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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

MRCGP examination

Sir,

Dr Makin's letter questioning the wisdom of trainees taking the membership examination after their trainee year (April *Journal,* p. 180) must force us to think about the purpose of the MRCGP examination. The examination can be regarded as a test of competence to enter general practice; as an entrance examination to the College; as a test of basic knowledge to determine if a potential trainee knows enough to enter a vocational training scheme; or as a specialist qualification of a high standard reflecting not just competence but excellence.

A 'test of competence' would be taken at the end of the vocational training period and the standard would be as it is at present. An 'entrance examination to the College' is not needed because a test is not necessary for membership of a learned society and those who are not interested in the improvement of standards would not bother to join. If the College examination were to be a test of basic knowledge before training then it would only test theoretical knowledge but it could provide a framework for the depth and breadth of knowledge to be acquired. The last possibility, which reflects my own point of view, is that the MRCGP examination should be a difficult test after a longer period of training than the law requires, possibly five years after registration instead of three. This would then serve as a specialist qualification engendering the sort of respect discussed by Dr Ridsdill Smith (Letters, May *Journal,* p.229).

Those doctors wishing to be included in the activities of the College but who would not achieve a qualification at this level could be associate members. This could not be the first change made in the requirements for membership of the College.

In order to achieve excellence in general practice we should not be afraid of increasing the length of training to include a broader range of experience than is currently acquired during vocational training. The potential examinee should also have an adviser for the period when he or she is already a principal. This last point is included in Israeli specialist training for family medicine.

The pass rate of 74% for the examination indicates that it provides little challenge and is hardly worth taking. By aiming for a much higher standard we would be taken much more seriously as practitioners of a specialty than we are at present.

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Night visits in inner cities

Sir,

The paper by Conrad Harris and Frances Hanson (May, *Journal,* p.217) reported that the night visiting rate (23.00 to 07.00 hours) for 1983 based on FP81 claim forms, recorded by Lambeth, Southwark and Lewisham Family Practitioner Committee was 130.6 per 1000 patients. However, we were uncertain whether this reflected the true rate.

In Nottinghamshire it was found that night visiting rates ranged from 1.2 to 46.1 per 1000 patients per year with a mean of 15.5, and other studies have shown rates of 7.7 to 23.9.[1] Rates in industrial Inverclyde were found to be higher, ranging from 25.8 to 43.5 per 1000 patients.[2]

The most recent figures for our practice are 27.5 night visits per 1000 patients per year. We make 142 out-of-hours visits per 1000 patients per year, as part of a rota system, and our surgeries are open every weekday from 8.30 to 18.30 hours. We serve a population of over 13 000 in inner east London, with a night duty rota spanning two practices and three surgeries.

Deputizing services began in east London in the 1950s and were used extensively by our predecessors in both practices until the early 1980s. Tower Hamlets is also an area where there is a strong tradition of using hospital casualty departments for out-of-hours care.

The workload in general practice is higher in deprived areas than in more privileged areas, and this is reflected by an increased consultation rate, day and night. Closure of casualty departments and more appropriate use of general practice may well lead to further increases in these rates.

A local out-of-hours service, where all visits and phone calls are notified to the patients' own doctor by the beginning of the next surgery and where doctors have access to notes, meet regularly, and share common policies is likely to provide a better service in terms of continuity and quality of care than a deputizing service operating on a London-wide basis.

We feel strongly that if inner city general practitioners, working in areas where deputizing services are readily available and relatively cheap, are to do their own night visits, then they have to be adequately and appropriately recompensed.

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References

1. Sheldon MG, Harris SJ. Use of deputising services and night visit rates in general practice. *Br Med J* 1984; **289:** 474-476.
2. Usherwood TP, Kapasi MA, Barber JH. Wide variations in the night visiting rate. *J R Coll Gen Pract* 1985; **35:** 395.

Management of known epileptic patients

Sir,

Drs Hunt and Touquet (Letters, May *Journal,* p.224) have focussed interest on the role of accident departments in the management of known epileptic patients presenting with fits, by suggesting