Many other voluntary organizations work with women of childbearing age and can incorporate a significant health dimension—given the necessary encouragement and help, not least from their local primary health care teams.

Specialized advice and support.
Voluntary organizations provide much specialized advice on subjects like breastfeeding and maternity rights. Equally significant is their support to 'special needs' groups such as single women, ethnic minorities, prospective mothers of twins or those facing complications in their pregnancies. Such support is often based on mutual aid and the use of lay peers and, like a great deal of voluntary action, endures far beyond birth itself.

To talk about voluntary projects in such general terms always does them a disservice—they sound abstract, and fall prey to the reader's prejudices about the character and value of voluntary action. The detailed facts of what is actually being done speak loudest, and our report is punctuated with case studies, information sheets and practical information. Busy professionals can use it to see how particular needs can be tackled without necessarily reading more than the summaries of the accompanying arguments.

Need for Professional Backing

And this *is* very much a matter for health professionals themselves. Of course there is much more that various voluntary organizations and community health councils can do. But virtually all the pioneering initiatives under consideration rely to a greater or lesser extent on professional backing. They need reliable, statutory funding. They need access to NHS facilities. They need support and expertise from NHS staff.

This presents a major challenge to those working in the NHS who are accustomed to dealing exclusively with individual patients. Even if they are aware that voluntary action and volunteers do not grow on trees, they can assume that their development must be somebody else's business. Our argument is that meeting the health needs of future parents in the round should involve the health services at all levels in an active commitment to partnership with groups of lay people—in enabling voluntary action as well as treating individual patients.

Nor is this a utopian idea. Practical initiatives under way testify to the practicability and promise of partnership with the voluntary sector. Individual general practitioners are to the fore in beginning to develop voluntary action in the seven growth areas identified above. We hope this report will be a helpful starting-point and guide for many others.

CONTROVERSY

Why time the MRCGP examination at the end of vocational training?

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Surveys of attitudes to the MRCGP examination amongst trainees have all shown similar reasons for sitting it (Griffiths, 1981; Taylor, 1982; Bond, 1982). The most common reasons are to help get a job, and a fear that the examination may become more important in ways that are not foreseeable at present, but of which becoming a trainer is an obvious example. Self-assessment, pride and a stimulus to study are also common reasons, but very few (3 per cent in Devon and Cornwall) stated the reason that they wanted to become members of the College.

THESE feelings were again expressed at the Sixth National Trainees' Conference in 1982, at which there was overwhelming support for an alternative to the examination—possibly along the lines of "What Sort of Doctor?". There seems to be general discontent amongst trainees with the present arrangements.

The Peterborough scheme, amongst others, proposes that admission to the examination be postponed until about two years after completing vocational training. However, Dr John Hasler, speaking at the Sixth National Trainees' Conference on behalf of the College, stated that the College saw a need to provide an endpoint assessment to vocational training "for those who want it"—only 21 per cent in Devon and Cornwall—or as stated in the Conference Report, "if that is what is demanded" (Bradley, 1982). I have a nagging feeling of unrest about this difference of attitude.

A good doctor?

What makes a good doctor is that indefinable element called spirituality to which Prince Charles alluded in his Presidential message to the *British Medical Journal* on the BMA's 150th anniversary. Since it cannot be dissected nor boiled in a test tube, we have no teaching on spirituality. My own understanding of it has grown because I am a Christian doctor and because my belief that Man is body, soul and spirit with a conscious mind, not just body and mind, affects my medical practice. Our entire medical training and hospital service is body orientated, with only a passing reference to pathology of the mind. The whole concept of mind that we thus develop is inadequate for the practice of medicine outside hospitals, where problems of the soul or spirit may be of prime importance.

The trainee year in general practice provides inestimable potential for making a transition from body and biochemistry orientated medicine to whole person medicine under the supervision of an experienced practitioner. This transition requires personal growth, not only emotionally but spiritually, to produce a shift from understanding diseases to understanding people. Such growth proceeds by diversification and experimentation hand in hand with the application of knowledge: and the product is known as sound clinical judgement.

Wasted opportunities

While recognizing that the Modified Essay Question is designed to test clinical judgement, I believe that the timing of the examination has a counterproductive effect and wastes that potential of the trainee year. The prospect of an examination inevitably encourages doctors to perpetuate their previous habits of narrowing their minds onto a syllabus, real or imagined, instead of encouraging them, perhaps for the first time in their medical lives, to move their eyes off hard facts and onto the more intangible nature of people as well as their own personal growth.

