predictor of date of delivery (August Journal, p.322). As the authors suggest, accurate prediction of estimated date of delivery has profound implications for a pregnant woman. However, so does the increasing medicalization of pregnancy. We do not believe that this paper’s conclusion, to ignore dates derived from last menstrual period once a scan date is available, is adequately supported by the study or wise in an era of increasing maternal empowerment, as recommended by the Winterton report.1

Two flaws in the method are apparent: first, no correction for cycle length was made; and secondly, the performance of the scans is likely to have been enhanced by the use of unblinded scanners and a protocol of repeating all scans with a discrepancy of over one week. The combined effect of these biases is likely to far outweigh the benefit or error (five to seven days) when the scan dating was found to be significantly more accurate.

The study makes firm recommendations based on an analysis of only 116 pregnancies, suggests that litigation could be appropriate for those who choose not to follow them and has ignored any costs to the women involved. We agree that an accurate estimated date of delivery is important in many cases, but with no clear benefit from a debatable improvement in estimating the due date and no measure of the impact or loss of trust that may result should the date not be accurate these recommendations should not be accepted. Obstetrics is a subject where many modern techniques have become routine before their adequate assessment, and this trend should be reversed not encouraged.2 4

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References

Minor surgery

Sir,
The editorial on the potential pitfalls of minor surgery in general practice (September Journal, p.358) raises many important issues, principally about training. It paints an unnecessarily bleak picture of minor surgery in general practice, and ends with a threat about the imposition of guidelines.

Almost any review on minor surgery in general practice raises the issue of inaccuracy in pre-operative diagnosis. McWilliam and colleagues’ study is most frequently cited but the findings require careful interpretation. Only 5% of general practice specimens submitted for examination were malignant compared with nearly a fifth of hospital based cases. McWilliam makes the presumption from this data that most malignant lesions are correctly identified by general practitioners and appropriately referred to specialists. What the authors of the editorial fail to mention is the additional fact that 16% of lesions in this study were completely excised by specialists, who carry out these procedures daily as one of their core tasks.

The authors of the editorial correctly make the point about the lack of confidence of vocational trainees in carrying out minor surgery: this could probably be said about their confidence in any aspect of primary care. In quoting Chew, who identified the subtle difference between confidence about performing an operation, and competence to do so, the authors failed to quote Dowling, who summarized the inappropriate self-confidence in skills in house officers with regard to resuscitation, urethral catheterization and cardiotocography.2 3 Thus, the issue of competence is not one that is exclusive to training in minor surgery, but extends across professional attitudes to training in many activities at this level of junior doctor.

Minor surgery has been carried out in general practice since before the start of the National Health Service and is likely to continue to do so. The authors of the editorial correctly point out the need for formalization in training, but these issues are well addressed in the guidelines for minor surgery in general practice drawn up jointly by the General Medical Surgeons Committee, the Royal College of General Practitioners, the Royal College of Surgeons of England and Edinburgh, and the Joint Committee on Postgraduate Training for General Practice. Far from an outside authority imposing the regulations on general practitioners, the different branches of the profession are collaborating constructively in a process where both general practitioners and their surgical colleagues will draw up guidelines for training, accreditation and review of competence in the future.

Such is the increase in minor surgery activity presently taking place in primary care it would be difficult to envisage a situation in which this was all transferred to the secondary sector. Patients do not want this, the evidence is that it is not cost effective, and appropriate professional action is now being taken to ensure that competence and further education in this activity is assured.4

The real issue which may still damage the future of minor surgery in general practice is not addressed in the editorial: it must surely be a matter of time before the first litigation surrounding an inappropriate minor surgical procedure dissuades general practitioners from their current enthusiasm for the activity.

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References

Assessment at last

Sir,
In his editorial (October Journal, p.402) Pereira Gray outlines the welcome move towards ‘the principle of individual endpoint assessment of all vocational trainees.’ He also points out the differences between formative and summative assessment, and stresses the need to keep these separate. However, I would suggest that the endpoint assessment to which he refers should be both — summative assessment marking the end of formal training under supervision, and also formative assessment, an opportunity to assess further training and support needs, and areas of strength that may be built on, shared and developed with others.

One of the weaknesses of the British medical education and training system is that it has been based on a time-serving process with summative assessment that, at best, tests a narrow range of skills and knowledge, and at worst allows students to get away with second-guessing the examiner on which aspects to revise out of the huge range of existing knowledge.
New ‘transparent’ assessment methods make explicit to both student and assessor not only the content of the assessment, but also the criteria by which success or lack of success will be measured.1 They are based on criterion rather than norm referencing, and are tackling some of the problems associated with more traditional forms of examination. The four parts to the proposed endpoint assessment of trainees, based on tests of factual knowledge and problem solving, practical work, evaluation of clinical and consulting skills, and the trainer’s overall assessment,2 will, hopefully, follow this pattern.

