determined efforts by a wide range of professionals on all sides of the medical profession, particularly those with academic responsibilities. We owe this to the "endless oceans of talent and enthusiasm [that] have been lost to the profession" and to ourselves if we are to maintain the title of "the caring profession."[1]

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MRCGP: examining the exam

SIR,—Dr Fiona Godlee commends the Royal College of General Practitioners for opening its doors to outside scrutiny of its examinations.[1] She claims that this sends an unmistakable challenge to other colleges to do the same. She will be reassured to know that two years ago the Royal College of Surgeons of England, while in the midst of a major review of its examinations, did precisely what she suggests.

The college asked a non-medically qualified professor of education with a special interest in examinations to observe and comment on the fellowship examinations, including the clinical examinations and vivas. He was also invited to attend the examiners' meetings. His detailed report contained a large measure of approval of the techniques used, several criticisms, and many innovative ideas. The college now employs the professor on a sessional basis to help implement his suggestions, to advise on developments, and to monitor the changes that are being introduced.

I think it is now generally acknowledged that examinations should incorporate current educational ideas about assessment of knowledge, skills, and attitudes. As is often the case, the surgeons are in the forefront of the introduction of new ideas and just get on with the job without making a fuss about it.

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1 Godlee F. MRCGP: examining the exam. *BMJ* 1991;**303**:235-8. (27 July.)

SIR,—Having just passed the MRCGP examination I was interested to read about how my examiners had been scrutinised before they even saw me.[1] Dr M J Evans should take hope from the fact that when I received my results I was given my marks in all five aspects of the exam.[2] Had I failed, at least I would have known which aspects to improve next time. Like Dr Susie Waterman, though, I am uneasy about the number of postgraduate exams general practitioners are "expected" to take.[3] The long string of letters after the name on the consulting room door may look impressive to the patient, but does it really make for a better general practitioner?

It is high time that there was one exam for general practice, and that is the MRCGP exam. Our physician and surgical colleagues seem happy with one set of letters, so why not general practitioners? One reason might be the view of some of our hospital colleagues, not always refuted by general practitioners, that the MRCGP is an inferior qualification—"a bit of a Mickey Mouse exam" was how I once heard it described. Is this why so many budding general practitioners turn to the Royal College of Obstetrics and Gynaecology and the Royal College of Physicians to supplement their qualifications with a DRCOG and a DCH, seeing these as "proper" exams?

Dr Fiona Godlee's article may go some way to dispelling the myths about the ease of the MRCGP exam,[1] but the Royal College of General Practitioners needs to continue to press for just one exam for general practice. A start would be to make the MRCGP a prerequisite for any principal in general practice.

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Drugs, HIV, and prisons

SIR,—Drs Michael Farrell and John Strang call for "a radical rethinking of the role of the judicial system in managing drug misusers."[1] Their estimate that there are 225 to 450 drug users who are seropositive for HIV in English prisons—together with Messrs Stephen Dye and Chris Isaacs's finding that 22 of 29 prisoners who had misused intravenous drugs in Saughton prison in Scotland admitted having shared needles while in prison,[2]—gives ample support to their plea. What a pity that Drs Farrell and Strang were unable to provide a lead that was in any sense radical.

For 15 years the Geneva prison has operated a five to 10 day programme of detoxification with methadone.[3] Although the seroprevalence of HIV among those undergoing this programme is 45%, no claims are made that the programme reduces injecting in prison; it is justified on humanitarian grounds as it allows prisoners to defend their rights and interests in an optimal state of mental health.

The opioid antagonist naltrexone blocks the effect of opioids and has proved useful as an adjunct to prevent relapse.[4] Detoxification followed by supervised administration of naltrexone would offer far greater protection from relapse than detoxification alone. Maintenance treatment with methadone is an alternative for those unwilling to undergo detoxification. Compliance with programmes of detoxification and treatment with naltrexone or maintenance treatment with methadone could be confirmed by analysis of urine and rewarded with remission of sentence or linked to continued compliance as a condition of parole, or both. Costs incurred would be more than offset by the shorter time spent in prison.

Prolonged abstinence from opioids is hard enough to achieve in those well motivated for detoxification; we do not believe that results will improve merely with the carrot of one week of detoxification with methadone and the stick of imprisonment.

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SIR,—I am grateful to Drs Michael Farrell and John Strang for mentioning Holloway prison in their editorial on drugs, HIV, and prisons.[1] This is the first time that the prison has been complimented since Smith's fairly favourable article two years ago.[2] All those who work at Holloway prison, however, are surprised at the misinformation that "detoxification with methadone was introduced in Holloway in 1987." It was introduced in the late 1970s or early 1980s but certainly long before 1987.

I work in a unit in Holloway prison that sees 160-170 pregnant women each year. About 10% of these women misuse drugs (opiates) whereas the national average for drug misuse is one in 500. The detoxification programme in each case depends on the gestation and the extent of abuse. Each woman is detoxified within an average of 12 weeks, but patients' compliance is essential to achieve the target. Obstetric variables are monitored by regular ultrasound scans. The women have a better performance during labour, and the paediatricians are informed about the drug misuse and the detoxification regimen they are undergoing.

All our blood tests are done through the Whittington Hospital, where we take the facility of anonymous testing of pregnant women for HIV with their consent. I am quite reassured by the fact that in our hospital one in 1100 samples (not one in 275) are positive for HIV.

I also have some help from the Terrence Higgins Trust, which sends representatives to brief the pregnant women on the current issues related to HIV and AIDS so that more women agree to counselling before undergoing voluntary testing for HIV, although the risk of transmission from mother to fetus is only between 13% and 35%. The women are all provided with educational leaflets routinely.

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1 Farrell M, Strang J. Drugs, HIV, and prisons. *BMJ* 1991;**302**: 1477-8. (22 June.)
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SIR,—As HIV infection continues to spread in the general population it is important to monitor changes in its prevalence in people who continue high risk activities. Intravenous drug users, who constitute a large, mixed section of society, will probably be the most important group of people to be infected in the immediate future. Drs Michael Farrell and John Strang refer to estimated figures for the numbers of prisoners in England and Wales who are positive for HIV antibody.[1] Most of these will be drug users.

HIV is a problem in large urban conurbations, but London has a disproportionate number of infected people. Brixton prison, with about 1000 inmates, many on remand, is in an area of socio-economic deprivation, drug misuse, and sexually transmitted diseases. About 150 inmates, mostly drug users, request an HIV antibody test each year; 10% have a positive result. Recently, a method of testing dried blood spots, obtained by pricking a finger, has encouraged more testing, being less physically and psychologically traumatic than venepuncture, especially for drug users with absent peripheral veins (paper presented at meeting of Medical Society for the Study of Venereal Diseases, Heidelberg, 1991). Being quick, cheap, and safe, it is ideal for large studies of seroprevalence. Markers of hepatitis and syphilis can also be detected.

I agree with Dr Rosemary J Wool that all verbal claims of HIV seropositivity should be confirmed