can be run by non-specialist personnel with minimal training. In addition to this the more important aspect of calibration and quality control is now handled by the use of lot number.calibration coefficients so one can be sure of results without continual cross reference to external laboratories: this means that assays such as cholesterol are reliably accurate and will correlate to standard, consensus methodologies.

I would like to correct the inference that the Analyst is the most expensive system available; in fact the biochemistry module is around half the price quoted, at £7850.00. More modules can be added to this to give more specialized uses. Indeed, one can produce a full biochemistry screen, plus a 10 parameter blood count plus sodium, potassium and lithium ions, and add further parameters via the health data message computer. Du Pont would be delighted to supply details.

BRUCE LAWRIE

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Reference

1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.

Myalgic encephalomyelitis

Sir,

During the past few months the Myalgic Encephalomyelitis Association has initiated a determined effort to find a cure for this devastating disease. A scientific and medical advisory panel has been formed under the chairmanship of Professor James Mowbray of St Mary's Hospital Medical School, and in order to fund much needed research the Breakthrough Trust has been established and is already attracting money.

The scientific and medical advisory panel is anxious to stimulate new thought on research into the causes of myalgic encephalomyelitis, its possible treatments and, most important of all, research into finding a cure. Because of the complexities of the disease members of the panel would welcome new ideas and requests for grants from a wide variety of disciplines. Any such applications should be sent to me at the Myalgic Encephalomyelitis Association.

STEPHEN POWELL

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Medical Association of South Africa

Sir,

You published a letter by Norman Levy (December *Journal,* p.521) appealing for support for the Medical Association of South Africa (MASA). He based his request for support on the grounds that MASA had made a policy statement expressing 'deep concern felt by MASA regarding the unrest situation [South Africa under apartheid]. It deplored violence from whatever source and deplored the concept of detention without trial.' Secondly he based his request for support on a policy statement made by MASA expressing the 'abhorrence which MASA felt at the misuse of children to obtain certain aims and which could as a consequence lead to their arrest.'

There are serious problems with these statements and they certainly do not qualify for any support from the international medical community. There is no evidence that MASA has taken any action to back up the first statement. Before the international medical community can support MASA, we need to be assured that they have actually taken steps to implement this statement. The second statement is typical of the propaganda machine which is so well established in apartheid South Africa. The statement is very cleverly worded, and if it is read carefully, one can see that what MASA is in effect doing is condemning the mass democractic movement by suggesting that 'they' misuse children to obtain 'certain aims'. The MASA statement, instead of condemning the arrest and detention of children by the South African security services in fact justifies the arrest of these children.

In the absence of any evidence that MASA is in fact opposed to apartheid, international pressure should be sustained rather than relaxed to bring about change in that country.

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Budget holding

Sir,

At the very time when general practitioners need to be united in their opposition to the white paper,[1] some are breaking ranks. Naively they believe that they can maintain or improve standards of patient care by becoming budget holders, even though the concept has not had pilot studies in this country. 'Expressing an interest' in budget holding sounds innocent enough, but if the government had been snubbed on this issue we might have seen the setting up of a properly organized pilot scheme. We should not delude ourselves that budget holding will always be voluntary. How long will it be before all practices have it imposed on them? There will not be any sweeteners then.

Perhaps the time has come for the British Medical Association and the Royal College of General Practitioners to consider denying membership to those general practitioners who put self interest before the greater interests of the profession. Money, alas, appears to be influencing clinical judgement.

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Reference

1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.

MRCGP examination

Sir,

Dr Russell (letters, November *Journal,* p.480) is concerned that 'the figures suggest experienced principals often find it difficult to pass the MRCGP examination.' I imagine he refers to my annual report (1987/88) as convener of the panel of examiners. Unfortunately the figures are distorted by candidates who resit the examination for the second, third or fourth time (the pass rate seems to diminish by a law of halves). Thus for the 1988/89 academic year 60% of principals passed the examination and 79% of trainees were successful. However, if candidates resitting the examination are excluded, 70% of principals (n = 159) sitting the examination for the first time passed, whereas among trainees (n = 880) the pass rate was 79%. Although there is still a disparity in the figures the gap between the two groups is less than it would at first appear. Even closer results might occur if one corrects for sex, as women candidates have a higher pass rate than men and a greater proportion of women candidates sitting the examination are trainees.

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