Content validity of video recorded consultations needs to be proved

EDITOR,—Douglas Carnall voices his doubts about the introduction of summative assessment for registrars in general practice.¹ We are concerned about the use of video recordings of consultations with patients in one component of the assessment. Although one team of researchers has shown the reliability of its method of video recorded assessment (that is, that repeating the exercise produces consistent results),² no one has shown that assessment with video recording has content validity.³ To show content validity, assessors would need to show that consultations video recorded for assessment purposes were not vastly different from others. Unfortunately, our experience of using video recorded consultations for research purposes suggests that this is unlikely to be so.

In two separate research projects, patients' consent to video recording was sought in accordance with recent guidelines.⁴ We independently investigated the factors associated with patients withholding consent to recording. In both analyses the demographic characteristics of patients who agreed to recording seemed to be significantly different from those of patients who withheld consent. Additionally, one study has shown significant differences in the clinical problems presented in each of these two groups.⁵

We cannot present our detailed conclusions here because we are preparing papers for publication. We believe, however, that the assessors of registrars in general practice will need to give our findings close scrutiny. The onus is likely to fall on them to prove that the differences we have highlighted are not present when patients' consent to video recording is sought for assessment purposes.

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Childbirth practice should take women's wishes into account

EDITOR,—I was interested to read Kathryn M Grady's and Charles Essex's letters about my personal view of the experience of becoming a grandmother.¹ Unfortunately, the *BMJ's* convention for personal views is that scientific references are not included. I had included some references in the original version of my article, including one to the evidence assembled and analysed by the international Cochrane Collaboration. These data suggest that the presence of a supportive birth companion is probably the most effective form of care in childbirth introduced in the past 25 years. The continuous presence of a trained support person

reduces the length of labour, the use of drug treatment for pain relief, and the incidence of operative vaginal delivery and of low Apgar scores and decreases the likelihood of women giving a negative rating to the experience of childbirth.² Midwife managed care has been shown to be an efficacious choice for low risk women.³ My original article also referenced the non-health promoting effects of procedures such as shaving⁴ and enemas.⁵ The evidence from prospective randomised studies is less likely to be biased than that from the retrospective studies drawn on by Essex.

As a professor of social science, I am concerned that the treatment of women during childbirth (including my daughter in law) should be informed more by science than by the individual choices of care givers and that the evidence about women's own preferences (which are sometimes, as in my daughter in law's case, for non-epidural analgesia and a spontaneous delivery) should be respected by those who make decisions about care.

I would not query the "validity" of Essex's practice as a doctor because he holds a personal view in favour of doctors taking decisions likely to protect them against the charge of medical negligence. Similarly, I do not think he should criticise the validity of my research as a sociologist because as a grandmother I wanted my daughter in law to have the kind of birth she wanted to have, or because as a sociologist I am concerned that childbirth practice should be based on scientific evidence about effective and appropriate care, including the evidence about women's own wishes.

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- 2 Hodnett ED. Continuity of caregivers during pregnancy and childbirth. In: Enkin MW, Keirse MJNC, Renfrew MJ, Neilson JP, eds. *Pregnancy and childbirth module. Cochrane database of systematic reviews* [updated 6 September 1996]. Available in *The Cochrane library* [database on disk and CDROM]. Oxford: Update Software, 1996.
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BMJ's audit should show actions planned to improve quality

EDITOR,—One audits something to assess quality and then acts to improve and assure that quality. The *BMJ's* audit shows that it fails to achieve its declared aims for papers submitted for publication and fails to show that it is acting to improve its performance.² Authors might have more confidence that the *BMJ* is committed to its aims if the audits included information on complaints from authors and the actions planned to improve quality.

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- 1 *BMJ* audit: time to decisions by publication. *BMJ* 1996;313:550. (31 August.)
- 2 Berwick D. A primer on leading the improvement of systems. *BMJ* 1996;312:619-22.

*Terry Kemple is right that we have not met completely the targets we set ourselves for making decisions on papers and publishing those we accept, although we do meet them about three quarters of the time. We deliberately set ourselves a target that we couldn't achieve all the

time. To have such a target would be pointless. I am confident that our performance will have improved in the next set of figures—not least because we have taken several steps to try to improve our performance. These consist mostly of a series of small steps, as advocated by Don Berwick in the paper that Kemple cites. For instance, all papers are now marked with dates by which the first and second readers should have read them; we have moved the timing of our editorial meeting to minimise the time that papers must wait before being considered there and have conducted an audit trail of papers passing through our system; and I now reject immediately, without a second reader, papers that I know will never ever be suitable for publication in the *BMJ*.

Table 1—Complaints and compliments received by *BMJ*, April 1993 to October 1996

Date	Complaints	Compliments
Apr-Jul 1993	30	Not collected
Aug-Oct 1993	37	14
Nov 1993-Jan 1994	47	46
Feb-Apr 1994	38	27
May-Jul 1994	25	24
Aug-Oct 1994	18	10
Nov 1994-Jan 1995	32	41
Feb-Apr 1995	31	22
May-Jul 1995	24	22
Aug-Oct 1995	39	24
Nov 1995-Jan 1996	61	95
	(2 on papers, 20 on obituaries)	(31 about <i>BMJ</i> on the Internet)
Feb-Apr 1996	48	62
May-Jul 1996	43	54
Aug-Oct 1996	33	41

Kemple will also be pleased to know that we have for several years been collecting all complaints we receive in the editorial office. We review these every quarter, and I respond to most of them personally. Table 1 shows the number of complaints for each quarter for the past three years, together with the number of compliments we received. Kemple should rest assured that we pay much more attention to the complaints than the compliments. We collect data on the cause of complaints and the source of compliments. From November 1995 until January 1996—our peak for both complaints and compliments—a third of complaints were about obituaries (down to 12% in the latest quarter) and a third of compliments were on our website.—RICHARD SMITH

Nucleus, not Student BMJ, was first international journal for medical students

EDITOR,—Richard Claxton lauds the *Student BMJ*, which started in spring 1992, as "the first international journal written specifically for medical students."¹ This is not so. That distinction goes to *Nucleus*, the international student journal of the Christian Medical Fellowship, which celebrated its 25th birthday in October. Produced quarterly by students for students, this publication has a circulation of 3300 in over 30 countries worldwide. Its growing readership includes 750 students in Britain, while 600 copies go to South Africa, 200 to Canada, and 180 to Nigeria alone.

RUTH SELWOOD
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- 1 Claxton R. The *Student BMJ*. *BMJ* 1996;313:766. (28 September.)