the results, and such conflicts should be made explicit.—EDITOR

1 Spece RG, Shimm DS, Buchanan AE, eds. *Conflicts of interest in clinical practice and research*. Oxford: Oxford University Press, 1996.

Summative assessment in general practice

Scheme is essential to protect public and train doctors to required standard

EDITOR,—We were pleased to see the subheading “Much to learn from new scheme” in Douglas Carnall’s editorial on summative assessment in general practice.¹ However, several of Carnall’s statements require correction and others require challenge. Firstly, the practical work on which registrars will have to submit a written report must be an audit, and the method developed by our team has now been shown to be valid and reliable.^{2,3} The scheme has been running in the west of Scotland for four years now, and only in the first year was it a pilot system; it has been operational since August 1993. Carnall reports opposition to the system and concern about validation and communication about the system but does not quote our rebuttal of this.⁴

The editorial questions whether summative assessment will enhance education in general practice. Summative assessment is not about education: it is regulatory, assesses the competence of doctors for independent practice, and protects the public from doctors whose performance is inadequate. This process has an effect on education, and we have found that formative assessment is being used much more rigorously in our region.

The editorial suggests that summative assessment should be optional. We tried this in our pilot year, with trainers being able to stop the assessment process for any registrar whose performance was identified as being of concern. Seventeen such registrars were identified, and 16 of the 17 trainers exercised this power. Subsequent review by our panel of assessors showed concern over the competence of four of the doctors. Our finding that 5% of registrars do not reach minimal competence¹ means that the scheme must be compulsory, because as a profession we must protect the public and train doctors to the required standard.

The introduction of summative assessment has been long and hard; it is universally favoured by the medical profession, but a number of them have nevertheless obstructed the process. An editorial in the *Lancet* about the proposed academy of medicine could also apply to summative assessment: “One sure sign of an inspired idea is the resentment that it elicits from those who should know better.”⁵

A considerable body of information about summative assessment is now in the public domain. No test has yet been devised that predicts future performance, but we believe that we have made some contribution to the process and that the scheme will benefit patients’ care.

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1 Carnall D. Summative assessment in general practice. *BMJ* 1996;313:638-9. (14 September.)

2 Lough JRM, McKay J, Murray TS. Audit and summative assessment: a criterion-referenced marking schedule. *Br J Gen Pract* 1995;45:607-9.

3 Lough JRM, McKay J, Murray TS. Audit and summative assessment, system development and testing. *Med Educ* (in press).

4 Murray TS. Summative assessment for general practice registrars. *BMJ* 1995;311:1299-300.

5 Horton R. The academy stumbles, then advances under fire. *Lancet* 1996;348:700.

Scheme has to be compulsory for proper evaluation

EDITOR,—Douglas Carnall is correct in pointing out the lack of evidence to show that there has been any improvement in patients’ care as a result of summative assessment in general practice.¹ This is hardly surprising, given the longstanding difficulties in deciding on reliable measures of practice performance and the achievement of Professor T Murray and his educational team in the west of Scotland in presenting a practical, validated assessment tool in so short a period.

Carnall’s demand that participation in summative assessment should be optional until there is “decent evidence” of improvement in patients’ care cannot, however, be justified and, indeed, would be self defeating. The corollary of Carnall’s admission that higher performing candidates are more likely to enter the examination for membership of the Royal College of General Practitioners is that poorer performers would be less likely to submit themselves to optional summative assessment. If the scheme were optional and less satisfactory registrars did not participate then the possible effects of assessment on their patients’ care would remain unknown.

Having raised doubts about summative assessment as a result of this absence of evidence, Carnall then spoils his argument by making two unsubstantiated assertions of his own—namely, that “trying to cut off the tail at the other end of this performance distribution is a futile exercise” and that “general practice educators would do better to concentrate their efforts in shifting the entire distribution of performance upwards.” Apart from the General Medical Council’s procedures, there has been no formal attempt to identify poorly performing practitioners in the United Kingdom and to improve their performance, and so there is no evidence for the futility or otherwise of such an exercise. Furthermore, even if it is accepted theoretically that clinical performance and patients’ care can be shown to have a normal distribution there is again no evidence to show that education results in universal improvement: the curve might merely be flattened, with a greater spread of performance, leaving the tail unchanged.

Of course summative assessment must itself be assessed. This will involve addressing the need for robust outcome measures, including clinical performance. The most discriminant aspects of the assessment process should be identified and enhanced; this should allow for the complexities and costs to be reduced in due course. For this to happen, all potential principals will have to participate.

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1 Carnall D. Summative assessment in general practice. *BMJ* 1996;313:638-9. (14 September.)

Procedure is too complex and intrusive

EDITOR,—Douglas Carnall’s courageous editorial on summative assessment in general practice should be taken seriously by the educational and regulatory establishment. I share Pereira Gray’s concern at the poor performance of a small minority of doctors after “satisfactory” completion of their training,² but I question whether this poor performance will necessarily come to light in the summative assessment now being implemented. The assessment tests are

measures of what a candidate can do (competence) rather than of what he or she does do (performance). Unfortunately, there is no evidence, either, that the new style trainer’s report will be completed any more objectively than the previous one, especially if there is no guarantee that a registrar who fails the assessment will obtain good counselling and the necessary further training.

I could perhaps accept the new scheme as a starting point were it not for my worries about the side effects. I have just received the latest bulletin on summative assessment from my region. The clear language cannot hide the overwhelming complexity and the intrusiveness of the whole procedure. Each component has a different closing date and a different application procedure. Just understanding the procedures and making the necessary applications is going to take up an appreciable portion of the precious year in general practice. More worrying still are some of the hidden agendas implied by these procedures:

- vast areas of the work of general practice are less important because they are difficult to measure
- recruitment into general practice needs to be made more difficult
- education ends with summative assessment
- the core of training in general practice is not assessed by summative assessment because most registrars could pass the current procedures before they start training
- a substantial portion of the education budget should be spent on testing.

I cannot believe that those responsible for instigating summative assessment had these agendas in mind. I believe that all that was necessary was to give the trainer’s report more teeth, though not necessarily more objectivity. I hope that the registrars will persuade the establishment to think again.

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1 Carnall D. Summative assessment in general practice. *BMJ* 1996;313:638-9. (14 September.)

2 Pereira Gray D. Assessment at last. *Br J Gen Pract* 1993; 43:402-3.

More registrars are being trained in consultation skills now

EDITOR,—Douglas Carnall attacks the new arrangements for summative assessment as being “potentially educationally deleterious.”¹ Some years ago, as a young course organiser, I made a similar attack on the fact that trainees were able to take the examination for membership of the Royal College of Practitioners at the end of vocational training.² My proposed solution was a more clinically based assessment at the end of vocational training, which would encourage the learners to focus more on essential skills in general practice, such as consultation skills.

Experience from the west of Scotland already indicates that far more registrars are having regular training in consultation skills as a result of summative assessment. The argument for ensuring adequate clinical performance before registrars go on to unsupervised practice is undeniable. As yet the tests are unproved, but at least they are focusing the learners in the right direction.

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1 Carnall D. Summative assessment in general practice. *BMJ* 1996;313:638-9. (14 September.)

2 Roberts G. The timing and purpose of the MRCGP. *J R Coll Gen Pract* 1989;39:30-1.