it stands: of all the Royal Colleges it is the only one whose exam receives such scrutiny and evaluative assessment, such as videotaping examiners at work. It is as inclusive as possible, but the College does have serious doubts about the competence of some of those who fail, he said. To this end, a course for some of those who had failed has recently been completed.

Discussion from the floor, and some *ad hoc* voting at the end, showed that nobody had any further concrete alternative proposals. But Dr Griffiths' Registrand and Licentiate grades were rejected (⅓ in favour, ½ against); while the status quo—the current pass/fail exam—for gaining membership was also summarily dismissed. The gathering then broke into small groups to chew over: women in medicine, Western diseases, doctors' roles in preventing nuclear war, alternatives to the MRCGP, prevention, whither from here?, NHS industrial dispute, trainers.

Tuesday heard Mr Brian Inglis present a fascinating journey through the history of medical thought: the dichotomy between vitalism and mechanism, through mesmerism, homoeopathy and nature cures, to the debate of the 1930s over the existence of functional illness. Biofeedback, acupuncture and moxybustion, healing and radiaesthesia are all of proven value. Allopaths and the rest of us, watch out.

Dr Malcolm Stuart delivered a mechanistic review of some herbal remedies, making it clear that we are all herbalists anyway since, in the USA, 40 per cent of all prescriptions contain at least one plant-based drug. Dr R. A. F. Jack and Dr Donald Davey gave, respectively, a practical and a research based résumé of how homoeopathy is of relevance to general practice, and distributed free bottles of arnica tablets. Mr Colin Dove then gave an entertaining introduction to osteopathy.

The motion for the debate was "Doctors have a duty to oppose the Nuclear Arms Race". Dr Tim Sheard (Cambridge trainee) was in the chair. The motion was proposed by Dr John Horder (PRCGP) and seconded by Dr Mo Reynolds (Bristol trainee). It was opposed by Dr Alastair Donald (Chairman of Council RCGP), who was seconded by Dr Stan Shepherd (Bristol trainee). The proposers argued that the arms race is spoiling our lives through fear, is wasting precious resources, and is an obvious kind of global madness which must be stopped. It is a supremely medical issue, and doctors should inform themselves and others about the medical effects; it resembles medicine in the way that it crosses national and cultural frontiers. Deterrence has been discredited by an overkill number of weapons. It is not too controversial an issue—compare seat belts, boxing and smoking sponsorship. There is no effective medical response after the holocaust: 150 million dead in a European theatre.

The opposers agreed that nuclear war and explosions are to be deplored; that peace is the ultimate aim; that individuals should be free to campaign; and that our duty as doctors is to be informed and to criticize government publications on their realism and accuracy. Why does the Soviet Union castigate its own antinuclear campaigners but approve of Western CND?, they asked. The motion demanded that doctors act as a group on a question of personal conviction and this was unethical. Religion, politics, sex and morality should all be kept out of the doctor–patient relationship.

Debate from the floor centred around whether it was professional to engage in such activities, and on the precise meaning of the words of the motion. The motion was carried overwhelmingly.

Wednesday was a salad of non-participatory presentations. Dr John Ball (Chairman GMSC) discussed the role of the BMA and the seven ages of medicine from lay citizen to widow, each under the BMA's wing. Dr Thorpe (Southampton consultant physician) gave a lecture on how GPs should best conduct terminal care in the home. Dr Fishlock (Cambridge GP) gave a personal travelogue of his years in Canadian medicine. Dr Allibone (Norfolk GP) presented figures on doctors' ill health and their increased mortality for many conditions. He outlined the new GMC information arrangements for dealing with alcoholism in particular.

Next year's conference will be in Liverpool on 6, 7 & 8 July 1983. It will tackle inner city medicine, the trainee year and medical employment. Dr Philip Monk (Liverpool trainee) is co-ordinating.

At Cambridge, we should have talked more of trainee matters. But trainees attending should have been more active in suggesting topics; lessons from previous years should have been heeded; and regional advisers might have steered the programme towards greater participation and regional cross-fertilization. Such conferences are to improve training: rare opportunities. Symposia, on the other hand, are common and need not be national. National representatives must be given a slot to report; and regional trainee organizations should at least bring a written report with them for circulation at the next conference.

N.C.A.B