examination exposed by Drs Norrell and Marinker.

Our Faculty MRCGP courses for established general practitioners are oversubscribed several times every year and it is the challenge of the examination as much as the wish to join the College which motivates the doctors attending. This is hardly surprising as we, the (successful) end products of an exam-orientated school and university system see another examination as a means of assessing our ability. It is not just the individual using the examination as a challenge. A fair examination helps course organizers assess their vocational training courses. It is the preparation for the examination which should improve the candidate but, as Marshall Marinker says, only if the examination is valid. I think it is valid and will be shown to be so. The examiners that I know are not interested in the candidate spouting the 'required dogma'. Using Marinker's example, the good candidate will know the advantages and disadvantages of asking a patient to return and will make a decision in a particular case when he has evaluated the problems.

All this does not negate the argument about the exclusivity of membership at present. In particular, as the only way to membership is by an examination designed to test knowledge, skills and attitudes at the end of vocational training, it has been shown to disadvantage established general practitioners. I would support him in the use of participation in performance review as an alternative method of entry and I certainly agree this should be a way for the attainment of fellowship. However, whether this should be without standards is surely something the membership as a whole should consider. Perhaps Members want defined standards to aim for. If performance review is to be used as a method of assessment there has, again to be fairness and reliability. Indeed we have to start from scratch in the new field which is going to prove more costly in time and resources than the traditional examination.

Perhaps the assessment of standards should be separated from membership – except isn't that what we now call associateship?

MARTIN RHODES

The Medical Centre
45 Enderley Road
Harrow Weald
Middx. HA3 5EF

Sir,

Recent correspondence about the 1984 William Pickles lecture makes me wonder if the 'Caritas' has gone from our motto. It seems to me that Jack Norell has highlighted some important areas connected with vocational training and even his critics agree that vocational training was commenced without any form of objective assessment. Such an exercise seems both costly and irresponsible, and without it who is to say if simple experience is not an equally valuable introduction to general practice? I cannot agree with Doctors Belton and Lee (Letters, October *Journal,* p. 551) that Pat Byrne demolished the credibility of the apprenticeship system and I can assure them as a Lancashire man that there was never any possibility of just 'picking up all Nellie's bad habits'. How on earth do you think they managed to stay in employment as cotton spinners in a hard world. The fact is that industry does have an objective way of assessment in terms of profits and wages, and perhaps in an indirect way we have the same in general practice if you consider such criteria as patients wishing to change their doctor or complaints to family practitioner committees (FPCs). Such simple aspects may not be enough for those who feel that 'by definition, education should stimulate behavioural changes so as to compel such changes in our practice of medicine.[1] Who is to decide on the change to be desired? The dictionary defines 'educate' as 'to instruct and train so as to develop the mental, moral and physical powers'. Which seems to me to be in conformity with Newman, who wrote: 'Education is a high word . . . it is the preparation for knowledge and it is the imparting of knowledge in proportion to that preparation.[1]

Surely the close attachment of trainer and assistant in the context of everyday work is an ideal climate for that preparation, but ultimately the final requirement is the desire to learn. As Newman also says, 'the most unpropitious circumstances cannot conquer an ardent desire for the acquisition of knowledge.' How otherwise would Madame Curie have discovered the secrets of radioactivity in her ramshackle laboratory or the university life of Leningrad continued during the siege of 1942 or even how would Acker Bilk have discovered the enchantments of the clarinet when incarcerated in a military prison!

Vocational training as it has been developed is a 'sacred cow' and I for one am grateful to Jack Norell for having the courage to point it out. All of us need to think carefully about what is assessable and what it is desirable to assess in the interests of our patients. Once that is done the criteria for College membership will be obvious but I suspect an examination will play a comparatively small part.

ANTHONY D. CLIFT

Broomfield
151 Manchester Old Road
Middleton
Manchester M24 4DZ

Reference

1. Newman J. *The idea of a university.* London: Longman Green and Co, 1898.

Sir,

Now we have it — 'the MRCGP examination, if nothing else, confers some respectability on the College in the eyes of sister disciplines.' (Letters, October *Journal,* p.551) But what are the side effects of this dubious respectability? Less than one in four of doctors in their forties who try to get in, actually succeed. On the other hand, more than three in four of recent trainees pass the examination but numerous surveys have shown that many of these are not in the least interested in College membership.

Those of us who joined the College because we thought it was a body dedicated to improving the standards of general practice as a whole, must be profoundly disturbed at the tone of Drs Belton and Lee's letter. The arrogance of their last sentence sadly confirms the feeling of many 'anti-Members' (and, I fear, many Members too) that those who control entry to the College are out of touch, élitist and so obsessed with the statistics of the examination that they are incapable of even considering its divisive effect.

Every doctor knows the crucial role the College has played in the recent renaissance of general practice. Are the next years to be merely seeking the 'respectability' desired of those who have become blinkered by authority? With ideas such as those of Marshall Marinker (October *Journal,* p.529) to guide us, we can, and must, do better.

P.A. SACKIN

The Surgery
School Lane
Alconbury
Huntingdon
Cambs. PE17 5EQ

Sir,

I am surprised that Drs Belton and Lee, in their spirited defence of the MRCGP examination (Letters, October *Journal,* p.551) should quote statistics based on percentages to support their

arguments, and then attempt to draw conclusions from them.

