situations are associated with strong emotions.

In an empirical way, I may suggest that the patient try to desensitize the area by stretching and by applying firm pressure. This idea corresponds to the first osteopathic treatment quoted by Williams: that of 'soft tissue techniques'. Such suggestions must be made having considered the patient's comfort with her own body and the possibility of underlying body fantasies, as well as her psychological tensions as reflected in the developing doctor–patient relationship.

Further study of the mechanisms of dysfunction as opposed to pathology would provide a scientific thrust for the much-needed paradigm shift towards body/mind doctoring.

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Pain: a functional disorder

Sir,

In the discussion paper on osteopathy (October *Journal*), Nefyn Williams puts forward the concept of back pain as a functional disorder. This concept originated from, and has long been integrated in, conventional thinking about back pain;[1] it is not an osteopathic idea as Williams would like *BJGP* readers to believe.

Williams goes on to discuss diagnostic osteopathic techniques without mentioning their (probably low) validity. (Asymmetry of movements or anatomy, for instance, has low specificity as these signs are also present in most people without back pain.) Williams then cites slightly outdated clinical evidence suggesting that chiropractic has been proven to work for acute (but not chronic) low back pain,[2] and states that 'an updated review is awaited'. Alas, an updated review appeared in 1996[3] and concluded that 'the efficacy of spinal manipulation for patients with acute or chronic low back pain has not been demonstrated with sound randomized clinical trials.'

Finally, Williams finds that, on the basis of all this, it is time for a 'paradigm shift' in favour of osteopathy. I ask myself whether this would truly be a paradigm shift or a shifty paradigm.

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The new-look *BJGP*

Sir,

I read with interest the new-style *Journal* but found that, as before, some of its contents were not relevant to me, a busy service general practitioner. Could a solution to this problem be that the *BJGP,* like the *BMJ,* has two separate editions: an education and research edition for those involved in teaching and research, and a general practice edition for the rest of us?

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MRCGP

Sir,

I write to you saddened and angry that there is to be yet another change to the MRCGP.[1]

Let me set the scene. I sat the MRCGP, along with five other trainees, in 1996. We formed a group and set to working towards the exam. We realized that examiners were looking for decent GPs rather than standard 'College' answers. We learnt to critically appraise, we learnt that there are several ways of looking at the same problem, each with pros and cons, we met every week from January to June and, as you would expect, we all passed.

I say this to assure you that there is no sense of sour grapes in what I have to say; so why my complaint? It is because of the impression that the examination gives of the College. I had an odd moment walking out of the examination room, knowing I had been well prepared, knowing I was a decent enough GP, and feeling 'I didn't expect that'. From that moment my opinion of the College fell. It was as if I was attempting to enter a College more proud of its examination than of its candidates. You have a wonderful quotation, made by Denis Pereira Gray, of the MRCGP as 'a lively institution, ready to review itself, ready to respond to the policies of the RCGP, ready to incorporate new ideas and new techniques in the light of evolving practice.'[2] If you had substituted 'obsessed with the need to', you would be spot on. However, I thought the point of the examination was to test for decent GPs with a lifelong commitment to education. I see no reason why an exam that constantly changes will be the one producing the most valid results. In fact, a good MEQ (modified essay question) may run as follows: 'An examination changes its structure as often as it can. Discuss the advantages and disadvantages of this approach with particular reference to its repeatability and reliability as a test and to the impression candidates will gain of the good sense of the institution they seek to join.'

There seems to be no thought given to the strategic importance of the MRCGP to the College. It is a new GP's first contact, and first impressions last. It is both demoralizing and daunting preparing for an examination when you have little idea of how you will be examined. Of course there needs to be change — the medical world is very different now to 1965 — but I question the wisdom of perpetual change that merely gives the illusion of progress.

I am somebody who loves general practice. I am passionately committed to the need for lifelong learning, but my commitment to the College is constantly undermined by the MRCGP, by its obsession with fashion as opposed to content, and by its need to be clever rather than to test.