It is self evident that there is a need to ensure the safety of trainees about to leave the training arena to become fully fledged, independent practitioners. But why let the assessment process stop there? In the light of the decision of the Joint Committee on Postgraduate Training for General Practice to introduce assessment for trainees,3 general practice has the opportunity to create an assessment system that can be both formative and summative in function. It can be based not on merely local, or even regional perceptions of a competent new general practitioner as suggested by Pereira Gray, but could be agreed nationally. With a national agreement on the standards embodied in such an assessment, the profession could establish an agreed definition of ‘competence’ in general practice, in line with reviews of training being carried out by other professions.4 Current discussions relating to reaccreditation of general practitioners indicate that the issue is already one which is occupying the minds of many.5 Such a framework of defined competence would allow students, trainees and practising general practitioners to work in a structured and self directed way towards achieving those standards. The endpoint assessment of trainees may then become a point on a continuum of training and development that begins with undergraduate training and ends at retirement.

Agreeing what such a continuum could look like would be arduous, but its existence would create a validity for the professional status of general practitioners, that could only be beneficial for both doctors and their patients. As change is on the way, it would be a shame to stop half way and miss this opportunity to create a national framework for assessment for all general practitioners.

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Sir,
I wish I could share Pereira Gray’s upbeat view of compulsory summative assessment of vocational training (October Journal, p.402). He particularly welcomes the idea of an objective examination at the end of training. In contrast, I believe that the words of another strong RCGP protagonist, the late John Stevens, are as valid now as they were in 1973: ‘Subjective and peer evaluation is of infinitely greater value than any so-called objective assessment. I believe it to be wholly wrong ever to prepare a trainee for an examination… To do so is an admission of educational failure’.1 It was Marinker, a distinguished former RCGP examiner, who pointed out the dangers of examinations in controlling the curriculum of training.2 I shudder at the thought, for example, of trainees practising videorecording their consultations with the idea of ‘passing’ in mind, rather than as part of a professional ethos of self criticism that does not stop the day training finishes.

From all over the country we hear of applicants to general practitioner training schemes being as scarce as oases in a desert. Is the prospect of another major compulsory examination likely to improve recruitment? Of course the public needs to be protected from incompetent doctors but, even if the proposed objective assessment were to work, it could well weed out the odd bad doctor at the price of a huge shortage of general practitioners. And there really pressure from the public for such a “bizarre rite de passage”? Pereira Gray admits that the details still need to be worked out. I share his admiration for many aspects of the MRCGP examination, but translating that examination to a compulsory endpoint assessment of training is more than a detail. Presumably the examination would have to be criterion referenced. This alone would alter its whole concept as it would be necessary to define precisely what standard is required to achieve a pass. I imagine there would be an outcry if the pass rate remained of the order of only 75%. If the standard is to be lowered, how is this to be done? How would the examiners feel about running an examination of a very different character and which might no longer be linked with RCGP membership? I, for one, will not be applying to become such an examiner.

‘I am horrified when I think of the rigidifying influence and sheer waste of resources in erecting an examination industry to process well over 500 candidates each’.3 1994 would be a landmark year for me if instead we used those resources to try and restore the morale of our profession. Only then can we adequately serve the public.

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References

Videotaping consultations for assessment

Sir,
The efforts of those seeking to formalize the assessment of general practice trainees are to be applauded. However, the long awaited discussion paper arising from the west of Scotland pilot project must be viewed with disappointment (October Journal, p.430). It fails adequately to justify the videotaping of live consultations, a technique which represents an unacceptable intrusion into the unique and intimate environment of the consultation.

To have cited the results of Martin and Martin does nothing to dissipate the ethical objections of many within and without the medical profession.4 This study is often quoted by proponents of videorecording of consultations, but it is inherently biased, as patients would potentially be influenced by an impression that their doctors’ participation rendered this to be an acceptable or desirable technique. Also of interest is the finding that 11% of those who consented disapproved of recording.

A recent survey of patients’ attitudes to videotaping of consultations has found that approximately half would feel under pressure to participate in a videotaped consultation.5 A significant majority anticipated feeling uncomfortable during such a consultation, said that they would find it either difficult to extremely difficult to forget that it was being recorded, and would not be able to discuss their problem(s) fully with the trainee.