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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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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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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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

situations are associated with strong emotions.

In an empirical way, I may suggest that the patient try to desensitize the area by stretching and by applying firm pressure. This idea corresponds to the first osteopathic treatment quoted by Williams: that of 'soft tissue techniques'. Such suggestions must be made having considered the patient's comfort with her own body and the possibility of underlying body fantasies, as well as her psychological tensions as reflected in the developing doctor–patient relationship.

Further study of the mechanisms of dysfunction as opposed to pathology would provide a scientific thrust for the much-needed paradigm shift towards body/mind doctoring.

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Reference

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Pain: a functional disorder

Sir,

In the discussion paper on osteopathy (October *Journal*), Nefyn Williams puts forward the concept of back pain as a functional disorder. This concept originated from, and has long been integrated in, conventional thinking about back pain;[1] it is not an osteopathic idea as Williams would like *BJGP* readers to believe.

Williams goes on to discuss diagnostic osteopathic techniques without mentioning their (probably low) validity. (Asymmetry of movements or anatomy, for instance, has low specificity as these signs are also present in most people without back pain.) Williams then cites slightly outdated clinical evidence suggesting that chiropractic has been proven to work for acute (but not chronic) low back pain,[2] and states that 'an updated review is awaited'. Alas, an updated review appeared in 1996[3] and concluded that 'the efficacy of spinal manipulation for patients with acute or chronic low back pain has not been demonstrated with sound randomized clinical trials.'

Finally, Williams finds that, on the basis of all this, it is time for a 'paradigm shift' in favour of osteopathy. I ask myself whether this would truly be a paradigm shift or a shifty paradigm.

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The new-look *BJGP*

Sir,

I read with interest the new-style *Journal* but found that, as before, some of its contents were not relevant to me, a busy service general practitioner. Could a solution to this problem be that the *BJGP,* like the *BMJ,* has two separate editions: an education and research edition for those involved in teaching and research, and a general practice edition for the rest of us?

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MRCGP

Sir,

I write to you saddened and angry that there is to be yet another change to the MRCGP.[1]

Let me set the scene. I sat the MRCGP, along with five other trainees, in 1996. We formed a group and set to working towards the exam. We realized that examiners were looking for decent GPs rather than standard 'College' answers. We learnt to critically appraise, we learnt that there are several ways of looking at the same problem, each with pros and cons, we met every week from January to June and, as you would expect, we all passed.

I say this to assure you that there is no sense of sour grapes in what I have to say; so why my complaint? It is because of the impression that the examination gives of the College. I had an odd moment walking out of the examination room, knowing I had been well prepared, knowing I was a decent enough GP, and feeling 'I didn't expect that'. From that moment my opinion of the College fell. It was as if I was attempting to enter a College more proud of its examination than of its candidates. You have a wonderful quotation, made by Denis Pereira Gray, of the MRCGP as 'a lively institution, ready to review itself, ready to respond to the policies of the RCGP, ready to incorporate new ideas and new techniques in the light of evolving practice.'[2] If you had substituted 'obsessed with the need to', you would be spot on. However, I thought the point of the examination was to test for decent GPs with a lifelong commitment to education. I see no reason why an exam that constantly changes will be the one producing the most valid results. In fact, a good MEQ (modified essay question) may run as follows: 'An examination changes its structure as often as it can. Discuss the advantages and disadvantages of this approach with particular reference to its repeatability and reliability as a test and to the impression candidates will gain of the good sense of the institution they seek to join.'

There seems to be no thought given to the strategic importance of the MRCGP to the College. It is a new GP's first contact, and first impressions last. It is both demoralizing and daunting preparing for an examination when you have little idea of how you will be examined. Of course there needs to be change — the medical world is very different now to 1965 — but I question the wisdom of perpetual change that merely gives the illusion of progress.

I am somebody who loves general practice. I am passionately committed to the need for lifelong learning, but my commitment to the College is constantly undermined by the MRCGP, by its obsession with fashion as opposed to content, and by its need to be clever rather than to test.

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