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Romanian PGEA: doctors' dilemmas

Sir,

Our Romanian medical colleagues were cut off completely from the West for about 50 years; the cost of such professional isolation is incalculable and is to be added to the suffering already portrayed in our media under the violent communist dictatorship. The West has already helped with generous gifts of equipment but there is still a vast need to help rebuild the medical wisdom and experience that we take for granted with our plethora of magazines, lectures, and audit meetings.

For the second year running, a group of English GPs has recently organized a week of teaching in Brasov, with full PGEA approval. Accompanied by two consultants as expert teachers, we shared gynaecological and respiratory medicine with a group of Romanian GPs and specialists, concentrating particularly on the huge tuberculosis problem.

It is hard to portray the enthusiasm and delight with which we were welcomed. While grateful for the gifts and teaching themselves, our hosts were especially blessed by the presence of professional colleagues.

It seemed to be a new experience for them to have the opportunity to grow in medical confidence and stature through sharing everyday management problems. They are used to didactic lectures and dry textbooks, but small group work with equal colleagues is a new way of learning, giving hope and encouragement for individuals at their point of need.

Therefore, the greatest gift we feel that we can give them after 50 years of such suffering is the opportunity to learn. We hope to arrange repeated PGEA courses out there, and to invite colleagues from nearby countries as well. In addition, we see great value in opening up opportunities for Romanian colleagues to travel to England to observe and participate in our hospitals and general practices, noting that this will require a healthy trust fund to cover air fares.

Our hearts went out to these charming, amusing, and highly intelligent doctors. With the cost of food approaching that in the United Kingdom, it is humbling to discover that a senior doctor earns only £50 a month. It is poignant to note that the £800 fee for PGEA approval represents 16 months' Romanian medical salary; equivalent in England to well over £60 000. Perhaps our senior UK colleagues in authority might graciously consider passing on the fee to our Romanian hosts for future conferences, which the doctors of both countries eagerly anticipate.

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Managing depression: cognitive behaviour therapy training for GPs

Sir,

We read with interest Moore's views on improving the treatment of depression (September *Journal*), and agree that there is much to gain from improving the acceptability and availability of existing treatments,[1] particularly with reference to cognitive behaviour therapy (CBT).

In the past years we have been extensively involved in the development of an educational training package in CBT specifically designed to meet the needs of GPs in the treatment of depression and anxiety. Preliminary results of a pilot study evaluating the educational training package in CBT appear optimistic, and suggest that GPs who had undertaken the training seemed to be better at identifying depression and made fewer referrals to other mental health services and hospital psychiatrists compared with those GPs who had not.

We feel that there is potential in the use of the training package in CBT and its use in addressing the great burden that depression places on primary care resources. We are currently conducting a randomized controlled trial to fully access the potential advantages of the educational training package in CBT as an intervention to improve the effectiveness[2] in the routine care of patients with depression and anxiety. We will be reporting the results in due course, but are happy to discuss any aspect of the educational training package in CBT or the trial with interested readers.

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GPs' views about out-of-hours working

Sir,

Bain *et al* (September *Journal*) report results from the first year of operation of a GP cooperative in Dundee.[1] We recently undertook a survey of GP principals in Lambeth, Southwark, and Lewisham that provides further evidence of the way that new arrangements are affecting a GP's quality of life, morale, and job satisfaction, and influencing concerns about out-of-hours services.

The questionnaire included open and closed questions about current out-of-hours arrangements, satisfaction, and concerns. Following reminders, a response rate of 68.5% (285/416) was achieved. Of these, 73% (208) were cooperative members (established in April 1996), and 25% (70) used a deputizing service.

Most responders (82.2%) were satisfied with their current arrangements, and 90.1% (245) thought that their patients were at least as satisfied as a year ago. Widespread satisfaction with the quality of care provided was reported (98%; 272), reflecting findings from a comparative evaluation of a GP cooperative in 1995.[2]

The new arrangements appeared to be leading to improved quality of life; for example, family/social life had improved for 78.1% (213) of respondents. Issues of concern included uncertainty about when to visit, high workloads on shifts (for cooperative members), perceptions of rising demand and need for patient education, safety (for those doing their own on-call), and costs of service provision (for deputizing service users).

Of particular interest was the considerable agreement on priorities for future service developments (Table 1). This related particularly to the need for GP training in telephone consultation skills. Inter-agency