explored the difficult area of pharmacists giving advice to patients.[1] The Nuffield report on pharmacy, published in 1986,[2] stated that the pharmacist could exercise a more important role as a provider of information to the general practitioner. Most recently the government foresaw an extended use of the pharmacist's skills.[3] Yet even when the pharmacy is based in a health centre the relationship may not be entirely satisfactory. Harding and Taylor, in a study of 10 such health centres noted disparities between the two groups that were either the result of inadequate communication or indicated that neither group expected to have a major influence on the activities of the other.[4] Finally, the advent of PACT (prescribing analyses and costs) and of indicative prescribing awards for practices has heightened the awareness of many doctors of their need for better information.

A study, supported by funding from the Department of Health, was carried out to try to develop a programme of continuing education which would encourage interaction between general practitioners and community pharmacists at a local level. Initially a series of workshops was held with a selected group of nine doctors and seven pharmacists to identify those areas which the group felt had the most relevance to joint continuing education. These were:

— to seek agreement between local doctors and pharmacists about advice given by pharmacists to patients;
— to provide better information to doctors about the range, nature and cost of 'over the counter' preparations;
— to consider guidelines for doctors and pharmacists that would facilitate cross referral;
— to seek agreement from both groups about areas of self-help for patients;
— to explore the contribution pharmacists might make to developing practice or local formularies;
— to explore the contribution pharmacists might make to a doctor's analysis of PACT data.

The workshops explored these areas by means of case studies and home assignments and a course was then designed for three evenings at a postgraduate centre. An invitation to attend was sent to all 150 general practitioners and 130 community pharmacists in a single town in the West Midlands. The 50 places available were filled by pharmacists and doctors in a ratio of 2:1. The letters to general practitioners were dispatched later than those to the pharmacists and this might account for the different uptake of invitations.

The three evening programmes were centred around responding to symptoms, generic prescribing and disease prevention. These topics were sufficiently broad to allow for discussion of all six areas listed above. Short presentations were made at the beginning of each evening followed by small group discussion of these topics reinforced by background papers and case studies circulated before each meeting.

Evaluation was carried out using a post-course questionnaire and the observations of a trained sociologist sitting in with the groups and observing the interaction. Thirty nine questionnaires were completed. The venue and time were convenient for 34 responders and all liked the format of the programme. Topics which were not covered but which were thought to be important included the use of computers and the function of the Prescription Pricing Authority. All participants welcomed the contact and nine wished to have a longer programme.

A number of important subsidiary issues were observed during the small group discussions. Doctors and pharmacists perceived themselves as being of different status — the doctors were more assertive, spoke first and emphasized how the pharmacist could help the doctor rather than vice versa. The pharmacists were mainly on the defensive, particularly in relation to commercial aspects of their work. Doctors were troubled by the change of staff in pharmacies whereas pharmacists were troubled by their view of the relative inaccessibility of doctors and the doctors perceived tendency to prescribe too readily. Both groups had a poor understanding of each others training and competencies and felt that this type of joint educational exercise helped to increase this understanding. Finally, both groups felt they would be helped by the establishment of local protocols for managing certain common conditions.

If such courses are to be promoted elsewhere we believe their success will depend upon the participation of a general practice organizer and a local pharmacist organizer working closely together and supported by prepared course material.

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Educational initiatives for patients

Sir,

The early stages of the government's current review of the National Health Service introduced the concept of 'good practice'[1] which despite many efforts has never been adequately defined. A new contract for general practitioners has now been imposed and internal markets will operate in which funds follow patients in a commercial atmosphere aimed at reducing costs.[2,3] Regrettably few constructive alternative proposals were ever voiced from either the parliamentary opposition parties or the profession which could have brought about the implementation of a negotiated review of the NHS.

Great emphasis has been placed on 'quality of care' but it was never in doubt that the majority of professionals loyal to the NHS are true carers and therefore possibly poor businessmen. It is regrettable that in a demand led organization no attempt has been made to re-educate the consumer who ultimately must pay for the service. Some of us have invested many years of professional time educating our patients in the appropriateness of prescribing treatment, the use of primary and secondary services, and in encouraging them to take greater responsibility for their own health. If it is the consensus view of government and the professions that limited funds should be targeted in the most effective and clinically appropriate manner, then perhaps the energy expended resisting any change to the status quo could be more effectively employed in a joint educational exercise aimed at the consumer.

