formation for anyone interested in further training.

The Andersons ask for 'adequate and recognized training' but what harm can ensue from homoeopathy without 'recognized' training? It is not inadequate training in homoeopathy and such like which makes a doctor dangerous; the danger stems from his inadequate training in the processes of rational thought.

It is not completely true to say that 'few concerted or systematic scientific trials have been carried out' in the area of alternative medicine. In the case of acupuncture, numerous trials have been published in reputable journals, showing that acupuncture does not differ from placebo.[2] Detailed critiques of acupuncture and homoeopathy[3] have been ignored by the advocates and remain unanswered. It is regrettable that the BMA report[1] accepted unsubstantiated claims for the role of acupuncture in pain and allowed themselves to be misled by partisan evidence.

We agree with the Andersons that 'we have a duty to the public to assess the benefits and harms of alternative practices'. This should be done before providing further training. We have the same duty to medical students and postgraduates, and we strongly recommend that critical appraisal of alternative medicine becomes a part of undergraduate teaching. The interest of some doctors in alternative medicine, however, is not a sufficient reason for teaching them how to earn money by employing it. For example, the present heightened interest in faith healing, including trials of faith healing in men with cataract and in horses with intestinal parasites, in British academic institutions, is surely not a sufficient reason for introducing courses in faith healing in medical schools.

As much of orthodox medicine is still magic, it is not easy to separate the husk of the absurd from the rational nucleus. The question is not how to accommodate more magic in medicine but how to get rid of it.

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The College and its Council

Sir,

The debate over 'What sort of College?' has continued for more than a decade but as yet no conclusion has been reached. As a College, we are pledged to help individual general practitioners to improve the standard of care they give to patients. We have produced important policy statements and recommendations about standards of care but cannot claim that these have been implemented by every member. There is a credibility gap between what we say is possible and what happens in our practices. (We sometimes give the impression of being a self-perpetuating oligarchy.)

Style. A small handful of people cannot and should not be seen to run the College. All the members of the General Purposes Committee and of Council must be actively involved in decision making. This will require more people to devote more time to the College but is likely to produce decisions which are not only correct and appropriate, but which are based on the practical problems faced by all general practitioners.

Structure. Having decided what the College seeks from its central organization in terms of policies and leadership, then the appropriate individuals for certain jobs must be more democratically selected than they are at the moment. Faculty representatives need to discuss the posts to be filled and the potential candidates with their faculties several months in advance. Council will then be in good position to democratically elect doctors to the important positions in the College.

Central thought versus peripheral action. The main aim of the College relates to the individual general practitioner's care of patients. The Communications Division through its information folders and the Education Division through the Annual Symposium are two ways in which the College seeks to help doctors. These successful initiatives are a guide for the College's future development. Faculties have shown in their work on the CASE programme and in preparation for the Annual Symposium 1986, that they can also produce high quality educational material. Council must encourage and trust College members and faculties to be active in practical educational projects.

The problems of the past year have been traumatic both for individuals and the College, but change is now likely to occur. However, the nature of any changes and their manner of introduction, need to be agreed and accepted by the whole membership. Without this agreement changes in structure are unlikely to produce the desired changes in behaviour.

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The Diploma in Geriatric Medicine

Sir,

As the only person as yet who has examined both for the Diploma of Geriatric Medicine and the MRCGP I should like to make a few comparative points.

The main difference between these examinations is the clinical orientation. The DGM is based, of course, on papers testing knowledge base and ideation, but the long and short cases presented to the candidate enable examiners to observe clinical, attitudinal and communicative techniques at the time. The examiners are consultants and specially chosen general practitioners working in pairs. The candidate is allowed half an hour with the long case, and then reports to the examiners who conduct an interview on the findings, the elicitation of physical signs, and the solution of problems. Other examiners take the candidate through three short cases, for example tardive dyskinesia or speech defects like fluent dysphasia.

I always found it difficult to estimate a doctor's real quality from the MRCGP oral examination, for even if his/her attitude seemed good I often wondered whether a doctor would always do what he told us. A good examiner is not left completely in the dark, however. What the DGM indicates is that after a few years in a medical service in which the average consultation time is six minutes clinical skills become eroded. For this reason alone, trainees have the advantage of being closer to hospital medicine but this is something I have recently deplored as an indoctrination from which the reconceptualization needed for general practice is almost impossible.

The DGM is a most important test at a time when the population is ageing and diseases of external origin have largely disappeared.

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