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.

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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.

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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.

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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