examinations for membership of the Royal College of General Practitioners. It is often proposed that the examination is a suitable end-point for judging competance to practice as a general practitioner. At the end of the day I came to the following conclusions about what the MRCGP examination does and does not achieve.

The examination did demonstrate which of the candidates had something extra, by which I mean those who read about their work, care about it and above all have a willingness and ability to think about and even advance their discipline. The examination thus achieves its aim of identifying doctors who one would like to see as members of the College. It also picks out the doctors who will be able to lead and inspire future trainees. None of the oral examinees, however, appeared to be in any way unsafe to practice as principals. A proportion of the candidates get such low marks on the written papers that they are not invited to the orals. Obviously, I am not able to say anything about these doctors beyond noting that they have failed tests which concentrate mainly on knowledge rather than performance.

The conclusion is that as a measure of satisfactory albeit pedestrian competence as a general practitioner the membership examination is not appropriate; some other criterion of assessment needs to be found. To this end both the Joint Committee on Postgraduate Training in General Practice and the Association of Course Organizers are looking at continuous end-point assessment of vocational training.

My thanks are due to the examiners in general for having me and especially to Tom Dastur for all his kindness to me during the day.

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Marriage guidance counselling

Sir,

In her article on marriage guidance counselling in general practice (September *Journal,* p.424), Dr Corney states that many studies have indicated a decrease in the number of visits to the doctor by patients after cessation of counselling in comparison with the period before referral. She also comments on studies that have found a reduction in the prescribing of psychotropic and other drugs. I would agree that the papers that she lists do in fact come to these conclusions.

My recent survey, however, using a one-year follow up period, detected no major change in the number of prescriptions for psychotropic drugs or consultation rate during the years that counselling was available in the practice.[1] In the year after counselling, the number of psychotropic drug prescriptions actually increased, though this was accounted for by a small number of patients. A recent review of literature on counselling in general practice[2] came to the conclusion that it has yet to be proved that meeting patient's needs by counselling is better, cheaper, or in the long run more effective, than these needs being met by consultation with the doctor and the prescription of psychoactive drugs.

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Primary care services

Sir,

We note that in the September *Quality in Practice Bulletin* College Council has issued a statement of the basic range of services that should be made available to patients by every practice in the United Kingdom. We assume that any resemblance between this list of services and our list published in the *Lancet* in February[1] is purely coincidental.

Nothing we have seen or heard in the debate about primary health care services, before or since the publication of the Government's green paper[2] has led us to change our views. We believe that a guaranteed minimum service comprising traditional demand-led service, continuity of care, care of certain common chronic conditions and specific preventive programmes, would give general practice a much needed sense of direction. We believe practices rather than individual practitioners should be made responsible for providing such a basic range of services. Furthermore, the development of a computerized information system for the activities of anticipatory care would allow health authorities, family practitioner committees and practices to concentrate their efforts on areas of need such as inner cities. Local medical committees would have the major constructive role of advising on appropriate annual targets for the care of specified chronic conditions, and for the various preventive measures.

This approach to the provision of primary health care follows the World Health Organization's philosophy of 'health for all', and could be the basis of a new contract for general practitioners. It could go some way to solving the major difficulties that beset general practice — namely, lack of direction, relative lack of accountability, poor measurement of outcome, inconsistency of service provision and difficulty in marrying the salaried community health service with the independent general practitioner service.

We welcome the College Council's statement.

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Fees and allowances

Sir,

The College has rejected the government's proposal to shift remuneration from basic practice allowance to capitation fees. This is understandable as we would not want a return to the oversize lists of the past. However, in some areas patients have difficulty getting a doctor to take them on even though lists are smaller than in the past.

The structure of our fees and allowances means that the highest rate of pay per patient is for the list of 1000 patients. Below that level basic practice allowance is cut, but once over 1000 patients the extra for each patient registered falls from over £20 to about £8. This leads to a dual population of general practitioners. Those with outside commitments with lists just over 1000, who are reluctant to take on extra patients, and full timers with lists of 2000 or more.

I would propose different thresholds for

full payment of allowances as follows: 1000 patients for rent, rates, staff reimbursement; 1200 for basic practice allowance; 1500 for group practice allowance; 1700 for seniority awards or vocational training allowance. Like the present system, the allowances would be proportionately reduced for smaller lists, that is, a doctor with a list of 1500 would get (1500/1700) x seniority award but full rate basic practice allowance and group practice allowance.

