a banner of 'cum scientia caritas'. These letters surely represent examples of 'sine scientia' and one is forced to ask to whom the 'caritas'?

S. SCHRIRE

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Lothian Hypertension Group Guidelines

Sir,

We are grateful to Dr Lowe (Letter, August *Journal,* p.497) for his interest in the Lothian Hypertension Group's Guidelines and for his question about the recommendation that serum urate levels should be measured in the initial assessment of hypertension. The Group would not claim that this is an essential estimation and would accept the point that hyperuricaemia is simply a biochemical abnormality.

However, the fact that such an abnormality could be exacerbated by the use of thiazide diuretics, which might precipitate clinical gout, can be a factor in determining the most appropriate management, and this seems to us to be sufficient justification for measuring urate levels before embarking on treatment.

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The 1984 William Pickles Lecture

Sir,

I would like to congratulate Dr Norell on his excellent 1984 William Pickles Lecture which I have read (August *Journal,* p.417), but was not privileged to hear. I am sure much was gained by those who attended — contentious issues and the slaughtering of sacred cows are best appreciated face-to-face.

However, the substance of his talk comes across very well on paper. Much as one appreciates the efforts of those who constantly strive to raise standards, general practice is an area where art will always rival science and where a theoretical examination will never be a proper test of competence to practice. Nevertheless I would not decry the examination out of hand as it can be rightly placed as complementary to vocational training.

The point of this short letter has put the Armed Forces viewpoint across as Dr Norell does draw attention to their training scheme and to general practice as it is carried out in the Forces.

Firstly, our spectrum of patients does indeed vary from that found in most civilian practices, even though in the latter there is also a variation depending on geography and interests. The forces' doctors see very few elderly patients, but they do look after a large number of younger ones, particularly young wives and children. Social problems arising out of this particular environment are a big problem, and the responsibility sometimes given to young doctors looking after young families separated from their relatives and home comforts is considerable. It is worth emphasizing that the Navy, Army or RAF each encapsulate a community with all the value that contains. Indeed some general practitioners become Regimental Medical Officers and have responsibility for the whole family within a forces environment, including the need to accompany the menfolk on military exercises, and maintaining their fitness as well as treating their disease. This is admirable practice.

What I am stressing, and I am sure Dr Norell understands, is that general practice in the forces *is* different in detail; and suffers not a bit in being so; also it is every bit as satisfying to individual medical officers as it is to civilian doctors in their practices.

I would agree we do pay strong attention to vocational training, which is I think of an almost uniformly high standard, and I suggest the good MRCGP results are not just a result of classroom teaching and a good examination technique following the attendance of a course, but reflections of wide, conscientious training and the accelerated maturity that goes with a doctor who serves in a varied and responsible forces environment.

Another point is that we encourage our doctors to do night calls. We do not use deputizing services, a source of some discontent in civilian life.

However, we are aware of our deficiencies and the fact that a military life does not always enable us to produce a moulded civilian general practitioner, but, as was pointed out in Dr Norell's excellent lecture, general practice covers a wide area. How can any doctor live up to the definition of a perfect general practitioner, and under what criteria can he be judged?

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Sir,

Reading Dr Norell's lecture (August *Journal,* p.417) was a pleasure. The lack of 'damned statistics' and the presence of elegant humour was refreshing in our often 'dry' *Journal.* This is not to say that his opinions are necessarily more valid than the nicely constructed reply of Dr Belton and Dr Lee.

Dr Norell struck the right chord in many of us who are beginning to wonder how far we need to stray from 'what every doctor knows' in pursuit of the indefinable. In con-

trast Drs Belton and Lee appeared to sabotage their own case with Exocet efficiency when commenting on the College examination,'...if nothing else, the examination confers some respectability on the College in the eyes of sister disciplines'. As one who was fortunate to sit the exam only once in spite of being doubly disadvantaged (statistically speaking!) namely a middle aged Service doctor, I feel sorry that this is the best case than can be put up in defence of MRCGP. Like many, I do not know whether the exam is a good means of College membership or whether some alternative will prove better, but need we be so insecure about our status?

I suggest that the fundamental purpose of postgraduate general practice education is to try and make the consultations between doctors and patients more effective.

This involves research, computer technology, audit and all the paraphernalia of modern practice. Where they help they are to be applauded. They will not turn a bad doctor into a good one nor a careless one into a caring one. Pare's much quoted triad should still remind us of how our skills, knowledge and attitudes are going to be tested and our time divided up.

May we strive to blend the best of the old and of the new. We appear to be getting a bit lost at present as to how to achieve this. Should we be perhaps asking our patients' views rather more and our colleagues views rather less?

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Future of the College and its examinations

Sir,

I have read with interest and mounting disquiet the recent internal and analyses of the College's future and relevance of its' examinations (October *Journal* p.529). Increasingly, Members are voicing uncertainty and self-doubt, and while this is not altogether a bad thing in any organization, the self-doubt is approaching the point of causing self-destruction. Let us stop squabbling over the details and look forward and plan to 50 years ahead when, if the College is allowed to live, it will have taken its place along with the College of Surgeons and the College of Physicians, membership being the natural goal for principals in general practice. We have only to live through the birth pangs and difficult childhood.

What has alienated many within and without the College has been the total and uncritical adoption of current educational theories with their one-way mirrors, video machines and Freudian analyses. Those more experienced centres of education are more cautious adding only those advances proven by time and experience. Where is the jargonese or one-way mirrors in the MRCP teaching and examination? No less a clinical subject. What is needed is more simple tried and tested clinical teaching and examples supported by the newer techniques where applicable.

No examination system is perfect and essentially examinations must assess one's ability to take them, apart from anything else. This applies to any examination in any subject. Let us by all means look at the examination and try to make it more relevant, but let us stop arguing about basic examination theory.

History has shown that preparation for examinations in the long term results in the raising of standards in professional bodies. Do not let our doubts which apply equally to any professional body fudge the future of the College and destroy the achievements already attained.

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Sir,

I read with interest Dr Marinker's editorial 'The MRCGP revisited' (October *Journal* p.529) in which he proposes that the criterion for membership be the compliance with the development of performance review in the first five years of practice.

One of the methods of assessing such development is by peer review within the practice as laid down in the College document 'What sort of doctor?' I cannot see any other way unless one reverts to the examination situation with all its drawbacks. Those of us who are newly in practice after completing vocational training, and especially after taking the present MRCGP examination, are familiar with the concept of peer-group review. However most of us join practices outside the teaching environment with long-established partners to whom the concept of peer review is likely to be totally alien and unpalatable. The atmosphere in practices with new partners is already charged with uncertainty and the prospect of having to face change is daunting enough without the further burden of early peer-group review from outside.

I feel that the opportunities of young principals for membership of the College would be hampered by their partners' natural resistance to any form of peer-group review occurring within their practices. If Dr Marinker's plans were adopted, many young principals would find the early attainment of membership a non-viable proposition. They would thus be isolated from the College at the time they need its fullest support — at the beginning of their careers.

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