Surely they must realize that when considering pass rates in relation to age, such an exercise is futile without reference to the total numbers of the sample under consideration.

One can only assume, when they ask the question, 'But how can you explain the improvement in performance over the age of 50 years?', that they are being either naive or patronizing. Either way, it does them and the College little credit, and only serves to strengthen Dr Norrell's case.

N.W.S. HESTER

The Surgery
Shaw Lane
Albrighton
Nr. Wolverhampton WV7 3DT

Sir,

The lengthy letter by Drs Belton and Lee (October *Journal,* p.551) seems to raise more questions than it answers, especially with regard to the MRCGP examination. I was particularly concerned to note that the examination 'discriminates effectively against the armed service trainees' and that their success was gained on the basis of classroom instruction rather than experience.

The statistics presented in their letter certainly demonstrated that the pass rate for service candidates is lower than the pass rate for trainees, but more disturbingly also demonstrates a sudden drop in the pass rate of some 15 per cent between 1979/80 (65.7 per cent) and 1980/81 (50 per cent). During the same period the pass rate for trainees rose from 70.3 per cent to 76.9 per cent. One can only assume that this remarkable deterioration is due either to a sudden and inexplicable change in the quality and training of the candidates or that the examining body is now actively discriminating against candidates from the armed forces. If active discrimination is being employed the credibility of the examination as a fair test for all must be impaired.

Drs Belton and Lee also suggest that their statistics demonstrate the lack of experience of armed services candidates. I would contend that the reverse is true. In my experience armed services candidates spend longer in general practice than equivalent civilian trainees. It is usual for them to spend 18 months in a training practice and often effectively longer, up to three years in many cases. Naturally the content of their experience is different but one would expect them to be more experienced in child health, obstetrics, gynaecology, and preventive medicine and less experienced in geriatrics, therapeutics, and the management of chronic disease. It also appears that mature experienced candidates have a greatly reduced chance of passing this examination so it would appear that increased experience is a handicap to passing, the reverse of Dr Belton and Lee's argument.

If we are to avoid the College being peopled by young inexperienced civilian trainees an alternative means of membership must be found for those mature practitioners who find the examination an impossible bridge to cross.

G.W. CRADDUCK

24 Station Road
Long Buckby
Northampton NN6 7QB

Sir,

The October issue of the *Journal* contained a spectrum of opinion regarding the MRCGP examination ranging from the editorial which favoured its abolition, to that expressed in a letter by A.E. Finnigan who suggested its repetition at 15-year intervals.

The MRCGP examination has a number of uses other than as a criterion for entry to the College. While it is too much to expect it to reflect the quality of work of a general practitioner it does help to make certain attitudes and facts known. It causes trainees to do some work that they might not otherwise do. It acts as a form of self-assessment for the trainee, and possibly for the course organizer by the pass rate on his training scheme. It does happen that course organizers design their half-day release schemes merely to ensure trainees pass the examination where local pass rates have not been good. This is a mistake (and possibly futile) since the value, if it has any, of the half-day release is its diversity.

However, a function of the examination is not to exclude those general practitioners who perhaps have a moral right to membership. It is not reasonable to expect older general practitioners to be familiar with modern examination techniques, particularly the MCQ. Examination technique is harder to pick up than the syllabus, and it may be (I admit speculation) that this is the reason why pass rates are lower for older general practitioners. Perhaps general practitioners of 10-years standing as principals who have taken part for, say, three years in what Marshall Marinker called the 'quality initiative' could be considered on merit by a local group of Members, along guidelines issued by the College.

Once membership is obtained, by either method, continued membership should be dependent on 'performance reviews' on the practice at some five-yearly intervals. Thus those Members not engaged in 'quality control' would automatically have their membership called into question — giving the College some control over standards that it presently lacks. To return to the editorial, what is the point of making all general practitioners Fellows after a certain level of time? I would not have thought having the examination occurring at 15-year intervals was a very popular way of maintaining standards!

I imagine that most trainees would opt for the examination method of entry to the College, and less people would use the alternative (but equal) method of gaining entry. If the choice existed it would be interesting to see how many preferred not to take the examination but to wait 10 years.

No one should be, or need be, excluded from the College.

PAUL VINCENT

25 Yearsley Grove
Huntington
York YO3 9BX

The clinical psychologist in primary care

Sir,

Peter Salmon, in the April 1984 *Journal,* (p.190) suggested that providing a specialist service within the general practice setting did not represent the optimum use of the clinical psychologist's time. The research designed by a general practitioner and a psychologist into benzodiazepine dependence and withdrawal[1] was cited as an example of an alternative to the specialist clinic.

When a specialist service has been provided in the general practitioner's practice, it has been found useful to have a monthly meeting to allow a forum for discussion of current cases and cases referred to the waiting list. The meeting also served to develop ways of working which allowed the doctors more scope in tackling the psychological or interpersonal problems of their patients. Viewing videotapes of consultations has been a useful method of generating debate about ways of helping patients and generating alternative strategies. The role of the psychologist has been to provide a new perspective on the ways in which the patient can be aided by the doctor during a consultation. Being able to discuss issues that arise with patients, and thus using