shown would be equivalent to (and hence would obscure) about two weeks and six months of normal weight gain in babyhood and mid-childhood respectively; when being weighed, infants should be naked and children should wear minimum clothing compatible with modesty. Despite the expensive apparatus featured in the photographs measurements of height as shown would be only an approximation of the true value, making any later inferences about rate of growth meaningless.

At a time when paediatricians and the government are trying to promote high quality child health surveillance such illustrations serve only to underline how much basic education still needs to be given to those who should know better.

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Health in Gaza

EDITOR,—Readers may be interested to learn of aspects of health in Gaza other than those mentioned in recent letters.^{1,2} A recent survey by Unicef reported a fall in infant mortality in Gaza from 76/1000 in 1978 to 40/1000 in 1991, with mortality in children aged under 5 falling from 105/1000 to 52/1000.³ Both rates for 1991 are below those in Egypt (62/1000 and 85/1000 respectively).

An immunisation programme implemented jointly by the government health service and the United Nations Relief Works Agency (Unrwa) has led to the control or eradication of diseases that are prevented by vaccines.^{4,5} Preventive, ambulatory, and inpatient services in the government health service are free for children up to the age of 3; this includes treatment in Israeli hospitals when services are not available locally.

Monitoring of growth, education about nutrition, oral rehydration, and iron and vitamin supplementation of children are part of routine care for children provided at 28 primary care centres operated by the government in the Gaza strip. Child health has benefited from improved living conditions: the proportion of homes with chlorinated running water increased from 14% in 1972 to 51% in 1981 and 93% in 1992; the proportion with an electricity supply increased from 35% in 1972 to 98% in 1992.⁵

The new surgical building at Shifa Hospital in Gaza provides excellent operating theatres and recovery rooms; modern anaesthesia is provided by local doctors trained in Israeli teaching hospitals. Referral to Israeli hospitals for medical and surgical care not available locally continues on a wide scale. For example, in 1992, 116 children from Gaza had heart surgery or investigations for heart conditions in Israeli hospitals. Many other medical and surgical patients, including patients with injuries sustained in the intifada, are referred to Israeli hospitals.

Palestinian doctors and nurses and other health professionals have received extensive professional training in Israeli teaching facilities since 1985. Currently 36 doctors are in training programmes in a wide range of medical and surgical specialties in Israeli teaching hospitals, including 14 in anaesthesia alone.

The health services in Gaza have continued to operate and to develop despite the intifada. Trained drivers drive the ambulances and have permits for unhindered movement to Israeli hospitals, even during curfews.

Israel has offered to transfer the health services operated by the civil administration to a Palestinian autonomous entity as part of negotiations toward peace. Organisations or governments wishing to help improve health conditions in Gaza can contribute to the building of the new non-government hospital (to be run by Unrwa) or extension of the municipal sewage networks.

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Counselling failed exam candidates

Plenty of room for improvement

EDITOR,—Robert Jones perceives that he has suffered at the hands of amateurs.¹ The Royal College of Anaesthetists may be one of the first medical colleges to offer counselling to candidates who have failed their examinations, but it does not seem, on the evidence presented, to have served Jones very well. Furthermore, since the Royal College of Anaesthetists claims an interest in the whole of Britain, and in the standards of anaesthesia everywhere, it is not helpful to single out two extremely pleasant places as “very peripheral,” where, it is implied, a lower standard of staff anaesthetists would be acceptable. This also flies in the face of the college's policy of encouraging staff grade applicants to possess the fellowship diploma.

Counselling sessions are not usually made as public as this one, and I will be surprised if an official response is made. Nevertheless, if counselling is to be offered to mature postgraduate students in Britain some improvement must be made, and a public debate in the *BMJ* might help. In addition, proper feedback to candidates might eliminate the need for amateur counselling.

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- 1 Jones R. Counselling or cancelled? *BMJ* 1993;306:1764. (26 June.)

Candidates choose when to stop

EDITOR,—I was disappointed to read Robert Jones's personal view of the counselling he received after applying to take the part 2 examination for fellowship of the Royal College of Anaesthetists, especially as I was involved in the counselling session to which he refers.¹ Candidates for the part 2 examination (the part concerned with physiology and pharmacology and related basic sciences) are counselled only after they have repeatedly failed the examination. Candidates are not stopped from taking the examination, and it is always left to them to make their own decision. Without counselling, a candidate would not be allowed to withdraw from the examination at such a late stage and would not be refunded the examination fee.

I do not wish to personalise my comments, and Jones does not indicate how many times he has

failed the part 2 examination. Most candidates pass on either the first or second occasion. Thereafter the distribution curve is skewed to the right, with some candidates still unsuccessful after 10 or more tries. We now insist that applicants making their fifth attempt are counselled, though as this is a comparatively recent innovation many candidates have attempted the examination many more times.

We have thought for some time that it is not in the interests of the candidates for them to become “chronic failures,” and the counselling session is used to discuss with candidates why they think they are failing and if there is anything they (not we) can do about it. A candidate's previous performance is crucial to the discussion. It can easily be appreciated if the failure is due to poor factual knowledge, which will result in low marks in the multiple choice questions, or to difficulty in presenting their knowledge, which will result in poor grades for the viva; poor factual knowledge is more usual. The logbook of clinical experience is largely irrelevant to this discussion. If factual knowledge is limited after many attempts it is always tempting to suggest a more radical solution. It is worth noting that the college tutor nearly always agrees fully with the counsellors' opinions.

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A happier experience

EDITOR,—My experience of counselling by the Royal College of Anaesthetists is in direct contrast to Robert Jones's.¹ Having failed the part 3 examination for fellowship of the college on four occasions, I was contacted by the college and asked to arrange a date for counselling before being allowed to sit the exam again. The time and date were left to my discretion. Initially I was upset by this requirement. The counselling would take place only two to three weeks before I next sat the exam, and I was annoyed at this interruption to my studies. I then began to look at this more positively and decided that the college was trying to help.

The meeting took place at the Royal College of Anaesthetists. While waiting in the examinations office with another trainee awaiting counselling I was offered coffee and made to feel at ease. This atmosphere continued when I was greeted by the two counsellors in another room, where I was again offered coffee and biscuits. The counsellors explained the purpose of the meeting clearly and made me feel that they were indeed trying to help. They had all my examination results to hand, and they also read the questionnaire completed by my college tutor that I had taken with me.

They asked a number of relevant questions and highlighted several points that might be contributing to my difficulty in passing the exam. They made a few suggestions, and I was encouraged about my abilities to pass the exam. They also said that they would be writing to my college tutor with recommendations. We did not discuss future career prospects. The session took twice as long as was planned. I found it to be a positive experience.

I was given 10 days to consider whether to sit the exam immediately or to wait until the next sitting. I decided that waiting was more appropriate as this gave me time to implement the suggestions made at the meeting. I passed the exam at the next sitting. I believe that the counselling made a great difference to my overall approach and that it should continue.

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- 1 Jones R. Counselling or cancelled? *BMJ* 1993;306:1764. (26 June.)