that some of these women will avail themselves of screening, if the smear is taken by a nurse. It is inappropriate to imply that anyone taking a smear without also undertaking a pelvic examination is offering an inferior service.

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Stinging nettles for osteoarthritis pain of the hip

Sir,

Dr Randall reports the use of stinging nettles in the treatment of osteoarthritis, and asks whether the effect is akin to acupuncture (letter, November *Journal,* p.533). My colleagues at the Centre for Complementary Health Studies have plenty of examples of the use of counter-irritation, and it seems that only Western doctors are unfamiliar with it, although liniments and rubefacient (literally 'make-red') ointments are listed in the *British national formulary.*

Acupuncture itself is not often practised as a counter-irritant by Western doctors, who in fact try hard not to let their patients feel the pinprick.[1] They either use guide-tubes, or practise swift insertion with a spinning action; it is only when the needle is advanced into subcutaneous or muscle tissues that the patients detect a 'needle sensation', which is a heavy pressure or dull ache.

On the other hand, traditional Chinese acupuncturists use a special plum-blossom needle, with several short points mounted on a flexible handle,[2] to redden the skin over arthritic joints; and one experienced doctor sends his patients home with a supply of acupuncture needles and instructions to peck repeatedly over their painful joints, every day, for pain relief.

Counter-irritation is well established in traditional medicine, and various topical treatments were used by Galen and Hippocrates to treat pain. The active ingredient of nettles is formic acid, which is also produced by insects; bee-stings have been fashionable in the treatment of arthritis, and cantharid plasters (which contain the bodies of Spanish fleas) are still available, in Germany at least.[3] Caustic chemicals and vesicants such as croton oil have also been used to raise blisters and 'draw out the toxins'. Moxibustion is a method of warming the skin by burning a herb to produce erythema and blistering.[2] Baunscheidt is a treatment offered by naturopaths in Germany: after the initial pricking with a special multiple needle, an irritant oil is rubbed into the punctured skin.[3]

Most of these therapies are applied locally, and presumably work on the spinal cord gate mechanism. However, gypsies in the south of France treated back pain by cauterizing the ear[4] (which is the origin of auricular acupuncture), and this has led to the concept of 'diffuse noxious inhibitory control'.[5]

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Leicester assessment package

Sir,

We were interested to read Dr Rutt's letter (November *Journal,* p.535) commenting on our paper about the Leicester assessment package.[1]

The Leicester assessment package consists of six separate but related sections. The explicit aim of our study was to test the face validity of one of these, namely the prioritized criteria of consultation competence as measures against which performance could be judged.[1] This was made clear in the title and in the introduction. Testing its validity/reliability[2] and utility/acceptability[3] as an assessment tool required different studies. Furthermore, we are not aware of published evidence of proven reliability and validity of 'tools we already possess' referred to by Rutt.

The course organizers were not just asked 'Do you agree with us?', but were given the 'opportunity to reject any of the proposed categories, components or weightings; to suggest additional categories or components... and to propose amendments to the suggested weightings'.[4] We cannot agree with Rutt, therefore, that our chosen methodology was an 'established but misleading ploy'.

We fully agree with Rutt that there is need to study the thought processes as well as the behaviour of consulting doctors. Indeed, teachers/assessors using the Leicester assessment package are required to probe the consulting doctor's thought processes by asking specific questions at various stages of the consultation to 'become better aware of the reasoning behind the doctor's actions...' (Leicester assessment package guidelines for use, p.6). Consequently, using the package, it is feasible 'to ascertain... whether the trainee really has considered "physical, social and psychological factors as appropriate"'. Furthermore, medical educators on both sides of the Atlantic have long recommended the need to 'explore cognition as well as action' of doctors.[4,5] This is an area, therefore, that the medical profession has addressed even if it may not have done so as a whole.

We also agree with Rutt that assessment should be 'an integral part of the teaching process', which is why the Leicester assessment package has been designed for both formative (educational) and summative (regulatory) purposes.

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Sir,

We are writing in response to the points raised by Campbell and Murray (letter, November *Journal,* p.535) on our paper on the reliability of the Leicester assessment package.[1]

As stated in the results section, the statistical analysis was carried out on the absolute scores for each case allocated and not on the rank ordering of candidates, as Campbell and Murray contend.

Furthermore, one of us (H M) was involved in a study (yet to be published) with multiple assessors using the Leicester assessment package to assess the performance of 10 trainees in simulated surgeries, in which the package proved to be reliable. Thus, we do not believe that our claims for the reliability of the Leicester assessment package 'give a misleading impression'.

