Sir,
Your somewhat neutral editorial on *Working for patients* (March *Journal*, p.87) fills me with concern that the College is losing touch with the feelings of its members.

Our present contract certainly penalizes investment of time and equipment and also high quality ancillary staff, but there can be no doubt that the new contract will increase the penalties for such investment — especially in small practices. Personal care will also be penalized. The best interests of our patients will be served by resisting strongly the imposition of such penalties.

KEVAN J. THORLEY

Higherland Surgery
9 Buckleys Row, Higherland
Newcastle, Staffs ST5 2TN

Sir,
The National Health Service has always been a political football. It was stampeded into being soon after the war as a great vote catcher despite the misgivings of the medical profession who had little say on how it was to evolve. Its tripartite inception as hospital, public health and general medical service each divorced from the other was a disaster from the outset and has made it impossible to fully integrate total medical care.

Politicians glibly thought that after the first few years when patients' immediate needs had been met, demands on the service would lessen. Thus the planners did not enlarge the service to cope with the explosion that did occur. New hospitals were not planned and existing hospitals were not expanded in time to meet the rush. Frustrated young doctors went abroad in the medical brain drain of the 1950s and when eventually a crisis developed, alternative labour was cheaply imported from under-developed countries.

It was not until this revolt, and the charter of the late 1960s, that the general practitioner began to come into his own; even so modern technology has remained largely out of reach within large hospitals together with the deliberate exclusion of community hospitals in which the family doctor could have a stake.

It has taken over 40 years of hard won negotiations for the family doctor to reach the present situation. Money made available as the result of the charter has seen a spectacular improvement in general practice. All this the health secretary intends to turn upside down without consultation with those who do the work. The majority of doctors, after years of exacting training, do a fair day's work and carry considerable responsibility. Any success attributable to the NHS is due largely to the dedicated hard work of those who labour long hours in it. Successive governments have relied undeservedly on this good will.

We are not against change, but it must not be reckless. Improvements will require more money not increasing bureaucracy. The country cannot have a first class health service at third rate prices.

The minister appears to have taken advice from academics and practitioners comfortably situated in large partnerships in those salubrious areas of the country within easy reach of the Royal College of General Practitioners. Those who work in isolated and deprived areas, especially those with single handed and small list partnerships, have been discounted.

D.J. DAVIES

Health Centre, Resolven
Neath, West Glamorgan SA11 4LL

What kind of College?

Sir,
Geoffrey Roberts' idea of government payments on reaching a certain standard (January *Journal*, p.30) is not new and the vocational training allowance has never been controversial. Seniority payments used to be conditional on attendance at a certain number of section 63 sessions, and the abolition of this link was a retrograde step. In the USA doctors have to be seen to be engaging in some form of postgraduate activity and in the UK our consultant colleagues have merit awards, although no objective assessment of merit is involved. It is noteworthy that the Doctors and Dentists Review Body in its 1988 report wanted distinction and merit awards to be for a fixed term only, renewable after review, and the current white paper[1] seems to be in favour of this. In the past good arguments have been advanced against merit awards in general practice and Fry[2] points out that the College has consistently opposed this, but there is nothing like a financial incentive for stimulating interest. Most of the objections to payment for merit in general practice were centred on difficulties of measurement, but in the last decade the College has been instrumental in the

development of methods which would be suitable. Perhaps such payments might even help offset the costs of College membership and the greater costs of fellowship.

For most of the large membership of the College, participation in College activities consists of receiving (and sometimes reading) the *Journal* and paying their subscriptions. If the MRCGP examination were taken after a year or two in general practice the College would shrink to a smaller, but far more involved membership who are at present starved of the funds necessary to put their ideas to good use.

A scheme of making higher qualifications more attractive by financial incentives may result in a more involved membership, but would not change the perceived remoteness of the College headquarters. The only way to achieve a sense of belonging is to meet regularly with like-minded people but most general practitioners will not be prepared to travel more than a few miles to meet their colleagues. Accordingly, the College must function at district level in order to achieve this sense of belonging. One advantage of the increasing College membership is that there should now be sufficient interested people to spark off activity in almost any conveniently small area. Many faculties have already set up such district groups, and it is these that will provide the focus that is needed for the future.

Thus, by combining district based activity with financial incentives for gaining higher qualifications it may become possible to move towards the goal that many of us wish to achieve — a large, broadly based, and powerful College in which a significant proportion of its members feel involved.

