Health care delivery

Sir,

Drs Crombie and Fleming are right to call for the collection of data about general practitioners' referrals to consultants (October *Journal,* p.462). They are, however, wrong in their description of the roles of health authorities and in their definition of need when they state, 'It is not their [health authorities] function to influence performance but to provide information and to meet patient need which can be equated with doctor demand on behalf of patients with problems.'

General practitioners and health authorities share the common aim of delivering the most effective and appropriate care to patients in the communities which they serve, within the resources at their disposal. It is therefore a proper function of both general practitioners and health authorities to attempt to identify and influence those factors that adversely affect health care delivery. Health authorities should attempt to influence general practitioners to make appropriate referrals. Equally, general practitioners should attempt to influence health authorities to provide appropriate services for their patients.

Currently, the definition of 'appropriate' is very subjective. Increased objectivity can only be acquired from closer investigation of both need and of outcome, for which indicators are, as yet, poorly developed. However, to equate patient need with doctor demand, as Crombie and Fleming do, is unsatisfactory. Need is a property of individuals and their circumstances. Health care services are provided in an attempt to meet perceived need. Time and again, when attempts are made to assess need by examining use of an available service, it is found that the only consistent correlate of service use is the amount of service provision. This frequently leads to the conclusion that need is greatest in those areas where service provision is greatest. With a homogeneous population and patchy service provision, such a conclusion is absurd. Drs Wilkin and Smith elegantly demonstrated that there was no difference between the patient mixes of general practitioners with high and low referral rates (August *Journal,* p.350).

If data about process, for example referrals, is to be of value it must be linked to data about outcome. This, in turn, is best interpreted in the light of need. Thus, the way ahead lies in the development of the difficult areas of need and outcome assessment. Such an approach will hopefully provide both general practitioners and health authorities with relevant information enabling them to influence their own performance and that of others.

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Medical care units

Sir,

The article by Professor Williams and Dr Wilson (November *Journal,* p.507) raised an interesting idea for a functional medical care unit as an alternative to the nursing care unit of the Cumberlege report.

In Exeter the mental health services are very advanced in moving into community-based work and several large mental hospitals have closed. Community mental health teams are arranged to work with groups of general practices in a functional way as suggested in the article. These units work very well and allow staff working in the community from mental health services to give the best possible service to patients, as patients turn naturally to their primary care doctor for medical input and these functional care teams are well placed to give the best possible service to each patient, linking specialist skills with the primary care medical services. The only problems in the system are that social services arrangements in Exeter are still by strict geographical boundary and there has of course to be a facility for patients to be referred to specialist medical services outwith the general practice based zones.

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MRCGP examination

Sir,

I am grateful to Dr Susan Brown (October *Journal,* p.466) and Dr Ian Tait and colleagues (November *Journal,* p.514) for taking the trouble to reply to my letter suggesting changes in the MCRGP examination. The main thrust of my letter, however, was not to bring our College into line or indeed compete with the Royal College of Physicians. If the idea of a common first part is not popular we could always devise one of our own. What is important is that the examination should be split into two parts with sufficient space to allow vocational training schemes to explore the wider concepts of general practice and not be bedevilled and constantly interrupted by the thoughts of the approaching membership examination. The second part should be based on general practice concepts and be assessed by general practice methods. It should not be taken until two years have been completed as a principal in general practice.

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Sir,

I wonder how many recently successful MRCGP examination candidates have seen the interesting piece 'Dual meaning of membership' in the *Lancet.*[1] The authors comment on the situation pertaining to the membership of the Faculty of Community Medicine and make the following points:

1. The right to use the qualification depends on infinite annual payments to the Faculty.
2. The documents dealing with the examination do not make this clear.
3. Annual payment of fees by a member cannot be equated with maintenance of standards or commitment to continuing education.

They contrast this situation unfavourably with the Royal College of Physicians, where continued membership depends only on an examination pass, and suggest that the rules should be changed so that the Faculty's membership examination would become like any other examination; a pass would be recognized by the irreversible award of the MFCM qualification and there would be no subsequent financial obligation. Paying membership of the Faculty would then be a voluntary act (one which they believe most successful candidates would embrace) and this form of membership could be extended so that (additionally) both doctors who had not passed the examination and non-medically qualified scientists could be invited to join.

What about our College? I sent for the 'notes on membership' but could find no mention of a link between continued membership and payment of an annual fee. I suspect that prospective examinees could be deceived into thinking that an examination pass alone entitles them to put and keep the letters MRCGP behind their name.

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Reference

1. Coleman MP, Mant D. Dual meaning of membership. *Lancet* 1987; **2**: 265.