They also comment on our choice of study subjects. The package is meant to be used to assess general practitioner trainees and principals for both formative and summative purposes. For formative purposes, it is intended for serial use throughout the vocational training phase (and later). Inevitably, all newly appointed general practitioner vocational trainees will have had little or no general practice experience. Accordingly, the choice of a hospital doctor who was soon to become a general practitioner vocational trainee was quite justified, since it reflected what would happen in the real world. It should also be remembered that the subjects of the reliability study were the assessors and their use of the Leicester assessment package, and not the consulting doctors. As a consequence, the experimental design required a range of capability of the consulting doctors in order to test the ability of the package to differentiate between capability across a wide range including the pass/fail margin.

We had originally considered using trainees with similar experience, as suggested by Campbell and Murray, but felt this could be a possible confounding variable. Such a group of doctors would be more likely to produce a narrow range of scores which could spuriously enhance claims for reliability on behalf of the package.

In turn, we are also puzzled by the comment by Campbell and Murray that the package does 'not offer any suggestions as to what score in the package would equate to minimal acceptable competence' and their claim that 'the system relies on rank ordering which would inevitably result in failing a fixed percentage of candidates...' if used for summative purposes. The full Leicester assessment package — a copy of which was sent to Professor Murray in November 1993 — contains explicit criteria for the allocation of marks and clearly includes a score 'which equates to minimal acceptable competence', that is 50%. Thus, the Leicester package is criterion- rather than peer-referenced and would not inevitably result in failing a fixed percentage of candidates, as claimed by Murray and Campbell. Alternatively, any examining body using the package for the summative assessment of consulting performance would be free to set its own pass standard as the Leicester assessment package returns absolute scores across the whole range of competence.

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MRCGP examination

Sir,

I have just taken, and survived, the examination for membership of the Royal College of General Practitioners. While awaiting my results I reflected on whether I benefited from taking the examination. Among recent vocationally trained general practitioners, it seems almost a knee-jerk reaction to take the examination to mark the end of training, although so far, this has not been a requirement to entering general practice. I have been a full-time principal for four years, and feel that my experience of general practice has prepared me well for this examination.

Surprisingly, after only four years into practice I was beginning to feel I had become set in the way I worked. My original enthusiasm was running at half strength, and my mind was distracted by other non-medical preoccupations. I felt this was a good time to sit the examination. I heaved a sigh of relief to find that the threatened videotaped assessments had not yet arrived, and that my original resuscitation certificate was still valid. I joined all the courses available at the time, and I am glad I did, because they provided some ideas about how to prepare for this examination.

Having spent four months studying and then finally taking the examination, has it been worth the effort? The answer must be 'yes'. I have done a small proportion of my study from textbooks, but the majority of work was spent reading relevant (and sometimes irrelevant) articles from the past two years of the *British Medical Journal* and this *Journal.* These are journals which previously sat in their wrappers collecting dust in several disorganized piles at home and in the office. Now, they are in disorganized piles in my study, but well-thumbed through. The amazing thing is that the habit has not stopped simply because the examination is now over.

The MRCGP is a relevant examination for general practitioners. Studying for it has increased my knowledge not only about clinical topics but also on current issues facing the National Health Service, the reasons behind new initiatives imposed on us from the government, what else we may come to expect, and what are the 'hot topics' under discussion. This is important in the face of rapidly deflating morale in general practice. If we have an understanding of the many changes which are happening, I feel we could cope with them better.

The other important feature of the examination is that it tries to increase interest in research and critical thought. As a fellow examinee once wrote, everything was simple and straightforward until he attempted the MRCGP examination. Perhaps a progression would be to consider the various masters programmes in general practice which are now available. Have I been drawn to academic practice?

What are the current drawbacks of the examination? Taking it straight after vocational training may not be appropriate. Vocational training is essentially hospital based, apart from the trainee year. I do not feel the trainee year prepares sufficiently for the rigours of full-time practice. After four years in practice, I am still finding out new facets of general practices which are challenging and which stretch me as a practitioner. The suggestion of a two-stage examination may be worth considering: a clinically based written examination at the end of the trainee year to test clinical competence, followed by an examination similar to the present one after three or four years in general practice. This will not only ensure clinical competence at entry into general practice but also will maintain it at least for the early formative years.

Dare I say it, but perhaps the current passing level to go forward to the orals could be raised so that perhaps 50–60% of candidates are invited rather than the current 80%. This would stretch the candidates more and also, importantly, would increase the credibility of the MRCGP. Being members of the RCGP should be a mark of excellence and the examination currently is in danger of getting a reputation of being an easy examination.

Regardless of the result I feel I have benefited by simply participating and I congratulate the RCGP examiners for formulating such a relevant and educative examination.

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