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Burnout

Sir,

I was interested in Ruth Chambers' editorial about avoiding burnout in general practice (November *Journal,* p.442). The pressures on general practitioners can be divided into a number of different areas. First, there is the stress of providing a readily accessible service, day and night, to the patients in the practice. That is what most of us anticipated as we entered medical school, and regard and welcome as our proper professional role. Incidental and vital to such a service is the establishment of good relationships with colleagues, both medical and non-medical, in the practice and the setting up of a well organized management structure. Naturally, indispensable to all this is a satisfactory, fulfilled and supportive domestic ambience. In addition, we must all, as individuals, ensure that we take steps to keep up to date across the whole spectrum of general practice.

Primary care in the 20th and 21st centuries requires a considerable input into the organizational structures above individual practices, to the benefit of all. It is only fair, therefore, that general practitioners should take their turn in representing their colleagues on National Health Service committees, and play their part in running postgraduate training and education, and generally pulling their weight in the organization of the Royal College of General Practitioners, the British Medical Association and local medical societies.

I think the general public acknowledges that the obligations of general practice outlined above constitute a full, even overburdened existence — far more so than those of, for example, lawyers, accountants, bankers and most business people. No wonder some of us burn out. Those of us that do not often do so at the expense of our cultural and social lives, with much less time for recreational reading, visits to the theatre or generally playing our part in the community.

You will recognize, of course, that the huge additional burdens of the new contract for general practitioners have not yet been listed. There is no need to enumerate them, for we are all only too well aware of them. It seems to me extraordinary that no reference was made to them in the editorial. Burnout is a concept of the last few years, and is clearly getting more common. If a vessel is full to the brim, and more is added to it, it can accommodate the extra either by overflowing or by springing a leak. Put another way, our reaction to trying to cope with the intolerable stresses of the last three or four years is either to burn out or to water down our erstwhile professional standards, in addition to encroaching on our domestic and social life. A critical difference between a general practitioner in the NHS and those in the professions mentioned is that the latter are able to limit their workload, and we clearly cannot.

SAMUEL PRIESTMAN

5 Church Street
Woolley
Bath BA1 8AS

Sir,

Ruth Chambers is right to remind us of the stresses from the kind of work that general practitioners do (editorial, November *Journal,* p.442). My departure from general practice at the age of 55 years has resulted in many general practitioners opening their hearts to me about their frustrations. This self-selected group rarely express as their main problem frustration 'by working in a partnership that is resistant to change or unwilling to invest in more practice resources'. These doctors, like me, suffer from stresses outside the practice. The year on year underfunding of the National Health Service, hugely increased in the last decade, means that we cannot get for our patients the services that we see that they need.

Mr X may cause us 'heartsink' but all too often it is not Mr X that is the problem, but the fact that he has been found on the floor again and is unable to get up unaided, incontinent and needs to be admitted to hospital. The heartsink is the awful knowledge that there are either no hospital beds available for Mr X, or that one will be found for him but that bed will be the one that was being kept for Mr Y, another patient who was booked in for the following day for the third time to have his triple bypass operation.

The enthusiasts for the NHS reforms may genuinely believe that the internal market will improve services. One certain effect of them, however, has been to shuffle the responsibility for the effects of underfunding from the shoulders of the government onto local doctors and managers. It is the helplessness that general practitioners feel when landed with the responsibility for telling patients that they cannot have treatment because it has been cut by the government, which is the source of the burnout, as well as the source of other symptoms of stress such as heart attacks, nervous breakdowns or addiction.

Virginia Bottomley tells us general practitioners that we are responsible for preventing heart attacks. Well, I have taken her advice and prevented my own heart attack by leaving general practice.

RICHARD STONE

15 Blenheim Road
London NW8 0LU

Chronic pain

Sir,

I read the paper 'Evaluation of a cognitive behavioural programme for rehabilitating patients with chronic pain' (December *Journal,* p.513) with interest and admiration. Management of chronic pain is a daily challenge for the rank and file general practitioner and this stimulating original paper made a lot of sense.

It is surprising that behaviour therapy, so well established in Sweden and the United States of America has not caught on in the United Kingdom for the management of chronic pain. This is despite the fact that the role played by perception and belief in the aetiology of chronic pain is not disputed.[1-3]

For some reason this paper has remained low profile; it has escaped the radar screens of the lay media especially the women's magazines which often provide advice on such matters. Despite this I believe that if these results could be substantiated by others, we could be observing the signal of a new dawn in the management of patients with chronic pain.

