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

the psychologist as a resource of information and ideas, broadened the range of interventions that the doctor in the practice could make. In this way, referrals to the psychologist became fewer and more specific to the particular skills which the psychologist could offer.

Other ways of using the resource of a clinical psychologist include involvement in general practitioner training courses, both in teaching trainees about common psychological disturbances encountered in general practice, and also in giving instruction on interviewing skills in the consultation. In Mersey region, the latter has been done with trainers using video feedback to train them in ways of enhancing the consultation skills of their trainees.

Often doctors are unclear about the nature of the work of a clinical psychologist and do not refer to a hospital-based service, nor think of providing a specialist session in the practice, because they are not sure of what constitutes an appropriate referral. Two practices in Liverpool who used clinical psychologists, combined to provide an evening to share experiences with a number of other general practitioners. Discussion and comment from the general practitioners and psychologists helped to further ideas about the potential joint work that could be undertaken. Clinical psychology has also been represented at the annual meeting of the branch of the Royal College of General Practitioners through invitations to present papers on benzodiazepine dependence in general practice and on the work of the clinicial psychologist in primary care.

Given the scarce resource of the clinical psychologist, developments must be made in a direction away from mere specialist clinics towards joint venture and co-operation in patient care.

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Reference

1. Cormack MA, Sinott A. Psychological alternatives to long-term benzodiazepine use. *J R Coll Gen Pract* 1983; **33**: 279-281.

Urinary tract infection in children

Sir,

Houston's letter (September *Journal,* p.494) questions the validity in our study (May *Journal,* p.324) of extrapolating findings in Smellie's highly selected group of children to the general population. We share these doubts.

Far from seeking to promulgate this view our study was designed to test the opinions of general practitioners and non-specialist paediatric consultants in our area to the view that all children under five years who have a urinary tract infection require both an intravenous pyelogram (IVP) and micturating cystogram (MC). It demonstrated quite clearly that paediatricians in south-east Thames consider IVP only as the first line investigation in first time childhood urinary tract infection (UTI). Seven of the 20 paediatricians who took part in the survey would consider MC as well for a two-and-a-half-year-old boy, but none would do so in an eight-year-old girl. Interestingly about 50 per cent of general practitioners expected this boy to get both IVP and MC. Quite clearly the role of MC as part of radiographic investigation is contentious.

In Medway Health District during the years 1980–83, 107 boys and 169 girls were referred to the paediatric department for investigation of urinary infection. One hospital provides the sole paediatric department for the district and does not receive referrals from elsewhere. Eighty per cent of children were referred after what was presumed to be their first infection. All had IVP and the results of those whose records could be traced are shown in Figure 1. Interestingly 33 per cent of the children with abnormal IVPs had no urinary symptoms at first presentation. The commonest abnormalities were pelviureteric junction obstruction and bifid drainage systems in boys and vesicouretaric relux (VUR) with renal scars in the girls.

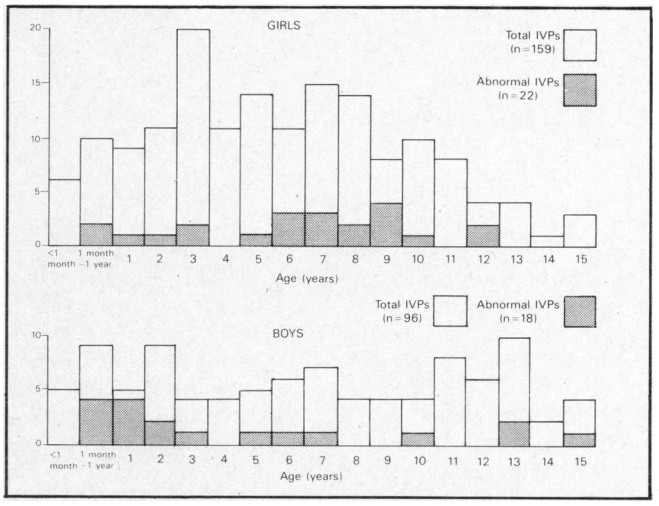

Figure 1. *Number of normal and abnormal intravenous pyelograms (IVP) for 255 children with urinary tract infection, by age and sex; All Saints Hospital, Chatham 1980–83*

The proportion of children with urinary tract abnormality is, as we expect, lower than in surveys from specialized centres, but is still so great that an IVP must be done for every child with a proven UTI — to do otherwise might possibly be construed as inexcusable.

The date in Figure 1 illustrates precisely the point made in the concluding paragraph of our study, namely that in any health district general practitioners and consultants should together be able to implement a practical management policy for childhood UTI based upon local data, and hence relevant to that population.

In the absence of other widely available techniques for identifying children at risk after UTI, it is difficult to imagine how a prospective longitudinal study from general practice of childhood UTI is going to shed light on 'best current management' without recourse to radiographic investigation even if this is to include only an IVP.

Using our incidence rate, we would expect about 50 boys and 90 girls aged between one and twelve years to be referred to the Medway Health District in any one year. Over the past four years the actual numbers are about half of that. What would be a fruitful exercise is to study prospectively the characteristics and investigation results of those not being referred.

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Medicines Surveillance Organisation

Sir,

Work coming from the Medicines Surveillance Organisation, directed by Clifford Kay, naturally attracts serious consideration (September *Journal,* p.509). We are therefore all the more