CHRIS BARRY

RCGP Wessex Faculty
36 Draycott Road, Chiseldon
Nr Swindon, Wilts SN4 0LS

References

1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555)*. London: HMSO, 1989.
2. Fry J. At the crossroads of time. *J R Coll Gen Pract* 1987; **37**: 280.

Sir,

Since becoming a trainee, I have felt that the MRCGP examination is something of an anathema. The College states that its prime aim is to be concerned with the broad day to day operating standards of general practice. To this end, it should be able to afford its members a forum for the sounding out of ideas for the improvement of primary care, ideas coming from the working membership, rather than authoritarian statements from a seemingly elite and remote group. All general practitioners should have an interest in the improvement of the professional standards of their work and thus wish to be members of the College.

Why then have an examination to become a member? As the College exists essentially for the improvement of standards, qualification for membership should be by virtue of being a principal in general practice and not by taking an examination. There should be a minimum standard necessary to be a general practitioner and it should be the responsibility of the trainee schemes to ensure that anyone qualifying for the Joint Committee on Postgraduate Training for General Practice certificate reaches that standard. Just as importantly, doctors should have the ability to maintain that standard and commitment for the whole of their professional lives. The idea that people may qualify as doctors, qualify to be a principal in general practice and yet fail to reach the standard required by the Royal College of General Practitioners to become a member is nonsense. To then say that anyone passing through a scheme satisfactorily will not fail the MRCGP examination makes the examination unnecessary. I therefore agree with Dr Roberts (January *Journal*, p.30) about the necessity of making trainee schemes more responsible for ensuring the quality of doctors completing their courses. The people who will not satisfactorily complete a trainee scheme should be identified along the way and helped to achieve the adjudged criteria or helped to find their place in medicine elsewhere, if it is clear they are not suitable general practitioner material.

I cannot agree, however, with Dr Roberts' idea of giving financial inducements for passing the examination. It would not say anything about competence or commitment to general practice, only about a doctor's need for the money. As for a career structure, I would have thought that attaining the FRCGP would be sufficient provided that justice is seen to be done when it is awarded.

S.J. CORNELL

Stocksbridge Medical Group
The Health Centre, Johnson Street
Stocksbridge, Sheffield S30 5BX

Richard Colman: GMC candidate

Sir,

I am a candidate in the General Medical Council election in June. My concern for the profession goes beyond the advertising issue in which I am currently involved. The June edition of the *Journal of Medical Ethics* carries a full debate of this issue.

With world wide budget travel over a number of years I have developed a strong sense of survival and independence, a love of people and a concern for the more environmental and spiritual rather than material values of life. My respect needs to be earned.

Helped and encouraged by a supportive wife I have looked critically at medical care. Deciding that full time general practice constituted a real threat to my existence as well as inevitably compromising my medical care I started in independent practice, preferring to offer more of me to fewer people. I also work as a medical boarding doctor for the Department of Health.

My recent dispute with the standards committee of the GMC over the advertising issue has been a sobering experience which has led me to believe that the GMC is becoming more concerned with the professional than the public interest. The sponsoring of candidates by the British Medical Association and the royal colleges encourages this. My reason for standing in the election is to counteract this unhealthy trend and to represent the independent and vital spirit of a profession.

My concern for people and my professional colleagues raises points of relevance to the GMC. I have a deep concern for the health of doctors. I believe that medical education both undergraduate and postgraduate is limited by adherence to the reductionist model. As a student of moral philosophy I have become critical of much medical dogma. The ethics of the profession need to be reviewed.

RICHARD COLMAN

Cowl House, Bransdale,
Fadmoor, York YO6 6JW

Social programme at Brighton

Sir,

There appears to have been a misunderstanding about the social programme at the College's spring meeting in Brighton (Letters, February *Journal*, p.81). The events were chosen specifically with husbands as well as wives of general practitioners in mind. The sentence referred to by Dr Haworth means that the wives of the organizing committee arranged the alternative academic morning on 'Stress and the family' themselves to appeal to the whole family, and indeed 'accompanying persons' rather than 'wives' was carefully used. I trust this clears up any confusion.

SALLY GRAY

10 Mushroom Field, Kingston,
Nr Lewes, East Sussex BN7 3NT