K A JAFRI

202 Barlaston Old Road
Trentham
Stoke-on-Trent
Staffordshire ST4 8HL

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Estimating date of delivery

Sir,

We should like to answer Dowell and Astburys' criticisms (letters, January *Journal,* p.42) of our paper.[1] We do not accept their view that routine ultrasound scanning has been introduced into antenatal care before adequate assessment. While there may be no measurable improvement in outcome of pregnancies which continue beyond viability, routine ultrasound scanning is effective in detecting fetal abnormality.[2]

Dowell and Astbury agree with us that an accurate estimated date of delivery is important. They do not, however, believe that our conclusion, to use the scan estimated date of delivery in preference to the last menstrual period estimated date of delivery, is valid. They imply that our sample size was too small; we were at pains to explain how we ensured it was not. Our results are in line with several larger hospital-based series.[3-5]

It is alleged that our methodology was flawed in two ways. First, because we did not correct our last menstrual period data for cycle length. There is great variation in cycle length, not only between women but also from one cycle to the next in individual women. Approximately one third of all cycles in adult women depart by more than three days from the individual's mean cycle length.[6] One study of women's menstrual charts showed that 28-day cycles occur no more than 16% of the time.[7] Of the 106 women in our study 62 (58%) opted for 28 days as their commonest cycle length. Just as many women's given date of last menstrual period is inexact,[6] uncharted cycle length information tends to be unreliable.

During recruitment we performed a preliminary analysis correcting for cycle length; it made no improvement to the accuracy of the last menstrual period estimated date of delivery. We have now reanalysed the complete dataset with a cycle length adjustment where applicable equal to the reported commonest cycle length minus 28 days. Overall, adjustment seems to have made the last menstrual period estimated date of delivery less accurate, rather than more; for example, the mean error of the last menstrual period estimated date of delivery was 2.6 (standard deviation 10.3) days before adjustment, and 3.2 (SD 10.5) days after it. The scan was significantly ($P<0.05$) more accurate than the adjusted last menstrual period estimated date of delivery when the error was between five and 10 days, compared with between five and seven days before adjustment. However, when the discrepancy between the scan and adjusted last menstrual period estimated date of delivery was 13 days or more, the performance of the last menstrual period was marginally better than before; nevertheless, the scan estimated date of delivery was consistently more accurate in at least 75% of cases when the discrepancy was eight days or more. Our data therefore indicate that cycle length adjustment is likely to be of no benefit in improving the accuracy of the last menstrual period estimated dates of delivery, and could make them less accurate.

Secondly, we are criticized because the radiographers were unblinded to the study and scans with a discrepancy of more than one week were repeated. Since the scan-based estimated dates of delivery were by definition calculated prospectively, the unblind nature of the scans would have no effect on their accuracy. Similarly, we can see no logic in the assertion than rescanning in cases of uncertainty would necessarily improve the accuracy of the scan estimated date of delivery. Some of the repeat scans would have been performed later than 24 weeks' gestation when it is well known[6] that scans are less accurate in predicting the estimated date of delivery than earlier in pregnancy.

SAM ROWLANDS

Ivel Medical Centre
35-39 The Baulk
Biggleswade
Bedfordshire SG18 0PX

PATRICK ROYSTON

Department of Medical Physics
Royal Postgraduate Medical School
Hammersmith Hospital
Ducane Road
London W12 0NN

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Summative assessment

Sir,

Having recently passed the MRCGP examination a year after completing my trainee year, I am glad that circumstances led me to leave the examination preparation until after the trainee year was finished. During the trainee year I had the opportunity and time to put together my own programme of training under the guidance of my trainer. The preparation time I put into the examination would have seriously affected this opportunity.

The present drive towards summative assessment, however framed, will result in what will be seen as an examination, and its content will be seen as the curriculum for the year. Trainees will lose the time and opportunity to develop their individual skills, and the essence of the trainee year which I so valued will have been sacrificed. We do not need to find out if trainees are able to pass examinations, as this has been proven many times over at university.

I agree that a wide spectrum of abilities exists in general practice, but I have seen little evidence that the tests being devised are aimed at identifying specific deficiencies in those less able, more at testing the small minority of attributes that are testable in a reproducible and valid way.

I predict that imposing this development will further exacerbate the recruiting problem for our branch of the profession. General practitioner trainees opposed summative assessment at their last national conference, and their call for a survey of trainees' views has been turned down by the General Medical Services Committee (Medicopolitical digest, *British Medical Journal* 1993; **307:** 330). I hope the experiences of those of us who have recently come through the system are sought and listened to.

MILES MACK

Muircroft
Jamestown
Strathpeffer
Ross-shire IV14 9ER