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Summative assessment

Sir,
Lennox attempts to trivialize the message conveyed in our paper[1] in his letter to the editor (August *Journal*). Far from 'undetected sophistry', the Joint Committee, as a result of its regulatory reaccreditation visits to all regions in the United Kingdom, recognizes that there is a major problem in the profession's acceptance of audit as a routine mechanism to practising quality care.

Our published works are the only academic studies describing the reality of audit in training practices, warts and all. It gives us little pleasure to highlight such findings, except for the hope that serious debate about rectifying this dire situation will ensue.

Audit, as part of summative assessment, and in particular of a critical attempt to analyse such audits through an objective assessment tool, has given some insight into the scale of the problem of implementing audit. Consider the facts shown in Table 1.

The fact that 15% of registrars required two attempts at their audit project, and that even after this 3% still could not achieve minimum competence, is worrying indeed. One-to-one interviews with these registrars implicated their trainer's advice.

Quoting from the Christmas issue of the *BMJ*, noted for its light-heartedness, will not deflect from the seriousness of our profession's ambivalence towards assessing quality of care.

If there is a better way, let's see it.

Published or be damned.

Table 1. Results of summative assessment.

Year	Registrars finishing summative assessment	Audits requiring resubmission	Audits failing after resubmission
1995	102	10	4
1996	103	24	5
1997	98	12	1
Total	303	46 (15%)	10 (3.3%)

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Reference

1. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.

Training for audit

Sir,
I write regarding the conclusions of a recent article by Lough and Murray entitled 'Training for audit: lessons still to be learned' (May *Journal*).[1] I have much experience in research and research methodology and have concerns about how summative assessment is being assessed.

This article, which sends out a warning to GP trainers, concludes that 'trainers are failing to recognize basic audit methodology using a marking schedule they themselves help to design.' This does not fill me or my GP registrar colleagues with confidence in trainers' teaching and in those marking audit projects submitted as part-fulfilment for summative assessment. How can a GP registrar, having submitted an audit project, accept the decision of trainers marking the project in whom knowledge of audit methodology has been assumed[2] as first being accurate (whether the project is passed or referred), and secondly as being fair in light of the findings presented by Lough and Murray?[1] Moreover, accuracy and fairness become even more important if, as Lough and Murray point out, the trainers marking audit projects are unaware that they are deficient in recognizing basic audit methodology and, if I might say, the differences between evidence-based audit and research.

I also wonder to what degree such inadequacies apply to the assessment of consultation skills when videotaped consultations are submitted for summative assessment.

I and my colleagues feel that urgent action is required to ensure that only trainers with proven expertise are used as assessors to guarantee accuracy and fairness in marking, Otherwise there is indeed a risk of the much criticized summative assessment becoming a farce rather than a test of so-called competence.

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References

1. Lough JRM, Murray TS. Training for audit: lessons still to be learned. *Br J Gen Pract* 1997; **47:** 290-292.
2. Baker R, Thompson J. Innovation in general practice: is the gap between training and non-training practices getting wider? *Br J Gen Pract* 1995; **45:** 297-300.

Sore throat

Sir,
Howe's paper regarding the use of penicillin in sore throats (May *Journal*)[1] has a flaw that can be found in all similar studies when applying them to general practice.

The study compares penicillin with placebo. In general practice, the option is whether to prescribe an antibiotic or to give appropriate advice.

I would acknowledge, of course, the importance of the education of patients in the appropriate use of medical services and simple home treatment. It is a pity, however, that it would not be possible to perform a blinded study comparing penicillin with advice. If, in such a study, those patients prescribed penicillin fared better, then perhaps, considering the evidence that patients who received placebo fared better than those who received pencillin,[1] we should start prescribing placebo!

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Reference

1. Howe RW, Millar MR, Coast M, *et al.* A randomized controlled trial of antibiotics on symptom resolution in patients presenting to their general practitioner with a sore throat. *Br J Gen Pract* 1997; **47:** 280-284.

Like mother, like daughter

Sir,
We were glad to see the letter from Gbolade (August *Journal*) written in response to our paper.[1] We felt, however, that it deserved comment.

