Sir,

In his William Pickles Lecture Dr Norell informs us that by 'doctor' he is naturally referring to proper doctors; that is to say, general practitioners. I was puzzled.

Is he implying that general practitioners have a monopoly on propriety? I was not aware that our hospital colleagues were more indecent or venal than us — on the contrary it seems that impropriety is spread throughout the breadth of the profession. Surely general practitioners are not more strict or appropriate, thorough or befitting than other doctors.

For years general practitioners have had to suffer the real or imagined disdain of some ill-informed hospital consultants. The Royal College has done much to reveal the futility of these attitudes. Surely Dr Norell is not taking a sideways swipe at his colleagues?

No; it must be the word 'doctor' that I am misinterpreting. The dictionary provided the answer as 'a ship's cook'. Being ignorant of culinary matters and with memories of cross-Channel trips causing increasing nausea I decided I could miss out on the William Pickles Lecture of this year.

RUPERT GUDE

Abbey Surgery
Russell Street
Tavistock
Devon PL19 8BG

Sir,

I did enjoy the William Pickles Lecture. Dr Norell has expressed his thoughts on education for general practice with considerable elegance and wit, and I am in agreement with him on many points. How much nicer would the field of general practice look without some of its worn out sacred cows. I cannot help regretting that a government Statute ensures that the present Vocational Training cow has to be kept indefinitely, but hopefully some of the others, the exam cow, the associateship cow perhaps, could be taken to the knackers yard, leaving room in the field which could be used more effectively.

I was at first rather taken aback when the worth of the sacred cow Caritas was called into question, but on further thought I realized what every doctor knows, that patients come to us for advice because we know more about the human mind and body than they do. Kindness they can be given by their auntie, the milkman, or even by an ignorant charlatan, and kindness can sometimes encourage self pity and reinforce harmful attitudes. Thoughtfulness sounds a more promising beast.

As well as being stimulated to think I was also very cheered to find that there is a doctor in the upper reaches of the College who thinks as he does, and who wants others to think for themselves and not just to follow the latest fashionable trends.

Thank you Dr Norell for telling us what every doctor knows.

ANNE BRYAN
Associate

31 Colcot Road
Barry
South Glamorgan CF6 8BP

Sir,

I have a bone to pick with the College.

Jack Norell rightly stated in the 1984 William Pickles Lecture many of its Fellows had not taken the membership examination. Indeed the *History of the RCGP* states the hospitality of some of the original founding fathers was such that they could hardly be refused. No doubt those who were entertained at the Rockerfeller villa in Italy *were* all suitably entertained.

In answer to the question 'What can you give?' posed on page 34 of the *History,* I would say simply this:

> To my patients; nine years of devoted service while myself suffering from what I am told is an incurable genetic disease. I won the admiration and respect of the whole community despite my handicap.
>
> To my partner; a year of service working for him while he was himself ill and giving him half my earnings so that he could support his wife and family.
>
> To my education; a year in the UK to prepare for the examination of the College as a trainee, having been nine years in practice.
>
> To the College; three sets of fees for the examination.

I do not mind failing because of lack of knowledge but I find it difficult to accept that my attitude is not up to the required standard when I have stood in for my partner night after night, and never missed a call for a whole year, unable to afford a locum.

There was something rotten in the House of Denmark. Is all well in the Royal College?

P. M. QUINN

The Woman's Health Centre
65B North Main Street
Cork, Eire.

PS. Publish, if you dare.

Membership

Sir,

The Royal Commission on Medical Education is absolutely right to consider the ongoing education of the established general practitioner: the Scottish Council planned experiment is well worth watching, but is only likely to help the keen general practitioners.

Reading journals (which ones? You would not learn much if you only read the RCGP *Journal!*) for 140 hours per year or attending selected Section 63 courses will not necessarily 'plug the gaps' for those that do so: but what about those who do not? At present a new principal, complete with MRCGP, can sit back and do nothing until he reaches age 70 years. Did not my generation all swear we would keep ourselves up-to-date with our MB ChBs? Who knows where the medical gaps actually are in our knowledge unless we are probed? The fact is there is no incentive to do anything.

Training committees are probably moving in the right direction in requiring trainers to have membership of the RCGP and also expecting *all* members of the practice to teach and have a well-run practice. This I believe is right as no trainer, no matter how good, can 'go it alone': the trainee could well pick up bad habits if this were not so.

But even if all the members of a teaching practice were to be MRCGPs this in itself would be insufficient — for reasons stated. However, suppose the MRCGP was *only for 15 years* (to be retaken at ages 45 and 60 years) and that membership was linked to seniority awards? Many general practitioners already do resit the exam regularly.

Speaking as only an Associate of the College I would be the first to agree that the exam is far from perfect(!) However, what would the effects of *some* suitable exam be? Surely the answer is that we would *have* to ensure we kept up on all-round competence, not just attending courses on our favourite subjects or reading interesting articles; and if we did not we would lose the right to display the magic letters, lose out financially and perhaps feel less inclined to 'hang on' when we reach our sixties (or alternatively demonstrate to the brash youngsters they are not the only ones who know anything about medicine!).

A. E. FINNIGAN

Summertown Health Centre
160 Banbury Road
Oxford OX2 7BS

Sir,

I have just had a note about a course for established general practitioners who wish to join our College. 'This may be particularly difficult for the established GP' it says!

If we are making it particularly difficult for an established GP to join our College then there is something the matter with our College.

P. N. JARVIS

'Whaddon House'
221 Whaddon Way
Bletchley
Milton Keynes MK3 7EA

Social class and health status

Sir,

The recent report *Social class and health status*[1] and the editorial regarding it (May *Journal,* p.241) appear to have more in common with polemics than objective appraisals of the subject. The report starts by drawing a somewhat dubious distinction between difference and inequality stating that inequality is a 'weasel word' and best replaced in this context by the word 'different'. Does the author really believe that inequality is an inappropriate concept when describing variations in such events as perinatal death? Surely the anodyne term 'difference' is only more appropriate if there is no agreement that one situation is preferable to another. The study concludes by stating dogmatically that there is clear evidence that general practitioners compensate for any inadequate use or misuse of health services by social class 5, and that equal opportunities for health are already largely realized.

On what evidence are these reassuring statements made? The data presented show that patients of lower social class consult more frequently, particularly for chronic conditions. No justification is given for the assumption that consultations involving these chronic conditions are doctor- rather than patient-initiated. It is also shown that variation between doctors is one of the most important factors in consultation and referral rates. Neither of these pieces of evidence is new, and neither justify the conclusion drawn. No attempt is made to utilize a use : need ratio as previously developed.[2] This is calculated by dividing use (number of consultations) by a measure of need (days off work). A study that considered general practitioner usage using this ratio showed that the advantages for lower social class suggested by consideration of consultation rates alone were eliminated or reversed when such ratios were compared.[3]

It is surely equally naive to assume that by simply counting consultations one can make any statements about the quality of care offered to each group. No mention is made of studies which have shown that consultations with patients from lower social classes are shorter, and that within this time the consultation is used less effectively with a higher administrative (for example, sickness certification) and lower clinical content.[4,5] It has also been shown that middle-class patients are more likely to have general practitioners with a high level of characteristics (for example, no use of deputizing, well-baby clinic, list size below 3,000) generally approved by the College.[6] The Black Report[7] suggests that middle-class patients appear to receive a better service when they present themselves than do their working-class counterparts. No evidence is cited in Dr Crombie's report to refute this suggestion.

The report becomes even more polemical when discussing prevention and social class. In denying any responsibility for low use of preventive services by social class 5, the explanation given is that 'under-usage by patients and