LETTERS

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

guidelines to reduce the need for hospital attendance. It would have been interesting to apply these guidelines prospectively as there would appear to be intrinsic difficulties in the suggested protocol.

The main difficulty would be in obtaining the information necessary to apply the guidelines. This is demonstrated by the data presented; epileptic patients are unlikely to carry any information about themselves and, as half the fits occurred outside the home and less than half the cases had transport arranged by relatives, there may be no one to speak for them. Elderly epileptic patients are likely to live alone and even a well-meaning neighbour, who might call an ambulance, could not be expected to have the information required. Finally, patients who are having a fit, or are even post-ictal may not be able to cooperate.

Drs Hunt and Touquet have formulated an idea for the better management of epileptic patients. It would appear that the most crucial improvement would be for all epileptic patients to carry up-to-date and detailed information about their condition.

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Teams for tomorrow

Sir,

Dr Brook's article (June *Journal,* p.285) says nothing new, and those of us who have a continuing interest in primary health care have continually tried to draw attention to the failure of the present system.

It is obvious that no one profession can cope alone and I have stated that there must be a new approach to primary health care.[1] I have advocated a system in which there is complete surveillance of every household in each community provided by three new categories of members of the primary health care team, supported by the general practitioner. The new categories proposed are clinical associate, community nurse and nursing aide, each with well-defined training programmes and roles.[2]

I have also addressed the question of team work in primary health care.[3] It is essential that all the professional members of the team are equal, but the doctor must assume overall responsibility for that is his legal brief. Professional equality allows ideas to be proferred, discussed and rejected or accepted on merit. However, is it of any value talking about a primary health team when the goals of primary health care have not been clearly defined?

Dr Brooks has failed to address the financial implications of the present primary health care system, and of any proposed changes to it. After consideration, I have come to the conclusion that where cost-benefit and cost-efficiency are of prime importance the basic services of primary health care are potentially better provided by suitably trained paramedical staff.[4]

I have recently been in general practice in Alva, Clackmannanshire and I have no doubt where a caring, cost-effective, all-embracing, comprehensive primary health care system lies in the future — certainly not with the general practitioner, as at present.

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2. Saint-Yves IFM. The training of paramedics for primary health care. *J R Soc Health* 1983; **103:** 135-137.
3. Saint-Yves IFM. Teamwork within the primary health team. *J R Soc Health* 1982; **102:** 232-233.
4. Saint-Yves IFM. Staffing costs in primary health care. *J R Soc Health* 1984; **104:** 108-110.

Ethical guidelines for sick doctors

Sir,

It became apparent at a recent post-graduate meeting on ethical problems in general practice that family doctors of all ages experience great difficulties in coping with the problems posed by illness within their family or their partnership. A wide range of views also exists regarding self-diagnosis and -treatment.

No one present was aware of any guidelines, either from the College or elsewhere, on ethical behaviour in such circumstances. We believe that such guidelines would provide a framework within which better care for sick doctors and their families could be provided. Our recommended guidelines are as follows:

1. Doctors should be registered with a general practitioner who should not, except in exceptional circumstances, be a partner.
2. Doctors' families should be similarly registered.
3. Doctors should not refer themselves directly to a consultant for an opinion except in circumstances where any other patient would do so, for example venereology clinics or family planning clinics.
4. Doctors should be wary of self-diagnosis and should not initiate treatment with 'prescription only' medications, including antibiotics, for themselves or their families.
5. In general, sick doctors should act as model patients. Any special consideration shown by colleagues caring for them should be regarded as a privilege and not as a right.

These recommendations should not be regarded as comprehensive or restrictive. They are intended to help those who choose to care for sick colleagues to provide the same high standard of medical care we would wish our other patients to receive. We would urge family practitioner committees to forbid the registration of a principal on his or her own list of patients.

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Caritas, quality and general practice

Sir,

Primary health care — an agenda for discussion,[1] the Government's green paper, raises major clinical, educational and political issues. The faculties are discussing this document to enable the College to make an informed contribution towards the Government debate.

However, the document asks more questions than it answers; what constitutes good practice is still uncertain, although a good practice allowance is now being talked about. The College has considered quality in general practice in detail. Indeed the recent policy statement[2] raises many of the same issues as the Government's green paper. The policy statement is an excellent discussion about quality in primary care and its importance, and follows on naturally from the College's consultation document