The suggestion is made that the social and sexual milieu is different for today's teenagers, and that, because of the more liberal attitudes to such events, more teenagers continue their pregnancies. Although it is true that today's teenagers are probably starting sexual intercourse at an earlier age,[2] this is not reflected in the number of teenagers becoming pregnant: of 1000 women aged 16–19, 19 fewer conceived in 1992 compared with 1969. Far more of today's teenagers have their pregnancies terminated than was the case in their mother's generation. We calculated that in England and Wales the actual births to teenage mothers in this age group in 1992 totalled only 53% of the births in 1969.[3]

The second point made is that the pregnant teenagers may also have a father who was a parent as a teenager. This is a possibility, and for some of the girls in our study, which was part of a much wider study of teenage pregnancy in general practice, this was actually the case. However, finding fathers is far more difficult, and many of the girls no longer lived with their natural father.

As mentioned, this was a much more detailed study (Seamark C. MPhil thesis, University of Exeter, 1996) than there was room to publish in a brief report. The medical notes of both the girls and the mothers were carefully searched, and the knowledge of their GP was also sought. There were no suggestions of sexual abuse or incest being responsible for any of the pregnancies in the present day teenagers, nor did it feature in the records of their mothers, although it is an interesting hypothesis.

We agree that no one study should be seen in isolation, although this was probably one of the most detailed studies of teenage pregnancy undertaken from a general practice perspective. We hope we have also managed to correct some commonly held misconceptions on the level of teenage pregnancy in this country in the 1990s.

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References

1. Seamark CJ, Gray DJP. Like mother, like daughter: a general practice study of maternal influences on teenage pregnancy. *Br J Gen Pract* 1997; **47:** 175-176.
2. Wellings K, Field J, Johnson A, Wadsworth J. *Sexual behaviour in Britain.* Harmondsworth: Penguin, 1994.
3. Office of Population Censuses and Surveys. *Birth statistics.* [FMI 1969-1992.] London, HMSO (published annually).

Folic acid supplements and NTDs

Sir,
The study by McGovern *et al*[1] is very welcome, as it highlights the issue of poor compliance with the Department of Health guidelines regarding the use of folic acid supplements to prevent neural tube defects (NTDs).[2] It is clear that women's knowledge and use of folic acid supplements has increased since the guidelines were first issued.[3] However, if one considers that neural tube closure is complete by the end of the fourth week of gestation, the proportion of women taking supplements at a time when they are most likely to be useful remains disappointingly low.

On the basis of the results of NTDs that have been prevented, it would seem prudent that we continue with a broad-based health education campaign regarding the potential benefits of folic acid prophylaxis, but focus discussion on the importance of taking supplements before conception and early on in the pregnancy. One way of achieving this would be to develop the concept of a 'critical period' in relation to neural tube formation.

Folic acid prophylaxis is a primary prevention intervention of proven efficacy and is therefore a health promotional activity that warrants our support.

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References

1. McGovern E, Moss H, Grewal G, *et al.* Factors affecting the use of folic acid supplements in pregnant women in Glasgow. *Br J Gen Pract* 1997; **47:** 635-637.
2. Chief Medical Officers and Chief Nursing Officers of the UK. *Folic acid and neural tube defects: guidelines on prevention.* London: DoH, 1992.
3. Clark NAL, Fisk NM. Minimal compliance with the Department of Health recommendations for routine folic acid prophylaxis to prevent neural tube defects. *Br J Obstet Gynaecol* 1994; **101:** 709-710.

Psychosomatic medicine

Sir,
The paper by Nefyn Williams (October *Journal*) has far-reaching importance for psychosomatic medicine. The idea of somatic dysfunction, as opposed to pathology, is crucial for doctors and their patients. The author makes little reference to emotional causes of hyperexcitability, but the neurological work he refers to could provide the beginning of an explanation of the mechanisms whereby people experience their emotional pains within their bodies.

Working in psychosexual medicine, I see many women with dyspareunia in whom no pathological cause can be found. Careful examination of the introitus often reveals areas of tenderness, which may be anterior, lateral, or posterior. Such hypersensitivity may follow an attack of thrush, childbirth, or an episode of painful intercourse owing to lack of arousal. All these