We cannot expect all our patients to make reasonable and appropriate demands upon the limited resources of the NHS but we could place greater emphasis on educational initiatives aimed at improving the use of restricted services to the benefit of the provider, the consumer and the treasury.

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Diplomatosis

Sir,

There is currently a great deal of concern about the quality, quantity and appropriateness of teaching of general practitioner trainees while in hospital senior house officer appointments. It was for this reason that the third day of the 14th national GP trainee conference last year in Exeter was devoted to discussion of the issues raised by a nationwide trainee survey conducted earlier in the year (unpublished results).

The timely restatement of the Royal College of General Practitioners' policy towards education and training[1] leaves one in no doubt that the RCGP is committed to the principle of endpoint assessment of training so that patients can be assured of a general practitioner's competence. Although the MRCGP examination remains voluntary, it represents such an endpoint and this leads me to question the value of diploma examinations in certain core subjects such as child health, obstetrics and gynaecology and geriatric medicine.

The three year training period for general practice is short, given that trainees have a great deal of information to learn and attitudes and experience to acquire. Examination oriented work for diplomas may occupy a disproportionate amount of this time and when the examination is sat after only a short attachment in the specialty, most of this disruption will occur during attachments in other specialties or during the one year spent in general practice.

The survey undertaken prior to the 14th national GP trainee conference sent questionnaires to 3800 trainees nationwide and had a response rate of 42%. The results showed that the respondents had taken or intended to take the following diplomas: DRCOG 80%, DCH 44%, DGM 16%, FPCert 95%, others 16%.

Diplomas are described by the relevant colleges as an indication that the diplomate has reached a specific level of competence and experience in that particular specialty. However, the DRCOG, the family planning certificate and perhaps the DCH appear to represent a level of specialization and experience that is expected from a suitably trained future general practitioner. Therefore experience and competence in core subjects should be implied by success in the MRCGP examination, which should be structured to ensure this. Trainees should question their motives for taking these diploma examinations as the diplomas may represent duplication on their curriculum vitae rather than enhancement, and often at considerable financial cost and personal and educational disruption.

Diplomatosis was not welcomed by the delegates at the conference. It was felt that diplomas should only be considered important if they represented experience and specialization and that this level of competence should require a minimum of 12 months in an adequately supervised post to be of any value. Some diplomas, such as the DA, already have such a requirement. Otherwise diplomas represent no more than a convenient source of income to the respective colleges and an unnecessary expense and disruption to general practitioner trainees.

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Trainee assessment

Sir,

The paper on trainee assessment by Campbell and Murray (December *Journal,* p.507) is timely. Data from a study in the north western region supports their statement that 'there is little evidence that trainers are entering enthusiastically into assessment'.

A questionnaire survey of trainees was carried out in 1987 covering the general practice component of their training. Replies were received from 140 trainees out of a possible 177 (response rate 79%). Ninety trainees (64%) stated that their educational needs had been assessed at the start of the trainee year, the remainder were unaware of this having taken place. Subsequently only 79 trainees (56%) received feedback about their performance and continuing educational needs.

Seventy six respondents (54%) reported that their trainers had sat in on their consultations. Review of consultations using video recordings was used in only 64 cases (46%). Further analysis revealed that 62 trainees (44%) had not been observed consulting at any time, either by their trainer 'sitting in' or by video recording. This is a cause for real concern. The consultation is the cornerstone of general practice but many trainees are completing their training without their performance in this key area being directly observed, evaluated and discussed with them. It is to be hoped that in the three years since this survey the situation in the north western region has improved. However, more recent anecdotal evidence is not encouraging.

Given the recent statement of the Joint Committee on Postgraduate Training for General Practice that their training certificate is one of competence and not simply attendance,[1] and the increasing evidence of inadequate assessment of trainees,[2] surely the time is right for our expectations in the area of assessment to become more explicit. I am not arguing for a rigid national programme of assessment. Rather that each region and therefore every trainer, should be able to demonstrate clearly for individual trainees both the assessment methods used and the results obtained. I recognize that this is not a revolutionary proposal but if it becomes the norm then vocational training will have taken a quantum leap forward. Attention could then be turned to the problem of trainee assessment in hospital posts.

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Doctorates by thesis among GPs

Sir,

I was encouraged by W O Williams' observations and conclusions about British general practice theses from 1973 to 1988 (December *Journal,* p.491). We must hope that the apparent decrease in the number of MDs over the past 30 years is part of a normal variation rather than a statistically significant finding.

I am currently carrying out an MD in the protected environment of a practice based department of general practice; but I am aware that some of my full time col-