This system would lead to a gradual change in remuneration per extra patient. It would encourage a reasonable list size of 1700 which the British Medical Association has recommended and it would give patients more choice without encouraging giant list sizes.

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Buying and selling practices

Sir,

Dr Robson and colleagues (Letters, September *Journal,* p.431), have highlighted a dilemma facing an increasing number of general practitioners as a result of the present boom in independently owned purpose-built surgeries. Having built two such surgeries ourselves, and being involved in the planning of several others my partners and I have arrived at a formula which, although not ideal, goes a long way to solving the potential problems.

Premises can be valued in three ways. First, rebuilding value; this is obviously unfair to incoming partners. Secondly, market value, either open or closed. Open market valuation is simply what an estate agent would hope to get for you were you to sell your surgery tomorrow. Closed market valuation is what you would get if you sold your premises tomorrow but continued to act as a practice — in other words it takes into account the constraints imposed by the National Health Service on how many doctors can practise in an area. Thirdly, the cost or notional rent valuation, whichever is greater.

The last valuation has three advantages. First, the valuation is free; getting a building worth half a million pounds valued is very expensive. Secondly, it is always possible to borrow money cost effectively against it; in other words the cost rent or notional rent, whichever is higher, will always cover to a large extent money borrowed to either build or buy into premises. Thirdly, it is equitable; there can be no further disputes about who makes the valuation and on what terms — figures obtained from estate agents, even those with theoretical expertise in this field often appear to be little more than arbitrary.

In order to accept this one has to realize that an existing partner will not 'make a killing' out of his premises on retirement, as has often been the case in the past. In order to maintain a reasonable succession of partners who have not had to find vast sums to enable their predecessors to buy *bijou* residences in the sun, one must accept that having an acceptable environment in which to work is in itself an advantage. A gain made over the life of a practitioner will be significant but not vast. It would also equate more accurately to the area in which he practices, once again facilitating succession.

The problem of succession during the lifetime of a loan, be it from the General Practice Finance Corporation or a bank, also needs clarifying. The overall value of the building is known accurately from the rental paid less the total of the outstanding loan on it. At any given moment the exact amount of capital repaid by either an individual or a partnership can be calculated from GPFC or bank figures if direct repayment is used, or surrender value of life insurances if endowment repayment is used. A simple formula can be worked out which summarizes all this. In practice, it is not as complicated as it sounds, and it has removed a significant bone of contention from our practice at least for the foreseeable future.

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Clinical strategies in family practice

Sir,

The paper on clinical strategies in family practice by Dixon (October *Journal,* p.468) emphasizes the importance of concepts of health and illness in providing appropriate care. They are also important in the advancement of the discipline of general practice. To date general practice research has been enormously productive of information, but only now is serious attention being paid to the evolution of models and theories within which this information can be used to test ideas and to better understand 'intellectual processes which may be of significance to all levels of medicine'.

It is interesting that Dixon discusses diagnosis almost entirely in relation to disease, emphasizing the evidence which shows how often in general practice no disease is diagnosable. An alternative to the idea of 'non-disease', which he rightly proposes as an appropriate aim for general practice diagnostic effort, is to consider diagnosis also in relation to illness (patient feeling) and sickness (patient behaviour) as outlined by Barrand.[1] That is, diagnosis is related to patient problems rather than to disease entities.

This is to 'borrow liberally from other conceptual models' but not to 'reformulate the problem in psychological or sociological terms'; rather it is to reformulate the problem in general practice terms. This is perhaps more useful than a 'management diagnosis', because it is more likely to imply ideas about how resolution of the problem can be measured. Delay is only useful as 'a deliberate strategy to change the probability of disease', if the goals of non-intervention and the means of monitoring their achievement are clearly understood by both patient and doctor.

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Reference

1. Barrand J. A model of health. *Aust Fam Phys* 1985; **12:** 1302-1307.

Low immunization rates among students

Sir,

At the beginning of the academic year we interviewed 1800 new students registering with the University health service. We observed that it is quite exceptional for 18-year-old British boys and girls in this intake to have up-to-date polio and tetanus immunizations and many who missed Heaf testing at school had no subsequent follow-up to check tuberculosis immunity.

We feel this should be brought to the attention of school and family doctors so that more use can be made of age–sex registers and computerized recall of patients and the theory of the MRCGP examination actually put into practice. Note also that a fee is payable for such immunizations.

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