

daily ward visits by general practitioners employed as clinical assistants in the hospital. The patients generate a large amount of correspondence including progress reports to the hospital, but there is as yet no recognition of the additional resources required, not even an elderly patient capitation fee.

General practitioners in Clitheroe are perhaps more able than most to absorb these demands — we have average lists below 2000, with good living conditions and low unemployment among our patients,³ but we feel the strain. How will other practices, which are already severely stressed, cope? Perhaps by refusing to accept such patients.

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Safest place of birth

Sir,

Marjorie Tew's letter (November *Journal*, p.521) repeats her well known position that it is safest to give birth away from consultant obstetric units, with their increased likelihood of obstetric intervention. This position has been thoroughly argued,¹ but her method has been shown to contain important methodological and logical flaws.²

Mrs Tew quite rightly states that the hypothesis that 'obstetric management is especially valuable to babies who are at risk because their mothers have certain characteristics or obstetric experiences' has never been tested. However, her challenge to use the Oxford obstetric data system for this purpose is misconceived; observational data sets of this type cannot be used for this task. In clinical practice women are not assigned randomly to their treatment (or place of booking or place of delivery), and statistical analysis, however ingenious, can never make up for this deficiency. In our hospital all women with risk characteristics will have received consultant care, making a comparison with general practitioner care impossible.

Indeed, it is partly because both Mrs Tew and her critics have had to rely on observational data, that there has been

such confusion and controversy surrounding the issue of the safest place of birth.

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Training for hospice care

Sir,

I would like to support the views expressed by Dr Finlay in her editorial 'Training for hospice care' (January *Journal*, p.2). However many hospice beds there are, only a small proportion of patients will spend a small proportion of their illness in them. It is well recognized that hospitals are not an ideal place to care for dying patients from the medical, social and emotional points of view. The majority of patients are going to spend most of their time at home and it is the doctor's ability to liaise closely and sympathetically with the patient's general practitioner and the whole primary care support system, and to appreciate and respond to the pressures of the home environment as well as its opportunities, which are adequately prepared for by experience in general practice. I would like to see this go beyond completing a trainee course to the inclusion of at least two or three years of active practice, with final responsibility for patients.

Dr Finlay's suggestion of a diploma in palliative medicine, well balanced between clinical, communication and management skills seems to be well worth considering.

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Timing and purpose of the MRCGP examination

Sir,

I would like to respond to Dr Robert's paper on the timing of the MRCGP ex-

amination (January *Journal*, p.30). I sat the examination two months after completing my vocational training and I learned a lot from this. The emphasis on reading current medical literature including that on non-clinical subjects such as politics, computers and screening is relevant not just to general practice but to medicine as a whole. Trainee day release courses and trainers are not necessarily examination oriented and may teach other equally, or even more valuable approaches, such as Balint type group meetings. For me, the examination was complementary to the trainee year in many respects.

I am currently a senior house officer in psychiatry and intend to make psychiatry, and not general practice, my career. If I had to gain years of further experience in general practice I would not have sat the examination. Many doctors now have more than one postgraduate membership, and it would be a pity if interested non-general practitioners were to be prevented from broadening their knowledge of general practice in this way. A hospital patient has many of the same needs as a general practice patient. Doctors in different hospital specialties may not need to talk to each other, but they all need to communicate with general practitioners and have some understanding of their work.

I hope this viewpoint will be taken into account in debating the re-scheduling of the examination.

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Sir,

It seems almost impossible to open a general practice journal or newspaper without seeing something about the MRCGP examination. Unfortunately, most articles appear to cover the same ground. The latest offering in the *Journal* (January, p.30) is no exception. However, there were one or two points on which comment should be made. The fact that many candidates devote time to modified essay questions and attempt to increase their factual knowledge appears to be anything but reprehensible, especially if you bear in mind that you cannot develop a questioning approach to general practice without first having a sound basis of factual knowledge.

The article also implied that the good practice allowance/postgraduate education allowance, should become tied to the