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MRCGP

Sir,

I was saddened to read St John Livesey's letter (December *Journal*). In any examination like the MRCGP, where we are looking for excellence rather than just a minimum level of competence, the examiners need to stretch the candidates to find out just how good they can be. If every candidate has the same level of questioning, then the more able candidates will not have an opportunity to shine. As a result, in the oral examinations some of our candidates may feel surprised at the depth of questioning that they experience. However, they are only being questioned at this depth because they are doing well. It is likely that this is what happened in the case outlined in St John Livesey's letter.

The changes that we are bringing into the examination are certainly not being introduced for reasons of fashion, or because we want to appear clever. When developing the changes we were at all times very careful to take particular note of the needs of candidates. Indeed, we talked to a large number of candidates about their hopes and expectations about the exam. To date, our changes have been greeted with near unanimous support — only an absurd optimist would expect total unanimity. Nevertheless, I do take Dr St John Livesey's comments very seriously and have shared these with the examination board. We genuinely value feedback, however negative it might be.

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Evidence-based health care

Sir,

Rarely if ever, in discussions about evidence-based health care, is the hypothesis

even considered that the doctor, and not the intervention he or she prescribes, is more likely to materially affect the outcome of a consultation. Psychotherapy research is beginning to produce evidence that it is often the 'effect' of the therapist and not the 'effect' of the therapy that it is likely to produce favourable outcomes. I believe this to be true also of the profession of medicine as a whole.

The psychological components of many patient illnesses is thought to contribute up to 50% of the symptoms presented, and careful categorization often fails to 'label' more than 50% of illness presented to GPs by patients.

My own observations over nearly 40 years of doctor-watching have certainly convinced me that some doctors are naturally therapeutic and some are certainly not so. Until this matter is addressed and researched, I can see that using evidence-based medicine to inform practice will have mixed outcomes. It could be that a doctor, naturally therapeutic, following no protocols or guidelines, could nevertheless manage to influence consultation outcome more favourably than a poorly-communicating or psychologically-impaired doctor who slavishly applies the medical intervention decreed by the most advanced evidence base. I suspect that this is likely to be so. Surely we need to attend to those factors that influence 'therapeutic' power, other than evidence base that informs practice, if we are really to learn how to practice 'effective' health care.

I believe we need to be sure that all the evidence available to inform our practice is used, including those psychological components that seem to be absent from much of the literature presently generated by the evidence-based health care lobby.

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Teenagers' views on seeking contraceptive advice

Sir,

The paper by Donovan *et al*¹ highlights the difficulty that teenagers feel in seeking contraception advice from their general practice surgery, with only 159 of the 1074 responders indicating that their GP was their preferred source. I agree that it is important that consideration be given to enable teenagers to more readily attend the GP surgery for information and supply of contraception, including condoms. GPs are able to offer both sexual health and contraceptive information and advice, but are only able to prescribe oral or depot contraception or contraceptive devices in spite of repeated calls for a procedure to make condoms available.^{2,3}

A number of unpublished reports and one published⁴ report on GP distribution of condoms agree that, given staff training and support, GP surgeries are an appropriate setting for distributing condoms. However, cost-benefit analysis has suggested that they should only be available to those at high risk in sexual health terms.⁵ It would seem appropriate that high risk should also include the newly and potentially sexually active patients.

In a pilot project in one health authority, 16 practices were supplied condoms, funded from an HIV/AIDS budget. Staff collected data about the consultation with 766 patients, to whom they distributed a total of 12 665 condoms. Half (52%) of the patients were aged under 25 years and 378 patients (49%) were being supplied with condoms for the first time, with nearly a quarter not using any form of contraception at the time.

Nearly half the men (47%) who received condoms in a GP consultation did so in a travel clinic, compared with only 8% of the women; nearly half the women (47%) received condoms in family planning consultations, compared with 22% of the men. Sixty-five per cent of the 20 patients under 16 years of age received condoms in a family planning consultation, compared with 44% among the patient group as a whole.