improve their prescribing and save money. He also gives a good account of the mechanics of creating a formulary for their use. However, the summary of the article says that the 'estimated saving resulting from the creation of the formulary was £150 000 (£3000 per doctor) per year.' There is no evidence in the article that it was the creation of a formulary rather than the hard work of a number of doctors that caused the money to be saved. Others have saved money without formularies.

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Summative assessment for GP registrars

Sir,

Dr Grant's letter on behalf of the Tayside Trainers (June, p373) surprised us, as all of the issues raised have been widely discussed and debated. Perhaps talking to their neighbouring region could have prevented the concern. The first point was about insufficient consultation: widespread consultation took place via the Joint Committee and the UK. Advisers as early as 1992, and our original paper[1] appeared in the College *Journal* in 1993. The only part which has changed since that paper is the detail of the trainers' report and this is a change which we are sure the trainers welcome. The second point concerned a challenge to the process. This has already taken place within the West of Scotland and the system has been fully operational since August 1993. Our experience has been passed to the other regions and we have also been responsible for training the other regional assessors in the various techniques. Sixteen publications have appeared in the peer-referenced literature, which includes correspondence in the learned journals related to these publications. Under 'Critical Reading Policy' the Tayside trainers criteria states 'selecting relevant medical literature as part of keeping abreast of developments in medicine': in view of this, the lack of knowledge of summative assessment is surprising.

As far as the MCQ is concerned, it would be logical to use the multiple choice paper of the MRCGP in summative assessment. We approached the College in 1993 to see if this was possible and indeed we ran a pilot study together. However, the College refused further use of the question bank and would only permit the use of the MCQ by candidates taking the whole exam. In the absence of an alternative test of factual knowledge, this would mean that the MRCGP exam would be compulsory for all prospective GPs. As a result, we approached the Royal Australian College of General Practitioners who agreed to provide the UK Advisers with their question bank. The major difference between the question banks is that the MRCGP exam contains more items on epidemiology, research methods and administration than that in use for summative assessment. Since the summative assessment paper is about minimum competence, we would suggest that this is appropriate. The UK Advisers' exam has now been taken by over 1000 candidates with a pass rate of 97% and a pass mark carefully set at the level of minimum acceptable competence. Details of setting the pass mark are in press.[2]

In addition, it is worth noting that the RACGP exam has published reliability data on its exam which the UK College has never done.[3]

The next point regarding sufficient assessors is puzzling, as the number of people who attended our preparatory courses from Tayside was way in excess of their regional requirements. Regional Advisers have also worked very hard in identifying funding for the delivery system. The concern about summative assessment dominating the GP registrar year is unfounded, but there is no doubt that the GP registrars will be concerned if trainers are unaware of the process. Summative assessment is about minimal competence, and the content is based on the work of a general practitioner and should not in any way interfere with the GP registrar year. To deliver the various components, however, personal organisation is important and planning is required throughout the year.

We agree with the final point regarding medico-political and educational manoeuvrings being frankly unacceptable: at present the only provider of a complete package of summative assessment is the UK Conference of Regional Advisers, and their concern about standards. However, the Regional Advisers have had a high degree of co-operation from the GMSC, RCGP and JCPTGP. We hope the Tayside trainers are reassured by the facts. It is important that our discipline has a credible entry standard for independent practice and summative assessment will provide that.

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Psychiatric illness in General Practice

Sir,

With regard to the editorial in the June issue of our *Journal* (page 327–328) concerning the identification of psychiatric illness in general practice. I think the time is about ripe to introduce some totally new ideas about mental health into general practice.

Until now our guiding light has come from the psychiatrist, who believes that mental illness is something that is wrong with the brain. By and large we are taught that all psychiatric disorders are due to a deficiency of drugs. What is missing is scientific data concerning the mind as opposed to the brain.

We talk of body, mind and spirit, and then make the assumption that the mind is a function of the brain and the soul or spirit is some sort of electric circuit in the frontal lobes of the brain. In other words, we reduce the parameters of science to that of the body, with its brain and with its higher centres of the brain; i.e. body, body and body.

Looked at in these rather harsh terms, we find ourselves stuck down a cul-de-sac which leads nowhere.

Scientific data does now exist concerning the mind and the mechanisms of mental aberration in a subject called dianetics. Perhaps our *Journal* could bring this fact to the attention of the practising GP.

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Chronic pain in dementia – underdetected or undertreated?