Why waste the opportunities offered by the trainee year? Any doctor who passes the MB examination can, if he applies himself, learn up a few facts, whether it is at the end of the trainee year or after two years as a principal. It may be more difficult later, but is that a reason for not doing it then? The contribution to sound clinical judgement from knowledge requires continuous updating of facts, not a once-and-for-all swot. The personal development in that trainee year could reasonably be hoped to include a desire and technique for keeping up-to-date, rather than time spent preparing for an examination.

The argument that the examination is a powerful tool to control the content of vocational training does not require that it be held at the end of vocational training. On the contrary, if it were held two years later everyone could judge whether or not the training received had been appropriate.

How unfortunate for so young a College that it is engendering in trainees precisely the opposite attitudes to those which it hopes to encourage, foster and maintain. Most trainees see it as an expensive examining body and many see it as trying to press young doctors into a mould.

Are these the reasons?

When I try to rationalize my unrest I arrive at these reasons: The examination remains timed at the end of vocational training because this is intellectually tidy, and because leaving loose ends to such unassessable subjects as personal growth and diversity of approach induces stress symptoms in those who feel a responsibility for the medical profession's standards. Also, and more seriously, there is a fear that if the examination is moved, then fewer doctors will sit it and the College will consequently lose money.

Since I do not like the implications of my own reasoning, I would be grateful if somebody responsible could refute these points and explain the real purpose of the timing of the MRCGP examination.

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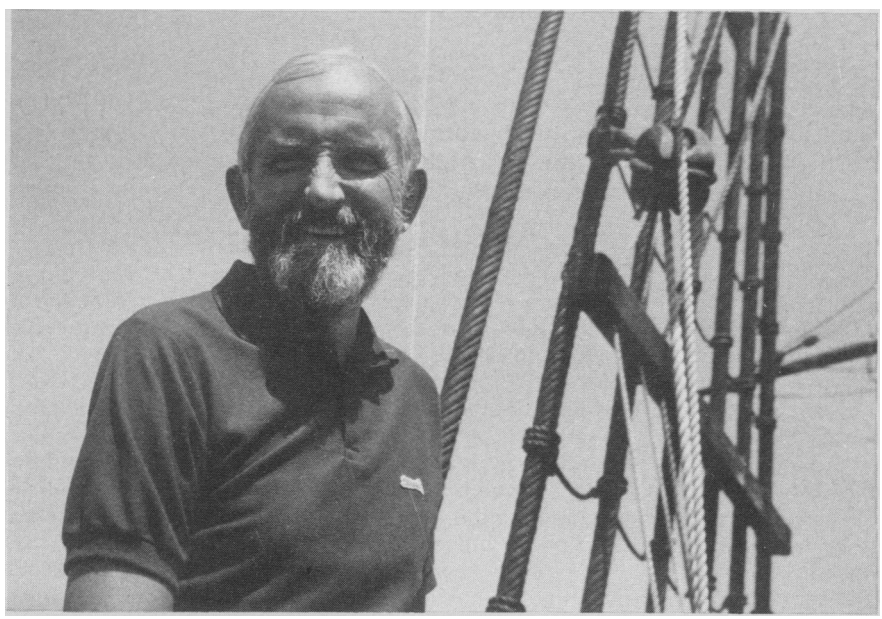
LETTERS

How Should We Remember John Stevens?



Sir,

Over a year has now passed since John Stevens sailed from Panama into the Pacific to continue his single-handed world voyage. He had already crossed the Atlantic; a truly remarkable feat for a man seriously handicapped by a severe stroke. Since he left Panama there has been no news of him, and the likelihood must now be that he has been lost at sea. That is a great sadness to his family, and to his many, many friends. But if it has to be a time to accept his loss, it is also a time to honour his memory, his qualities and achievements. We remember him for his extraordinary energy and enthusiasm, his loyalty to his friends, his articulate anger and his leaping wit; and surely also for us his friends, his moments of outrageous and gut-convulsing clowning. All these gifts he shared with us and gave to the causes he served so well. He had a truly original mind, and his contributions to general practice and to the work of the College were richly creative.

It was a personal loss for many when his stroke, now over four years ago, robbed us of his unique brand of leadership. How to remember him well must now be our concern. It seems appropriate that his many friends and admirers in the College should have an opportunity to share their thoughts on this subject at this stage. This could be done publicly by replies to this letter sent to the *Journal,* or by personal letters to me. Out of such correspondence will come, I am sure, ideas that will help the College to decide how best to salute his memory.

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