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 brief period (during an error of 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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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 incompletely 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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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 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.