Sir,

Although about 4000 papers are produced annually on the subject of pain, less than 1% are confined to older people.[1] Pain is

known to be accompanied by significant psychiatric morbidity[2] and may be a precipitant to suicide in older people.[3] In a pilot study aimed at setting up a 'pain management group', a retrospective case note study was performed on 40 consecutive referrals to the service by local general practitioners. In all cases, documentation was made of all medical diagnoses and medication. Results of all radiological investigations performed within the past year were also sought. Patients were asked if they had experienced any pain within the past week, and, if so, for a description of its severity; in cases where cognitive impairment was suspected, patients' reports of pain were corroborated by relatives/carers.

Of the 40 referrals, 31 were women and 9 were men; ages ranged from 70 to 94 years (sd ±6). A total of 23 out of 31 people had experienced pain within the previous week, but there was no association with age or sex. Osteoarthritis (confirmed by radiological changes) was the commonest suspected aetiology associated with pain, accounting for 15 out of 23 cases. In 7 out of 23 cases, no analgesics had been prescribed within the past month. In all these cases the pain was described as being constant during the previous week (confirmed by descriptions from a carer/relative), and all 7 had a diagnosis of dementia. Although people with cognitive impairment were less likely to have been prescribed analgesics, this was not statistically significant (possibly because of the small sample size). However, the finding does raise the issue of detection and treatment of pain in dementia. Cognitive impairment may result in both the under-reporting of pain and poor compliance with analgesic treatment as a result of memory disturbance. It is possible that, in many of the cases above, treatment for pain had been attempted on previous occasions, but aborted.

Although it is known that the incidence of painful medical illnesses increases with age, and that there was no control group in this study, the finding that a large proportion of those with dementia have chronic pain without analgesia calls for similar studies aimed at examining the detection and treatment of pain in people with cognitive impairment by general practitioners.

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Fragmentation of the health service and the future of general practice

Sir,

At the recent RCGP scientific symposium in Aberdeen, the plenary on the future of general practice presented four views: an alliance between public health and primary care, the political fragmentation of the health service and primary care, the relationship between research and service general practice, and a registrar's view including the rural/out-of-hours debate. The future may seem uncertain, but the present looks chaotic. Attempts to draw parallels between primary and secondary care does not help matters. There are other uneasy alliances: recruitment and the profile of associates, guidelines and equity, and joint clinical managerial posts; and other uncomfortable issues: the internal market, the increasing role of nurses and the increasing accountability of health care professionals.

It is claimed that we are in a cultural transition marked by a quest for diversity; 'never again one voice' echoes the poet Michael O'Siadhail.[1] In our changing culture, we must resist the fragmentation of general practice threatened by the myriad of conflicting demands and constraints. In doing so there is a real danger that we will create a 'flat' plurality which irons out diversity: a featureless, visionless and unimaginative profession. Alternatively, there is the possibility that we shall experience a new Babel — a great project to build a new general practice — but alas, our diversity becomes merely an instrument of division: a divided, directionless and frustrated speciality.

Each of the views proffered in the RCGP symposium plenary session is limited and can provide only a partial answer to the question of the future of general practice. A hallmark of our evolving culture is the movement towards polyvocalism, in which organizations are held to account and consumer views are fed into policy making. One result of such a move will be to qualify the phenomenon of increasing consumer expectations. The College's task is to embrace all of the views and possible answers to the question of its future and to balance diversity with unity. Paradoxically, the diversity experienced at Babel retarded the inevitable iniquity that arises as a society or organization progresses.

Like an adolescent, the College is interested in forming relationships before it has the courage or confidence to do so: the discussions on the future of general practice need to be brought out from behind the bike shed. There will never be uniform nor fair solutions to the apparent chaos but there will always be uniting aims, values and principles to which the College must remain true.

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The DCCH examination

Sir,

I recommend to fellow members of the RCGP the Diploma in Community Child Health examination organized by the RCP(Edin), RCGP and Faculty of Public Health Medicine. It is especially suitable for GPs in the UK and overseas. Very detailed paediatric knowledge is not tested; however, a positive attitude to evidence-based child health promotion and a lot of common sense are needed.

I like this examination for several reasons: it is highly relevant to general practice; it boosts candidates' interests in quality assurance and audit; it is well organized. Playing with the children, and even an infant, in the Objective Structured Clinical Examination is much fun. Moreover, it gave me an excuse for a much needed vacation.

Any GP who enjoys working with children will benefit greatly from taking this examination.

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