the qualification would be diminished. In addition, assessment would mean a much more subjective decision for the examiners than the awarding of marks for say, a multiple choice paper.

I would like to suggest a compromise: the awarding of the MRCGP(E) for those who pass the examination, and the MRCGP(A) for those who pass by assessment. In this way, the two qualifications could be distinguished, and each would have its own cachet.

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Outcome in smoking cessation

Sir,
The recent review of determinants of outcome in smoking cessation (June *Journal,* p.247) was informative and interesting. Dr Lennox succeeded in addressing issues of practical importance as well as recent research findings and theoretical hypotheses.

It is known that many psychiatric patients smoke. Psychiatric outpatients have been demonstrated to be more likely to smoke than a matched control group comprising people from the general population.[1,2] Similarly, it has been reported that 69% of psychiatric inpatients smoke.[3] There are many possible explanations for this. Dr Lennox indicated the importance of stress and coping skills in influencing attempts at smoking cessation; however, the importance of major depressive illness was not discussed.

There is evidence to suggest that people with a major depressive illness are more likely to smoke, and less likely to succeed in an attempt at cessation, than are people in good mental health or with an alternative psychiatric diagnosis.[4,5] The use of doxepin as an adjunct to smoking cessation has provided encouraging, but not conclusive, results.[6] The concept of self medication to alleviate symptoms, in which there is much current interest,[7,8] may in part account for these findings.

Hence, in a small proportion of people, failure to stop smoking may be symptomatic of a specific psychiatric disorder. For this group, benefit would be gained from specific antidepressant intervention. Indeed, Glass[7] has indicated that patients who smoke and who are unable to maintain cessation should be asked about depressive symptoms. This may become an essential aspect of the doctor's role in dealing with this problem.

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Treatment of non-melanoma skin cancers

Sir,
Readers should not be carried away by Dr Henry's letter (June *Journal,* p.261). Curettage and cautery may be largely a disregarded technique in Dr Henry's environment but it is not so in my environment or that of others.[1,2]

Histopathologists recommend tumour-free margins when lesions are excised and I would totally agree with this. With curettage this is not possible, but it is still an acceptable form of treatment for selected lesions, as stated in one of Dr Henry's references.[3] In the same article, it is stated that reported cure rates for primary basal cell carcinomas are in the range 90–100% regardless of the therapy used.

In another of Dr Henry's references curettage and cautery is a recommended treatment for keratoacanthoma.[4]

As regards a squamous cell carcinoma, it may be primary and if small, would be suitable for curettage. Alternatively, it may arise in lesions of Bowen's disease or solar keratosis. In these cases, where diagnosis may be in doubt, curettage is also suitable. In these types of lesions metastasis is virtually unknown.

In summary, I can state that careful and selective curettage and cautery is a very useful and highly effective form of therapy for non-melanoma skin cancers.

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GPs and work in the third world

Sir,
I agree with Dr Pearson that cooperation between the Royal College of General Practitioners and the Royal College of Surgeons to give those with the MRCGP additional surgical expertise before going abroad would be useful (letters, June *Journal,* p.260). However, I would suggest that the best way for a general practice trained doctor to be competent to treat surgical emergencies abroad would be to work on a supernumerary basis for approximately one month at the hospital where he or she will work or at a large district general hospital near where he or she will eventually work. This would also allow initial adaptation to the different culture, and the opportunity to learn about the local practice of primary health care.

While working in a large non-government managed rural hospital in Chogoria, Kenya, I arranged such training for expatriate doctors who were to work in smaller units and it was always greatly appreciated. In this way caesarian sections (the most commonly performed operation) and surgery for ectopic pregnancy could be learnt as well as general surgery.

Furthermore I am glad to report that having returned to work in Scotland I have been accepted on the relevant minor surgery list.

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