Putting research into practice

Sir,

The editorial by Fahey and Newton (July *Journal*, p.339) on the benefits and risks of treatment repaid careful reading, and leads me to ask whether more could be done to help general practitioners to help their patients in making decisions regarding treatment. The arguments in favour of using the number of patients to be treated as the best single measure of the usefulness of an intervention are persuasive, but it remains difficult in day-to-day practice to use such information.

What I would like to see is a published set of tables, based on reliable research and regularly updated, that would present data for absolute and relative risk, and number of patients to be treated, for those important clinical conditions for which the results of treatment have been established. Hypertension, hyperlipidaemia, heart failure and atrial fibrillation are obvious examples. The tables could be presented with data broken down by age and sex and could also take into account the interaction of risk factors, the implications of which are difficult to carry in one's head.

Does anyone know if such information is available in an accessible form? And if not, does anyone else think it a worthwhile suggestion?

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Your anxieties are shared: in her discussion paper in the October issue of the *Journal* (p.557) Penny Owen highlights clinicians' urgent need for information on the predictive value of symptoms and signs seen in everyday clinical practice. Owen calls for additional methods of presenting research information, that are clinician friendly, to be devised. A recent publication (*Effectiveness Matters*) produced by the NHS Centre for Reviews and Dissemination, University of York, may go some way to answering clinicians' needs. These easy-to-read bulletins summarize relevant research in specific clinical areas, for example, the use of aspirin in myocardial infarction (Editor).

Future of general practice: despair or hope?

Sir,

The increase in general practitioners' workload attributed to the 1990 contract and rising patient expectations have fuelled reports of low morale in the profession (editorial, May *Journal*, p.227). Poor recruitment, low morale and the recent dispute over night visits and the 24-hour commitment may be all that is required to produce the self-fulfilling prophesy of a profession in decline. It is a paradox that this occurs at a time when a health service led by primary care is within our grasp. The experience of two general practitioners in this practice attending annual meetings highlights this paradox.

One of us (R G) attended the annual conference of representatives of local medical committees. The flavour of the conference was one of unhappiness and low morale. General practitioners felt that their work was undervalued and that they were no longer in control of their workload. They did not want to continue their out-of-hours commitment, were unhappy about doing home visits, did not want to continue health promotion and were not interested in reaccreditation.

The less widely reported annual scientific meeting of the Association of University Departments of General Practice in Birmingham (attended by V D) suggests that there is an alternative view of the state of the profession. Attendance broke all previous records and slots for presentations in the parallel sessions were heavily oversubscribed. The prevailing mood was one of optimism based on creative and scientifically sound responses to the challenges confronting the profession in clinical practice and teaching.

These perspectives reflect more than the difference between optimism and pessimism. Increasingly polarized attitudes within the profession weaken our role as advocates for general practice and for our patients.

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Membership of the RCGP by assessment

Sir,

Membership examinations are used by the royal colleges of other medical specialties in the United Kingdom as a method of restricting the number of doctors entering a specialty. Examinations are difficult and failure rates are high. In contrast, general practice with its current recruitment crisis has no need to stem the flow of prospective practitioners. The Royal College of General Practitioners membership examination has a high pass rate and is, unfortunately, poorly discriminatory (I know five excellent general practitioners who failed the examination at the first sitting).

Membership by assessment as advocated by Baker and Pringle (August *Journal*, p.405) is thus a welcome proposal but surely should be introduced for all applicants rather than just for established principals. By abandoning the current examination the RCGP could devote more time to the real issues in general practice. Then maybe membership of the RCGP would be perceived as more useful to ordinary general practitioners, and the high percentage choosing to relinquish their membership might fall.

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MRCGP examination 1996

Sir,

If any process can be guaranteed to deter the already dwindling number of medical graduates from entering into general practice as a career, it must be the suggested changes for the 1996 examination for membership of the Royal College of General Practitioners and summative assessment proposals, details of which were distributed in an insert in the July issue of the *Journal*. A more daunting and confusing set of proposals I have yet to read. No one would dispute the ideology of improving the professional quality of tomorrow's general practitioners, but if there has to be an entry qualification to family practice let it be the MRCGP examination and be done with it. The examination should be able to encompass all of the requirements of summative assessment and so rid us of the ever increasing obstacles placed in the path of aspiring general practitioners.

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