the patients, giving them permission to change treatment and, in particular, to increase inhaled steroids as their lung function falls.

Martys misquotes our study in saying that the peak flow meter is not crucial to managing asthma. We considered that both peak flow meters and symptoms play an important part in self management by teaching the patients the importance of their symptoms and what action they should take.⁶ This is best achieved by written self management plans linked to diary cards and reinforced by colour coded labels on the peak flow meter.⁷

The Darley Dale clinic saw 78 patients in one year with six monthly review. Our clinic ran for nine hours a week and monitored 115 patients in a year with a median of four consultations with the nurse and one consultation with a doctor. The overall consultation rate did not change, but the redistribution in work resulted in a halving of emergency steroid courses, nebulisations, and absenteeism.

Martys recognises that gathering information about a patient's condition does not necessarily change the management of asthma. Unless we can develop techniques that result in steroids being taken in the right doses and at the right time then little is likely to change.

IAN CHARLTON
GILLIAN CHARLTON

Kincumber 2251,
New South Wales,
Australia

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Videotaped interviews with children suspected of being sexually abused

SIR,—M R Wiseman and colleagues report that agreement between professional groups and a consensus rating was good when raters were asked to assess the likelihood of child sexual abuse on the basis of videorecorded interviews with children.¹ There are several reasons, however, for thinking that their study overestimates the level of agreement that will generally be found during such assessments.

Firstly, the design of the research tends to maximise the chances of agreement since, as they point out, the cases were not randomly selected and the professionals rating the videos were highly experienced.

Secondly, their study of videotaped interviews is mainly a test of the reliability of the criteria used to define the probability of sexual abuse. In clinical practice there will be additional variability arising from differences in the amount and quality of other information that raters have (such as direct interviews and statements). Such information was available only to the consensus panel in the authors' study.

Thirdly, the statistic that the authors use to assess agreement, the raw percentage agreement, does not correct for the fact that 50% agreement

would occur by chance. If the data in their first table are reanalysed with a statistic that corrects for chance agreement, the κ statistic, then the level of agreement for all groups is 0.71, less than the 0.85 raw agreement calculated from the same data.

Thus the level of agreement in routine clinical practice is most unlikely to be any higher than the authors report, and for the reasons given above it will probably be much lower. Even if the level of agreement in practice is just 0.2 lower, at a κ coefficient of 0.51, there would be disagreement on a considerable number of cases. For instance, two professionals rating 100 videotapes at this level of agreement (with a "true" rate of high likelihood cases the same as in the reported study) would disagree on 24 cases. Thus more work seems to be needed on standardising the assessment of children suspected of being sexually abused.

RICHARD HARRINGTON

University Department of Psychiatry,
Queen Elizabeth Psychiatric Hospital,
Birmingham B15 2QZ

- 1 Wiseman MR, Vizard E, Bentovim A, Leventhal J. Reliability of videotaped interviews with children suspected of being sexually abused. *BMJ* 1992;304:1089-91. (25 April.)

Being a house officer

SIR,—Most of us prefer to forget about our house jobs as soon as we reach the relative sanctuary of a senior house officer post. We each spent our preregistration year working in different institutions in different parts of Britain, yet we found that John Lear's comments described accurately the misery and frustration of our own experiences as junior house officers¹; we would be surprised if many other readers did not have the same response. The comments of Lear's consultants, with their implication that he was out of the ordinary in having problems, show their perception that the fault lies with the people rather than with the system within which they work. Junior doctors are still not listened to when they are honest and brave enough to express their feelings of inadequacy.

If we are not to train another generation of doctors who become disillusioned so quickly with their first experience of work, two changes are necessary: firstly, medical undergraduate training must prepare new doctors for the job they have to do when they qualify instead of trying to produce brilliant diagnosticians; and, secondly, senior doctors need to take their juniors' complaints seriously and lobby on their behalf for more humane conditions of work.

JEREMY GRIMSHAW

Department of General Practice,
University of Aberdeen,
Medical School,
Aberdeen AB9 2ZD

BRENDA WILSON
DANNY RUTA

Department of Public Health,
University of Aberdeen

- 1 Lear J. The beginning of the end. *BMJ* 1992;304:1122. (25 April.)

SIR,—I am intrigued that at the end of John Lear's personal view the *BMJ* decided to publish a response from his consultants.¹ The response seems to cast doubt on the veracity of Lear's eloquent description of the difficulties he faced as a house officer. The suggestion that he has been economical with the truth tends to diminish the impact of the message he is conveying. In the short response from the anonymous consultants I am reminded obliquely of the importance of a referee and a referee. Unfortunately, this may have the effect of discouraging other disaffected preregistration house officers from speaking out.

I think it should concern all in the medical profession that the consultants wrote, "The patients were as well 'protected' during this time as we could devise." The crucial issue must be the protection of house officers. Recognition that the preregistration year is, and must remain, primarily a training experience would ensure that house officers no longer had to "survive" a traumatic first year in their chosen career. Awareness has been raised; change has surely got to occur.

O JUNAID

Department of Health Care of the Elderly,
University Hospital,
Queen's Medical Centre,
Nottingham NG7 2UH

- 1 Lear J. The beginning of the end. *BMJ* 1992;304:1122. (25 April.)

SIR,—John Lear speaks for many in his personal view on being a house officer.¹ The open acknowledgment of the difficulties of this challenging year allows for change.

Stress in students and junior doctors may affect their physical, psychological, and social health as well as impair their performance as doctors.^{2,3} We are looking at the experience of house officers with a view to preparing students for this extraordinary year. Key topics that we have identified as being appropriate for training are clinical skills,⁴ personal support,⁵ and management skills at both the personal and the professional level.⁶

This summer we plan to run the first of a series of workshops for our clinical students, entitled "Being a doctor: are you ready?" We would be interested to hear from other groups running similar or alternative projects.

C VAUGHAN
S PEZESHGI

Department of General Practice and Primary Care,
King's College School of Medicine and Dentistry,
London SE5 9PJ

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Maternity services

SIR,—Correspondents are critical of the report of the Commons select committee aiming at empowering women to have more choice and control over the place and style of birth.¹ Indeed, it would be surprising if the medical profession did not oppose recommendations to "demedicalise" a service that doctors have tried to monopolise for generations. But the select committee's findings reflect accurately both the needs of women and the views of enlightened health professionals.

Paul Sackin misses the point in claiming that the report is unrealistic in its expectation that all general practices can offer a home birth service.¹ Though it is true that many general practitioners do not wish to provide intrapartum care themselves, they can and should offer every woman a genuine choice (which includes home birth for women considered to be at low risk), referring her to colleagues if necessary.

Adam Balen and John McGarry are shroud waving.¹ A growing body of evidence shows that care by a general practitioner and community midwife is no less safe than consultant care for women already selected to be at low risk,² and there is no evidence to support the claim that the safest policy is for all women to give birth in hospital.³